CAMBRIDGESHIRE HEALTH AND WELLBEING BOARD

Cambridgeshire County Council

Date:Thursday, 30 March 2017

09:15hr

Democratic and Members' Services
Quentin Baker
LGSS Director: Lawand Governance

Shire Hall
Castle Hill
Cambridge
CB3 0AP

Swansley Room, South Cambridgeshire Hall, Cambourne CB23 6EA

AGENDA

Open to Public and Press

1	**Apologies for absence and declarations of interest** *Guidance on declaring interests is available at http://tinyurl.com/ccc-dec-of-interests*	
2	**Minutes of the Meeting on 19 January 2017**	**5 - 18**
3	**Action Log**	**19 - 22**
4	**A Person's Story** Oral report.	
5	**Dual Diagnosis of Substance Misuse and Mental Health Conditions**	**23 - 40**
6	**Review of the Better Care Fund** *To follow.*	

7	**Public Health Reference Group Report**	**41 - 64**
8	**Sustainability and Transformation Plan (STP)**	**65 - 76**
9	**Agenda Plan**	**77 - 80**

10 Date of Next Meeting

An Extraordinary Meeting of the Cambridgeshire Health and Wellbeing Board will take place on Thursday 27 April 2017 from 11.30am-1.00pm in the Kreis Viersen Room, Shire Hall, Cambridge.

The Cambridgeshire Health and Wellbeing Board comprises the following members:

Councillor Tony Orgee (Chairman) Tracy Dowling (Vice-Chairwoman)

Councillor Margery Abbott Councillor Mike Cornwell Councillor Sue Ellington Kate Lancaster Chris Malyon Lance McCarthy Val Moore Wendi Ogle-Welbourn Dr Sripat Pai Councillor John Michael Palmer Stephen Posey Liz Robin Councillor Joshua Schumann Vivienne Stimpson Aidan Thomas and Matthew Winn Councillor Paul Clapp Councillor David Jenkins Councillor Peter Topping and Councillor Joan Whitehead

For more information about this meeting, including access arrangements and facilities for people with disabilities, please contact

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Twitter and Facebook) to communicate with people about what is happening, as it happens. These arrangements operate in accordance with a protocol agreed by the Chairman of the Council and political Group Leaders which can be accessed via the following link or made available on request: http://tinyurl.com/ccc-film-record.

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CAMBRIDGESHIRE HEALTH AND WELLBEING BOARD: MINUTES

Date: 19 January 2017

Time: 10.05 – 13.05

Venue: Kreis Viersen Room, Shire Hall, Cambridge

Present: Cambridgeshire County Council (CCC)
Councillors T Orgee (Chairman), P Clapp, D Jenkins, P Topping and J Whitehead
Dr Liz Robin, Director of Public Health (PH)
Charlotte Black, Service Director – Older People's Services and Mental Health (substituting for Wendi Ogle-Welbourn)

City and District Councils
Councillors M Abbott (Cambridge City), M Cornwell (Fenland), John Palmer (Huntingdonshire) and J Schuman (East Cambridgeshire).

Cambridgeshire and Peterborough Clinical Commissioning Group (CCG)
Tracy Dowling, Chief Officer (Vice-Chairwoman) and Dr Sripat Pai.

Healthwatch
Val Moore, Chair

NHS Providers
Phil Walmsley, Hinchingbrooke Health Care NHS Trust (HHCT) (substituting for Lance McCarthy); Stephen Posey, Papworth Hospital NHS Foundation Trust; Mandy Renton, Cambridgeshire Community Services NHS Trust (CCS) (substituting for Matthew Winn); Aidan Thomas, Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)

Voluntary and Community Sector (co-opted)
Julie Farrow, Chief Executive Officer, Hunts Forum of Voluntary Organisations

District Council non-voting officer advisor
Mike Hill

Also in attendance:
Jessica Bawden, Director of Corporate Affairs, CCG
Kate Parker, Head of Public Health Programmes, CCC
Lucy Dennis, Head of Cambridgeshire and Peterborough Workforce Partnership (Health Education England) (for items 4 & 12, minutes 249 & 258)
Ruth Kent, NHS England (NHSE) (for item 8, minute 254)

Apologies: Dr Cathy Bennett (CCG), Cllr S Ellington (South Cambridgeshire District Council), Kate Lancaster (Cambridge University Hospitals NHS Foundation Trust, CUHFT), Lance McCarthy (HHCT), Chis Malyon (Section 151 Officer, CCC), Wendi Ogle-Welbourn (Interim Executive Director, Children, Families and Adult [CFA] Services, CCC), Vivienne Stimpson (NHS England), Claire Tripp (Papworth Hospital NHS Foundation Trust) and Matthew Winn (CCS)

247. APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST

Apologies were noted as recorded above. The Chairman welcomed Stephen Posey and Councillor John Palmer to their first meeting. There were no declarations of interest.

With the consent of the meeting, the Chairman changed the agenda running order to take Item 3 (A Person's Story) immediately before Item 6 (Priority 1 Report from Children's Trust Executive Partnership [CTEP]) because the story was relevant to the work of CTEP.

248. MINUTES OF THE MEETING ON 17 NOVEMBER 2017 AND ACTION LOG

The minutes of the meeting on 15 September 2016 were agreed as an accurate record and signed by the Chairman.

The Board received the Action Log. The Director of Public Health provided the following oral updates:

- Minute 214, Quality Premium indicators – on the agenda (item 13, minute 259); action complete
- Minute 226, Long-Term Conditions JSNA – A Mavrodaris has confirmed that the issues have been resolved through the Sustainability and Transformation Programme (STP) processes; action complete
- Minute 238, Community Resilience Strategy – a workshop took place earlier in January, led by the Interim Executive Director, CFA]Services; action complete
- Minute 244, Health and Care System STP Memorandum of Understanding – on the agenda (item 9, minute 256); action complete
- Minute 245, Forward Agenda Plan – plans for development sessions had been discussed at the officer support group. Because there were often changes in the membership of the Board in May, the question arose of whether it would be better to postpone further sessions until after the local government elections.

249 OUTCOMES FROM 17 NOVEMBER DEVELOPMENT SESSION

The Board received a report setting out the outcomes from a development session held for Board members on 17 November 2016. The session had covered both the local devolution plans for Cambridgeshire and the topic identified as a priority at the development session on 14 June 2016, 'Developing and retaining the future health and care workforce'. The Board considered both the report and its appendix, the draft 'Cambridgeshire and Peterborough Integrated Workforce Strategy'.

Members noted that the draft strategy's vision for the workforce was expressed in five ambitions: improving supply; improving retention; new role development; scaling up new ways of working and up-skilling; and leadership development. The question now was how to take these aspirational ambitions and move to projects aligned round the Sustainability and Transformation Programme.

In the course of discussion, Board members

- pointed out the need to ensure that the link with the devolution agenda was maintained; both the CCG and CPFT were encouraging the use of the apprenticeship levy

- urged that measures be taken to address working conditions at the lower end of the workforce; many care workers were paid the minimum wage on contracts that did not guarantee employment. Much of their time working was unpaid, which made jobs unattractive, and while it was not possible to change national conditions, something should be done by employers and commissioners locally to ensure that Cambridgeshire and Peterborough provided better than average conditions. The Head of Cambridge and Peterborough Workforce Partnership said that growing one's own staff, using the levy as a catalyst, was one mechanism for improvement; she agreed with the suggestion that this should be set out explicitly within the strategy

- enquired whether anybody was able to clarify practical mechanisms by which to take forward the development session work on district council input to the workforce strategy discussion

- reported that East Cambridgeshire District Council was developing a supplementary planning document on the Community Infrastructure Levy (CIL), which included provision of housing for people who worked in education; it would be possible to include health workers in the housing allocation policy

- commented that district councils were not in a position to solve the shortage of affordable housing at present

- noted that the devolution deal had included the allocation of £70m over five years for council housing in Cambridge City, and of £100m for housing across Cambridgeshire and in Peterborough, including affordable housing

- commented that, while there were long-term plans, there was also a range of short-term problems, not helped by, for example, the government decision to cut grants for nursing training; there were no obvious short-term solutions

- stated that there was a large NHS-owned building standing idle in Churchill Road, Wisbech, and suggested that this could be used to house nurses in affordable flats

- reported that CPFT was exploring what could be done about housing for staff, and noted that the STP housing workstream was looking at the NHS estate, including for example Hinchingbrooke

- noted that there was a severe lack of affordable housing in the north of the county and rental costs were increasing disproportionately there too, causing a real problem throughout the area

- drew attention to the discrepancy between pay rates offered to unqualified carers by NHS employers and the lower rates offered by private sector employers, which might be the result of the funding received; the recruitment of unqualified carers in the private sector was an even more pressing problem than that of recruiting them to work in the NHS

- commented that the workforce development strategy was a good, iterative document that would change as the STP changed.

It was resolved unanimously to consider the Cambridge & Peterborough Workforce Strategy and how the Board could further support the development of a whole system strategy across Health and social care.

250. CAMBRIDGESHIRE BETTER CARE FUND PLANNING 2017-19

The Board received an overview of progress in the delivery of the Cambridgeshire Better Care Fund (BCF) Plan in the current year, and seeking guidance on the future approach to the BCF, including further joint work with Peterborough City Council, to inform future development of the plan. Members noted that performance on non-elective admissions and delayed transfers of care (DTOCs) continued to worsen, and that the national planning guidance for 2017/18 and beyond had still not been published. It was intended to bring the draft BCF Plan to the Board in March, but this might not be possible if the guidance had still not been received.

Board members commented on the proposals set out in report paragraph 4.2, for
- Greater alignment of BCF activity with the Sustainability and Transformation Programme (STP) and local authority transformation plans
- Greater alignment of Cambridgeshire and Peterborough BCF Plans
- A single commissioning Board for Cambridgeshire and Peterborough.

Points raised included

- the three proposals seemed eminently sensible and obvious

- good progress was being made on non-elective admissions in Peterborough and Huntingdon, helped by both the Mental Health Vanguard and the development of a good model of ambulatory care; this should be put in place at Addenbrooke's too

- as part of the STP, a local investment fund was being created, to be used to reduce non-elective admissions and DTOCs

- the NHS locally had already finished it planning for the coming year, as contracts had had to be agreed by the end of December and plans submitted to NHSE. It was therefore not helpful that the timing of the issue of BCF guidance did not synchronise with NHS planning; it was difficult to see how it would be possible to provide additional NHS funding for the BCF next year

- a fourth point could usefully be added about achieving more aligned working with the County Council and district councils, because of the need to join up funding for non-elective admissions. Officers advised that this was already covered within the first bullet point; there was a very different culture and knowledge between NHS and local authority delivery officers, and the proposed approach of establishing a single BCF commissioning board for Cambridgeshire and Peterborough should mitigate some of the effects of silo working

- the source of funding, and the uncertainties for next year, should be set out in the table of BCF spending categories at Appendix A, along with the performance metrics mentioned in the report. The Transformation Manager undertook to address these points in his next report to the HWB in March, reminding members

that the funding in question was not new money, but a reorganisation of existing funding, a point which he was urged to stress. **Action: G Hinkins**

It was resolved unanimously to

1. agree the proposals set out at paragraph 4.2 of the report before the Board to inform the development of the Better Care Fund Plan for 2017-19; and

2. agree to receive a more detailed performance update alongside a draft Better Care Fund plan at the Board meeting in March 2017.

251. A PERSON'S STORY

The Service Director, Strategy and Commissioning recounted a young person's story of their experience when suffering depression; only after starting to self-harm and talk of suicide did they feel taken seriously. After a long wait for an appointment, support from the Child and Adolescent Mental Health (CAMH) service had initially been good, but later appointments were during school hours, which meant that the absence had to be explained to teachers. Points made summing up the experience included

- the stigma associated with taking anti-depressants
- the wish that somebody had explained that the mental health problems being experienced were not the young person's fault
- the unwelcome requirement to keep retelling the case history in hospital
- young people knew they had to self-harm or attempt suicide to get help.

The Service Director reported that Children's Trust Area Partnerships were carrying out work around emotional health and wellbeing, and young people's mental health. These were key areas of Area Partnership activity, and were reflected constantly in information from schools and GPs. There was a stigma around mental health, and people had difficulty in understanding how to address that across the system in a way that accepted the maturity of the young people experiencing problems.

In discussion, Board members

- expressed concern at the repeated use of the term 'patronising' describing the attitude of professionals encountered

- stressed the importance of GP practices providing a private area so that people were not expected to air problems in an open reception area

- said that it was difficult to assess accounts of what happened between GP and patient, that there had been issues round access to CAMH services, and that it was difficult to manage risk associated with CAMH within primary care

- commented that the whole story was a condemnation of the whole system; there was a great deal of work to be done to improve matters.

The Chief Executive of CPFT said that there had been investment by both the CCG and the County Council in CAMH services, following a 20% rise in referrals over a two-year period. Changes in society and changes in service provision at a lower level had probably contributed to this rise; the resulting CAMH waiting list had now been cleared. While greater investment in secondary care CAMH services was desirable, this would not necessarily provide the solution to the problems described in the young

person's story. As both commissioners and providers understood, greater collective involvement was needed, with schools, parents, and young people themselves. The statistic sometimes quoted, that one in five teenage girls self-harmed, represented a problem which was beyond the powers of formal children's services to solve alone.

The Board noted the personal story as context for the remainder of the meeting.

It was resolved unanimously to ask the Service Director, Strategy and Commissioning to convey the Board's thanks to the young person for sharing the story.

252. PRIORITY 1 REPORT FROM THE CHILDREN'S TRUST EXECUTIVE PARTNERSHIP

The Board received a report on progress made by the Children's Trust Executive Partnership (CTEP) against the Health and Wellbeing Plan Priority 1 - 'to ensure a positive start to life for children, young people and their families'.

In the course of discussion, Board members

- commented that the term 'emotional health', as used in the Prime Minister's recent speech on mental health, seemed to have a resonance among young people generally, and could helpfully be more widely used

- welcomed the work described in the report, but urged that regard be had to the national evidence on what interventions worked, what they cost, and how their outcomes could be measured; this information could aid the delivery of better care and ongoing support

- reported that, in addition to the work described in the report, Area Partnerships had worked with schools, setting up opportunities for pupils to talk to an adult informally in the playground

- pointed out that Area Partnerships operated on very little funding, with some administrative assistance from the County Council. They did not have the resources to undertake the detailed analysis of interventions suggested; the Area Partnerships did a tremendous job for very little input, and their schemes became self-sustaining

- noted that some very successful work to support children's mental health and emotional wellbeing had been undertaken in primary schools in north Cambridge, demonstrating that much could be done on little money.

The Board noted the report.

253. UPDATE REPORT - NEW HOUSING DEVELOPMENTS AND THE BUILT ENVIRONMENT JOINT STRATEGIC NEEDS ASSESSMENT

The Board received a report updating it on the progress on actions arising from the New Communities and the Built Environment Joint Strategic Needs Assessment (JSNA), which had been agreed by the Board in March 2015. The JSNA was concerned with how people's health could be supported in the new housing developments in the county, and the links between the NHS and planning authorities.

In discussion, Board members

- on the question of NHS involvement in the commissioning of primary care services, reported that the CCG was due to hold discussions with NHSE later that day about the CCG taking on delegated responsibility for primary care commissioning. The CCG was likely to do this provided it did not worsen its budget position; there was no apparent funding stream, and it seemed that the NHSE forward plan did not allow for the level of population growth due to be seen in Cambridgeshire. Because the funding was likely to come in only once the people had arrived, there was a risk of a significant lag between the population growing and the provision of primary healthcare

- said that members of district planning committees would welcome any feedback from the NHS on what planners could do to help; in East Cambridgeshire, for example, the NHS had not been involved in discussions on how to spend the CIL

- reported that the Fenland Local Plan had preceded the JSNA, but was broadly in compliance with it

- noted that development sites were not being included in NHSE forecasts where they had not been formally agreed in the local plan, and that the increasing pace of development posed a problem in the context of the STP

- pointed out that different growth projections were being used in different contexts; the Cambridgeshire Heads group for example was forecasting a far higher growth rate in the local economy than the 0.9% which it was understood NHSE was using

- noted that the CCG wanted to discuss with NHSE what the funding plans were, and how far it was recognised that the potential gap in funding for growth needed to be addressed, as there could be a three-year gap between the population growth and the growth in funding.

Summing up, the Chairman said that it was easier to plan for development in new towns than for expansion of existing settlements. As a Board, the HWB would wish to encourage greater involvement by the NHS in the planning process with regard to health services. The CCG Chief Officer confirmed that this would happen.

It was resolved unanimously to note the update report and suggest further opportunities to share and embed the JSNA, and to suggest ways to capture how the JSNA had made a difference.

254. UPDATE ON THE PHARMACEUTICAL NEEDS ASSESSMENT FOR CAMBRIDGESHIRE (2017) & PUBLIC CONSULTATION JAN-MAR 2017

The Board received a report updating it on the development and key findings of the Pharmaceutical Needs Assessment (PNA) 2017 for Cambridgeshire, and providing a briefing on the local impact of the new national pharmacy contract (2016). Members noted that many agencies had had input into the PNA, which represented a statement of needs for the area. The PNA had found no significant need for additional pharmacies; the Local Pharmaceutical Committee would continue support for pharmacies in deprived areas. The planned consultation period of nine weeks could be expanded to three months if the Board so wished.

In the course of discussion, members

- noted that the next PNA was due in three years' time. There was a requirement to produce a statement of fact in between PNAs, but there was no legislation on when this should be done; efforts were being made to identify triggers for the statement of fact

- expressed concern at the number and spacing of pharmacies, and the difficulties of accessing pharmacies for people living in rural areas. Members noted that the main PNA, unlike the summary attached to the report, was a 120-page document

- suggested that the consultation should include a specific question asking people about their experience of getting to pharmacies, particularly given the lack of public transport in some parts of Cambridgeshire.

  Members noted that dispensing GPs needed a degree of rurality; if there was a pharmacy within 2.5km of a dispensing practice, that practice could lose its licence to dispense, which could adversely affect the viability of the practice

- accepted that there was no threat to close pharmacies, but suggested that there was a reluctance to accept volunteers to open new pharmacies; the rule about a dispensing practice losing its licence if a pharmacy opened nearby was an internal NHS rule, which could be changed. It was however pointed out that setting up a new pharmacy required NHS funding, so was a cost to the local health system, and the conditions for dispensing practices were subject to legislation and beyond the scope of the local health system to change

- enquired how the PNA fitted with the STP, pointing out that it saved money if people could go to a pharmacist rather than a doctor for health advice

- noted that the PNA included information on the proportion of the population within 20 minutes' drive of a pharmacy or dispensing practice but it had not proved practicable to map access by public transport. This exercise had shown that only a relatively small number of people lived beyond the 20-minute drive time; information on home delivery services had also been included in the PNA.

  The Chair of the Cambridgeshire PNA Steering Group agreed to add a question to the consultation questionnaire asking the public whether they had any difficulties accessing pharmacies

- expressed concern that the consultation was trying to achieve two different aims, that of satisfying the statutory requirement to consult on the PNA, and of seeking information about people's experience of local pharmacies. It was suggested that two separate documents were needed to meet the two separate aims

- suggested that Healthwatch colleagues and consultation groups might be well placed to undertake work with stakeholder groups and feed back on people's experience with pharmaceutical services

- noted that the PNA was a statutory document that was used routinely by NHSE when making representations to pharmaceutical companies, and that there was a statutory requirement to consult on every three-year report, asking the public and stakeholders whether they agreed with the report's findings

Summing up, the Chairman said that, while members accepted that there was a statutory duty to consult, and a need to do so in a way that would not be open to challenge, the Board thought it important to obtain information on the usability and accessibility of pharmacies, done carefully, avoiding raising expectations of change.

The Chairman invited the Board to consider the length of time that the consultation should last, saying that it was important that as many people and organisations as possible responded. He proposed, and the Board agreed, that the consultation should commence on 30 January 2017 (the date suggested orally by the Chair of the PNA Steering Group) and an additional resolution be added to the recommendation, requiring that the consultation be of three months' duration.

It was resolved unanimously to

1) note that a draft PNA document had been produced by the PNA Steering Group in close consultation with key stakeholders and partners;
2) endorse the proposal that a public consultation on the draft PNA commence on 30 January 2017;
3) require that the consultation run for a period of three months;
4) note that the findings of the consultation and a full revised PNA report were due to be submitted to the HWB in June 2017;
5) note that the HWB had new additional statutory responsibilities under the *National Health Service (Pharmaceutical Services, Charges and Prescribing) Regulations* 2016 to produce a supplementary statement should any pharmacies propose a consolidation of two or more pharmacies onto one site

With the consent of the meeting, the Chairman decided to take agenda Item 11 next, immediately after Item 8, as the presenting officer had to leave shortly for another engagement.

255. MENTAL HEALTH STRATEGY FRAMEWORK

The Board received a report introducing the STP Mental Health Strategy Document 'Working together for Mental Health in Cambridgeshire and Peterborough – a framework for the next five years. Members noted that

- the draft strategy drew together much previous work and previous different strategies from various NHS and local authority organisations
- the public health and social care agendas had been embedded firmly within the strategy
- the document set out a strategic approach under three headings, prevention, community-based care and specialist, secondary care where it was needed 2021;
- Cambridgeshire was receiving £12.8m of the £1bn investment for mental health being made available between the present and 2020
- it would be necessary to align this additional money with social care and other funds; the strategy would provide a framework for making any bids for funding.

Discussing the report and draft strategy document, Board members

- welcomed the bringing together of the many various strategies; concern had previously been expressed to the Director of Public Health about having seven different mental health strategies

- noted that this strategy did not refer to dementia; it was included in the primary care strategy of the STP because only 20% of people with dementia did not have another condition alongside dementia

- welcomed the document, describing it as very good and clear; people often did not understand what mental health was unless they had personal or family experience of mental health problems

- noted that the document had been drawn up with input from service users and organisations through the engagement processes undertaken when the strategies that informed the framework document had been formulated

- expressed concern that the document was a vision of how to deliver mental health support, without describing how outcomes would be achieved

- stressed the importance of having people with mental health knowledge within schools.

The Chairman asked that the document be amended to include information on outcomes. Members noted that the strategy would eventually go to the CCG Governing Body and to CPFT for approval.

It was resolved unanimously to note and endorse the draft STP Mental Health Strategy.

256. SUSTAINABILITY AND TRANSFORMATION PROGRAMME (STP)

The Board received a report updating it on the latest Sustainability and Transformation Plan (STP), which had been published on 21 November 2016 by the Sustainability and Transformation Team and was an update of the summary first produced in July 2016. The full, more detailed document had been submitted to NHS England.

Members noted that the STP set out a response to a funding gap which could only get worse if nothing were done. The STP identified four main priorities for change:

- At home is best
- Safe and effective hospital care, when needed
- We're only sustainable together
- Supported delivery.

The priorities would be delivered through eight delivery groups, each responsible to a chief executive officer drawn from across the health and social care system. Aims included engendering a culture of learning, meeting the challenge posed by significant levels of retirement in some occupational groups, developing the hospital sites in Ely and North Cambridgeshire, and making greater and better use of technology. Unlike many other STPs, the Cambridgeshire and Peterborough one did not seek to close sites or services, but to get people to use services appropriately, and to develop community-based services and workforce. Because of population growth in the area, the decision had been taken not to reduce hospital beds.

A member asked why the structure of an accountable care organisation (ACO) was not being adopted. The CCG Chief Officer said that the approach that needed to be taken was to function as if within an ACO, but it was not yet clear that accountable care organisations worked well, and it had been thought more important to get the

services established, rather than being distracted by the demands of structural reorganisation. She added that she was personally accountable for the CCG's budget, but not for the whole system – each chief executive faced a tension between their own organisation's needs and those of the system as a whole.

One Provider Chief Executive said that he supported the idea of establishing an accountable care organisation, but the problem was that it would require legislation and would be a distraction. Disadvantages of an ACO included that it would make contracting more difficult. His responsibility was to his Foundation Trust, not to the STP or the health system.

The Chairman asked the Director of Public Health to clarify the difference between the Health and Wellbeing Board's interaction with the Sustainability and Transformation Plan and the Health Committee's interaction with it. She explained that

- the HWB did not have a specific responsibility for the STP, but did have a duty to promote the integration of healthcare and healthcare commissioning. When looking at the STP, the Board had to be mindful of this duty to promote integration

- the Health Committee had a scrutiny function under legislation; its duties included ensuring good consultation on any proposed service changes. An NHS Provider Chief Executive appearing before the Health Committee was in a very different position from an NHS Provider Chief Executive sitting as a member of the Health and Wellbeing Board.

Members raised the lack of funding for the delivery of services, commenting that while people's optimism and determination to provide even better services were admirable, it was impossible to provide services out of nothing. However, opinions varied on how much energy should be put into protest when schemes were being developed for providing services; it was suggested that before complaining, it was necessary to show that the system was undertaking the necessary transformation, but it was also pointed out that it was difficult to achieve transformation while under immense financial pressure. Some of the innovations would temporarily require additional resources to allow double running of the existing system while the new one was being set up; for example, patients would still need to occupy hospital beds while community services were being developed.

The Chief Officer reported that the CCG was in conversation with NHSE about the resources needed to implement the STP; she was urged to use the argument of the economic growth taking place in Cambridgeshire, which was of importance to the Government. The Chairman suggested that she explain the problem more fully at the Board's next meeting.

257. HEALTH AND CARE SYSTEM SUSTAINABILITY AND TRANSFORMATION PROGRAMME MEMORANDUM OF UNDERSTANDING: LOCAL AUTHORITY APPENDIX

The Board received a report updating it on progress with the sign off of the Cambridgeshire and Peterborough Sustainability and Transformation Programme Memorandum of Understanding (Local Authority Appendix) and proposing a phased approach to sign off. Members noted progress with the actions identified at the Board's November meeting. It had not proved feasible to take the STP MOU LA Appendix through District and City democratic processes in the time available, and

there had been a failure to realise in time that it would have been helpful to include the Board's District Council Observer in the early drafting work. The recommendation before the Board was therefore to agree a two-stage sign-off process.

In discussion, a District member said he expected that the District councils would ask what actions were required from a District perspective; greater clarity on this would be welcome. The Chair commented that the Health and Wellbeing Board had a statutory duty to promote integration, and it would not fit well with this if the Board were to postpone signing the MOU until long after the other signatories.

It was resolved unanimously

- to consider the phased approach to HWB Board sign off of the Sustainability and Transformation Programme Memorandum of Understanding Local Authority Appendix, as laid out in paragraph 3.4 of the report before the Board

- agree to the Chair signing the STP MOU LA Appendix, to demonstrate the Boards' overall support for the principles of joint working outlined within it. This was subject to a clear note with the Chair's signature, stating that at this point the HWB Board could not sign on behalf of the District and City Councils, as further work (phase 2) was needed to re-word the MOU to fully clarify the role of District/City Councils in the documentation, and to take it through each Council's democratic processes

258: PRIMARY CARE STRATEGY – FOCUS ON GP RECRUITMENT AND RETENTION IN CAMBRIDGESHIRE

The Board received a report on the General Practice Forward View (GPFV), with a focus on GP recruitment and retention in Cambridgeshire. Members noted the Cambridgeshire situation was similar to that elsewhere in the country; there were issues of both capacity and demand. The paper recognised both the national initiative and local work around recruitment and retention of GPs and of other practice staff, especially of nurses. Attention was drawn to the specific workforce elements of the strategy; the national position on GP supply was challenging, so ways were being sought to support efforts to grow our own staff locally, and to retain Cambridgeshire GPs within the Cambridgeshire system.

In discussion, Board members

- in relation to increased demand, asked what the Board, as a Health and Wellbeing Board, could do to start educating people about not attending emergency departments and GP surgeries for treatment of trivial conditions about which nothing could be done, such as the common cold. In the speaker's experience, older people were more stoical in their attitude to health.

  Comments in response included that there had been research on how to discourage inappropriate attendance, but had not reached any consensus. It was often possible to reach the regular attenders, but not the one-off callers. There was an increase in the number of older people attending with multiple conditions simultaneously. Some people going past the hospital thought would provide a good opportunity to see a doctor quickly, though it was likely that the doctor they saw would have less experience than a fully-qualified GP

- reported that the Health Committee recently had identified failure to influence behaviour change as a risk to be included in the risk register, and had said that people had to take on board the message of the STP; it was a matter of voluntary change, and of people needing to recognise that this was their service

- stressed the importance of educating people in school, and people coming into the county from abroad, not all of whom spoke English fluently

- said that the CCG had developed the GP strategy, but needed to work on delivery plans for it; it could be helpful if the Board were to look at these with Dr Gary Howsam, the GP lead.

The Board noted the report.

259. QUALITY PREMIUM

The Board received a report on the construction of the Quality Premium available to CCGs for the financial years 2017/18 and 2018/19. Members noted that five of the six indicators were now being set nationally, and one by the CCG in conjunction with the NHS Regional Team; the Health and Wellbeing Board no longer had any input into the setting of the Quality Premium.

The Board noted the information about the CCG Quality Premium scheme for 2017/2018 and 2018/2019.

260. FORWARD AGENDA PLAN JANUARY 2017

The Democratic Services Officer was asked to incorporate the items identified in the course of the meeting into the forward agenda plan, including a review of the Better Care Fund plan at the next meeting. **Action: R Yule**

261. APPOINTMENTS TO EXTERNAL BODIES

It was resolved unanimously to appoint Councillor Orgee to represent the Health and Wellbeing Board on the Primary Care Co-Commissioning Joint Committee.

262. DATE OF NEXT MEETING

Members noted the date of the Board's next meeting:

- 10am on Thursday 30th March 2017, in the Council Chamber, South Cambridgeshire Hall, Cambourne, Cambridge CB23 6EA.

Chairman

Agenda Item No: 3

HEALTH & WELLBEING BOARD ACTION LOG: MARCH 2017

MINUTE & ITEM TITLE	ACTION REQUIRED / UPDATE	STATUS
Meeting Date: 15.09.16		
235. Safeguarding Adults Board Annual Report 2015-16	To share with the Board any recommendations arising from the review of the increase in reported cases of abuse and/ or neglect in care homes in 2015-16 compared to the previous year when this information was available. **UPDATE 17.03.17: An update has been requested from Claire Bruin.** **Action: C Bruin**	**On-going**

MINUTE & ITEM TITLE	ACTION REQUIRED / UPDATE	STATUS
236. Cambridgeshire Local Safeguarding Children Board (LSCB) Annual Report 2015-16	To draft a letter to NHS England for the Chairman's signature seeking an assurance that an adequate mechanism is in place to ensure that they are able to discharge their statutory duties if they are not able to attend meetings with the LSCB. **Action: A Jarvis** **UPDATE 23/10/16: Awaiting confirmation from Andy Jarvis that the response from NHS England in relation to Minute 236 above covers the points to be raised.** **UPDATE 27.02.17: Andy Jarvis confirmed that the response to NHS England addressed all the necessary issues.**	**Completed**
Meeting Date: 17 November 2016		
244. Health and Care System Sustainability and Transformation Programme - MOU	The Voluntary and Community Sector representative would provide feedback on where she felt the voluntary sector could contribute via the Chief Executive of the Cambridgeshire and Peterborough NHS Foundation Trust. **UPDATE 16.03.17: An update has been requested from Julie Farrow** **Action: J Farrow/ A Thomas**	**On-going**

MINUTE & ITEM TITLE	ACTION REQUIRED / UPDATE	STATUS
245. Forward Agenda Plan	To consider the following topics for future development sessions: • Understanding county council, district and city council and NHS budgets and budget processes; • The future development of primary care in Cambridgeshire, including the location of services, integrated use of the estate and estate development. **UPDATE 09.03.17: Part of the meeting on 6 July 2017 will be used as a development session to consider one or both of the above.** **Action: L Robin/ K Parker**	**Completed**
Meeting Date: 19 January 2017		
250. Cambridgeshire Better Care Fund (BCF) Planning 2017-19	To provide a more detailed performance update alongside the draft Better Care Fund Plan at the next HWB meeting in March 2017. **Action: G Hinkins** **UPDATE 16.03.17: Reports to be considered at the Health and Wellbeing Board meetings on 30 March 2017 and 27 April 2017.**	**Completed**

MINUTE & ITEM TITLE	ACTION REQUIRED / UPDATE	STATUS
260. Forward Agenda Plan	To incorporate the items identified in the course of the meeting into the Forward Agenda Plan. **Action: R Yule**	**Completed**

Agenda Item No. 5

Dual Diagnosis of Substance Misuse and Mental Health Conditions

To: Health and Wellbeing Board

Date: 30th March 2017

From: Val Thomas, Consultant in Public Health, Cambridgeshire County Council

1.0 PURPOSE

1.1 The purpose of this report is to provide the Health and Well Being Board with information regarding issues, concerns and recommendations relating to dual diagnosis of substance misuse and mental health conditions. For the purposes of this paper substance misuse refers to drugs and alcohol. This is a cross cutting issue and a similar issue is being taken to the Peterborough Health and Wellbeing Board.

2.0 BACKGROUND

2.1 There is a spectrum of overlapping or co-occurring substance misuse and mental health conditions, which range from mild to severe. The severity of each of these conditions may vary greatly, and at what point, or threshold, a dual diagnosis is defined will vary. Locally the term dual diagnosis is used for patients with both severe mental illness and drug and/or alcohol use. In clinical terms severe mental illness refers to a clinical diagnosis of schizophrenia, schizotypal and delusional disorders, bipolar affective disorder, severe depressive episode(s) with or without psychotic episodes and specific personality disorder. These individuals have very complex issues and are often very vulnerable with multiple needs.

Co-occurring disorder is a broader term that encompasses a wider range of people who have alcohol/drug misuse problems together with a mental health problem of any severity.

2.2 People with these co-existing mental illness and substance misuse have some of the worst health, wellbeing and social outcomes. Duality serves to amplify their health and social problems dramatically, leading to greater rates of homelessness, suicide, relapse, crime, and isolation with social function and quality of life rapidly declining.

2.3 The following data taken from a range of national studies describe the scale of dual substance misuse and mental health issues, indicate that it is a long standing issue and describe the context and how it impacts upon different parts of the system.

- Signs of drug dependence were evident in one adult in thirty, with a similar level found for probable alcohol dependence. Both types of substance dependence were twice as likely in men as women. (2016)
- Approximately 40% of people with psychosis misuse substances at some point in their lifetime, at least double the rate seen in the general population. (2016)

- 20% of mental health hospital admissions were due to alcohol use (the second highest cause after self-harm and undetermined injury. (2015)
- More than one in five (22%) of 189 drug treatment services in England say that access to mental health services deteriorated over the 12 months to September 2014.
- 54% of suicide and homicide by people with mental illness had a history of drug or alcohol misuse (or both): an average of 671 deaths per year. (2015)
- 12% of homeless people have both a mental health and substance misuse problem. 41% of homeless people surveyed by Homeless Link said that they used alcohol or drugs to cope with their mental health issues. (2014)
- Up to 70% of people in drug services and 86% of alcohol services users experienced mental health problems. (2003)
- 14% of alcohol dependent adults also receive treatment for a mental health issue. (2007)
- 4 in 5 prisoners who are drug dependent have 2 additional mental health problems. (2009)
- Between 22 and 44% of adult psychiatric inpatients in England also have a substance misuse problem. (2009)

2.4 Data from mental health and substance misuse services for Cambridgeshire paints the following picture:

- In 2014/15 the Camdbridgeshire Child and Adolescent Substance Use Service (CASUS) received 38 referrals from health and mental health services; this was 17-19% of referrals each quarter.
- Of those in adult drug treatment in 2014/15 in Cambridgeshire, 23% of newly presenting clients (126 individuals) were also in contact with mental health services for reasons other than substance misuse. This is slightly higher than the England average. (21%)
- Of those in adult alcohol treatment in 2014/15 in Cambridgeshire, 51 clients (6%) were also receiving care from mental health services for reasons other than substance misuse. This is below the England average (20%).
- In 2013/14 there were 732 hospital admissions where there was a secondary or primary diagnosis of drug related mental health and behavioural disorders and in 2014/15 2,125 hospital admissions due to alcohol related mental or behavioural disorders in Cambridgeshire. There has been an increase in concurrent mental health and substance misuse hospital admissions between 2013/14 and 2015/16. This is described and broken down to Appendix 1.

2.5 In 2015 an audit of suicides in Cambridgeshire and Peterborough was undertaken. There were 66 suicides and of these 52 of the cases were audited. Fifteen of the cases had a current or historical substance misuse problem. Of these cases nine also had a diagnosis of a mental health condition. None fell into the definition of the local definition of dual diagnosis, that is, severe mental health and substance misuse issues. Care should be taken however in interpreting this as other factors may be implicated in the suicide.

2.6 Dual substance misuse and mental health conditions impacts on physical health and is associated with a wide range of socio-economic issues that demand input from a range of services. The prevalence of health and social care needs are much higher for individuals with dual conditions than for comparable groups without duality, particularly in terms of

severity of mental health symptoms, medication non-adherence, homelessness, violence and contact with the criminal justice system as either a perpetrator or a victim.

2.7 These wide ranging impacts are difficult to quantify and, along with the lack of agreement with regard to definitions, has affected the development of any robust economic evidence for impact and treatment. There is limited economic analysis of the costs of treating severe mental health and substance misuse issues. The costing statement for the recent National Institute for Health and Care Excellence (NICE) guidelines on dual diagnosis states that hospital episodes may be twice as long for people with psychosis and co-existing substance misuse when compared with people with psychosis alone, the costs are likely to be higher for people with both conditions. The cost of inpatient mental health episodes per occupied bed day varies between £418 in a low security service and £763 in a maximum secure unit. NICE recommends that effective management of these patients can avoid hospital admissions.

With regard to service configurations, NICE concluded that currently there is no robust economic evidence for collaborative models for people with a dual diagnosis and the important public sector and wider societal costs are excluded in any studies to date.

2.8 The model of individually funded and commissioned mental health and substance misuse services has a risk of creating a fragmented approach which is reflected in the experience of the service user. It has the potential to exacerbate issues for those who suffer with both, given the enhancing nature of the problems. There are longstanding policies from, for example, NICE and the NHS's Five-year Forward View for Mental Health that call for early intervention and effective collaboration across substance misuse and mental health services along with other support organisations that address factors such as criminal justice, housing or employment.

NICE guidelines produced in 2011 and more recently in 2016 on severe co-existing mental health and substance misuse problems advocate a multi-agency approach to provide holistic care and ensure that joint strategic working is in place to provide continuity of care and services. Working between agencies should include joint assessments and agreeing joint care pathways and a protocol for sharing information between mental health, substance misuse services, health, social care, education, housing, voluntary and community services. The emphasis is on flexibility and adapting existing services, rather than creating a specialist 'dual diagnosis' service that requires a whole systems approach to commissioning.

2.9 In 2014 the Cambridgeshire and Peterborough Dual Diagnosis Strategy and Protocols were produced by a range of agencies that included the Cambridgeshire and Peterborough Clinical Commissioning Group, mental health and substance misuse providers, the constabulary and voluntary sector. The Strategy reflects the NICE guidelines and has a focus upon those with a dual diagnosis having ready access to co-ordinated inter-agency assessment, treatment and support to address the complex mix of problems they present with. It calls for a consistent model for service delivery with more effective working across individual agencies with clear access arrangements. Training and upskilling of staff was seen as essential to enable them to effectively identify, assess needs and plan collaboratively a joint care plan. To support the Strategy, Protocols were developed that for the shared processes and pathways that would be used in the management of dual diagnosis.

3.0 SUPPORTING PARAGRAPHS

3.1 In 2016 the Cambridgeshire Drugs and Alcohol Joint Strategic Needs Assessment (JSNA) described on-going issues with the management of dual diagnosis that were undermining the implementation of the Dual Diagnosis and Protocols. Subsequent discussions with key stakeholders, which included commissioners and providers, have confirmed and developed the issues associated with managing dual substance misuse and mental health problems.

3.2 As indicated above, defining dual diagnosis can be problematic and this is impacting upon identification, diagnosis and treatment. The effective use of the pathways found in the Strategy and Protocols could be enhanced if definitions were universally agreed between all services and embedded into commissioned service pathways.

3.3 Training for staff working in substance misuse and mental health services is recommended by NICE and is an integral part of the Strategy and Protocols. The aim is to increase their awareness and enable them to assess, refer and manage patients collaboratively with other relevant services. Although some staff have received training this is by no means universal. A report by Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) describes a further layer of complexity to this issue. This involves the difference in philosophies and therapies traditionally used by mental health and substance misuse services. Standard psychiatric practice once was to recommend treatment for substance misuse prior to mental health treatment as it was thought that this was necessary for engagement with therapy. Furthermore, it required drug users with mental health problems to cease drug use completely for recovery. Conversely, people who worked in the drug treatment field did not have knowledge or training around recognition of mental health problems.

3.4 A strongly held view is that the lack of any data sharing agreements between substance misuse and mental health services exacerbates staff reservations relating to joint care planning. The lack of data sharing agreements has the potential to create risks for the patient. This has been referred to in the initial responses to a survey currently being undertaken by the Cambridgeshire Drug and Alcohol Commissioning Team amongst staff working in substance misuse services, where it is associated with serious incidents. However, it should be noted that the results of this staff survey have not been validated through any type of audit.

3.5 There is a need for caution when interpreting data relating to dual substance misuse and mental health issues. The data provided above excludes those not seeking treatment for their mental illness or substance misuse problems. NICE estimates this to be around 50% of those affected which is linked to stigma. In addition, patients are not routinely asked in some services about both conditions as part of a routine initial assessment. This has been attributed to staff concerns about it undermining the therapeutic relationship. These factors combined with limited training and concerns with data confidentiality have the potential to underestimate need.

It is possible to apply national prevalence figures to local populations and use small studies to identify how many patients with the conditions should be represented in local services. This analysis suggests that the numbers identified with these conditions are lower than that suggested by the modelling. However, these kind of national study estimates, applied to

local demography for mental health related issues, often generate wide ranges of estimated numbers for prevalence/cases/clients.

3.6 The local Strategy and Protocols have three core pathways and supporting protocols that reflect the severity of mental health and substance misuse issues. This includes those with lower levels of severity who do not fall into the severity associated with the term dual diagnosis. (See Appendix 2).

1. Severe mental health and severe substance misuse leads to the dual diagnosis pathway which provides a joint assessment and a collaborative care package approach.
2. Severe mental health and low substance misuse leads to a mental health pathway.
3. Severe substance misuse and low mental health issues leads to substance misuse pathway.

The concerns associated with these pathways focus most strongly upon the criteria for accessing services:

a. The threshold for accessing the dual diagnosis pathway, which is considered to be the most effective pathway, is set too high and excludes patients who have complex mental health and substance misuse issues that might not require the care provided by the dual diagnosis pathway but are unable to access other appropriate provision;

b. Patients with mild to moderate mental health issues access the Increasing Access to Psychological Therapies (IAPT). However, if they have severe substance misuse issues this service will not provide care. A similar situation is found amongst those assessing the personality disorder services.

The shared view amongst stakeholders is that the needs of those who are unable to access the Dual Diagnosis Pathway are not being met and they are excluded from collaborative care planning processes.

3.7 In summary, these factors contribute to a fragmented and uncertain picture of both the scale and management of dual diagnosis and co-occurring disorders. As indicated earlier the current NICE Guidelines do not recommend a bespoke dual diagnosis or co-occurring condition service, but comprehensive collaborative planned services. These include not just mental health and substance misuse services but also those that help address wider socio-economic issues that are barriers to recovery. A number of recommended actions have emerged for addressing the issues highlighted in this paper and improving services in Cambridgeshire and Peterborough. The aim is to ensure that services are providing the most effective accessible collaborative treatment pathways and wider interventions for the full spectrum of dual mental health and substance misuse issues.

3.8 **Identify an inclusive collaborative delivery model.** Local stakeholders to revisit the Strategy and Protocols to ensure that pathways capture the full spectrum of mental health and substance misuse needs. They need to be supported by clear definitions of diagnoses, protocols for ensuring that all patients with either what is classified as a dual diagnosis or on the wider spectrum of co-occurring disorders, have access to a collaborative care plan that addresses both conditions, as well as their socio-economic issues.

3.9 **Evidence for service delivery**: There is a lack of evaluated evidence based service delivery models. However, there are some examples from around the country where more innovative approaches to collaborative service delivery have been explored which could inform many aspects of the pathways.

3.10 **Robust alignment of commissioning strategies to underpin the local Strategy and Protocols.** A business case needs to be developed to inform the alignment of commissioning strategies and their translation into robust commissioning practice that will deliver positive outcomes. This will include the identification of the any innovation that is cost effective and has the potential for cost savings.

3.11 **Data Sharing Agreements**: An audit is required to validate the anecdotal reports of risks to patients that are linked with a lack of data sharing agreements. The feasibility of establishing data sharing agreements could be explored.

4.0 ALIGNMENT WITH THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

4.1 This paper links to Priority 4 of the Cambridgeshire Health and Well Being Strategy "Create a safe environment and help to build strong communities, wellbeing and mental health" This priority includes a focus upon implementing early interventions and accessible, appropriate services to support mental health, particularly for people in deprived areas and in vulnerable or marginalised groups, minimise the negative impacts of drug and alcohol misuse, working with local partners to prevent and tackle homelessness. http://www.google.co.uk/url?url=http://www.cambridgeshire.gov.uk/download/downloads/id/359/cambridgeshire_health_wellbeing_strategy_2012-2017&rct=j&frm=1&q=&esrc=s&sa=U&ved=0ahUKEwjRkJrChMfSAhXnBsAKHU6fAbAQFggUMAA&usg=AFQjCNHHXBDKFye01DkFeKhCX9kbB9xqXg

5.0 IMPLICATIONS

5.1 In terms of resources the alignment of commissioning has the potential to increase effectiveness and efficiency through patients being treated more effectively, preventing progression to more intensive possibly more costly inpatient services.

5.2 There is a risk of patients with complex conditions not receiving the appropriate evidence based services that will address both their mental health and substance misuse needs. There are also risks related to the need for information sharing agreements that would facilitate the improvement of patient care.

5.3 Those who misuse substances and have mental health issues are a highly vulnerable group and the recommendations in the paper target this group.

5.4 It is recommended by NICE that patients and their families are included in service development initiatives.

6.0 RECOMMENDATION/ DECISION REQUIRED

6.1 The Health and Wellbeing Board is recommended to:

- Comment on the issues raised in this paper;

- Endorse the recommendations for taking forward the alignment of commissioning strategies to strengthen and develop services for those who have mental health problems and misuse substances.

7.0 SOURCE DOCUMENTS

Source Documents	Location
Cambridgeshire Drug and Alcohol Joint Strategic Needs Assessment (2016)	*http://cambridgeshireinsight.org.uk/JSNA/Drugs-and-Alcohol-2015*
Crome I. et al The relationship between dual diagnoses: substance misuse and dealing with mental health issues. Social Care Institute for Social Excellence 2009	Social Care Institute for Social Excellence 2009 *http://www.scie.org.uk/publications/briefings/briefing30/*
Co-existing alcohol and drug misuse with mental health issues: guidance to support local commissioning and delivery of care. Draft	Public Health England:
NHS Five Year Forward Plan for Mental Health	Department of Health
Coexisting severe mental illness and substance misuse: community health and social care services	NICE Clinical Guideline 58 2016 https://www.nice.org.uk/guidance/ng58
Cambridgeshire and Peterborough Dual Diagnosis Strategy	2014
Cambridgeshire and Peterborough Dual Diagnosis Protocol	2014
Weaver et al (2003) Comorbidity of substance misuse and mental illness in community mental health and substance misuse services.	The British Journal of Psychiatry Sep 2003, 183 (4) 304-313
The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness	Annual Report 2015: England, Northern Ireland, Scotland and Wales July 2015. University of Manchester.
Care Quality Commission (2015) Right here, right now	http://www.cqc.org.uk/sites/default/files/20150611_righthere_mhcri

	siscare_summary_3.pdf
The Bradley Commission (2009) the Bradley Report	*http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_098698.pdf*
Seeing double: meeting the challenge of dual diagnosis	*NHS Confederation (2009)*
The unhealthy state of homelessness: health audit results 2014	*Homeless Link*
Adult Psychiatric Morbidity Survey 2014	*http://content.digital.nhs.uk/catalogue/PUB21748*
Understanding dual diagnosis	*Cambridgeshire and Peterborough Foundation Trust http://www.cpft.nhs.uk/downloads/martin/dualdiagnosis.pdf*
Bell D: Leeds Dual Diagnosis Project Bell D 2014	*Leeds Clinical Commissioning Group http://www.dual-diagnosis.org.uk/wp-content/uploads/2011/09/Future-DD-Needs-Report-2014-final.pdf*
Hawkings C., Gorry Y., Todd T., King M. Listening to Service Users: Developing Service User Focused Outcomes in dual diagnosis. A Practical Tool	*National Mental Health Development Unit http://www.dualdiagnosis.co.uk/uploads/documents/originals/listening-to-service-users.pdf*
State of the Sector 2014 – 15	*Drugscope*
Platt S, McLean J, McCollam A, Blamey A, Mackenzie M, McDaid D, et al. Evaluation of the first phase of Choose Life: the national strategy and action plan to prevent suicide in Scotland.	*Scottish Executive Social Research; 2006 / PHE (2017) Support after a*

	suicide: a guide to providing local services
Watson, S; Hawkings, C. Dual diagnosis: Good practice handbook 2007	*Turning Point.*
Rassool, H. Dual Diagnosis in Nursing. 2006	Blackwell Publishing
NICE Guideline NG 58 Coexisting severe mental illness and substance misuse: community health and social care services (2016)	https://www.nice.org.uk/guidance/ng58/history
Lankelly Hard Edges: Mapping Severe and Multiple Disadvantage in England (2015)	Chase Foundation and Heriot-Watt University
Megnin-Viggars o. , Brown M., Marcus E., Stockton S., Pilling S.The epidemiology, and current configuration of health and social care community services, for people in the UK with a severe mental illness who also misuse substances - A systematic review (2016)	National Collaborating Centre for Mental Health https://www.nice.org.uk/guidance/ng58/evidence/evidence-review-1-the-epidemiology-and-current-configuration-of-health-and-social-care-community-services-for-people-in-the-uk-with-a-severe-mental-illness-who-also-misuse-substances-2727941293
Slade E., Stockton S. Pilling S. Which service models for health, social care and voluntary and community sector organisations are cost-effective and efficient at meeting the needs of people with a severe mental illness who also misuse substances? (2016)	National Collaborating Centre for Mental Health (NCCMH) https://www.nice.org.uk/guidance/ng58/evidence/evidence-review-4-which-service-models-for-health-social-care-and-voluntary-and-community-sector-organisations-are-costeffective-and-efficient-at-meeting-the-needs-of-people-with-a-severe-mental-illn-98205886548

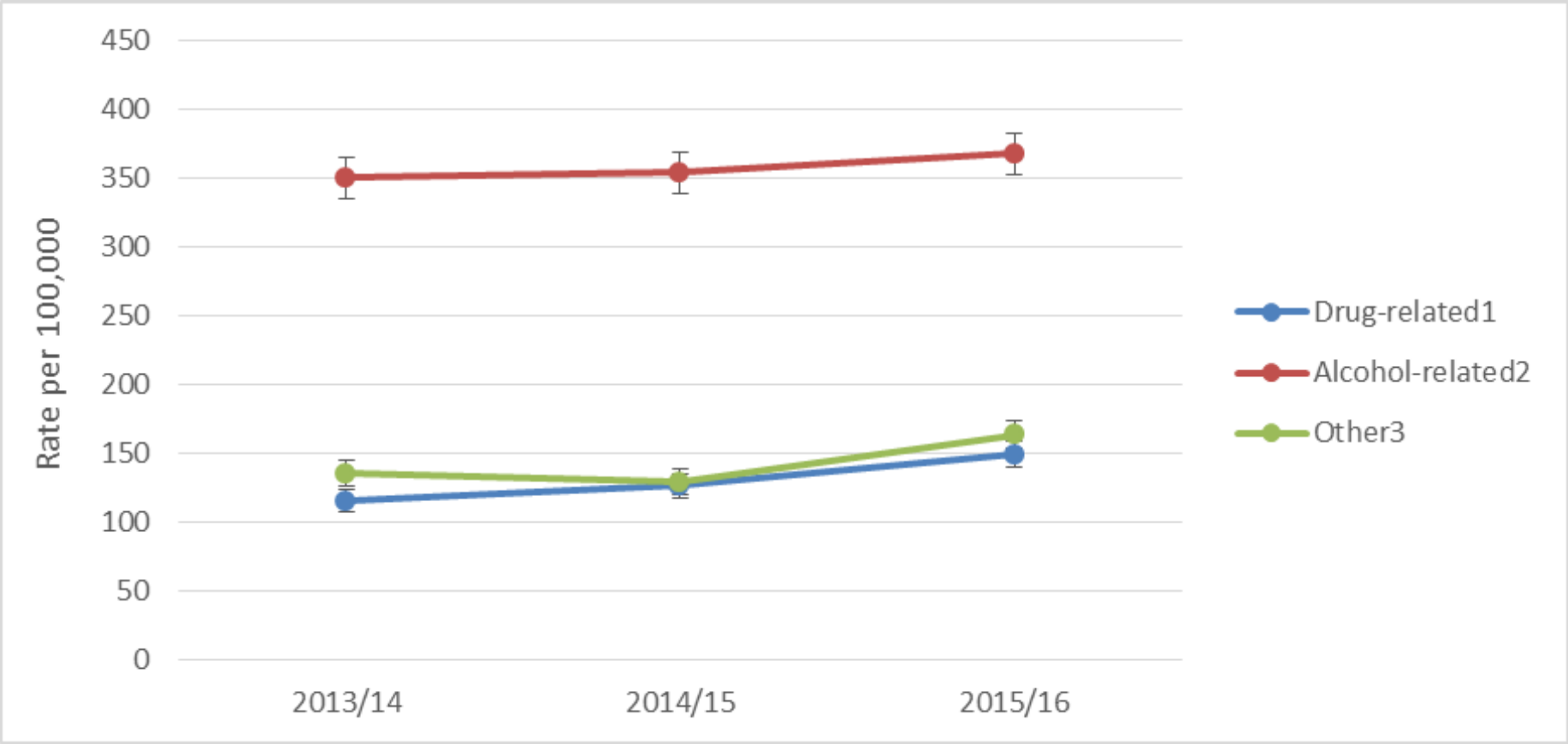
APPENDIX 1

Hospital Admissions for Dual Diagnosis

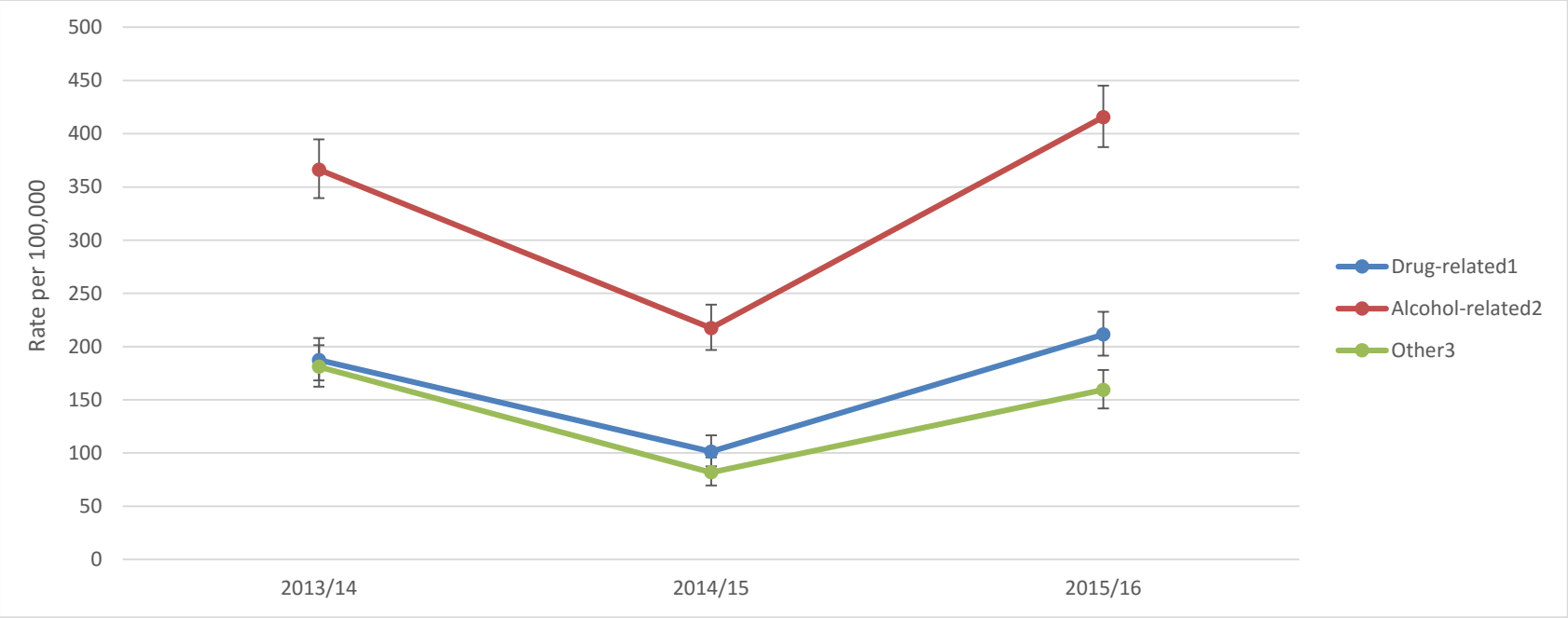
In Cambridgeshire, there was a 28% increase in concurrent mental health and drug admissions between 2013/14 and 2015/16 and a 10% increase in concurrent mental health and alcohol related admissions. In Peterborough, there was a 16% increase in concurrent mental health and drug admissions between 2013/14 and 2015/16 and a 17% increase in concurrent mental health and alcohol related admissions

This increase is shown in the graph below where 'other' relates to admissions with both a recorded mental health or behavioural condition and substance misuse problem but where the admission was for a different reason.

Hospital Admissions with recorded concurrent substance misuse and mental and behavioural disorders Cambridgeshire 2013/14 – 2015/16

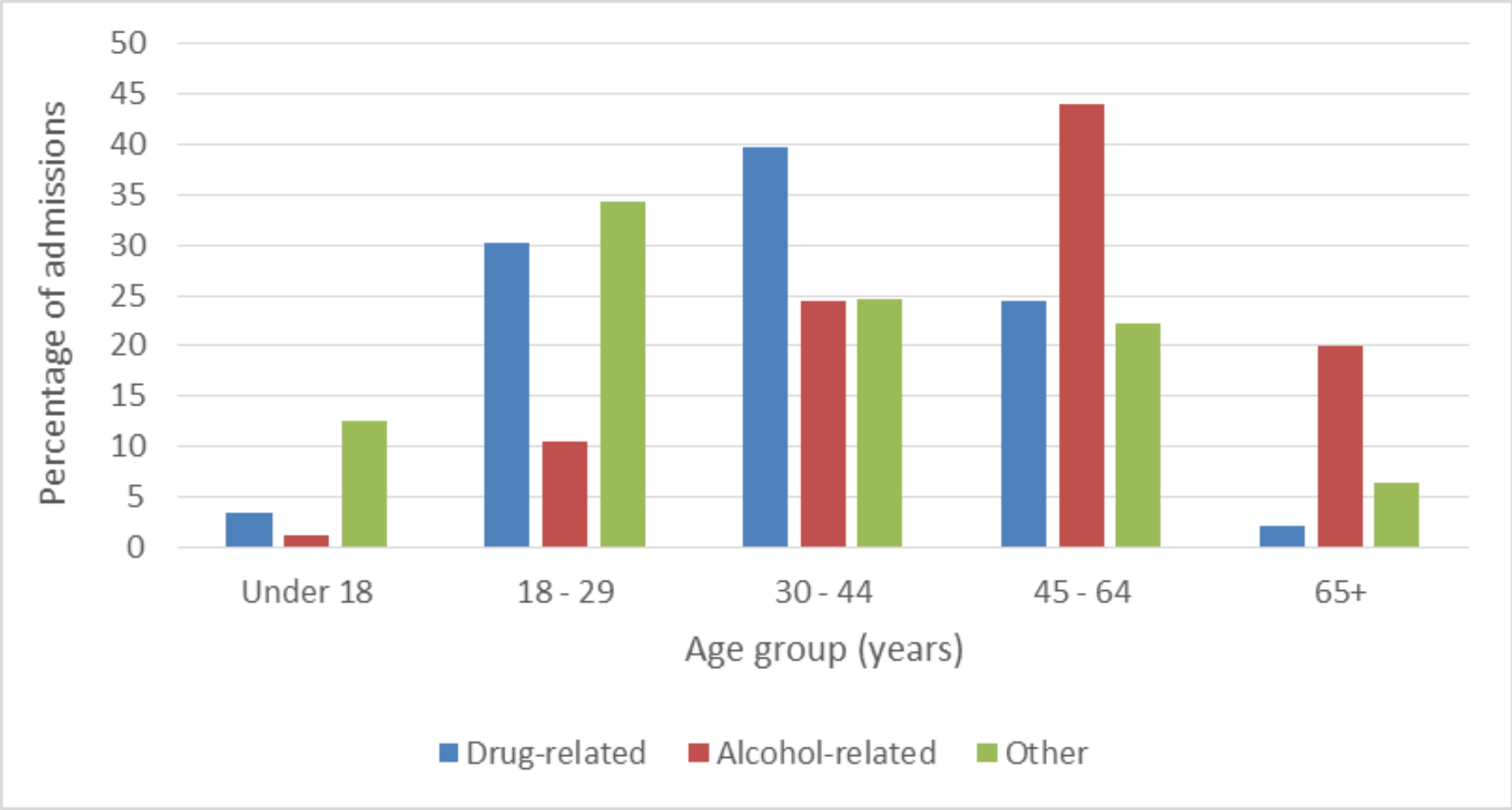


Hospital Admissions with recorded concurrent substance misuse and mental and behavioural disorders Peterborough 2013/14 – 2015/16

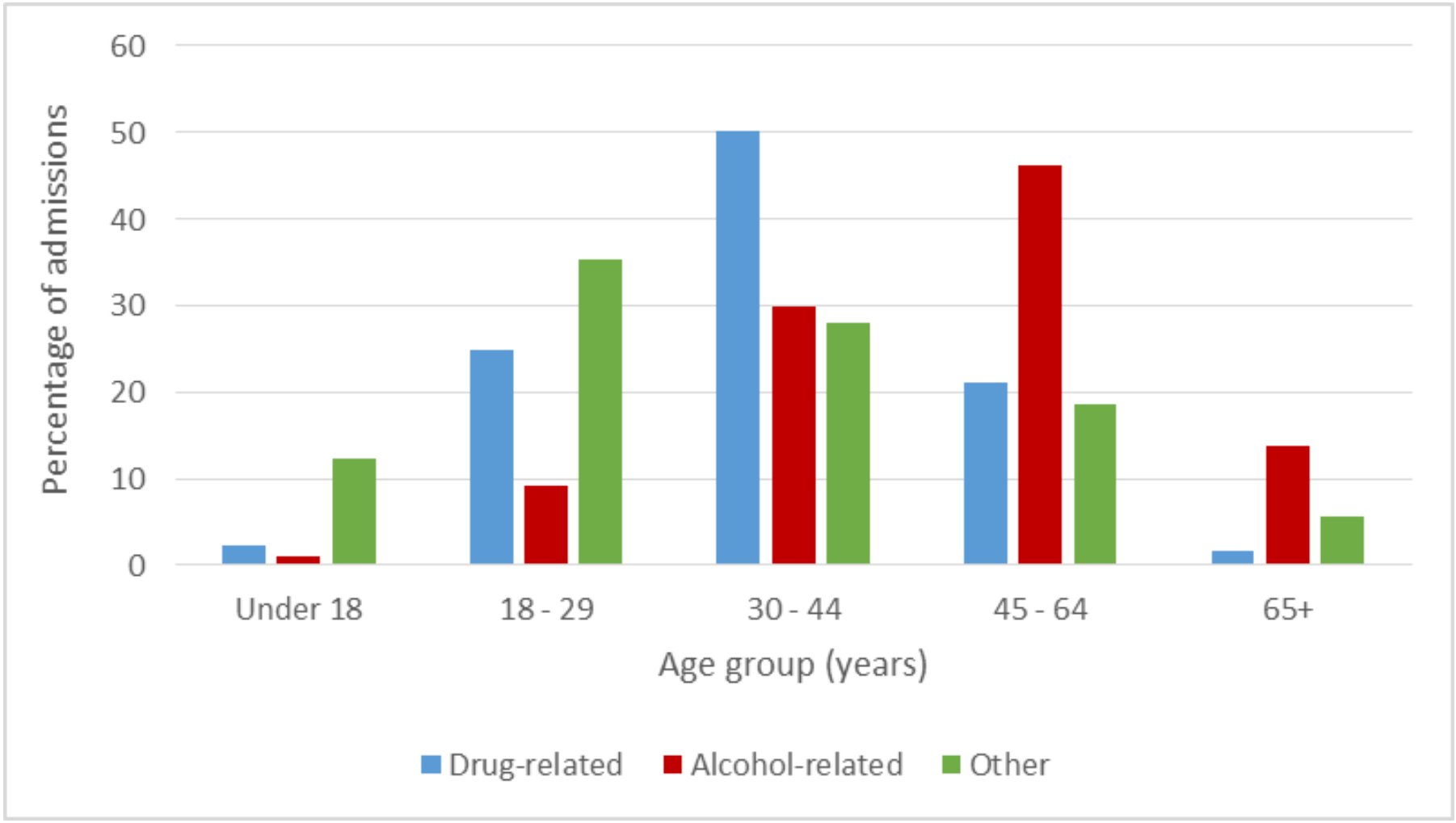


A breakdown of these admissions by demographics shows drug related admissions are highest in the 30-44 age bracket whilst alcohol related is highest in the 45-64 group in both Cambridgeshire and Peterborough.

Hospital Admissions Age Distribution Cambridgeshire

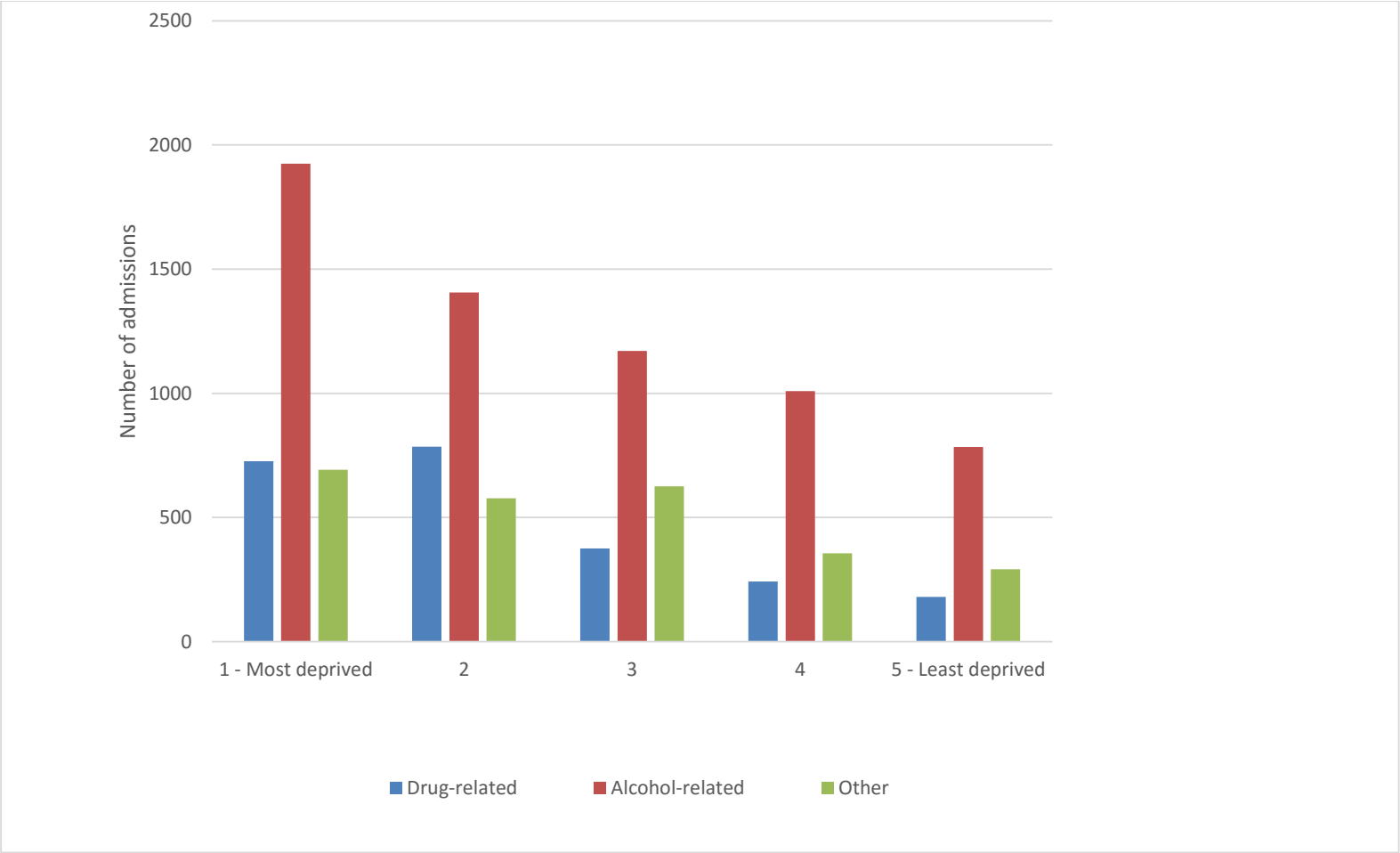


Hospital Admissions Age Distribution Peterborough

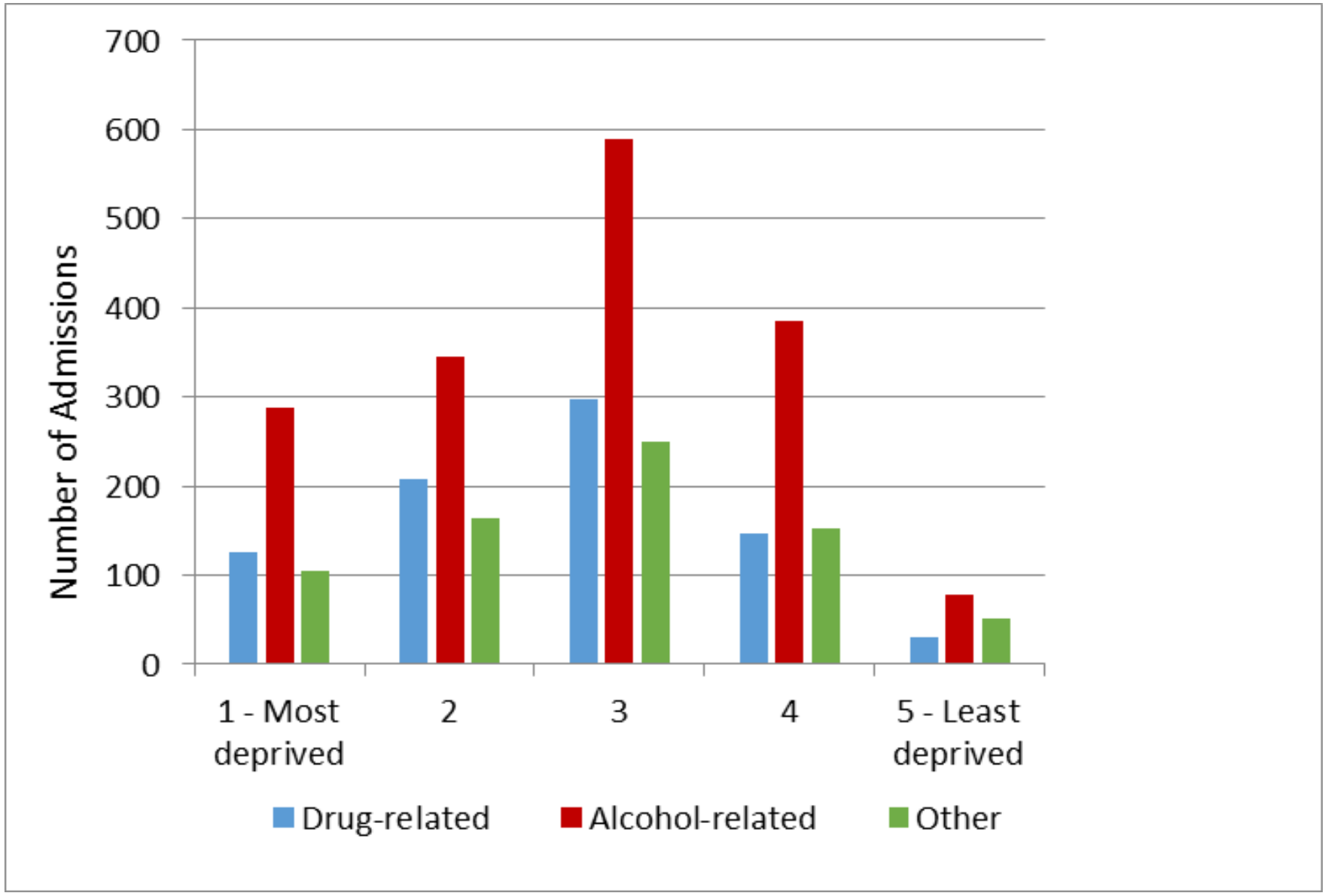


In terms of deprivation, there is a decreasing incidence of concurrent substance misuse and mental health related admissions as deprivation decreases. This can be seen on the graph below.

Hospital Admissions by Deprivation Cambridgeshire

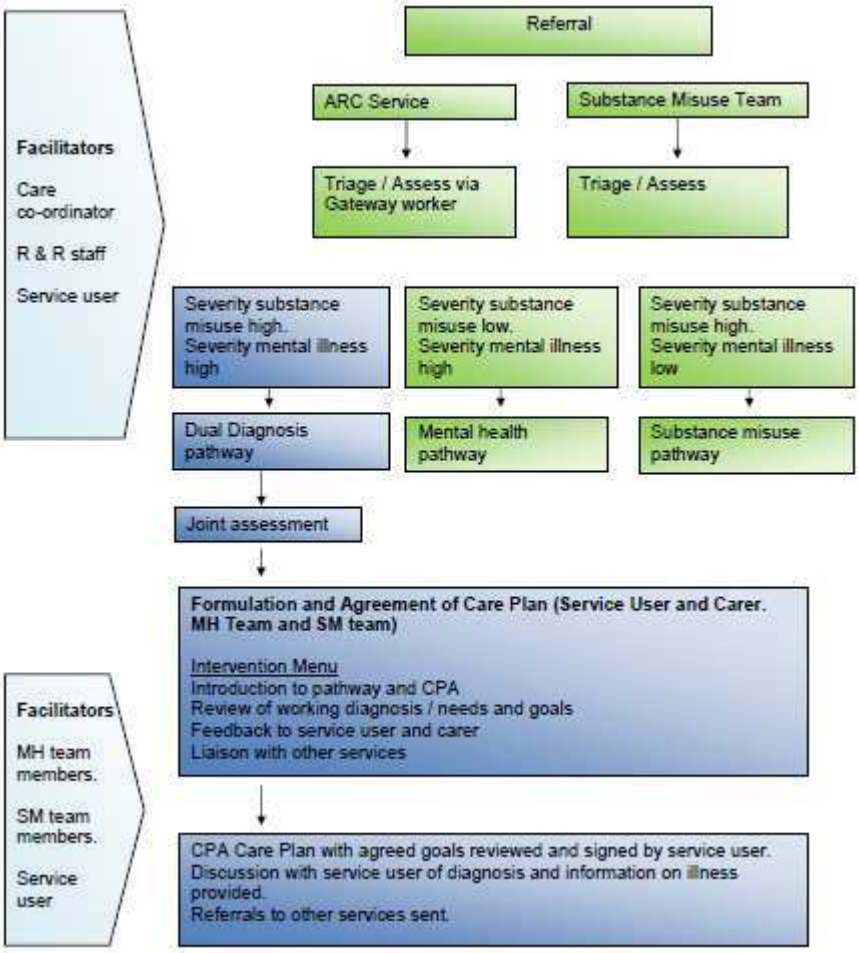


Hospital Admissions by Deprivation Peterborough



APPENDIX 2

Cambridgeshire and Peterborough Dual Diagnosis Strategy Treatment Pathways



Agenda Item No: 7

PUBLIC HEALTH REFERENCE GROUP REPORT

To: **Health and Wellbeing Board**

Meeting Date: **30 March 2017**

From: **Director of Public Health**

Recommendations: **The Health and Wellbeing Board is asked to:**

1. **Note and comment on the Public Health Reference Group report of activity in 2016/17**

Officer contact:	
Name:	Dr Liz Robin
Post:	Director of Public Health
Email:	Liz.robin@cambridgeshire.gov.uk
Tel:	01223 703261

1. PURPOSE

1.1 The purpose of this paper is to report on the work of and outcomes achieved by the Cambridgeshire Public Health Reference Group over the year 2016/17.

2 BACKGROUND

2.1 The purpose of the Cambridgeshire Public Health Reference Group (PHRG) is to provide whole system leadership and multi-agency co-ordination for public health initiatives in Cambridgeshire focussed on improving outcomes for residents and reducing health inequalities. It meets quarterly and includes senior officer membership from the County Council, all District/City Councils, the Clinical Commissioning Group, Public Health England, the Cambridge University Public Health Institute, Community and Voluntary sector, Police and Crime Commissioners Office and Regional Housing Board.

2.2 The PHRG reports primarily to Cambridgeshire Health and Wellbeing Board, but also to the County Council Health Committee (in its public health executive function) and the Cambridgeshire Public Service Board.

2.3 The PHRG provides a report on activities and outcomes achieved to the Health and Wellbeing Board on an annual basis. The previous report was brought on January 14th 2016.

3. MAIN ISSUES

The activities led and overseen by the PHRG during 2016/17 have been as follows:

3.1 Implementation and Evaluation of diet/physical activity pilots

An initial focus of the PHRG was to fund small local pilots of initiatives to improve healthy eating and physical activity rates in identified populations or communities, which had a good fit with the developing national evidence base. The expectation was that where pilots were successful they would be self-sustaining and potentially provide a model which other local areas could follow. These pilots commenced in 2015/16 and continued during part of 2016/17. The total funding allocated from the County Council's public health grant was £73k. The evaluation summary for the pilot projects is attached as Appendix A. Key points and outcomes include:

- Good uptake of **Soil Association Food For Life (FFL) Early Years Award** by nurseries invited to participate. This programme supports nurseries with training, resources and an award scheme over a prolonged period as they adopt an evidence based and sustainable whole setting approach to healthy eating. This models and embeds healthy eating behaviours for the young children attending the nurseries. The funding was targeted to nurseries in areas of higher deprivation. This programme is being continued in 2017/18 through a contract variation of the existing Soil Association Food for Life contract with primary schools.

- Active participation by District Councils in the **Healthy Workplace** initiative for their staff, including training of in-house health champions. A pilot weight management course was held for a group of staff at Addenbrooke's hospital, which evaluated well against generally recognised benchmarks for average weight loss of participants.

- Other small programmes such as Fenland Walk Buggy and Physical Activity for two-five year olds, where participating organisations expressed the intention to continue with the activities after the end of the funded pilot. More recently funding has been awarded for the establishment of a Junior Park Run and two others are in development.

  Overall, the pilots provide useful examples of initiatives which can be taken forward in different settings with limited funding. The majority of spend was on the Soil Association FFL Early Years Award, which is a more in depth programme leading to evidence based changes in policy and practice in nursery and early years settings.

3.2 **Cambridgeshire Healthy Weight Strategy**

Achieving a Healthy Weight for the population is a major public health challenge. Healthy weight is fundamental for good health and wellbeing and demands a joined up collaborative whole systems wide approach if it is to be addressed effectively. The PHRG led the development of a Cambridgeshire Healthy Weight Strategy, of which a draft version was approved for consultation by the Cambridgeshire County Council Health Committee in July 2016. A 'Strategy on a page' summary is attached as Appendix B.

The Strategy describes a whole system, joined up approach to healthy weight across the three key themes of:

- **Environment:** Adopt policies and programmes for the built and natural environments that support a healthy weight
- **Settings:** Ensure that the places or social context in which people engage in daily activities support a healthy weight
- **Information and Skills:** Create opportunities for individuals, communities and organisations to build knowledge and skills that support a healthy weight

The public consultation lasted from August to November 2016 and the findings were presented at a stakeholder consultation event in November, which included input from a range of external speakers. Local stakeholders were asked to prioritise the different areas of the Strategy, taking into account feedback from the consultation, and the PHRG members are developing a multi-agency action plan to deliver against the identified priorities. The final draft Strategy and Action Plan will be brought back to the Health Committee

3.3 Developing a locality delivery model to increase physical activity levels across Cambridgeshire

The PHRG led and supported development of the Collaborative District Physical Activity Programme - part of a system wide approach to increasing the numbers of people who are physically active in the county. This is the first example of this kind in Cambridgeshire, of a consistent collaborative programme for health improvement between all the district authorities and their partner Living Sport. It has been commissioned by the County Council using public health grant funding, and was approved as a key decision by the Council's Health Committee in November 2016 (total contract value £513k over two years). Further details are provided in Appendix C.

This proposal aims to deliver a consistent and comprehensive pilot physical activity programme across the county. It acknowledges that there has been a varied approach amongst the district councils to delivering their health and leisure activities. The programme reflects the system wide approach that evidence indicates is necessary to increase levels of physical activity. It will include evidence based interventions at a population level and also for higher risk inactive individuals in a range of settings.

The Programme is branded as "Let's Get Moving Cambridgeshire". Each district will implement the programme and will have a district co-ordinator who will be employed and managed by the district authorities. This will ensure that all local authority health and leisure services are integrated into the Programme. A countywide coordinator will ensure consistency and quality across all the district projects along with co-ordinating elements of the Programme that are countywide.

3.4 Joint working between District Councils and public health

District Councils play an essential role in improving public health by delivering a number of services which have a direct impact on health including environmental health, general environmental services, housing, licensing, physical activity and leisure, planning, economic development and benefits advice. In addition, District Councils often have a close relationship with the local community, including residents, businesses and voluntary sector organisations.

Recognising this, the PHRG led the co-production of a delivery plan for joint working between the District and City Councils in Cambridgeshire and Cambridgeshire County Council Public Health Directorate, to maximise the public health impact of district council policies and services. We will do this by achieving the following priorities:

- Priority 1: Improve understanding and support of the role of district council services in improving the health of the public.
- Priority 2: Embed health in the planning, delivery and evaluation of all district council services and policies.
- Priority 3: Improve the translation of the Joint Strategy Needs Assessment into strategic action by the district councils to improve health outcomes.

- Overarching principle: Improve the ways district councils and the county council public health team work together to maximise the public health impact of district council services.

Each District Council has identified a number of actions that they wish to work with the County Council public health team to deliver, and our learning from these will be shared with other District Councils and public health colleagues so that we can improve how we are working together. Delivery of the action plan has already started, including 'Health is Everyone's Business' workshops for officers and members in district councils.

3.5 Promoting academic links

The membership of the PHRG means that it is a useful forum for organisations in the wider public health system in the county to exchange information and advice based on the expertise of PHRG members. For example senior officers planning services have found academic input on the latest relevant research evidence valuable, while researchers have learned about local organisations and services which may offer research opportunities. During 2016/17 the Cambridge Institute of Public Health prepared an ambitious bid to the Wellcome Trust to create a **Translational Centre for Global Ageing**, which would be dedicated to providing a multi-disciplinary approach to the generation of new evidence for sustainable health improvement and wellbeing of ageing populations. The intention was to carry out international research to understand community priorities and test interventions in five communities, of which one would be Fenland, Cambridgeshire. The research proposal was brought the PHRG for comment before submission. Although the bid was shortlisted it was not ultimately successful. However further bids are likely to be submitted in future.

3.6 Other issues/programmes on which the PHRG has made an input

The PHRG has acted as a stakeholder group for discussion of:

- Development of a joint **'Be Well in Cambridgeshire'** communications strategy and web-pages which will be launched shortly as part of the Cambridgeshire County Council public health transformation workstream. The PHRG discussion resulted in agreement amongst all district/city councils to participate in the programme and district representatives have regularly attended the steering group. 'Be Well in Cambridgeshire' will link to pages on each District/City Council website, and will provide information about relevant local activities.

- The **Cambridgeshire and Peterborough Sustainability and Transformation Plan (STP)** – following approval of the C&P Health System Prevention Strategy by Cambridgeshire Health and Wellbeing Board in January 2016, the PHRG have received regular updates on the development of the STP.

- The successful Cambridgeshire and Peterborough CCG bid to NHS England to participate in the second wave of the **National Diabetes Prevention Programme (NDPP)**. The NDPP provides intensive lifestyle support for people identified from blood tests and other factors as being at high risk of developing type 2 diabetes.

- The successful **'Healthy New Towns Bid'** for Northstowe – a joint bid to NHS England from South Cambridgeshire District Council, Cambridge University Hospitals Trust and the Homes and Communities Agency. More detail is available on https://www.england.nhs.uk/ourwork/innovation/healthy-new-towns/northstowe/

- Early work on how the wider public health research evidence base could contribute to taking forward the following commitment in the **Cambridgeshire and Peterborough devolution proposal** 'The Government and the Combined Authority will also focus on tackling socio-economic issues in areas of deprivation, such as parts of Fenland, Cambridge, Huntingdon and Peterborough, to improve the quality of life for local residents.'

4 RECOMMENDATIONS

4.1 The Health and Wellbeing Board is asked to Note and comment on the Public Health Reference Group report of activity in 2016/17

5 ALIGNMENT WITH THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

5.1 The work of the PHRG to date has some relevance to all priorities of the Health and Wellbeing Strategy with the strongest emphasis on priorities 3, 5 and 6:

- Priority 3: Encourage healthy lifestyles and behaviours in all actions and activities while respecting people's personal choices.
- Priority 5: Create a sustainable environment in which communities can flourish.
- Priority 6: Work together effectively.

Source Documents	Location
Public Health Reference Group Terms of Reference (Public Health Reference Group Update Appendix B)	https://cmis.cambridgeshire.gov.uk/ccc_live/Meetings/tabid/70/ctl/ViewMeetingPublic/mid/397/Meeting/22/Committee/12/Default.aspx
Cambridgeshire Healthy Weight Strategy consultation draft	https://cmis.cambridgeshire.gov.uk/ccc_live/Meetings/tabid/70/ctl/ViewMeetingPublic/mid/397/Meeting/189/Committee/6/Default.aspx
Paper to Cambridgeshire County Council Health Committee: Proposal for a locality delivery model to increase physical activity levels across Cambridgeshire	https://cmis.cambridgeshire.gov.uk/ccc_live/Meetings/tabid/70/ctl/ViewMeetingPublic/mid/397/Meeting/191/Committee/6/Default.aspx

To: Public Health Reference Group

Date: 17th October 2016

From: Val Thomas, Consultant in Public Health

Healthy Eating and Physical Activity Projects – Progress Report

1.0 PURPOSE

1.1 The purpose of this report is to provide the Public Health Reference Group (PHRG) with feedback on the small healthy eating and physical activity projects that were funded.

2.0 BACKGROUND

2.1 The PHRG undertook in 2015 a review of public health evidence relating to the key lifestyle behaviours. This resulted in the prioritising of healthy eating, physical activity and community engagement for health. Organisations were invited to submit proposals for funding to be used for small pilot projects that would inform the development and implementation of the Healthy Weight Strategy. The funding was awarded in October 2015 and projects were asked to implement as soon as possible. Project leads met regularly with Public Health and provided updates on the progress of the projects. The leads were provided with a simple evaluation template to complete. The initial timeline was for project completion by March 2016. However many of the projects were slow to develop and implementation was delayed for varying reasons. A number of the projects are currently ongoing.

3.0 SUPPORTING PARAGRAPHS

3.1 Table 1 provides a summary of the projects, the funding awarded and actual spend, outputs and any other pertinent information. **Appendix 1** provides fuller description of the projects along with some evaluation information that was provided by the project leads.

Table 1: Project Summary

No.	Project	Provider	Outputs	Sustainability	Funding award	Actual spend	Unit cost
1.	**Fenland Walk Buggy** Wild Play Walk Buggy was based in two Children's Centres in Wisbech and Littleport, developed in partnership with the Green Spaces Team of Cambridgeshire County Council (CCC). It objectives were to encourage and enable young parents to experience the benefits of walking and 'pushing' their children, starting with children at a very young age	CCC plus community volunteers	Measures: number of sessions and participants. Target number of sessions achieved. Total of 18 sessions, (12 in Wisbech and 6 in Littleport) 247 participants." Children's centres. This includes 3 staff training days which along with nature kits were designed to support the sustainability of the project. Evidence of support but evaluation questionnaire was not issued.	Children centres are continuing to support volunteers to organise walks.	£4,800	£4585	£19.52 per child
2.	**Sports and Physical Activity programme in Pre-Schools, Nurseries and Schools** The objectives were to engage 2-5 year olds in physical activities, to enable nursery staff to lead physical activity sessions	Living Sport	Measures: number of settings and participants. Target number of settings achieved. The programme engaged 10 settings, which consisted of three	Four of the settings have expressed the intention to continue with the programme	£6,000	£6,000	£42.00 per child

	and to support parents and carers to encourage and engage their child in physical activity at home		pre-schools, five nurseries, one primary school and one playgroup. 142 children engaged in physical activity sessions, 82 completed 10 weeks, 48 completed 5 weeks and 12 children completed activity on an ad hoc basis. Reported benefits: increased confidence, skills, shred learning, introduced to new equipment/skills, learning together, embedding physical activity into nursery settings.				
3.	**Targeted Change 4 Life Programme with Primary Schools** The objectives were to engage 3 to 4 year olds in physical activities, to support the school lead for physical activity by providing advice and ideas to engage children in physical activity clubs, to support parents and carers to encourage and engage their child in physical activity at home.	Living Sport	Measures: number of schools and participants. Ten schools targeted, 2 engaged in the programme. Schools were targeted across the Hunts Schools Sports Partnership with Bury Primary School and Stilton Primary School being the only schools to participate in the programme. Physical	The two schools have stated that they will continue with the programme	£7,500	£3,000	£134.00 per child

			activity school clubs were delivered once a week for 10 weeks in the schools. Training was provided to teachers and resources were provided to children. A total of 22 years 3 and 4 children participated. One school reported that that the pupil's activity had increased and they have the confidence to participate in school sport and physical activity.				
4.	**Soil Association Food For Life (FFL) Early Years Award** To deliver an Early Years programme to support 15 nurseries with training, resources and an award scheme to help them adopt a whole setting approach to healthy eating. Ongoing.	CCC	Measures: number of nurseries and specified developments in the nurseries. Target number of nurseries 15, 12 engaged. Other measures not yet available. The twelve nurseries were enrolled from across all 5 districts in the county. The more deprived areas were targeted. All the participating nurseries are provided by private	Ongoing support for the Programme will be assessed at the end of the year. However these programmes usually receive low level support to sustain their engagement.	£19,792 Extension £22, 346 Total £42,138	£19,792 Extension £22, 346 Total £42,138	£3,512 per nursery

			organisations. They have engaged and are participating in the programme. This has been extended as changing school policy and culture requires a minimum of one year.				
5.	**Park Run** Park Run is an international intervention to increase physical activity through running. Run by volunteers it is a free, weekly, 5km timed run. Park Run is open to everyone as a free, safe and easy activity to take part in. They take place in parkland surroundings and encourage people of every age and ability to take part. The aim was to establish one Park Run.	Living Sport	Measures: One Junior Park Run in Huntingdon funded Two other areas still in development are Cambridge City-Trumpington and another Junior Park Run in Wisbech Another Park Run was established independently of PHRG funding in March. Other areas have been interested but have been unable to secure local volunteers to run the programme.	n/a	£3,000	£0	n/a
6.	**Forest Schools** Forest Schools encourage and inspire individuals of any age through supporting the development of innovative,	CCC ETE Forest Schools	Measures: number of schools and sessions No data available. This project was slow to progress largely	The programme is still in its early stages.	£550	£150	n/a

	long term, educational approach to outdoor play and learning in a woodland environment. Planned engagement of 3-5 schools. Ongoing.		because of the numerous staff changes. One training event has taken place at the Clarkson Infant and Nursery School in Wisbech. Staff from the Forest School project intend to continue to develop the Project.				
7	**Personal Travel Planning** Established programme for promoting travel behaviour through individualised travel plans. Objective of 5,000 plans to be undertaken. Ongoing.	Commissioned : by CCC, ETE	Measures: number of LAS engaged and number of travel plans completed. Target number of travel plans 5,000. 1,379 travel plans completed. Awaiting full dataset Linked to the Workplace Programme. See below. 3 L.A.s already participating.	This could continue, but awaiting with information from new Project lead.	£9,000	£2,483	£1.80 per travel plan
8.	**District and Borough Workplace Health Programme** Provides health improvement interventions within the workplace setting through the development of workplace policy and providing access for employees to lifestyle services that they may not access elsewhere. LAs offered a menu of	Lifestyle Service provider Everyone Health, Business in the Community, Kaleidoscope, CAMQUIT, In House Public Health staff	Measures: number of participating Das and interventions. Target number of DAs- 5. Participation of all DAs with the exception of Cambridge City, although there has been some contact but not possible to progress. Health Champions trained or identified in	This still requires developmental support. Its sustainability will depend on the continued support of the authorities and the continued engagement of the Health Champions	Costs absorbed into existing contracts.	n/a	n/a

	interventions but must recruit and ensure that there are trained Health Champions from their workforces before proceeding with the Programme. Ongoing.		the 4 participating districts. Two authorities progress mental health first aid lite training and NHS Health Checks.				
9.	**Workplace Health Programme Cambridge University Hospitals Foundation Trust** (CUHFT) Pilot Staff Weight Management Programme. The objectives of the programme were to deliver an adult weight management programme in a workplace setting for staff with a BMI classification of overweight or obese. And to achieve a 5% weight loss over a 12 week programme.	Everyone Health	Measures: 1 completed weight management course with specified weight loss in line with NICE. Weight Management course completed with good weight loss outputs. (see below and Appendix1) 15-20 places were available on the programme. 16 participants registered on the course and 13 attended an initial assessment. 8 participants completed the programme (attended 7 sessions or more). The mean weight loss from baseline to completion was 4.39kg, equating to 5.3% weight loss. 80% of completers recorded a weight loss greater than 3%, whilst	The opportunity cost of providing this course was fewer courses in the community. An option would be for CUHFT to support courses on a regular basis	Costs absorbed into existing contracts.	n/a	n/a

			40% of completers recorded a weight loss greater than 5%. The mean change in moderate exercise from baseline to completion was 177 minutes per week. 80% of completers achieved the physical activity guidelines, compared to just 20% at baseline. The mean intake of fruit portions increased by 1 portion per day and vegetable portions increased by 0.8 portions per day from baseline to completion. 60% of patients achieved the guidelines for fruit & vegetable intake at completion, compared with 20% at baseline.				
TOTAL COST					**Allocated £72,988**	**Actual £58,356**	
TOTAL underspend					**- £7,500**		
Funding committed but not spent						**£6,917**	

Please note that the costs include the additional £22,346 for the extension of the Food for Life programme in nurseries.

3.2 Ten projects were awarded funding. Living Sport withdrew its Healthy Workplace project. The Food for life Programme in nurseries also has a “Healthier Options” element (funded at £2,000) which it has not introduced as the focus has been on developing the core programme.

3.3 Of the nine proposals that were implemented, four are ongoing. The Workplace Programme is supported by existing services and is gradually developing and expanding. Food for Life, the healthy eating project in nurseries was extended as it was difficult to achieve all the desired outputs in one year and there was a high level of support amongst the nurseries for the Project. Both the Personal Travel Planning and Forest Schools projects were late commencing and consequently have funding which is being used to continue to develop the projects.

3.4 There is learning from the implementation of the projects.

- Projects took longer to establish than planned. This largely reflected the issues of working with organisations and communities that had existing commitments and were consequently challenging to engage. The Park Run project in particular encountered issues with identifying community groups to support the establishment of a new site.

- It was easier to engage with nurseries than with schools that could reflect the greater number of competing demands upon schools than for nurseries.

- There is the issue of sustainability for the projects. The project leads were asked to engage individuals, communities and organisations in acquiring the skills and motivation to sustain the projects. Wild Buggy Play, Food for Life in Nurseries, Forest Schools, the Sports and Physical Activity in Nurseries and Pre-schools and the Change 4 Life Programme with Primary Schools included an element of staff and volunteer training to ensure sustainability along with the provision of resources to support the Programmes. Food for Life and Forest Schools are at the time of this report at too early stage to assess sustainability, the others have expressed to varying degrees a commitment to continuing with the projects However there was limited long term follow up to establish if the projects were embedded and sustainable.

- Some projects will depend on the longer term organisational support to ensure their sustainability especially the workplace, travel planning and weight management programmes. Although they are generally popular with staff and valued by organisations and there have been requests for them to be maintained.

3.5 Overall it is possible to state that all of the programmes achieved most or some of the desired outputs. Appendix I supplies more detail about individual projects. However the numbers engaged, whether individuals or organisations were small in some of the projects and the lack of longer term follow limits the assessment of the projects.

3.6 The cost of the interventions has not been compared for cost-effectiveness with other interventions or against each other as the projects were very different and essentially very short term. Individual unit costs have been indicated where it is possible to calculate them.

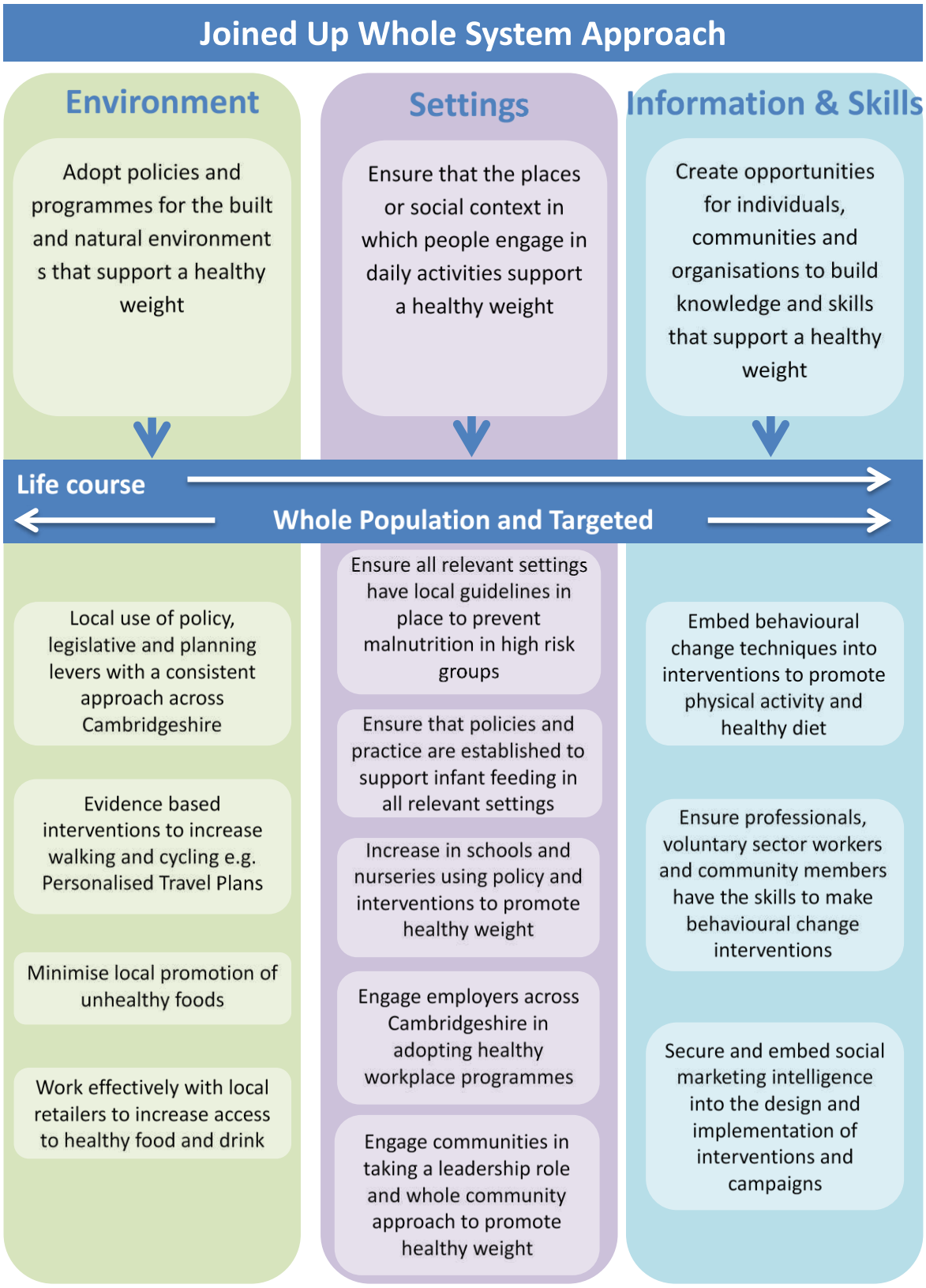
4. **Recommendations**

The PHRG is asked to discuss the following.

- The summary of the funded projects and associated learning.
- The approach with regard to incomplete projects.
- The sustainability issues.
- The contribution of the learning to the implementation of Healthy Weight Strategy.

Annex B:

Cambridgeshire Healthy Weight Strategy 'on a page'



PROPOSAL FOR A LOCALITY DELIVERY MODEL TO INCREASE PHYSICAL ACTIVITY LEVELS ACROSS CAMBRIDGESHIRE

APPENDIX to Health Committee Paper September 8th 2016

1. Proposal

The proposal is for a countywide physical activity programme that will be implemented across all five districts and borough authorities along with Living Sport. Living Sport is the Cambridgeshire Sports Partnership. It is a charity that aims to improve the health and well being of population in Cambridgeshire and Peterborough through participation in sport.

It Programme's overall aim is to increase levels of physical activity and it has the following objectives.

- Provide organised physical activities within the different localities that will support people to increase their physical activity.
- Contribute to the maintenance of healthy behaviour change through the provision of ongoing opportunities for those leaving weight management and other behavioural change services.
- Engage and strengthen communities to enable them develop and deliver activities within their communities.
- Promote and signpost individuals and communities to existing activities.

2. The Evidence

Being physically active is good for overall health but it also contributes towards maintaining a healthy weight. In Cambridgeshire 58% of adults are estimated to be active and 25% inactive. In Fenland the figure for those being active is 48% and for inactivity it is 37%. In terms of obesity, 64% of adults and 27% of 11 year olds are estimated to have an unhealthy weight.[1]

The programme that is proposed is based upon the Let's Get Moving - Physical Activity Pathway [2] [3] model. This is an evidence based model that was developed by the Department of Health that brings together a range of evidence based interventions. The model includes both universal (population

[1] Public Health Outcomes Framework http://www.phoutcomes.info/

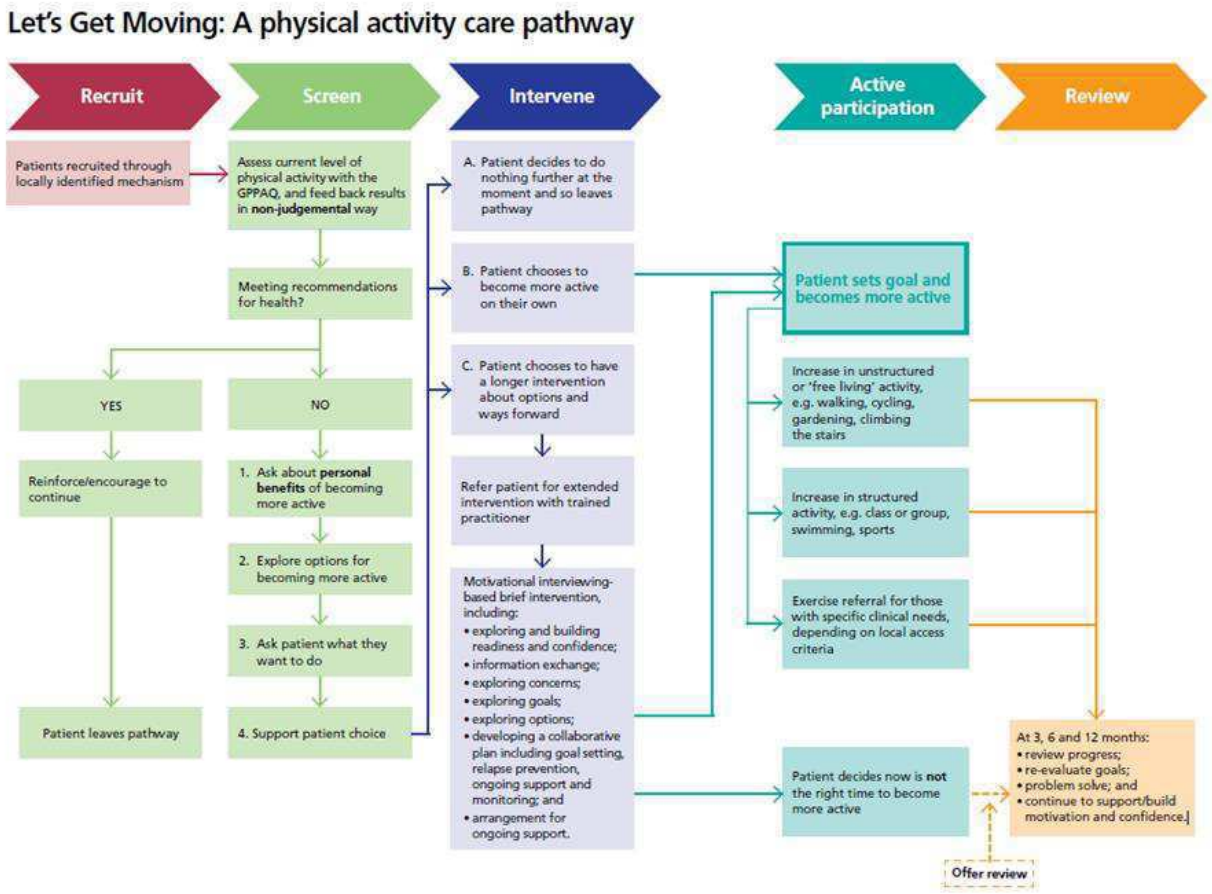
[2] Department of Health Leys Get Moving (2010) http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publichealth/Healthimprovement/PhysicalActivity/DH_099438 2010

[3] UK Active Lets Get Moving Report http://www.ukactive.com/partnerships/working-with-ukactive/let-s-get-moving 2013

wide) and targeted approaches and will also provide the brand. It will provide consistency across the county that will ensure quality and also enable a more robust evaluation.

The evidence that underpins the model reflects behavioural change theory and includes the use of brief interventions and motivational interviewing to engage people in programmes that will increase their levels of physical activity. At a population level there will be promotional activities and an increase in opportunities to engage in physical activities. At a more targeted level communities identified as having low levels of physical activity will be targeted to stimulate community engagement in developing and owning physical activity opportunities along with providing motivating interventions for individuals. Individuals who have been through a behavioural change programme or weight management programme will be signposted to the local programmes to help them maintain any behavioural changes.

Figure1: Let's Get Moving Physical Activity Pathway ***(please note the diagram refers to patients not clients as the model was developed by the NHS)***



3. Delivery Model

3.1 Programme delivery will be through a team of coordinators and will include one in each district supported by countywide coordinator.

3.2 The district co-ordinators will be responsible for co-ordinating the local delivery of the programme. They will develop, identify and promote local structured and unstructured activities for the identification and referral of individuals and communities with low levels of physical activity. A significant part of their roles will be around engaging communities in the development and ownership of sustainable activities. They will also be responsible for local monitoring and reporting of the programme outcomes to the countywide Programme Coordinator. These posts will be employed and managed by the local authority line management structures.

3.3 The countywide Programme Co-ordinator - will be responsible and accountable for the overall delivery of the programme, ensuring the aims and objectives are met along with ensuring consistent and quality standards of any of the interventions. In addition the post will have responsibility for the co-ordinated marketing and promotion of the programme, ensuring the brand is widely recognised. A key element of the role will be to monitor the programme and ensure that the district coordinators are delivering the key outputs and that the key performance indicators are met. The coordinator will also have responsibility for ensuring that the Programme is evaluated. Furthermore the programme co-ordinator will seek external and partnership funding to support the ongoing delivery and sustainability of the programme.

3.4 The inclusion of the countywide coordinator is fundamental to the successful delivery of the programme. It will ensure that the programme is consistent across the county, that there is shared learning to inform Programme development, that it is monitored and steps are taken if it is underperforming, a countywide consistent approach to campaigns and that there is a robust evaluation. This post will be hosted and managed by Living Sport – Cambridgeshire County Sports Partnership.

4. Key Elements of the Programme

4.1 **Targeted** interventions – for those identified through for example the Health Trainer Service or through GP practices who have low levels of physical activity or communities where evidence suggests there is a greater need. The aim is to motivate these high risk individuals and communities to increase their physical activity levels.

Individuals

<u>Identification and referral</u>
The Health Trainer services and professionals in other organisations will identify and refer individuals to physical activities. In support of this the district coordinators will facilitate behavioural change training for professionals in

organisations (brief interventions) to enable them to make a motivating intervention and refer individuals who are more likely to engage in the activities.

Maintenance of behaviour change

Individuals who have been involved in structured behaviour change programme will be referred to the local activities. This is particularly relevant for individuals who have been through weight management services where maintenance of weight loss can be challenging.

Communities and other settings

The local coordinators will identify communities and other settings such as schools or workplaces with low levels of physical activity for an intervention. Across Cambridgeshire there are a number of programmes that are working to engage and strengthen communities. The coordinators will work with these programmes to encourage and support communities to develop and participate in physical activity opportunities.

4.2 **Universal interventions** are activities that are designed to encourage behavioural change and a resultant increase in physical activity in the general population. This will include the following activities.

Development of physical activity programmes

The district coordinators supported by the county coordinator will build upon the existing offers within the districts and support the development of new initiatives which could include those listed below. The role of the Programme staff will be to work with the existing programmes to identify how uptake could be improved, develop new programmes, signposting and engagement of communities in structured and unstructured programmes across a wide range of settings such as schools, workplaces, community halls and leisure centres.

Examples of structured activities - delivered in Community settings and other leisure facilities.

- Swimming
- Fitness / Exercise Classes

Examples of *unstructured activities*

- Walking for health
- Mile a Day
- Go Run For Fun
- Kids Run Free
- Park Runs (version of for families / non-competitive versions to stop them being a barrier to participation
- Park Tennis
- Outdoor exercise - outdoor gyms

Promotion and campaigns

The County Coordinator will be responsible for the development and implementation of an ongoing physical activity promotion campaign that will complement other initiatives to increase levels of physical activity in the wider population. It will involve working with other organisations to develop joint campaigns and consistent messages. District coordinators will reflect this activity in their local areas.

4.3 Integration with other services will be essential to ensure that services are complementary. This will require clear referral pathways, joint planning to avoid duplication and to ensure that consistent messages are given to the public. As indicted above working with community engagement programmes and on promotional activities will be important but also lifestyle services such the Integrated Lifestyle Service provided by Everyone Health and the Healthy Workplace programme.

5. Implementation Costs

5.1 The proposal is for the Programme to be initially implemented over a two year period. To support the delivery of this Programme it is essential that it is consistently resourced across all districts. The required funding is detailed below in Table 1.

Table 1: Annual Implementation costs for Cambridgeshire Lets Get Moving Programme

	Cost	Living Sport Contribution		Actual Funding required
		Cash	In-kind	
Programme Co-ordinator	£39,000*	£10,000		£29,000
Locality Co-ordinators x 5 @ £32.5K	£162,500**			£162,500
Training, Development and Mentoring	£5,000			£5,000
Operational Budget	£50,000			£50,000
Promotion and Marketing	£10,000		£2,500	£7,500
Evaluation	£10,000		£7,500	£2,500
Total	**£276,500**	**£10,000**	**£10,000**	**£256,500**

* Approximate salary including 'on costs'. This post will be hosted and managed by Living Sport
** Contribution to District Council's to either employ a member of staff to undertake this role, or contribute to funding existing member of staff(s) to undertake this role.

6 Monitoring and Evaluation

6.1 Due to the investment into the programme, monitoring and evaluation will be fundamental for demonstrating the impact of the programme, future investment / funding and return on investment. Where the activity permits, the following will be measured and monitored for all participants in the programme.

- Attendance / Participation
- Physical Activity levels before and after programme / intervention. (e.g. International Physical Activity Questionnaire IPAQ)
- Weight
- Heart Rate / BMI / or waist circumference (where possible)
- Self-efficacy measurement before / after intervention
- Behaviour change – adherence to increased physical activity levels, 6 & 12 month check

An initial evaluation report will be completed at the end of the first year and will influence delivery in year 2.

6.2 Key Performance Indicators have been developed which will be monitored through the contractual process.

- Baselines will be established in the first 6 months of the Service to establish ongoing targets.
- There will be thresholds for each target.
- Reporting will be at district level and will be quarterly unless there is performance issues. This will be captured in the formal agreement
- Providers will take part in audits

7. Governance

7.1 It is proposed that there will be a formal contractual agreement with each local authority through a Section 75 agreement. The option of a procurement exemption for the contract with Living Sport is being explored. Each contract will be monitored individually.

7.2 The countywide Programme Co-ordinator will be responsible for reporting through the usual contractual processes. The PHRG will regularly review progress and provide support if possible to mitigate any barriers to Programme delivery. The Programme will be part of the regular reporting of Public Health activity to the Health Committee.

Jane Wisely
Huntingdonshire District Council

Val Thomas
Consultant in Public Health

SUSTAINABILITY AND TRANSFORMATION PLAN (STP)

To: Health and Wellbeing Board

Date: 30th March 2017

From: Scott Haldane, Executive Programme Director, STP

1.0 PURPOSE

1.1 The purpose of this report is to update the Health and Wellbeing Board on progress relating to the Cambridgeshire & Peterborough Sustainability and Transformation Plan (STP).

2.0 DEVELOPMENT OF THE STP

2.1 In Cambridgeshire and Peterborough, the NHS, general practice, and local government have come together to develop a five-year Sustainability and Transformation Plan (STP) to improve the health and care of our local population and bring the system back into financial balance. The development of this plan has been led by chief executives, frontline staff, and patients.

2.2 Cambridgeshire and Peterborough is one of the most, if not the most, challenged health systems in England, making it essential that we work together to develop robust plans for long-term change. We have in place strong, visible, collective leadership and a well-resourced programme of work to address:

- the health and care needs of our rapidly growing, increasingly elderly population;
- significant health inequalities, including the health and wellbeing challenges of diverse ethnic communities;
- workforce shortages including recruitment and retention in general practice;
- quality shortcomings, with two thirds of our acute hospitals under severe operational pressure;
- inconsistent operational performance, particularly in meeting the four hour Accident and Emergency (A&E) standards; and
- financial challenges which exceed those of any other STP footprint on a per capita basis, such that by 2021 we expect our collective NHS deficit, if we do nothing, to be £504m.

2.3 To enable us to deliver the best care we can, we have agreed a unifying ambition for health and care in Cambridgeshire and Peterborough. This is to develop the beneficial behaviours of an ‘Accountable Care Organisation’ (ACO) by acting as one system, jointly accountable for improving our population’s health and wellbeing, outcomes, and experience, within a defined financial envelope.

2.4 Through discussion with our staff, patients, carers, and partners, our STP, published in November 2016, has identified four priorities for change and developed a 10-point plan to deliver these priorities, as set out below and illustrated at Annex 1.

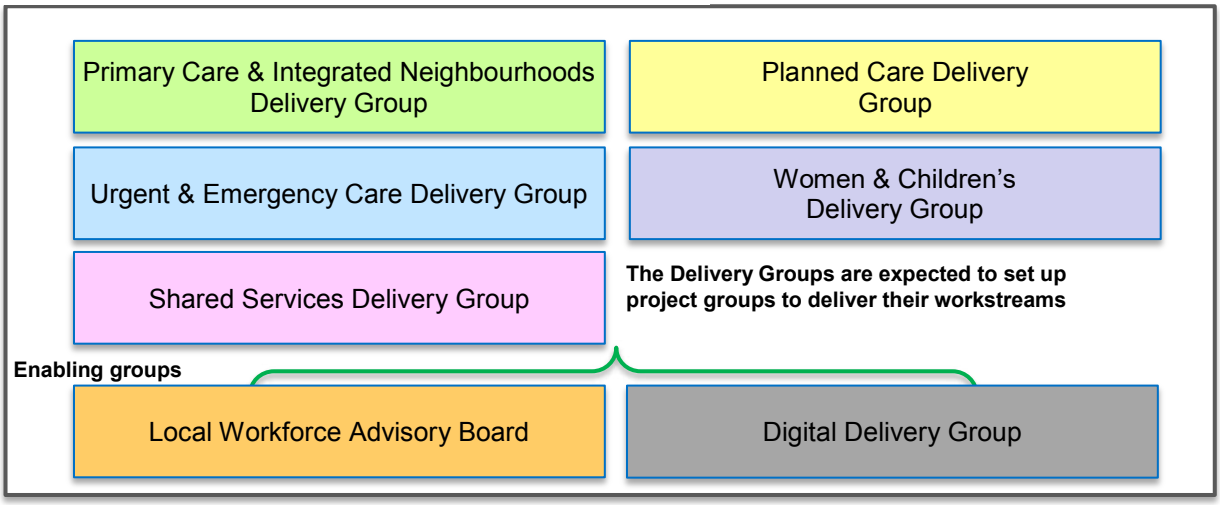
Priorities for change	10-point plan
At home is best	1. People powered health and wellbeing 2. Neighbourhood care hubs
Safe and effective hospital care, when needed	3. Responsive urgent and expert emergency care 4. Systematic and standardised care 5. Continued world-famous research and services
We're only sustainable together	6. Partnership working
Supported delivery	7. A culture of learning as a system 8. Workforce: growing our own 9. Using our land and buildings better 10. Using technology to modernise health

2.5 The STP also addresses the system-wide financial challenge of £504m over the next four years. It estimates the need to invest £43m to improve services over these four years, which increases the total system-wide financial challenge to £547m.

3.0 DELIVERING THE STP

3.1 Over the past few months, we have transitioned from STP development to implementation. We have put in place *Fit for the Future* (STP) programme arrangements, with a delivery governance structure to ensure effective implementation and this is illustrated at Annex 2, with an explanation of the purpose of each Group provided at Annex 3. At its core are seven Delivery Groups, each one responsible to Accountable Officers who are Chief Executive Officers from across the health and social care system, as set out below.

***Fit for the Future* (STP) Delivery Groups**



3.2 The Delivery Groups cover clinical services, workforce and support services and are designed to encourage system-wide working and to allow for patient-led care to be at the forefront of everything we do. Membership includes clinicians from organisations across

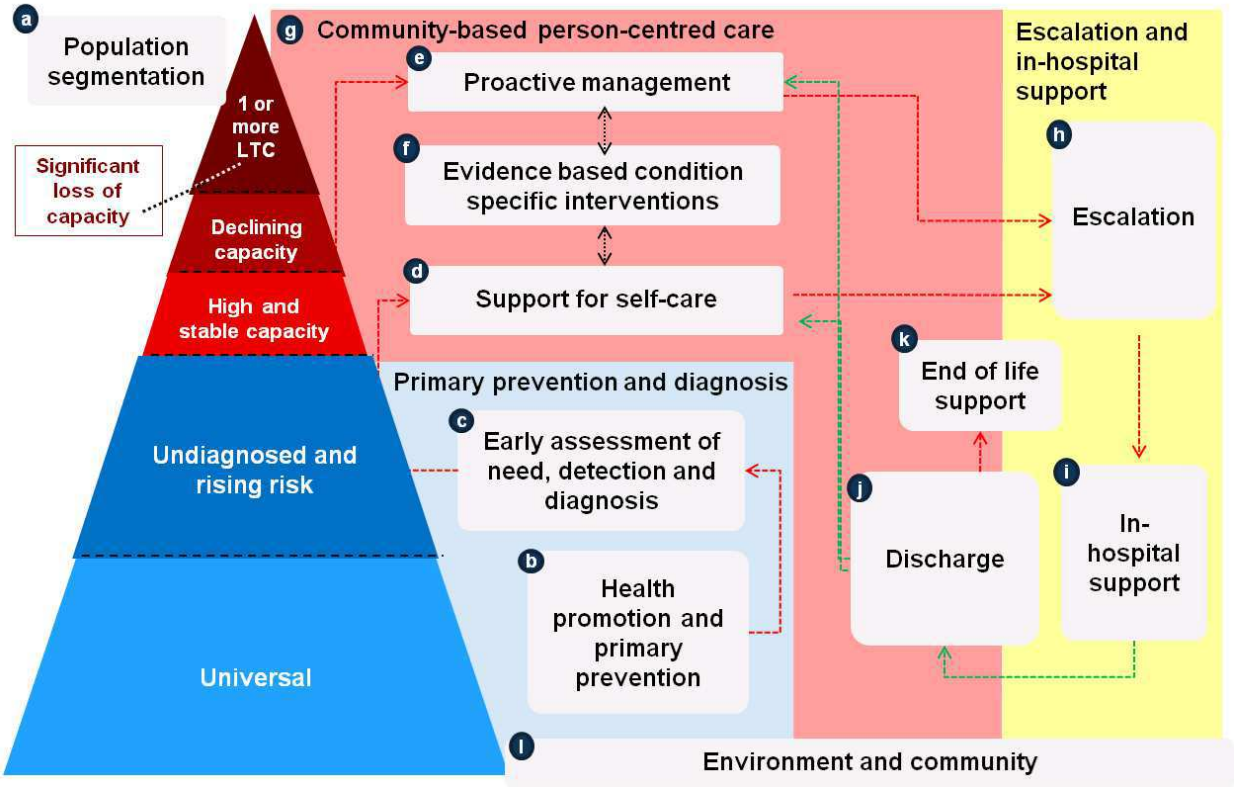
the system and we are currently ensuring that each Delivery Group has patient and public representation. Project groups have been established within each Delivery Group to take forward specific aspects of work and, again, these groups include clinical membership and will have patient and public representation.

4.0 KEY ISSUES

4.1 This section summarises the focus for early implementation across the seven Delivery Groups within *Fit for the Future*.

4.2 Primary Care and Integrated Neighbourhoods

4.2.1 The purpose of this Delivery Group is to implement integrated health and care neighbourhood teams providing proactive care stratified by different levels of need, as determined by peoples medical and psychosocial conditions, and as illustrated in the diagram below. We have brought together previously disparate work on healthy ageing, long-term conditions management, and mental health for the first time in this delivery programme.



4.2.2 Early implementation work is underway in a number of areas, including:

- '*Social Prescribing'*: This is where a healthcare professional can refer people to a link worker to co-design a non-clinical 'social' prescription. For example, an older single man experiencing loneliness and depression could receive a social prescription to an organisation such as Men's Sheds Association (see http://menssheds.org.uk/what-is-a-mens-shed/);

- Stroke prevention: Improving atrial fibrillation identification and management to reduce the risk of Stroke and manage Cardio vascular disease;

- Community Diabetes: Establishing a transformational community based diabetes model bringing care out of the acute setting and providing a holistic local offering to diabetic patients;

- Proactive Case Management: The identification and management of a wider cohort of at-risk patients than are currently cared for to maintain people in the Community; and

- Community Respiratory services: The development of community respiratory clinics run by Community Respiratory Consultant and follow-up clinics run by dedicated community respiratory nurse.

4.3 **Urgent and Emergency Care**

4.3.1 This Delivery Group is seeking to manage demand for urgent and emergency care services which have seen significant increases over recent years resulting in clinical and financial challenges for the system. The increase in demand in Cambridgeshire & Peterborough is driven mainly by population growth and, in particular, by growth in the older frail population, as well as a lack of community based services to support vulnerable people.

4.3.2 The focus for early implementation is:

- Extended Joint Emergency Team (JET): The Health & Care Executive (HCE) (see diagram at Annex 2) has agreed to provide additional investment to recurrently fund an expansion of and enhancement to the current JET service to enable it to care for an increased cohort of vulnerable patients. This increased funding will be used mainly to recruit additional staffing;

- Stroke Early Supported Discharge (ESD): Funding has been approved by the HCE to allow the commissioning of an Integrated Community Neurorehabilitation and Early Supported Discharge Service. This will combine therapy and associated staff to support all patients on the neuro and stroke pathways ensuring equity of provision and economies of scale. The service will provide both intensive stroke discharge support for six weeks and home based neuro rehabilitation; and

- Mental Health Crisis First Response Service: Funding to continue the urgent & emergency mental health liaison services has been agreed by the HCE. The First Response Service provides a comprehensive crisis assessment pathway, covering all ages, and providing a genuine alternative to A&E. The current service has demonstrated that it can improve patient care and safety, as well as reduce A&E attendance, therefore providing savings for the urgent and emergency care system.

4.4 **Planned Care**

4.4.1 The focus for Planned Care is to define, design and implement shorter, faster, better and more cost effective pathways of care for patients needing planned (or sometimes known as

'elective') care. This involves looking at every stage of the patient 'journey' from GP referral, outpatient appointment, procedure to follow up, ensuring that we are making the most effective use of clinical and financial resources.

4.5 Women and Children

4.5.1 The Women, Children and Maternity Services STP Delivery Group is leading seven projects over the next five years to improve services and outcomes for women and children.

4.5.2 Early implementation work across these projects includes:

- Maternity network developments**:** The initial focus is on developing a networked model of maternity care across Cambridgeshire and Peterborough to ensure consistent, high quality care and outcomes. Developing a community perinatal mental health service (see below), reviewing clinical protocols for the transfer of pregnant women and focussing on services for unwell, new born babies are also initial priorities for this work programme;

- Perinatal mental health: A priority is to develop a business case to establish a specialist community perinatal mental health service. Whilst there are pockets of expertise in our localities, there is currently no dedicated community service and the benefits for mothers and babies of introducing an evidence-based service would be significant;

- Urgent care: An early priority for this group is to identify new pathways of care for conditions that are currently seen in A&E, for example, minor illnesses and accidents, which could be treated closer to home if appropriate services were available. More joined up and integrated pathways across community and hospital services would ensure safe and sustainable services are provided at the right time, in the right place, by the right practitioner;

- Specific disease pathways: Developing proactive asthma and continence pathways and care models is the focus of this work stream, with the aim of developing community based clinics and improving the tools and information available to children and families. This would enable children and young people with asthma to be treated closer to home where appropriate, reducing A&E attendances, whilst community continence clinics will enable more routine cases, currently seen in hospital outpatient clinics, to be seen in the community with earlier, more proactive intervention.;

- Mental health support for children: This work programme is seeking to transform emotional health and wellbeing services for children and young people, with an initial focus on the introduction of a Crisis Assessment Team for children and adolescents with mental health issues. We will also be seeking to implement, locally, the national I-Thrive framework; an integrated, person centred and needs led approach to delivering mental health services for children, young people and their families;

- 0-19 universal services: Developing an integrated Healthy Child Programme for 0 – 19 year olds which meets the needs of children and young people and their families is central to this work programme. Our aim is to improve access to services and ensure

equity of service provision across Cambridgeshire and Peterborough to ensure our children and young people are supported to have the very best start in life; and

- Specialist disability services: The focus of this group is to improve pathways for children who have a disability to ensure care and services are co-ordinated and that we are able to achieve positive outcomes for young people with disabilities supporting them to become independent adults.

4.6 Shared Services

4.6.1 This Delivery Group is focussed on ensuring that we optimise the use of our resources, assets and potential. This includes, for example, making best use of NHS buildings and land, sharing 'back office' functions such as Human Resources, and streamlining our procurement and purchasing processes.

4.6.2 Key projects for early implementation include:

- Merger of Hinchingbrooke Healthcare NHS Trust and Peterborough & Stamford Hospitals NHS Foundation Trust to enable shared service savings;
- Exploring back office consolidation across primary care at scale;
- Implementing a single approach to procurement; and
- Development and sign off of a strategic estate plans, (including potential for primary care co-location, including other public services like Citizens Advice)

4.7 Workforce

4.7.1 Our new models of care will have significant implications for our workforce. In order to maximise the impact of the care models, the Local Workforce Action Board is working closely with clinical leads to ensure that workforce requirements can be met. Care models must take into account current workforce capacity and capability, and consider the change required to develop a workforce which is capable, competent, motivated, and supported to provide the best care for the population in future.

4.7.2 Key projects for early implementation include:

- Development of a system wide Workforce Investment Plan, with a commitment to investment priorities in relation to Apprenticeships (via LEVY), Pre-Registration, Continued Professional Development (CPD) and wider workforce transformation; and
- Linking to the supply improvement programme and design a tailored programme for primary care, linking to case load management trailblazers.

4.8 Digital Delivery

4.8.1 This Delivery Group is concerned with how best we can meet the opportunities and challenges of providing healthcare in a digital world by making best use of technology to support care, for example, tele-medicine, tele-monitoring, remote monitoring and paper free care delivery.

4.8.2 A key component of this work is the Cambridgeshire & Peterborough Local Digital Roadmap (LDR) which was published in January 2017 and which supports the delivery of the STP given the central role of digital technology.

5.0 IMPLICATIONS

5.1 If the Trusts and CCG meet their savings and efficiency plans, and all aspects of the STP are delivered, this will achieve the savings and efficiency target and produce a small NHS surplus by 2020/21.

5.2 Due to the high levels of acute hospital activity, and resulting deteriorating financial position in our system, we are looking at ways to accelerate the pace of change and focus early investment on the areas that will have greatest impact on reducing hospital activity levels.

5.3 Our priorities are to increase the amount of care delivered closer to home and to keep people well in their communities.

5.4 There are opportunities for patients, carers, and local people to be involved with the specific improvements we would like to make, and we will provide opportunities for staff and local people to help shape proposals for service change and to be involved with any formal consultation process. Please contact the team via email: contact@fitforfuture.org.uk

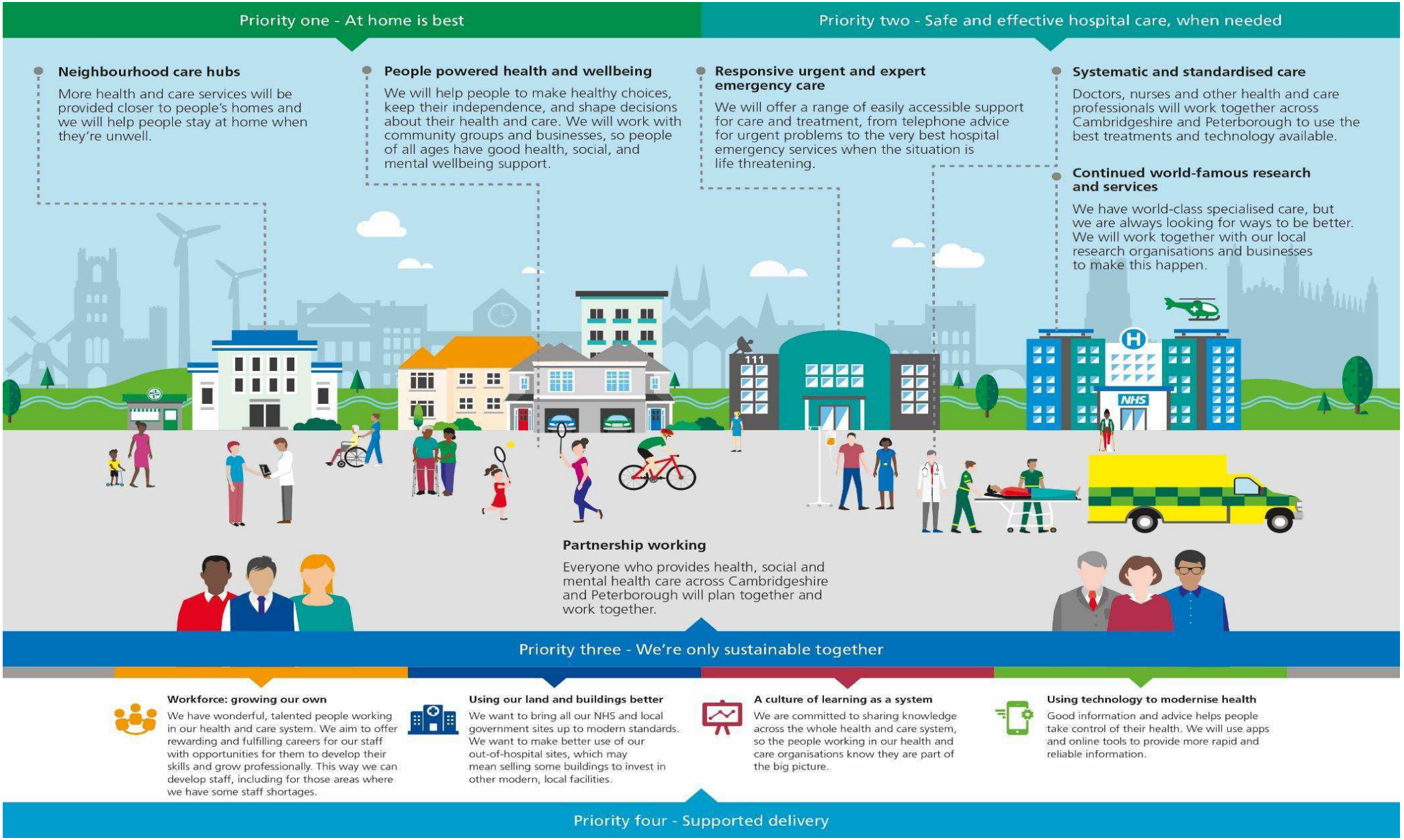
6.0 RECOMMENDATION/DECISION REQUIRED

6.1 The Health and Wellbeing Board is required to comment upon and note this update report.

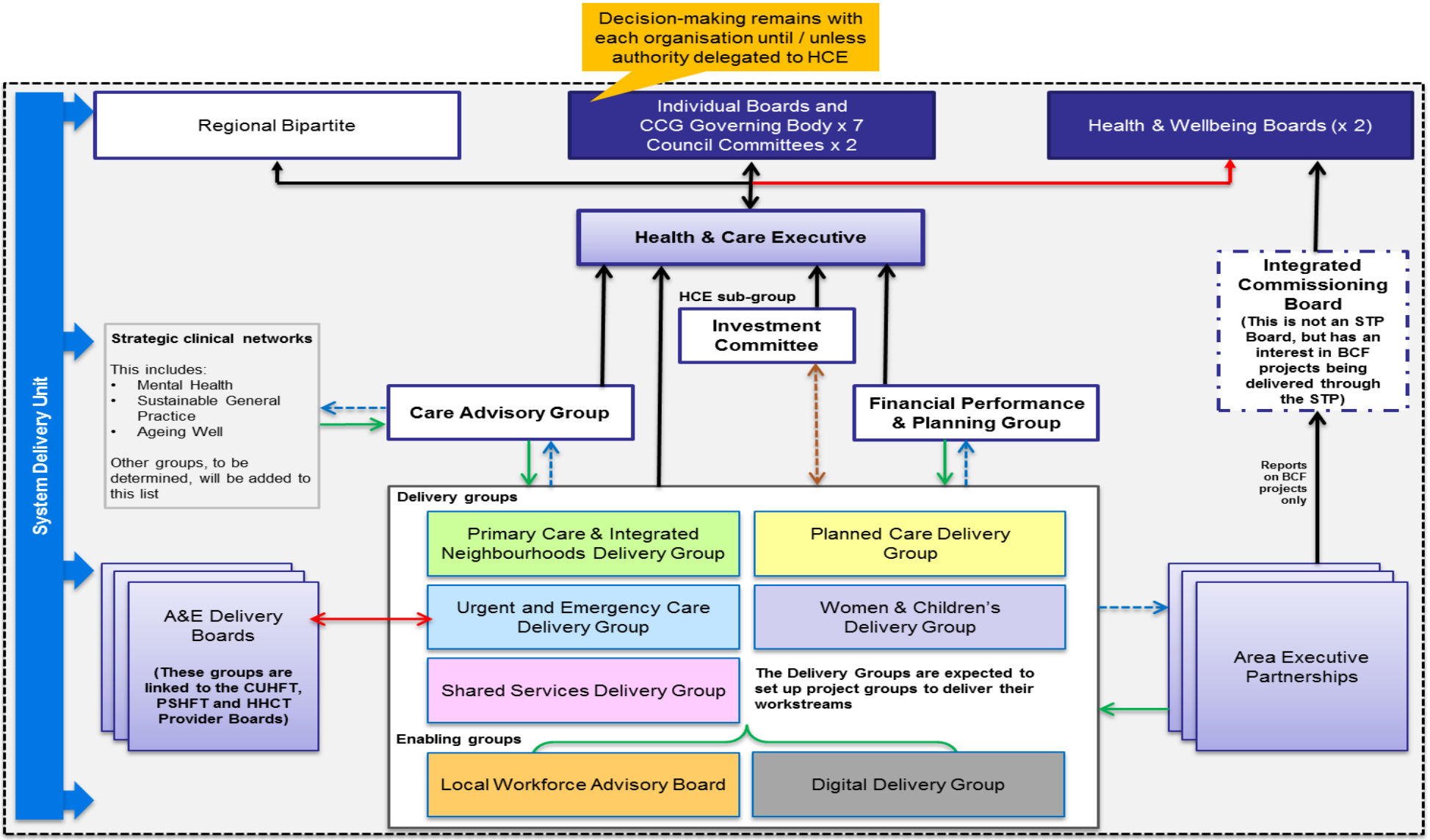
7.0 SOURCE DOCUMENTS

Source Documents	Location
• Cambridgeshire and Peterborough Sustainability and Transformation Plan • Sustainability and Transformation Plan summary document • Frequently Asked Questions	All available at www.fitforfuture.org.uk/what-were-doing/publications/
• Cambridgeshire and Peterborough Local Digital Roadmap	http://dev.speed.agency/fitforfuture/wp-content/uploads/2017/01/0064-PH-STP-DRM-Public.pdf

ANNEX 1: Cambridgeshire & Peterborough *Fit for the Future* Priorities



ANNEX 2: *Fit for the Future* Delivery Governance Structure


Decision-making remains with each organisation until / unless authority delegated to HCE
Regional Bipartite
Individual Boards and CCG Governing Body x 7 Council Committees x 2
Health & Wellbeing Boards (x 2)
System Delivery Unit
Health & Care Executive
HCE sub-group
Investment Committee
Integrated Commissioning Board
(This is not an STP Board, but has an interest in BCF projects being delivered through the STP)
Strategic clinical networks
This includes:
• Mental Health
• Sustainable General Practice
• Ageing Well
Other groups, to be determined, will be added to this list
Care Advisory Group
Financial Performance & Planning Group
Reports on BCF projects only
Delivery groups
Primary Care & Integrated Neighbourhoods Delivery Group
Planned Care Delivery Group
Urgent and Emergency Care Delivery Group
Women & Children's Delivery Group
Shared Services Delivery Group
The Delivery Groups are expected to set up project groups to deliver their workstreams
Enabling groups
Local Workforce Advisory Board
Digital Delivery Group
A&E Delivery Boards
(These groups are linked to the CUHFT, PSHFT and HHCT Provider Boards)
Area Executive Partnerships

ANNEX 3: Purpose of each Group within the *Fit for the Future* Delivery Governance structure

1. Health and Care Executive (HCE)

Organisations from across the system have agreed to work together, taking joint responsibility for improving the population's health and wellbeing within a defined financial envelope. The Health and Care Executive (HCE) exists to provide strong, visible and collective leadership to this process.

The HCE's main purpose is to commission and oversee a programme of work that will deliver the *Fit for the Future* priorities:

Priorities for change	10 point plan
At home is best	People powered health and wellbeing Neighbourhood care hubs
Safe and effective hospital care, when needed	Responsive urgent and expert emergency care Systematic and standardised care Continued world-famous research and services
We're only sustainable together	Partnership working
Supported delivery	A culture of learning as a system Workforce: growing our own Using our land and buildings better Using technology to modernise health

2. Care Advisory Group (CAG)

The main purpose of the Care Advisory Group (CAG) is to contribute to the overall delivery of *Fit for the Future* objectives by reviewing care model design proposals, horizon scan for innovations, ensure that there is a robust evidence base behind decisions, and making recommendations to the HCE. Expertise and opinion will be represented and sought from the public, from health and care providers and from clinical experts. The CAG will prioritise clinical issues to be considered by HCE and make recommendations for their consideration.

3. Financial Performance and Planning Group (FPPG)

The main purpose of the FPPG is to contribute to the overall delivery of *Fit for the Future* objectives by promoting financial sustainability of health and care provision within the Cambridgeshire and Peterborough footprint.

The responsibilities of the FPPG are as follows:

- To ensure that proposals are affordable, efficient, and represent value for money;
- To ensure that investments reduce health inequalities;
- To ensure that financial incentives are aligned around minimising system costs; and
- To ensure that patient benefit is maximised.

4. Investment Committee (IC)

Organisations from across the system have agreed to work together, taking joint responsibility for improving the population's health and wellbeing within a defined financial envelope. In order to deliver this aim, a number of organisations in the system have committed to the creation and funding of an investment pot to fund some of the initiatives necessary to deliver the required change. The main purpose of the Investment Committee is to assess and evaluate Business Cases submitted for funding from this investment pot and, where supported, to recommend to the HCE for approval.

5. Delivery Groups

The structure includes the following Delivery Groups:

- Primary Care & Integrated Neighbourhoods;
- Urgent and Emergency Care;
- Planned Care;
- Women & Children's;
- Shared Services;
- Digital; and
- Local Workforce Advisory Board

The role of the Delivery Groups is to contribute to the overall delivery of *Fit for the Future* objectives by ensuring that the quality improvements and financial opportunities identified are realised. In particular, the delivery groups will be responsible for ensuring implementation (including savings realisation) of design projects, and delivery projects where implementation needs to happen consistently across the system.

6. Local Workforce Advisory Board (LWAB)

Critical to the successful delivery of *Fit for the Future* is the creation of an enabling workforce strategy for health and care. The Cambridgeshire and Peterborough Local Workforce Advisory Board (LWAB) has been established to create this strategy which will align and develop the local workforce to meet the priorities set out in *Fit for the Future*. The LWAB brings together health and care organisations and key stakeholders across a broad range of workforce issues, current and future, and its purpose is to ensure that the people elements of the 5 year service strategy can be identified and delivered.

7. Area Executive Partnerships (AEP)

Three Area Executive Partnerships have been established around the following areas: (1) Cambridge and Ely, (2) Huntingdon and Fenland and (3) Greater Peterborough. Their role is to contribute to the overall delivery of *Fit for the Future* objectives by providing strategic advice and local knowledge and expertise to the Delivery Groups within the structure. They have a key role to play in ensuring that the local context is factored into project design as well as a role to assist delivery by providing links to local groups, unblocking any issues related to the local context and helping the Delivery Groups to address local barriers to change.

Each Area Executive Partnership:

- works with local communities (residents, patient groups, voluntary sector) and staff (primary care, NHS and local authorities) and develops an understanding of how to build capacity for proactively keeping people independent, well, and at home;
- provides a vehicle for strong and visible front-line clinical leadership and resident/ patient involvement; and
- promotes a culture of continuous quality improvement.

8. A&E Delivery Boards

Each A&E Delivery Board's main purpose is to:

- ensure urgent care needs are dealt with in the most appropriate setting by the most appropriate services (which in many cases should not be in A&E departments or acute hospital beds);
- provide a vehicle for strong and visible front-line clinical leadership and resident/ patient involvement; and
- promote a culture of continuous quality improvement

The A&E Delivery Boards are expected to oversee improvement projects that require locality tailoring for successful implementation. The over-arching guiding principle is that 'the same things are done differently' rather than 'different things are done' across Cambridgeshire and Peterborough.

HEALTH AND WELLBEING BOARD SUPPORT GROUP
FORWARD AGENDA PLAN

MEETING DATE	ITEM	REPORT AUTHOR	
30 March 2017 9.15am-11.00am (S.Cambs Hall, Cambourne)	**Health and Wellbeing Board**		
	Apologies and Declarations of Interest	Oral	**Reports to Richenda Greenhill by Thursday 16 March 2017**
	Minutes of the Meeting on 19 January 2017	Richenda Greenhill	
	Action Log Update	Richenda Greenhill	
	A Person's Story	Val Thomas	
	Dual Diagnosis of Mental Health and Substance Misuse Issues	Val Thomas	
	Review of the Better Care Fund	Geoff Hinkins	
	Report from the Public Health Reference Group	Liz Robin	
	Cambridgeshire and Peterborough Health and Care System Sustainability and Transformation Programme	Scott Haldane	
	Forward agenda plan	Richenda Greenhill	
	Date of Next Meeting		
27 April 2017 11.30am, Kreis Viersen Room, Shire Hall	**Health and Wellbeing Board – Extraordinary Meeting**		
	Apologies and Declarations of Interest	Oral	**Reports to Richenda Greenhill by Tuesday 18 April 2017**

MEETING DATE	ITEM	REPORT AUTHOR	
	Developing the Better Care Fund Plan 2017-19	Geoff Hinkins	
	Date of Next Meeting		
1 June 2017 10.00am (Shire Hall)	**Health and Wellbeing Board**		
	Election of Vice-Chairman/woman	Oral	**Reports to Richenda Greenhill by Friday 19 May 2017**
	Apologies and Declarations of Interest	Oral	
	Minutes of the Meetings on 30 March 2017 and 27 April 2017	Richenda Greenhill	
	Action Log Update	Richenda Greenhill	
	Person's Story	TBC	
	Better Care Fund Plan 2017-18	Geoff Hinkins	
	Cambridgeshire and Peterborough Health and Care System Sustainability and Transformation Programme	Scott Haldane	
	Approach to refreshing the Cambridgeshire Health and Wellbeing Strategy (2012-2017)	Dr Liz Robin	
	Forward agenda plan	Richenda Greenhill	
	Date of Next Meeting		
6 July 2017 10.00am (venue tbc)	**Health and Wellbeing Board**		
	Apologies and Declarations of Interest	Oral	**Reports to Richenda Greenhill by Friday 23 June 2017**
	Minutes of the Meeting on 1 June 2017	Richenda Greenhill	
	Action Log Update	Richenda Greenhill	
	Person's Story	TBC	

MEETING DATE	ITEM	REPORT AUTHOR	
	Pharmaceutical Needs Assessment Followed by development session	Katie Johnson	
	Forward agenda plan	Richenda Greenhill	
	Date of Next Meeting		
21 September 2017 10.00am (venue tbc)	**Health and Wellbeing Board**		
	Apologies and Declarations of Interest	Oral	**Reports to Richenda Greenhill by Friday 8 September 2017**
	Minutes of the Meeting on 6 July 2017	Richenda Greenhill	
	Action Log Update	Richenda Greenhill	
	Person's Story		
	Safeguarding Adults Board Annual Report for 2016-17	Claire Bruin	
	Local Safeguarding Children's Board Annual Report 2016-17	Andy Jarvis	
	Forward Agenda Plan	Richenda Greenhill	
	Date of Next Meeting		
23 November 2017 10.00am (venue tbc)	**Health and Wellbeing Board**		
	Apologies and Declarations of Interest	Oral	**Reports to Richenda Greenhill by Friday 10 November 2017**
	Minutes of the Meeting on 6 July 2017	Richenda Greenhill	
	Action Log Update	Richenda Greenhill	
	Person's Story		
	Forward Agenda Plan	Richenda Greenhill	
	Date of Next Meeting		

MEETING DATE	ITEM	REPORT AUTHOR	
1 February 2018 10.00am (venue tbc)	**Health and Wellbeing Board**		
	Apologies and Declarations of Interest	Oral	**Reports to Richenda Greenhill by Friday 19 January 2017**
	Minutes of the Meeting on 6 July 2017	Richenda Greenhill	
	Action Log Update	Richenda Greenhill	
	Person's Story		
	Forward Agenda Plan	Richenda Greenhill	
	Date of Next Meeting		
22 March 2018 10.00am (venue tbc)	**Health and Wellbeing Board**		
	Apologies and Declarations of Interest	Oral	**Reports to Richenda Greenhill by Friday 9 March 2018**
	Minutes of the Meeting on 6 July 2017	Richenda Greenhill	
	Action Log Update	Richenda Greenhill	
	Person's Story		
	Forward Agenda Plan	Richenda Greenhill	
	Date of Next Meeting		
31 May 2018 10.00am (venue tbc)	**Health and Wellbeing Board**		
	Apologies and Declarations of Interest	Oral	**Reports to Richenda Greenhill by Friday 18 May 2018**
	Minutes of the Meeting on 6 July 2017	Richenda Greenhill	
	Action Log Update	Richenda Greenhill	
	Person's Story		
	Forward Agenda Plan	Richenda Greenhill	
	Date of Next Meeting		

Updated: 21.03.17