Health and Wellbeing Board

Thursday 12 June 2014

PRESENT:

Councillor McDonald, in the Chair.
Professor Richard Stephenson, Vice Chair.
Clive Turner, Steve Waite, Ian Ansell, Tony Fuqua, Veryan Berneby, Carole Burgoyne, Councillor Ian Tufin, Kelechi Nnoaham, Nick Thomas, Chris Singer, Councillor John Mahony, Dr Paul Hardy and Sue Taylor.

Apologies for absence: Ann James, David Bearman, Amanda Fisk, Peter Edwards, Jerry Clough and Lesley Gross.

Also in attendance: Nicola Jones, Ross Jago, Craig Williams, Craig McArdle, Katy Shorten and Amelia Boulter.

The meeting started at 10 am and finished at 1.20 pm.

Note: At a future meeting, the committee will consider the accuracy of these draft minutes, so they may be subject to change. Please check the minutes of that meeting to confirm whether these minutes have been amended.

1. CONFIRMATION OF CHAIR AND VICE CHAIR

Agreed to -

1. confirm the appointment of Councillor Sue McDonald as Chair for the municipal year 2014 – 2015

2. confirm Professor Richard Stephenson as the Vice-Chair of the Board for the municipal year 2014-2015.

2. APPOINTMENT OF CO-OPTED REPRESENTATIVES

Agreed the following co-opted representatives -

Statutory Co-opted Members

- Carole Burgoyne, Director for People, Plymouth City Council;
- Kelechi Nnoaham, Director of Public Health;
- Jerry Clough, NEW Devon
- Dr Paul Hardy, NEW Devon Clinical Commissioning Group representative;
- Peter Edwards, Healthwatch;
- Amanda Fisk, NHS England, Devon, Cornwall and Isles of Scilly.

Non-Statutory Co-opted Members

- Veryan Berneby, Community and Voluntary Sector Representative;
- Lesley Gross, Community and Voluntary Sector Representative;
- Clive Turner, Chief Executive, Plymouth Community Homes;
- Steve Waite, Chief Executive, Plymouth Community Healthcare;
- Ann James, Chief Executive, Plymouth NHS Hospitals Trust;
- David Bearman, Chair, Devon Local Pharmaceutical Committee;
- Richard Stephenson, Dean and Pro Vice-Chancellor, Plymouth University;
- Chief Superintendent Andy Boulting, Devon and Cornwall Police;
- Tony Hogg, Devon and Cornwall Police and Crime Commissioner.

3. DECLARATIONS OF INTEREST

In accordance with the code of conduct, the following declarations of interest were made –

Name	Subject	Reason	Interest
Dr Paul Hardy	Minute 7 – Co-commissioning of Primary Care Services	Is part of the GP commissioning body which could be commissioning GP services	Private

4. CHAIR'S URGENT BUSINESS

The Chair reported that she had met with Paul Woods, Chair of the Growth Board in relation to the Alcohol Strategy. It was reported that the Growth Board were fully supportive of the aims and actions contained within the Plymouth Strategic Alcohol Plan. The Growth board welcomes the Health and Wellbeing Board's future consideration of the impact of specialist commissioning spend in research and development on the medical campus. This would be important moving forward and as Chair would continue to strengthen the relationship between the two boards.

Kelechi Nnoaham reported that progress had been made on the Alcohol Strategy. At the March meeting this board agreed to have the plan at its next meeting, however, it had been useful to receive the inputs of the board to bring a more comprehensive delivery plan in September. In September this board to review in detail all the actions proposed in the plan to ensure clarity of leadership and ownership and to enable the board to have a clear sense of where we are with the delivery of the action plan.

In response to questions raised, it was reported that a draft implementation plan had been produced and was relatively clear on where growth could contribute. The Alcohol Programme Board had been delegated to deliver the implementation plan and clearly growth would have an input at that level. In September the board may want to consider whether growth could add something more specific than the offer currently on the table.

5. **MINUTES**

Agreed that the minutes of the meeting of 27 March 2014 were confirmed.

It was raised that the minutes did not accurately reflect discussions that took place.

In response it was reported that this is the formal meeting of the board and behind this meeting there were opportunities to meet and talk with the Chair. Regular development groups take place and all members were welcome to attend.

It was further reported that verbatim minutes were not taken. If there was a particular point a board member would like minuted they were requested to raise this at the meeting. It was also highlighted that the most important record of the meeting was the webcast and was one of a number of different avenues to ensure that these discussion were open and transparent.

6. **FAIRNESS COMMISSION RECOMMENDATIONS**

It was reported that the Board had received the summary of the recommendations from the Fairness Commission and Richard Stephenson, Vice-Chair and Fairness Commissioner reported that –

(a) the work undertaken by the Fairness Commission was done exceptionally well and they had listened to what the city said was fair and unfair;

(b) the Board may want to consider the city's response to the 85 recommendations. There were some quick wins and consideration should be given on how to take a cohesive system leadership response rather than rely on the collation of a number different individual responses to the 85 recommendations;

(c) the Board should look at how to utilise the systems leadership approach and consider a stewardship role in order to implement the recommendations that the city choses to be the top priority.

The following discussions and comments took place -

(d) in terms of the system leadership, in particular around mental health in how we commission, the provision, schools, community and voluntary sector and statutory bodies all working together. There were good examples of joint working in the city and through systems leadership could be embedded across all services to ensure good access to quality services;

(e) it was highlighted that a good discussion took place at a previous meeting when Dame Suzi presented the interim findings from the Fairness Commission report. The board embraced the direction of travel and there were no surprises as to some of issues that Dame Suzi highlighted for Plymouth. The Board needs to take a leadership

role and endorse the leadership recommendations and take an active interest in the recommendations that apply to alcohol and mental health. The Board could perhaps endorse the report and pull together a small working group to look at a number of recommendations for the Board to respond to and to ensure they get delivered;

(f) the report had been through the NEW Devon CCG Board and they very much supported this paper and wanted to move this forward. Health had a huge part to play in Plymouth and as one of the biggest employers with a high achieving primary care workforce NHS services would take some responsibility to move this forward;

(g) building on the proposal of a small working group, there were a number of plans in place and the group should be asked to ensure that plans were looked at through the lens of the Fairness Commission identifying quick wins;

(h) recommendation 6 regarding public sector engagement with communities was relevant to the board. Engagement with communities was fundamental to ensure equitable access to services;

(i) that work was already on-going in relation to community engagement and the Board needed to ensure current work programmes were aligned to fairness does not necessarily fit in with work of this Board and how we share this to have an awareness of that activity and progress otherwise we risk duplication or broadens out our scope so that we won't get through the business;

(j) there was significant activity elsewhere, the Board would take the opportunity to join things up using a systems leadership approach to reduce duplication.

Agreed that –

1. The Board commends the Fairness Commission report and gives thanks to Dame Suzi Leather;

2. A small working group to carry forward the work of the Fairness Commission.

7. CO-COMMISSIONING OF PRIMARY CARE SERVICES

Dr Paul Hardy and Nicola Jones, NEW Devon CCG provided the Board with a report on Co-commissioning of Primary Care Services. It was reported that-

(a) co-commissioning would focus on the integration agenda and about breaking down barriers and getting the systems to work in a more cohesive way;

(b) the Health and Social Care Act generated clinical commissioning groups (CCGs) to come into existence. The legislation was quite divisive and had resulted in a fragmented approach to commissioning. This was disruptive for service planning but co-commissioning provided a real opportunity for the CCG to take on primary care commissioning which would help to ensure services run more smoothly;

(c) the recent publication of various papers that set out the challenges the health community had to face. The Call for Action report highlighted –

- the demographic challenges;
- that the GP workforce was changing with a significant 25% reduction in next 5 years. The NHS faces a challenge in drawing people into general practice;
- current financial constraints with all organisations looking to make savings in an environment of higher and rising demand;

(d) in the future General Practice would need to operate at a greater scale and with greater collaboration with other providers, professionals, patients, carers and the local community;

(e) developing a modernised primary care service aligns with CCG Strategies for a shift of services into the community and maintaining people at home;

(f) a focus on how we look at harnessing technology for the benefit of patients for the future e.g. using Skype was required;

(g) Peninsula Primary Care Commissioning Group (PCOG) had been established with membership including the Area Teams, CCGs, Local Medical Committees (groups of GPs), PHE;

(h) a successful bid for the Prime Ministers Challenge Fund was submitted one of 11 that won funding. There was a need to have local discussion on how money was used to make a sustainable shift in our primary care;

(i) work was on-going with the local professional networks (pharmacists, dental, opticians) to improve how we work together to consider whether care was being delivered in the right way and to harness the skills of professional networks within primary care;

(j) An expression of interest would be completed by 20 June 2014;

The following questions and comments were made -

(k) it was noted that there was evidence to suggest that –

- variation in primary care could be found across a number of key domains, such as:
  - systematic implementation of primary and secondary prevention initiatives such as immunisation screening;
  - management of ambulatory care sensitive conditions, e.g. through self-management, lifestyle advice, use of disease registers, etc;
  - quality of end-of-life care;
  - elective referral activity;

- As much as a 10-fold variation can exit between practices in elective referral rates within specialities;
- Nearly 1 in 5 emergency admissions for adult social care conditions can be avoided be removing variation in primary care and spreading good practice.

(l) The Board should encourage both the CCG and the local authority's public health function to undertake a programme of work that uncovers and tackles variation where it exists in primary care. The CCG taking the position of getting the highest level of co-commissioning was welcomed;

(m) co-commissioning could lead the CCG into issues of conflicts of interest the Board was assured that this was being dealt with;

(n) co-commissioning gave us an opportunity to undertake preferential investment to deal with health inequality which exists in Plymouth;

(o) the Quality Outcome Framework (QOF) had resulted in a large amount of micro-management. This arrangement could potentially get rid of some of the QOF and could re-use the money in a more creative way;

(p) when Plymouth Community Healthcare (PCH) first started they worked with one commissioner and now have 9 commissioners. The fragmentation and lack of common themes through those commissioning streams does cause issues for service delivery so any opportunity to combine commissioning would be welcomed. PCH were also having discussions with schools but would need to link with the GPs to progress these discussions further;

(q) the Joint Commissioning Partnership was the vehicle to use on how we commission together against the Health and Wellbeing Strategy. The only way the Board would make a difference is by using a systems leadership approach and look at how we co-commission and make the money and resources in the city deliver a better service that makes us more sustainable;

(r) an understanding of CCG activity with bodies like Health Education England (HEE SW) was required for input into future workforce discussions. Where is the dialogue around this and ensure that scenario planning and the role of IT and technology in driving healthcare for the future workforce was placed in a better position. Not sure how we link with education but we do have exciting initiatives we will be delivering locally with workforce planning but need to give some focus to the education component, to have a conversation with education on professional growth would be a worthy conversation;

(s) Steve Waite responded that he is a Board member of the HEE SW and happy to take that challenge to them to ensure this Board where has been significant challenge in developing the primary care workforce and beyond and work is in hand;

(t) the Board needed greater visibility of strategic partners;

(u) ensuring that every citizen has good access to a GP was picked up by the fairness commission. Barne Barton was identified as an area that needed to have more accessible services and work was ongoing to ensure that it was addressed;

(v) part of the problem was the take up of services and how we influence the culture of communities to look after their own health better. Preventative services would not addressed by putting in more GPs. The Pharmacy needed to be used in a new way to tap into the knowledge base in that sector.

Agreed that –

1. The Health and Wellbeing Board is invited to engage and contribute views in relation to the potential new arrangements for co-commissioning of primary care services.

2. The Health and Wellbeing Board encourage both the CCG and the local authority's public health function to undertake a programme of work that uncovers and tackles variation where it exists in primary care.

3. Discussions take place with Health Education England SW and other strategic bodies to build links with the Health and Wellbeing Board.

4. The public and patient voice is involved in this process.

8. INTEGRATED, PERSONAL AND SUSTAINABLE COMMUNITY SERVICES

Nicola Jones, NEW Devon CCG provided the Board with a presentation. It was reported that –

(a) this strategy was the result of an extensive engagement;

(b) during the engagement positive messages were heard on the services currently provided;

(c) questions were not limited to community health services but included targeted questions e.g. 'do you want to stay in hospital?' and covered personalised care and carers;

(d) there were four main groups of services –
- prevention and personalising support;
- personal health budgets;
- pathways for adults with complex needs - community services needed to support the whole pathway in terms of people in crisis and preventing the needs of people going into the acute setting;
- urgent care.

(e) current contract with Plymouth Community Healthcare runs until the end of March 2016;

(f) the strategy was based very heavily on what was heard from people and views were being sought on the position set out in the strategy ahead of the decision being made.

In response to questions raised, it was reported that -

(g) whilst strategic framework was welcomed further clarity was required on the role of 'Health and Wellbeing hubs' in transforming community services and a clearer sense of the intended geographical distribution across Plymouth and Devon. Further information would be available as proposals moved into the detailed planning stage;

(h) with this area being the one of the 11th most challenged health economies in England, work was underway to identify what level of investment into community services was affordable;

(i) the impact on the Minor Injury Unit model in place in Plymouth would be carefully considered along with the role and impact of shared resource around information technology;

(j) hubs would need to address the needs of individual communities and whilst there was a requirement for some consistency the hubs must be locally designed. There was a role for the voluntary sector to help shape what was required locally;

(k) public health were key to giving the assurance investment now was shaping the future and reducing morbidity;

(l) our ultimate purpose is to deliver improvements in health and wellbeing for the people in Devon by the promoting the integration of health care service and anything that takes in that direction was welcomed.

Agreed that the Health and Wellbeing Board is assured that the direction of travel in this document begins to fulfil the Health and Wellbeing Strategy.

9. UPDATE ON INTEGRATED HEALTH AND WELLBEING TRANSFORMATION PROGRAMME

Craig Williams, Interim Director for Integrated Health and Wellbeing, Craig McArdle, Head of Corporative Commissioning and Nicola Jones, Commissioning Lead provided the Board with an update on Integrated Health and Wellbeing Transformation Programme. It was reported that -

(a) this was an update on progress towards integration, looking back at what we have achieved to date and next steps. Seeking to build one system one budget for sustainable community care;

(b) Plymouth does have significant health inequalities, if were to make a lasting change to ensure that everyone in the city had the best start to life which fits with the Marmot agenda this would clearly fit with our ambition;

(c) there was a greater complexity of need and this was across the system and reflected in packages in care both in continuing healthcare but also adult social care. There was also a rise in the number of children placements;

(d) the co-operative principles and values was really big agenda and challenges the way we deliver public services. The fundamental transfer of responsibility and power to citizens and communities and how we deliver services in a different way. If we are serious about hubs we need to involve communities of interest;

(e) this integration was owned by both political parties and the commitment to integration would not change;

(f) this Board set us the challenges in June 2013 and the Board's vision for integration to take the challenge back to commissioners and community. We want to adopt a whole systems approach in three ways –

- Integrated commissioning
- Integrated health and care services
- Integrated systems of health and wellbeing

The Board needs to check back that we are on track to delivering that vision.

(g) the four strands of work to make up the integrated health and well-being programme -

- Integrated commissioning
- Integrated delivery
- Children and Young People
- Care Act 2014

(h) this was a joint programme between PCC and CCG but moving forward we can only achieve this agenda by taking a collaborative approach;

(i) the outcomes were ambitious and support the agenda for health and wellbeing. There was a need to focus on prevention and early intervention to reduce health inequalities and ensure the best start to life. We need to deliver this service co-operatively and we have a strong partnership with the CCG and PCC looking at alternative delivery models and hubs would form a strong part of this. The children's agenda would follow the same model;

(j) the programme focused on the care and support to be co-ordinated around the individual and ensure that the individual is at the centre. The Director of Public Health provided support and challenge to make commissioning really "smart" and use the integrated information at the heart of that process;

(k) this was a journey which had already resulted in co-located commissioners at Windsor House which had helped the conversation, networking and trust building. There were good examples of pooling budgets around dementia and CAMHS and PCH and PCC were actively involved in the role out of care co-ordination. The emerging co-operative models for children's services, completion of the Better Care Fund (BCF) and the development of the outline business case was moving us towards an integrated approach;

(l) the work around transforming community services would inform our design. The pathways would work in a seamless way with the individual receiving the care they need in their own home.

In response to questions raised, it was reported that -

(m) the adults agenda was moving faster than the children's agenda due to additional complexity such as having to arrange a tripartite arrangements with schools. Whilst the design and outcomes would look similar for children's services there would be some key differences, further work would be provided to the Board;

(n) the challenge of highlighting end of life care would be addressed by commissioners;

(o) with joint commissioning spend we would start to focus on that together to deliver the best outcomes.

Agreed that the Health and Wellbeing Board to be provided with a further update on Integrated Health and Wellbeing Transformation programme in September.

10. PLEDGE 90 - MENTAL HEALTH REVIEW REPORT

Katy Shorten, Strategic Commissioning Manager provided the board with an overview of the findings. It was reported that –

(a) the review was completed in partnership with a number of key stakeholders, service users and carers groups. Caring Plymouth undertook a review of the Pledge in December 2013. They wanted to avoid duplication and identify the gaps and to reach out to as many people as possible as mental health was everyone's business;

(b) the review describes the journey from a health based clinical approach to mental health today being everyone's business and looking at ensuring that mental health has parity with physical health in mainstreaming our approach;

(c) the review highlighted that there were a number of strategies in existence or in development. Crucially what was identified was strong and motivated stakeholders across providers, commissioners and service users and that stakeholder sector was well engaged with the governance arrangements in place;

(d) the review refreshed and updated the Mental Health Needs Assessment and looked at –

- Risk and protective factors
- Prevalence data
- Demand for services
- Veterans

(e) the review also built a picture of the currently commissioned mental health services and corresponding spend. There were a wide spectrum of services commissioned in the city ranging from promotion of mental wellbeing services to acute inpatient services;

(f) the review covered key performance highlights –

- Increasing number of people accessing low level services having their needs met

- A proportion of adults with mental health receiving self-directed support higher than average
- PCH services which all meet the CQC standards

(g) the review identified areas for improvement -

- lower number of mental clients supported through adult social care
- suicides rates lower
- Section 136. Devon and Cornwall Police an outlier nationally

(h) a report commissioned by Plymouth Involvement and Participation group (PIPs) used a wide range of methods to gather feedback from a cross section of the population and covered the whole of Plymouth geographical. They looked at current services and provided ideas on how we could work differently moving forward on access to services and how services work together better;

(i) common themes from the review –

- Greater focus on early intervention and prevention;
- Involve services users, carers and stakeholders more;
- Access to services (waiting times)
- Person centred care – wider determinance
- Integration
- Existing spend

(j) progress since the review completed –

- Set up a new mental health carers support group
- Clearly demonstrating the pledge 90 is feeding into wider commissioning plans

(k) Pledge 90 was signed off by Cabinet in March 2014 and recommend that the Health and Wellbeing Board to lead on the development of a single implementation plan and work together with the mental health provider network to facilitate an open space event that will form part of solution workshop. The Joint Commissioning Partnership was looking at the review to form a commissioners' response.

In response to questions raised, it was reported that -

(l) Section 136/place of safety was identified as a key area for improvement through the performance review and quite significant amount of work undertaken with new services being developed such as street triage and liaison services and how we ensure more appropriate use of 136. Plymouth Community Healthcare and the police were working together to address some of the issues;

(m) the full detail of who was consulted with was contained within the PIPs service user report. They have a large number of people on their books and went out to community groups to tap into as many people as possible who may not be aware of mental health. The full needs assessment and in terms of the needs of the silent population we understand that need was not being met, this was a challenge and more difficult in understanding what needs were not being met;

(n) some of the key players have left the meeting and mental health was an important issue and as a Board need to consider the information here and make sure we are delivering to our communities;

(o) this review provides relatively sufficient information to give the Board a sense of the real needs around mental health in our population and recommend that this Board how we consider this and could an implementation plan to be laid over this?;

(p) the chair thanked Katy Shorten and to all involved with this review.

Agreed that –

1. The Health and Wellbeing Board commission an Implementation Plan to ensure a consistent and comprehensive response to the findings of Pledge 90, bringing together all strategic plans and activity impacting on mental health and wellbeing.

2. The Health and Wellbeing Board to monitor the Implementation Plan annually and by exception.

11. EXEMPT BUSINESS

There were no items of exempt business.