CAMBRIDGE LOCAL HEALTH PARTNERSHIP

Date: Thursday, 7 February 2013
Time: 12.00 pm to 1.30 pm
Venue: Committee Room 2 - Guildhall
Contact: Graham Saint **Direct Dial:** 01223 457013

AGENDA

1 APOLOGIES

2 PUBLIC QUESTIONS

3 MINUTES AND MATTERS ARISING *(Pages 1 - 18)*

To approve the minutes of the meeting held on the 29th November 2012.

Progress Update.

a. Actions from our recent Housing and Health Workshop, included:

- Raising awareness about how housing need is assessed and housing is allocated (briefing note to be prepared and circulated to GPs). This is being prepared.
- Focus on housing and welfare reform at a future joint GP governance day.
- Preparation and piloting of a shared Medical Information Form before its adoption. A draft form has been prepared.

b. Mental Health Reviews and Commissioning - minutes from the 13 December 2012 Adults, Wellbeing and Overview Scrutiny Committee are attached for the information of members. They show some clarifications being sought about the staffing budget for mental health services in the Adult Social Care Business Plan 2013/14.

A working group of the committee has commented on an early draft of the 'Joint Commissioning Strategy for the Mental Health and Wellbeing of Adults of Working Age', and a very early draft of the 'Joint Commissioning Strategy for the Mental Health and Wellbeing of Older People'. Neither of these documents is published yet. It is combining its next meeting with a

visit to the Advice and Referral Centre in Peterborough at the end of February. This approach is being trialled in Peterborough, and will be gradually rolled out across the County, due to reach the Cambridge area by summer 2013.

Also, attached for information is a presentation about the draft Joint Commissioning Strategy. This provides background to the approach being taken. *(Pages 1 - 18)*

4 UPDATE ON THE WORK OF THE SHADOW HEALTH AND WELLBEING BOARD (SHWB) *(Pages 19 - 30)*

Minutes of the SHWB meeting of the 16th January 2013 and the Forward Plan for the Board are attached.

Liz Robin (Director of Public Health, Cambridgeshire County Council) will provide an update on the work of the Board.
(Pages 19 - 30)

5 UPDATE ON CLINICAL COMMISSIONING PLANS *(Pages 31 - 34)*

The Partnership will receive a presentation about the development of Clinical Commissioning Plans from Nigel Smith, Local Chief Officer for Camb Health and Cambridgeshire Association to Commission Health (CATCH), at its next meeting on **18 April**.

In the meantime members are asked if they would like to convey any early views as a Partnership about the three outcome priorities that the CCG should adopt for 2012/13. These should highlight any local issues for the provision of services.

Slides outlining the proposed priorities, for information attached.
(Pages 31 - 34)

6 PREPARATION OF THE HEALTH AND WELLBEING ACTION PLAN *(Pages 35 - 42)*

Work is progressing to produce partnership action plans for the first five priorities of the HWB Strategy. A paper is attached asking members to agree to hold a workshop to identify how we can work together more effectively and set out our own priorities for action. *(Pages 35 - 42)*

7 DEVELOPMENT OF HEALTHWATCH CAMBRIDGESHIRE *(Pages 43 - 48)*

Ruth Rogers, newly appointed Chair of Healthwatch Cambridgeshire, will outline the emerging framework for engaging with the public, which is being developed. A paper setting out the background is attached.

Members are asked to give their initial views on how the Partnership can link with local Healtwatch representatives and assist their work. *(Pages 43 - 48)*

8 FORWARD PLAN *(Pages 49 - 50)*

A copy of the Partnership's Forward plan is attached. Members are invited to consider the issues they wish to discuss at future meetings. *(Pages 49 - 50)*

9 DATE OF NEXT MEETING

The next meeting is scheduled for 18 April 2013 starting at 12 noon.

Information for the public

Public attendance
You are welcome to attend this meeting as an observer, although it will be necessary to ask you to leave the room during the discussion of matters which are described as confidential.

Public Speaking
You can ask questions on an issue included on either agenda above, or on an issue which is within this committee's powers. Questions can only be asked during the slot on the agenda for this at the beginning of the meeting, not later on when an issue is under discussion by the committee.

Fire Alarm
In the event of the fire alarm sounding please follow the instructions of the Chair.

CAMBRIDGE LOCAL HEALTH PARTNERSHIP 29 November 2012
12.15 - 1.45 pm

Tom Dutton (Assistant Director, Strategy & Delivery Directorate / Strategy Lead CATCH)
Rachel Harmer (GP Cam Health),
Jas Lally (Head of Refuse and Environment, Cambridge City Council)
Inger O'Meara (Health Improvement Specialist, Cambridgeshire NHS)
Mike Pitt (Executive Councillor, Cambridge City Council)
Catherine Smart (Executive Councillor, Cambridge City Council)
Liz Robin (Director of Public Health, Cambridgeshire County Council)
Graham Saint (Strategy Officer, Cambridge City Council)
Sandie Smith (Cambridgeshire County Council)
Sally Roden, (Neighbourhood Community Development Manager, Cambridge City Council)
Louise Peden (Community Navigator, Cambridgeshire County Council)
Toni Birkin (Committee Manager, Cambridge City Council)

FOR THE INFORMATION OF THE COUNCIL

12/18/CLHP Apologies

Apologies were received from Mike Hay, Rachel Harrison and County Councillor Paul Sales.

12/19/CLHP Public Questions

There were no public questions.

12/20/CLHP Change to Published Agenda Order

Under paragraph 4.2.1 of the Council Procedure Rules, the Chair used his discretion to alter the order of the agenda items. However, for ease of the reader, these minutes will follow the order of the agenda.

12/21/CLHP Minutes

The minutes were agreed as a correct record subject to the following correction:

- Councillor Smart to be added to those present.

3a Matters Arising
Actions from previous meeting:

- 12/12/CLHP Safer Homes – Update to follow.
- 12/13/CLHP Terms of Reference for Ageing Well Group – To be emailed to panel members.
- 12/13/CLHP Community Navigators – To be addressed later in the meeting.
- 12/15/CLHP New communities and community cohesion – A briefing note had been circulated.

12/22/CLHP UPDATE ON THE WORK OF THE SHADOW HEALTH AND WELLBEING BOARD (SHWB BOARD)

Liz Robin updated the panel on the work of the SHWB. Multi agency funding bids had been largely successful. An action plan was under development to deliver the 6 key priorities in the new strategy, as detailed in the report.

The Partnership welcomed the inclusion of mental as a high priority. The development of a robust action plan would create a large workload. The Partnership also welcomed the completely new area of working jointly with the Armed Forces. Councillor Smart suggested consulting the Covenant Board.

12/23/CLHP Case Study Workshop

Jas Lally stated that the workshop had been well attended and useful. GP's reported an improved understanding of the pressures and limitation of the housing department. Welfare reform had been highlighted as a key issue for the future. An action list had been agreed and would be brought to this meeting in the near future.

The workshop was agreed to have been a useful activity and a repeat session, in six months time, was suggested to see what improvements could be implemented.

12/24/CLHP AGEING WELL AND COMMUNITY NAVIGATORS

Louise Peden (City Community Navigator) outlined the Navigator programme. There were five navigators across the County and their brief was to map out the networks and services available to older people in local areas. They would then provide signposting service and seek to build upon the networks to increase the capacity of local communities to support older people and maintain their independence. They would also train volunteers to become local navigators for their communities. Interest was growing.

Key issues were noted as:

i. The need for a good induction programme to ensure a consistent standard.
ii. Motivated and skilled volunteers, who were aware of their limitations.
iii. Local knowledge.
iv. Raising awareness of the Your Life, Your Choice website.

The Partnership made the following comments and suggestions:

v. Making best use of links already in place.
vi. Contacting the sheltered Housing Residents Association.
vii. Ensuring all contact information is up to date.
viii. Using exiting newsletters and publication to spread awareness.
ix. Using the local knowledge of networks such as Friends of … groups.
x. Placing the navigators in GP surgeries for special sessions such, as flu inoculations, where older people were likely to attend.

The Partnership discussed using the Council's Diversity Forum to consult local stakeholders about the need for a Cambridge Ageing Well Forum. The Diversity Forum is only held twice a year and the next meeting was six months away. Members felt there was a lot of good joint working going on in Cambridge and that events held by other groups such as COPE, could explore how an Aging Well Forum might contribute. Sally Roden said that she would meet with the local Community Navigators to make sure that they were aware of existing networks and contacts. The panel said that it would look again at this issue once the local Community Navigator had got a feel for the Cambridge situation, so that any decision to set up an Ageing Well Forum was better informed.

Action: Sally Roden

There was also concern that frail, elderly, people who were presently isolated and removed from existing networks would only come to notice when they presented to GP's at a point of a crisis. The Partnership felt that additional

work was required to help identify these people and that this could be considered in any future Community Navigator report.

12/25/CLHP JOINT COMMISSIONING STRATEGY FOR THE MENTAL HEALTH AND WELL-BEING OF ADULTS OF WORKING AGE

This item had been included on the agenda for information and the Partnership was asked how they wished to approach this subject.

The following points were raised:

i. This matter is under discussion elsewhere.
ii. The approach is unclear, was it a medical issues or something wider?
iii. Was funding in the correct place?
iv. Should the focus be in prevention (linked to improved social care) or treatment?
v. There was a discrepancy between the national and local agenda on this matter.
vi. How helpful was it to divide the issues along age lines when this was a whole life issue?
vii. Physical health was also linked to mental health.

The Partnership agreed to keep this item on the Forward Plan in order to keep abreast of developments and work taking place elsewhere.

12/26/CLHP FORWARD PLAN

The Partnership agreed the following Forward Plan:

MEETING DATE	ITEM
10th January 2013	Progress with developing Joint Commissioning Strategy for Mental Health and Well-Being of Adults of Working Age
	Consider arrangements for Healthwatch in Cambridge
	Action Plan: to link to Council Portfolio Plans and the plans of partners
MEETING DATE	**ITEM**
7th March 2013	Progress with project looking at information flows between GP's and Housing Officers
	Update on Ageing Well project and work in Cambridge
	Looking at Community Safety and Health including Streetlife issues

Action: Jas Lally and Rachel Harmer in consultation with Tom Dutton regarding developing the Partnership's contribution towards the SHWB's action plan.
Action: Graham Saint to draft a paper showing suggested priorities for the Partnership – so that this can be circulated wider amongst local stakeholders, to show what the Partnership is doing and going to do.

12/27/CLHP Date of Next Meeting

Future meeting dates to be agreed by email.

The meeting ended at 1.45 pm

CHAIR

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ADULTS, WELLBEING AND HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Cambridgeshire County Council

13th December 2012

Action

96. DECLARATIONS OF INTEREST

Councillor Heathcock declared an interest in agenda item 3 (minute 98) as a carer in a mental health context.

97. MINUTES OF THE LAST MEETING – 25th OCTOBER 2012

The minutes of the meeting held on 25th October 2012 were confirmed as a correct record and signed by the Chairman.

98. ADULT SOCIAL CARE BUSINESS PLAN 2013/14

The Committee considered a report updating it on progress against the delivery of the 2012/13 Integrated Plan and giving a high level overview of the draft 2013/14 Adult Social Care Business Plan. Members noted that the Business Plan (known in previous years as the Integrated Plan) would cover the five years 2013 to 2018. Councillor Martin Curtis, Cabinet Member for Adult Services, and Adrian Loades, Executive Director: Adult Social Care (ASC) attended the meeting to present the report and respond to members' questions and comments.

Introducing the report, the Cabinet Member said that the budget situation remained very challenging. He paid tribute to the superb work being done by officers, and announced that the projected overspend in the ASC budget for 2012/13 had now dropped from the £900k stated in the report to £400k. This had been achieved by tighter budget control, management of costs, and the use of money taken from reserves; no activity had been cut in pursuit of this reduced overspend.

Looking ahead, the Cabinet Member said that in some areas of ASC where funding was being reduced in 2013/14, e.g. for profoundly deaf adults, the reductions actually reflected that the budget for the area had traditionally been underspent. Taking out the underspends would remove some of the flexibility in the budget, but he stressed that the areas in which these reductions were being made would still be demand-driven, and demand would be funded if it were present.

In the course of a wide-ranging discussion, members raised a number of questions about ASC current spending and future spending plans.

Mental Health

Members sought clarification of proposals to review and reduce the mental health staffing budget in order to provide a service focused solely on the Council's statutory obligations. They were reminded that mental health was an area of

traditional underspend and advised that the Council currently exceeded its statutory obligations. Community-based services provided by the Council would be reduced, but ways of working more closely with Cambridgeshire and Peterborough Foundation Trust (CPFT) to replace these services were being explored; the proposals concerned not only staff capacity but changes in the ways of working.

A member pointed out that the current year's mental health budget had been underspent. The Cabinet Member replied that some of the underspend had been the result of understaffing and vacancies; while he would be happy to be able to spend more on mental health, it was essential to look at everything spent on non-statutory services, because there was a statutory requirement to provide adult social care. In response to the suggestion that the mental health budget had been underspent in order to enable it to be cut in the coming year, the Executive Director gave an absolute assurance that no instruction had been given to underspend any of these budgets this year in order to justify cutting them next year.

Drawing attention to members' recent work examining proposals for mental health provision, a member asked what the Council was delivering in the area of mental health services. The Cabinet Member said that the mental health agenda had widened in recent years, and the question now was what it was necessary to do to deliver mental health across the public sector, rather than viewing the Council's work – and that of other organisations – in isolation.

The Executive Director offered to provide a briefing note on what the Council's current responsibilities were. He added that it was becoming increasingly evident that the Council did far more to support mental health than it appeared from the budget; for example, many of the troubled families whom the Council worked to support also had mental health needs. Efforts were being made to develop the model of service to be less clinic-based; all parties would benefit if CPFT could do more to equip the Council's staff to identify and respond to mental health needs, but progress was slow. **AL**

Responding to an observation about the importance of early intervention and provision of support outside working hours, the Executive Director said that the Council was participating in a review of mental health out of hours services and the use of Council staff; these services were currently shared with Peterborough. The Cabinet Member pointed out that any case for greater investment in mental health must also articulate the source of that investment. Working more smartly with the available resources, joint working, and a better understanding of mental health across the GP sector could all lead to improvement without additional spending.

<u>Eligibility Criteria</u>

Asked whether the reduction in Mental Health provision meant that there were implications for broader social services provision, the Executive Director assured the Committee that eligibility criteria would not be changed.

Explanations were sought for how a rise in the number of referrals could be accompanied by a fall in the number of assessments and reviews; a member's suggested answers included that this might be the result of stricter gate-keeping, stricter application of eligibility criteria, or a de facto change in criteria. The Committee was advised that the criteria were unchanged, but more work was being undertaken to ensure that they were being applied consistently across the county, which would result in some people not receiving a service who might previously have received it. It was also possible that people's awareness of social care had

risen as a result of national discussion and local promotions such as Ask SARA, leading to an increase in referrals that did not necessarily meet the criteria. Asked how it was assessed that an assessment was not required, he Executive Director undertook to supply a briefing note to the Committee on the referral process. **AL**

Reablement

Asked what the difference was between avoided costs and savings in the context of reablement, the Executive Director said that when making a demographic projection, account was taken of the profile of need and of the population. The question would then be asked as to what could be done to avoid expenditure, by such means as reablement. Each reablement package was examined to establish what costs would have been incurred without reablement.

Members noted that Addenbrooke's was putting some funding into the enlarged reablement programme, but the County Council currently met the bulk of the cost.

Demography

Asked what was being done to address demography, the Cabinet Member reported that the Leader had asked the Council to be more challenging and less accepting of demographic information. The history of the last ten years suggested that the forecast of continuing population growth was probably correct. There was a "graph of doom" scenario under which local authorities would find themselves only spending on statutory duties (such as adult social care, learning disability, children with special educational needs) unless circumstances changed; the question was what could be done to influence the situation.

Budget management and planning

The Executive Director confirmed that the £16m savings being sought for 2013/14 included provision for the £3m vired from reserves in the current year. Members pointed out that reserves could not be relied on indefinitely.

A member recalled suggesting in the past that it would be a good idea to split the budget into costs over which the Council had some control (e.g. staffing) and costs over which it had no control (e.g. demography). He also drew attention to the risk of shunting costs from one organisation to another (e.g. a resident with mental health problems running up rent arrears, being evicted and needing to be housed in temporary accommodation). The Cabinet Member said that the Leader was keen for the public sector to work more holistically, avoiding the situation where one organisation's saving cost another organisation double the amount saved. The creation of the Clinical Commissioning Group and the Health and Wellbeing Board would provide forums for discussion between public sector bodies in the county.

The Cabinet Member undertook to talk to the Executive Director about a statutory/ non-statutory split; he was determined that the Council be seen to be as efficient and lean as possible. The Executive Director said that work on splitting costs was already under way, and it was necessary to do more. He also drew attention to the report's list of strategic actions to be taken forward over the next 12-18 months.

A member expressed concern that small teams of ASC staff were getting smaller, and there were high rates of staff sickness and stress-related absence. The Executive Director said that a business case could perhaps be made for employing more social workers in order eventually to achieve savings, through for example

improvements in the number and quality of assessments carried out; this had been the experience of some other local authorities.

Information Technology

Replying to questions about whether the IT currently in use was satisfactory, the Cabinet Member said that it was not. The current underlying platforms were not good enough, so it would be necessary to invest in IT over roughly the next two years. He gave the example of the current invoicing system, which a domiciliary care agency had told him was very complex by comparison with that used by other commissioners; better IT would bring long-term financial savings to both the Council and service providers. IT systems would also need to be changed in order to facilitate closer working with Local Commissioning Groups (LCGs).

The Executive Director added that changes would be made to SWIFT (the adult social care database) to bring it more closely into line with ASC processes, which should result in improved reporting and efficiency. However, it was also necessary to examine the corporate IT infrastructure, which was struggling to keep up with the service demands being made on it. ASC had fundamentally changed its way of working, so IT systems that reflected these current arrangements were required.

Assistive Technology

Members queried the removal of additional planned revenue investment in transformation, used to support service developments such as prevention. The Cabinet Member said that he was convinced more could be done, e.g. to expand assistive technology, but it was necessary to fit in with the resource capacity. The Executive Director added that the report could have been clearer on this point, which was linked to the ASC Capital Programme for 2013/14.

Cambridgeshire Community Services NHS Trust (CCS)

Members raised the question of CCS's status. The Service Director said that the fact that CCS's application for foundation status would not be progressed had significant implications for the Local Authority, because providers were now required to have foundation trust status, and CCS had been providing services to the Authority. It was therefore necessary to ensure that these services continued to be undertaken; one option would be for the Authority to bring the services back in house, though no decision had yet been taken. The Cabinet Member added that entering into the Section 75 agreement with CCS for CCS to provide services had been the right decision at the time it was made, and no criticism of CCS by the Authority was intended. However, this change in circumstances should be treated as an opportunity to be used to realign services and improve ways of working.

Independent Service Providers (ISPs)

A member, recalling that the member-led review of home care had found many ISPs to be financially vulnerable, suggested that it was dangerous not to give an uplift to ISPs, because this was effectively a cut in their funding. The Executive Director responded that a major home care contract exercise had recently been completed, and rates agreed in November would not be increased in March. Some contracts had been let for a lower amount in the tendering process.

In reply to the comment that problems identified by the home care review (such as low pay, lack of training and career progression, and poor recruitment and

retention) were likely to continue, the Cabinet Member said that the new structure in place for domiciliary care would improve care services. Agencies were now being grouped geographically, in order to reduce carers' (frequently unpaid) travelling time and increase the time they could spend with service users, and the structure of six major providers with smaller providers grouped under them meant that the major providers could take the lead on such matters as training.

A member commented that it was difficult for some recipients of Self-Directed Support (SDS) to find care agencies, particularly in Cambridge and South Cambs, and that there were too few care workers. So far, she had seen little evidence that carers were travelling less and spending longer with service users. The Cabinet Member reminded members that the new structure represented a significant change, and its effects should not be judged merely on the first few months.

Members noted that options for using call monitoring systems were being looked at with care agencies; the Council's thinking on how to deliver call monitoring had changed since the member-led review into home care services.

Informal Carers

In response to the suggestion that there was a danger of imposing too many demands on informal carers, members were advised that work was being developed with a carers' organisation to improve support for informal carers. It was important to identify those people who were acting as carers, and to provide them with effective support, as a means of preventing carer breakdown, which had expensive consequences for the Council; this was the least costly and most compassionate option.

Self-Directed Support (SDS)

A member reported hearing of one recipient of SDS who appeared to have been using some of their personal budget in a way that suggested that the service user did not need or was not spending the money for its intended purpose. Members were advised that both individual recipients' use of SDS and the amount of money going in to it was being kept under review. The Cabinet Member added that it was difficult to judge without knowing the individual circumstances; he knew of one group of SDS recipients who had shared resources to set up a photography club, which had had a very positive impact on their lives and their mental health.

Clinical Commissioning Group (CCG) and Local Commissioning Groups (LCGs)

A member asked what discussions were taking place on how to reconcile the current financial pressures and the need for equality of service delivery across the county with the local bias of LCGs. Cabinet Member and Executive Director acknowledged that the tension between the whole and the local was perplexing authorities across the country. It was a question of the balance between applying eligibility criteria equitably and allowing services to be shaped by local demands and needs.

Members noted that discussions were taking place with the CCG about how the services currently delivered by CCS could be provided in future. The CCG was keen that these should be delivered more locally, which would however raise the issue of equity across the county.

The Chairman thanked the Cabinet Member and the Executive Director for their attendance and helpful answers. The Cabinet Member invited members to contact him and ask for further information if they felt his answers had not been clear.

The Chairman then led the Committee in summing up its findings. Points identified included:

- mental health was an important factor in service delivery and budget; there was a view that there should be more investment in mental health (not disinvestment), and that the existing budget should be spent in full
- the Committee had heard a clear statement that eligibility criteria were not being changed, but there seemed to have been some erosion of access to services, with criteria being applied more strictly and some enquirers not getting beyond the Contact Centre – the apparent increased difficulty in accessing services might merit further exploration
- geographical differences in the amount spent above eligibility criteria
- the budget implications of CCS's failure to achieve foundation status, and the possible consequences of this failure for CCS
- possible scope for tightening SDS arrangements, given examples of apparently inappropriate expenditure
- the Committee had been clearly assured that there had been no deliberate underspending of budgets as a means of paving the way for cuts
- the challenge to demographic projections needed to be more robust, and there was some way to go to meet the challenge posed by these projections
- hospitals needed to work in a different way, and become more accountable, particularly as their budget overspends had become an issue
- a frequent reply to questions had been that work was in progress, or that work was at an early stage; the Committee needed to monitor progress in such areas as care agencies, commissioning and changes at CCS
- there had been little reaction to the member suggestion that it would be useful, when building the budget, to separate out the costs over which the Council had control (for example, staffing) and the costs over which it had no control (such as demography)
- the aim of increasing capacity in families might prove difficult to achieve in practice.

The Scrutiny and Improvement Officer informed members that the Scrutiny Management Group proposed to establish a working group, with a representative from each Overview and Scrutiny Committee, to look at the Business Plan before it was considered by Cabinet in January 2013. The Committee delegated the Chairman to attend as its representative; the Chairman asked members to convey any further observations on the Business Plan to himself or the Scrutiny and Improvement Officer.

99. FORWARD WORK PROGRAMME

a) Committee Priorities and Work Programme 2012/13

The Committee reviewed its work programme. Members were advised that the proposals for specialised regional treatment centres for liver metastases were now

unlikely to emerge until March 2013, with the result that the joint Overview and Scrutiny Committee would probably not meet until the municipal year 2013/14.

The Committee agreed

- to invite representatives of the Huntingdonshire District Council Social Well-Being Overview and Scrutiny Panel to attend its next meeting for an item reporting progress at Hinchingbrooke Hospital
- to authorise the Chairman, in consultation with the Scrutiny and Improvement Officer, to finalise the detailed work programme for the remainder of the municipal year.

b) Cabinet Agenda Plan

The Committee noted the Cabinet Agenda Plan.

100. CALLED IN DECISIONS

There were no called in decisions.

101. DATE OF NEXT MEETING

The next meeting of the Committee would be held at 10am on Tuesday 5th February 2013, preceded by a preparatory meeting for members of the Committee at 9.30 am.

Members of the Committee in attendance: County Councillors K Reynolds (Chairman), J Batchelor, N Guyatt, G Heathcock (substituting for Cllr Austen), G Kenney (Vice-chairman), V McGuire, P Read (substituting for Cllr Hutton), P Reeve, P Sales, S Sedgwick-Jell, F Whelan and F Yeulett; District Councillors S Birtles (Cambridge City, substituting for Cllr S Brown), M Cornwell (Fenland). R Hall (South Cambridgeshire) and R West (Huntingdonshire)

Apologies: County Councillors S Austen and C Hutton; District Councillor S Brown (Cambridge City)
Also in attendance: County Councillor M Curtis

Time: 11.05am – 1.10pm
Place: Kreis Viersen Room, Shire Hall, Cambridge

Chairman

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Cambridgeshire and Peterborough Shadow Clinical Commissioning Group
Cambridgeshire County Council
Peterborough City Council

South Cambs Local Health Partnership

Draft Joint Commissioning Strategy for Adult Mental Health Services

January 2012

NHS Cambridgeshire and NHS Peterborough

The new Cambridgeshire and Peterborough Clinical Commissioning Group

- One Cambridgeshire and Peterborough CCG
- Eight "Local Commissioning Groups"
- Clinically-Lead Commissioning
- Our Values
- Our Challenges
- "Mainstreaming" Mental Health
- Joint Working with Local Authorities

NHS Cambridgeshire and NHS Peterborough

If authorised by the NHS Commissioning Board later this year, the CCG will be one of the largest in the country ..

The Shadow CCG covers a population of nearly 864,000 people.

It will include 3 practices from North Hertfordshire and 2 practices from Northamptonshire.

It will have links to two Health and Well Being Boards

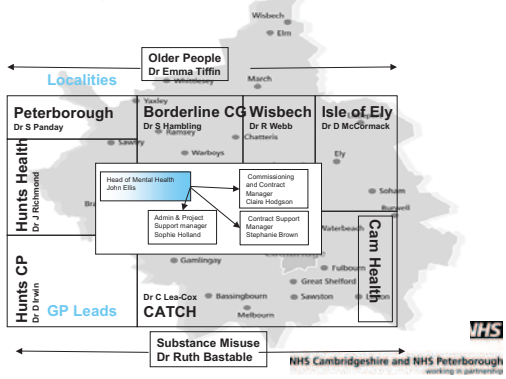
NHS Cambridgeshire and NHS Peterborough

Local Commissioning Groups

Borderline Commissioning Cluster	9 practices
Cam Health Integrated Care	9 practices
Hunts Care Partnership	16 practices
Hunts Health	10 practices
Isle of Ely Health	10 practices
Cambridge Association to Commission Health (C.A.T.C.H.)	28 practices
Wisbech Locality Group	4 practices
Peterborough	22 Practices

NHS Cambridgeshire and NHS Peterborough

The GP-Lead Model for Mental Health Commissioning



NHS Cambridgeshire and NHS Peterborough

The Story So Far…….

- the need for this document;
- the feedback we and GPs regularly receive from service users and carers;
- the public consultation last autumn / winter;
- our "financial challenges";
- the NHS changes, especially GP-lead CCGs and focus on outcomes for service users;
- the new national "No Health Without Mental Health" strategy;
- we acknowledge we could commission services better, especially from the voluntary organisations;
- the views of the LCG GP mental health leads;

NHS Cambridgeshire and NHS Peterborough

The Draft Joint Commissioning Strategy 2013-6

Chapter 1 - The Importance of this Document

Chapter 2 - How It Has Been produced

Chapter 3 - Current Local Service Provision

Chapter 4 - Local Joint Strategic Needs Assessment

Chapter 5 - Our Commissioning Priorities 2013-16

Chapter 6 - Specialist Mental Health Services

Chapter 7 - Summary (not yet written)

Glossary and Appendices

NHS

NHS Cambridgeshire and NHS Peterborough

working in partnership

Some Key Points

- We have identified three "over-arching" themes
  - Prompt Access to Effective Help
  - Recovery Model
  - Inter-Relationship with Physical Health
- Also our "commissioning processes "could be improved
- Each LCG has some local issues and priorities for action
- Our timetable targets the Health and Well-Being Board for sign-off March 2013
- A draft Commissioning Strategy for Older Peoples Mental Health Services is also now in circulation
- A draft Commissioning Strategy for Child and Adolescent Mental Health Services is being prepared

NHS

NHS Cambridgeshire and NHS Peterborough

working in partnership

Priority 1: Prompt Access to Effective Help

1. Introduce a **single-point of access** Advice and Resource Centre (ARC) to local mental health services for referrers, carers and service users which is open 24/7
2. Increase access to **psychological therapies** to widen the range of interventions available locally
3. Ensure **equitable access** to the services that we commission across each of the LCGs throughout Cambridgeshire and Peterborough
4. Ensure that staff in all local agencies coming into contact with people with mental health problems receive appropriate **training**;
5. Address barriers to access to "main stream" mental health services for **marginalised groups**(e.g. ethnic minorities, people with learning disabilities, deaf people, the homeless and travellers);
6. Improve the help offered within the criminal justice system to offenders with mental health problems

NHS

NHS Cambridgeshire and NHS Peterborough

working in partnership

Priority 1: Prompt Access to Effective Help (continued)

7. Ensure a smooth **transition** between age appropriate services when clinically appropriate for people of all ages
8. Improve access to diagnosis and local support for people with the life-long conditions **Autism** and **ADHD**
9. Review **perinatal** pathways so that mothers can promptly access help when needed.
10. Exploit whenever appropriate the opportunities offered by modern **information technology** to widen the range of ways through which people can access effective help
11. Provide information, education and support for people to take control of/manage their own symptoms and the way they are treated
12. Prompt access to an Approved Mental Health Practitioner (AMHP) for people requiring assessment under the Mental Health Act.

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Priority 2: The "Recovery" Model

1. All local services to demonstrably hold hope and belief in "**recovery**" – i.e. the potential of everyone using services to live a meaningful and contributing life;
2. Promote the **social inclusion** of people with mental health problems, including assistance with employment, accommodation, advocacy, etc.
3. Improve support for **Carers**
4. Maximising the **independence** of service users so that they can identify and work towards their personal goals and ambitions, by ensuring that local services embrace the principles of recovery and personalisation, including more flexible person-centred care plans;.
5. **Modern purpose-built facilities** for those requiring in-patient admission

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Priority 2: The "Recovery" Model (continued)

6. Robust **discharge planning** processes
7. Make more use of **peer support** and **volunteers** to facilitate the recovery process.
8. Ensuring there is access to a specialist community-based **forensic** mental health service throughout Cambridgeshire and Peterborough
9. Improved partnership working between primary care, secondary services, and voluntary organisations to strengthen the local response to people who may be at risk of **suicide**
10. Continue to challenge **stigma** in all services and through our mental health promotion activities;
11. Support the development of a Recovery College locally.

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Priority 3 – The Link Between Physical and Mental Health

1. Improve the **physical health** of people with severe and enduring mental health problems
2. Explore the opportunities for psychological therapy and other interventions to improve the health and well-being of people with **long-term conditions** such as diabetes, asthma and chronic pain
3. Introduce **Liaison Psychiatry** Services to local hospitals. Liaison Psychiatry Services (LPS) work at the interface of physical and mental health, addressing the psychiatric and psychological needs of people with physical health problems who are being treated in physical healthcare settings
4. Ensure people with **Dual Diagnosis** promptly receive the help they need for both their mental health and substance misuse problems

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Priority 4 – Improve Our Commissioning Processes

1. Focus on **outcomes** achieved for local service users as our key measure of the effectiveness of the services that we commission;
2. More closely monitor the **quality** of local services, including safety, safeguarding, environment, risk assessment, and especially for those with severe and enduring mental illness
3. Systematically use data from local **Joint Strategic Needs Assessments** to ensure equality of access to the services that we commission
4. Systematically use feedback from the Cambridgeshire **Service User Network** and equivalent forums in Peterborough to determine appropriate outcome measures, as a key measure of service quality, and to help us improve services generally
5. Continue to improve the **quality of data** collected about local services so that this can be reliably used as the basis for future commissioning decision
6. Strengthen our links with local **Carer** groups in order to improve the feedback we receive from them about local services

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Priority 4 – Improve Our Commissioning Processes (continued)

7. Develop a **commissioning framework** for the services provided by local **voluntary organisations**
8. Ensure that the mental health services we commission are **evidence need based** and **value for money**
9. Ensure through our contract management that there is **partnership working** between local service providers (including substance misuse services) in order that service users receive an integrated and seamless service
10. Continue and strengthen the already close working between the respective local commissioners of **health and social care.** 11. Clarify the processes by which local stakeholders can seek to influence the commissioning of local mental health services

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The Comments So Far:-

- Service users and carers recognise the “key themes” especially “recovery focussed” services
- More emphasis on access to appropriate housing;
- Access to services from the criminal justice system
- Even more emphasis on prevention and early intervention
- Joint CCC and PCC OSC sub-committee for mental health recognise the themes and are adding comments
- There are too many priorities and these need to be reduced to a realistic and achievable number for the document to have value

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Feedback Welcome

- Is the document readable and generally understandable?
- Is the format clear?
- Do the priorities cover the things most important to you?
- Have we missed anything major?
- Have we attached too much to something that is actually not quite so important?
- How can we best ensure you have the chance to regularly comment on any issue you have in relation to mental health services as the strategy moves forward?

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Your comments can be forwarded please to our new single point of access for queries about local mental health services:-

C-pct.MHLDCommissioning@nhs.net

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SHADOW HEALTH AND WELLBEING BOARD: MINUTES

Date: 16th January 2013

Time: 1400hrs – 1535hrs

Place: Kreis Viersen Room, Shire Hall, Cambridge

Present: J Bawden (substituting for S Bremner), C Bruin (substituting for A Loades), Councillor M Curtis (from item 72), Councillor S Ellington (Vice-Chairman), M Hewins, Dr N Modha, Dr D Roberts, Dr L Robin, M L Rowe, I Smith substituting for M Bowmer) and Councillor S Tierney

Also Present: M Hill (District Officer Support), A Mays (item 72) and Councillor A G Orgee (item 72)

Apologies: M Bowmer, Councillor N Clarke, A Loades and S Bremner

68. MINUTES & AGREED ACTIONS – 11TH OCTOBER 2012

a) Minutes

The minutes of the meeting held on 11th October 2012 were approved as a correct record and signed by the Chairman subject to the Senior Democratic Services Officer amending, in consultation with the representative from Cambridgeshire LINk, the first bullet of the recommendation in Minute 62. In relation to this recommendation, the Cambridgeshire LINk representative explained that Healthwatch England would establish a national database but it would not be accessible to all parties; local authorities would not be classified as an authorised body for access purposes.

The Vice-Chairman raised concerns regarding a recent Local Government Chronicle article, which appeared to indicate that the Government would restrict local Healthwatch groups from campaigning. The Cambridgeshire LINk representative reported that there had been some concern that this would prevent local Healthwatch groups from campaigning for better local service provision. However, he had recently met with Civil Servants who had confirmed that it was not the intention of the regulation to the Health Act to prevent local Healthwatch groups from campaigning on local changes but they would not be able to campaign politically. The Government would therefore be producing guidance notes to accompany the regulation.

b) Update on Agreed Actions

In considering the list of agreed actions following the last meeting (attached as Appendix 1 to the minutes), the Shadow Board noted that:

- a letter would be sent to the Department of Health (DoH) week beginning 21st January 2013 highlighting the Board's concerns on the late start to the Warm Homes Healthy People bidding process. The Shadow Board was informed that there had been a delay in identifying the best person to write to the DoH.

- actions relating to the Cambridgeshire and Peterborough Road Safety Partnership (CPRSP) would be covered by Agenda Item Number 6.

- Councillor Ellington had agreed to investigate further the funding issues from the District authorities towards core funding of the Cambridgeshire Domestic Abuse and Sexual Violence Partnership Action Plan. Councillor Ellington reported that South Cambridgeshire District Council had supported funding for the Independent Domestic Violence Adviser post but the County Council had secured other funding. The County Council had subsequently asked for the funding to be available for pooled funding to promote activities but it did not have a costed plan. As a result some funding had been used locally for victim support of domestic abuse and agreement had been reached that further funding might be available for specific projects. She also reported that Huntingdonshire District Council had reported that it had never had an ongoing Domestic Violence budget and that funding had been made available on a one-off basis for one year. Huntingdonshire Community Safety Partnership was unlikely to be able to contribute to a pooled promotional fund in future as funding was likely to be cut by at least 50% in 2012/13. She added that Fenland District Council had committed to check what funding had been provided and future availability.

- the Domestic Abuse Partnership Manager had not yet attended the Clinical Commissioning Group's (CCG) Governing Body to gain their financial support. However, the CCG had received data evidence in November regarding the pool, and the Manager was on the CCG agenda to attend a future meeting.

- the partnership business case i.e. evidence that reducing domestic abuse reduced costs for partners, was being prepared. Discussions would take place with partners once preparation work had been completed. The Shadow Board was informed that the Domestic Abuse Partnership Manager had received, as part of the process, responses from the District Forum and other partners.

- the Director of Public Health had discussed further wider communications issues with the communications team. She reported that communication support had been factored into the Business Plan process for 2013/14. The Shadow Board was informed that it would involve engaging some specific input from the County Council's Communications Team solely for the Health and Wellbeing Board; the proposal also included some specific officer support time.

69. REVIEW OF THE YEAR

The Shadow Board received a report detailing a review of its first year. Attention was drawn to the lessons learned, prior to the Board becoming statutory on 1st April 2013. The main focus of the report was on the work of the Shadow Board and its relationship with the Network. It was noted that significant partnership work to address local health and wellbeing needs had also been carried out within district based Local Health Partnerships (LHPs).

The Cabinet Member for Health and Wellbeing reported that before the establishment of the Shadow Board, there had been a complicated road map of organisations working together or in silos. The Shadow Board had tried to join up these organisations, which had taken some time, and there was still some work to do. He

congratulated all those involved on a successful year, which had built a solid foundation for going forward. The District Council representative highlighted the positive links with partners. The CCG representatives reported that they had welcomed the opportunity to work closely with the Shadow Board whilst the CCG had also been in shadow form. Unlike other colleagues in the country, they had been fortunate to have had such a developed Board.

In considering the report, the Board discussed the need to:

- improve communication in order to make it more robust. The Shadow Board acknowledged that communication was critical to prevent good work passing by unnoticed.

- engage key partners and stakeholders.

- provide improved and clear routes for local groups to access and influence the Health and Wellbeing Board. The District Council representative suggested that this could be achieved by allowing non-voting representation from each LHP. These representatives would then be able to present the health needs of each District and highlight the work of each LHP. The CCG representative reported that some of the Districts were already represented by members of the Board. He explained that as a member of the Huntingdonshire LHP, he was already representing Huntingdonshire. He suggested the need to identify those Districts, which did not currently have representation on the Board. The Cabinet Member for Health and Wellbeing reminded the Shadow Board of the need to prevent the membership from becoming unwieldy. It was therefore important to consider all options such as a member of the Board attending each LHP, holding a specific Board meeting with LHP representatives or using co-optees.

It was agreed to:

- note the progress made in developing the Health and Wellbeing Board and Network and delivering key aspects of its workplan.

- consider the key issues raised during learning and development events during the past year and actions being taken to address them.

- ask the Health and Wellbeing Support Group to consider the options for managing the links between the LHPs and the Board.

70. REVIEW OF TERMS OF REFERENCE

The Board considered a report reviewing the Terms of Reference of the Shadow Health and Wellbeing Board and Network before the Board achieved statutory status on 1 April 2013. The Terms of Reference had been amended, in consultation with the County Council's Legal Team, to reflect learning over the last year, the fact that the Board would be a committee of the County Council, and the Government's proposed regulations, which provided that any enactment relating to a committee appointed under section 102 of the 1972 Act did not apply in relation to a Health and Wellbeing Board. As the Board would be a committee of the County Council, the Terms of Reference would need to be considered by the Council's Constitution and Ethics

Committee on 8 March and then Full Council for approval on 26 March to enable them to be included in the Council's Constitution.

In considering the report, the Board discussed the need to:

- amend the membership of the Board to allow for the appointment of two Cabinet Members as opposed to naming specific portfolios.

- review Section 2 on Co-optees. The Shadow Board acknowledged that it might need to co-opt an active member of a political party to a meeting such as the Police and Crime Commissioner. It was suggested that the current wording was therefore counter productive particularly as these members were non voting members. The Senior Democratic Services Officer reported that she would work with the County Council's Monitoring Officer to amend this wording.

- clarify the implications of the Health and Wellbeing Board being a committee of the County Council formed under Section 102 of the Local Government Act. There was concern that the Board's status as a committee of the County Council clashed with point 14.3 on page 5 stating that decisions did not require ratification by Member organisations. The Director of Public Health reminded the Shadow Board that it had always been the Government's explicit policy intention that Health and Wellbeing Boards would, as a forum for collaborative local leadership, be very different to a normal local authority committee appointed under Section 102. Regulations to be laid in January would therefore remove some requirements for Health and Wellbeing Boards appointed under Section 102.

- provide an opportunity for the District Forum and the Officer Group to comment on any proposed amendments. It was noted that the Terms of Reference would need to be approved by Full Council in March before the Board achieved statutory status in April. Any further changes to the Terms of Reference would need to be approved by Full Council at a later meeting.

It was agreed to:

- recommend to the County Council's Constitution and Ethics Committee and Full Council the revised Terms of Reference for the Health and Wellbeing Board subject to the amendments to Section 1 on Membership and Section 2 on Co-optees.

- delegate approval to the Chairman and Director of Public Health to make any further recommendations, for example those arising from changes to Government regulations.

71. APPOINTMENT OF CHAIRMAN

The Board confirmed the appointment of Councillor S Tierney as Chairman of the Shadow Health and Wellbeing Board. Members were reminded that the appointment of the Chairman of the Board, from April 2013, would be determined by full Council.

72. CAMBRIDGESHIRE AND PETERBOROUGH ROAD SAFETY PARTNERSHIP (CPRSP)

The Board welcomed Councillor Tony Orgee, Cabinet Member for Community Infrastructure, to introduce an update on activities for casualty reduction. The report also included the Cambridgeshire and Peterborough Road Safety Partnership's (CPRSP) investigation of new opportunities for data sharing and targeted casualty reduction interventions that where ever possible made a positive contribution to increasing activity and long term health.

The Cabinet Member for Community Infrastructure drew attention to the generally positive situation regarding casualty reduction over the last 20 years. He highlighted the East of England Casualty Trends detailed in Appendix A, which demonstrated a downward trend over a 17 year period. However, he acknowledged the importance of not being complacent and continuing to work to reduce the figures even further. He suggested that the Shadow Board might wish to focus on road casualties on rural roads, which were worse than the national average.

The Safety Manager drew attention to the response detailed in the report to the Board's question regarding holding meetings in public. The Cabinet Member for Community Infrastructure stressed that the current arrangement would be kept under review. The Chairman queried whether at least one meeting could be held in public. The Cabinet Member agreed to take this request back to the CPSRP. In conclusion, the Safety Manager highlighted the next steps for the Partnership.

In considering the report, the Board discussed the need to:

- review why casualty figures for men aged over 65 years had increased by 17%. The Safety Manager reported that there was a certain amount of random variation in the figures but acknowledged the need for continued monitoring. The Cabinet Member for Community Infrastructure suggested that there was a need to provide a breakdown of the age range over 65 years. The CCG representative highlighted the need to identify whether the increase was health related e.g. memories failing etc.

- integrate the planned review of the CRSRP planned for April with the work to develop Action Plans for the Health and Wellbeing Strategy.

- review what speed reduction measures had worked in relation to reducing casualties. The Cabinet Member for Community Infrastructure reported that data was available before and after the introduction of highway schemes. One representative highlighted the impact of 30mph countdown signs and suggested the need to place them further back to prevent the need for braking. The Safety Manager added that the Joint Casualty Data Report would include more information about the impact of these signs. One Member commented that there had been a lot debate about reducing vehicle speeds in urban areas. However, the majority of major casualties occurred on rural roads with a national speed limit. Casualty rates were higher in urban areas but the severity of casualties in rural areas was much higher.

- consider the unforeseen consequences of speed reduction measures such as introducing speed humps. The Chairman highlighted the importance of building a broad evidence base.

- receive a map of the County detailing accident 'hot spots'.

- encourage Public Health to continue to work together with the County Council's Road Safety Team. The Director of Public Health reported that the Public Health data base was used by the Road Safety Team.

73. THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY ACTION PLAN

The Board considered an update on progress with the Action Plan for the Cambridgeshire Health and Wellbeing Strategy. Members were reminded of the six priorities contained in the Strategy. Five workstreams had been set up to produce partnership action plans for the first five priorities. All workstreams would incorporate Priority 6 – work together effectively. Each workstream included multi-agency representation led by a senior officer.

Initially each workstream had identified strategies and action plans already in place to see whether they could add value. It was expected that this process would lead to efficiencies and better outcomes. They had also identified a small number of new short to medium term actions, which reflected the key focus areas of Priority 6. Attention was drawn to further work needed to develop the Action Plan. It was noted that this work should be achievable within available resources. A long term strategy would be presented to the Board at its April meeting.

Representatives on the Board commended the Director of Public Health and all those involved in the action planning for this work. The Chairman commented that Health and Wellbeing was an enormous subject. The Board had tried to avoid making impossible promises instead it had been quietly aspirational. He welcomed the good start which had been made to achieve strategy objectives.

During discussion, the Board identified the need to:

- plan beyond one year. The CCG representative reported that he would take the report back to the CCG Governing Body for discussion.

- bear in mind the scale of the work involved. The District Council representative suggested that the Action Plan was too big to monitor and review at one meeting. She therefore proposed that a 'theme' be taken to each meeting to give the Board space and time to focus in more detail and depth on just one or two priorities. There was also a need for a co-ordinator post to support the delivery of the action plan. The Director of Public Health reminded the Board that officer time had been identified in the business planning process to support this process.

- learn and take on board the views of local communities. The Cambridgeshire LINk representative queried whether some thought had been given to this in relation to the first two priorities. He suggested the development of a metrics to enable the Board to move forward positively with communities.

- demonstrate progress over time intervals by translating the high level plan into meaningful action. The Service Director: Adult Social Care suggested that any metrics should fit with each local environment as the vehicle to achieve results could be different. She also queried where the LHP would be involved.

It was agreed to:

- note the progress being made in action planning for the Cambridgeshire Health and Wellbeing Strategy, and acknowledge the work and leadership contributed by a range of partner agencies.

- approve the initial Health and Wellbeing Action Plan attached at Appendix A as moving in the right direction, recognising that further work needed to be done as outlined in paragraph 3.3 of the report.

74. CAMBRIDGESHIRE COMMISSIONING GROUP (CCG) AND COMMISSIONING INTENTIONS

a) CCGs Commissioning Intentions

The Board received a presentation (**Appendix 2**) on Cambridgeshire and Peterborough Clinical Commissioning Group's plans from Dr Neil Modha and Dr David Roberts. Members were informed that the CCG would be informing providers of the need to live within our means, and the challenge to providers would be to stop wasting money.

During discussion, the Board identified the need to:

- bear in mind that the CCG covered both Cambridgeshire and Peterborough.

- support Proposed Indicator One – The reduction of the inappropriate use of in emergency bed days by the over 65s. The Service Director: Adult Social Care highlighted the importance of understanding the interaction between this indicator and the indicator relating to Emergency readmissions following 30 days of discharge. It was important to investigate why older people were going back to hospital. Dr Modha reported that the 30 day readmission was in the standard contract and was already an area of focus. Dr Roberts added that there was a lower tariff for readmissions, which would be even lower next year. The next CCG Board would be considering what to spend its money on so there was therefore an incentive to get this area right.

- understand in relation to Proposed Indicator One the different performance of each geographical area.

- understand whether patients were being damaged by the need to meet targets. Members noted that the targets in relation to Proposed Indictor One reflected the number of days patients spent on a ward. There was concern that releasing patients too early could result in their early readmission at a later stage. Dr Roberts reported that there tended to be a generational view that when people were ill they needed to be hospital, which sometimes resulted in them staying longer than was actually good for them. He explained that it was not good in relation to core outcomes for some patients to be immobile in

hospital waiting for days for something to happen. It was therefore important for hospitals to make things happen quicker, which might result in the shortening of emergency bed days.

- consider ways to stop older people going into hospital. It was noted that Mid Bedfordshire GPs by visiting residential homes had reduced admissions by 80%. It was important therefore to take an holistic view of health.

- consider whether identifying three priorities, which related solely to one cohort was the best way forward - for example it might be appropriate to have priorities which focus on different age groups.

- tackle the need to explain the priority on emergency bed days in a way the public would understand.

The CCG representatives reported that they would take away the Board's comments. Discussions on the three local outcomes would be taking place with the National Commissioning Board Local Team on 25 January 2013. It was noted that the CCG would need to consider how it planned to communicate its launch from shadow to statutory status. It would also need to consider how it could launch its priorities in a way the public could understand.

b) <u>NHS Commissioning Board Update</u>

The Shadow Board was informed that the National Commissioning Board Area Team was almost complete. It was noted that recruitment would end in February. The NHS Commissioning Board representative reminded the Shadow Board that emergency planning was one of the NHSCB priorities. She reported that a Director of the NHSCB Area Team would be co-chair of the Local Health Resilience Partnership for Cambridgeshire and Peterborough, together with a local Director of Public Health. It was noted that there would be a substantive Health and Wellbeing Board member from the NHSCB area team operational for April.

75. FORWARD AGENDA PLAN

The Board agreed its current forward agenda plan subject to the following amendment:

- the addition of an agenda item to ask the LHPs to provide the Board with update reports on their activities.

76. DATE OF NEXT MEETING

The Board noted that the next meeting would take place on Tuesday, 16th April 2013, 1400hrs – 1600hrs in the Kreis Viersen Room, Shire Hall, Cambridge.

Chairman

Appendix 1

AGREED ACTIONS

Minute 68 (a)

- **Senior Democratic Services Officer** to liaise with the Cambridgeshire LINk representative to amend the first bullet of the recommendation in Minute 62 to ensure it accurately reflected the current situation.

Minute 68 (b)

- **Service Director: Adult Social Care** to ensure that the Department of Health received a letter highlighting the Board's concerns on the late start to the Warm Homes Healthy People bidding process.

- **Domestic Abuse Partnership Manager** to attend the Clinical Commissioning Group's (CCG) Governing Body to gain its financial support for the pooled budget to fund actions identified in the Domestic Abuse and Sexual Violence Partnership Action Plan.

- **Service Director: Adult Social Care** to ensure that discussions take place with partners once preparation of the partnership business case for reducing domestic abuse had been completed.

Minute 69

- **Director of Public Health** to ask the Health and Wellbeing Support Group to consider the options for managing the links between the Local Health Partnerships and the Board.

Minute 70

- **Senior Democratic Services Officer** to amend the Terms of Reference for consideration by the Council's Constitution and Ethics Committee and approval by Full Council. The Chairman and Director of Public Health to make further recommendations arising from changes to Government regulations.

Minute 72

- **Cabinet Member for Community Infrastructure** to ask the CPSRP whether at least one meeting could be held in public.
- **Road Safety Manager** to provide Board members with a map of the County detailing the accident 'hot spots'.

Minute 75

- **Director of Public Health** to ask the LHPs to provide the Board with update reports on their activities.

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Shadow Health and Wellbeing Board Forward Agenda Plan **Agenda Item No. 9**

MEETING DATE	ITEM	REPORT AUTHOR	DEADLINE
Tuesday, 16 April 2013	Cambridgeshire Health and Wellbeing Strategy: Action Plan	Director of Public Health	Thursday 28 March 2013
	Cambridgeshire Domestic Violence Business Case	Executive Director - Children and Young People's Services and Adult Social Care	
	Joint Strategic Needs Assessment Phase 7	Director of Public Health	
	Safer Homes Scheme	Trish Read	
	Ageing Well Programme – Report from Local Health Partnerships	Service Director: Adult Social Care	
	The Role of the Area Director of the NHS Commissioning Board	S Bremner Interim Local Area Director, NHS Commissioning Board	
	How the Board can best work with the Police and Crime Commissioner – Action Plan		
	Terms of Reference (as approved by full Council) and Election of Vice-Chairman		

MEETING DATE	ITEM	REPORT AUTHOR	DEADLINE
Thursday, 11 July 2013 Stakeholder Event			Wednesday, 26 June 2013
Thursday, 17 October 2013			Wednesday, 2 October 2013
Thursday, 23 January 2014			Wednesday, 8 January 2014
Thursday. 3 April 2014			Wednesday, 19 March 2014

03 January 2013

Cambridgeshire & Peterborough Clinical Commissioning Group - Our developing plans

Dr Neil Modha & Dr David Roberts

A brief update

- One clinical commissioning group (CCG) for Cambridgeshire & Peterborough
- Federation of eight local commissioning groups (LCGs)
- Delegated budgets for local decision making with central accountability and robust governance
- Awaiting 'authorisation' from National Commissioning Board
- CCGs take on full responsibilities from April 2013.

Our work so far

- Operating in Shadow Form since April 2012.
- Establishing our Governing Body. Clinical Accountable Officer plus eight GPs, secondary care doctor, three lay members and executive directors
- Recruiting to new structures
- Building relationships with partners & communities
- Developing our vision and values
- Developing our medium-long term plans.

The context in which we work

- 2013/14 allocations: £854 m
- Population: 831,000 (based on ONS figs, not registered)
- Challenged provider landscape
- A growing and ageing population with health inequalities
- An efficiency plan in 2013/14 of £30m.

Our priorities 13/14

- Clinically led
- Focused to ensure maximum success
- Based on the needs of our communities
- Based on the context in which we work and on JSNAs
- Programme Boards established to ensure good governance and progress
- Plans submitted to National Commissioning Board end March.

We will work with partners to build a system of care that meets the needs of our community by:

- Focussing on driving improvements in our clinical priority areas
- Focusing on outcomes from the Outcomes Framework
- Working at LCG level with districts and local stakeholders
- Improving services for frail older people
- Improving care for those towards the end of their life
- Improving care for those with coronary heart disease

We will focus on what is important to our patients by:

- Ensuring their NHS Constitutional rights and pledges are protected
- Improving co-ordination of care through closer working with our valued partners
- Providing friendly, caring, quality services to all our patients and carers
- Responding to complaints and compliments in appropriate manner and timescales

We will strengthen our organisation to be the best at what we do by:

- Driving change at a local level to respond to individual community needs
- Working to remove inefficiencies that cause delay and incur unnecessary cost
- Delivering and measuring at all levels to ensure consistent high quality service provision
- Identify and promote innovation that enhances quality of services through our participation in Health research networks .

Next steps: working with HWBs to select three local outcomes- 1st draft 25 Jan

- The NHS Commissioning Board guidance provided on 21 December requested CCGs select three local outcomes where visible improvement can be measured in 13/14

These outcomes must be:

- Agreed with NHS CB after consideration with Health and Well Being Boards and key stakeholders
- Focussed on local issues and priorities, especially where the outcomes are poor compared to others
- In areas where improvement will reduce health inequalities
- Based on robust data

We are asking for you views on which outcomes to propose to CCG Governing Body and then to the NHS CB, fitting in with overall direction

Proposed indicator one

We would like to reduce the inappropriate use of in emergency bed days by the over 65s from the current baseline rate shown below & measuring patient experience

LCG	Baseline 2012/13 Forecast	2013/14 Target Month
[redacted]	[redacted]	[redacted]

The target is based on achieving top Quartile performance levels

Remaining two indicators

To help create a shortlist for discussion we have applied the following criteria

- What outcomes have been selected in Health and Well Being Board strategies?
- What outcomes have been selected by the CCG?
- What outcomes meet the NHS CB criteria?
  (1) Poor outcomes compared to others
  (2) Will reduce health inequalities
  (3) Robust data exists
- Do we have ideas or projects that would deliver the improvements in these areas?

This has enabled us to develop a shortlist; the full CCG Outcomes Indicator list is also available for you to review

Shortlist

Indicator	Rationale
Emergency re admissions following 30 days of discharge	• Aligned to commissioning intentions • Aligned to HWBB strategies • Currently performance shows deterioration year on year
Maternal smoking at time of delivery	• Aligned to HWBB strategies
Dementia diagnosis rates	• Aligned to commissioning intentions • Aligned to HWBB strategies • Current performance shows the PCT in the bottom half of all PCTs nationally
Stroke care plans	• Aligned to commissioning intentions • Aligned to HWBB strategies • Draft projects exist to improve performance
Antenatal assessment	• Aligned to HWBB strategies
Emergency admissions for alcohol related liver disease	• Aligned to commissioning intentions • Aligned to HWBB strategies • Draft projects exist to improve performance
Primary Prevention of Cardiovascular Disease	• Aligned to commissioning intentions • Aligned to HWBB strategies

Emergency readmission

What the metric covers:

Percentage of emergency admissions to any hospital in England occurring within 30 days of the last, previous discharge from hospital after admission; indirectly standardised by age, sex, method of admission and diagnosis / procedure. Admissions for cancer and obstetrics are excluded.

How have we performed?

In absolute terms, the level of emergency re admissions is increasing

Fin Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2011/ 2012	877	759	880	860	881	853	926	883	940	926	852	981
2012/ 2013	848	910	918	1,002	921	881	878	928				

13

Maternal smoking at delivery

What the metric covers:

This indicator measures a key component of high-quality care as defined in NICE clinical guideline, the smoking status at time of delivery.

How have we performed?

In NHS Cambridgeshire, data for Quarter 1 showed that 13.7% of women smoked at the time of delivery which we would like to reduce to 11.6%

In NHS Peterborough, data for Quarter 1 showed that 16.6% of women smoked at the time of delivery.

	2011/12 - Q1	2011/12 - Q2	2011/12 - Q3	2011/12 - Q4	2012/13 - Q1	2012/13 - Q2
NHSC	9.5%	Not available	14.5%	14.6%	13.7%	13.3%
NHSP	16.9%	16.5%	17.3%	16.6%	17.4%	17.7%

14

Dementia diagnosis rates

What the metric covers:

This indicator measures the number of people on the dementia register for England in the Quality and Outcomes Framework (QOF) against estimated prevalence.

Estimated diagnosis rate for people with dementia (NHS OF 2.6i)	2011		
	Number of patients with a diagnosis of dementia (based on QoF register)	Number of people estimated to have dementia (diagnosis and undiagnosed)	Best-worse overall ranking (1 = highest UK ranking, 176 = lowest)
NHSC	2959	7544	116
NHSP	671	1758	131

15

Antenatal assessment

What the metric covers:

Number of women in the relevant CCG population who have seen a midwife or a maternity healthcare professional for health and social care assessment of needs, risks and choices by 12 weeks and 6 days of pregnancy.

How have we performed?

	Q1	Q2	Q3	Q4
2010/11	87.7%	88%	88.1%	89.1%
2012/13	89.7%	93.8%	TBC	TBC

The above table shows performance against a target of 93.2%

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Primary Prevention of Cardiovascular disease

What the metric covers:

The percentage of patients who have been newly diagnosed with hypertension who have had their cardiovascular disease risk assessed

And

The percentage of patients with hypertension who have had advice about increasing physical activity, smoking cessation, safe alcohol consumption and healthy diet in the last 15 months

primary prevention acts here

Person has no increased risk of heart disease

Person has increased of heart disease but no disease yet

secondary prevention acts here

Person has heart disease

Primary prevention prevents twice as many deaths as secondary prevention

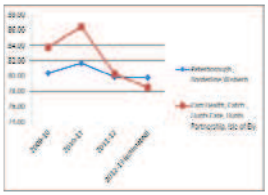
17

Primary Prevention of Cardiovascular disease

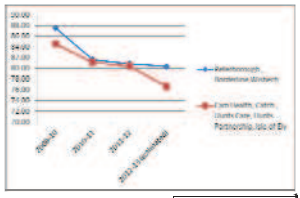
How have we performed?

The level of primary prevention of cardiovascular disease is falling

PP1 2009-2013



PP2 2009-2013



Data from Primary Care Improvement Team, analysis Improving Outcomes Team

18

Primary Prevention of Cardiovascular disease

Proposed measure:

Improve to 90% on both PP1 and PP2

Opportunity for joint work across the system:

- Local Authorities: increasing physical activity, smoking cessation, safe alcohol consumption and healthy diet.
- Primary care :Identification and advice

Reducing inequalities in premature deaths from coronary heart disease is an interim strategic priority of the CCG

19

Process

Jan – Feb Discussions on developing priorities with:

- Health & Wellbeing Boards
- Scrutiny Committees
- LINKs
- District councils
- Patient Reference Group
- Local Patient Groups
- Members/LCG Boards

Timing is tight so meeting all we can, sharing with others

Thoughts?

Appendix A: Cambridgeshire Health and Wellbeing Strategy: Initial Action Plan

Priorities 1-5: Focus Areas	Priority 6: work together more effectively - Initial actions	Lead partnership/ post	Timescale
Priority 1:Ensure a positive start to life for children, young people and their families			
Strengthen our multi-agency approach to identifying children who are in poverty, who have physical or learning disabilities or mental health needs, or whose parents are experiencing physical or mental health problems.	Within Early Support (joint commissioning across children services and health for 0-5 year olds with acute needs), further develop multi-agency coordinated person centred, needs led planning with performance monitoring and review.	Jo Sharman	October 2013
1.2 Develop integrated services across education, health, social care and the voluntary sector which focus on the needs of the child in the community, including the growing numbers of children with the most complex needs, and where appropriate ensure an effective transition to adult services.	Build understanding, awareness and agreement for a joint commissioning unit across County Council children's services and the Clinical Commissioning Group, To include: agreed strategic framework for children's health services and agreement of operating and governance model by April 2013.	Eva Alexandratou	April 2013
1.3 Support positive and resilient parenting, particularly for families in challenging situations, to develop emotional and social skills for children.	Work across the public sector to deliver the Troubled Families ambition of reducing significant absenteeism, antisocial behaviour and worklessness in the identified families for the TF cohort.	Sarah Ferguson	October 2014 (Oct 2013 mid point with first evaluative report)
1.4 Create and strengthen positive opportunities for young people to contribute to the community and raise their self esteem, and enable them to shape the programmes and services with which they engage.	Work with the Young Lives consortium to increase citizenship and volunteering opportunities through the National Citizenship Service. Improve take up of 16-19 apprenticeships across the County	Steve White Andy Sanders	October 2013
1.5 Recognise the impact of education on health and wellbeing and work to narrow local gaps in educational attainment	Deliver a fully funded place for every 2 year old from a vulnerable or deprived family who wants one	Graham Arnold	Sept 2013
Priority 2: Support older people to be independent safe and well			
2.1 Promote preventative interventions which reduce unnecessary hospital admissions for people with long term conditions, enable them to live independently at home or in a community setting where appropriate and improve their health and wellbeing outcomes e.g. through falls prevention, stroke and cardiac rehabilitation, supporting voluntary organisations and informal carers.	Work across agencies to maximise impact of piloted preventive projects: Community navigators GP information officers Multi-disciplinary team case-workers. Set up a task and finish group to map the current remit of these programmes and to share robust evaluation.	HWB Priority 2 steering group	February 2013

2.2 Integrate services for frail older people and ensure that we have strong community health, housing, voluntary support and social care services tailored to the needs of older people, which enable them to improve their quality of life and minimize the need for long stays in hospitals, care homes or other institutional care. 2.3 Enhance services for the early prevention, intervention and treatment of mental health problems in older people, including timely diagnosis and joined up services for the care and support of older people with dementia and their carers.	**Strategic leadership to develop and realise a whole system shift to preventative, integrated approaches**, through, for example: • Integrated pathways wrapped around the whole person/family • Multi-disciplinary teams • Personal health budgets for people with long term conditions • Integrated communications and information • Joint commissioning of key voluntary sector services • More effective hospital discharge processes, especially involving housing providers • Quantify the need for intermediate care beds, to enable hospital discharge and some support, before person returns home full-time	CCG led Older people's programme Board	Ongoing
2.4 Ensure appropriate and person-centred end of life care for residents and their families and informal carers.	13. Work with local partners to ensure effective information, support and services for end of life care	CCG led End of Life Programme Board	Ongoing
Priority 3: Encourage healthy lifestyles and behaviours in all actions and activities while respecting people's personal choices			
3.1 Encourage individuals and communities to get involved and take more responsibility for their health and wellbeing.	Develop the Making Every Contact Count behavioural change strategy, focussing on services where a commitment has already been made to staff training and supportive organisational policy changes Increase the integration of organisations that provide information, support, and signpost or refer individuals and communities to make behavioural changes. Projects such as Health Trainers, Community Hubs and Community Navigators provide similar services which could be enhanced through collaborative cost-effective commissioning arrangements that would avoid duplication and ensure that patients/clients receive the most appropriate services to meet their needs. Immediate focus on establishing pathways and referral systems across the different initiatives	Val Thomas	March 2013 March 2013 (Pathways and Referral systems)

3.2 Increase participation in sport and physical activity, and encourage a healthy diet, to reduce the rate of development of long-term conditions, increase the proportion of older people who are active and retain their independence, and increase the proportion of adults and children with a healthy weight.	Making Every Contact Count applies in terms of behavioural change training and supportive organisational policy change in relation to physical activity, healthy eating, embedding into children and family services and long term condition pathways and initiatives that support older people's independence Establish a countywide physical activity strategy that encompasses existing strategies and plans and ensures that physical activity is embedded into the planning process	Countywide Obesity Strategy Group	March 2014 September 2013
3.3 Reduce the numbers of people who smoke.	Making every contact count behavioural change strategy applies.	Ellen Nicholson	September 2013
3.4 Promote individual and community mental health and wellbeing, prevent mental illness and reduce stigma and discrimination against those with mental health problems.	Making Every Contact Count behavioural change strategy applies Develop suicide prevention strategy for the county, building on the national strategy	Claire Hodgson Sara Godward	March 2013
3.5 Work with local partners to prevent hazardous and harmful alcohol consumption and drug misuse.	Strengthen the current Alcohol Identification and Brief Advice behavioural change intervention for alcohol in appropriate service contracts e.g. sexual health services	Drug and Alcohol Commissioning Group	June 2013
Promote sexual health, reduce teenage pregnancy rates and improve outcomes for teenage parents and their children.	Making every contact count behavioural change strategy applies. Target initiatives on vulnerable young people and adults	County Sexual Health Network	September 2013
Priority 4: Create a safe environment and help to build strong communities, wellbeing and mental health			
4.1 Implement early interventions and accessible, appropriate services to support mental health, particularly for people in deprived areas and in vulnerable or marginalized groups.	Explore further integrating mental health commissioning and service provision with the community safety and criminal justice services to reduce service gaps/grey areas where vulnerable people may become inappropriately criminalised. Early dialogue with Community Safety Partnerships and the Police Commissioner.	District Community Safety Partnerships, CCG Mental Health Commissioning Group, working with Police and Crime Commissioner	June 2013
4.2 Work with partners to prevent domestic violence, raise public awareness especially amongst vulnerable groups, and provide appropriate support and services for victims of domestic abuse.	Develop the current Domestic Abuse and Sexual Violence action plan further to use available resources effectively to minimise the risk; reduce the rate of repeat domestic violence/abuse in Cambs.	Cambridgeshire Domestic Violence Partnership	April 2013

4.3 Minimise the negative impacts of alcohol and illegal drugs and associated antisocial behaviour on individual and community health and wellbeing. Linked to 3.5	Establish use of Alcohol Screening tool for young people accessing appropriate services e.g. sexual health services [as in 3.5 above]	DAAT	June 2013
4.4 Work with local partners to prevent and tackle homelessness and address the effects of changes in housing and welfare benefits on vulnerable groups.	Continue to assess the impact of welfare reforms on vulnerable groups/individuals and where necessary/appropriate devise interventions to minimise negative impacts.	CPSB	Ongoing
Priority 5: Create a sustainable environment in which communities can flourish			
5.1 Develop and maintain effective, accessible and affordable transport links and networks, within and between communities, which ensure access to services and amenities and reduce road traffic accidents.	Explore potential for better co-ordination of service provision by the health sector, local authorities and transport providers by bringing stakeholders together. Change approach to stakeholder involvement in the Road Safety Partnership and Strategy, to create improved community support and involvement.	Priority 5 task group CPRSP	Ongoing
5.2 Ensure that housing, land use planning and development strategies for new and existing communities consider the health and wellbeing impacts for residents in the short and long term	Focus on embedding health and the prevention of health in the planning process. Provide a local countywide event to focus on this issue with planners and also to bring in new health organisations.	Priority 5 task group	September 2013
5.3 Encourage the use of green, open spaces including public rights of way, and activities such as walking and cycling	Greater Cambridgeshire Local Nature Partnership to be launched January 10 2013. Ensure linkage with Health and Wellbeing Strategy from the start.	GCLNP	January 2013
5.4 Seek the views of local people and build on the strengths of local communities, including the local voluntary sector, to enhance social cohesion, and promote social inclusion of marginalised groups and individuals.	We need to plan in discussions with voluntary sector and local community representatives regarding the implementation of the Health & Wellbeing Strategy and the working of the Health & Wellbeing Network. Voluntary and community sector representatives to be invited to stakeholder planning events for the Strategy and Action Plan.	Health and wellbeing support group	February 2013

Cambridge Local Health Partnership

7 February 2013

Contributing to the Cambridgeshire Health and Wellbeing Strategy Action Plan

1. Members are asked to:

1. Agree to the holding of a workshop in the near future to identify how we can work more effectively together across each of the priority areas in the health and wellbeing strategy and to firm-up the Partnerships own actions and contribution to the Health and Wellbeing Strategy.

2. Convene a small working group to prepare for the workshop and lead its delivery.

2. Background

2.1 We, as a partnership ("the Partnership"), have agreed terms of reference setting out a vision for what we want to achieve for the citizens of Cambridge and started to define some short-term work we can progress. We also identified a number of issues for Cambridge, based on local evidence and practice, when responding to the consultation about the draft Health and Wellbeing Strategy ("the strategy"). This strategy has now been adopted and actions are being developed to for its priority areas.

2.2 We are now being asked to identify the actions we will as a partnership be taking forward to support the strategy. One important principle that we chose to adopt at an early point was to avoid duplication of effort and to add value, where we can, with any actions we choose to take forward. We have also said we want to focus on a limited number of actions where we can as apartnership, make a difference.

3. The six priorities in the strategy

3.1 The Strategy identified the following six priorities for health and wellbeing in Cambridgeshire:

Priority 1:	Ensure a positive start to life for children and young people
Priority 2:	Support older people to be independent, safe and well
Priority 3:	Encourage healthy lifestyles and behaviours in all actions and activities, while respecting people's personal choices
Priority 4:	Create a safe environment and help to build strong communities, wellbeing and mental health
Priority 5:	Create a sustainable environment in which communities can flourish
Priority 6:	Work together effectively

Each priority is underpinned by more detailed areas of focus, and the full strategy is available on www.cambridgeshire.gov.uk/hwb

4. Short-term work of the Partnership

4.1 The short-term work of the Partnership to date has covered:

1. Improving the flow of information and the quality of communication between local GP's and local Housing Officers, so that people presenting can receive a service appropriate to their needs.
2. Keeping an eye on local provision for mental health services, taking into account work carried out by the county Adults Wellbeing and Health Overview and Scrutiny Committee, and to help improve local service delivery.
3. Looking at how the "Aging Well" initiative, including Community Navigators, can be best supported in Cambridge, taking advantage of the existing networks and support available.

5. County-wide Workstreams

5.1 Five county-wide workstreams have been set up to produce partnership action plans for the first five priorities in the strategy. All workstreams incorporate Priority 6 – work together effectively: Each workstream includes multi-agency representation, and the senior officer lead for each workstream is as follows:

Priority 1: Hannah Woodhouse, Service Director - Strategy and Commissioning, Children & Young People's Services, Cambridgeshire County Council

Priority 2: Matthew Smith, Assistant Director - Improving Outcomes, Cambridgeshire and Peterborough Clinical Commissioning Group.

Priority 3: Val Thomas, Public Health Consultant - Health Improvement, NHS Cambridgeshire/Cambridgeshire County Council.

Priority 4: Sue Lammin, Head of Environmental and Community Health Services, Huntingdonshire District Council

Priority 5: Gary Garford, Corporate Director, Fenland District Council.

5.2 The Health and Wellbeing Support Group acts as a reference group for the overall action plan.

6. Developing longer-term county-wide actions to support the strategy

6.1 For the January 2013 meeting of the shadow Health and Wellbeing Board, each workstream produced:

1. A list of multi-agency strategies and action plans that are already in place, which will contribute to the HWB strategic priorities and focus areas.
2. A small number of new short to medium term actions, which reflect the key focus areas of Priority 6 'Working together effectively'. The focus areas for Priority 6 are:

    - Commit to partnership working, joint commissioning, and combining resources in new ways to maximise cost-effectiveness and health and wellbeing benefits for individuals and communities.
    - Identify sustainable, long-term solutions to manage the increased demand on health and social care services.
    - Encourage increased partnership working with research organisations to better inform the evidence base supporting the development and evaluation of services.
    - Encourage increased involvement of service user representatives and local groups in planning services and policies.

- Recognise the importance of the Voluntary and Community sector and their valuable contribution to implementing the Strategy.

6.2 A summary of this work is presented in **Appendix A** 'Initial Health and Wellbeing Action Plan'.

7. Firming up the Partnership's contributions

7.1 Whilst we are pursuing some short-term work as a partnership we will need to set out how we will contribute to the strategy and the actions we will look to achieve over the longer-term (3 years).

7.2 The Summary JSNA 2012 report, that accompanied the developing Health and Well-being Strategy, identified the following issues for Cambridge:

- Local inequalities in health, Mental health needs,
- Homeless people and maintaining a focus on prevention,
- Alcohol related harm,
- Smoking,
- Lack of physical activity and obesity.

7.3 Our own individual business plans will also set out priorities, which each organisation could share and then work together to progress if there is an agreed common purpose. The Partnership can look at each issue for Cambridge in more depth at its meetings, including them in its Forward Plan, but it may take a while for a longer-term action plan to emerge this way.

7.4 It is recommended that the Partnership convene a workshop in the near future to identify how we can work more effectively together across each of the priority areas in the strategy and to firm-up the Partnerships own actions and contribution. This workshop could be a half-day or early evening event.

healthwatch Cambridgeshire

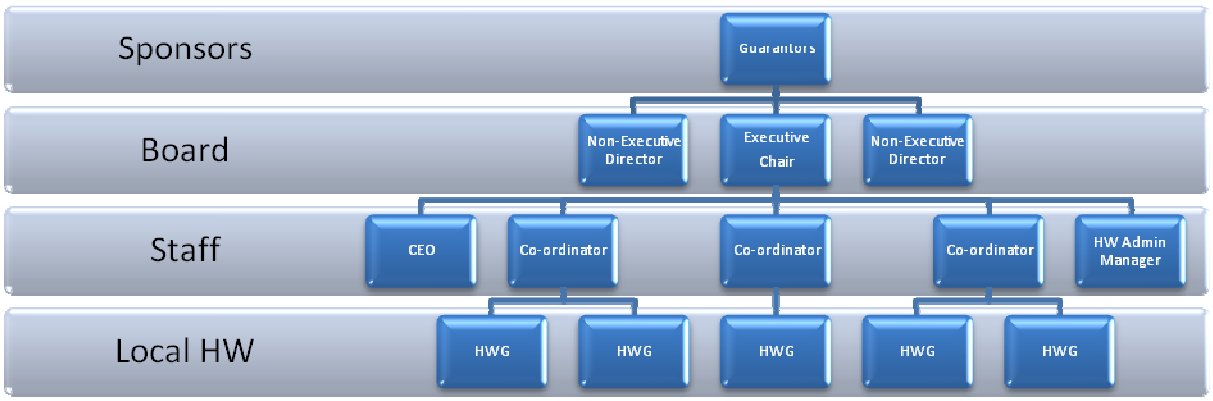
Background

The Local Government and Public Involvement in Health Act 2007 introduced a way for individuals and communities to become involved in the planning, commissioning, and delivery of health and social care. This role has been provided since 2008 through a service known as the Local Involvement Network (LINk).

Building on LINks, the Health and Social Care Act 2012 creates Healthwatch as the new independent consumer champion for health, public health and social care. Each top tier Local Authority is required to establish a local Healthwatch by 01 April 2013. Until then LINks will continue to operate as usual. It will exist in two distinct forms – at a local level as Healthwatch Cambridgeshire, and as Healthwatch England at national level. Healthwatch England was established on 01 October 2012.

Healthwatch Cambridgeshire will give citizens and communities a stronger voice to influence and challenge how health and social care services are provided within their locality. It will be the local consumer voice for the whole county including children and young people, working age adults, parents, older people and people with disabilities on health, public health and social care issues. It will also provide a voice for out of area users of health, public health and social care, for example tertiary hospitals and care homes. Healthwatch Cambridgeshire will support health, public health and social care services by working with and listening to local people, their views and experiences of using services. It will build on the work already done by Cambridgeshire LINk and can have additional functions and powers – providing or signposting people to information to help them make choices about health and care services.

The local Healthwatch will be an independent organisation, able to employ its own staff and involve volunteers, so it can become the influential and effective voice of the public. It will have to keep accounts and make its annual reports available to the public. In Cambridgeshire, this will be set up as a Company Limited by Guarantee (CLG) with the indicative governance structure.



The National Requirements for a Local Healthwatch

Department of Health guidance states that a Local Healthwatch will:

- Have a seat on the statutory Health and Wellbeing Board, ensuring that the views and experiences of patients, carers and other service users are taken into account when local needs assessments and strategies are prepared, such as the Joint Strategic Needs Assessment (JSNA)
- Enable people to share their views and concerns about their local health and social care services and understand that their contribution will help build a picture of where services are doing well and where they can be improved
- Be able to alert Healthwatch England or Care Quality Commission (CQC) where appropriate, to concerns about specific care providers, health or social care matters
- Provide people with information about their choices and what to do when things go wrong
- Sign-post people to information about local health and care services and how to access them
- Give authoritative, evidence-based feedback to organisations responsible for commissioning or delivering local health and social care services
- It may help and support Clinical Commissioning Groups (CCGs) to make sure that services really are designed to meet citizens' needs
- Be inclusive and reflect the diversity of the community it serves. (It is an explicit requirement of the Health and Social Care Act 2012 that membership is representative of local people and of different users of services, including carers and hard to reach groups from across the whole County.)

Cambridgeshire Healthwatch Vision

In fulfilling the national requirements we require Healthwatch Cambridgeshire to:

- Be representative of the local community it serves
- Engage and represent the community it serves with particular emphasis on seldom heard groups
- Engage with commissioners (including Local Commissioning Groups and Clinical Commissioning Groups), providers and communities when changes to service provisions are planned or public health issues addressed
- Carry out visits, to enter, view and observe health and social care activities in order to assess the nature and quality of services and obtain the views of people using those services
- Work closely with the County Council Adults Wellbeing and Health Overview and Scrutiny Committee and Children and Young People Overview and Scrutiny Committee, to share intelligence, work plans and refer issues when appropriate
- Be accountable to the Council for its performance and its use of public funds

Healthwatch will need to demonstrate that:

- It has an open and transparent recognised structure for making decisions and enabling local people to influence what it does (e.g. internal processes, work prioritisation, recommendations, impact analysis) and acts in accordance with the Nolan principles of standards in public life.
- It has good governance and management arrangements in place including processes to maintain robust accounts of how it has used its funds.
- It can demonstrate accountability to the local community for the way it takes decisions through adoption and use of good governance principles including transparency, independence and lay leadership.
- It has a strong volunteering culture, values people and skills and has a set of competencies that enables it to deliver its statutory roles

Healthwatch Cambridgeshire will be:

- **Independent** - people tell us that it is important that Healthwatch Cambridgeshire must be seen as being independent from the County Council and health, public health and social care services and will be a free-standing body which is respected for its independence and trusted by residents and stakeholders.
- **Clearly recognised** – a body with a clear identity which is strong and distinctive from existing local organisations. It will embrace and utilise the Healthwatch brand and identity developed at national level.
- **Credible** – local people, commissioners and partners are able to trust the reliability of information, the ability to influence and the evidence underpinning its work
- **User-focused** – relentlessly championing the voice of the patient and service user in the health and social care system
- **Inclusive** – an organisation which finds ways to work with the many different patient and service user representative groups across Cambridgeshire
- **Well-connected** – able to signpost people to good quality information to help them make choices about health and social care; with access to established networks to gather comprehensive patient and service user views.
- **Evidence based** – a body which uses evidence to underpin its priorities and target its efforts
- **Competent** – an organisation that can demonstrate the relevant skills and competencies required to deliver its functions including new technologies
- **Influential** – able to make an impact on the local commissioning of health and social care; complement other inspection regimes; and support patients and residents with signposting to information about the quality of local health services
- **Flexible** – an organisation which can work in partnership with key decision-makers (including Cambridgeshire County Council, District Councils, Cambridgeshire and Peterborough Clinical Commissioning Group, the Health and Wellbeing Board, the

Voluntary Sector and other bodies at strategic level) while still being able to listen to individual patient concerns, represent them effectively, and challenge those same decision-making bodies when necessary.

- **Self-aware** – an organisation which actively seeks feedback on its own performance and critically assesses its strengths and weaknesses.
- **Accountable** – working to a clear set of standards against which the local authority and the residents it serves can appreciate its success.
- **Good value for money** – an organisation that makes the best use of its resources by seeking to avoid duplication with other bodies in the local authority area and, where possible, working creatively with them to deliver the most cost effective solutions to achieve its chosen priorities.

Healthwatch Cambridgeshire Functions

Healthwatch Cambridgeshire will carry out its functions in accordance with the Health and Social Care Act 2012 and relevant legislation and regulations. It is envisaged Healthwatch Cambridgeshire will fulfil a number of key functions which are detailed below but subject to national and local guidance.

Function 1 – Providing advice and information about access to services and support for making informed choices:

- Develop and deliver effectively an accountability policy aimed at ensuring that Healthwatch Cambridgeshire understands how local people prefer to seek and receive information; that information is up to date, relevant, impartial and accurate; and that people can have access to this information regardless of background, disability, age, etc.
- Develop access to, capacity to provide and analytical capacity for currently available information e.g. NHS Choices
- Develop the availability of good quality information in the formats that people want and in the places that people go and make best use of partnerships and collaboration to achieve this
- Develop a 'triangulation' system to ensure that feedback about the quality, effectiveness and availability of information informs the future development of information and advice systems
- Develop and maintain a clear 'whole-system' view of the health and social care 'landscape' in Cambridgeshire
- Board members, staff, volunteers and representatives will need to be aware of the adult and child safeguarding procedures as current.

Function 2 – Making the views and experiences of people known to Healthwatch England (HWE) and provide a steer to help it carry out its role as national champion:

- Develop a plan for timely two-way information flows and clarity of accountability between HWE and Healthwatch Cambridgeshire
- Develop a process for informing HWE of local matters relevant to wider public health agendas and ensure that such involvement is more than just 'a conversation'

- Foster its own independence.

Function 3 – Recommending investigation or special review of services via Healthwatch England or direct to the Care Quality Commission:

- Agree and establish an ongoing dialogue with Healthwatch England
- Develop good information governance
- Ensure that urgent concerns are escalated effectively
- Work to NHS Constitution (Health) and 'Think Local, Act Personal' (Social Care).

Function 4 - Promoting and supporting the involvement of people in the commissioning and provision of local care services:

- Develop 'easy to reach' facilities and capacity – local people will know how to contact Healthwatch Cambridgeshire
- Develop an understanding of and strategies for inclusion of all groups in the Cambridgeshire local community and to ensure that groups and networks are kept up to date with Healthwatch Cambridgeshire plans and how they can be involved
- Develop effective collaboration and involvement with existing networks
- Develop suitable arrangements for the practical support and training for board members, staff and volunteers
- Develop and support the integration of the Enter and View process into Healthwatch Cambridgeshire in accordance with current legislation including a quality assurance mechanism. Volunteers will be safely recruited, trained, CRB checked and supported in accordance with this legislation
- Develop an effective programme of community dialogue activity
- Develop the 'critical friend' role with the Health and Wellbeing Board.

Function 5 – Gathering views and understanding the experiences of patients and the public:

- Information that is currently collected separately needs to be co-ordinated, consolidated and analysed in order to get a wide understanding of local views and experiences of health and social care services
- Develop strategies for identifying and engaging with those who don't generally come forward
- Develop processes for making decisions over the effectiveness of information gathering, how this is used and opportunities for publicising information
- Develop collaboration and co-ordination with CQC leading to improved dialogue
- Develop capacity and expertise for the interpretation of data and information
- Develop methods to collate evidence and information to support recommendations to Healthwatch England/CQC.

Function 6 – Making people's views known:

- Development of a shared information structure with other organisations to avoid duplication
- Develop systematic methods for gathering views (local and national sources)
- Develop responsiveness, reporting back processes and making the publishing of findings fully accessible
- Develop a systematic approach to analysing gathered community views and provide ongoing feedback to CQC
- Develop a strong representational role on decision making bodies, relevant scrutiny committees and other quality assurance groups such as the proposed Quality Surveillance Groups.

Function 7 – Provide access to the NHS Complaints Advocacy Service (to be confirmed):

- Ensure effective signposting to the NHS Complaints Advocacy Service

Performance Measures

Performance measures and targets will be developed and agreed with the council. Targets will be developed where appropriate. Areas to be covered will include but not necessarily limited to:

- Size and scope of Volunteer workforce and impact
- Representativeness of local community
- Media profile
- Volumes and nature of enquiries and signposting activity (TBC)
- Timeliness of responses
- Customer satisfaction
- Numbers and characteristics of customers assisted through Healthwatch Cambridgeshire (TBC)
- Accessibility
- Numbers of reports and recommendations produced and the outcomes of these
- Numbers and nature of enter and view visits undertaken and the outcomes of these
- Annual Report and Audited Accounts

Amended Partnership Forward Plan:

MEETING DATE	ITEM
18th April 2013	Looking at Community Safety and Health including Streetlife issues.
	Update on Clinical Commissioning Plans: Presentation by Nigel Smith, (Local Chief officer for Camb Health and CATCH).
	Progress developing our action plan.
MEETING DATE	**ITEM**
25th July 2013	What are we doing to address local health inequalities?
	Looking at the Supporting People programme and the support available locally for vulnerable people.
	Update on the Ageing Well project and work in Cambridge.
MEETING DATE	**ITEM**
24th October 2013	

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