MEETING OF THE CAMBRIDGESHIRE HEALTH AND WELLBEING BOARD: MINUTES

Date: 11th June 2014

Time: 2.00. - 4.48 p.m.

Place: Council Chamber, the Grange, Ely

Present: C Bruin (substitute for A Loades) Councillor S Ellington (Vice-Chairman), Councillor K Ellis, Dr J Jones, C Malyon, Councillor L Nethsingha, Councillor T Orgee (Chairman), Dr D Roberts (Substitute for Dr Modha), Dr L Robin, R Rogers, Councillor J Whitehead and Councillor R West.

Present by Invitation: Emma De Zoete presenting Item 7 'Joint Strategic Needs Assessment (JSNA) Autism, Personality Disorders and Dual Diagnosis', Iain Green as a substitute for Mike Hill, District Council officer advisor and Andy Vowles presenting Items 4 'NHS Cambridgeshire and Peterborough CCG – Update on Local Quality Premium Indicators' and 5 'Local Health Economy 5 Year Strategic Plan.

Apologies: Councillors: A Bailey, M Cornwell and S Rylance, M Berry OBE, Adrian Loades and Dr N Modha.

NEW APPOINTMENTS TO THE BOARD

The following changes were announced:

In relation to the County Council:

Councillor Yeulett had been replaced by Councillor Anna Bailey from the Conservative Group as a full Board Member. Councillor Yeulett was now to be a Substitute Member for the Conservative Group.

In relation to Cambridge City Council, Councillor Sarah Brown was not returned in the May local district council elections. Notification had been received that Councillor Peter Roberts would be her replacement, but would require formal confirmation following their forthcoming Annual Council meeting.

In relation to East Cambridgeshire District Council, Councillor Ellis indicated that this would be his last Board meeting as he was due to be replaced by Councillor Joshua Schumann.

For NHS England it was indicated that Margaret Berry who had been unable to attend Recent meetings would have a substitute or replacement confirmed shortly.

49. APPOINTMENT OF VICE CHAIRMAN / VICE CHAIRWOMAN

As an introduction, Councillor Orgee explained with reference to the text on the agenda front page reading "the appointment of the Chairman was reserved to the County Council" that due to an oversight, the Chairman appointment had not been confirmed at the County Council Annual Meeting in May. To ensure continuity, County Council Group Leaders had agreed that Councillor Orgee should continue as the Chairman for the June and July Board meetings until an appointment was made at the next Council meeting on 22nd July.

Having been formally moved and seconded, it was unanimously resolved:

to appoint Councillor Ellington as the Vice Chairman for the Municipal Year 2014/15.

50. DECLARATIONS OF INTEREST

Ruth Rogers declared a personal interest in Item 7 'Summary Report on the findings of the Joint Strategic Needs Assessment on Autism, Personality Disorder and Dual Diagnosis' as the Chief Executive of the local organisation 'Red 2 Green'.

51. MINUTES OF THE MEETING HELD ON 3RD APRIL 2014

The minutes were agreed as a correct record and were signed by the Chairman.

52. MINUTES ACTION LOG UPDATE

This document, providing details of responses for all the actions arising from the April Board meeting as set out in the minutes, was noted.

The only current outstanding action was in relation to a response having not yet been received from NHS England in relation to the to the wider questions raised at the April Board meeting included in Minute 45 'Update on the Pharmaceutical Needs Assessment for Cambridgeshire'. In the absence of the current lead officer, a request for a response had been escalated to the NHS England Board and assurance had been received that a response would be provided.

53. NHS CAMBRIDGESHIRE AND PETERBOROUGH CCG - UPDATE ON LOCAL QUALITY PREMIUM INDICATORS

This report updated the Health and Wellbeing Board on the achievement of the NHS Quality Premium in the 2013/14 financial year. A copy of the end of year balanced scorecard was set out as Appendix 1 to the officer's report.

The Board was reminded that the NHS Quality Premium being an incentive scheme payable to Clinical Commissioning Groups (CCGs) designed to reward CCGs for improvements in the services that they commissioned and for improvements in health outcomes and in reducing health inequalities. The NHS Quality Premium was paid when certain pre-qualification criteria were met, including financial balance, which for Cambridgeshire equated to a potential maximum value overall of £5 per head of population.

It was highlighted that in 2013/14 the CCG achieved some of the indicator targets, (including all its local measures) as follows:

National measures:

- Friends and family roll-out plan
- Friends and family improvement – Accident and Emergency – CCG

Local measures:

- Older people emergency bed days rate per person
- Primary prevention of Coronary Heart Disease (CHD) in deprived areas – CCG
- Smoking at time of delivery – CCG

NHS Constitution measures:

- Incomplete Referral to Treatment (RTT) (Waiting) Time Pathways
- 62 day cancer waits

However as the CCG did not achieve financial balance in 2013/14 and reported an end of year deficit of £4.9 million and as financial balance was one of the pre-qualification criteria, the CCG would not receive any Quality Premium payment for 2013/14.

Board Members' comments included:

- With reference to Appendix 1 one Member sought further information on the performance against those national 'NHS Constitution Measures' that had failed to meet the target. The Member drew particular attention to Category A Red Calls (Most urgent category of Ambulance Response) bearing in mind the severe performance difficulties that the service had suffered in the past. It was indicated in response that the CCG was working with the relevant Authority and had agreed a recovery plan, which included investment to increase the workforce and milestones in terms of a re-investment programme in vehicle replacement. In relation to the other target missed – 'Accident and Emergency Waits Target' it was highlighted that this had only just failed to meet the target (Target 95% performance 94.6%) largely as a result of the poor performance at the Peterborough Hospital.

- Further information was sought regarding the robustness of the local measures threshold that had been set and whether benchmarking comparisons had been used. In response it was highlighted that the local measures set had been ambitious and had been the subject of very substantial benchmarking comparison work and therefore their achievement represented significant progress. Even more so, as when they had been proposed, doubts had been expressed regarding whether the local measure for 'Smoking at time of delivery' was deliverable. In discussion it was felt that the performance achievements required greater recognition, especially as some of the national measures had only been narrowly missed and took no account of the change in the financial circumstances during the year.

It was resolved:

a) To note the report.

b) That the Board through the Chairman should write to NHS England to express its concerns at the reward funding being fully withheld from the CCG when its overall performance had been good. The response should highlight that of the National Indicators, two had only been missed two by a small margin, and that 100% of the ambitious local targets set had been achieved. As a result the letter should further request that a part payment was made and should also highlight the changes in financial circumstances which had occurred during the year, which represented special circumstances. **Action: Liz Robin in consultation with Chairman**

54. LOCAL HEALTH ECONOMY FIVE YEAR STRATEGIC PLAN

This report provided an update on the ongoing development of the Local Health Economy 5 Year Strategic Plan.

Apologies were provided for the late production of the report, as the work to refine the Plan had been continuing right up to its publication on the website. It was explained that it was an iterative plan and was therefore appropriate for the Health and Wellbeing Board (HWBB) to receive the most up to date version. The Director of Public Health explained that the Board was required to receive it at the current meeting as it had a statutory duty to comment on CCG Commissioning Plans and for the CCG to take into account the views of the Board. There was also the need to ensure the CCG Commissioning Strategy was aligned with the Health and Wellbeing Strategy.

It was noted that a draft 'Clinical Commissioning Group (CCG) Strategic Plan had been submitted to NHS England on 4th April and following this, feedback had been received from NHS England and from partner organisations. It was reported that the CCG was now at the stage of developing the content further with partnership organisations undertaking a similar 5 Year Planning process, although the content of each organisation's plan varied, depending on the requirements of their regulator. In addition to producing a plan for the CCG, there was also a requirement to write a 'system blueprint' setting out a 5 Year Plan for the whole of our local health economy from 2014/15 to 2018/19 in recognition that the current model of care was unsustainable in the current economic climate and with a larger than average growing local population. The current working draft was attached to the officer's report as Appendix 3.

It was highlighted that The Cambridgeshire and Peterborough health system had been identified as one of 11 'challenged health economies' nationally, which reflected some of the complex challenges faced by both the CCG and their provider organisations. As a result, the system was being supported by external advisors PricewaterhouseCoopers (PwC) to support the CCG to develop a joint strategy across the Cambridgeshire and Peterborough Local Health Economy that would deliver clinically and financially sustainable healthcare. PwC had begun working with the

Cambridgeshire and Peterborough system on 3rd April with an end date set of 30th June. The CCG intended to use PwC's work as a catalyst for the wider Five Year planning process. The report explained the approach being used which was based around "Care Design Groups" and detailed the work that had already been undertaken.

Issues raised by Board Members' included:

- With reference to page 17 showing where GP practices were situated one Member suggested the nee**d** for a paragraph under the current map to provide more details of the number of GPs / size of practices. **Action: Andy Vowles / Dr Modha**

- Drawing attention on page 42 to the reference to the expansion of the local workforce in Cambridgeshire and Peterborough growing by 60% between 2000 and 2010 which appeared to indicate a local, rather than a national phenomenon, as it was stated that it had been faster growth than across other counties in the East of England. One Member in response indicated that while the growth locally was higher than the surrounding areas, it did represent the previous National Government's policy of unprecedented increased investment in hospitals / medical workforce to reduce waiting times for operations etc. The Chief Executive of the CCG confirmed that this was the case and that the growth locally, was not radically different from the growth which had occurred nationally during the period referred to.

- In relation to the above, one of the doctors present suggested scrutiny should be undertaken through engagement with the CCG on whether during this growth period, the quality / standards of care had improved and to look at the provider plans described on page 42 of the CCG Five Year Plan.

- With reference to page 42 and figure 24 'Establishment by profession 2013-2018' due to concerns at the projected reduction of staff shown between the two dates, It was proposed and agreed that NHS England should be written to, asking when the Board would see their Plan in relation to the provision of primary care services and seeking explanation on the staffing figures, and how the reduction in the acute sector would be translated to the required increases in the community sector. This was especially important as it made no sense to take more money out of the overall system in an area with a recognised, challenged health economy. **Action: Liz Robin**

- Requesting more detail on how the Acute Trusts were planning future service provision in the light of the identified staff reductions **Action by Andy Vowles.**

- There was a need to lobby the view that acute hospitals should receive a fixed amount of money, as the current model of hospitals expanding and taking resources that could be re-directed to community services sector, was not sustainable. It was explained that a debate was required to be undertaken with the provider trusts regarding the resourcing of a whole system approach. It was agreed that the above should not stop early lobbying to press for a change of

direction. It was suggested that adding the voice of the HWB Board would help support provider and commissioners in reviewing together local systems. The exact action to be taken to be further discussed outside of the meeting. **Action : Liz Robin**

- There was a suggestion from one of the doctors present that NHS England should be asked to provide clarity on Budgets for practitioners in relation to the planning for the recruitment of doctors to replace those retiring etc. and also to provide details of any proposals for re-balancing budgets in a similar way to the arrangements previously in place with Primary Care Trusts.

- A suggestion was made that information was needed on how General Practitioners (GPs) could utilise technology to help in the move away from Acute Hospital provision.

- A request that Acute Providers should submit their Plans for scrutiny to a future Health Committee **Action: Liz Robin** to discuss with Health Committee.

- One Member suggested consideration should be given to the provision of smaller specialist hospitals to deal with more routine, small scale operations to keep them away from the larger hospitals like Addenbrooke's. This would be looked at by the CCG as part of reviews being undertaken as to the best way of undertaking future services in a challenged economy environment.

- There was agreement that there was a need for the Board and individual Board members / politicians to seek to influence a change to the current payment by results ethos whereby Foundation trusts / acute hospitals received payments for all people attending hospitals, even when their treatment would have been more appropriately dealt with at GP level etc. This continued funding was seen as a serious anomaly, as Community provision received flat line income to deal with demand that did not increase if the local service demand increased.

- Page 87 Appendix 4 'Assumption underlying the PwC financial (spelt incorrectly in the table heading) Projections' required to be populated with numbers, as population increases expressed as a percentage did not provide adequate explanation without information on the original and increased population expressed in numerical terms. **Action: Andy Vowles / Dr Modha**

- There was discussion on the need for a fast track response mechanism for the Board when responding to consultations outside of the scheduled meetings as it was identified that four meetings a year was proving to be inadequate. This included looking at the potential of teleconferencing, identifying additional reserve dates, using scheduled development dates, agreeing final changes by e-mail correspondence and calling additional, special meetings. It was agreed these would be looked at in more detail and proposals brought back to the next meeting. **Action: Liz Robin to co-ordinate the preparation of a short report for the July meeting on options.**

- Information should be included on monitoring quality of provision.

- The issue was raised of whether joint responses from more than one Health and Wellbeing Board would be appropriate. In response the CCG lead officer indicated they would welcome views from Board as either singular responses, or as part of a joint response if there was common ground / agreement from more than one Board.

- There was a request for regular report updates on the Plan to each Board meeting. **Action: Andy Vowles / Dr Modha**

It was resolved:

To note the update with the comments made, actions suggested to be actioned / forwarded as appropriate.

55. ANNUAL PUBLIC HEALTH REPORT

The Board received the Annual Public Health Report (APHR) for Cambridgeshire 2013/14 as attached at Appendix 1 to the officer covering report. It was highlighted that the Health and Social Care Act (2012) included a requirement for Directors of Public Health to prepare an independent annual report on the health of local people. The current report had been based on the findings of the national Public Health Outcomes Framework (PHOF), which provided detailed information on health in Cambridgeshire as compared with other areas nationally, including the lifestyle and environmental factors which influence health.

The APHR covered the following overarching outcome indicators in the Public Health Outcomes Framework (PHOF):

- Increased healthy life expectancy
- Reduced differences in life expectancy and healthy life expectancy between communities.

as well as the following four main domains of the PHOF:

- Improving the wider determinants of health
- Health improvement
- Health protection
- Healthcare public health and preventing premature mortality.

The APHR compared outcomes for Cambridgeshire and its districts with the national average. Where the PHOF showed outcomes to be below average, this indicated a potential opportunity for local action to improve outcomes by learning from good practice elsewhere with the opportunities identified as being:

- Targeted work to understand and address high rates of smoking in parts of the county
- A focus across organisations on inequalities in the early years
- Work with communities in Fenland on health and lifestyles

- Reviewing reasons for lower coverage of individual vaccination and screening programmes and taking action to address this
- In addition, the APHR identified that developing a preventive approach for mental health was a priority for several stakeholders in the county, although the PHOF did not show high level outcomes locally to be worse than average and Cambridgeshire is worse than average for some indicators in the more detailed 'Community Mental Health Profiles' produced by Public Health England.

Comments from Board Members' included:

- One Member, referring to the text on page 8, highlighted the statistic that "the percentage of children receiving free school meals achieving a good level of development at the end of reception was worse than the national average in Cambridgeshire", made the point that the Health System needed to be aware of the pockets of deprivation in Cambridge.

- With reference to Page 12, one Member suggested that the reasons provided for the reduction in screening coverage for breast cancer, especially the temporary issue of a loss site for the breast screening mobile as being cited as a contributory factor, was considered weak. The Board agreed there was a need to encourage a more pro-active approach in terms of improving the uptake of screening and in terms of the mobile sites, to plan to identify alternative sites in advance in order to deal with any short term site access issues so that this problem did not occur in the future. **Action Liz Robin to bring to attention of NHS England and request a report back on what action was being taken to improve breast screening coverage.**

- There was discussion regarding geographical inequalities and the worse health outcomes identified on page 12 of the report in relation to Fenland, with diabetes in Fenland being significantly higher than the national average which was likely to be linked to higher obesity rates and lower physical activity levels. In addition, as set out on page 10, the percentage of Cambridgeshire's routine and manual workers who smoked was identified as being higher than the national average, with Fenland particularly high, having the highest rates of all local authorities in the east of England. There was concern that there was no Councillor representative from Fenland District Council at the meeting to be able to comment on the findings, and to be able ask what action the District Council was undertaking on the issues highlighted. In relation to what wider action was being taken, it was reported that officers from Health were in discussion with the local Fenland Partnership to help target resources.

- The Chairman referring to text on page 20 highlighted that hospital admissions for self-harm for both adults and children and young people was higher than the national average. There was discussion whether the large student population in Cambridge contributed to this and whether it was separately identified in the Cambridge City statistics. In response it was indicated that the student population was not separately identified, but the point was made that students often enjoyed better health than the local population. Due to their fast turnover, as a group they were difficult to capture in statistical information seeking to identify longer term trends.

- The need to ensure that a sufficient the focus on Mental Health was not lost.

- There was discussion regarding benchmarking road accidents, which led on to a discussion on what district councils could do to help. The District Officer adviser present indicated that South Cambridgeshire District Council had recently hosted a Road Accidents Conference involving partners including the Police, Addenbrooke's Hospital and other district councils. There was a request that the report on Reducing Road Traffic Accidents from the conference should be more widely circulated to the Board and to County Councillors, as County Councillors present had been unaware of the Conference and would have expected to have received an invite. **Action: Iain Green**

- In relation to obesity, there was discussion regarding the role of traffic lighting in relation to the contents of foods in supermarkets. The Director of Public Health indicated she would be happy to bring a report to a future meeting (possibly October - to be confirmed) on Food Labelling and the wider food and nutrition issues regarding the action being taken on obesity **Action: Liz Robin**

It was resolved:

The need to target work to further understand and to take action to address the high rates of smoking in parts of the County, (especially Fenland) as the key area of concern identified from the Annual Report.

56. SUMMARY REPORT ON THE FINDINGS OF THE JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) ON AUTISM, PERSONALITY DISORDERS AND DUAL DIAGNOSIS

This report summarised the findings of the above JSNA which was attached in full as an appendix to the report. The JSNA had been produced in response to the HWBB previously highlighting adult mental health as a priority area for JSNA work.

In consultation with partners, the scope of the adult mental health JSNA had been refined to focus on personality disorder, autism and dual diagnosis. It was explained that the JSNA had made an important distinction between mental wellbeing or mental health and mental illness or disorder, with the definitions as set out in the report. The three conditions which were the focus of the JSNA were all diagnosable, but less common mental illnesses. The JSNA also highlighted some of the factors which overall might increase the overall risk of poorer mental health.

It was explained that as there had been no capacity to produce this JSNA within the public health team, this JSNA, along with one on the mental health of older people, had been commissioned from 'Solutions for Public Health' a not for profit NHS public health consultancy in November 2013.

The JSNA highlights a number of areas for further work including:

- Further work for commissioners to benchmark service specifications, and current provision against National Institute for Clinical Excellence (NICE) guidance and/or quality standards, particularly to ensure all the early intervention opportunities were being maximised.

- Work to ensure that those adults who have mental disorders are receiving physical health care, particularly through GPs and health improvement services. The development of a Public Mental Health strategy is likely to cover this issue.
- CCG Commissioners should consider a review of services for dual diagnosis given the gaps identified.
- That work is taken forward work to implement the Crisis Care Concordat to ensure that Cambridgeshire 'has plans to ensure no one in mental health crisis will be turned away from health services'.
- An analysis of Cambridgeshire and Peterborough Foundation Trust (CPFT) service activity from the Mental Health Minimum Dataset (MHMD) was not possible for this JSNA as the data was not available in time, or complete enough, to be included within this work. It was indicated that it was now a specific requirement of the contract which CPFT have with the CCG to provide the MHMD in a timely and accessible format to commissioners. The Public Health team were to undertake an analysis of the data made available going forward, to provide additional service information for this JSNA.

Board Members' comments on the report included:

- Criticism that there was a lack of context with no distinction between the different severity levels: e.g. Severe / less severe / moderate etc. In relation to this point, it was explained that the data did not provide for this level of detail.

- page 34 table 25 - Lack of explanation on the figures 'on changes in projected numbers of people with borderline personality disorder' between 2012 and 2026 provided in the table. Especially highlighted was a query on why Cambridge City was projected to increase by a much higher variance than Fenland and also the lack of explanation for figure variations on page 32 and page 33. Information was required on the risk factors contributing to the projected changes and also the percentage increase as a proportion of the overall local population. In response to the point on risk factors, it was explained that the national prevalence had been taken and then applied.

- On table 23 page 33, One Member highlighted that the East Cambridgeshire increase figures seemed very high when compared to Fenland, with the latter showing a reduction in 2016 and 2021.

Action: Liz Robin agreed to take away and circulate an explanation by e-mail for the source used for the figures.

- The need to ensure the statistics around severity highlighted any geographical variations.

- One Member made the point that there was no recognition of the whole person and that physical illness may have caused mental illness and there was therefore a need to refer to physical problems at the same time.

- Concern was expressed by one Member of how the focus of this particular JSNA had been agreed without further consultation with the Board, who were required to be consulted on the commissioning of JSNA's. In reply it was explained that a

previous JSNA had undertaken as its main focus research work in relation to depression, which was why in further discussion with commissioners, the focus had been narrowed by officers to those areas not covered by the previous JSNA. Further to this concern expressed at the lack of Board input, which it was agreed was an omission, there was a request for an overview report to come back to the next Board meeting on future JSNA's beyond July, including the proposed Transport and Health JSNA to provide details of proposed focus for Board input / comment. **(***Note since the meeting it has been clarified that the Transport and Health JSNA update cannot be provided until the October meeting as until nearer that date the proposals from the JSNA Steering Group would not be known)* **Action: Liz Robin to co-ordinate.**

- Page 49: in relation to section 4.2 – 'exclusion criteria on those people with Personality Disorders currently treated within secondary care being excluded from receiving specialist input', while in discussion it was explained that people had to engage, otherwise they were excluded from receiving specialist treatment, there was a request for the Board to receive more detail of the care pathways involved in making such a decision, as there was concern expressed that people should not be left in a position where they were not receiving any treatment. **Action: Liz Robin to provide details for all Board Members.**

- The point was made that early diagnosis in schools and effective early intervention was vital to help reduce overall costs. It was highlighted by one doctor that the real cost of treating autism in the Country was more than the costs of heart disease / strokes combined. In reply it was explained that while the material in the current JSNA would not help in relation to this, other work being undertaken taking into account the latest Autism standards and the Autism Strategy and joining up pathways between children's and adult services and other partners services, would be of benefit. It was requested by one Member that a short report on the progress of the work reflecting the Autism standards and the Autism Strategy should be presented with the JSNA at the October Board meeting

It was resolved:

a) To agree not to approve the current JSNA, as further work was needed to be undertaken including information that had not been made available from the Mental Health Trust.

b) To agree to receive an updated JSNA at the October Board meeting but to agree not to delay any work that had been identified as requiring to be started and to take notice of the National Institute of Clinical Excellence (NICE) guidance as being the appropriate framework going forward.

57. CURRENT AND FORWARD AGENDA PLAN

The current Forward Plan was noted taking into account the additional reports requested to be made to the July meeting.

Changes orally reported from the printed Plan included for the July meeting:

- Deleting reference to JSNA Adult Mental Health under d) of the list of JSNAs' to come forward, as this was an error.
- Noting that the reference to the Quality Premium Indicators report should be deleted as this had in fact been included as a report on the current meeting agenda.
- Noting that the Domestic Abuse Report had now been moved from July to the October meeting as further update work was required which would not be available to be incorporated in a report to the next meeting.
- Adding CCG 5 Year Plan Update to the next meeting and each subsequent meeting.
- A report on the intended focus / proposals of Future JSNA's for comment / approval.
- Short Paper on how to undertake future urgent action through identified fast response mechanisms between Board meetings.

As agreed earlier in the meeting an addition to the October meeting was the further update report on the Autism, Personality Disorders and Dual Diagnosis etc JSNA.

There was a suggestion from one Member that the Older People Mental Health JSNA should also be moved to October. **Action: Liz Robin would investigate practicalities**.

RE-SUBMISSION OF BETTER CARE FUND DOCUMENT FOR APPROVAL

With the agreement of the Chairman this was raised as an urgent issue in relation to the Better Care Fund Update report listed for the July meeting. It was highlighted that while the final submission deadline was still awaited in terms of submitting the revised Better Care Fund document to Government, it was likely that this date would be before the next scheduled Board meeting in July. In order to agree the final document to be able to be sent to meet the submission deadline, after discussion:

it was unanimously resolved that:

> Officers in consultation with the Chairman and Vice Chairman should be authorised to agree the final version of the document for submission, after first electronically circulating the revised draft document to the whole Board seeking their comments and taking them into account when finalising the document.

58. NEXT MEETING THURSDAY 10TH JULY 2014 – Venue Shire Hall, Cambridge.

59. AGREED DATES BEYOND JULY (venues to be confirmed)

Thursday 2nd October
Thursday 15th January 2015
Thursday 30th April 2015

Chairman
10th July 2014