AGENDA

Part 1: Introductions and Apologies

1.1 Declarations of Interest
   All

1.2 Minutes and action points from the last meeting held on 11 February 2014
   Attached
   All

1.3 Matters Arising
   All

Part 2: Updates

2.1 Feedback from committees:
   - Healthy Liverpool Programme Leads Board – 11 February 2014
   - Primary Care: 25th February 2014
   - Finance Procurement & Contracting: 27 February 2014
     Report no: GB 12-14
     Tom Jackson

   - Feedback from CCG Network – 5 March 2014
     Report no: GB 13-14
     Katherine Sheerin

2.3 Joint Commissioning Group 6 February & 25 February 2014
   Report no: GB 14-14
   Simon Bowers

2.4 Chief Officer’s Update
   Verbal
   Katherine Sheerin

2.5 NHS England Area Team
   Verbal
   Clare Duggan

2.6 Public Health Update
   Verbal
2.7 Feedback from Health & Wellbeing Board

Part 3: Strategy & Commissioning

3.1 Partnership Agreement for Liverpool

3.2 All Equal All Different

Part 4: Governance

4.1 CCG responsibilities regarding Serious Case Reviews, Domestic Homicide Reviews and Mental Health Homicide Reviews

4.2 Liverpool Women’s Hospital Report

Part 5: Performance

5.1 CCG Performance Report

5.2 Corporate Risk Register

6. Questions from the Public

7. Date and time of next meeting:

Tuesday 26 March 2014 at 1pm, to be held in the Boardroom at Arthouse Square

For Noting:

- Minutes of Primary Care Committee - 28 January 2014
- Finance Procurement & Contracting Committee 28 January 2014
- Healthy Liverpool Programme Leads Board – 14 January 2014

Exclusion of Press and Public: that in view of the confidential nature of the business to be transacted, members of the public, press and non voting members be excluded from the meeting at this point.
# Feedback from Committees

**Title of Report**
Feedback from Committees

**Lead Governor**
Dr Jude Mahadanaarachchi  
Dr Nadim Fazlani  
Dr Simon Bowers

**Senior Management Team Lead**
Tony Woods, Head of Strategy & Outcomes  
Cheryl Mould, Head of Primary Care Quality & Improvement  
Tom Jackson, Chief Finance Officer  
Ian Davies, Head of Operations & Corporate Performance  
Jane Lunt, Head of Quality/Chief Nurse

**Report Author(s)**
Tony Woods, Head of Strategy & Outcomes  
Cheryl Mould, Head of Primary Care Quality & Improvement  
Tom Jackson, Chief Finance Officer  
Ian Davies, Head of Operations & Corporate Performance  
Jane Lunt, Head of Quality/Chief Nurse

**Summary**
The purpose of this paper is to present the key issues discussed, risks identified and mitigating actions agreed at the following committees:

- Healthy Liverpool Programme Leads Board  
  14th January 2014  
- Primary Care: 25th February 2014  
- Finance Procurement & Contracting:  
  27th February & 4th March 2014

This will ensure that the Governing Body is fully engaged with the work of committees, and reflects sound governance and decision making arrangements for the CCG.

**Recommendation**
That Liverpool CCG Governing Body:
- Considers the report and recommendations from the committee
<table>
<thead>
<tr>
<th><strong>Impact on improving health outcomes, reducing inequality and promoting financial sustainability</strong></th>
<th>As per each Committee’s Terms of Reference</th>
</tr>
</thead>
</table>
| **Relevant Standards or targets** | Standards of Good Governance  
NHS Operating Framework 2012/13 |
Healthy Liverpool Programme Leads Board
11 February 2014
(Immediately following the Governing Body meeting
Approx 4:30pm – 6:30pm)
3RD floor Collaboration Zone, Arthouse Square

AGENDA

1. Welcome and Introductions

2. Minutes from 14 January 2014 (page 2-9)

3. Actions (page 10 of 12)

4. HLP Update Report (page 12 -24)

5. Workstreams Update (from page 25 - 53)

6. Date of Next Meeting
Tuesday 11 March 2014
(approx. 4:30pm–6:30pm immediately following the Governing Body)
4th Floor Boardroom
Arthouse Square
### Committee: Healthy Liverpool Programme Leads Board (HLP-LB)  
### Meeting Date: 11 February 2014  
### Chair: Dr Nadim Fazlani  
### Programme Director: Tom Jackson

<table>
<thead>
<tr>
<th>Key issues:</th>
<th>Risks Identified:</th>
<th>Mitigating Actions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Clinical leads continue to develop their own programmes as part of Phase 2 of the development of the programme and in anticipation of the development of the CCG’s 5 year strategy.</td>
<td>The work of clinical programmes is not aligned with the CCG’s 5 year strategy.</td>
<td>Key CCG officers continue to work with clinical programmes to ensure alignment of outcomes ambitions and other aims.</td>
</tr>
</tbody>
</table>

### Recommendations to NHS Liverpool CCG Governing Body:

1. Note progress to date.
NHS LIVERPOOL CLINICAL COMMISSIONING GROUP
PRIMARY CARE COMMITTEE
TUESDAY 25TH FEBRUARY 2014 AT 1PM – 3PM
BOARDROOM – ARTHOUSE SQUARE

A G E N D A

Part 1: Introductions and Apologies

1.1 Declarations of Interest  

1.2 Minutes and action points from the last meeting held on 28th January 2014  

1.3 Matters Arising:  

1.3.1 Lung Cancer Pathway  

1.3.2 Primary Care Quality Framework Year 2 Options  

1.3.3 Cervical Screening Coding  

Part 2: Updates

2.1 Feedback from Workstreams February 2014  

a) Localities  

b) Medicines Management Sub-Committee  

c) Innovations  

d) Transformed Neighbourhood Services  

Report no: MA 1.3.3

Report no: PCC 05-14

PCC 05a-14  
North, Central & Matchworks  

PCC 05b-14  
Peter Johnstone  

Verbal  
Ed Gaynor  

PCC 05d-14  
Jude Mahadanaarachchi/ Paula Finnerty
2.2  Update from NHS England  Verbal – Tom Knight/Rose Gorman

Part 3:  Service Development/Implementation

3.1  A New Model for Delivery of Primary Care to Liverpool Care Home Residents aged over 65  PCC 06-14  Jacqui Campbell/Chris Peterson

3.2  Health at Work Commissioning  PCC 07-14  Cheryl Mould

3.3  Outline model of Medicines Management Services – 2014 onwards  PCC 08-14  Peter Johnstone

Part 4: Quality & Performance

4.1  Update on Neighbourhood Innovations Bids  PCC 09-14  Jacqui Waterhouse

4.2  Primary Care IM&T Update  PCC 10-14  Steve Appleton

5.  Any Other Business  ALL

6.  Date and time of next meeting  25th March 2014, 1pm to 3pm, Boardroom, Arthouse Square
### Key issues:

<table>
<thead>
<tr>
<th></th>
<th>Risks Identified:</th>
<th>Mitigating Actions:</th>
</tr>
</thead>
</table>
| 1. Update on Cervical Screening | - Use of QoF data not addressing issue.  
- Lack of training, education from Public Health England  
- Liverpool Central 2nd highest across Core Cities for exception reporting. | - Respond to Public Health England and request support for training  
- Understand “opt out” figures.  
- Neighbourhood intelligence to support uptake – Insight, screening rates.  
- Localities to formulate improvement plan |
| 2. Medicines Management Services | - Allocation to small practices  
- Medicines co-ordinator role  
- Change in allocation could disengage larger practices  
- Funding for role and sustainability  
- Management of post holder (mixed economy)  
- Resulting in sub-optimal prescribing and use of resources | - Clear model to be prepared for proposal to Medicines Management Sub-Committee and Primary Care Committee for agreement.  
- Proposal to Finance, Procurement & Contracting Committee  
- Clear outcomes to demonstrate benefits and impact.  
- Model to be included in Neighbourhood Working Group. |

### Recommendations to NHS Liverpool CCG Governing Body:

1. To note the issues and actions
AGENDA

1. Welcome and Introductions
   All

2. Declaration of Interests (form attached)
   All

3. Minutes and action notes of previous meeting held on 28 January 2014
   Chair

AGENDA ITEMS

4. Specialised Commissioning (Standing Item)  Verbal
   Tom Jackson

5. Improving Access to Psychological Therapies (IAPT) Report no: FPCC07-14
   Derek Rothwell

6. Anti-Coagulation Tender
   Report no:FPCC08-14
   Derek Rothwell

7. Contract Planning Tracker Update
   Report no:FPCC09-14
   Derek Rothwell

8. Contract Performance Month 10
   Report no:FPCC10-14
   Derek Rothwell

9. Finance/Performance Month 10
   Report no:FPCC11-14
   Alison Ormrod

10. Financial Planning Update
    • Allocations and Planning Requirements
        Report no:FPCC12-14
        Phil Saha

11. Commissioning Request Services (CRS)  Verbal
    Derek Rothwell
Alison Ormrod

13. Legacy Balances  Report no:FPCC14-14
Alison Ormrod

Derek Rothwell

15. Any Other Business  All

16. Date of the next meeting(s)

PLEASE NOTE: PAPERS NOT ON THE AGENDA WILL NOT BE TABLED/DISCUSSED

Dates of 2014 of meetings

<table>
<thead>
<tr>
<th>DATES FOR FINAL PAPERS AND AGENDA ITEMS (7 WORKING DAYS)</th>
<th>DATE PAPERS SENT OUT TO THE COMMITTEE MEMBERS (5 WORKING DAYS)</th>
<th>DATE OF MEETINGS (10am – 12 noon unless otherwise stated)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FRIDAY 14TH MARCH 2014</td>
<td>TUESDAY 18TH MARCH 2014</td>
<td>Tuesday 25 March 2014</td>
</tr>
<tr>
<td>FRIDAY 16TH MAY 2014</td>
<td>TUESDAY 20TH MAY 2014</td>
<td>Tuesday 27 May 2014</td>
</tr>
<tr>
<td>FRIDAY 18TH JULY 2014</td>
<td>TUESDAY 22 JULY 2014</td>
<td>Tuesday 29 July 2014</td>
</tr>
<tr>
<td>FRIDAY 12TH SEPTEMBER 2014</td>
<td>TUESDAY 16TH SEPTEMBER 2014</td>
<td>Tuesday 23 September 2014</td>
</tr>
<tr>
<td>FRIDAY 14TH NOVEMBER 2014</td>
<td>TUESDAY 18TH NOVEMBER 2014</td>
<td>Tuesday 25 November 2014</td>
</tr>
<tr>
<td>FRIDAY 16TH JANUARY 2015</td>
<td>TUESDAY 20TH JANUARY 2015</td>
<td>Tuesday 27 January 2015</td>
</tr>
<tr>
<td>FRIDAY 13TH MARCH 2015</td>
<td>TUESDAY 17TH MARCH 2015</td>
<td>Tuesday 24 March 2015</td>
</tr>
</tbody>
</table>
Key issues: | Risks Identified: | Mitigating Actions: |
--- | --- | --- |
1. It was agreed to initiate procurement for the ‘Improving Access to Psychological Therapies (IAPT)’ as planned, the IAPT procurement will commence in March 2014 and be completed by end 2014. | • LCCG Services are put at risk if planned procurement does not commence in March 2014. | • A detailed procurement plan and proven process will be followed. |
2. Ensuring all LCCG providers sign off all 2014/15 NHS contracts by March 2014. | • Contracts are not agreed and services are put at risk if contract not signed. | • The CCG has made offers to all providers in Feb 2014, Contracts, Finance, Business Intelligence and Quality teams have followed standard contracting formats to ensure offers were submitted. Negotiations are on-going, however, given the financial position of some providers, sign off by 1st April 2014 may not be achieved. |
3. The Committee received a paper on the CCGs financial allocations and headline financial planning assumptions | • Financial resources are insufficient to secure services and future reconfiguration | • Detailed plans will be discussed at the March Governing Body Committee and (if appropriate), approved at the March Governing Body |

Recommendations to NHS Liverpool CCG Governing Body:

1. To note the above key issues
NHS LIVERPOOL CLINICAL COMMISSIONING GROUP
GOVERNING BODY

TUESDAY 11 MARCH 2014

<table>
<thead>
<tr>
<th>Title of Report</th>
<th>Feedback from Merseyside Clinical Commissioning Groups Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead Governor</td>
<td>Dr Nadim Fazlani, Chair</td>
</tr>
<tr>
<td></td>
<td>Dr Fiona Lemmens</td>
</tr>
<tr>
<td>Senior Management Team Lead</td>
<td>Katherine Sheerin, Chief Officer</td>
</tr>
<tr>
<td>Report Author</td>
<td>Katherine Sheerin, Chief Officer</td>
</tr>
</tbody>
</table>

**Summary**

The purpose of this paper is to present the key issues discussed, risks identified and mitigating actions agreed at the Merseyside CCG Network on 5th March 2014.

This will ensure that the Governing Body is fully engaged with the work of the Merseyside CCG Network and reflects sound governance and decision making arrangements for the CCG.

That Liverpool CCG Governing Body:

- Considers the reports and recommendations from Merseyside CCG Network

**Impact on improving health outcomes, reducing inequalities and promoting financial sustainability**

By working collaboratively with CCGs across Merseyside we will ensure that opportunities are maximised for Liverpool patients and the consequence of commissioning services understood and managed.

**Relevant Standards or targets**

Standards of Good Governance
NHS Operating Framework 2012/13
# Merseyside CCG Network

Wednesday, 5 March 2014, 13.00 to 16.00 (lunch available from 12.30)
Meeting, Boardroom, Third Floor, Merton House, Bootle L20 3DL

## Agenda

<table>
<thead>
<tr>
<th>No</th>
<th>Item</th>
<th>Report/Info</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>14/24</td>
<td>Welcome &amp; Introductions</td>
<td></td>
<td>Dr Niall Leonard</td>
</tr>
<tr>
<td>13.00 – 14.30 Guests</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14/25</td>
<td>Strategic Planning</td>
<td></td>
<td>NHS(E)</td>
</tr>
<tr>
<td>14/26</td>
<td>Trauma &amp; Critical Care Operational Delivery Network</td>
<td></td>
<td>Jane Keenan (LCCG) with Sarah Clark and Gary Masterson Cheshire &amp; Mersey Critical Care Network</td>
</tr>
<tr>
<td>14.30 – 16.00 Formal Meeting</td>
<td></td>
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<td></td>
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<tr>
<td>14/27</td>
<td>Apologies for absence</td>
<td></td>
<td>Dr Niall Leonard</td>
</tr>
<tr>
<td></td>
<td>- Dr Cliff Richards</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14/28</td>
<td>Minutes from the previous meeting</td>
<td>✅</td>
<td>All</td>
</tr>
<tr>
<td>14/29</td>
<td>Actions from the previous meeting</td>
<td>✅</td>
<td>All</td>
</tr>
<tr>
<td>14/30</td>
<td>EPRR</td>
<td></td>
<td>Roger Booth</td>
</tr>
<tr>
<td>14/31</td>
<td>General Practice Workforce - Update</td>
<td></td>
<td>All</td>
</tr>
<tr>
<td>14/32</td>
<td>Ensuring Continuity of Health Services: Designating Commissioner Requested Services and Location Specific Services</td>
<td></td>
<td>Derek Rothwell (LCCG) Carole Hodgkinson (CMCSU)</td>
</tr>
<tr>
<td>14/33</td>
<td>Liverpool Women’s Hospital NHS Foundation Trust</td>
<td></td>
<td>Katherine Sheerin</td>
</tr>
<tr>
<td>14/34</td>
<td>CSU Data Capture Support Offer</td>
<td>✅</td>
<td>Fiona Clark</td>
</tr>
<tr>
<td>14/35</td>
<td>Any Other Business</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14/36</td>
<td>Date of Next Meeting</td>
<td></td>
<td>Wednesday, 2 April 2014, Boardroom, Regatta</td>
</tr>
</tbody>
</table>
## Key issues:

<table>
<thead>
<tr>
<th></th>
<th>Risks Identified:</th>
<th>Mitigating Actions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Trauma and Critical Care Operational Delivery Network</td>
<td>• That the expertise of the network is not effectively supporting commissioning strategies.</td>
<td>• Formal involvement of CCG Clinical and Managerial Leads in the Network (Dr Fiona Lemmens and Ian Davies)</td>
</tr>
<tr>
<td>2. Designating Commissioner Requested Services</td>
<td>• That the process for designating commissioner requested services does not align with CCG Strategic Plans</td>
<td>• Formal connection between HLP and this process to be established.</td>
</tr>
</tbody>
</table>

## Recommendations to NHS Liverpool CCG Governing Body:

1. That the CCG Governing Body notes the issues, risks and mitigating actions.
<table>
<thead>
<tr>
<th><strong>Title of Report</strong></th>
<th>Feedback from the Joint Commissioning Group of the Health &amp; Wellbeing Board/Liverpool CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lead Governor</strong></td>
<td>Dr Simon Bowers</td>
</tr>
<tr>
<td><strong>Senior Management Team Lead</strong></td>
<td>Tony Woods, Head of Strategy and Outcomes</td>
</tr>
<tr>
<td><strong>Report Author</strong></td>
<td>Tony Woods, Head of Strategy and Outcomes</td>
</tr>
<tr>
<td><strong>Summary</strong></td>
<td>The purpose of this paper is to present the key issues discussed, risks identified and mitigating actions agreed at the Joint Commissioning Group on 6th February 2014 &amp; 25th February 2014. This will ensure that the Governing Body is fully engaged with the work of the Joint Commissioning Group and reflects sound governance and decision making arrangements for the CCG.</td>
</tr>
</tbody>
</table>
| **Recommendation**  | That Liverpool CCG Governing Body:  
|                      | ➢ Considers the reports and recommendations from Joint Commissioning Group |
| **Impact on improving health outcomes, reducing inequalities and promoting financial sustainability** | • Reduction of health inequalities in the city  
|                      | • Improve the physical and mental health and well-being of the population of residents in Liverpool |
| **Relevant Standards or targets** | Preventing people from dying prematurely  
|                      | Helping people to recover from episodes of ill-health or following injury  
|                      | Ensuring that people have a positive experience of care |
JOINT COMMISSIONING GROUP (INTERIM) OF THE HEALTH AND WELLBEING BOARD
Thursday, 6 February 2014

9.30 A.M.

AGENDA

1. Welcome / Apologies
For the Chair to –
   i) Welcome all attendees to the meeting; and
   ii) Receive any notices of apologies for absence.

LAST MEETING - 16th DECEMBER 2013

2. Notes of the Last Meeting
To received and consider –
   i) The Notes of the Last Meeting of the Joint Commissioning Group, held on 16th December 2013; and
   ii) The summary report of the activities of the Joint Commissioning Group, as submitted to the Liverpool Health and Wellbeing Board meeting on 16th January 2014.

   (Pages 1 - 8)

3. Matters Arising
To provide an opportunity to raise any matters from the notes of the last meeting that are not covered elsewhere on the agenda.
DEVELOPMENT ACTIVITY

4. Better Care Fund
To receive and consider a report providing an update on the Better Care Fund submission.

Report to follow

5. Partnership Agreement and Partnership Schedules
To receive and consider an update report on proposals for the development of the Partnership Agreement and associated Schedules between Liverpool City Council and Liverpool Clinical Commissioning Group.

Report to follow

JOINT WORKING

6. Mental Health Transformation End of Life
To discuss the development of cohesive working arrangements between Liverpool CCG and LCC on ‘End of Life’.

HEALTH AND WELLBEING BOARD MEETING OF 13th MARCH 2014

7. Proposed Agenda Items
To agree a draft list of agenda items for the next meeting of the Liverpool Health and Wellbeing Board, to be held on 13th March 2014, being –

   i) Partnership Agreement between Liverpool Clinical Commissioning Group and Liverpool City Council;
   ii) Partnership Agreement between Liverpool Community Health and Liverpool City Council;
   iii) Better Care Fund;
   iv) Report of the Better Lifestyles Programme, (to include smoking and alcohol);
8. Other Relevant Items
To consider any relevant items not covered elsewhere on the agenda.

9. Date and Time of the Next Meeting
To note the date and time of the next meeting of the Joint Commissioning Group, as –

Tuesday 25th February 2014 at 3pm in the Huskisson Room, Millennium House, Victoria Street.

JOINT COMMISSIONING GROUP (INTERIM) OF THE HEALTH AND WELLBEING BOARD
Tuesday, 25 February 2014
3.00 P.M.

SUPPLEMENTARY AGENDA

10. Memorandum of Agreements under Section 256 and 76 of the Health Act 2006
To receive and consider a report in relation to the use of additional S256 funding to be transferred to Liverpool City Council (LCC) from Liverpool Clinical Commissioning Group (LCCG), prior to the report being submitted to the Liverpool Health and Wellbeing Board meeting to be held on 13th March 2014.

(Pages 1 - 11)

11. Joint Care Homes Project
To receive and consider a report in regard to the Joint Care Homes Project.

(Pages 12 - 31)

To receive verbal information on an evaluation of the Liverpool Health and Wellbeing Board undertaken by the University of Liverpool.
LIVERPOOL CCG CORPORATE GOVERNANCE TEMPLATE – COMMITTEE MINUTES

| Committee: Joint Commissioning Group | Meeting Date: 6th February 2014 | Chair: Samih Kalakeche Director Adult Services and Health Co-Chair: Katherine Sheerin, Accountable Officer Liverpool Clinical Commissioning Group |

**Key issues:**

<table>
<thead>
<tr>
<th></th>
<th><strong>Risks Identified:</strong></th>
<th><strong>Mitigating Actions:</strong></th>
</tr>
</thead>
</table>
| 1. Development of Better Care Fund (‘BCF’) Draft submission | • Failure to agree Better Care Fund between Health & Wellbeing Board and Clinical Commissioning Group  
• Agreement of performance metrics that lack deliverability. | • Continued work of Liverpool City Council and Liverpool Clinical Commissioning Group to establish credible plans. |
| 2. Update report on Partnership Agreement and schedules to provide the legal basis for integrated working and pooled budgets. | • Failure to agree between Liverpool City Council and Liverpool Clinical Commissioning Group. | • Continued work of Liverpool City Council and Liverpool Clinical Commissioning Group Officers and legal representation to agree final version.  
• Approval of Agreement and Schedules by Liverpool Clinical Commissioning Group Governing Body in March 2014. |
| 3. Agreement of collaborative working arrangements for Mental Health and End of Life Care | • Failure to establish clear approach engaging all relevant organisations. | • Clear governance arrangements to be established. |

**Recommendations to NHS Liverpool CCG Governing Body:**

1. To note the issues, risks and actions from the Joint Commissioning Group
1. Welcome and Introductions
For the Chair to welcome attendees to the meeting and lead introductions.

2. Declarations of Interest
To provide an opportunity for officers to declare any pecuniary or significant prejudicial interests they may have in any item on the agenda.

3. Note from the Last Meeting
For the Joint Commissioning Group to –

   i) receive the note of the last meeting, held on 6th February 2014; and
   ii) raise any matters arising on issues not covered elsewhere on the agenda.

   (Pages 1 - 6)

4. Better Care Fund: Programmes and Metrics
To receive and consider a report providing proposals on programmes and measures of performance for joint service improvement and transformation to inform the two and five year strategy and delivery of Better Care Fund.

   (Pages 7 - 54)

5. CCG 2 and 5 Year Strategies
For the Group to receive a verbal update on the Liverpool Clinical Commissioning Group two and five year strategies.

6. Other Relevant Items
To provide an opportunity to raise other relevant items, subject to the agreement of the Chair.
7. **Date and Time of the Next Meeting**

To note the date and time of the next meeting, as –

Tuesday 25th March at 3pm in the Herculaneum Room, Millennium House, Victoria Street.
<table>
<thead>
<tr>
<th>Key issues:</th>
<th>Risks Identified:</th>
<th>Mitigating Actions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Review of Better Care Fund development following feedback from NHS England on draft submission.</td>
<td>• Positive feedback on draft submission.</td>
<td>• Paper to be received by Health &amp; Wellbeing Board on progress of submission in March 2014.</td>
</tr>
<tr>
<td></td>
<td>• Failure to complete and agree final submission between Health &amp; Wellbeing Board and Liverpool Clinical Commissioning Group.</td>
<td>• Liverpool Clinical Commissioning Group Governing Body to receive final submission of Better Care Fund in March 2014.</td>
</tr>
<tr>
<td>2. To receive a report on the development of a Joint Care Homes Project.</td>
<td>• Lack of clear governance arrangements.</td>
<td>• Established governance arrangements within Health Ageing Workstream of Healthy Liverpool Programme.</td>
</tr>
</tbody>
</table>

**Recommendations to NHS Liverpool CCG Governing Body:**

1. To note the issues, risks and actions from the Joint Commissioning Group
### Title of Report
Partnership Agreement and Arrangements between Liverpool CCG and Liverpool City Council

### Lead Governor
Nadim Fazlani

### Senior Management Team Lead
Ian Davies, Head of Operations & Corporate Performance

### Report Author
Ian Davies, Head of Operations & Corporate Performance

### Summary
The purpose of this paper is to present to the Governing Body the formal ‘Section 75’ Partnership Agreement and Partnership Schedule for approval.

### Recommendation
That Liverpool CCG Governing Body:
- Approves the draft Partnership Agreement and
- Approves the draft Partnership Schedule

### Impact on improving health outcomes, reducing inequalities and promoting financial sustainability
The proposed partnership arrangements provide the necessary foundation and structure upon which the CCG and City Council can build pooled funding and joint commissioning arrangements for the benefit of local people.

### Relevant Standards or targets
Organisational and corporate governance requirements; development of CCG and local authority partnership arrangements.
PARTNERSHIP AGREEMENT AND ARRANGEMENTS BETWEEN LIVERPOOL CCG AND LIVERPOOL CITY COUNCIL

1.0 Introduction

The development of a new Partnership Agreement under Section 75 of the NHS Act 2006 between Liverpool City Council (LCC) and Liverpool Clinical Commissioning Group (CCG) has been in progress following the agreement of the Liverpool Health and Wellbeing Board at its meeting in June 2013.

The Agreement it is intended would be formally adopted and signed by LCC and CCG and commit the parties to working together to a common vision of health and well-being, providing the governance and accountability framework for pooled funding and joint commissioning arrangements going forward for the benefit of the city’s residents. This report presents to the CCG Governing Body for approval the overarching Partnership Agreement and underpinning outline template schedule.

The overarching Partnership Agreement sets out the terms of the partnership in detail, in essence it provides the framework and structure that would govern individual schemes/pooled funding arrangements that the two partners might agree to enter into. The Agreement does not mandate the creation of such arrangements, rather it directs the shape and format of any such schemes that the two partners and their respective accountable bodies decide to enter into. The Partnership Agreement will be supported by a number of Partnership Schedules that will detail the specific partnership arrangements in relation to individual commissioning intentions, schemes and pooled funds. Each proposal or scheme will require completion and agreement of an individual Partnership Schedule that provides the specific details of the scheme including aims, outcomes, finance and performance arrangements.
2.0 Partnership Agreement

A new Partnership Agreement has been taking shape over the last six months to provide the foundations and structure for future joint commissioning and funding arrangements between LCC and the CCG. The approach has been developed with officers and legal advisers from both partners working collaboratively to arrive at an agreement that meets both partners’ local needs within the terms of The NHS Act 2006 and subsequent Regulations and guidance. The agreement is attached to this report as Appendix A. A schedule of agreed joint performance indicators and an information sharing protocol will also be added to the final ‘agreed’ document.

The key areas of agreement are set out below and can be used as a reference point to the document and principles of the agreement.

<table>
<thead>
<tr>
<th>Area of the agreement</th>
<th>Proposed content and approach.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 1 and 2 Definitions and interpretations</td>
<td>Legal definitions and interpretations that apply in the document are described.</td>
</tr>
<tr>
<td>Section 3 Purpose of the agreement</td>
<td>Summary of the purpose and intentions of the Agreement and Partners.</td>
</tr>
<tr>
<td>Section 4 Duration of the agreement and partnership arrangements</td>
<td>It is proposed that the Partnership Agreement should be in place for a minimum of three years. However a formal review is built in on an annual basis, with oversight of the arrangements by the Health &amp; Wellbeing Board but final formal agreement is required by the individual partners. The agreement will remain in place for the duration of any partnership schedules.</td>
</tr>
<tr>
<td>Section 5 Aims and objectives of the partnership arrangements.</td>
<td>Description of the high level aims and objectives of the Partners in entering into this agreement</td>
</tr>
<tr>
<td>Section 6 Protocols</td>
<td>Requirement to develop protocols to</td>
</tr>
<tr>
<td>Area of the agreement</td>
<td>Proposed content and approach.</td>
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<tr>
<td>‘govern’ any proposed joint or otherwise staffing arrangements that might be required in the future.</td>
<td></td>
</tr>
<tr>
<td><strong>Section 7,11 and 12 Partnership arrangements covered by Partnership Schedules</strong></td>
<td>A Schedule will be completed for each of the agreed joint commissioning initiatives or schemes and which will form an individual partnership arrangement. Training will be arranged for managers and clinicians who might be identified as leads for a schemes(s). Currently within the current pooled funds and joint commissioning arrangements there are approximately 20 areas that would be covered by a Partnership Schedule(s) and which will require to be completed and agreed by the 31/03/14 if the schemes and investments are to continue into 2014/15.</td>
</tr>
<tr>
<td><strong>Section 8 Functions to be exercised by the Partners</strong></td>
<td>Outlines the legal functions and duties to be included or covered by this agreement.</td>
</tr>
<tr>
<td><strong>Section 9 Notification to the Department of Health</strong></td>
<td>Requirement upon the CCG as an NHS body to notify the Department of Health of the adoption of this Agreement and any associated partnership arrangements (Schedules)</td>
</tr>
<tr>
<td><strong>Section 10 General Principles</strong></td>
<td>A set of principles are included that set out the structure, intentions and boundaries for the relationship between the partners. These relate to the provision of such matters as information concerning the delivery of obligations of each partner e.g. termination of services contract, investigations of services provider, breaches identified by partners, complaints, challenge etc.</td>
</tr>
<tr>
<td>Area of the agreement</td>
<td>Proposed content and approach.</td>
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</tr>
<tr>
<td>Section 13 Employment indemnities</td>
<td>This provides for how any possible employment arrangements and liabilities would be addressed.</td>
</tr>
<tr>
<td>Sections 14, 15 and 16 Financial Contributions Establishment and Administration and Expenditure of Pooled Funds</td>
<td>The financial contributions included within the pooled fund(s) will relate to those services covered by the individual partnership schedule(s). Details will be agreed and financial liabilities and responsibilities made clear and documented from the outset.</td>
</tr>
<tr>
<td>Section 17 General provisions on overspends and underspends</td>
<td>It is proposed that principles relating to the management of overspends and underspends will be according to a simple formula agreed in the relevant partnership schedule. That formula should be appropriate for the particular partnership arrangement. For example, it may be appropriate to use the same percentage as the parties’ respective first year contributions to a pooled fund (or perhaps an average of, say, the previous 3 years).</td>
</tr>
<tr>
<td>Section 18, 19 and 20 Other financial arrangements</td>
<td>These provide for specific financial matters concerning possible Grant funding, capital and VAT/Tax arrangements.</td>
</tr>
<tr>
<td>Section 21 Audit and right of access</td>
<td>This details the Audit arrangements and access to each respective Partners records/information held in relation to this Agreement and the associated Schedules.</td>
</tr>
<tr>
<td>Section 22 Insurance arrangements</td>
<td>Details insurance arrangements in so far as they might apply.</td>
</tr>
<tr>
<td>Section 23 Indemnity and liability</td>
<td>This section addresses the liabilities of Partners under this Agreement, including limits on such liability.</td>
</tr>
<tr>
<td>Area of the agreement</td>
<td>Proposed content and approach.</td>
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<tr>
<td></td>
<td>The limits on liability of £1 do not apply in the following circumstances:</td>
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<td></td>
<td>- negligence of a Partner resulting in death or personal injury.</td>
</tr>
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<td></td>
<td>- a Partner acting beyond the agreed Level of Authority</td>
</tr>
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<td></td>
<td>- the liability relates to any payment of any specific liquidated sum</td>
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<tr>
<td></td>
<td>- any fraud or other serious misconduct where it was done with the actual or constructive knowledge of a Partner(s) senior management.</td>
</tr>
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<td></td>
<td>- where the liability cannot otherwise be limited or excluded by law.</td>
</tr>
<tr>
<td>Section 24 Reconciliation on termination</td>
<td>Here the Agreement outlines how any under or overspends would be resolved upon termination of the Agreement.</td>
</tr>
<tr>
<td>Section 25 Contracting</td>
<td>The host or lead for each Partnership Schedule / Arrangement will be agreed on an individual basis. The agreed host will procure services based on the organisation’s scheme of delegation and constitution. Non-financial authority will also be agreed on an individual basis and cover such areas as: exclusivity, subcontracting. The non-host partner will be part of the procurement process and agree the specific approach in relation to each of the services.</td>
</tr>
<tr>
<td>Section 26 Information sharing and</td>
<td>An overarching Information sharing agreement will be appended to the</td>
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<tr>
<td>Area of the agreement</td>
<td>Proposed content and approach.</td>
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</tr>
<tr>
<td>confidentiality</td>
<td>Partnership Agreement. Specific information sharing protocols will be developed as they relate to the individual services set out in the respective Partnership Schedule.</td>
</tr>
<tr>
<td>Section 27 The press</td>
<td>Details how media enquiries would be managed and dealt with.</td>
</tr>
<tr>
<td>Section 28 standards of conduct</td>
<td>Here the specific standards of behaviour and conduct expected of the Partners are described and outlined.</td>
</tr>
<tr>
<td>Section 29 Standards of service</td>
<td>General standards of service are described.</td>
</tr>
<tr>
<td>Section 30, 31, 32 and 33 Performance management and monitoring arrangements quarterly and annual review</td>
<td>The Joint Commissioning Group will receive performance reporting on an at least quarterly basis (monthly for the more significant schemes and investments) and which will feed into the formal annual review process of the agreement. Performance reporting requirements will be agreed on a scheme by scheme basis and take into account such matters as risk, level of investment and service delivery. Reports will also be provided to the Liverpool Health and Wellbeing Board and through into the respective organisational governance arrangements. Monitoring will be proportionate to the level of investment of the individual Partnership Arrangement.</td>
</tr>
<tr>
<td>Section 34, 35 and 36 Other corporate matters</td>
<td>Specific attention paid to managing conflicts of interest, substandard performance and complaints.</td>
</tr>
<tr>
<td>Area of the agreement</td>
<td>Proposed content and approach.</td>
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</tbody>
</table>
| **Section 37** Termination of the Agreement | The framework envisage three possible principle scenarios, all of which result in termination, and the same procedures once termination is effected:  
  - A party terminating for the other’s breach.  
  - A party terminating for convenience (i.e. where the other party is not in breach).  
  - Where the section 75 automatically comes to an end  
The parties will agree in advance, as far as they are able, a strategy and/or exit plans for each partnership arrangement, the details of which are to be outlined in the Partnership Schedule(s) |
<p>| <strong>Section 38</strong> Exit arrangements | Duty to co-operate in the event of termination. |
| <strong>Section 39</strong> Waivers | Specific duties and responsibilities of Partners. |
| <strong>Section 40, 41 and 42</strong> Other legal scenarios | Deals with legal scenarios concerning the scope of the Agreement, future changes in legislation and governing law. |
| <strong>Section 43</strong> Resolution of Dispute between Partners | In the event of a dispute between the Partners in connection with this Deed the Partners shall first refer the matter to the Accountable Officer of the CCG and the Chief Executive of the Council or their nominated deputies who shall endeavour to settle the dispute between themselves on behalf of the Partners as quickly as possible. |
| <strong>Section 44 and 45</strong> | Partners cannot assign the Agreement |</p>
<table>
<thead>
<tr>
<th>Area of the agreement</th>
<th>Proposed content and approach.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assignment, subcontractors and partnerships</td>
<td>or any obligations to any successor. The clause covers the area of subcontracting and ensures that there is transparency of decision-making and of advising each other of changes in arrangements.</td>
</tr>
<tr>
<td>Section 46, 47, 48 and 49. Matters of variation and changes.</td>
<td>Deal with specific legal matters including notices, contractual rights and variation.</td>
</tr>
</tbody>
</table>

### 3.0 Partnership Schedule

To support the Partnership Agreement a set of Partnership Schedules will be developed that will set out the individual or grouped partnership arrangements in respect of the separate joint initiatives and joint commissioning intentions. A template Partnership Schedule has been developed and a copy is attached as Appendix B to this report. The schedule(s) once completed sit beneath the overarching Partnership Agreement and govern the relationship, delivery and accountability of each scheme. A short explanatory note has also been developed to accompany the Partnership Schedule and a copy is attached as Appendix 3 to this report.

It is intended that all current joint funding transfer arrangements under S256 and S76 of the Health Act 2006 will be included within new individual Partnership Schedule(s) if they are to continue into 2014/15. A new scheme can be developed at any time during the lifetime of the Partnership Agreement with the agreement of the partners. It is further intended and indeed directed that the recently introduced Better Care Fund arrangements will sit beneath the Partnership Agreement and will require the completion of appropriate Schedule(s).
4.0 Recommendations.

The CCG Governing Body is asked to:

i) Approve the draft Partnership agreement with Liverpool City Council and

ii) Approve the draft Partnership Schedule.

Ian Davies
Head of Operations & Corporate Performance
4th March 2014.
APPENDICES:

1. Partnership Agreement
2. Partnership Schedule
3. Explanatory Note
Dated
Partnership Deed
Section 75 National Health Service Act 2006
Between
(1) Liverpool Clinical Commissioning Group
And
(2) Liverpool City Council
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SCHEDULE 1 - Health and Wellbeing Board
SCHEDULE 2 - Joint Commissioning Group
SCHEDULE 3 - Integrated Working Group Structure Chart
SCHEDULE 4 - Joint Performance/Indicators
SCHEDULE 5 - Information Sharing Protocol
MADE BETWEEN the following Partners:-

(1) LIVERPOOL CLINICAL COMMISSIONING GROUP of 1 Arthouse Square, Liverpool, L1 4AZ

(2) LIVERPOOL CITY COUNCIL of Municipal Buildings, Dale Street, Liverpool, L2 2DH

1 (A) DEFINITIONS

1.1 “the 2006 Act” means the National Health Service Act 2006.

1.2 “the 2012 Act” means the Health and Social Care Act 2012.

1.3 “Deed” means this agreement made pursuant to S.75 of the 2006 Act comprising the terms and conditions together with the schedules and appendices attached to this agreement.

1.4 “Capital Expenditure” means such sum which, according to the internal accounting rules and procedures of the respective Partner, would be considered capital expenditure requiring expenditure out of a capital budget.

1.5 “CCG” means the Liverpool Clinical Commissioning Group a statutory body authorised by NHS England.

1.6 “CCG’s Constitution” means the CCG’s constitution from time to time including (a) all rules and procedures set out therein or made in accordance therewith; (b) CCG’s Standing Orders; (c) CCG’s standing financial orders; (d) the CCG’s Scheme of Delegation and (e) such other corporate governance requirements as may be imposed upon the CCG from time to time.

1.7 “Clause” means a clause of this Deed.

1.8 “Client” means a person who satisfies the relevant Eligibility Criteria for one or more of the Services.
1.9  "Client Group" means a group of Clients for whom one or more of the Services will be commissioned and which will be set out in the relevant Partnership Schedule.

1.10 "Commencement Date" means 1st April 2014.

1.11 Complaints System" means the complaints procedure of each of the respective Partners which will be applied to the respective complaint subject to which of the Partners has the statutory responsibility for the respective functions.

1.12 "Council" means Liverpool City Council.

1.13 "Council's Constitution" means the Council's Constitution from time to time including

1.13.1 all its rules and procedures

1.13.2 the Council's Contract Standing Orders;

1.13.3 the Council's financial orders; and

1.13.4 such other governance requirements as may be imposed upon the Council from time to time.

1.14 "the CCG Director" means the Accountable Officer of the CCG or his/her delegate.

1.15 "the Directors" means the CCG Director and the Director of Adult Social Care and Health[or the equivalent from time to time, or his/her delegate].

1.16 "the Director of Adult Social Care and Health” means the Director of Adult Social Care and Health of the Council [or the equivalent from time to time, or his/her delegate].

1.17 "Eligibility Criteria" means the criteria agreed by the JCG and set out in the Partnership Schedule which must be satisfied for a Client to receive the Services.
1.18 “Financial Year” means each financial year commencing on 1st April and ending on the following 31st March.

1.19 “Functions” means the Health Related Functions and the NHS Functions.

1.20 “Health Related Functions” means such of the functions of the Council as are prescribed in regulation 6 of the Regulations (or other relevant law from time to time).

1.21 “Host Partner” means the Partner indicated in a relevant Partnership Schedule (or such replacement as the Partners agree from time to time).

1.22 “HWB” means the Health and Wellbeing Board established pursuant to the terms of the 2012 Act whose aims, objectives, terms of reference and constitution are more particularly set out in Schedule 1 of this Deed and which is intended to satisfy the terms of paragraph 10(2) of the Regulations only insofar as being a joint committee which has responsibility for monitoring the Partnership Arrangements and receiving reports and information on the operation of those arrangements.

1.23 “Information Sharing Protocol” means the protocol adopted and agreed by the Partners which provides a framework for the secure and confidential sharing of information between the Partners and their Staff as set out in Schedule 5.

1.24 “JCG” means the Joint Commissioning Group which has been established by the Partners to carry out the day to day executive decisions of the Partnership Arrangements whose aims, objectives, terms of reference and constitution are more particularly set out in Schedule 2 of this Deed.

1.25 “Joint Commissioning” means a joint process of commissioning the Services undertaken by both Partners as proposed by the JCG for the benefit of one or more Client
1.26 “JSNA” means the Joint Strategic Needs Assessment prepared by the HWB.

1.27 “Integrated Working Group Structure Chart” means the chart evidencing the working groups and associated groups of the HWB as shown in Schedule 3.

1.28 “Intellectual Property” means copyright, trade marks (whether registered or otherwise), service marks (whether registered or otherwise), patents, design rights (whether capable of registration or otherwise), registered designs, domain names, know how rights, rights in relation to databases, trade secrets, rights to take action for passing off, and all other relevant intellectual property rights as ordinarily recognised as such throughout and in any parts of the world, and in relation to the items so listed in this definition, all registrations, pending registrations, reversions, extensions and renewals of such rights.

1.29 “Lead Commissioning” means a lead process of commissioning the Services undertaken by the Lead Partner.

1.30 “Lead Partner” means (for the purposes of a Partnership Arrangement) the Partner identified as such in the relevant Partnership Schedule, or such other Partner as otherwise agreed by the Partners in writing from time to time.

1.31 “Levels of Authority” means those authorities of the respective Partners relating to each Partnership Arrangement as indicated in the relevant Partnership Schedule and in any case, such authorities will in the case of the Council be subject to the Council’s Constitution and in the case of the CCG subject to and in compliance with the CCG’s Constitution.
1.32 “Liverpool Health Watch” means the Local Health Watch for the City of Liverpool

1.33 “Miscellaneous Property” means any property of a tangible or intangible nature (other than Intellectual property) which is acquired with funds of a Pooled Fund or Non Pooled Fund or which belongs to one of the Partners as a result of a Service Contract.

1.34 “NHS England” means a non-executive agency of the Department of Health formerly known as the National Commissioning Board.

1.35 “NHS Functions” means such of the functions of the CCG as are prescribed under regulation 5 of the Regulations in so far as they relate to the Partnership Arrangements.

1.36 “Non-Pooled Funds” means the financial contributions of the Partners for the purposes of commissioning the Services which are not included in Pooled Funds from time to time.

1.37 “Partners” means the Council and the CCG.

1.38 “Partnership Arrangements” means each partnership arrangement established by the Partners from time to time by executing a relevant Partnership Schedule, being arrangements for the purposes of the Regulations and Section 75 of the 2006 Act.

1.39 “Partnership Schedule” means a schedule substantially in the form set out in Appendix 1 (or such other form lawfully agreed by the Partners in writing from time to time), which (when executed by the Partners) will result in the establishment of a relevant Partnership Arrangement. and which will document the arrangements agreed by the Partners in relation to a Project and any variations to this Deed (as agreed between the Partners)
1.40 “Project” means such of the Functions and such of the Services as agreed by the Partners which shall be set out in a Partnership Schedule.

1.41 “Pooled Fund” means a fund established by the Host Partner from time to time under a Partnership Schedule and administered in accordance with this Deed, and/or a Partnership Schedule administered by a Pool Manager in accordance with the terms of regulation 7 of the Regulations and all relevant law as may apply to this agreement from time to time.

1.42 “Pool Manager” means the person appointed by the Host Partner to administer and be responsible for managing the Pooled Fund and complying with the Regulations insofar as they relate to a Pooled Fund.

1.43 “Procurement Regulations” means section 75 of the 2012 Act, the NHS (Procurement Patient Choice and Competition) (No 2) Regulations 2013 and the Public Contracts Regulations 2006 (as amended) and such other rules, regulations and guidance that may be issued from time to time as relate to and/or affect the method of procuring the Services by either Partner.

1.44 “Quarter” means each of the following periods in the Financial Year (or parts of such periods):-

1st April to 30th June
1st July to 30th September
1st October to 31st December
1st January to 31st March

(or such parts of those periods during the term of this Deed or the relevant Partnership Arrangement, as the context requires)

1.45 “Regulations” means the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 SI No. 617 and any amendments thereto and subsequent re-enactments thereof.
1.46 **“Responsible Commissioner”** means that body responsible for commissioning health services on behalf of a patient as more particularly defined in Section 3(1A) of the 2006 Act and any subsequent enactment or guidance made pursuant to those provisions.

1.47 **“Revenue Expenditure”** means sums which is not Capital Expenditure but which may be incurred by one or both of the Partners in accordance with the terms of this Deed in respect of the costs of the Services and which may be funded from a Pooled Fund or the Non-Pooled Funds.

1.48 **“Services”** means any of the Functions agreed by the Partners to be exercised and commissioned from time to time by either or both of the Partners.

1.49 **“Service Contract”** means a contract entered into by either or both of the Partners pursuant to a Partnership Arrangement.

1.50 **Service Provider”** means the relevant provider of the Services with whom either or both of the Partner contracts for the provision of Services for the purposes of a Partnership Arrangement.

1.51 **“Staff”** means employees of the Council or employees of the CCG as the case may be who are made available by a Partner for a Project in accordance with a Partnership Schedule or as otherwise agreed in writing from time to time.

1.52 **“Strategic Plans”** means the CCG’s Strategic Commissioning Plan, the Council’s commissioning plans, the CCG’s Operational Plan, the Public Health Annual Report, the JSNA and the HWB’s Joint Commissioning Plans and the Health and Wellbeing Strategies.

1.53 **“Term”** means the term of this Deed which shall be for a period of 3 years from the Commencement Date.
1.54 "Transfer Regulations" means the Transfer of Undertakings (Protection of Employment) Regulations 2006 (as amended).

1.55 "Working Day" means a day (other than a Saturday, Sunday or a public holiday in England).

2 (B) INTEPRETATIONS

2.1 If there is any inconsistency between these Clauses and a Partnership Schedule, the Partnership Schedule shall prevail to the extent of the inconsistency unless the Partners agree otherwise in writing.

2.2 References to statutory provisions shall be construed as references to those provisions as respectively amended or re-enacted (whether before or after the Commencement Date) from time to time.

2.3 The headings of the Clauses in this Deed are for reference purposes only and shall not be construed as part of this Deed or be deemed to indicate the meaning of the relevant Clauses to which they relate.

2.4 References to Schedules are references to the Schedules to this Deed and a reference to a paragraph is a reference to the paragraph in the Schedule containing such reference.

2.5 References to a person or body shall not be restricted to natural persons and shall include a company corporation or organisation.

2.6 Words importing one gender only shall include the other genders and words importing the singular number only shall include the plural and vice versa.

3 PURPOSE OF THIS AGREEMENT

3.1 The purpose of this overarching Deed is to establish a strategic commissioning partnership framework under Section 75 of the 2006 Act to enable the Council and the CCG to meet their respective statutory obligations and responsibilities to improve the health and well being of the population of the City of Liverpool.

3.2 This overarching Deed includes the terms and conditions which are to be applied to a Partnership Schedule except insofar as varied in that Partnership Schedule.

3.3 This Deed shall only apply to Partnership Arrangements that involve the commissioning of the Services.
3.4 In conducting the Partnership Arrangements, the Partners will take account of the advices and representations received by Liverpool Health Watch and the emerging neighbourhood agenda of the respective Partners.

3.5 The Partners agree that they will work with, contribute to and implement (insofar as they relate to and effect but do not conflict with the Partnership Arrangements) the policies and strategies of the HWB.

3.6 The overall aims and objectives for this Deed and for improving the commissioning of health and wellbeing services of the population of the City of Liverpool are more particularly set out in clause 5.

3.7 Neither Partner is obliged under this Deed to enter into a Partnership Arrangement with the other Partner.

4 DURATION OF THIS AGREEMENT AND PARTNERSHIP ARRANGEMENTS

4.1 This Deed will come into force upon the Commencement Date and subject to the terms of Clauses 37 and 38 shall end at the expiration of the Term provided always that the Partners may agree to extend this agreement for a further term of 3 years upon the same terms and conditions contained in this Deed.

4.2 Each Partner will review each Partnership Arrangement at least once a year. Such review shall include consideration as to whether to continue or end a Partnership Arrangement and/or relevant Service Contract and which will occur in a timely manner within 3 months before each anniversary of the commencement of that Partnership Arrangement and shall (when conducting such a review) measure the success of that Partnership Arrangement on all relevant matters, including without limitation, the achievement of the aims and objectives set out in Clause 5 of this Deed. The Partners will thereafter make their decision, which shall be given and communicated to the HWB.

5 AIMS AND OBJECTIVES OF THE PARTNERSHIP ARRANGEMENTS

5.1 The aims and objectives of the Partnership Arrangements are designed to jointly improve outcomes for patients and service users through jointly agreed commissioning strategies and intentions.

5.2 The overarching commissioning aims the Partners are to improve the physical and mental health and well-being of the population of residents in Liverpool and to reduce the health and wellbeing inequalities that may exist through:
5.2.1 to improve the physical and/or mental health, and/or the well-being of the population of the City of Liverpool and/or to reduce the health and well-being inequalities that may exist in the City of Liverpool;

5.2.2 to ensure that local communities served by the Partners will be more informed and involved, experience better health and well-being, and improved health care services;

5.2.3 Reducing duplication to make the best use of commissioning resources;

5.2.4 Aligning investment and service development to make best use of public resources across health and social care;

5.2.5 Ensuring that strategic commissioning and service development responds to the expressed needs of Liverpool residents through a joint approach to the engagement of service users and citizens;

5.2.6 Better and more economic use of resources and improved value for money;

5.2.7 Easier identification of gaps in provision;

5.2.8 The development of joint Performance Indicators and monitoring processes;

5.2.9 Commissioning of Services designed around the needs of Clients;

5.2.10 Sustained improvement in quality.

5.3 The Partners will measure the extent to which the aims and objectives in relation to a particular Partnership Arrangement have been met by reference to the Strategic Plans and the terms of Clause 5.1. Any other specific aims and objectives for a Partnership Arrangement shall be agreed by the Partners and shall be set out in a Partnership Schedule.

6 PROTOCOLS

The Partners will work together to formulate joint protocols (if applicable) for the management and administration of Staff included in these Partnership Arrangements including those who may be the subject of a Partnership Schedule.

7 PROJECTS TO BE INCLUDED IN THE PARTNERSHIP ARRANGEMENTS

7.1 The Partners shall agree which Projects are to be the subject of a Partnership Arrangement.
7.2 The terms and conditions and other relevant criteria of a Project will be set out in a Partnership Schedule.

7.3 The Project the subject of a Partnership Schedule will be subject to the Levels of Authority and any variations to the Levels of Authority or any additional forms of authority relating to a Project shall be set out in the relevant Partnership Schedule.

8 FUNCTIONS TO BE EXERCISED BY THE PARTNERS

8.1 The NHS Functions of the CCG which may not be delegated to the Council under the Regulations include but without limitation emergency ambulance services and the provision and arrangements for the provision of surgery, endoscopy and invasive treatments; and

8.2 The Health Related Functions of the Council which may not be delegated to the CCG under the Regulations include but without limitation the functions under Sections 114 and 115 of the Mental Health Act 1983 as amended by the Mental Health Act 2007 and subject to Regulation 6(k) Sections 22, 23(3) 26(2) to (4), 43, 45 & 49 of the National Assistance Act 1948

8.3 The Partnership Arrangements shall not affect:-

8.3.1 the liabilities of the Partners to any third parties for the exercise of their respective Functions and obligations; or

8.3.2 the powers or duty of each Partner to recover charges for the provision of any Services in the exercise of any of the Functions.

8.3.3 the statutory obligations which either Partner is obliged to discharge at law.

9 NOTIFICATION TO THE DEPARTMENT OF HEALTH

The CCG agrees that it shall promptly notify the Department of Health of completion of this Deed and each Partnership Schedule in accordance with the guidance issued by the Department of Health from time to time.

10 GENERAL PRINCIPLES

10.1 The Partners will in relation to the Partnership Arrangements:-

10.1.1 be open with information about the performance and financial status of each other insofar as relevant to activities incidental to this Deed and/or a particular Partnership Arrangement;
10.1.2 provide (in a timely manner) information and notice about any of the following issues to the extent known by the relevant Partner

10.1.2.1 Any serious disruption to the provision of any Service, regardless of whether the fault of the Service Provider;

10.1.2.2 A Partner giving a Service Provider any notice or notices to remedy a material breach of its contract Service Contract;

10.1.2.3 Either Partner having any grounds to terminate any Service Contract (in part or full) due to an event of default of the Service Provider;

10.1.2.4 Any investigation into any alleged misconduct by a Service Provider in tendering for its Service Contract, including any collusion, canvassing and/or the provision of gifts, bribes or the like;

10.1.2.5 Any misconduct or serious breaches identified by the relevant Partner in relation to any audit, inspection or other investigation it has carried out in relation to a Service Contract;

10.1.2.6 Any material or significant complaint it has received from any person (including any Client) in relation to the provision of any Service and in respect of any other complaints each Partner shall maintain a complete record, a summary of which will be supplied to the other Partner at the end of each Quarter Date.

10.1.2.7 The receipt of any claim from, and/or the issue of proceedings by, any person (whether a Service Provider, Client, regulatory body or otherwise) in relation to the Service and/or any Service Contract;

10.1.2.8 Any dispute arising with any person (whether a Service Provider, a Client, member of the public, regulatory body or otherwise) in relation to a Service Contract;

10.1.2.9 Any challenge, complaint or dispute relating to any procurement process for an existing or proposed Service Contract.

10.1.2.10 Any event or circumstance in relation to a Service Contract which is reasonably likely to lead to an insurance claim being made by a Partner against its insurers or which may lead to legal proceedings
or which may lead to a claim against a Partner;

10.1.2.11 The receipt of any request from a Service Provider to amend any Service Contract to which it is a party;

10.1.2.12 The receipt of any notice of termination from a Service Provider in relation to a Service Contract to which it is a party;

10.1.2.13 Any investigation by the police, any regulatory body or other body or person into any misconduct, breach of the law or other irregularity by any Service Provider (regardless of whether the investigation relates to the Service Contract or otherwise);

10.1.2.14 Any individual providing any Service being under any investigation in relation to (or convicted of) any crime relating to safeguarding issues, dishonesty, violence, and/or property damage, regardless of whether the investigation or conviction relates to his/her activities in relation to the Service;

10.1.2.15 Any serious incident or serious untoward incident or never event in relation to the provision of the Services;

10.1.2.16 Any loss, unauthorised access or other serious adverse consequence relating to personal data in the care of the relevant Partner and/or in the care of a Service Provider relating to a particular Service Contract;

10.1.2.17 Any unauthorised disclosure or misuse of any information which is subject to a duty of confidentiality under Service Contract;

10.1.2.18 Any media interest in any matter relevant to this Deed and/or a particular Partnership Arrangement;

10.1.3 ensure the Clients shall include, in so far as health services are concerned, those who may be the responsibility of the CCG to commission health services for in accordance with such guidance issued by the Department of Health or NHS England from time to time relating to the Responsible Commissioner.

10.1.4 ensure the Clients for the purposes of social care commissioning shall not include those who are ordinarily resident outside the City of Liverpool.
11 PARTNERSHIP SCHEDULES

11.1 The Partners will carry out such consultation in accordance with the 2006 Act and the Regulations for each Partnership Arrangement.

11.2 Each Partnership Schedule shall be substantially in the form set out in Appendix 1.

11.3 No Partnership Schedule shall be entered into unless the Partners are satisfied that it shall:-

11.3.1 Fulfil at least one of the objectives of the Strategic Plans
11.3.2 Improve the health and well-being of the population of the City of Liverpool

12 PROVISIONS ON STAFF IN RELATION TO A PARTNERSHIP SCHEDULE

12.1 The Staff to be made available by the CCG for a Project shall be specified in the relevant Partnership Schedule.

12.2 The Staff to be made available by the Council for a Project shall be specified in the relevant Partnership Schedule.

12.3 Where Staff are employed by one Partner but made available to the other Partner pursuant to a Project, day to day management of such Staff shall be the responsibility of the Lead Partner. However, the personnel procedures operating in relation to such Staff shall be those of the employing Partner and matters relating to terms and conditions of employment, discipline, grievances and all other employment procedures shall be the responsibility of the employing Partner.

13 EMPLOYMENT INDEMNITIES

13.1 Unless otherwise agreed in writing the Partners intend that the Transfer Regulations shall not apply to any Staff and accordingly they agree that no Staff shall transfer from the employment of the Council into the employment of the CCG and that no Staff shall transfer from the employment of the CCG into the employment of the Council by virtue of this Deed. The Council and the CCG each agree that they will not at any time hereafter contend (unless they otherwise agree in writing) for any purpose whatsoever that the Transfer Regulations apply to this Deed and that nothing in this Deed is intended to cause a change in the identity of the employer of an employee holding a Staff post or an employee who falls within the definition of Staff.
13.2 If a Partner receives a claim, or notice of an intention to make a claim, which may reasonably be considered likely to give rise to a liability on the part of the other Partner under this Clause 13 that Partner shall:

13.2.1 as soon as reasonably practicable, give written notice of the claim to the other Partner specifying the nature of the claim in reasonable detail;

13.2.2 not make any admission of liability, agreement or compromise in relation to the claim without the prior written consent of the other Partner (such consent not to be unreasonably conditioned, withheld or delayed); and

13.2.3 give the other Partner access at reasonable times to its premises and its officers, directors, staff, agents, representatives or advisers, documents and records within its power or control so as to enable the other Partner and its professional advisers to examine them and to take copies for the purpose of assessing the claim.

13.3 Nothing in this Clause 13 shall restrict or limit a Partner's general obligation at law to mitigate a loss it may suffer or incur as a result of an event which may give rise to a claim under the indemnities contained in this provision.

14 FINANCIAL CONTRIBUTIONS – FIRST FINANCIAL YEAR

14.1 The financial contribution of the Partners to any Pooled Fund and any Non-Pooled Fund for each Project in the first Financial Year shall be set out in the relevant Partnership Schedule.

14.2 For the avoidance of doubt any personal contributions which a Client or Client Group has or is required to pay towards the costs of any of the Services will be paid as follows:

14.2.1 If there is a Pooled Fund in relation to the relevant Partnership Arrangement, such monies shall (to the extent lawful) be paid into the Pooled Fund.

14.2.2 Otherwise, in the event of there being no Pooled Fund such monies shall be paid to the relevant Partner which has statutory responsibility to provide the Services.

15 FINANCIAL CONTRIBUTIONS – SUBSEQUENT FINANCIAL YEARS

15.1 The Partners agree to co-operate in the production of financial plans for each Financial Year after the first Financial Year for each Partnership Arrangement. These plans will
cover both Pooled Funds and Non-Pooled Funds for each Partnership Arrangement and identify in so far as reasonably possible:-

15.1.1 trends in activity levels or the demand for the Services covered by the relevant Project that are likely to impact on the cost of those Services;

15.1.2 the estimated cost of planned changes to the Services; and

15.1.3 the anticipated impact on the Services of any changes planned to the Services provided by either Partner that do not form part of a Partnership Schedule.

15.2 When determining the Partners’ contributions to any Pooled Fund and any Non-Pooled Fund for a Partnership Arrangement in Financial Years subsequent to the first Financial Year it is the intention of the Partners, to apply the following principles:-

15.2.1 Each Partner shall take into account its previous full Financial Year's baseline contribution and any actual or proposed local and national efficiency savings requirements that relate to their respective commissioning strategies.

15.2.2 In determining financial contributions for subsequent Financial Years the Partners will also consider whether it is possible to fund any growth proposals or make any savings as appropriate.

15.3 In the event that the financial contributions of any Partner to any Non-Pooled Fund or any Pooled Fund in any Financial Year subsequent to the First Finance Year (the “New Financial Year”):

15.3.1 are intended to be less than that in the previous Financial Year

15.3.2 do not cover cost pressures on the relevant Services

the Partners shall (wherever it is permissible and accepted by both Partners) subject always to the rights contained in Clause 37.3 renegotiate (within three months of the beginning of the relevant Financial Year) appropriate changes in the Services so that expenditure will be within the financial contributions by both Partners for the New Financial Year

15.4 The Partnership Schedule will specify how payments are to be made between the Partners.

15.5 The Partners shall act in good faith and in a reasonable manner when determining their respective contributions to the Pooled Fund but in the event that agreement cannot be
reached by the commencement of the New Financial Year either Partner may be at liberty to serve notice in writing to the other Partner terminating a Partnership Schedule in accordance with Clause 37.3 of this Deed.

16 ESTABLISHMENT, ADMINISTRATION AND EXPENDITURE OF POOLED FUNDS AND NON-POOLED FUNDS

16.1 The Partners may establish a Pooled Fund and Non-Pooled Fund for an individual Partnership Arrangement which will be set out in a Partnership Schedule. A Pooled Fund shall only be established where it is considered that it will provide improved Services to a Client or Client Group. When considering whether and when it would be appropriate to establish a Pooled Fund the Partners shall consider whether the establishment of the Pooled Fund and/or the activities for which that Pooled Fund is used would:

16.1.1 lead to a single point of assessment for Clients or Client Groups
16.1.2 provide more efficient or effective service delivery
16.1.3 support more effective co-ordination of Services
16.1.4 increase efficiency
16.1.5 provide greater flexibility in the use of resources
16.1.6 promote independence well being and choice for a Client or Client Group
16.1.7 help maximise creativity and innovation
16.1.8 contribute to taking forward joint strategies
16.1.9 develop co-operative working arrangements in respect of the Functions or Services concerned;
16.1.10 predict future costs of the Functions or the Services.

16.2 When establishing a Pooled Fund the Partners will decide:

16.2.1 which of them shall act as Host Partner for the purposes of Regulations 7(4) and (6) in relation to any Pooled Fund
16.2.2 which officer of the Host Partner shall act as the Pool Manager for the purposes of Regulation 7(4) of the Regulations.

16.3 The Pool Manager from time to time of the Pooled Fund shall be the individual identified as such in the relevant Partnership Schedule, or such replacement officer of the Host Partner appointed by it from time to time, (subject to the written approval of the other Partner (not to be unreasonably withheld).
16.4 The relevant Host Partner from time to time of a particular Partnership Arrangement shall give the Pool Manager such direction, resources and support to enable him/her to undertake the following with reasonable skill and care and in a reasonably timely manner:

16.4.1 manage the relevant Pooled Fund and/or any Non-pooled Fund; and

16.4.2 submit to the Partners monthly reports on the Pooled Fund and/or Non Pooled Fund and an annual return and all other information required by the Partners in order to monitor the Pooled Fund and/or Non Pooled Fund.

16.5 The Host Partner of a particular Pooled Fund may spend monies in that Pooled Fund on NHS Functions and/or Health Related Functions without being required to have regard to the proportions in which the Council and the CCG shall have contributed to the Pooled Fund.

16.6 The monies in any Pooled Fund shall be spent in accordance with any restrictions agreed by the Partners on the establishment of the Pooled Fund in the relevant Partnership Schedule or as varied by agreement between the Partners from time to time but otherwise in accordance with the Levels of Authority of the relevant Host Partner.

16.7 The Host Partner must not cause or permit funds to be transferred from one Pooled Fund to another Pooled Fund and/or to a Non-Pooled Fund without the consent of the other Partner.

16.8 The Host Partner’s management of a relevant Pooled Fund shall be subject to the CCG’s Constitution (if the CCG is the Host Partner) or the Council’s Constitution (if the Council is the Host Partner), and in any case, such management shall be subject to the Regulations and other relevant law.

16.9 For the CCG, accountability for the Pooled Fund and/or the Non-Pooled Fund is to the Accountable Officer.

16.10 For the Council, the role and responsibilities of the Section 151 Officer under the Local Government Act 1972 will be paramount in determining financial accountability for the Pooled Fund and/or the Non-Pooled Fund and the roles fulfilled by the Pool Manager.

16.11.1 In the event any release, credit, refunds, rebates, awards of damages or other compensation (or the like of any of these) are received by a Partner in connection with a Service Contract and/or in relation to the Services any of these shall be paid into the Pooled Fund (or Non-Pooled Fund as the case may be) and distributed in
accordance with the terms of this Deed (except to the extent such such relief credit, refund, rebate, award of damages (or the like) or other compensation are intended to be applied in compensating that Partner for its separate loss) in which event such money shall be paid to that Partner and not the Pooled Fund (or Non-Pooled Fund as the case may be)

16.11.2 Clause 16.11 is subject to any variation in the Partnership Schedule of a Partnership Arrangement

17 GENERAL PROVISIONS ON OVERSPENDS AND UNDERSPENDS

17.1 The Partners shall use all reasonable endeavours to ensure that:

17.1.1 the Health Related Functions funded from Non-Pooled Funds for each Partnership Arrangement are carried out within the Council contribution to the Non-Pooled Fund for the relevant Partnership Arrangement in each Financial Year

17.1.2 the NHS Functions funded from the Non-Pooled Funds for each Partnership Arrangement are carried out within the CCG contribution to the Non-Pooled Funds for the relevant Partnership Arrangement in each Financial Year; and

17.1.3 the NHS Functions and the Health Related Functions funded from any Pooled Fund for each Partnership Arrangement are carried out within the financial resources available in the relevant Pooled Fund for the relevant Partnership Arrangement in each Financial Year

17.2 Without prejudice to Clause 17.1 each Partner shall keep the other Partner regularly informed of any actual or projected overspend or underspend in a Pooled Fund or a Non-Pooled Fund.

17.3 Where the Partners establish a Pooled Fund or a Non-Pooled Fund on more than one Partnership Arrangement reference to "each Partnership Arrangement" in Clause 17.1 shall be regarded as reference to the Partnership Arrangement or Partnership Arrangements which the Pooled Fund or Non-Pooled Fund have been established to cover.

17.4 Management of Overspends:-

17.4.1 Whenever an overspend is projected or otherwise known for a Pooled Fund the Host Partner responsible for management of the Pooled Fund shall present to the other Partner within 30 days of the projection being made
proposals for management of the overspend to ensure that the overspend is met from the financial resource contributions available from the Pooled Fund in the then current Financial Year. The Partners will make recommendations to the JCG which shall manage the overspend and the Partners shall keep the position under review acting in good faith and in a reasonable manner in agreeing the management of the overspend.

17.4.2 If at the end of any Financial Year (or at any other relevant time) there is an overspend of a Pooled Fund for a Partnership Arrangement, the Partners will identify the reasons for the overspend and shall apportion the overspend between themselves according to the principles and/or formulae indicated in the relevant Partnership Schedule or as otherwise agreed by the Partners in writing.

17.4.3 Neither Partner shall be required to contribute to an overspend to the extent that it is the direct result of any one or more of the following by the other Partner:-

17.4.3.1 Any act of that other Partner which is beyond its Level of Authority.

17.4.3.2 Any of that other Partner which is contrary to any other constraints on that other Partner’s authority indicated in a Partnership Schedule, or in any resolution of the JCG and/or in any applicable written agreement between the Partners applying at the time, except to the extent that act was carried out with the express authority of the JCG and/or the other Partner to carry out that act.

17.4.3.3 The fraud or other serious misconduct by that other Partner’s Staff or separate contractors where it was done with the actual or constructive knowledge of that other Partner’s senior management.

17.4.3.4 That other Partner’s deliberate breach of this Deed and/or a relevant Partnership Schedule where that breach was done with the actual or constructive knowledge of the other Partner’s senior management.

17.5 Management of Underspends
17.5.1 Whenever an underspend of a Partner's contribution to a Pooled Fund or Non-Pooled Fund is projected at any time during the current Financial Year the Host Partner or Partner responsible for the management of such funds (whichever is applicable) shall as soon as reasonably practicable inform the other Partner.

17.5.2 Any underspend of a Partner's contribution to a Non-Pooled Fund at the end of a Financial Year or upon termination shall belong to the Partners according to the relevant principles and/or formulae indicated in the relevant Partnership Schedule or as otherwise agreed by the Partners in writing.

17.5.3 In the event that there is an underspend in relation to any Pooled Fund which arises either during the Financial Year or at the end of a Financial Year or upon termination of this Deed or a Partnership Arrangement those monies shall be refunded to the Partners in proportion to their contributions to the relevant Pooled Fund by the Partner responsible for the Pooled Fund unless the Partners agrees that the underspend shall be managed by one of the following methods:

17.5.3.1 the underspend may be retained as a contingency in the relevant Pooled Fund; or

17.5.3.2 the underspend may be transferred from the Pooled Fund where it arose to another Pooled Fund or to a Non-Pooled Fund; or

17.5.3.3 the underspend may be carried forward into the next Financial Year.

subject always to the approval (where required) of the responsible auditors for each Partner

17.5.4 Specific rules concerning virements and the treatment of underspends and overspends may be agreed in individual Partnership Schedules or by the Partners in writing from time to time, subject to compliance with this Clause 17 and subject to compliance to the Council’s Constitution and the CCG’s Constitution.
18 **GRANTS**

The Partners will review and maximise opportunities to obtain such additional grants as may be available to commission and support the Functions, the Partnership Arrangements and/or a Project from time to time.

19 **CAPITAL EXPENDITURE**

19.1 The financial contributions referred to in Clauses 13 to 17 inclusive are in respect of Revenue Expenditure and shall not be applied towards Capital Expenditure other than for minor items of expenditure agreed by the Partners and in accordance with relevant guidance and all applicable laws (which expenditure shall not be regarded as Capital Expenditure for the purposes of the remainder of this Clause 19).

19.2 Where Capital Expenditure is to be incurred by one or both of the Partners it may be transferred between the CCG and the Council by agreement under Sections 76 or 256 of the 2006 Act as appropriate and will be subject to the following provisions of this Clause 19 and in such circumstances S.75 of the 2006 Act shall not apply.

19.3 Subject to Clause 19.1 no Partner shall incur any item of Capital Expenditure out of a Pooled Fund unless otherwise agreed by the other Partner

19.4 Subject to this Clause 19 where Capital Expenditure is incurred out of a Pooled Fund, the Pooled Fund Manager may only do so within the limits of the Level of Authority.

20 **VAT AND INCOME TAX**

The Partners shall agree the treatment of a Partnership Schedule for VAT and Income Tax purposes. This shall be in accordance with any directions and/or guidance of HM Revenue and Customs and the Partners shall take specific advice from relevant financial advisers in relation to each Partnership Arrangement

21 **AUDIT AND RIGHT OF ACCESS**

21.1 Each Partner shall promote a culture of probity and sound financial discipline and control and shall ensure that full and proper records for accounting purposes are kept in respect of the Partnership Arrangements.

21.2 The Partners shall co-operate with each other in preparation of accounts in relation to the Partnership Arrangements and with each other’s internal and external auditors insofar as their activities are relevant to those Partnership Arrangements.
21.3 Each Partner acting as Host Partner of a Pooled Fund in accordance with Clause 16.2 shall arrange for the audit of the accounts of the Pooled Fund.

21.4 The Partners will supply all information reasonably required by:

21.4.1 persons exercising a statutory function in relation to either Partner;

21.4.2 other persons or bodies with an authorised monitoring or scrutiny function, including a Council Scrutiny Committee, having regard to the Partner's obligations of confidentiality, and the Information Sharing Protocol as shall be agreed between the Partners from time to time.

21.5 The Partners will provide to each other all reasonable information as may be held by them to respond to enquiries from members of the public.

21.6 The Partners may agree protocols in relation to the management of and provision of information relating to the finances of a Partnership Schedule from time to time.

22 INSURANCE ARRANGEMENTS

22.1 The Partners shall, so far as possible at reasonable cost and allowable by law or guidance effect appropriate insurance arrangements in respect of all potential liabilities arising from the Partnership Arrangements. In the case of the CCG it may effect, through the National Health Service Litigation Authority, alternative arrangements in respect of NHS schemes in lieu of commercial insurance. Insurance effected by the Council may include such provision as to the excess or deductible to be funded by the Council as it shall consider appropriate.

22.2 The obligations in this Clause shall include insurance (or equivalent) arrangements after the date of determination of this Deed or a Partnership Schedule in respect of any claims arising prior to such determination.

22.3 The Partners may agree from time to time, common policies and protocols for the handling of claims covered by the Partners' insurance arrangements (or equivalent) for the Functions.

23 INDEMNITY AND LIABILITY

23.1 No Partner shall be entitled to be indemnified or reimbursed out of any Pooled Fund established in connection with this Agreement and/or any one or more particular Partnership Arrangements for any cost, loss, damage or expense or the like incurred by
that Partner to the extent any one or more of the following applies to that cost, loss, damage or expense:

23.1.1 It relates to that Partner’s act to the extent it is beyond its applicable Level of Authority, or to the extent that act is contrary to any other constraints on that Partner’s authority indicated in a relevant Partnership Schedule, in any resolution of the JCG and/or in any applicable written agreement between the Partners applying at the time, except to the extent that Partner otherwise had the express authority of the JCG and/or the other Partner to carry out that act.

23.1.2 It results from the fraud or other serious misconduct by that Partner’s employees or separate contractors where it was done with the actual or constructive knowledge of that Partner’s senior management.

23.1.3 It results from that Partner’s deliberate breach of this Agreement and/or of the Partnership Schedule of the relevant Partnership Arrangement where that breach was done with the actual or constructive knowledge of that Partner’s management.

23.2 Subject to the exceptions in Clause 23.1, each Partner shall be entitled to an indemnity from any Pooled Fund of a particular Partnership Arrangement for all the following to the extent relevant to it:

23.2.1 That Partner’s reasonable and actual damages, costs, disbursements and losses (including legal costs incurred on a solicitor-client basis) incurred in relation to any third party claim made or against it to the extent that claim relates to acts (or failures to act) of that Partner (or of anyone acting on its behalf) which are reasonably incidental to that Partnership Arrangement but are within that Partner’s Level of Authority.

23.3 Any limits or exclusions of the liability of a Partner (‘X’) to the other Partner (‘Y’) in this Deed (particularly in Clause 23.4) and/or in any Partnership Schedule of a Partnership Arrangement shall not apply to the extent any one or more of the following applies:

23.3.1 The liability relates to death or personal injury caused by X’s negligence.

23.3.2 The liability relates to X’s act to the extent it is beyond its applicable Level of Authority, or to the extent that act is contrary to any other constraints on X’s authority indicated in a relevant Partnership Schedule, in any resolution of the JCG and/or in any applicable written agreement between the Partners.
applying at the time, except to the extent that X otherwise had the express
authority of the JCG and/or the other Partner to carry out that act.

23.3.3 The liability relates to any payment of any specific liquidated sum which X is
required to make to Y in connection with this Deed and/or any particular
Partnership Arrangement including any contribution to a Pooled Fund, and any
payments in relation to any overspend.

23.3.4 The liability relates to any fraud or other serious misconduct by X’s employees
or separate suppliers or service providers where it was done with the actual or
constructive knowledge of X’s senior management.

23.3.5 The liability results from X’s deliberate breach of this Deed and/or of the
Partnership Schedule of the relevant Partnership Arrangement where that
breach was done with the actual or constructive knowledge of X’s senior
management.

23.3.6 The liability cannot be limited or excluded by law.

23.4 Subject to the exceptions in Clause 23.3, the liability of a Partner to the other Partner
arising under or in connection with this Deed and/or any particular Partnership
Arrangement (whether that liability arises in tort, contract, under statute or otherwise)
shall be limited to one pound (£1.00) in relation to each relevant incident or series of
connected incidents.

23.5 The Partners acknowledge that the limit on liability in Clause 23.4 is reasonable on the
understanding that significant liability of one Partner to the other in connection with this
Deed and/or any Partnership Arrangement is likely to impose disincentives on the
Partners to accept responsibility for the activities under a particular Partnership
Arrangement, and is likely to be detrimental to the spirit of cooperation this Deed is
intended to encourage.

24 **RECONCILIATION ON TERMINATION**

24.1 Clause 17.5 shall apply to any underspends upon termination or expiry or completion of
a Partnership Arrangement and the Partners shall make such payments to each other as
shall be required to reflect this.

24.2 Clause 17.4 shall apply in respect of any overspend existing at the date and shall be
apportioned between the Partners as stated therein.
24.3 The Partners shall act in good faith and in a reasonable manner in reaching agreement on the matters referred to in Clauses 24.1 and 24.2.

25 CONTRACTING

25.1 Where a Service Contract relates to both Health Related Functions and NHS Functions the JCG shall agree which Partner shall enter into that Service Contract.

25.2 All Service Contracts entered into by the Council shall be procured in accordance with the Council’s Constitution and all contracts entered into by the CCG shall be procured in accordance with the CCG’s Constitution and in any case all Service Contracts shall be procured in compliance with relevant law including (where relevant) the Procurement Regulations.

25.3 Any Service Contracts to be entered into by a Partner (but only where it is proposed that the Service Contract will exceed the Level of Authority of that Partner) shall be first approved by the other Partner and shall include such terms and conditions for like termination as set out in Clause 25.12 of this Deed and shall be in compliance with the requirements of S.75 of the Procurement Regulations and in particular with Regulation 2 of the same regulations insofar as they relate to the procurement of health services for the purposes of the NHS Functions.

25.4 The Partner who has entered into the relevant Service Contract shall unless otherwise agreed oversee compliance by the Service Providers with the terms and conditions of that Service Contract.

25.5 Each Partner shall co-operate with the other to facilitate the overseeing and monitoring of Service Contracts, and to ensure that the relevant Service Contract is performed in accordance with its terms, which may include visiting and inspecting the Service Providers’ property from where the Services are provided.

Any material breach by a Service Provider of a Service Contract’s terms or any irregularity relating to it which comes to the attention of a Partner shall be reported to the other as soon as reasonably practicable after the Partner becomes aware of such breach or irregularity. The Partners shall agree what action shall be undertaken to remedy such breach or irregularity to ensure compliance with the relevant Service Contract and the Partner who is a party to the Service Contract shall where agreed with the other Partner and where duly authorised by the other Partner take such action as has been agreed. Responsibility shall be with the Partner who has entered into the Service Contract for the enforcement of the terms of any Service Contract or on behalf of
the other Partner and to the extent that the Contract and law permits) to the extent that it relates to Services commissioned by it on its own behalf.

25.6 Each Partner shall remain responsible for the performance of its own statutory functions in respect of the Services that are being procured under a Service Contract either on its own behalf or on behalf of the other Partner in accordance with this Deed regardless of which Partner has entered into the Service Contract.

25.7 The Council’s Constitution shall apply to all actions undertaken by the Council in pursuance of this agreement including the procuring and commissioning of any of the Services on behalf of the CCG under this Deed.

25.8 The CCG’s Constitution shall apply to all actions undertaken by the CCG in pursuance of this agreement including the procuring and commissioning of any of the Services on behalf of the Council under this Deed.

25.9 For the avoidance of doubt neither Partner shall be obliged to enter into any Service Contracts or otherwise carry out any dealings on behalf of the other under this Deed if they believe that:

25.9.1 to do so would be a breach of either the CCG’s Constitution of the Council’s Constitution; or

25.9.2 any proposed Service Contract (including action by the Council or the CCG to enforce or claim a breach of the Service Contract) would constitute an unacceptable and unreasonable high level of financial risk; or

25.9.3 any decision made by a Partner under this Deed was based on incorrect information and that information may have affected the Partner’s decision,

25.9.4 and both Partners must act reasonably in such circumstances and in any such event arising shall inform the other of its intention and permit the other Partner to make representations to it.

25.10 The Partner entering into a Service Contract shall ensure that such Service Contract shall be terminable upon termination of this Deed or termination of any Partnership Schedule to which such Service Contract relates subject always to Clause 38 hereof.

25.11 The Partner entering into a Service Contract shall do so in accordance with the Levels of Authority.
25.12 It is recognised by the Partners that each of them may have pre-existing Service Contracts in place prior to the date hereof and which will continue following the date hereof and that arrangements will be put in place to continue monitoring those Service Contracts by the Lead Partner.

26 INFORMATION SHARING AND CONFIDENTIALITY

26.1 For the purposes of this Clause 26:-

26.1.1 “applicable legislation and guidance” shall mean:

26.1.1.1 the Data Protection Act 1998;

26.1.1.2 the Freedom of Information Act 2000;

26.1.1.3 the Environmental Information Regulations 2004;

26.1.1.4 all statutory instruments or orders made pursuant to those Acts referred to at Clauses 26.1.1.1 and 26.1.1.2.;

26.1.1.5 all guidance and Codes of Practice issued by HM Government in respect of those Acts referred to at Clauses 26.1.1.1 and 26.1.1.2 including without limitation those with regard to information sharing;

26.1.1.6 the Caldicott Guidelines; and

26.1.1.7 the Information Governance Framework

26.1.1.8 as from time to time amended, extended, re-enacted, re-issued or consolidated whether before or after the date of this Deed.

26.1.2 “Confidential Information” shall have the meaning given to that term by Clause 26.1.8.

26.1.3 “Party A”, “Party B” and “Request for Information” shall have the meaning given to those terms at Clause 26.3.

26.1.4 Both Partners will comply with applicable legislation and guidance in connection with each of the Partnership Arrangements.

26.1.5 The Partners will comply with the standards set out in the Information Sharing Protocol. The Partners may enter into information sharing
agreements under the Information Sharing Protocol in relation to particular services or functions covered by the Partnership Arrangements. Any such agreements will be consistent with applicable legislation and guidance.

26.1.6 The Partners will establish and keep operational and ensure that there are kept operational:

26.1.6.1 a procedure for the provision of documentation to Clients explaining their rights to access information, the relevance of their consent, rules and limits on confidentiality, and how information about them is processed; and

26.1.6.2 such additional policies, procedures and documentation as shall be necessary in order to meet the purposes and requirements of HM Government and the Information Commissioner and of applicable legislation and guidance as they apply to the Partners and the Partnership Arrangements.

26.1.7 The Partners shall comply with the conditions and terms set out in the Information Sharing Protocol and with applicable legislation and guidance as apply to this Deed.

26.1.8 Except as required by law (including under the Freedom of Information Act 2000), each Partner agrees at all times during the continuance of a Partnership Arrangement and for seven years after its expiry or earlier termination to keep confidential and use only for the purposes of the relevant Partnership Arrangement all records which it receives or otherwise acquires in connection with the other which are confidential in nature and all those documents and papers referred to in this Clause 26.1.8 shall be described as “Confidential Information”

26.2 Each Partner acknowledges that the other Partner is subject to the requirements of the Freedom of Information Act 2000 and the Environmental Information Regulations 2004 and shall assist and co-operate with it (at its own expense) to enable it to comply with such requirements.

26.3 Where one Partner (“Partner A”) receives any request under the Freedom of Information Act 2000 or Environmental Information Regulations 2004 to disclose any information received from the other Partner (“Partner B”) (“the Request for Information”), then Partner A shall:
26.3.1 provide a copy of the Request for Information, together with all such other information as Partner A considers relevant to the Request for Information to Partner B as soon as possible and, in any event, within 5 Working Days of receipt of the Request for Information by Partner A; and

26.3.2 provide Partner B with the date by which it intends to reply to the Request for Information not being sooner than 15 Working Days following the date of receipt of the Request for Information by Partner A.

26.4 Partner B shall have the right to make representations to Partner A before the end of the period indicated in Clause 26.3.2 as to whether or not or on what basis the information requested should be disclosed. Partner A shall not respond to the Request for Information prior to such date.

26.5 Partner A shall take into account all reasonable representations made by Partner B in relation to the Request for Information but Partner A shall be responsible for determining at its absolute discretion whether any information:

26.5.1 is exempt from disclosure in accordance with the provisions of the Freedom of Information Act 2000 or the Environmental Information Regulations 2004; and/or

26.5.2 is to be disclosed in response to a Request for Information.

26.6 Partner B shall in no event respond directly to a Request for Information unless expressly authorised to do so by Partner A.

26.7 Partner A shall provide to Partner B a copy of all correspondence with the third party in relation to the Request for Information as soon as reasonably practicable and in any event within 2 Working Days of its despatch or receipt by Partner A.

26.8 Each Partner acknowledges that the other Partner may acting in accordance with applicable legislation and guidance be obliged by law to disclose information:

26.8.1 without consulting the other Partner; or

26.8.2 following consultation with the other Partner and having taken its views into account.

Provided always that where this Clause 26.8 applies the Partner making such disclosure shall, in accordance with applicable legislation and guidance, draw such disclosure to the attention of the other Partner where permissible.
26.9 Each Partner shall to the extent that the law permits ensure that all information relating to this Deed is retained for disclosure and shall permit the other Partner to inspect the same as requested from time to time.

26.10 Each Partner undertakes to take appropriate technical and organisational measures and to maintain appropriate security systems for the purposes of preventing access so as to ensure no unauthorised person gains access to any Confidential Information held by either Partner.

26.11 Each Partner will promptly notify the other Partner of any breach of security in relation to Confidential Information that it becomes aware of and will keep a record of such breaches. Each Partner will use its reasonable endeavours to recover such Confidential Information however it may be recorded. Each Partner will co-operate with the other Partner in any investigation that the other Partner considers necessary as a result of any breach of security in relation to Confidential Information.

27 THE PRESS

Prior to the issue of any press release relating to the Partnership Arrangements or making any contact with the press on any issue attracting or which would reasonably be expected to attract media attention the Chief Executive and Accountable Officer of the Partners (or such persons as they each shall designate) will wherever practicable consult with each other (acting reasonably at all times) to agree a joint strategy for the release or handling of the issue. The provisions of this Clause 27 are subject to any alternative arrangements that the Partners may agree for press relations in particular situations, and shall not prevent either Partner from issuing their own press release in such form and within such timescales as they may determine.

28 STANDARDS OF CONDUCT

28.1 The Partners will comply and will ensure the Partnership Arrangements (including all Projects) comply with all statutory and regulatory requirements national and local and other guidance on conduct public accountability and probity and good corporate governance (including the CCG’s Constitution and the Council’s Constitution).

28.2 Neither Partner shall offer or give or agree to give to any person, any gift or consideration of any kind as an inducement or reward for doing, refraining from doing, or for having done or refrained from doing, any act in relation to the obtaining or execution of this Deed a Partnership Schedule or any other agreement with the other Partner, or for showing or refraining from showing favour or disfavour to any person in relation to this Deed or any other agreement. The attention of each Partner is drawn to S.117 of the Local Government Act 1972 and to the Prevention of Corruption Acts 1889 to 1916.
28.3 Without prejudice to the generality of Clause 28.1:

28.3.1 neither Partner shall unlawfully discriminate either directly or indirectly on such grounds as disability, race, ethnic or national origin, gender, sexual orientation, religion or belief or age and shall comply with all statutory and legislative codes of practice in relation to such matters,

28.3.2 each Partner will discharge its obligations under this Deed without infringing the human rights of any person (as defined by the Human Rights Act 1998);

28.3.3 each Partner shall at all times procure the Services in accordance with a commitment to equal access to services for all sections of the community;

28.3.4 each Partner shall at all times perform this Deed in accordance with its environmental policy from time to time; and

28.3.5 the Projects shall be performed with proper regard to health safety and security.

28.4 Without prejudice to the generality of Clause 28.1 each Partner shall comply with all of its health safety security and welfare policies (as amended and/or updated from time to time) insofar as they affect or relate to the Services:

28.5 The Parties shall:-

28.5.1 Comply with all applicable laws, statutes, regulations and codes relating to anti-bribery and anti-corruption including but not limited to the Bribery Act 2010

28.5.2 Not engage in any activity, practice or conduct which would constitute an offence under sections 1, 2 or 6 of the Bribery Act 2010 if such activity, practice or conduct had been carried out in the UK.

28.5.3 Comply with each other ethics, anti-bribery and anti-corruption policies insofar as they do not conflict with each other.

29 STANDARDS OF SERVICE

29.1 Best Value

The Council is subject to the duty of Best Value under the Local Government Act 1999 and the CCG is subject to the principles of “value for money” and “best use of resources”. The Partnership Arrangements will therefore be subject to such obligations
and the Council and the CCG will cooperate with all reasonable requests from each other in order to fulfil such obligations

29.2 Clinical Governance

The CCG is subject to a duty of Clinical Governance, being a framework through which it is accountable for continuously improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. The Partnership Arrangements will therefore be subject to Clinical Governance obligations as may be required by the Department of Health from time to time.

29.3 Corporate Governance

The Partners must comply with the principles and standards of corporate governance relevant to the CCG and the Council.

29.4 General Service Standards

General service standards for the Partnership Arrangements will be set in accordance with legislation regulations and guidance produced by all relevant government departments or bodies and as may be agreed locally by the Partners.

29.5 Equality and Equal Opportunities

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

30 PERFORMANCE MANAGEMENT AND INSPECTION

30.1 The Partners will be subject to performance management by the appropriate statutory bodies. The Partnership Arrangements (including each Partnership Schedule) will be subject to the scrutiny of the Partners' internal and external auditors. Each Partner agrees to co-operate with each other and each other's auditors and to provide all necessary information when reasonably requested.

30.2 Where agreed by the Partners specific performance management arrangements relating to the Lead Commissioner's responsibilities in relation to the Schedule or the Pooled Fund or such other matters as may be agreed by the Partners will be included in each Partnership Schedule.
31 MONITORING ARRANGEMENTS

31.1 The Partners will monitor the effectiveness of the Partnership Arrangements using the agreed joint performance indicators as are set out in Schedule 4.

31.2 The Partners shall ensure that adequate and appropriate Staff are provided to help support and monitor any Pooled Fund arrangement.

31.3 The JCG shall monitor the day to day effectiveness of the Partnership Arrangements and report quarterly to the HWB.

32 QUARTERLY REPORTING AND REVIEW

32.1 The Partners shall jointly carry out a quarterly review and prepare a report within 28 days of the end of each Quarter in each Financial Year of:

32.1.1 the Partnership Arrangements and all Projects; and

32.1.2 the statutory functions of each Partner which have been carried out by the other Partner,

and which it will then submit to the respective Boards of each of the Partners.

33 ANNUAL REVIEW AND REPORTING

33.1 The Partners agree to carry out an annual review and prepare a report by no later than 60 Working Days after the end of each Financial Year (and submit a copy to the HWB) of the operation of this Deed including:

33.1.1 an evaluation of performance against agreed performance measures targets and priorities;

33.1.2 review of the targets and priorities for the forthcoming Financial Year;

33.1.3 service delivery;

33.1.4 changes to Services proposed;

33.1.5 shared learning and apportionments for joint training;

33.1.6 an evaluation of any statistics or information required to be kept by the Department of Health from time to time; and
33.1.7 the statutory functions of each Partner which have been carried out by the other Partner in accordance with the provisions of Section 75 of the 2006 Act.

34 CONFLICTS OF INTEREST

The Partners shall maintain and adopt policies for identifying and managing conflicts of interest.

35 SUBSTANDARD PERFORMANCE

In the event that either Partner shall have any concerns over the operation of all or any of the Partnership Arrangements or the standards achieved in connection with the carrying out of the Functions it may convene a review with the other Partner with a view to agreeing a course of action to resolve such concerns. Nothing in this Clause shall prejudice the Partners’ rights to terminate this Deed in accordance with the terms of Clause 37.

36 COMPLAINTS

Complaints will be dealt with by the Partners under the Complaints System, which shall be adopted for the purposes of satisfying the Regulations. The Partners agree to assist one another in the management of complaints and may agree a protocol arising under a Partnership Arrangements and will report annually the number, types and outcome of complaints to the JCG and the HWB. The Complaints System may change from time to time and shall be subject to such other legal requirements regulations and enactments as may affect this Deed.

37 EARLY TERMINATION

37.1 Either Partner may at any time by the service of not less than three months previous notice in writing to the other Partner terminate this agreement and/or a Partnership Arrangement either in whole or in reasonably severable part if:

37.1.1 the other Partner commits a material breach of any of its obligations under the Partnership Arrangement which is not capable of remedy; or

37.1.2 the other Partner commits a material breach of any of its obligations under the Partnership Arrangement which is capable of remedy but has not been remedied within 30 days after receipt of written notice from the terminating Partner requiring remedy of the breach; or

37.1.3 the statutory functions of either Partner are transferred in full or in part to a statutory successor in title (but in this case the notice is required to be such notice as is reasonable having regard to the expected transfer date or that
such transfer does not adequately transfer the rights, liabilities and obligations of this agreement to the said transferee); or

37.1.4 a change in legislation which prohibits or results in a Partner being unable to fulfil some or all of its obligations under that Partnership Arrangement; or;

37.1.5 the undertaking of any commitment or decision pursuant to the Partnership Arrangements which would contravene the guidance or legislation issued by the Secretary of State for Health; or

37.1.6 an act or omission by any one or both of the Partners which is considered by the Department of Health or its advisors to be ultra vires; or

37.1.7 the fulfilment of the obligations of a Partner under a Partnership Arrangement would be ultra vires.

37.2 Termination or expiry of this Deed or a Partnership Arrangement shall not affect a Partner’s rights in respect of any breach or liability by the other Partner which had occurred, arisen or accrued beforehand. This Clause 37 shall not limit any other rights of termination contained in this Deed or in the Partnership Schedule of a particular Partnership Arrangement or otherwise not shall it affect the arrangements and terms contain in a Service Contract where the term of such Contract has yet to expire and which is not capable of early determination.

37.3 Either Partner may at any time terminate this Deed subject always to the terms of clause 38 upon six month previous notice in writing served upon the other Partner if:

37.3.1 the Partners being unable to agree appropriate changes to the commissioning of the Services pursuant to Clause 15.3; or

37.3.2 the Partners being unable to agree their respective financial contributions to a Pooled Fund or Non Pooled Fund for a Financial Year or in relation to an overspend of the Pooled Fund;

37.4 Notwithstanding the term of this Clause 37, either party may terminate this agreement on the service of six month previous notice in writing to expire on the anniversary of the Commencement Date, subject always to the terms of Clause 38.

38 EXIT ARRANGEMENTS

38.1 If a Partnership Arrangement expires or when notice to terminate this Deed or a Partnership Schedule is given by one of the Partners, the Partners agree to co-operate
with each other to ensure an orderly exit of those arrangements and to ensure service continuity.

38.2 Detailed provisions as to exit arrangements for a Partnership Schedule may be set out in any relevant Partnership Schedule.

38.3 Where a Partnership Arrangement expires or is otherwise determined, the Partner who has the relevant statutory responsibility to provide such of the Functions as may be the subject of a Partnership Schedule, shall (where applicable) use its reasonable endeavours to novate any Service Contract to the other Partner who has those responsibilities where that Partner is not a party to the Service Contract.

39 WAIVERS

39.1 Any waiver of a Partner’s rights and/or powers under this Deed or in connection with a particular Partnership Arrangement shall not be binding on that Partner unless evidenced in writing, signed by its properly authorised representatives and clearly intended to waive that right or power.

39.2 The failure of either Partner to enforce at any time or for any period of time any of the provisions of this Deed and/or the Partnership Schedule of a Partnership Arrangement shall not be construed to be a waiver of any such provision and shall in no way affect the right of that Partner thereafter to enforce such provision.

39.3 No waiver in any one or more instances of a breach of any provision hereof shall be deemed to be a further or continuing waiver of such provision in other instances.

40 ENTIRE AGREEMENT

This Deed and a Partnership Schedule constitute the complete agreement between the Partners in relation to a particular Partnership Arrangement and supersede all previous communications representations understandings and agreement and any representation promise or condition not incorporated in this Deed and/or in the relevant Partnership Schedule.

41 CHANGES IN LEGISLATION ETC

The Partners may review the operation of the Partnership Arrangements and all or any procedures or requirements of this Deed on the coming into force of any relevant statutory or other legislation or guidance affecting the Partnership Arrangements so as to ensure that the Partnership Arrangements comply with such legislation.
42 **GOVERNING LAW**

This Deed shall be governed by and construed in accordance with the Law of England and the Partners agree to submit to the non-exclusive jurisdiction of the English Courts.

43 **RESOLUTION OF DISPUTE BETWEEN THE PARTNERS**

In the event of a dispute between the Partners in connection with this Deed the Partners shall first refer the matter to the Accountable Officer of the CCG and the Chief Executive of the Council or their nominated deputies who shall endeavour to settle the dispute between themselves on behalf of the Partners as quickly as possible.

44 **ASSIGNMENT AND SUB-CONTRACTING**

44.1 The Partners may not assign mortgage transfer or dispose of this Deed or any Partnership Arrangement or any benefits and/or obligations hereunder except to any statutory successor in title with the appropriate statutory functions and obligations as herein before referred to.

44.2 The Partners agree that either of them may sub-contract the rights and obligations they may have for the commissioning of the Service Contracts (where it is proposed that such Partner will materially devolve such rights and obligations to a third party) provided that such Partner shall obtain the prior approval of the other Partner and the terms and conditions of such approval shall be more particularly set out in a Partnership Schedule.

45 **NO PARTNERSHIP**

Nothing in this Deed shall create or be deemed to create a legal partnership or the relationship of employer and employee between the Partners.

46 **NOTICES**

46.1 Any notice in connection with this Deed and any Partnership Arrangement shall be in writing.

46.2 Any notice to the relevant Partner shall be deemed effectively served if sent by registered post or delivered by hand at the address of the Partners set out above and marked for the Accountable Officer of the CCG or the Director of Adult Services & Heath of the Council (or the holder of such other post from time to time which carries out substantially the same activities, regardless of his/her job title) or to such other addressee and address notified from time to time to the other Partner.
46.3 Any notice served by delivery shall be deemed to have been served on the date it is delivered to the addressee. Where notice is posted it shall be sufficient to prove that the notice was properly addressed and posted in accordance with Clause 46.2 and the addressee shall be deemed to have been served with the notice 2 Working Days after the time it was posted.

47 THE CONTRACTS (RIGHTS OF THIRD PARTIES) ACT 1999

47.1 The Contracts (Rights of Third Parties) Act 1999 shall not apply to this Deed and/or any Partnership Schedule and accordingly the Partners do not intend that any person not party to it should have any rights in respect of this Deed and/or any Partnership Schedule by virtue of that Act except to the extent indicated in this Deed and/or a Partnership Schedule.

47.2 For the avoidance of doubt the Partners may amend, vary or rescind this Deed and/or the Partnership Schedule of a Partnership Arrangement in accordance with its terms without the consent of any third party, even if such variation or rescission affects the benefits of such third party.

48 VARIATIONS

48.1 The Partners may agree in writing variations to this Deed and/or any Partnership Schedule by deed of variation.

48.2 Such variations shall only be made in accordance with all applicable law and guidance and after such consultation as shall be required by law and guidance.

48.3 No variations shall be binding on the Partners unless made in writing and signed by a duly authorised officer or representative of each of the Partners.

49 CIRCUMSTANCES OUTSIDE CONTROL OF THE PARTNERS

49.1 Neither Partner shall be liable for delay in performing or failure to perform any of its obligations under this Deed, if such delay or failure results from any of the following:

49.1.1 fire or explosion; or

49.1.2 any cause or circumstance whatsoever beyond the particular Partner’s reasonable control other than those in clause 49.2.2.

(any of these "Uncontrollable Circumstances").
49.2 For the avoidance of doubt:

49.2.1 any such event or circumstance shall only be Uncontrollable Circumstances where it occurs after the Commencement Date; and

49.2.2 lack of funds, strikes or labour disputes involving the Staff, or foreseeable adverse weather (or other similar) conditions shall not be Uncontrollable Circumstances.

49.3 If either Partner is prevented or delayed in the performance of any of its obligations under the Deed by Uncontrollable Circumstances, that Partner shall give notice on the other Partner (or communicate in any other reasonable way where giving notice is not reasonably practicable) specifying the nature and extent of the circumstances giving rise to Uncontrollable Circumstances and shall (subject to service of such notice and to Clause 49.5) have no liability in respect of the performance of such of its obligations as are prevented by Uncontrollable Circumstances during the continuation of such Uncontrollable Circumstances, except that rights and liabilities which have accrued prior to such Uncontrollable Circumstances shall continue to subsist.

49.4 The Partner claiming to be prevented or delayed in the performance of any of its obligations under the Deed and/or a particular Partnership Arrangement by reason of Uncontrollable Circumstances shall use all reasonable endeavours to mitigate the effects of the Uncontrollable Circumstances upon the performance of the Deed and to bring the Uncontrollable Circumstances to a close or to find a solution by which the Deed may be performed despite the continuation of the Uncontrollable Circumstances.

49.5 Neither Partner shall be entitled to relief under this Clause 49 to the extent that it has caused or substantially contributed to any delay or failure in the performance of its obligations, including any failure to place orders or issue instructions when it ought reasonably to have done so.

49.6 Nothing in this Clause 49 shall entitle either Partner to avoid or mitigate their obligations to commission such of the Services as is their respective statutory responsibility

50 **INTELLECTUAL PROPERTY**

50.1 Any Intellectual Property supplied by or on behalf of the Service Provider under a Service Contract shall be dealt with in the following manner:

50.1.1 To the extent such Intellectual Property is to belong to a party identified in the Service Contract as ‘the client’ (or the like), it shall belong (as between the
Partners) to whichever of the Partners is identified in the Service Contract as ‘the client’ (or the like).

50.1.2 If the Intellectual Property is to belong to a Partner referred to in paragraph 50.1.1, that Partner shall grant the other Partner a Licence to use that intellectual property on the terms described in clause 50.2 except to the extent otherwise varied in the relevant Partnership Schedule or by agreement of the Partners in writing:

50.2 The terms of any licence granted by the relevant Partner (‘Licensor’) to the other Partner (‘Licensee’) in relation to relevant Intellectual Property (‘Licensed Intellectual Property’) for the purposes of clause 50.1.2 shall be as follows (except to the extent otherwise indicated in the relevant Partnership Schedule or to the extent otherwise agreed by the Partners in writing):

50.2.1 Modifications, adaptations or the like to the Licensed Intellectual Property shall belong to the Licensor regardless of whether created by or on behalf of the Licensor or the Licensee. Such modifications, adaptations or the like shall also be considered ‘Licenced Intellectual Property’ for the purposes of this licence.

50.2.2 The Licensee may be permitted to use the Licensed Intellectual Property only for any of the following purposes to the extent lawful:-

50.2.2.1 For its own internal purposes.

50.2.2.2 To provide services to members of the public which are within the scope of its respective Functions

50.2.3 A Licensee is not permitted to use the Licensed Intellectual Property for any of the following purposes:-

50.2.3.1 Any purpose beyond that indicated in sub-paragraph 50.2.2.

50.2.3.2 For any purpose that puts the Licensor in breach of the Service Contract or otherwise causes it to infringe the intellectual property rights of any third party (even if otherwise within the description in sub-paragraph 50.2.2.

50.2.4 Any use of the Licensed Intellectual Property by the Licensee shall be restricted to the geographical area served by the Licensee from time to time.
50.2.5 No royalty shall be payable by the Licensee to the Licensor in relation to the royalty.

50.2.6 The licence shall be granted on a non-exclusive basis.

50.2.7 Subject to clause 50.2.8, this licence shall continue forever.

50.2.8 The Partners recognise that the licensed over certain kinds of Intellectual Property cannot continue after the termination of a relevant Partnership Arrangement (i.e. where it is not possible for both the Licensor and the Licensee to continue using that Intellectual Property – for example, a website domain name, a mobile telephone ‘app’ etc.). In these circumstances, the following shall apply to the licence granted by the Licensor to the Licensee in relation to the affected Licensed Intellectual Property:

50.2.8.1 That licence shall immediately terminate in relation to that Licensed Intellectual Property on termination of the relevant Partnership Arrangement.

50.2.8.2 The Licensor shall compensate the Licensee for its reasonable costs in obtaining a reasonable replacement to the Licensed Intellectual Property.

50.2.8.3 The Licensor’s obligation to make the above compensation shall not apply if the Licensee has failed (more than 12 months after the termination of this Partnership Arrangement) to give the Licensor notice of the Licensee’s intention to obtain a reasonable replacement (such notice to contain sufficient detail of the proposed replacement, and the Licensee’s reasonable costs).

50.2.9 The Licensee may assign or sub-licence its licence in relation to any particular Licensed Intellectual Property but only with the prior written consent of the Licensor, such consent not to be unreasonably withheld (on the understanding that such consent shall not in itself relief the Licensee of its obligations under the licence).

50.2.10 The Licensor excludes all warranties and representations otherwise implied by Law in relation to the Licensed Intellectual Licensed Property to the fullest extent permitted by law.

50.3 If and to the extent a Partner is granted any licence under or in connection with a Service
Contract (e.g. any arising Intellectual Property, any background Intellectual Property of the Service Provider and/or its third party licensors), the following shall apply:

50.3.1 That Partner shall grant a sub-licence (on comparable terms) to the other Partner promptly on the other Partner’s written request; and

50.3.2 The Partner granting the sub-licence shall be responsible for obtaining all necessary consents (e.g. from the owner of the relevant Intellectual Property) in relation to that sub-licence; and

50.3.3 The cost of granting the sub-licence and obtaining necessary consents shall be borne out of the Pooled Fund (if there is one) or otherwise by the Licensor.

50.4 Any variations to the terms of this clause 50 (where permitted by law) shall be set out in the relevant Partnership Schedule

51 MISCELLANEOUS PROPERTY

The following shall apply to the acquisition or creation of the Miscellaneous Property in existence from time to time unless the Partners otherwise agree in a Partnership Schedule or separately in writing:-

51.1 any Partner which holds any interest in any Miscellaneous Property shall do so as Trustee on its own behalf and on behalf of the other Partner. It shall do so in the same proportions as the Partners have made contributions to the relevant Pooled Fund or (if there is no Pooled Fund in relation to the Miscellaneous Property) those proportions in which they have otherwise contributed to the acquisition or creation of the Miscellaneous Property.

51.2 A Partner must not dispose of its interest in any Miscellaneous Property unless authorised under this Deed, a relevant Partnership Schedule or by the other Partner in writing.

51.3 In the event of a Partnership Arrangement ending for whatever reason Miscellaneous Property shall be dealt with as follows:-

51.3.1 It shall be sold if possible

51.3.2 Each Partners shall have a right of first refusal to purchase the relevant Miscellaneous Property as its then current open market value
51.4 If both partners express an interest in purchasing the relevant Miscellaneous Property the Partners shall conduct a reasonable exercise in which they make closed bids with the highest bidders being entitled to purchase the item.

51.5 All proceeds of sale shall be paid into the relevant Pooled Fund to be dealt with according to this Deed.
IN WITNESS WHEREOF this Deed has been executed as a Deed by the Partners on the date of this Deed

THE COMMON SEAL of )
LIVERPOOL CLINICAL COMMISSIONING )
GROUP was hereunto been affixed )
the day and year first before )
written in the presence of )

EXECUTIVE DIRECTOR

EXECUTIVE DIRECTOR

EXECUTED (but not delivered until the date )
hereof) as a deed by affixing the Common )
Seal of LIVERPOOL CITY COUNCIL )
SCHEDULE 1

Health and Wellbeing Board

Terms of Reference of the Liverpool Health and Wellbeing Board

Introduction

The Health and Social Care Act 2012 states that every upper-tier and unitary local authority in England has a statutory duty to establish a Health and Wellbeing Board for its area, and these boards are treated as if they were a committee appointed under Section 102 of the Local Government Act 1972.

Vision

The Health and Wellbeing Board will improve the outcomes of the citizens of Liverpool through partnership and integrated commissioning.

Accountability

The Health and Wellbeing Board shall be accountable to the City Council.

Functions of the Board

The Health and Social Care Act 2012 gives health and wellbeing boards specific functions. These are a statutory minimum and further functions can be given to the boards in line with local circumstances. The statutory functions are:

- To commission and approve the Joint Strategic Needs Assessments (JSNAs) and the Joint Health and Wellbeing Strategies (JHWSs), (which is a duty of local authorities and clinical commissioning groups (CCGs));

- A duty to encourage integrated working between health and social care commissioners, including providing advice, assistance or other support to encourage arrangements under section 75 of the National Health Service Act 2006 (i.e., lead commissioning, pooled budgets and/or integrated provision) in connection with the provision of health and social care services;

- A power to encourage close working between commissioners of health-related services and the board itself;
• A power to encourage close working between commissioners of health-related services (such as housing and many other local government services) and commissioners of health and social care services;

• Such other functions that may be delegated by the Council under section 196(2) of the Health and Social Care Act 2012. For example, this could include certain public health functions and/or functions relating to the joint commissioning of services and the operation of pooled budgets between the NHS and the Council. Such delegated functions need not be confined to public health and social care. Where appropriate, they could also, for example, include housing, planning, work on deprivation and poverty, leisure and cultural services, all of which have an impact on health, wellbeing and health inequalities.

**Underlying Principles of the HWB**

A number of principles underlie the creation of health and wellbeing boards. These include:

• Shared leadership of a strategic approach to the health and wellbeing of communities that reaches across all relevant organisations;

• A commitment to driving real action and change to improve services and outcomes;

• Parity between board members in terms of their opportunity to contribute to the board’s deliberations, strategies and activities;

• shared ownership of the board by all its members (with commitment from their nominating organisations) and accountability to the communities it serves;

• openness and transparency in the way that the board carries out its work;

• inclusiveness in the way it engages with patients, service users and the public.

**Aims**

The primary aims of the HWB are to promote integration and partnership working between the Local Authority, the NHS and other local services, and improve the local democratic accountability of health.

The HWB will achieve this by –

• Receiving the Annual Review of this agreement carried out by the Partners within 60 days of the end of the relevant Financial Year;
• Receiving such reports as may be prepared by the Partners relating to the Partnership Arrangements

• Promoting the reduction in health inequalities across the City through the commissioning decisions of member organisations and building up strong and effective partnerships;

• Reporting on progress of reducing health inequalities, delivered through commissioning and delivery of services by LCC and the NHS;

• Having the responsibility for delivering the Joint Strategic Needs Assessment for Liverpool;

• Delivering and implementing its Joint Health and Wellbeing Strategy for Liverpool;

• Promoting service integration through effective joint commissioning arrangements and pooled budget arrangements.

**Membership of the HWB**

The Membership of the HWB was agreed at the City Council meeting held on 16th January 2013, as follows:-

<table>
<thead>
<tr>
<th>Appointed Position</th>
<th>Current Holder</th>
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<tbody>
<tr>
<td>Mayor of Liverpool</td>
<td>Mayor Joe Anderson OBE</td>
</tr>
<tr>
<td>Cabinet Member for Adult Social Care &amp; Health /Assistant Mayor</td>
<td>Councillor Roz Gladden</td>
</tr>
<tr>
<td>Cabinet Member for Children’s Services</td>
<td>Councillor Jane Corbett</td>
</tr>
<tr>
<td>Cabinet Member for Housing</td>
<td>Councillor Ann O’Byrne</td>
</tr>
<tr>
<td>Liberal Democrat Elected Member</td>
<td>Councillor Richard Kemp CBE</td>
</tr>
<tr>
<td>Representative of Liverpool Clinical Commissioning Group(1)</td>
<td>Katherine Sheerin</td>
</tr>
<tr>
<td>Representative of Liverpool Clinical Commissioning Group(2)</td>
<td>Dr Nadim Fazlani</td>
</tr>
<tr>
<td>Representative of Liverpool Clinical Commissioning Group(3)</td>
<td>Ray Guy</td>
</tr>
<tr>
<td>Director of Adult Services &amp; Health for Local Authority</td>
<td>Samih Kalakeche</td>
</tr>
<tr>
<td>Director of Children &amp; Young People’s Services for Local Authority</td>
<td>Colette O’Brien</td>
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</tbody>
</table>
Director of Public Health for Local Authority  
Dr Paula Grey

Director of Regeneration & Employment for Local Authority  
Nick Kavanagh

Director of Community Services for Local Authority  
Ron Odunaiya

Director of Finance & Resources for Local Authority  
Becky Hellard

Representative of Liverpool Healthwatch  
To be appointed

Representative of NHS England  
Dr John Hussey

Advisory Member

Former co-Chair of Shadow Health & Wellbeing Board  
Gideon Ben-Tovim OBE

**Further Membership**

The Health and Social Care Act 2012 (Part 5, Chapter 2, Section 194 (8)) states –

“The Health and Wellbeing Board may appoint such additional persons to be members of the Board as it thinks appropriate.”

Prior to the establishment of the Health and Wellbeing Board, Mayor Anderson had written to former co-chair of the Shadow Health and Wellbeing Board Gideon Ben-Tovim inviting him to continue his involvement with the HWB for his extensive knowledge in health matters and for purposes of continuity in the HWB’s development from shadow to full responsibilities. This position as an advisory member of the Board was accepted and was appointed at the Council meeting of 16th January 2013.

The HWB may consider the appointment of further members as it continues its development. This could include representatives from other groups or stakeholders who can bring in particular skills or perspectives, or have key statutory responsibilities which can support the work of the HWB, such as local representatives of the voluntary sector, from criminal justice agencies, academic partners, and clinicians or providers (whilst seeking to avoid potential conflicts of interest in relation to providers.)
**Standing Orders of the Board**

1. **Establishment of Committees and Other Bodies**

The HWB may establish Sub Committees to carry out the work of the HWB and may refer to those bodies such matters as are considered appropriate. Such Committees will operate under Section 102 (2) of the 1972 Local Government Act.

2. **Chairing of Meetings**

The Chair of the Health and Wellbeing Board will be the Mayor of Liverpool, with the Assistant Mayor being Deputy Chair.

3. **Meeting Facilitation and Frequency**

Meetings of the HWB are open to the public, and held in publicly accessible venues. There will be a minimum of six meetings of the Board each municipal year (a minimum of five in its inaugural year). The public may be excluded from meetings whenever it is likely in the nature of the proceedings that exempt information would be disclosed.

4. **Agendas**

The meetings and agendas of the HWB will comply with the Local Government Access to Information rules. Meetings will be summoned with agendas published at least five clear working days before the date of the meetings by electronic notice of the agenda or hard copy. The agenda summons will give the date, time and place of the meeting and specify the business to be transacted, and will be accompanied by such reports as are available. Reports to be submitted to the HWB Board must comply with the attached submission process. (As below)

5. **Urgent Items**

If the Mayor (Chair of the Board) decides that an item of business not included in the agenda for the meeting sent with the summons may be taken for reasons of urgency (which must be specified), that item shall be taken at the end of the other items of business.

6. **Quorum**

The minimum number of voting members to form a quorum for each meeting of the Board is four, to include a minimum of one elected Member and one CCG Member.

7. **Voting**
The HWB will aim for decisions and recommendations will be reached on a consensus basis.

In exceptional circumstances and where decisions cannot be reached by a consensus of opinion, voting will take place and decisions will be agreed by a simple majority by means of a vote of all members with voting rights present. The Chair will exercise a casting vote in cases where there is an equality of votes.

8. Code of Conduct for HWB Members

All Members of the HWB are required to sign up to the Liverpool City Council Code of Conduct 2012.

9. Conflicts of Interest

In accordance with the Code of Conduct, members will need to complete a notification of disclosable pecuniary interests form, and declare any relevant interests at the meetings of the HWB.

10. Public Questions

A question to the HWB by a Member of the Public may only be asked if notice has been given by delivering it in writing or by electronic mail to the Committee Clerk a minimum of three working days prior to the date of the meeting.

11. Audio or Visual Record of Proceedings

No audio or visual record of the proceedings or part of the proceedings of the meetings of the HWB may be taken without the express permission of the HWB.
SCHEDULE 2

Joint Commissioning Group

Terms of Reference

1. **AIMS**

To ensure that the needs for care and health and well being services for people in Liverpool are met effectively and that the resources available across the care and health economy are maximised

2. **CONSTITUTION**

2.1 The Partners have established a joint committee known as the Joint Commissioning Group (JCG) to carry out the day to day management of the decisions of the Partners and HWB. The representation from the Partners will be as follows:-

The Co Chairs will be

- Accountable Officer of Clinical Commissioning Group
- Director of Adult Social Care & Health /Director Public Health

Its membership will comprise;

<table>
<thead>
<tr>
<th>Accountable Officer of Clinical Commissioning Group Liverpool CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director of Adult Social Care &amp; Health LCC</td>
</tr>
<tr>
<td>Director of Public Health LCC</td>
</tr>
<tr>
<td>Assistant Director of Childrens Services LCC</td>
</tr>
<tr>
<td>Associate Director Public Health/Health Improvement LCC</td>
</tr>
<tr>
<td>Assistant Director of Communities LCC</td>
</tr>
<tr>
<td>Director of Finance – Liverpool CCG</td>
</tr>
<tr>
<td>Head of Finance Adults and Children LCC</td>
</tr>
<tr>
<td>Assistant Director of Adult Social Care - LCC</td>
</tr>
</tbody>
</table>
Vice Clinical Chair – CCG

Head of Quality and Chief Nurse / Managerial Lead for Childrens Commissioning Liverpool CCG

Head of Strategy and Outcomes / Managerial Lead for Adults Commissioning, Liverpool CCG.

Lead Officers of operational working groups charged with the delivery of work programmes of HWB will be required to attend as appropriate or when their work is scheduled on the agenda (see list of groups at 4.7)

2.2 The members of the JCG must declare any personal or private business interest they have which might conflict with the decisions and / or interests of the JCG.

2.3 Any of the members or Partners may from time to time replace or fill a vacancy of one or more of its appointees to serve on the JCG.

2.4 Each of the members and Partners shall appoint named persons as substitute members who shall attend meetings of the JCG in the absence of the member.

2.5 The JCG may co-opt persons to sit on the JCG for a fixed period or to assist with specific matters. Any member of the JCG wishing to resign shall give written notice to the Chair of the JCG who shall report the matter to the Partner who has appointed the representative who may then appoint a replacement.

2.7 Extraordinary meetings of the JCG may be called at any time upon a request by a member giving at least 5 prior working days written notice.

2.8 Meetings will only be quorate if no less than 3 members of each Partner organisation is in attendance.

3. **Principles of the Joint Commissioning Group**

3.1 Maximise a collaborative approach and bring together joint arrangements for planning and commissioning, including jointly owned process of strategic realignment of resources and or investment planning.

3.2 Identify and remove barriers that hinder joint commissioning.
3.3 Ensure that in any commissioning decision made, that the seamless delivery of care is seen as paramount.

3.4 Review and build on current commissioning and governance arrangements. Make recommendations for change including widening and deepening of arrangements where it adds value to do so through this Deed and any Partnership Arrangements.

4. Objectives of the Joint Commissioning Group

4.1 The JCG will meet at least bi-monthly and will minute its activity for reporting to the HWB, but will not sit in open meetings, unless for the purpose of a consultative activity and as required by law.

4.2 Agree and manage a joint programme of work that support the principle of ensuring an integrated approach to service delivery and make recommendations on joint commissioning to the HWB.

4.3 Develop and monitor this Deed and any Partnership Arrangement that reflects the intentions of joint commissioning and integrated delivery, providing reports to the HWB on performance.

4.4 Provide leadership to the HWB on the strategic direction for health and wellbeing in Liverpool and the effective management of resources across the health and wellbeing system.

4.5 Ensure that the HWB, the Council and the CCG are fully informed of the key decisions of the JCG and that any issues relating to this Deed and any Partnership Arrangement and the or Partners are fully explained to the HWB.

4.6 Agree a set of outcomes that provides a framework for monitoring of progress of the priorities identified within the Joint strategic Needs Assessment and set out in the Health and Wellbeing Strategy and joint commissioning recommendations and report to the HWB and the Partners upon progress from time to time.

4.7 Define the responsibilities of working groups to ensure delivery of the JCG agreed work programme and agreed outcomes contained within the performance management framework. The working group structure will include the following:

- Joint Strategic Needs Assessment Steering Group
- Health Improvement and Better Lifestyles Group
- Healthy Liverpool Programme Group
- Integrated Care Steering Group
- Childrens Trust Board
- Sports and Physical Activity Strategy Group
- Health Protection Working Group
- Families Strategic Group
- Making It Happen Groups for:
  - Physical Disability and Sensory Impairment and Older People
  - Learning Disability
  - Mental Health
  - Carers
  - Military Veterans

4.8 The Local Safeguarding Boards for Adults and Children will also report to the HWB and provide reports as required to the JCG.

4.9 Prepare responses on request from the New Health Board Scrutiny Panel as required.

4.10 Receive relevant statutory reports and subsequent action plans, including Performance Reviews, reports from the Care quality Commission (CQC) will be presented to the JCG for agreed action and for subsequent reporting to the HWB and the Partners.

5. **Review**

Terms of reference and frequency of meetings will be reviewed on an annual basis.
SCHEDULE 3
Integrated Working Group Structure Chart
Health and Wellbeing Board Delivery Structure

Liverpool City Council Full Council

Liverpool Clinical Commissioning Group Governing Body

Liverpool Health and Wellbeing Board

Local Safeguarding Board for Children

Joint Commissioning Group (Interim)

Local Safeguarding Board for Adults

Delivery Groups
SCHEDULE 4
Joint Performance/Indicators

To be inserted
SCHEDULE 5
Information Sharing Protocol

To be inserted
<table>
<thead>
<tr>
<th>Name of this S75 Partnership Schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Project title</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Lead Partner/Host Partner</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Summary of Services</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
28. **WARRANTIES IN RELATION TO SERVICE CONTRACTS WHICH HAVE ALREADY BEEN ENTERED**
Partnership Schedule to establish a Partnership Arrangement

To be a partnership arrangement for the purposes of section 75 of the National Health Service Act 2006

Project title: indicate

Date of this Partnership Schedule:

Partners: see section 2 (Details of the Partners) of the attached terms of this Partnership Schedule.

1. Introduction:

(A) The parties are Partners under a framework agreement entered into on the [ ] day of [ ] 2014 between for the purposes of section 75 of the National Health Service Act 2006 (“Framework Agreement”).

(B) Under the Framework Agreement, the Partners may from time to time enter into Partnership Arrangements by entering into a Partnership Schedule substantially in this form.

(C) This document is a Partnership Schedule intended to establish and set out the terms of a Partnership Arrangement under the Framework Agreement.

Each Partner agrees as follows:

| 1. Establishment of a Partnership Arrangement | The Partners have on the date above established a Partnership Arrangement under and for the purposes of the Framework Agreement and Section 75 of the National Service Act 2006. |
| 2. Nature of the Partnership Arrangement | The Partnership Arrangement established under this Partnership Schedule for the purposes of commissioning the Services set out below is a partnership arrangement for the purposes of the section 75 of the National Health Service Act 2006. |
| 3. The terms of this Partnership Arrangement: | • As indicated in the Framework Agreement and in this Partnership Schedule. • This Partnership Schedule shall (to the extent lawful) override the Framework Agreement to the extent of any inconsistency. |
| 4. Lead Partner and Host Partner for this Partnership Arrangement: | |
| 5. Pool Manager (in the event of there being a Pooled Fund) | |
6. Partner responsible for notifying the Department of Health of this Partnership Arrangement:
The CCG to do so promptly after this Partnership Schedule is entered.

7. The Services which are to be commissioned:

8. Definitions and rules of interpretation:
Those indicated in the Framework Agreement shall apply to this Partnership Schedule except to the extent that they are otherwise clearly indicated elsewhere in this Partnership Schedule.

Executed by the parties (or on their behalf by their respective authorised representatives) as an agreement on the date indicated above:

<table>
<thead>
<tr>
<th></th>
<th>Council</th>
<th>CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name of signatory (please print)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Title or role of signatory (please print)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Terms of this Agreement

### 2. Details of the Partners

<table>
<thead>
<tr>
<th>Council</th>
<th>CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Liverpool City Council</td>
</tr>
<tr>
<td>Address</td>
<td>Municipal Buildings, Dale Street, Liverpool, L2 2DH</td>
</tr>
</tbody>
</table>

**Current contact person (to be the Pool Manager of whichever Partner is the Host Partner if there is a Pooled Fund)**

**Current contact person’s landline number**

**Current contact person’s mobile number**

**Current contact person’s e-mail address number**

### 3. Background

3.1 Background to this Partnership Arrangement

### 4. Duration of this Partnership Arrangement

4.1 Commencement date of this Partnership Arrangement

The date of this Partnership Schedule.
4.2 When this Partnership Arrangement to end

When neither Partner has any rights, obligation, liabilities, duties, restrictions, prohibitions (or the equivalent) under any of the following:

- Any Service Contract entered under this Partnership Arrangement; and/or
- This Partnership Schedule.

5. Aims and objectives of the Partnership Arrangements

5.1 How the aims and objectives of the Framework Agreement are to be met by this Partnership Arrangement: indicate how at least one of the following aims and objectives of the Framework Agreement are to be met. Complete as many as relevant. At least one is sufficient. Not every item in the list will be relevant – just say 'N/A' in the space for those which don't apply.

(a) To improve the physical and/or mental health, and/or the well-being of the population of the City of Liverpool and/or to reduce the health and well-being inequalities that may exist in the City of Liverpool

(b) To ensure that local communities served by the Partners will be more informed and involved, experience better health and well-being, and improved health care services

(c) To reduce duplication to make the best use of commissioning resources

(d) To lead to a single point of assessment for Clients or Client Groups

(e) To provide more efficient or effective service delivery

(f) To promote independence wellbeing and choice for a Client or Client Group

(g) To contribute to taking forward joint strategies

(h) To develop co-operative working arrangements in respect of the Functions or Services concerned;

(i) To predict future costs of the Functions or the Services.

(j) To align investment and service development to make best use of public resources across health and social care
(k) To ensure that strategic commissioning and service development responds to the expressed needs of Liverpool residents through a joint approach to the engagement of service users and citizens

(l) To result in better and more economic use of resources and improved value for money

(m) To result in easier identification of gaps in provision

(n) To develop joint Performance Indicators and monitoring processes

(o) To result in the commissioning of Services designed around the needs of Clients

(p) To result in sustained improvement in quality

5.2 Other aims and objectives for this Partnership Arrangement (if any and in addition to any identified in clause 5.1):

6. **Strategic Plans**

6.1 How the Partners have satisfied themselves that this Partnership Arrangement will fulfil at least one objective in each of the following Strategic Plans:

| (a) | CCG’s Strategic Commissioning Plan |
| (b) | Council’s commissioning plans |
| (c) | Public Health Annual Report |
| (d) | The JSNA |
| (e) | The HWB’s Joint Commissioning Plans |
| (f) | Health and Wellbeing Strategic Plans |

7. **Projects including terms and conditions**

7.1 This Project shall comprise the following Functions of the respective Partners:

| (a) | Health Related Functions of the Council |
7.2 Any specific requirements or conditions of each Project to which the Partnership Arrangement is to apply

8. JCG approval
8.1 Date of the approval of the JCG for the commissioning of the Services to which this Partnership Arrangement is to apply

9. Consultations
9.1 Summary of consultations which the Partners have already undertaken before entering this Partnership Schedule
9.2 Summary of further consultations which the Partners intend to undertake after entering this Partnership Schedule in order to commissioning the Services

10. Improvements
10.1 How this Partnership Arrangement will improve the outcomes for the health and well-being of the population of the City of Liverpool

11. Client Groups
11.1 Client Groups for whom relevant Services are to be commissioned under this Partnership Arrangement

<table>
<thead>
<tr>
<th>Services</th>
<th>Client Group(s)</th>
</tr>
</thead>
</table>
12. Eligibility criteria

12.1 Eligibility Criteria which must be met by prospective Clients before being eligible to receive Services to be commissioned under this Partnership Arrangement (if applicable)

<table>
<thead>
<tr>
<th>Services</th>
<th>Eligibility Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

13. Pooled Fund

13.1 Is any Pooled Fund to be established under this Partnership Schedule in relation to this Partnership Arrangement?

13.2 If a Pooled Fund is to be established for the purposes of this Partnership Arrangement according to clause 13.1, indicate how the Partners have considered (for the purposes of clause 16 of the Framework Agreement) whether the establishment the Pooled Fund (and the activities for which it will be used) would do any of the following:

(a) Support more effective co-ordination of Services

(b) Increase efficiency

(c) Help maximise creativity and innovation

13.3 The Host Partner of the Pooled Fund (if there is a Pooled Fund) will be:

13.4 Contributions to be made by the Partners to the Pooled Fund (if applicable).

<table>
<thead>
<tr>
<th>By the Council</th>
<th>By the CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(a) First year – capital budget

(b) First year – revenue budget

(c) Subsequent years – capital budget

(d) Subsequent years – revenue budget

13.5 Any third party funds including grant monies to be contributed to the Pooled Fund and by whom and any conditions which have been applied to those funds.
13.6 Any particular activities and/or items of expenditure for which Pooled Funds cannot be used (except by written agreement of the Partners)

14. Overspends

14.1 Basis (i.e., principles, formula etc.) on which the Partners are to contribute to a Pooled Fund established for the purposes of this Partnership Arrangement to meet any overspends from time to time in relation to that Pooled Fund provided that and (unless they otherwise agree in writing, at their discretion)

14.2 Other rules regarding virements and the treatment of overspends and underspends

15. Non-Pooled Fund

15.1 Is any Non-Pooled Fund to be established under this Partnership Schedule in relation to this Partnership Arrangement

15.2 If a Non-Pooled Fund is to be established according to clause 15.1 indicate any special conditions which are to apply:

16. Making payments

16.1 How the Partners are to make payments to each other in relation to this Partnership Arrangement and the Pooled Fund including the date, frequency and mechanism for such payments.
17. **Staff to be made available**

17.1 Staff to be made available by the Partners to take part in activities contemplated in this Partnership Arrangement (or as the Partners otherwise agree in writing from time to time):

<table>
<thead>
<tr>
<th>By the Council</th>
<th>By the CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Staff to be made available – indicate by role</td>
<td></td>
</tr>
<tr>
<td>(b) Extent of availability</td>
<td></td>
</tr>
<tr>
<td>(c) Activities for which relevant Staff are to be engaged</td>
<td></td>
</tr>
<tr>
<td>(d) Whether there is to be Secondment Agreement</td>
<td></td>
</tr>
</tbody>
</table>

18. **Subcontracting the Lead Partner’s commissioning functions**

18.1 Is the Lead Partner to subcontract any of its commissioning functions in connection with this Partnership Arrangement

18.2 If the answer to 18.1 is yes, please indicate when approval has been given by the other Partner which must be in writing.

19. **Financial Levels of Authority of the Partners**

The financial Levels of Authority (i.e. the financial limits to the authority) of the Partners which apply to this Partnership Arrangement, being the levels to which the respective Partners indicated below may make a decision in relation to this Partnership Arrangement without being required to consult the other Partner (such levels to apply to each relevant event or circumstance, or series of connected events or circumstances):

<table>
<thead>
<tr>
<th>By the Lead Partner/Host Partner</th>
<th>By the other Partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>19.1 Placing orders under a Service Contract up to the following amount</td>
<td></td>
</tr>
</tbody>
</table>

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Section 75 Commissioning Schedule
19.2 Agreeing to amendments, variations or the like to a Service Contract resulting in increases in charges, reimbursement of expenses or the like up to the following amount and/or percentage

19.3 Disbursing funds out of a Pooled Fund in relation to a single transaction (or series of connected transactions) up to the following amount

19.4 Other (if applicable)

20. **Non-financial authority of the Partners**

20.1 Rules in relation to any consent a Partner is to give under clause 20.2 to enable the other Partner to act beyond the Levels of Authority referred to in clause 20.2 below

| (a) How the Partner’s consent is to be given: | • In writing unless consent is deemed to have been given in paragraph 20.1.(b).  
• Not to be unreasonably withheld |
| (b) How the Partner’s consent is deemed to have been given: | • If the other Partner fails to respond within the period indicated in the table in clause 20.2, it shall be deemed to have approved the relevant Partner’s action.  
• For this purpose, a response by the other Partner is either of the following:  
  - A clear decision whether consent is (or is not given). If consent is not given, reasons must be included.  
  - A genuine complaint, query and/or request for further information |
20.2 Levels of non-financial authority of the Partners in relation to activities in relation to this Partnership Arrangement (indicate the extent to which a Partner may make decisions in relation to particular matters without requiring the consent of the JCG and/or the other Partner), with the rules in clause 20.2 applying to any consent of the other Partner required below.

<table>
<thead>
<tr>
<th>Issue</th>
<th>Whether the consent of the other Partner is required (yes or no)</th>
<th>Period for the other Partner to respond (10 working days unless otherwise indicated below)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Granting any waivers to compliance with relevant contract procedure rules, standing orders etc. in any competitive exercise (e.g. tender) in relation to any Service Contract</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(b) Issue of any PQQs, RFQs, ITTs or the like (including amendments) for any competitive exercise (e.g. tender) in relation to any Service Contract.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(c) Issue of any contractual documents (e.g. terms and conditions, specifications) in relation to any Service Contract</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(d) Disqualification of any prospective bidder from any tender exercise</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(e) Selection of any evaluation panel in any competitive exercise (e.g. tenders) in relation to any Service Contract</td>
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<td></td>
</tr>
<tr>
<td>(f) Decision to abandon any competitive exercise (e.g. tenders) in relation to any Service Contract</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(g) Decision to award any Service Contract</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(h) Decision to revoke the award of a Service Contract</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(i) Extending a Service Contract</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Section 75 Commissioning Schedule</td>
<td></td>
</tr>
<tr>
<td>---</td>
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<td></td>
</tr>
<tr>
<td>(j)</td>
<td>Amending a Service Contract</td>
<td></td>
</tr>
<tr>
<td>(k)</td>
<td>Granting any consent to the use of subcontractors in connection with a Service Contract</td>
<td></td>
</tr>
<tr>
<td>(l)</td>
<td>Granting any consent to any change in control of a Service Provider</td>
<td></td>
</tr>
<tr>
<td>(m)</td>
<td>Granting any other material consent in connection with a Service Contract</td>
<td></td>
</tr>
<tr>
<td>(n)</td>
<td>Requiring the removal of subcontractors and/or personnel from a Service Contract</td>
<td></td>
</tr>
<tr>
<td>(o)</td>
<td>Granting any material waiver, release or the like in connection with a Service Contract</td>
<td></td>
</tr>
<tr>
<td>(p)</td>
<td>Exercising any rights of set off, deduction or the like in connection with a Service Contract</td>
<td></td>
</tr>
<tr>
<td>(q)</td>
<td>Exercising any step in rights in relation to a Service Contract</td>
<td></td>
</tr>
<tr>
<td>(r)</td>
<td>Exercising any rights to require suspension of activities in relation to a Service Contract</td>
<td></td>
</tr>
<tr>
<td>(s)</td>
<td>Making any claim and/or issuing proceedings against the Service Provider and/or against anyone connected with the Service Provider (e.g. its personnel, subcontractors) in relation to a Service Contract</td>
<td></td>
</tr>
<tr>
<td>(t)</td>
<td>Making any insurance claim in relation to any Service Contract</td>
<td></td>
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<td></td>
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<td>---</td>
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<tr>
<td>(u)</td>
<td>Settling any insurance claim in relation to any Service Contract below the value of the loss</td>
<td></td>
</tr>
<tr>
<td>(v)</td>
<td>Settling any dispute with the Service Provider and/or with anyone connected with the Service Provider (e.g. its personnel, subcontractors) in connection with a Service Contract</td>
<td></td>
</tr>
<tr>
<td>(w)</td>
<td>Disposing of any Miscellaneous Property provided by the Service Provider in relation to a Service Contract which is intended for the joint benefit of the Partners</td>
<td></td>
</tr>
<tr>
<td>(x)</td>
<td>Allowing any person (other than a Partner) to use any property described in section 22 (Property acquired in Partnership Arrangement activity)</td>
<td></td>
</tr>
<tr>
<td>(y)</td>
<td>Appointing any agent to act on behalf of the Partners jointly in connection with this Partnership Arrangement and/or any particular Service Contract</td>
<td></td>
</tr>
<tr>
<td>(z)</td>
<td>Appointing any person or firm to provide the Partners jointly with any professional advice in relation to this Partnership Arrangement and/or any particular Service Contract</td>
<td></td>
</tr>
<tr>
<td>(aa)</td>
<td>Amendment, destruction or removal of records in relation to this Partnership Arrangement and/or any particular Service Contract</td>
<td></td>
</tr>
<tr>
<td>(bb)</td>
<td>Other – to indicate</td>
<td></td>
</tr>
</tbody>
</table>
21. Terminating Service Contracts

21.1 **Right** of the Lead Partner to terminate a Service Contract (or any part) for convenience or for the Service Provider’s default (if any such termination is permitted under the Service Contract) without requiring the consent of the other Partner (Y/N)

21.2 **Obligation** of the Lead Partner to terminate the Service Contract (or any part) for convenience or for the Service Provider’s default (if any such termination is permitted under the Service Contract) if requested to do so by the other Partner (Y/N)

22. Property acquired in Partnership Arrangement activity

22.1 Indicate any **changes** to the arrangements set out in the Framework Agreement between the Partners in relation to Miscellaneous Property and/or property acquired by a Partner whether in connection with a Service Contract and/or using funds from a Pooled Fund and/or a Non-pooled Fund:

22.2 Indicate any changes to the arrangements in the Framework Agreement between the Partners in relation to any Intellectual Property acquired or supplied by or on behalf of the Service Provider under a Service Contract (where permitted in law)

23. Refunds, credits etc

23.1 Indicate any **changes** to the standard arrangements indicated in the Framework Agreement between the Partners in relation to reliefs, credits, refunds, rebates, awards of damages or other compensation (or the like of any of these) received by a Partner in connection with a Service Contract and/or in relation to the Services (see the Framework Agreement itself or the accompanying guidance for details):
24. Performance management

24.1 The details of performance management’s arrangements in relation to this Partnership Arrangement of the Lead Commissioner obligations and/or the Pooled Fund shall be as follows:-

<table>
<thead>
<tr>
<th>Frequency/due date</th>
<th>Information required</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Financial</td>
<td></td>
</tr>
<tr>
<td>(b) Activity</td>
<td></td>
</tr>
<tr>
<td>(c) Quality indicators</td>
<td></td>
</tr>
<tr>
<td>(d) Project specific outcomes</td>
<td></td>
</tr>
<tr>
<td>(e) Other indicators, as appropriate</td>
<td></td>
</tr>
</tbody>
</table>

24.2 Whether this Partnership Arrangement is expected to satisfy any of the following elements of the Better Care Fund (where applicable) and in particular the requirement to retain the 25% of such fund attributed by the Secretary of State for Health for meeting the required performance standards (yes/no):

<table>
<thead>
<tr>
<th>Yes/no</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(a)</td>
<td>Delayed transfers of care</td>
</tr>
<tr>
<td>(b)</td>
<td>Emergency admissions</td>
</tr>
<tr>
<td>(c)</td>
<td>Effectiveness of reablement</td>
</tr>
<tr>
<td>(d)</td>
<td>Admissions to residential and nursing care</td>
</tr>
<tr>
<td>(e)</td>
<td>Patient and service user experience</td>
</tr>
<tr>
<td>(f)</td>
<td>Other conditions</td>
</tr>
</tbody>
</table>

25. VAT and Income Tax

25.1 VAT and Income Tax treatment of this Partnership Arrangement shall be dealt with in the following manner:
26. **Exit obligations**

26.1 Indicate any exit plan applicable to this Partnership Arrangement with which the Partners must comply when a Service Contract comes to an end and the relevant services which are not to be re-commissioned under this Partnership Arrangement (any specific plans should be set out in a separate Annexure to this Agreement)

27. **Service Contracts which have already been entered into prior to the date of this Partnership Schedule**

The relevant details of the Service Contracts which are to become part of these Partnership Arrangements are set out below

<table>
<thead>
<tr>
<th>Issue</th>
<th>Service Contract 1</th>
<th>Service Contract 2</th>
<th>Service Contract 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>27.1  Brief description of the Service Contract</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27.2  Which Partner is the relevant client under the Service Contract?</td>
<td>The Lead Partner</td>
<td>The Lead Partner</td>
<td>The Lead Partner</td>
</tr>
<tr>
<td>27.3  the terms and conditions of the Service Contract recorded (e.g. whether a formal contract, SLAs, etc.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27.4  Whether the terms and conditions of the Service Contract (including any SLAs or the like) have been disclosed to the other Partner</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27.5  Expiry date of Service Contract</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27.6  Whether there is any right of the relevant client to extend the Service Contract</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
27.7 Effective date on which the Service Contract is to form part of this Partnership Arrangement

<table>
<thead>
<tr>
<th>Service Contract 1</th>
<th>Service Contract 2</th>
<th>Service Contract 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

28. Warranties in relation to Service Contracts which have already been entered

Warranties and representations given by the Partner who is the relevant client under the Service Contract according to clause 27.2 (‘Warrantor’) to the other Partner (‘Other Partner’) on the date of this Partnership Schedule. These warranties and representations apply except to the extent otherwise disclosed by the Warrantor to the Other Partner below, or in writing on or before the date of this Partnership Schedule:

<table>
<thead>
<tr>
<th>Service Contract 1</th>
<th>Service Contract 2</th>
<th>Service Contract 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

28.1 The terms and conditions of the Service Contract as disclosed to the Other Partner are materially accurate and complete, and properly incorporate any amendments.

Indicate whether the above statement is true or not (yes/no), indicating any disclosures, qualifications to the above statement:

<table>
<thead>
<tr>
<th>Service Contract 1</th>
<th>Service Contract 2</th>
<th>Service Contract 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

28.2 The Warrantor has no good reason to believe (having made reasonably necessary inquiry) that any events or circumstances have occurred (or are imminent) which are reasonably likely to result in the Service Provider being unable to materially meet its obligations under the Service Contract.

Indicate whether the above statement is true or not (yes/no), indicating any disclosures, qualifications to the above statement:

<table>
<thead>
<tr>
<th>Service Contract 1</th>
<th>Service Contract 2</th>
<th>Service Contract 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

28.3 The Warrantor is not aware (having made reasonably necessary inquiry) that any reasonably significant change to the way the Service Provider is to carry out its activities in relation to the Service Contract (e.g. changes to material subcontractors, key personnel etc., changes to the method of service delivery) is reasonably imminent.

Indicate whether the above statement is true or not (yes/no), indicating any disclosures, qualifications to the above statement:

<table>
<thead>
<tr>
<th>Service Contract 1</th>
<th>Service Contract 2</th>
<th>Service Contract 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
28.4 The Warrantor has not issued any unresolved claim or proceedings (or the like) against the Service Provider and/or its subcontractor in connection with the Service Contract (whether seeking compensation, any injunction or specific performance, or any other remedy).

Indicate whether the above statement is true or not (yes/no), indicating any disclosures, qualifications to the above statement:

28.5 The Warrantor has no good reason to believe (having made reasonably necessary inquiry) that it has good reason to issue any claims or proceedings of the like described in clause 28.4 against the Service Provider or anyone else in connection with or arising out of the Service Contract.

Indicate whether the above statement is true or not (yes/no), indicating any disclosures, qualifications to the above statement:

28.6 The Warrantor is not in receipt of any unresolved claim or proceedings (or the like) from the Service Provider in connection with the Service Contract (whether for unpaid charges or otherwise) and has no reasonable grounds to believe any such claim, proceedings or the like is imminent.

Indicate whether the above statement is true or not (yes/no), indicating any disclosures, qualifications to the above statement:

28.7 The Warrantor is not in receipt of any unresolved claim or proceedings (or the like) made against it by any third party relating to the acts or omissions of the Service Provider (and/or those of anyone acting on its behalf) in connection with the Service Contract and has no reasonable grounds to believe any such claim, proceedings or the like is imminent.

Indicate whether the above statement is true or not (yes/no), indicating any disclosures, qualifications to the above statement:
28.8 The Warrantor is not in receipt of any unresolved claim or proceedings (or the like) made against it by any third party relating to the procurement of the Service Contract by or on behalf of the Service Contract and has no reasonable grounds to believe any such claim, proceedings or the like is imminent.

Indicate whether the above statement is true or not (yes/no), indicating any disclosures, qualifications to the above statement:

28.9 There is no unresolved dispute between the Warrantor and the Service Provider in connection with the Service Contract and has no reasonable grounds to believe any such dispute is imminent.

Indicate whether the above statement is true or not (yes/no), indicating any disclosures, qualifications to the above statement:

28.10 The Warrantor has not issued any notice to terminate the Service Contract.

Indicate whether the above statement is true or not (yes/no), indicating any disclosures, qualifications to the above statement:

28.11 The Warrantor has not received any notice given by or on behalf of the Service Provider to terminate the Service Contract.

Indicate whether the above statement is true or not (yes/no), indicating any disclosures, qualifications to the above statement:

28.12 The Warrantor has not issued any notice to the Service Provider requiring it to remedy any breach, which (if not remedied) would result in an event of default (or the like) of the Service Provider under the Service Contract.

Indicate whether the above statement is true or not (yes/no), indicating any disclosures, qualifications to the above statement:
28.13 **The Warrantor has not received any notice given by or on behalf of the Service Provider requiring the Warrantor to remedy any breach, which (if not remedied) would result in an event of default (or the like) of the Warrantor under the Service Contract.**

Indicate whether the above statement is true or not (yes/no), indicating any disclosures, qualifications to the above statement:

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Disclosures</th>
<th>Qualifications</th>
</tr>
</thead>
</table>

28.14 **The Warrantor has not issued any notice to the Service Provider requesting any change to the Service Contract where that change is not currently included in the terms and conditions of the Service Contract.**

Indicate whether the above statement is true or not (yes/no), indicating any disclosures, qualifications to the above statement:

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Disclosures</th>
<th>Qualifications</th>
</tr>
</thead>
</table>

28.15 **The Warrantor has not received any notice given by or on behalf of the Service Provider requesting any change to the Service Contract where that change is not currently included in the terms and conditions of the Service Contract.**

Indicate whether the above statement is true or not (yes/no), indicating any disclosures, qualifications to the above statement:

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Disclosures</th>
<th>Qualifications</th>
</tr>
</thead>
</table>

28.16 **The Warrantor has no good reason to believe that any notice of the kind described in clause 28.11, clause 28.13 and/or clause 28.15 is to be issued by or on behalf of the Service Provider reasonably imminently.**

Indicate whether the above statement is true or not (yes/no), indicating any disclosures, qualifications to the above statement:

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Disclosures</th>
<th>Qualifications</th>
</tr>
</thead>
</table>

28.17 **The Warrantor has no good reason to believe (having made reasonably necessary inquiry) that any event of default (or other circumstance justifying termination for default by the Warrantor) applies to the Service Provider in relation to the Service Contract.**

Indicate whether the above statement is true or not (yes/no), indicating any disclosures, qualifications to the above statement:

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Disclosures</th>
<th>Qualifications</th>
</tr>
</thead>
</table>
28.18 The Warrantor has no good reason to believe (having made reasonably necessary inquiry) that any event of default (or other circumstance justifying termination for default by the Service Provider) applies to the Warrantor in relation to the Service Contract.

Indicate whether the above statement is true or not (yes/no), indicating any disclosures, qualifications to the above statement:

28.19 Services and other activities under the Service Contract are not currently suspended for any reason, and there is no good reason for the Warrantor to believe (having made reasonably necessary inquiry) that such suspension is reasonably imminent for any reason.

Indicate whether the above statement is true or not (yes/no), indicating any disclosures, qualifications to the above statement:

28.20 The Warrantor has not granted the Service Provider any relief, exemption, waiver, extension of time (or the like) in connection with the Service Contract to which either or both of the following apply:

- It is reasonably significant.
- It reasonably affects activities in connection with the Service Contract expected to continue after the date of this Partnership Schedule.

Indicate whether the above statement is true or not (yes/no), indicating any disclosures, qualifications to the above statement:

28.21 None of the rights, benefits, entitlements or powers (or the like of any of these) of the Warrantor have (to the knowledge of the Warrantor, having made reasonably necessary inquiry) been assigned (in full or part) to any person.

Indicate whether the above statement is true or not (yes/no), indicating any disclosures, qualifications to the above statement:
28.22 The Warrantor has not made any disclosures to the Other Party about the Service Provider and/or the Service Contract and/or the Services and/or any other reasonably relevant matter which are reasonably likely to mislead the Other Party.

Indicate whether the above statement is true or not (yes/no), indicating any disclosures, qualifications to the above statement:

28.23 The Warrantor has not deliberately failed to make any disclosures to the Other Party about the Service Provider and/or the Service Contract and/or the Services and/or any other reasonably relevant matter which, on a reasonable view, would materially affect a reasonable person in the Other Party's position to enter into this Partnership Schedule on these terms.

Indicate whether the above statement is true or not (yes/no), indicating any disclosures, qualifications to the above statement:
EXPLANATORY NOTE
FOR
PARTNERSHIP SCHEDULES

Explanatory Note
This document is intended to aid those who are to complete Partnership Schedules for such of the Services, which are to be the subject of Partnership Arrangements. Where appropriate, the Partnership Schedules may need to be completed by reference to the main Framework Agreement.

The comments below should be read in conjunction with the same numbering set out in the draft Partnership Schedule. This Note does not deal with each and every clause where completion of those clauses may be self-explanatory. However, in the event of any query or uncertainty, such matters should be referred to the relevant Director of the Partners for further clarification.

<table>
<thead>
<tr>
<th>SIGNATORIES</th>
<th>The Partnership Schedule should be completed by the Authorised Officers of the Council and the CCG where indicated on page 4 and once it is agreed that the document should be completed, both parties should date their relevant copies at the top of page 3.</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. DURATION OF THE PARTNERSHIP ARRANGEMENT</td>
<td>The partnership arrangement shall commence on the dating of the Partnership Schedule and as referred to in paragraph 4.2 will only end when both the Partnership Schedule and any Service Contract has come to an end. Therefore, while the Partnership Schedule might have been terminated by the parties, if there is a Service Contract still in existence, with time still to run, the partnership arrangements will continue until that Service Contract has ended. It is therefore important, that wherever possible, a Service Contract should have an additional clause which would allow it to be terminated</td>
</tr>
</tbody>
</table>
should the parties terminate the respective Partnership Schedule.

| 5. AIMS AND OBJECTIVES OF THE PARTNERSHIP ARRANGEMENTS | Examples of proposed aims and objectives of the partnership arrangements should be set out in this clause, but all may not necessarily be applicable in which case it should simply state “N/A”.

Additional aims and objectives should be identified in paragraph 5.2 appropriate to the service. |
|-------------------------------------------------------|
| 7. PROJECTS INCLUDING TERMS AND CONDITIONS            | • Depending upon which of the Councils and CCG services are to be the subject of these arrangements, the details of the functions should be set out in sub-paragraph (a).

• Any specific requirements in relation to those functions and arrangements should be set out in paragraph 7.2. |
<p>| 9. CONSULTATIONS                                      | It is important that appropriate consultants including those required under statute should be listed under paragraph 9.1 and 9.2. Where possible consultation should have been undertaken prior to entering into the Partnership Schedule. |</p>
<table>
<thead>
<tr>
<th></th>
<th><strong>POOLED FUND</strong></th>
<th>Where the contributions by the Partners to the Pooled Fund are known, these should be completed and if subsequent years are known these may also be completed where indicated. If they are not known then simply enter “N/A” Subsequent contributions need to be recorded separately by the Partners during each year of the term by simple completion of a Memorandum of Agreement and signed by both parties.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>OVERSPENDS</strong></td>
<td>Contributions to an overspend of the Pooled Fund may differ from one partnership arrangement to the other so, for example, where the initial contribution by one Partner was not equal to the other, any overspend should not be shared equally. Contributions may be effected by not only finance, but by the size of the service being commissioned by either Partner. Any other specific rules regarding the treatment of overspends or underspends should be set out in paragraph 14.2.</td>
</tr>
<tr>
<td></td>
<td><strong>NON-POOLED FUND</strong></td>
<td>A non-pooled fund may be established for a capital budget. Those monies may also be the subject of Grant payments received from third parties or other NHS bodies. Special conditions may apply as to how those monies are to be spent, particularly where conditions were attached to those Grant payments and these should be set out in paragraph 15.2.</td>
</tr>
</tbody>
</table>
| 18. **SUBCONTRACTING THE LEAD PARTNER’S COMMISSIONING FUNCTIONS** | It will be important for the non lead Partner to understand whether some of the commissioning functions are to sub-contracted to third party organisations. These should be set out in paragraph 18.1.  

In the event that sub-contracting does take place this must be approved by the other Partner and the date of such approval, which must be writing, should be entered in paragraph 18.2. |
|---|---|
| 19. **FINANCIAL LEVELS OF AUTHORITY** | The Host Partner will manage the Pooled Fund and will be entitled to commission the cost of Services up to but not beyond their respective levels of authority in accordance with the Standing Financial Instructions. However, the Partners may decide that the levels of authority may differ from service to service and the maximum amount which may be expended by a Partner should then be set out in paragraph 19.1  

In the event of any amendments or variations to a particular Service Contract which may lead to further costs, approval will be required from the non Host Partner, unless otherwise stated. Details should be set out in paragraph 19.2.  

Additionally, certain disbursements may be funded out of the Pooled Fund, but again the maximum amount should be set out. |
<table>
<thead>
<tr>
<th>20. <strong>Non-Financial Authority of the Partners</strong></th>
<th>It is accepted that certain actions, other than financial ones, but will require the authority of the other Partner. These must be writing, unless, as stated in paragraph 20.1.(b), the other Partner has failed to respond within the time limits listed in paragraph 20.2 when approval will be deemed to have been given. If the other Partner does respond in time, but consent is not given, the reasons must be given in writing. Examples of any issues which will require the approval of the other Partner are listed in paragraph 20.2. These require a response within 10 days. There is provision to add further matters requiring approval, in addition to those listed in this clause.</th>
</tr>
</thead>
<tbody>
<tr>
<td>21. <strong>Terminating Service Contracts</strong></td>
<td>It is intended that the Lead Partner will only be able to terminate a Service Contract with the prior approval of the other Partner unless the other Partner has no wish to do so, in which event, this should be stated in paragraph 21.1. If it intended that the other Partner should unilaterally be able to call upon the Lead Partner to terminate a Service Contract then clause 21.2 should be completed.</td>
</tr>
</tbody>
</table>
| 22. **PROPERTY ACQUIRED IN PARTNERSHIP ARRANGEMENT ACTIVITY** | Miscellaneous Property is defined in the Framework Agreement as being tangible or intangible property other than intellectual property which is acquired with monies from a Pooled Fund or Non-Pooled Fund. Tangible property is one where there is an estimated lifespan in excess of twelve months at the day of purchase.

If neither a Pooled or Non-Pooled Fund is used to acquire or create some Miscellaneous Property then the purchasing Partner shall hold it on Trustee on behalf of the other Partner.

Specific provisions as to how Miscellaneous Property is to be dealt with are set out in the main Framework Agreement but if they are to be varied they should be set out in this clause. |

| 23. **REFUNDS AND CREDITS** | The main Framework Agreement provides that any credits, refunds, rebates, damages or like compensation received by a Partner in connection with the Service Contract and/or relating to the Services shall be paid into the Pooled Fund or Non-Pooled Fund (as applicable) in accordance with the Framework Agreement unless it is a compensating a Partner for its own loss. Should there be any changes to these arrangements, they will need to be set out and indicated here. |
| **24. Performance Management** | It should be noted that under paragraph 24.2, there is specific mention of the Better Care Fund and reference should be made to the National Conditions and the Matrix which have been set out and whether these are likely to be met by:- a yes or no answer. 
Both Partners are able to agree other conditions which should be set out in paragraph 24.2.(f). While there is no requirements for the matrix to be in place before the 1st April 2015, the intention of the Partners is to review the Matrix and for arrangements to be put in place during the financial year 2014/15 (wherever possible). |
| **25. VAT and Income Tax** | Specific arrangements may apply to a Partnership Arrangement and the tax implications and treatment for such matters will be different for each Partner. Appropriate professional advice will need to be taken prior to the completion of each Partnership Schedule. |
| **26. Exit Obligations** | In the event of the Partnership Schedule coming to an end specific arrangements will need to be put in place. However, if both parties have agree a pre-existing plan, (in the event of a Partnership Schedule or a Service Contract coming to an end), these should be set out either in the box provided or by a separate Annex to the Agreement. |
| **27. SERVICE CONTRACTS ENTERED INTO PRIOR TO THE DATE OF THE PARTNERSHIP SCHEDULE** | If the Partners have agreed that pre-existing Contracts should now come within the lead commissioning arrangements and pooled budget arrangements, details should be set out within this clause. If there are numerous Contracts they may be set out in a separate excel spreadsheet by way of a separate annexure if it is felt appropriate. It is intended that the relevant Lead Partner will act as agent on behalf of the other, in the event that they are not the client under a Service Contract. |
| **28. WARRANTIES IN RELATION TO SERVICE CONTRACTS WHICH HAVE ALREADY BEEN ENTERED INTO** | The Warranties which are intended to be given in the Partnership Schedule are important to the extent that any misrepresentation or incorrect Warranty will have adverse implications for the Partner giving the same. Therefore, they need to be accurate and any exceptions or qualification of matters which need to be disclosed, should be set out clearly where appropriate, against each entry. |
**Title of Report**
All Equal All Different
A report of an Action Learning Group investigation into what Liverpool CCG can do to address health inequalities and how

**Lead Governor**
Ed Gaynor  
Maureen Williams  
Moira Cain  
Dave Antrobus

**Senior Management Team Lead**
Tom Jackson, Chief Finance Officer

**Report Author**
Health Inequalities Action Learning Group, HiCCG Project

**Summary**
The purpose of this paper is to:
- review the current local policy approach to health inequalities in the wider context
- make specific recommendations to enable achieving LCCG’s vision to reduce health inequalities a reality

**Recommendation**
That Liverpool CCG Governing Body:
- Considers and accept the 12 recommendations from the paper
- Considers supporting the use of the Action Learning model in other areas of LCCG’s work
- Considers the next steps for internal and wider circulation of the report

**Impact on improving health outcomes, reducing inequalities and promoting financial sustainability**
The recommendations of the report were guided by the notion of proportional universalism as described in the Marmot review and therefore are expected to reduce the gradient of health inequalities, leading to improved health outcomes for the city. Financial sustainability comes through the improved health status of the population thereby decreasing demand on health services.
All Equal All Different

A report of an Action Learning Group investigation into what Liverpool CCG can do to address health inequalities and how

Authors:

Members of the Health Inequalities Action Learning Group of the HiCCG Project, supported by the HiCCG research team (Appendix 3, p. 25)

Funded by Liverpool Health Inequalities Research Institute (LivHIR)

Hosted by The University of Liverpool

January 2014
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</tbody>
</table>
EXECUTIVE SUMMARY

Report from the HiALG investigation into possibilities for the CCG’s Action against Health Inequalities in Liverpool

The Health Inequalities Action Learning Group (HiALG) consisted of 12 professionals from Liverpool City Council (LCC) and Liverpool Clinical Commissioning Group (LCCG), and a researcher from the University of Liverpool (UoL). The group was formed within an action research project on health inequalities (HiCCG Project), funded and monitored by the Liverpool Health Inequalities Research institute (LivHIR). The researcher from the University of Liverpool supported the group and observed its performance.

The group was united in recognizing the importance of reducing health inequalities for many reasons. There are the obvious ethical and moral issues, the legal responsibilities of relevant organisations (including the one placed by the government on the CCGs), and the economic implications of tackling and not tackling such inequalities. There are also opportunities for the new LCCG to build on, and go beyond, the legacy of the old Primary Care Trust (PCT).

The group accepted the evidence presented in The Marmot Review and elsewhere that health inequalities are the result of multiple factors beyond the control of any one organisation. There are also multiple equally valid ways of considering the solutions.

However, there was a clear recognition that by reducing some aspects of health inequalities in the city, LCCG actions could, would and do make a difference to the outcomes of the life chances of people in Liverpool.

Many of the recommendations from the group confirm and fall within the current strategy of LCCG, its commissioning intentions, programmes and methodologies. There are no red hot discoveries to be implemented, but rather a confirmation of “what works” and a strong recommendation for LCCG to raise the profile of its work in this area and to systematise and embed this work in its structures and processes.
MAIN RECOMMENDATIONS TO LCCG

LCCG tackles inequalities as a commissioner of services, as a direct employer of around 80 people and as a membership organisation of 94 GP practices providing primary health care to around 490,000 people across the city.

Much of LCCG current activities and work streams are focused on reductions in health inequalities but some of this work would benefit from being articulated and acknowledged, more explicitly, as intending to deliver the outcome of reducing health inequalities.

LCCG is not just a membership organisation but also a partnership organisation. As well as raising the profile of its own work around health inequalities, in its three roles mentioned above, it should consistently put this issue into its shared services and working agenda, remembering that many policies addressing health Inequalities may not bear fruit for several decades.

As a group we have concluded that LCCG should:

**Keep working collaboratively with Liverpool City Council.** Specifically, supporting the establishment of a working group of the Health and Well Being Board expressly charged with ensuring that addressing health inequalities is reflected in all spending plans, strategic decisions and operational matters.

**Ensure that no commissioning decision actually increases health inequalities.** When commissioning, de-commissioning or reallocating resources, LCCG needs to continue using the extensive knowledge and critical skills it has within the organisation. Any change in commissioning strategy should be evaluated by appropriate stakeholders/experts (including the in-house analysts/intelligence team) in terms of its positive and negative impact on health inequalities.
Make sure that the responsibility and vision of tackling health inequalities is embedded in LCCG’s governance and operational procedures. We suggest that a dedicated Committee, with a very senior chair, takes on the responsibility for advocating, monitoring and supporting progress on this issue.

Make formal arrangements for training (continual professional development) for LCCG, from Governing Body Members and General Members through to all employees in relation to health inequalities.

Require everybody to consider health inequalities explicitly. Ensure that all papers being considered by the board and the senior management team have a response to the following question on their front cover: “Does this proposal have any positive or negative impact on health inequalities? If so, give details including how this might be measured.”

Be a strong advocate of a seamless service delivery for all children and young people. The current fragmentation of Children’s Services impacts disproportionately on vulnerable children, as they and their families are less able to negotiate the increasingly divided services.

Use its power as a direct employer and commissioner to write into service specifications and procurement tenders a requirement for good employment practice. Ensuring, through contracts, that all providers pay at least the Living Wage could have a considerable impact on inequalities. LCCG should also consider the health consequences of gaps in pay differentials. It would be an important sign of CCG commitment to reducing health inequalities if the board passed a resolution to work towards decreasing current pay differentials.
Increase understanding and develop the use of the Social Value Act (2012) within the organisation to help increase the cohesiveness of our communities and society in Liverpool.

Continue to prioritise, and increase collaboration and co-operation between GP practices and community groups and organisations at the neighbourhood level and encourage an understanding of how joint working can help define inequities within a community and work towards ameliorating them.

Value and enhance the important roles undertaken by many of the Membership Practices in training the next generation of Primary Care professionals (including GPs), recognising such training as an important tool in the long term project of reducing health inequalities.

Continue to beat the drum of health inequity and the need to diminish it for all our sakes. Make combating health inequalities a keynote strand of the overall communication strategy which will be two-way communication and will include a range of ways of tapping into citizens’ views.

Use the strength this city has in its various organisations, including its universities which have some of the top academics in the field of health inequalities, to continue to educate us all, support our actions and to continue raising awareness and knowledge of the negative impacts of inequalities on social determinants of health.
INTRODUCTION

About the Health Inequalities Action Learning Group (HiALG)

The Health Inequalities Action Learning Group (HiALG) consisted of 12 professionals from Liverpool City Council (LCC) and Liverpool Clinical Commissioning Group (LCCG), and a researcher from the University of Liverpool (UoL). The HiALG was formed within an action research project on health inequalities (HiCCG Project\textsuperscript{1}), funded and monitored by the Liverpool Health Inequalities Research institute (LivHIR). The researcher from the University of Liverpool supported the group and observed its performance.

The HiALG was united in recognizing the importance of reducing health inequalities for many reasons. There are the obvious ethical and moral issues, the legal responsibilities of relevant organisations (including the one placed by the government on CCGs), and the economic implications of tackling and not tackling such inequalities. There are also opportunities for the new LCCG to build on, and go beyond, the legacy of the old Liverpool Primary Care Trust (PCT).

The group met on a regular basis from Feb to Oct 2013 (one hour long preliminary meeting and six half days), to engage in a collaborative learning process and develop ideas around what LCCG can do to address health inequalities and how. The membership included senior GPs, LCCG governing body members, senior LCC and LCCG managers, a public health consultant, a practice nurse and an NHS information analyst. The group determined its own priorities. Individual members chose their own different aspects of the work to complete and then share their results. The findings, recommendations and conclusions in this paper are the final results of this collaboration.

\textsuperscript{1} HiCCG web page: http://bit.ly/11mAHWK
What are health inequalities and what is the key evidence for action needed?

Health inequalities are commonly defined as socially produced and therefore avoidable systematic differences in health between different populations (1-3). They are considered to be a composite and proxy indicator of other societal inequalities such as those found in education, income and housing (3). They are unjust but also costly and harmful for society (3,4).

Liverpool is repeatedly positioned among the most deprived local authorities in England (5) and has many well-evidenced inequalities clearly illustrated in the health statistics (6-8). In comparison to average life expectancy in England, average life expectancy in Liverpool is lower by 3.8 years for men, and 3.4 years for women. Difference in life expectancy between the most and least deprived wards in the city is 11.0 years for men and 8.1 years for women (8).

During the course of its work, HiALG examined and discussed evidence from primary and secondary data on this theme, examining evidence from national and local reports, articles, and data sets. Four main directions for action stood out as producing evidenced beneficial outcomes for addressing health inequalities. We suggest these areas should form the cornerstone of LCCG’s explicit action in the struggle against health inequalities.

Proportional universalism (3). Although not new, this concept was fleshed out in the Marmot Review. It offers Commissioners a way to deliver universal services across the city, not disadvantage any who have a right to access services, but at the same time to vary the proportion of service provision or spend towards those individuals or activities where there is evidence of greater need.

Working practically in areas of non-medical determinants of health. Whitehead (1) proposed the following areas for action as those producing positive outcomes for health disadvantaged people and communities:

- Strengthen individuals
- Strengthen communities
- Improve living and working conditions
- Promote healthy macro policies
**Development and Implementation of Marmot’s Policy Streams.** The Marmot Review (3) provides strong evidence for action on six policy objectives as a good foundation for action planning. LCCG has taken these policies on board and they are key planks of the Healthy Liverpool Programme, a 5 year strategy currently in formulation. However HiALG wishes to stress the importance of profiling these areas as part of addressing health inequalities:

- Give every child the best start in life
- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure a healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health prevention

**The importance of Health Professionals as a resource.** Working for health equity report (9) identifies key areas in which health professionals can be empowered and then used as a major resource in the fields of health inequalities:

- Workforce education and training
- Working with individuals and communities
- NHS organisations (as employers and contractors)
- Working in partnership
- Workforce as advocates

This report reinforces the work LCCG is doing at the Neighbourhood level and is a powerful argument for maintaining and further developing this work, along with the other recommendations we highlight in our report.

As LCCG in all its roles understands and works with the challenges and opportunities of the national and local health economy it must prioritise monitoring and evaluation of outcomes in reducing health inequalities.
Building on the action research conducted by the HiALG, its members reached unanimous conclusions as to the actions we believed that LCCG could take which would make a positive difference to health inequalities in the city.

Not all of the recommended action we propose below is new, but where the actions are currently in operation we acknowledge them as important for addressing health inequalities and include them in this report to support and encourage their maintenance.
WHAT CAN LCCG DO TO ADDRESS HEALTH INEQUALITIES AND HOW?

LCCG tackles inequalities as a commissioner of services, as a direct employer of around 80 people and as a membership organisation of 94 GP practices providing primary health care to around 490,000 people across the city.

Much of LCCG’s current activities and work streams are focused on reductions in health inequalities. However some of this work would benefit from being articulated and acknowledged more explicitly as intending to deliver the outcome of reducing health inequalities.

LCCG is not just a membership organisation but also a partnership organisation. In raising the profile of its own work around health inequalities, in the three roles mentioned above, it should consistently put this issue into its shared services and working agenda, remembering that many policies that address health inequalities may not bear fruit for several decades.

As a group we have concluded that LCCG should:

Keep working collaboratively with Liverpool City Council. The work with the City Council through the Health and Wellbeing Board (HWB) is vital to many of the issues described within this report. All aspects of their work need to be viewed through the lens of health inequalities. The HiALG proposes a specific sub-group/working group, expressly charged with ensuring the health inequalities agenda is reflected in all spending plans, strategic decisions and operational matters. The establishment of this group will have several benefits. Primarily it will provide the HWB with the assurance that addressing health inequalities is at the heart of all developments across the city’s health and social care sphere. In addition, it will provide a platform for representatives from all the agencies, LCC and its Public Health Directorate, LCCG, NHS England Area Team, and the community sector to influence their respective organisations’ strategic direction and policy decision-making process. It should consist of senior people from the respective organisations including possibly members of the relevant faculties of the local universities. The sub-group/working
group should also be open to health inequalities champions from the other sub-
groups. It needs to be formally recognised in the governance structure of the Health
and Wellbeing Board with all contributors to the Board instructed to consider the
impact of health inequalities within their submissions.

Ensure that no commissioning decision actually increases health inequalities.
LCCG needs to find ways of building a focus on health inequalities into each element
of the commissioning cycle and of ensuring that all decisions do not have the
unintended consequences of increasing health inequalities. The award of North West
Coast CLAHRC (NWC Collaboration for Leadership in Applied Health Research and
Care) money will result in increased investment into high-quality applied health
research and support the translation of research evidence into practice in the NHS
and local authorities to reduce health inequalities in the region. Part of the project is
to develop a health equity lens. There is an opportunity for LCCG to use NWC
CLARHC as a vehicle to assess existing programmes and policies. Whether
commissioning new services or reallocating existing resources, LCCG needs to
ensure that health equality impact assessments are strongly considered in any
investment strategy. Any change in commissioning strategy should be looked at by
appropriate stakeholders and experts including the in-house analyst/intelligence
team and evaluated in terms of the positive and negative impact on health
inequalities.

HiALG recognises that there are many unknowns in this work; for example, what are
the best and most feasible approaches/tools for health equity assessment to be used
in a standardised way by LCCG? Also, changing mind-sets may be difficult, with the
medical profession tending to focus on ‘conditions’ rather than holistic care. LCCG
also has to consider the strategic and operational issues around impacts on equity
when trying to find the right balance between spending money early in the life course
(children now but future older people) and recognising the increasing complexity and
expense of health and social care for the currently ageing population.
Make sure that the responsibility and vision of tackling health inequalities is embedded in LCCG's governance and operational procedures. LCCG should create its own Health Inequalities Committee that would have a specific role to systematically implement and monitor LCCG’s actions to reduce health inequalities, including linking with any subcommittee/working group in LCC. This committee would be key in promoting and monitoring LCCG’s progress in relation to its vision of reducing health inequalities affecting the population of Liverpool. This would be supported by identifying committee members from a range of key areas throughout the organisation such as programme areas, localities and finance. It is very important that a senior member of LCCG such as the Director of Finance or Chief Officer chair this committee.

Make formal arrangements for training (continual professional development) for LCCG in relation to health inequalities. The responsibility for developing a range of training opportunities in health inequalities for LCCG and its member practices should be part of the role of the above proposed LCCG Health Inequalities Committee. Addressing health inequalities is a responsibility for all of us but we need to have a clear understanding of the issues and the skills to take action at all levels.

Require everybody to consider health inequalities explicitly. All papers for the LCCG Governing Body should have evidenced that the following question was considered “Does this proposal have any positive or negative impact on health inequalities? If so, give details including how this might be measured.” Emphasising measurement of outcomes will help to ensure that both Governing Body members and senior management have a clear idea of the positive and negative impact of the issue under consideration in relation to health inequalities.
Be a strong advocate of seamless service delivery for all children and young people. A key challenge facing all those in the struggle against health inequalities relates to the fragmentation of commissioning responsibilities since the introduction of The Health and Social Care Act (2012) (10). Some of this fragmentation lies in areas where addressing inequality can be most effective, such as early years’ provision. LCCG must be a strong advocate of seamless service delivery for all children and young people. Since this Act was introduced it is the responsibility of NHS England to commission services for those aged 0-5 years, but it is the responsibility of CCGs to commission ante-natal services. Public Health commissions the preventive services that operate within these areas and NHS England hold the substantive GP contracts in primary care. This fragmentation of Children’s Services impacts disproportionately on vulnerable children as they and their families are less able to negotiate increasingly divided pathways. The recent moves towards a model of integrated care and co-commissioning may reduce this fragmentation at patient level and is a prerequisite for improving services for children. Targeting children’s wellbeing is a key element of The Marmot Review’s recommendations to reduce health inequalities (3) and the CCG needs to develop a range of effective partnerships to influence this area.

It is worth noting that improving the health of 1-5 year olds may result in less need for substantial medical intervention later in life and this links with the self-care strand of the Healthy Liverpool Programme (11). LCCG should explore opportunities for more involvement in schools and healthy living education.

LCCG should use its power, as a direct employer and a major commissioner of services, to write into service specifications and procurement tenders a requirement for good employment practice. The health and social care economy in Liverpool employs 16.17% of all 16-74 year olds in employment, which is remarkably higher than the average in England & Wales (12.5%) (12). Clearly in such a huge sector ensuring, through contracts, that all providers pay at least the Living Wage would
produce a major positive impact on inequalities. LCCG should also consider the health consequences of gaps in pay differentials. It would be an important sign of LCCG’s commitment to reducing health inequalities if the governing body passed a resolution to work towards decreasing current pay differentials.

There are multiple challenges in this area. Reduction in funding across the public sector has led to both a much reduced local workforce and increased pressures on the remaining workforce. The capacity to provide high quality training has also been reduced. Limited financial resources restrict the ability of the health economy to increase levels of pay and improve conditions, whilst the increase in demand without corresponding resources leads to higher stress levels in the social care sector, where we find some of the most disadvantaged employees doing the most demanding and lowest paid work in the city.

To Liverpool’s credit, despite funding reductions, large amounts of investment in staff development have occurred. There have been a series of health at work initiatives such as stopping smoking, exercise, and cycling which appear to be producing positive outcomes. LCCG could examine ways in which these initiatives are evaluated and could be extended further to target specific groups both inside and outside the direct health economy. Many gains in this field are to be won from partnership working with LCC Public Health and targeted employers.

HiALG suggests that LCCG takes the lead in the introduction of the Living Wage for all directly employed staff and employees of services it commissions, thus improving the life chances of staff affected, but also providing a role model for the Liverpool Health and Social Care sector.

We also suggest LCCG could consider leading by example on pay differentials, for example introducing a policy which restricts maximum pay in the organisation to an agreed multiple of the lowest pay – e.g. Chief Executive limited to 10 times the lowest paid member.

In terms of success it is clear that a reduction in the income gap across the health sector will signal progress - perhaps measured between income in the top and bottom quintiles - but this may take considerable time to achieve and has to be balanced within a national context. We are very aware that the profile of the
workforce in the health sector in the coming years will change significantly – there will be a move from public sector employees to commissioned staff working in the independent sector. This carries a number of challenges around the ability to mandate or influence some of the initiatives listed above, but this should not stop LCCG from trying.

Increase understanding and develop the use of the Social Value Act (2012) (13). LCCG has begun to increase its corporate understanding and use of this important legislation. Developing a robust procurement protocol which prioritises use of the opportunities in the Social Value Act (2012) will help increase the cohesiveness of our communities and challenge some of the non medical causes of health inequalities in a head-on fashion. To make this work in the spirit of the HiALG, rather than it becoming a bureaucratic tick box process, we suggest LCCG incorporates continuing education and awareness programmes, specifically for Governing Body members and senior managers, into the above mentioned formal arrangements for training, ensuring that commissioning for social value is embedded in corporate values and is understood and implemented.

This new Act may well be a vital and dynamic tool in the fight to reduce health inequalities and therefore it is essential that LCCG as an organisation has the best possible understanding of its use.

Continue to prioritise, and increase collaboration and co-operation between GP practices and community groups and organisations at the neighbourhood level and encourage an understanding of how joint working can help define inequities within and between communities and work towards ameliorating them.

One of Liverpool’s assets is having strong primary health care teams. The GP specification (Liverpool Quality Improvement Scheme) (14) has been developed to drive up a consistent standard of primary care in the city, therefore a potential asset
that can be used to address health inequalities in Liverpool. For example, it creates opportunities to develop specific health inequality indicators in Primary Care including improved recording of ethnicity data. There is already a relatively strong structure of Neighbourhoods of practices, supported by Neighbourhood Managers, in which LCCG can take pride. However the neighbourhood model still faces many challenges in relation to health inequalities. For example, in resource allocation, the QOF targets drive a lot of primary care work, with risk of worse outcomes for the most disadvantaged. Resources may diminish due to a revised national spending formula, which will worsen the problem. Primary health care teams are unable to respond to increased work within their existing resources. Thus the challenge is: can the CCG find a fair and acceptable way to invest more in primary care to address the Inverse Care Law (15).

The second challenge to the neighbourhood model is fragmentation, with extended primary/community care being delivered by different organisations with different targets and financial incentives. This directly impacts on the work of the primary health care teams in their care of children and families.

The final challenge we wish to highlight in this section is the difficulty in measuring what really matters. The GP specification and QOF attempt to ensure increased population coverage for health promotion and prevention of illness/further illness. However they can inadvertently lead to increasing inequalities as teams target-chase and thus risk losing holistic care. Meaningful activity is often difficult to measure and differences in outcome for life expectancy are unlikely to be seen for decades.

Support and disseminate the training of the next generation of primary care professionals (including GPs) in the fight against health inequalities. Although not holding the substantive GP contracts or responsibility for training, LCCG should continue to value and enhance the important roles undertaken by many of the membership practices in training the next generation of Primary Care professionals. This training should be recognised as an important tool in the long-term project of reducing health inequalities.
There is an excellent GP training programme in Liverpool with high calibre GP trainees in several practices. Nursing training is also championed within the community. It is vital that students in both these disciplines, as well as others from the primary care community, such as receptionists, pharmacists, health visitors and managers, see role models both in their own professions and in good Primary Care Team working with care of the most vulnerable as a core value.

**LCCG must continue to beat the drum of health inequity** and the need to diminish it for all our sakes. In this regard it should make combating health inequalities a keynote strand of the overall communication strategy, which will in turn need to involve *two-way communication*.

LCCG has many available assets. One is undoubtedly Liverpool’s network of community groups, but there is also a range of ways of **tapping into citizens’ views** e.g. via neighbourhood meetings, consultation/needs assessment exercises, service users groups. This engagement with the third sector could become a real asset in the struggle to reduce inequalities. We know that the public can easily become cynical about 'consultation exercises' and whether they are a ‘dressed up’ explanation of what is being planned/going to happen anyway. Disadvantaged people are often too busy making ends meet/combatting the challenges of daily life to care about contributing views or believing they will be listened to. However if given the chance and supported they may contribute invaluable insights into possible solutions LCCG could consider. Like most cities Liverpool is faced with the challenge of a number of articulate lobby groups perhaps dominating engagement activities. Since there is a legal requirement for consultation on many aspects of NHS activity, LCCG, in recognising this requirement, could be doing much to empower some of the more disadvantaged people in Liverpool.
One possible way of furthering this work is to use our local public health team who already have expertise in this field and are aware of current good practice in community engagement, such as endorsing volunteers as community researchers in projects to lower inequalities\(^2\). When LCCG is involved in 'listening exercises', we suggest:

- Work at reaching the hard to reach groups
- Work with those already involved
- Listen carefully and act on what is said.

**Use the strength this city has in its various organisations**, including its universities, which have some of the top national and international academics in the field of health inequalities, to continue to educate us all and support our actions at multiple levels. Awareness and knowledge of the negative impacts of all types of inequality in society and specifically their effects on our health, increases our ability to work at being equal and different.

Liverpool as a City has a history of joint advocacy and political action. LCCG needs to place itself firmly in this tradition by continuing to highlight negative impacts of government policy at the highest level.

\(^2\) E.g. the work of Adelowale in the Turning-point project, web page: [http://www.turning-point.co.uk/](http://www.turning-point.co.uk/)
CONCLUSIONS

Health services alone cannot resolve the problem of health inequalities. However, we don’t agree that health services cannot make a positive difference, even in the challenging circumstances we currently face, where inequalities in social determinants of health may widen.

LCCG as a major commissioner of the health services for the Liverpool population has the power but also the legal responsibility to act upon health inequalities. If nothing else it should prevent worsening health inequalities, but we believe it can do more than that - congruent with its mission statements. To make this happen we must remember that critical analysis is continuously needed on this question: ‘Will this make for more or less inequality between people?’

We hope our action learning exercise and this resulting report will serve as an enhancement tool and a catalyst of change that is already taking place in LCCG.

REFERENCES


14. Liverpool Clinical Commissioning Group. (2013). Liverpool Quality Improvement Scheme. For those who have access to LCCG’s share drive the specifications can be found using the following link: K:\Clinicalcommissioning\PrimaryCareTeam\EnhancedService\201415\Completed Reviews

LIST OF ABBREVIATIONS

CCG  Clinical Commissioning Group
GP   General Practitioner
HiALG Health inequalities Action Learning Group
HiCCG Project  Action research project: ‘Addressing health inequalities through the work of a clinical commissioning group’
LCC  Liverpool City Council
LCCG Liverpool Clinical Commissioning Group
LivHIR Liverpool Health Inequalities Research Institute
NHS  National Health Service
NWC CLAHRC North West Coast Collaboration for Leadership in Applied Health Research and Care
PCT  Primary Care Trust
QOF  Quality and Outcomes Framework
UoL  University of Liverpool

LIST OF APPENDICES

Appendix 1: Reading list for commissioners

Appendix 2: Toolkits and online depositories

Appendix 3: List of contributors and acknowledgments
APPENDIX 1: READING LIST FOR COMMISSIONERS

Essential readings

✓ "If you could do one thing..." Nine local actions to reduce health inequalities (2014) Just released!
  http://www.britac.ac.uk/policy/Health_Inequalities.cfm
  http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review
✓ Working for health equity: The role of health professionals (2013) – Executive Summary
  http://www.instituteofhealthequity.org/projects/working-for-health-equity-the-role-of-health-professionals
  http://www.liv.ac.uk/psychology-health-and-society/research/impact/hia-reports/
✓ Health inequalities commissioning framework (2011)
  http://www.instituteofhealthequity.org/projects/health-inequalities-commissioning-framework-
✓ Closing the Gap in Generation (2008) – Executive Summary
✓ Review of Social Determinants and the Health Divide in the WHO European Region (2013) – Executive summary
  http://www.instituteofhealthequity.org/projects/who-european-review
✓ Tackling inequalities in life expectancy in areas with the worst health and deprivation; ‘NAO report on health inequalities’ (2010) – Executive summary

Further readings

  http://www.scotland.gov.uk/Publications/2008/06/09160103/2
➢ For more, see: King’s Fund reading list on health inequalities
  http://www.kingsfund.org.uk/topics/public-health-and-inequalities/library
APPENDIX 2: TOOLKITS AND ONLINE DEPOSITORIES

EDS2 Toolkit
http://www.england.nhs.uk/ourwork/gov/edc/eds/

Health Inequalities Action Framework (NHS Health Scotland)

Health Inequalities Interventions Toolkit
http://www.lho.org.uk/LHO_Topics/Analytic_Tools/HealthInequalitiesInterventionToolkit.aspx

South East Public Health Observatory – Gap Measurement tool (mortality)
http://www.sepho.nhs.uk/gap/gap_national.html

The Wakefield Public Health Commissioning Toolkit for Vulnerability
http://www.wakefieldcommissioningvulnerabilitytoolkit.co.uk/Default.aspx

Wellesley Institute Equity Toolkit for Public Health

WHO Urban Health Equity Assessment and Response Tool
http://www.who.int/kobe_centre/measuring/urbanheart/en/

HEAT – The Health Equity Assessment Tool (New Zealand)

MOHLTC Health Equity Impact Assessment (HEIA) tool (Canada)

London Health Observatory collection of resources on health inequalities
http://www.lho.org.uk/LHO_Topics/National_Lead_Areas/HealthInequalitiesOverview.aspx

Health Inequalities National Support Team resources
http://www.institute.nhs.uk/commissioning/general/health_inequalities_national_support_team_resources.html

European Portal for Action on Health Inequalities
http://www.health-inequalities.eu/

Centre on Dynamics of Ethnicity (CoDE): briefing documents from the Census 2011
http://www.ethnicity.ac.uk/census/

The Equity Trust
http://www.equalitytrust.org.uk/resources

UCL Institute of Health Equity
http://www.instituteofhealthequity.org/

GPs at the Deep End
http://www.gla.ac.uk/researchinstitutes/healthwellbeing/research/generalpractice/deepend/#reports
APPENDIX 3 – LIST OF CONTRIBUTORS AND ACKNOWLEDGEMENTS

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Acknowledgements

All ALG members contributed to production of this report. The research team designed the HiCCG project. Ed Gaynor led the work of the ALG. Mari Kovandzic provided academic and administrative support to the ALG, helped with the first draft of the report and with comments to subsequent versions. Lis Davidson and Maureen Williams co-led the production of the final report. Katy Gardner and Robin Munby went through the nearly final document with a fine-tooth comb.

We would like to thank to many who contributed with guidance, advice or critique

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As a group we are happy to receive any feedback or questions.

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For information about the HiCCG Project see LivHIR web pages at: http://bit.ly/11mAHWK
<table>
<thead>
<tr>
<th>Title of Report</th>
<th>CCG responsibilities regarding Serious Case Reviews (SCR), Domestic Homicide Reviews (DHR) and Mental Health Homicide (MHH) reviews.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead Governor</td>
<td>Jane Lunt, Head of Quality/Chief Nurse</td>
</tr>
<tr>
<td>Senior Management Team Lead</td>
<td>Jane Lunt, Head of Quality/Chief Nurse</td>
</tr>
<tr>
<td>Report Author</td>
<td>Jane Lunt, Head of Quality/Chief Nurse</td>
</tr>
<tr>
<td>Summary</td>
<td>The purpose of this paper is to inform the Governing Body regarding CCG responsibilities with regard to the following processes, Serious Case Reviews, Domestic Homicide Reviews and Mental Health Homicide Reviews and to update with regard to the current Liverpool CCG position.</td>
</tr>
</tbody>
</table>
| Recommendation | That Liverpool CCG Governing Body:  
    - Notes the content of the report  
    - Notes the current Liverpool CCG position with regard to the above processes                                    |
| Impact on improving health outcomes, reducing inequalities and promoting financial sustainability | Preventing people from dying prematurely  
Ensuring that people have a positive experience of care  
Treating and caring for people in a safe environment and protecting them from harm |
| Relevant Standards or targets | To ensure the CCG meets the standards and responsibilities set out in ‘Safeguarding Vulnerable People in the Reformed NHS: Accountability and Assurance Framework,’ NHS England, March 2013 |
CCG RESPONSIBILITIES REGARDING SERIOUS CASE REVIEWS (SCR), DOMESTIC HOMICIDE REVIEWS (DHR) AND MENTAL HEALTH HOMICIDE (MHH) REVIEWS.

1. PURPOSE
The purpose of this paper is to inform the Governing Body regarding CCG responsibilities with regard to the following processes: Serious Case Reviews, Domestic Homicide Reviews and Mental Health Homicide Reviews; and to outline the current Liverpool CCG position.

2. RECOMMENDATIONS
That Liverpool CCG Governing Body:
- Notes the content of the report
- Notes the current Liverpool CCG position with regard to the above processes

3. BACKGROUND
New guidance for the NHS came into effect on April 1\textsuperscript{st} 2013, replacing previous guidance (Safeguarding Vulnerable People in the Reformed NHS: Accountability and Assurance Framework, NHS England, March 2013). Section 3 of the guidance outlines the responsibilities for CCGs. The main responsibilities are as follows:

- CCGs are statutorily responsible for ensuring that the organisations from which they commission services provide a safe system that safeguards children and adults at risk of abuse or neglect

- CCGs have a statutory duty to be members of Local Safeguarding Children Boards (LSCBs) and are expected to be fully engaged with local Safeguarding Adults Boards (SABs), working in partnership with local authorities to fulfil their safeguarding responsibilities

- CCGs should ensure that robust processes are in place to learn lessons from cases where children or adults die or are seriously harmed and abuse or neglect is suspected
• NHS England provides oversight and assurance of CCGs’ safeguarding arrangements and supports CCGs in meeting their responsibilities; this includes working with the Care Quality Commission (CQC), professional regulatory bodies and other national partners.

The CCG is represented on the Safeguarding Adults and Children Boards via the Head of Quality/Chief Nurse role and the Designated Nurse for Safeguarding Children and the Adult Safeguarding Lead. There is also CCG representation within the subgroups via a number of colleagues from the CCG Safeguarding Service and via the named GP.

4. COMMUNITY SAFETY PARTNERSHIP

In addition to the CCG being required to be represented on the safeguarding boards, there is also a requirement for the CCG to be represented on the Community Safety Partnership (CSP). These were set up as statutory bodies under Sections 5-7 of the Crime and Disorder Act 1998 and are made up of representatives from the ‘responsible authorities’, which are the:

- police
- local authorities
- fire and rescue authorities
- probation service
- health (CCG and providers)

The responsible authorities work together to protect their local communities from crime and to help people feel safer. They develop and implement strategies to deal with local issues like antisocial behaviour, drug or alcohol misuse and reoffending. They annually assess local crime priorities and consult partners and the local community about how to deal with them. Since the creation of local Police and Crime Commissioners (PCC), they now work very closely with this role to ensure alignment of key issues. This partnership in Liverpool is named ‘Citysafe’ and the CCG is represented on this partnership via the Head of Quality/Chief Nurse role and within the subgroups.

5. IDENTIFYING LESSONS LEARNED

Each of the above partnerships has a process for dealing with serious incidents. For every case where abuse or neglect is known or suspected and either a child dies, or is seriously harmed, and there are concerns about how organisations or professionals worked together to safeguard the child, a Serious Case Review
(SCR) is conducted. This process would be led and overseen by the Local Safeguarding Children Board (LSCB).

For circumstances where the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom she/he was related, or with whom she/he had been in an intimate personal relationship, or a member of the same household as her/himself; the process is termed a Domestic Homicide Review (DHR) and is undertaken with a view to identifying the lessons to be learnt from the death. Overall responsibility for establishing and undertaking a review sits with the CSP- Citysafe here in Liverpool.

For other adult deaths, a Serious Case Review should be considered when:
- A vulnerable adult dies and abuse or neglect is known or suspected to be a factor in their death
- A vulnerable adult has sustained a potentially life threatening injury through abuse or neglect and the case gives rise to concerns about the way in which staff and agencies work together to protect vulnerable people
- Serious abuse takes place in an institution or when multiple abusers are involved
- There is actual abuse or mistreatment of sufficient complexity or significant public interest that a single agency review would not be considered adequate or appropriate
- Other requests made by the Coroner, MPs, Elected Members and other interested parties.

In these circumstances, the Serious Case Review would be led and overseen by the Safeguarding Adults Board (SAB).

In April 2013, one of the functions that transferred to NHS England was the function to commission independent investigations, including those in relation to serious incidents in mental health services. There are clear criteria set out in Health Service Guidance (94) 27 (HSG (94) 27) which determine the need for independent investigation in the context of a serious incident within mental health services. The criteria are:
- When a homicide has been committed by a person who is or has been in receipt of care and has been subject to the regular or enhanced Care Programme Approach of specialist mental health services in the six months prior to the event
- When it is necessary to comply with the State’s obligations under Article 2 of the European Convention on Human Rights. Whenever a State agent is, or may be, responsible for a death or where the victim sustains life-threatening injuries, there is an obligation on the State to carry out an effective investigation. This means that the investigation should be
independent, reasonably prompt, provide a sufficient element of public scrutiny and involve the next of kin to an appropriate extent

- Where NHS England determines that a serious patient safety incident warrants an independent investigation, for example if there is concern that an event may represent significant systemic service failure, such as a cluster of suicides

There is a national, single operating model for this process and it is undertaken via a nominated Area/Regional Team. For the Northwest, it is NHS North.

In terms of learning lessons, each relevant board will have a learning framework which enables the key learning to be identified and disseminated, including most importantly to practitioners and clinicians to support positive changes in practice. Ofsted reviews SCRs on a three yearly basis and publishes the themes and trends that have emerged to further support learning. Similar national processes are in place for DHRs, and MH Homicides.

6. CCG RESPONSIBILITIES
For each of these processes, the CCG has a key role to play. For the Serious Case Review (both adult and child) and the Domestic Homicide Review, these processes are managed locally via the safeguarding boards and the Community Safety Partnership. The CCG representatives will be part of the initial decision making process to determine whether the incident meets the criteria for the review. Any review is managed and overseen through the governance processes of the relevant board.

If an incident is deemed to meet the criteria for either a Serious Case Review or a Domestic Homicide Review, the respective board will appoint an independent reviewer and convene a panel comprising key representatives from the boards who will act as the key conduit into their sector. This role is fulfilled by the CCG Safeguarding Service and/or the named GP. They will support health providers with securing records and writing Individual Management Reviews (IMRs) regarding their involvement with the individual subject to the incident. In addition to this, there will be a requirement for a Health Overview Report (HOR) which reviews the health provider IMRs and summarises the involvement and the key issues emerging. This HOR forms the basis of the recommendations for the health economy action plan. Any immediate risks which are identified either at the time of the incident or during the review should be addressed immediately. The action plan should only focus on the issues which do not present immediate risk, but will improve the patient pathway, or inter-agency working.
These reviews are conducted in order to understand why the incident happened and if there is evidence of poor practice that may or may not have contributed to the incident, agencies are required to make the necessary improvements. They also form part of the mechanism of commissioners to ensure the quality of commissioned services. In order to support the ambition to learn lessons, there is a requirement to publish nationally the reports generated by either SCRs or DHRs. Only in exceptional circumstances can the requirement to publish be removed, and this decision is made by Ofsted in terms of a SCR relating to a child, and the Home Office in terms of a DHR. SCRs and the implementation of any associated action plans and their impact, form part of any Ofsted/ CQC safeguarding inspection.

The CCG role with a MHH review is different to that within SCRs and DHRs which are local processes. A MHH review is led by NHS North and the CCG role is to ensure that once an incident is reported the respective trust undertakes a 72 hour review. The aim of this review is to identify any immediate clinical or managerial action necessary to ensure patient safety. The CCG is then required to ensure that the trust undertakes a robust internal investigation which should be completed within 90 days. Once this review is completed, NHS North will assess whether the incident satisfies the HSG (94) 27 guidance and if it does, an independent investigation is commissioned. When the investigation is completed, which should be within the mandated 6 month timescale, there is a requirement for both NHS North and the relevant CCG to receive the report and associated action plan, and not sign off the report until satisfied with the content of the action plan. Following formal sign off, there is an expectation that the independent report is published on the CCG website. Historically, the investigation often took a long time to complete and the process could be very protracted. The 6 month timescale is an attempt to reduce the length of the process.

All of these processes aim to involve the family of the victim, and take into account their perspective of what happened. Although difficult, family involvement can often give a very beneficial perspective and can potentially help the family in coming to terms with the tragedy.

There may be circumstances where the circumstances of an incident may invoke a number of these procedures. In these circumstances, all agencies should consider, through their respective local boards, the possibility of jointly commissioning an investigation that satisfies the requirements for both procedures. This helps ensure that expertise is used appropriately, duplication of processes is minimised and the inter-agency lessons are identified and lessons learnt.
7. CURRENT POSITION FOR LIVERPOOL CCG:

The current position with regard to serious incidents is as follows:

- **Domestic Homicide Reviews (DHRs):**
  There are currently 3 in varying stages of completion.
  
  DHR 1- this has concluded and there is learning from this for both adult and children's services which will be shared via the children’s and adults safeguarding boards. A protocol exists to support this process.
  
  DHR 2- this review is at the stage where a draft overview report has been shared with the panel for consideration and amendments.
  
  DHR 3- this is a complex review, as the subject lived in other parts of the country as well as Liverpool, and the CitySafe Board is therefore working with other partnerships to complete the review.

- **Serious case Reviews (SCRs):**
  Child J, Child K, Child L- this review is complete and has been accepted by the LSCB. Consideration is being given to the requirement for publication.

  There are currently 3 other SCRs in progress.

- **Mental Health Homicide Reviews:**
  There are currently 5 MH homicide reviews outstanding. 4 of these are termed legacy cases in that they occurred prior to the formation of the CCG and NHS North have very recently confirmed that another independent investigation will be commissioned. Once complete, there is a requirement for the investigation reports to be published on the CCG website.

  Once these reviews have been concluded and signed off by the relevant boards, they will come to the CCG Governing Body for formal acceptance and to ensure implementation of recommendations.

8 CONCLUSION:

This report provides an explanation of the CCG's responsibilities in relation to Serious Case Reviews, Domestic Homicide Reviews and Mental Health Homicide Reviews.
It outlines the processes involved in each of these Reviews and gives an overview of the current position.

Whilst this is a complex and high risk area of work the Governing Body can be assured that the CCG has the skills, resources, and structure to ensure it is meeting its responsibilities.

Jane Lunt
Head of Quality/Chief Nurse
01/03/14

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LIVERPOOL WOMEN’S HOSPITAL QUALITY REVIEW PROCESS

1. PURPOSE
The purpose of this paper is to update the Governing Body with regard to the Quality Review process for Liverpool Women’s Hospital and the activity to support quality improvement.

2. RECOMMENDATIONS
That Liverpool CCG Governing Body:
- Notes the contents of the report
- Notes the process to support quality improvement at Liverpool Women’s Hospital

3. BACKGROUND
In March 2013 a whistleblower contacted NHS Merseyside highlighting a potential issue with a significant number of test results not acted upon or filed appropriately in the case notes. At this point, a decision was made to initiate a Quality Review (QR) process, led by NHS Liverpool CCG and NHS Merseyside (NHS England (Merseyside) with effect from April 2013). This process enables certain key lines of enquiry (hypotheses) to be determined, which are then tested by clinical visits, staff interviews and review of evidence from the trust to triangulate. The first Quality Review meeting took place in March 2013, with a follow up meeting in July 2013. The anonymity of the whistleblower has been maintained.

The Quality Review Team involved the following people from Liverpool CCG:

- Dr Nadim Fazlani, Chair
- Katherine Sheerin, Chief Officer
- Jane Lunt, Head of Quality/Chief Nurse
- Dr Donal O'Donoghue, Secondary Care Doctor
- Dr Fiona Lemmens, Clinical Lead

along with a representative from NHS England.
The key lines of enquiry for the March QR meeting were as follows:

- Trust procedure for the follow up of test results
- Assessment of the medical records processes for filing test results-including the current position for unfiled test results
- Determination of the new electronic process for follow up of test results
- Role of medical staff within these processes
- Management of Serious Incidents by the trust
- Current midwifery staffing position

The QR team found that there were issues with the process for actioning test results, that there was a back log in terms of unfiled test results, that the new electronic process had encountered some issues in terms of implementation, that the role of medical staff within the processes for follow up of test results was variable, that although the management of serious incidents by the risk management team within the Trust was robust, learning from incidents was not disseminated widely, and that there were some issues regarding staffing within the maternity unit.

An action plan to address the issues was developed by the Trust and monitored through the Clinical Performance and Quality Group (CPQG) and the Quality, Safety and Outcomes Committee (QSOC) with regular updates to the Merseyside Quality Surveillance Group (QSG). The Trust worked closely with key individuals from either the CCG or NHSE (Merseyside) to progress key workstreams, such as the improvements to the serious incident management process, particularly the dissemination of learning within the trust from these incidents.

In April 2013, the Trust was asked to complete a Root Cause Analysis (RCA) with regard to the 3 closures of the delivery suite which had taken place in October 2012, February 2013 and March 2013 to understand the issues related to this and to inform action to ensure that the unit did not have to close to admissions again.

A follow up QR meeting took place in July 2013, where it was evidenced that much progress had been made. At this point in time, the Trust had acted upon the findings within the RCA report regarding the 3 closures which identified that the midwifery staffing establishment was less than it should be and recruited 30 midwives. These midwives came into post in 2 cohorts during July and August 2013. In addition to this, the backlog in results that required filing had been cleared and the Trust had worked closely with the CCG to review governance processes in terms of serious incidents and to promote timely identification of
incidents that require reporting on STEIS (Strategic Electronic Information System – a national system for reporting of high level incidents).

The Trust found the QR process supportive and helpful in supporting quality improvement and requested that the QR team plan a further visit in 6 months (i.e. in early 2014). This visit would enable an assessment of the impact of the increased midwifery staffing and a review of progress with the follow up of test results.

Within this process, the Trust had been very open with the QR team and willing to supply any information required and facilitating the team to visit clinical areas of choice on the day of the visit without requiring to be informed prior to the QR visit. Access to staff was open, and members of staff interviewed as part of the process were cooperative and professional, and a credit to the Trust.

4. CQC INSPECTION

An unannounced inspection visit took place at Liverpool Women’s Hospital on the 7th and 8th of July 2013. The standards inspected were:
- Care and welfare of people who use services
- Staffing
- Supporting workers

The inspection team arrived on a Sunday evening and stayed within the hospital for several hours, witnessing shift handovers and interviewing staff. The team were also on site the following day, looking at the personal care or treatment records of people who used the service, observed how people were being cared for and talked with people who use the service. In addition, the team talked with carers and family members and reviewed information given to the team from the provider and a range of others, including the community and voluntary sector. The inspection team also took advice from specialist advisors and used information from the local Healthwatch to inform the inspection.

The unannounced inspection was carried out in response to concerns that one or more of the essential standards of quality and safety were not being met, specifically that the CQC had received information of concern related to staffing shortages having a negative impact on patient experience. The report was published in September 2013.
The report outlined that the Trust was not meeting the standards inspected and that action was required. The action plan to address the issues was monitored within the CPQG. The CGG was already aware of the staffing issues and of the Trusts action with regard to this as it formed one of the key lines of enquiry within the QR.

5. QUALITY REVIEW FOLLOW UP MEETING FEBRUARY 2014

In accordance with the trusts request, a further follow up QR meeting took place in February. The same team members took part in this meeting for consistency, utilising the same approach of discussion with the Executive team and key colleagues, in conjunction with visits to clinical areas and talking to staff. In light of 2 Serious Untoward Incidents (SUIs) declared by the trust in May and December 2013 relating to a failure to act on test results, a key line of enquiry was the management and follow up of test results to fully understand if the trust had identified the root causes via the subsequent investigations and addressed them. The other lines of enquiry were reviewing midwifery staffing and the impact of the new midwives, exploring a potential disconnect between management and clinicians (manifested in the management of test results and the ‘ownership’ of serious incidents), governance; especially how the Trust ensures the learning from serious incidents is embedded and how the Board is informed of the incidents and learning. In addition, the trust were given an opportunity to highlight what they had changed since the last QR visit, which may or may not be related to the lines of enquiry. The QR team also reviewed the action plan relating to the recommendations from the previous QR and the CQC inspection.

6. OUTCOME OF QR VISIT FEBRUARY 2014

A significant focus of the discussion with the Trust was the implementation of an electronic investigation ordering system to establish whether this would eliminate or reduce the potential to not act on results, and how this tied the ordering clinician or team into the follow up. The new system ensures that the ordering clinician or team is responsible and accountable for action required with a test result. A result cannot be filed unless actioned by the clinical lead responsible for requesting the investigation. This is outlined in the trust policy which has been recently signed off by the Clinical Governance Committee. Technical issues with ICE are being resolved and there is mitigation in place. The QR team only felt partially assured regarding this process, and will follow up progress through the CPQG.

In terms of staffing, the Trust highlighted that there have been 3 recruitment drives since July 2013 (a further cohort of staff had commenced in post in
addition to those who commenced in post in July and August), and work undertaken to reduce sickness levels. The Trust Board has regular reports regarding staffing levels, and the Trust is currently undertaking a ‘Birth Rate Plus’ assessment to identify the number of midwives required to meet the demands of numbers and acuity of patients. This is due to formally report to the Trust in March 2014.

The potential disconnect between managers and clinicians was challenged by the Trust as not being the view of the majority within the Trust and the team were informed of processes to enable managers and clinicians to come together within the organisation, including the Board, through the directorates to team level. It was stated that there may be disagreements, but not disconnect. The Trust felt that managers and clinicians worked well together.

The Trust evidenced the progress made in terms of embedding learning from incidents within the Trust and the clinical accountability in moving this forward. Examples of this are the ‘Lesson of the Week’ which takes a key message and uses a cascade system to inform all staff; and the ‘Great Day’ which takes place on a quarterly basis is a vehicle for getting a variety of key messages to staff. Patient’s stories (both good and bad) are regularly reported to Board to illustrate the effectiveness of the services provided by the Trust. Discussion with staff during the visit confirmed staff awareness of these mechanisms for feedback.

The Clinical Director outlined the Trusts’ process in terms of Medical Revalidation as the Trust responsible officer for this process, highlighting how the process supports both organisational and personal development. The Trust is currently performing at 75% of revalidations undertaken, but is aiming to achieve 100% by year end.

7. SUMMARY

Within the last year, Liverpool Women’s Hospital (LWH) has had a range of quality issues highlighted via a number of routes; namely whistleblowing, a Quality Review process, and a CQC inspection. The quality issues have been accepted by the Trust which has worked to address the issues and improve patient care and experience. During this period, the Trust has worked well with commissioners, being very open and transparent and welcoming their input. The Trust accepts that quality improvement is a continuous process, and in light of this is amenable to a further follow up Quality Review visit in 6 months (Summer 2014). Monitoring of progress in the interim will be undertaken by the CPQG, with reports to the QSOC and the Mersey QSG.
8. LEARNING FOR THE CCG

The Quality Review process undertaken with LWH took place at a time of great change in the NHS, in terms of the monitoring of quality in NHS commissioned services. During the last year, the responsibilities of CCGs and NHS England have become clearer and maturing relationships with the Care Quality Commission (CQC), Monitor and the Trust Development Agency (TDA) has enabled greater consultation and sharing of information and intelligence. The QR process leadership role now sits with NHS England, and for the Trusts currently subject to QR processes, NHS England lead this process, with the CCGs as active participants. Leadership for the LWH process has remained with NHS Liverpool CCG to ensure a consistent approach was maintained for the duration of the process.

There was a high degree of congruency between the issues highlighted within the QR process and the CQC inspection. This highlights the benefits of commissioners and regulators sharing information and intelligence to ensure that a complete view of a service is formed and that potential and/or actual poor quality is recognised and action taken to improve.

The methodology of the QR, i.e. the utilisation of existing quality data, visits to clinical areas and interviews with staff, provides a rich source of data and the opportunity to triangulate information. The Trust cooperated with the review process and was open and honest in their interaction with the QR Team. In addition, the Trust found the review process beneficial and following the second QR visit, specifically requested a third follow up visit. This positive response from the Trust to the review was facilitated by the process being framed as the supportive, with the CCG and the Trust having the common goal of improving quality. In addition, utilising the CPQG for monitoring the action plan from the review maintained the review process within the routine quality monitoring process.

Jane Lunt
Head of Quality/Chief Nurse
03/03/2014
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1. PURPOSE

The purpose of this paper is to report to the Governing Body key aspects of the CCG’s performance in delivery of quality, performance and financial targets for the year 2013/14.

2. RECOMMENDATIONS

That Liverpool CCG Governing Body:

➢ Notes the performance of the CCG in delivery of key national performance indicators and the recovery actions taken to improve performance, if required.

3. BACKGROUND

From April 2013 the CCG is held to account by NHS England on its performance in delivery of key indicators within the CCG Outcome Indicator Set of the NHS Outcomes Framework 2013/14 and operational standards expected from the NHS Constitution.

In addition the CCG needs to be assured that the services we commission are delivering the required quality standards and any risks and issues relating to service quality and patient safety are identified and positive action taken to rectify.

The CCG has established governance processes to monitor performance and provide assurance to the Governing Body that key risks to the organisation are identified and effectively managed. The Quality, Safety and Outcomes Committee are responsible for quality and performance issues within its commissioned services. The Finance, Procurement and Contracting Committee are responsible for financial monitoring.

Concerns remain as to the quality and accuracy of some of the data used and this continues to be investigated and worked upon by the CCG and the Cheshire & Merseyside Commissioning Support Unit.
4. NATIONAL PERFORMANCE MEASURES

These measures relate to Quality (Safety, Effectiveness and Patient Experience) and also Resources (Finance, Capability and Capacity) and reflect the key priority areas from Everyone Counts: Planning for Patients 2013/14.

Specific commentary is provided on the following areas of performance.

- **Health Care Acquired Infection**
  - C-Diff: Overall there have now been a further 10 incidences of C-Diff reported for Liverpool patients in January, a similar growth figure to the previous month. This brings the total year to date to 144, significantly higher than the tolerance level of 91. Of these additional cases, 6 were community acquired and 4 hospital acquired infections.
  - MRSA: during the month of January there were two new cases of MRSA reported both at the Royal Liverpool Hospital, although community acquired bringing the overall CCG total to 12 against the zero tolerance.

The continuing monthly increases in C-diff and MRSA remain a matter of significant concern and a high priority for continuing investigation, action and review by commissioners working collaboratively on an individual Trust by Trust basis.

- **Cancer**

The data shows that the improving picture seen for cancer waiting times overall has been maintained. In all cases the commissioners are working with the providers to understand the positions and where required seek recovery plans/assurances as to future service delivery and performance.

62 days wait for first definitive treatment (wait from urgent GP referral to first definitive treatment) – here we see some deterioration in the Liverpool Heart & Chest performance which stands year to date at 76.3% against their revised Monitor threshold of 79%. The small numbers of patients referred to this specialist Trust for treatment remains a challenge, with 8 patients treated in December and 2 ½ breaches.
62 days wait for first definitive treatment (following Consultant’s decision to upgrade the priority of the patient) – here performance at the Liverpool Heart & Chest Hospital is now ‘amber’, at 80%.

- **RTT.**

Data for December 2013 continues to show ‘Red’ performance at Alder Hey with 18 patients waiting over 52 weeks for complex spinal surgery, the responsibility of Specialist Commissioning.

Alder Hey continues to experience problems in meeting the 18 week target for referral to treatment, with some further slight deterioration seen in December with performance now at 80.1%. Here the principal problem continues to remain in ENT, with a backlog of patients having built up due to some increases in demand. Despite the Trust employing an additional Consultant to manage this demand problems persist.

- **Stroke**

Overall CCG performance now stands at a slightly improved 78.7% against the target of 80% (percentage of patients who had a stroke and spend at least 90% of their time on a stroke unit). However problems persist in Aintree Hospital although in December there was some improvement to 55.6% of Liverpool CCG eligible patients (10 out of 18) meeting the target. The April to December aggregated figure for Liverpool patients does however show delivery of 86.42% against the 80% target. As previously reported this is mainly as a consequence of medical outliers occupying beds in the Stroke Unit. The CCG with Sefton colleagues continue to monitor this important area and the actions planned by the Trust to achieve a sustainable improvement in performance, although as winter ‘pressures’ continue bed availability is likely to continue to have an adverse impact. Notwithstanding this Aintree Hospital does ensure that 100% of patients with a stroke are assessed and treated within 24 hours.

- **4 Hour AED Performance**

One of the key and high profile NHS constitutional rights measures is the percentage of patients who spend 4 hours or less in AED (95% target) Cumulatively up to the end of January the CCG met this target at 95.7% however underperformance continued at the Royal Liverpool Hospital whose performance stood at only 93.8% in January.

Following the issue to the Royal Liverpool of a formal ‘contract query’ under the standard terms of the national NHS contract the CCG urgent care team have
continued to work with the Trust to support their remedial action plan. As part of the latter the Trust have been further working with the national Emergency Care and Intensive Support Team and have recently undertaken an intensive ‘Fresh Start’ exercise involving the whole organisation to seek new ways of working and improving performance. Although some immediate improvement in performance was seen this was not immediately sustained and the outcomes from the weeks intensive activities are being assessed to see what further lessons can be learnt and changes made.

Performance against the 4 hour target continues to be monitored daily, with the weekly data summarised below showing Trust performance, CCG position and predicted performance through to year end.
Governing Body members should note that the CCG continues to be predicted to achieve the 4 hour target for its population for the year. However, as can be seen from the table performance at particularly the Royal Liverpool but also Aintree continues to give significant cause for concern. The impact of the additional ‘winter monies’ investment and subsequent schemes continue to be monitored closely and adjustments made to schemes where the predicted impact is not being seen or achieved.

The CCG will continue to monitor Trust performance against the 4 hour target closely and work with the Trusts and other partners to see how performance through winter can be improved to maintain patient safety, improve experience and outcomes.

• **Diagnostic Waiting times**

Performance in January showed a further very slight deterioration in performance with a further increase in delays for diagnostic tests. At the end of the month 9.16% of patients (520) were waiting over 6 weeks for diagnostic tests, against the 1% target.

Analysis shows that the principal problems continue at the Royal Liverpool and Broadgreen Hospitals with some further pressures seen in Liverpool Community Health. At the Royal a total of 483 patients waited over 6 weeks with the pressures seen in CT 59 patients; MRI 82 patients; and in non obstetric ultrasound 342 patients. The Trust expected improvement in waiting times back to a maximum of 6 weeks by the end of January has unfortunately not been achieved. A total of 36 patients are waiting for ultrasound in Liverpool Community Health and 1 patient is waiting for neurophysiology at Alder Hey.

A full dashboard is included at Appendix 1 including Merseyside benchmarks.

5. **CCG QUALITY PREMIUMS**

The quality premium, introduced from April 2013 is intended to reward CCGs for improvements in the quality of the services they commission and for associated improvements in health outcomes and reducing inequalities. The quality premium potentially available to CCGs in 2014/15, will reflect 2013/14 quality and will be based upon four national measures and three local measures. Currently the poor performance against the HCAI targets (MRSA/C-Diff) continues to present the major challenge in this area.

Appendix 2 provides a summary of this performance dashboard
There is an overlap in a number of the items shown in this dashboard and those in the CCG Corporate and Provider Performance tables.

6. NHS TRUST CLINICAL QUALITY AND NHS CONSTITUTIONAL RIGHTS

In line with the recommendations of the National Quality Board (NQB) and as previously agreed the Quality, Safety and Outcomes Committee have implemented a new Quality Early Warning Dashboard. This dashboard is designed to provide the CCG with a system to identify any issues and risks relating to patient quality and safety for areas identified by the NQB as potential indicators of quality and safety issues.

The dashboard covers all NHS Trusts within the Merseyside area and includes Risk Profiles for each organisation issued by the Care Quality Commission (CQC) and Monitor Risk and Financial Ratings.

Where risks have been identified these will be actively managed through the CCG governance arrangements overseen by the Quality, Safety and Outcomes Committee, Trust Clinical Quality and Performance Meetings and collaborative commissioning arrangements with Merseyside CCGs.

6.1 Care Quality Commission and Monitor Warning or Issue Notices

Liverpool Community Health Services

The CQC carried out an unannounced inspection on the 28th & 29th November and the 2nd December 2013. The inspection was initiated in response to concerns that one or more of the essential standards of quality and safety were not being met. The inspection team looked at the personal care or treatment records of people who use the service and talked with people who use the service and talked with carers and / or family members. CQC talked with staff, reviewed information given to them by the provider, reviewed information sent to them by other authorities and talked with other authorities. The CQC were accompanied by a specialist advisor and also reviewed other relevant records held by the provider.

Standards of Care Evaluated on Inspection:

- Care and welfare of people who use services - Action needed
- Safety, availability and suitability of equipment - Action needed
- Staffing - Action needed
• Supporting workers - Action needed
• Assessing and monitoring the quality of service Provision - Enforcement action taken

CQC requested a report from the trust in relation to the above to be 6th February 2014, setting out the action they will take to meet the standards. Enforcement action has been taken to protect the health, safety and welfare of people using the service.

Liverpool Community Health Services – Ward 35 Intermediate Care

The inspection was initiated in response to concerns that one or more of the essential standards of quality and safety were not being met. The CQC looked at the personal care or treatment records of people, who use the service, carried out a visit on 28th November 2013 and 5th December 2013, observed how people were being cared for and talked with people who use the service. CQC talked with carers and / or family members, talked with staff, took advice from the CQC pharmacist and reviewed information sent to them by other regulators or the Department of Health. The CQC team reviewed the information sent to them by other authorities, talked with other regulators or the Department of Health, talked with other authorities and took advice from specialist advisors. The CQC were supported on this inspection by an ‘expert-by-experience’. This latter person has personal experience of using or caring for someone who uses this type of care service and they also reviewed other relevant records held by the provider.

Standards of Care Evaluated on Inspection: -
• Care and welfare of people who use services - Action needed
• Management of medicines - Action needed
• Staffing - Action needed
• Supporting workers - Enforcement action taken
• Assessing and monitoring the quality of service – provision - Action needed

Following the publication of the CQC reports in January 2014, NHS England initiated a Single Item Quality Surveillance Group which took place on the 11th February 2014. The QSG made a recommendation to conduct a Quality Review Meeting which took place on the 18th February 2014. Each organisation in attendance provided the group with a brief summary on the areas of concern within each of the following headings: -

• Access
• Workforce
• Governance
• Culture
• Safety

The actions against the Trust CQC action plans will be monitored though the Clinical Quality and Performance Meetings. A further Quality Review Meeting will take place in 3 months time.

**Liverpool Women’s Hospital Trust**

The latest report published by CQC on the 18th September 2013, as previously reported, identified that the standard of care was not being fully met for the standards of providing care, treatment and support that meets people’s needs and also the standard for staffing. The Trust has an action plan in place which demonstrates completion of a number of these actions. A subsequent Quality Review Meeting took place on Friday 14th February 2014 and assurance was gained against the majority of initial concerns. The implementation of ICE (an electronic system to view and share test results) will provide additional assurance however Liverpool CCG felt until this system has been implemented fully and is working successfully within the organisation a further meeting visit will take place within the next six months.

**Liverpool Heart and Chest Hospital**

The latest report published by CQC on 4th December 2013, as previously reported, identified the standard of care in Management of Medicines required action. The CQC identified that patients were not protected against the risks associated with medicines because the Trust did not have appropriate arrangements in place to safely manage them. The Trust has completed all actions contained within the action plan and a further visit has been undertaken by CQC at the beginning of February. Initial feedback from the Trust is positive within this outcome. The final report is awaited and will be circulated to the CCG once available. However the Trust informed the Clinical Quality and Performance Meeting on 27th February 2014 that an unannounced visit was undertaken by CQC for two days in relation to whistleblowing concerns regarding staffing level on Critical Care. Initial feedback from the Trust is that CQC will be raising concerns regarding staffing levels in Critical Care. Assurances were gained during the visit but due to the whistleblowing concerns further investigation is underway.
Aintree Hospital

The latest report published by CQC on the 6th December 2013, as previously reported, identified that action was needed in a number of standards – Care and Welfare of People who use services and also in Complaints. However enforcement action was being taken by CQC for the areas of non-compliance identified in Assessing and Monitoring the Quality of Service Provision. A co-ordinated approach has been taken with partner CCGs and with NHS England (Merseyside) to manage these areas of risk. Collaborative working is evident through the recent Risk Summit, Clinical Quality and Performance Meetings and Collaborative Commissioning Forums. The Trust is due a further visit at the beginning of March to evaluate compliance against the initial concerns raised.

Alder Hey Children’s Hospital

CQC carried out an unannounced inspection on the 2nd December and the report was published on the 7th February 2014. The inspection was initiated in response to concerns that one or more of the essential standards of quality and safety were not being met. The CQC looked at the personal care or treatment records of people who use the service, carried out a visit on 2nd December 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. The CQC was supported on this inspection by an expert-by-experience. The Trust was required to respond to the concerns raised by the 13th February 2014, setting out the action they will take to meet the standards.

Standards of Care Evaluated on Inspection: -

- Care and welfare of people who use services Action needed
- Cleanliness and infection control Met this standard
- Staffing Action needed
- Supporting workers Action needed
- Assessing and monitoring the quality of service provision Action needed

6.2 Quality Risk Profiles

The Quality Risk Profile for February 2014 demonstrated that Mersey Care had improved against Outcome 6 – Cooperating with other providers. The Trust risk estimate for this outcome has improved from high yellow to low yellow rating. The Trust continues to be involved in a task and finish group along with the Local Authority. Performance and progress to embed robust systems and
processes will continue to be monitored through the Clinical Quality and Performance forum.

6.3 Patient Safety

The CCG monitors closely the incidence of patient safety incidents across providers and during the month of January there were 14 new patient safety incidents reported which are all subject to a thorough investigation and review under the quality and patient safety processes.

The CCG are currently working with all Providers to complete the legacy list of Serious Untoward Incidents occurring prior to the authorisation of Liverpool CCG. The following table highlights the transferred position with the current status. There are 4 legacy incidents currently being performance managed by NHS England (Merseyside)

<table>
<thead>
<tr>
<th>Provider</th>
<th>Number closed</th>
<th>Number outstanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alder Hey</td>
<td>16</td>
<td>4</td>
</tr>
<tr>
<td>Royal Liverpool &amp; Broadgreen</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Liverpool Heart &amp; Chest</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Liverpool Women's</td>
<td>14</td>
<td>11</td>
</tr>
<tr>
<td>Liverpool Community Health</td>
<td>26</td>
<td>18</td>
</tr>
<tr>
<td>Mersey Care</td>
<td>38</td>
<td>30</td>
</tr>
</tbody>
</table>

The CCG are working with each of the Providers to ensure that the legacy cases are closed in a timely fashion however due to changes in personnel within all NHS organisations the history and documentation are not either available or appropriate. The CCG are also requesting further evidence from each of the Providers that learning has been clearly embedded into practice and the impact that this is having.
The figures above highlight the significant number of SUIs outstanding for Liverpool Community Health and Mersey Care. Liverpool Community Health have recently commenced reporting of Pressure Ulcers as per national guidance that had previously gone unreported. Due to significant numbers involved the Provider has been asked to complete an aggregated review of Pressure Ulcers which will be submitted in April following the 45 day reporting timescale. It is accepted that Mersey Care, and indeed all Mental Health Trusts, will have significant reporting of SUIs due to the criteria for reporting all incidents for patients who are in receipt of services not just in-patients. These figures relate predominantly to actual and attempted suicide.

The CCG are meeting with each of the Providers on a monthly basis to gain understanding of the current position of each SUI and corresponding action plan. It is through these meetings that themes and analysis are developed specific to each individual Trust.

It is clear that the standard of information reported on StEIS; Root Cause Analysis Investigation reports and corresponding action plans are not of an appropriate quality or standard expected by the CCG. The CCG in partnership with NHS England (Merseyside) will be providing both RCA and action plan training to all Providers in an attempt to improve the quality and also to enable a more responsive learning outcome from the incident.

Current action plans predominantly state SOPS are developed or advice has been given to staff. The CCG are asking Providers to review actions and demonstrate their impact on practice and the system. This will result in incidents remaining open longer on StEIS however the CCG consider this to be appropriate as it will enable more assurance that learning has taken place and is embedded into practice.
The above work streams will both support and demand improved reporting; system learning with the subsequent demonstrable evidence of impact.

7. CCG FINANCIAL POSITION

The reported position as at 31st January 2014 showed a year to date overspend of £0.76m against planned expenditure, a reduction of £0.2m on the reported month 9 year to date position. Achievement of the planned £14.3m surplus for 2013/14 continues to be expected. In the remainder of the financial year unused reserves set aside as part of the 2013/14 financial plan will be applied to areas of agreed investment and identified cost pressures.

In accordance with guidance from NHS England legacy fixed asset balances and associated depreciation have been incorporated into the CCG accounts for the first time in the January 2014 reporting period. Remaining legacy asset and liability balances will remain with NHS England for the remainder of the 2013/14 financial year and are planned to be transferred to the CCG with effect from 1st April 2014.

<table>
<thead>
<tr>
<th>Area</th>
<th>Commentary</th>
<th>Rating - Year to Date</th>
<th>Rating – 31 March 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balanced Position</td>
<td>On track</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surplus</td>
<td>No significant issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2% Non recurrent Investment</td>
<td>On track</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Running Cost Allowance</td>
<td>Running Costs expected to be fully utilised in 2013-14, current year to date position shows an underspend to month 10.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
8. SUMMARY

Where performance is at variance to plan action is underway with Trusts to deliver corrective action to improve performance as we move towards the end of 2013/14 with contractual levers utilised to support improvements. These improvements are actively led by CCG Clinicians.

Ian Davies
Head of Operations & Corporate Performance
4 March 2014
### Appendix 1: CCG and Provider Dashboards

**CORPORATE PERFORMANCE DASHBOARD – LIVERPOOL CCG**

<table>
<thead>
<tr>
<th>Ref.</th>
<th>Performance Indicators</th>
<th>Frequency of Reporting</th>
<th>Reporting Period</th>
<th>Target/Baseline</th>
<th>Current Position</th>
<th>Movement since last report</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CCG Outcomes Framework &amp; Everyone Counts</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>CCG Outcomes Framework Measures</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td><strong>Local Measures</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>LPI 1</strong> (Quality Premium)</td>
<td>Quarterly</td>
<td>Q3 13/14 YTD</td>
<td>17.0%</td>
<td>17.2%</td>
<td>Down</td>
</tr>
<tr>
<td></td>
<td>Prevalence of Mothers Smoking at time of Delivery</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>LPI 2</strong> (Quality Premium)</td>
<td>Monthly</td>
<td>Feb-14</td>
<td>63.50%</td>
<td>64.07%</td>
<td>Up</td>
</tr>
<tr>
<td></td>
<td>Reducing the variation in General Practice: % of patients with CHD whose cholesterol is 5mmol or less measured in the previous 12 months (for bottom 25% of GP practices in 12/13)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td><strong>LPI 3</strong> (Quality Premium)</td>
<td>Monthly</td>
<td>Feb-14</td>
<td>41.7%</td>
<td>52.38%</td>
<td>Up</td>
</tr>
<tr>
<td></td>
<td>Diabetes management: To increase the % of Diabetics over 12 who have received all 9 care processes (within the previous 12 months) from 30.1% (Dec 12) to 42.8% (equivalent of 30% towards the England median (55.5%))</td>
<td></td>
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</tr>
<tr>
<td></td>
<td><strong>Preventing people from dying prematurely</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>CB_A1</strong> (Quality Premium)</td>
<td>Annual</td>
<td>2012</td>
<td>2,020</td>
<td>2,087</td>
<td>Up</td>
</tr>
<tr>
<td></td>
<td>Potential years of life lost (PYLL) from causes considered amendable to healthcare - Females (Rate per 100,000 pop)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>CB_A1_II</strong> (Quality Premium)</td>
<td>Annual</td>
<td>2012</td>
<td>2,737</td>
<td>2,828</td>
<td>Up</td>
</tr>
<tr>
<td></td>
<td>Potential years of life lost (PYLL) from causes considered amendable to healthcare - Males (Rate per 100,000 pop)</td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td></td>
<td><strong>CB_A2</strong></td>
<td>Annual</td>
<td>2012</td>
<td>94.79</td>
<td>83.58</td>
<td>Down</td>
</tr>
<tr>
<td></td>
<td>Under 75 mortality rate from cardiovascular disease - Males &amp; Females (Rate per 100,000 pop)</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td><strong>CB_A3</strong></td>
<td>Annual</td>
<td>2012</td>
<td>46.42</td>
<td>50.79</td>
<td>Up</td>
</tr>
<tr>
<td></td>
<td>Under 75 mortality rate from respiratory disease - Males &amp; Females (Rate per 100,000 pop)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>CB_A4</strong></td>
<td>Annual</td>
<td>2012</td>
<td>26.25</td>
<td>32.36</td>
<td>Up</td>
</tr>
<tr>
<td></td>
<td>Under 75 mortality rate from liver disease (Rate per 100,000 pop)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>CB_A5</strong></td>
<td>Annual</td>
<td>2012</td>
<td>158.30</td>
<td>163.17</td>
<td>Up</td>
</tr>
<tr>
<td></td>
<td>Under 75 mortality rate from cancer (Rate per 100,000 pop)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Enhancing quality of life for people with long term conditions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>CB_A6_01</strong></td>
<td>Monthly</td>
<td>YTD Dec-13</td>
<td>657.92</td>
<td>687.74</td>
<td>Up</td>
</tr>
<tr>
<td></td>
<td>Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 pop)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>CB_A6_02</strong></td>
<td>Monthly</td>
<td>YTD Dec-13</td>
<td>295.12</td>
<td>241.55</td>
<td>Down</td>
</tr>
<tr>
<td></td>
<td>Unplanned hospitalisation for asthma, diabetes and epilepsy in under 15s (Rate per 100,000 pop)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>CB_A9</strong></td>
<td>Monthly</td>
<td>Jan-13</td>
<td>56.1%</td>
<td>58.11%</td>
<td>Up</td>
</tr>
<tr>
<td></td>
<td>Estimated diagnosis rate for people with dementia</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>CB_B19</strong></td>
<td>Monthly</td>
<td>Jan-13</td>
<td>95.0%</td>
<td>97.32%</td>
<td>Up</td>
</tr>
<tr>
<td></td>
<td>Mental Health Measure: % of Patients on Care Programme Approach (Target 95%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Helping people to recover from episodes of ill health or following injury</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>CB_A6_03</strong></td>
<td>Monthly</td>
<td>YTD Dec-13</td>
<td>720.59</td>
<td>712.33</td>
<td>Down</td>
</tr>
<tr>
<td></td>
<td>Emergency admissions for acute conditions that should not usually require hospital admission (Rate per 100,000 pop)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>CB_A6_04</strong></td>
<td>Monthly</td>
<td>YTD Dec-13</td>
<td>67.21</td>
<td>44.8</td>
<td>Down</td>
</tr>
<tr>
<td></td>
<td>Emergency admissions for children with Lower Respiratory Tract Infections (LRTI) (Rate per 100,000 pop)</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td><strong>CB_A11_I</strong></td>
<td>Annual</td>
<td>2012/13</td>
<td>42.6</td>
<td>42.0</td>
<td>Up</td>
</tr>
<tr>
<td></td>
<td>Total health gain assessed by patients: i Hip replacement - (Av reported health gain)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>CB_A11_II</strong></td>
<td>Annual</td>
<td>2012/13</td>
<td>32.0</td>
<td>30.7</td>
<td>Down</td>
</tr>
<tr>
<td></td>
<td>Total health gain assessed by patients: ii Knee replacement - (Av reported health gain)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>CB_A11_III</strong></td>
<td>Annual</td>
<td>2012/13</td>
<td>8.8</td>
<td>11</td>
<td>Up</td>
</tr>
<tr>
<td></td>
<td>Total health gain assessed by patients: iii Groin hernia - (Av reported health gain)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ref.</td>
<td>Performance Indicators</td>
<td>Frequency of Reporting</td>
<td>Reporting Period</td>
<td>Target/ Baseline</td>
<td>Current Position</td>
<td>Movement since last report</td>
</tr>
<tr>
<td>--------------</td>
<td>-----------------------------------------------------------------------------------------</td>
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<td>------------------------</td>
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</tr>
<tr>
<td>CB_A11.1</td>
<td>Total health gain assessed by patients iv Varicose veins - (Av reported health gain)</td>
<td>Annual</td>
<td>2011/12</td>
<td>6.1</td>
<td>6.5</td>
<td></td>
</tr>
<tr>
<td>SQU0_01</td>
<td>Percentage of patients who had a stroke &amp; spend at least 90% of their time on a stroke unit</td>
<td>Monthly</td>
<td>Dec-13</td>
<td>80.0%</td>
<td>78.7%</td>
<td></td>
</tr>
<tr>
<td>SQU0_02</td>
<td>Percentage of patients with a high risk of Stroke who experience a TIA are assessed and treated within 24 hours</td>
<td>Monthly</td>
<td>Dec-13</td>
<td>60.0%</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td>CB_A12</td>
<td>Patient experience of primary care - % of patients satisfied with GP Services</td>
<td>Bi annual</td>
<td>Jan-Mar 13 and Jul-Sept 13</td>
<td>No Target</td>
<td>88.39%</td>
<td></td>
</tr>
<tr>
<td>CB_A12.1</td>
<td>Patient experience of primary care - % of patients satisfied with GP Out of Hours services</td>
<td>Bi annual</td>
<td>Jan-Mar 13 and Jul-Sept 13</td>
<td>No Target</td>
<td>74.29%</td>
<td></td>
</tr>
<tr>
<td>CB_B17.1</td>
<td>Number of Mixed Sex Accommodation breaches</td>
<td>Monthly</td>
<td>Jan-14</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>CB_B17</td>
<td>Mixed Sex Accommodation breaches per 1,000 FCEs</td>
<td>Monthly</td>
<td>Jan-14</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>CB_A15 (Quality Premium)</td>
<td>Incidence of healthcare associated infection (HCAI) MRSA</td>
<td>Monthly</td>
<td>YTD Jan -14</td>
<td>0</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>CB_A16 (Quality Premium)</td>
<td>Incidence of healthcare associated infection (HCAI) C.difficile</td>
<td>Monthly</td>
<td>YTD Jan -14</td>
<td>91</td>
<td>144</td>
<td></td>
</tr>
<tr>
<td>CB_B1</td>
<td>Admitted patients to start treatment within a maximum of 18 weeks from referral</td>
<td>Monthly</td>
<td>Jan-14</td>
<td>90.0%</td>
<td>92.1%</td>
<td></td>
</tr>
<tr>
<td>CB_B2</td>
<td>Non-admitted patients to start treatment within a maximum of 18 weeks from referral</td>
<td>Monthly</td>
<td>Jan-14</td>
<td>95.0%</td>
<td>98.5%</td>
<td></td>
</tr>
<tr>
<td>CB_B3 (Quality Premium)</td>
<td>Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral</td>
<td>Monthly</td>
<td>Jan-14</td>
<td>92.0%</td>
<td>95.1%</td>
<td></td>
</tr>
<tr>
<td>CB_S6.1</td>
<td>Number of 52 week Referral to Treatment Pathways - Admitted Patients</td>
<td>Monthly</td>
<td>Jan-14</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>CB_S6.2</td>
<td>Number of 52 week Referral to Treatment Pathways - Admitted Patients (adjusted)</td>
<td>Monthly</td>
<td>Jan-14</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>CB_S6.3</td>
<td>Number of 52 week Referral to Treatment Pathways - Non Admitted Patients</td>
<td>Monthly</td>
<td>Jan-14</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>CB_S6.4</td>
<td>Number of 52 week Referral to Treatment Pathways - Incomplete Pathways</td>
<td>Monthly</td>
<td>Jan-14</td>
<td>0</td>
<td>0</td>
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<tr>
<td>CB_B4</td>
<td>Percentage of Patients waiting for more than 6 weeks for a diagnostic test</td>
<td>Monthly</td>
<td>Jan-14</td>
<td>1.00%</td>
<td>9.10%</td>
<td></td>
</tr>
<tr>
<td>CB_B5</td>
<td>Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&amp;E department</td>
<td>Monthly</td>
<td>YTD Jan -14</td>
<td>95.00%</td>
<td>95.7%</td>
<td></td>
</tr>
<tr>
<td>CB_B6</td>
<td>Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP - % achievement</td>
<td>Monthly</td>
<td>YTD Dec-13</td>
<td>93.00%</td>
<td>95.68%</td>
<td></td>
</tr>
<tr>
<td>CB_B7</td>
<td>Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) - % achievement</td>
<td>Monthly</td>
<td>YTD Dec-13</td>
<td>93.00%</td>
<td>94.70%</td>
<td></td>
</tr>
<tr>
<td>CB_B8</td>
<td>Maximum one month (31 day) wait from diagnosis to first definitive treatment for all cancers - % achievement</td>
<td>Monthly</td>
<td>YTD Dec-13</td>
<td>96.00%</td>
<td>98.42%</td>
<td></td>
</tr>
<tr>
<td>CB_B9</td>
<td>Maximum 31-day wait for subsequent treatment where that treatment is surgery - % achievement</td>
<td>Monthly</td>
<td>YTD Dec-13</td>
<td>94.00%</td>
<td>99.60%</td>
<td></td>
</tr>
<tr>
<td>Ref.</td>
<td>Performance Indicators</td>
<td>Frequency of Reporting</td>
<td>Reporting Period</td>
<td>Target/ Baseline</td>
<td>Current Position</td>
<td>Movement since last report</td>
</tr>
<tr>
<td>------</td>
<td>----------------------------------------------------------------------------------------</td>
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<td>------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>CB_B10</td>
<td>Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen - % achievement</td>
<td>Monthly</td>
<td>YTD Dec-13</td>
<td>98.00%</td>
<td>99.14%</td>
<td></td>
</tr>
<tr>
<td>CB_B11</td>
<td>Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy - % achievement</td>
<td>Monthly</td>
<td>YTD Dec-13</td>
<td>94.00%</td>
<td>96.68%</td>
<td></td>
</tr>
<tr>
<td>CB_B12</td>
<td>Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer - % achievement</td>
<td>Monthly</td>
<td>YTD Dec-13</td>
<td>85.00%</td>
<td>88.64%</td>
<td></td>
</tr>
<tr>
<td>CB_B13</td>
<td>Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers - % achievement</td>
<td>Monthly</td>
<td>YTD Dec-13</td>
<td>90.00%</td>
<td>95.71%</td>
<td></td>
</tr>
<tr>
<td>CB_B14</td>
<td>Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) - % achievement</td>
<td>Monthly</td>
<td>YTD Dec-13</td>
<td>No threshold set - local target 85%</td>
<td>84.69%</td>
<td></td>
</tr>
</tbody>
</table>

**NHS Constitution - Ambulance Response Times**

<table>
<thead>
<tr>
<th>Ref.</th>
<th>Performance Indicators</th>
<th>Frequency of Reporting</th>
<th>Reporting Period</th>
<th>Target/ Baseline</th>
<th>Current Position</th>
<th>Movement since last report</th>
</tr>
</thead>
<tbody>
<tr>
<td>CB_B15</td>
<td>Ambulance clinical quality - Category A (Red 1) 8 minute response time. (NWAS)</td>
<td>Monthly</td>
<td>YTD Dec-13</td>
<td>75.00%</td>
<td>75.81%</td>
<td></td>
</tr>
<tr>
<td>CB_B16</td>
<td>Ambulance clinical quality - Category A (Red 2) 8 minute response time. (NWAS)</td>
<td>Monthly</td>
<td>YTD Dec-13</td>
<td>75.00%</td>
<td>77.73%</td>
<td></td>
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<tr>
<td>CB_B17</td>
<td>Ambulance clinical quality - Category A 19 minute transportation time. (NWAS)</td>
<td>Monthly</td>
<td>YTD Dec-13</td>
<td>95.00%</td>
<td>95.66%</td>
<td></td>
</tr>
<tr>
<td>CB_B18</td>
<td>Ambulance clinical quality - Category A (Red 1) 8 minute response time. (CCG)</td>
<td>Monthly</td>
<td>YTD Dec-13</td>
<td>75.00%</td>
<td>89.07%</td>
<td></td>
</tr>
<tr>
<td>CB_B19</td>
<td>Ambulance clinical quality - Category A (Red 2) 8 minute response time. (CCG)</td>
<td>Monthly</td>
<td>YTD Dec-13</td>
<td>75.00%</td>
<td>87.81%</td>
<td></td>
</tr>
<tr>
<td>CB_B20</td>
<td>Ambulance clinical quality - Category A 19 minute transportation time. (CCG)</td>
<td>Monthly</td>
<td>YTD Dec-13</td>
<td>95.00%</td>
<td>97.31%</td>
<td></td>
</tr>
</tbody>
</table>

- **Achieving Target**
- **Below Target**
- **Significantly Below Target**

Ref. No. highlighted in purple indicate Quality Premium indicators:

- **Improved Performance**
- **Reduced Performance**
- **No Change**
### Appendix 2a

**CORPORATE PERFORMANCE DASHBOARD - PROVIDER CATCHMENT**

<table>
<thead>
<tr>
<th>Performance Indicators</th>
<th>Aintree University Hospitals NHS Foundation Trust</th>
<th>Alder Hey Children’s NHS Foundation Trust</th>
<th>Liverpool Heart &amp; Chest NHS Foundation Trust</th>
<th>Liverpool Women's NHS Foundation Trust</th>
<th>Royal Liverpool &amp; Broadgreen University Hospitals NHS Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NHS Constitution Access &amp; Waiting Times</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>A&amp;E waits</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of patients who spent 4 hours or less in A&amp;E – 95% (Cumulative)</td>
<td>13/14 - January</td>
<td>95.22%</td>
<td>98.06%</td>
<td>99.86%</td>
<td>93.80%</td>
</tr>
<tr>
<td><strong>Cancer waiting times</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cancer waits – 2 week wait</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93% (Cumulative)</td>
<td>13/13 - December</td>
<td>97.57%</td>
<td>100.0%</td>
<td>97.89%</td>
<td>97.85%</td>
</tr>
<tr>
<td>Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93% (Cumulative)</td>
<td>13/14 - December</td>
<td>94.26%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td><strong>Cancer waits – 31 days</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96% (Cumulative)</td>
<td>13/14 - December</td>
<td>98.89%</td>
<td>100.0%</td>
<td>98.62%</td>
<td>98.03%</td>
</tr>
<tr>
<td>Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94% (Cumulative)</td>
<td>13/14 - December</td>
<td>98.70%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>99.01%</td>
</tr>
<tr>
<td>Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98% (Cumulative)</td>
<td>13/14 - December</td>
<td>100.00%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94% (Cumulative)</td>
<td>13/14 - December</td>
<td>100.00%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.00%</td>
</tr>
<tr>
<td><strong>Cancer waits – 62 days</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum two month (62 day) wait from urgent GP referral to first definitive treatment for cancer – operational standard target 85% (Cumulative). Local Target of 79% for Liverpool Heart &amp; Chest, Liverpool Women’s (Cumulative)</td>
<td>13/14 - December</td>
<td>88.03%</td>
<td>100.00%</td>
<td>76.35%</td>
<td>87.21%</td>
</tr>
<tr>
<td>Maximum 62 day wait from referral from an NHS screening service to first definitive treatment for all cancers – operational standard target 90% (Cumulative). Local Target of 81.8% agreed for Aintree (Cumulative)</td>
<td>13/14 - December</td>
<td>85.96%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Maximum 62 day wait for first definitive treatment following a consultant’s decision to upgrade the priority of the patient (all cancers) – no operational standard set. Local Target of 85% for all providers (Cumulative)</td>
<td>13/14 - December</td>
<td>92.58%</td>
<td>100.00%</td>
<td>80.00%</td>
<td>90.63%</td>
</tr>
<tr>
<td><strong>Diagnostic test waiting times</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of patients waiting 6 weeks or more for a Diagnostic Test</td>
<td>13/14 - December</td>
<td>0.59%</td>
<td>0.67%</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td><strong>Referral To Treatment waiting times for non-urgent consultant-led treatment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admitted patients to start treatment within a maximum of 18 weeks from referral – 90%</td>
<td>13/14 - December</td>
<td>94.7%</td>
<td>80.2%</td>
<td>91.1%</td>
<td>99.3%</td>
</tr>
<tr>
<td>Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95%</td>
<td>13/14 - December</td>
<td>97.9%</td>
<td>95.2%</td>
<td>96.8%</td>
<td>95.7%</td>
</tr>
<tr>
<td>Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92%</td>
<td>13/14 - December</td>
<td>96.98%</td>
<td>92.07%</td>
<td>96.20%</td>
<td>94.81%</td>
</tr>
<tr>
<td>The number of Referral to Treatment (RTT) pathways greater than 52 weeks for completed admitted pathways (Unadjusted)</td>
<td>13/14 - December</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Performance Indicators</td>
<td>Aintree University Hospitals NHS Foundation Trust</td>
<td>Alder Hey Children's NHS Foundation Trust</td>
<td>Liverpool Heart &amp; Chest NHS Foundation Trust</td>
<td>Liverpool Women’s NHS Foundation Trust</td>
<td>Royal Liverpool &amp; Broadgreen University Hospitals NHS Foundation Trust</td>
</tr>
<tr>
<td>------------------------</td>
<td>-----------------------------------------------</td>
<td>------------------------------------------</td>
<td>---------------------------------------------</td>
<td>----------------------------------------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>The number of Referral to Treatment (RTT) pathways greater than 52 weeks for completed admitted pathways (Adjusted)</td>
<td>13/14 - December</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>The number of Referral to Treatment (RTT) pathways greater than 52 weeks for completed non-admitted pathways</td>
<td>13/14 - December</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>The number of Referral to Treatment (RTT) pathways greater than 52 weeks for incomplete pathways</td>
<td>13/14 - December</td>
<td>0</td>
<td>15</td>
<td>0</td>
<td>0</td>
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**Supporting Measures**

<table>
<thead>
<tr>
<th>Quality (Safety, Effectiveness &amp; Patient Experience)</th>
<th>13/14 - December</th>
<th>13/14 - December</th>
<th>13/14 - December</th>
<th>13/14 - December</th>
<th>13/14 - December</th>
</tr>
</thead>
<tbody>
<tr>
<td>SQ06_01 - % who had a stroke &amp; spend at least 90% of their time on a stroke unit</td>
<td>54.4%</td>
<td>82.6%</td>
<td></td>
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<td></td>
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<tr>
<td>SQ06_02 - % high risk of Stroke who experience a TIA are assessed and treated within 24 hours</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Friends and Family Test Score - Inpatients &amp; A&amp;E</td>
<td>57</td>
<td>92</td>
<td>81</td>
<td>51</td>
<td></td>
</tr>
<tr>
<td>Friends and Family Test Score Inpatients &amp; A&amp;E (% of respondents) (15%)</td>
<td>27.3%</td>
<td>22.9%</td>
<td>22.6%</td>
<td>12.0%</td>
<td></td>
</tr>
<tr>
<td>National Maternity Survey - Antenatal Care Score</td>
<td>64</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Maternity Survey - Birth Score</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Maternity Survey - Postnatal Ward Score</td>
<td>79</td>
<td></td>
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<tr>
<td>National Maternity Survey - Community Provision Score</td>
<td>73</td>
<td></td>
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</tbody>
</table>

**Treating and caring for people in a safe environment and protecting them from avoidable harm**

<table>
<thead>
<tr>
<th>Incidence of healthcare associated infection (HCAI) C.difficile (Cumulative)</th>
<th>13/14 - January</th>
<th>71</th>
<th>1</th>
<th>3</th>
<th>2</th>
<th>43</th>
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</thead>
<tbody>
<tr>
<td>Incidence of healthcare associated infection (HCAI) MRSA (Cumulative)</td>
<td>13/14 - January</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Patient safety incidents reported (SUIs)</td>
<td>13/14 - January</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>1</td>
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<tr>
<td>Never Events (Of the SUIs reported above)</td>
<td>13/14 - January</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cancelled Operations - Operations cancelled on or after the day of admissions for non clinical reasons (28 day standard)</td>
<td>Q2 13/14</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Cancelled Operations - Operations cancelled for a second time</td>
<td>Q2 13/14</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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</tbody>
</table>

**Mixed Sex Accommodation breaches**

<table>
<thead>
<tr>
<th>Number of Mixed Sex Accommodation breaches</th>
<th>Jan-14</th>
<th></th>
<th></th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Achieving Plan</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
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<tr>
<td>Variance from Plan</td>
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<tr>
<td>Significant variation from plan</td>
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<tr>
<td>Not Applicable</td>
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<tr>
<td>Update not available</td>
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### NHS LIVERPOOL CLINICAL COMMISSIONING GROUP

**GOVERNING BODY**

**TUESDAY 11 MARCH 2014**

<table>
<thead>
<tr>
<th>Title of Report</th>
<th>Corporate Risk Register</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead Governor</td>
<td>Maureen Williams</td>
</tr>
<tr>
<td>Senior Management Team Lead</td>
<td>Ian Davies, Head of Operations &amp; Corporate Performance</td>
</tr>
<tr>
<td>Report Author</td>
<td>Ian Davies, Head of Operations &amp; Corporate Performance</td>
</tr>
<tr>
<td>Summary</td>
<td>The purpose of this paper is to present to the Governing Body the Corporate Risk Register as part of the governance and assurance process for the organisation</td>
</tr>
<tr>
<td>Recommendation</td>
<td>That Liverpool CCG Governing Body:</td>
</tr>
<tr>
<td></td>
<td>➢ Notes the revised and updated risk register and the actions underway to mitigate the risks identified</td>
</tr>
<tr>
<td>Impact on improving health outcomes, reducing inequalities and promoting financial sustainability</td>
<td>The risk register provides the Governing Body with assurances on the key risks that impact upon the delivery of the organisations key objectives and financial stability.</td>
</tr>
<tr>
<td>Relevant Standards or targets</td>
<td>Organisational and corporate governance requirements</td>
</tr>
<tr>
<td>Ref</td>
<td>Organisational Values &amp; Objectives</td>
</tr>
<tr>
<td>-----</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>C002</td>
<td>To hold providers of commissioned services to account for the quality of services delivered</td>
</tr>
<tr>
<td>C003</td>
<td>To hold providers of commissioned services to account for the quality of services delivered</td>
</tr>
<tr>
<td>C004</td>
<td>HRR</td>
</tr>
<tr>
<td>Date</td>
<td>Description</td>
</tr>
<tr>
<td>------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>14/05/2013</td>
<td>Complete legal transfer of assets and liabilities from former NHS organisations and structure</td>
</tr>
<tr>
<td></td>
<td>Failure to transfer correct financial 'opening' balance to the new CCG</td>
</tr>
<tr>
<td></td>
<td>Chief Finance Officer and finance team working closely with Legacy team North to ensure appropriate opening balances are established.</td>
</tr>
<tr>
<td></td>
<td>Chief Finance Officer monitoring position and lobbying for resolution; Regular update to SMT; MIAA leading the process locally</td>
</tr>
<tr>
<td>3</td>
<td>Issue formally raised at the Audit, Risk and Scrutiny Committee throughout the year, Chief Finance Officer continues to raise issue and risk with NHS England. Current position better understood and work underway to progress.</td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Mar-14</td>
<td></td>
</tr>
<tr>
<td>Ref</td>
<td>Organisational Values &amp; Objectives</td>
</tr>
<tr>
<td>-----</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>C008 FPCC</td>
<td>We will act with honesty and transparency in all our actions. We are committed to a teamwork environment, where every member of the CCG is valued, encouraged to contribute and recognised for their efforts.</td>
</tr>
<tr>
<td>C009 FPCC</td>
<td>To maximise value from our financial resources and focus on interventions that will make a major difference</td>
</tr>
<tr>
<td>C010 PCC</td>
<td>To hold providers of commissioned services to account for the quality of services delivered</td>
</tr>
<tr>
<td>Date</td>
<td>Action</td>
</tr>
<tr>
<td>----------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>11/06/2013</td>
<td>Delivery of commissioned services to patients by Aintree University Hospital NHS FT meets commissioning requirements (service and quality) and compliance with Monitor ‘operating licence’</td>
</tr>
<tr>
<td></td>
<td>Patient care and service delivery falling below an acceptable and safe standard and commissioner expectations /standards. Trust in potential breach of Monitor ‘operating licence’</td>
</tr>
<tr>
<td></td>
<td>Quality review completed in April 2013; NHS contract collaborative commissioning arrangements in place with South Sefton and Knowsley CCGs; CPQG; Monitor investigation commenced with regards to provider performance in AED, HCAI, RTT and mortality</td>
</tr>
<tr>
<td></td>
<td>Monthly reporting to Governing Body; CPQG on-going monitoring and assessment of provider service delivery; Monitor investigation completed and sanctions applied; regular reporting through Regional Quality Surveillance arrangements</td>
</tr>
<tr>
<td>4 5 20 N</td>
<td>CPQG monitoring and holding the provider to account for service delivery; Monitor investigation into Provider performance completed: licence breached action plan in place; details posted on Trust website. CQC Report published on the 6th December 2013, including a warning notice to be met by 28th February 2014. Matter raised in Part 2 of the Governing Body meeting held on the 10th December 2013 and way forward agreed. Liverpool CCG formal position communicated to Knowsley and South Sefton CCGs. Actions continue to seek sustainable improvements.</td>
</tr>
<tr>
<td>Ref</td>
<td>Objective</td>
</tr>
<tr>
<td>------</td>
<td>-----------</td>
</tr>
<tr>
<td>C012</td>
<td>To hold providers of commissioned services to account for the quality of services delivered</td>
</tr>
<tr>
<td>C013</td>
<td>To hold providers of commissioned services to account for the quality of services delivered</td>
</tr>
<tr>
<td>C014</td>
<td>We will act with honesty and transparency in all our actions. We are committed to a teamwork environment, where every member of the CCG is valued, encouraged to contribute and recognised for their efforts.</td>
</tr>
</tbody>
</table>
To hold providers of commissioned services to account for the quality of services delivered

<table>
<thead>
<tr>
<th>Date</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>06/08/2013</td>
<td>CCG use and reliance upon quality and timely performance data</td>
</tr>
<tr>
<td></td>
<td>Poor quality data leading to inaccurate monitoring and assessment of providers, operational and financial risk</td>
</tr>
<tr>
<td></td>
<td>CSU is commissioned to provide business intelligence support including data processing and validation.</td>
</tr>
<tr>
<td></td>
<td>Monthly performance meetings with CSU, 'in house' analyst capacity to review data accuracy and assess risk</td>
</tr>
<tr>
<td>4</td>
<td>CSU being held to account for the delivery of data to the required standard and quality, matters raised at monthly performance meeting with CSU leadership; some recent improvement in data quality seen; issues with individual providers being taken up via contract meetings. Inconsistent improvements in data quality and timeliness seen.</td>
</tr>
<tr>
<td>3</td>
<td>TJ/ID/TW on-going</td>
</tr>
<tr>
<td>Mar-14</td>
<td></td>
</tr>
<tr>
<td>Ref</td>
<td>Objective</td>
</tr>
<tr>
<td>-------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>CO16</td>
<td>To maximise value from our financial resources and focus on interventions that will make a major difference</td>
</tr>
<tr>
<td>CO17</td>
<td>To hold providers of commissioned services to account for the quality of services delivered</td>
</tr>
<tr>
<td>CO18</td>
<td>We accept responsibility for our actions. We make and support business decisions through experience, evidence and good judgement, and we will deliver against our promises</td>
</tr>
<tr>
<td>CO19</td>
<td>To maximise value from our financial resources and focus on interventions that will make a major difference</td>
</tr>
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<td>Ref</td>
<td>Organisational Values &amp; Objectives</td>
</tr>
<tr>
<td>------</td>
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</tr>
<tr>
<td>CO20</td>
<td>To maximise value from our financial resources and focus on interventions that will make a major difference</td>
</tr>
<tr>
<td>CO21</td>
<td>To maximise value from our financial resources and focus on interventions that will make a major difference</td>
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<td>Organisational Values &amp; Objectives</td>
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</tr>
<tr>
<td>CO22</td>
<td>To maximise value from our financial resources and focus on interventions that will make a major difference</td>
</tr>
<tr>
<td>CO23</td>
<td>We accept responsibility for our actions. We make and support business decisions through experience, evidence and good judgement, and we will deliver against our promises</td>
</tr>
<tr>
<td>CO24</td>
<td>To hold providers of commissioned services to account for the quality of services delivered</td>
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</tr>
<tr>
<td>CO25</td>
<td>To maximise value from our financial resources and focus on interventions that will make a major difference</td>
</tr>
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</table>

**KEY:**
- Updates to existing risks in 'blue'
- Recommend removal from the register

**Risk scoring = likelihood x consequence (L x C)**

<table>
<thead>
<tr>
<th>Likelihood</th>
<th>Likelihood Score</th>
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<tbody>
<tr>
<td>Rare</td>
<td>1</td>
</tr>
<tr>
<td>Unlikely</td>
<td>2</td>
</tr>
<tr>
<td>Possible</td>
<td>3</td>
</tr>
<tr>
<td>Likely</td>
<td>4</td>
</tr>
<tr>
<td>Almost certain</td>
<td>5</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Consequence Score</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 Catastrophic</td>
<td>5</td>
<td>10</td>
<td>15</td>
<td>20</td>
<td>25</td>
</tr>
<tr>
<td>3 Major</td>
<td>4</td>
<td>8</td>
<td>12</td>
<td>16</td>
<td>20</td>
</tr>
<tr>
<td>3 Moderate</td>
<td>3</td>
<td>6</td>
<td>9</td>
<td>12</td>
<td>15</td>
</tr>
<tr>
<td>2 Minor</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>1 Negligible</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

- Low risk (1 - 3)
- Moderate Risk (4 - 6)
- High Risk (8 - 12)
- Extreme Risk (15 - 25)