Wednesday 10 June 2015

The Health and Wellbeing Board

Official minutes, reports and the agenda will be available here: http://www.manchester.gov.uk/meetings/meeting/2375/health_and_wellbeing_board

There were 16 attendees and around half a dozen observers.

The chair began by noting that one member of the public had asked to speak on point 10 of the agenda, and reminded us that members of the public could speak but not debate.

The chair then welcomed the strategic partnership that would be mostly under discussion as "a major step forward", though laughed that the Office of Fair Trading might disagree. All around the table (ie not the observers) seemed to find this very funny.

1. Urgent Business
2. Appeals
3. Interests
4. Minutes

There was nothing raised in points 1-3 and the minutes from the previous meeting were agreed on in point 4.

5. The Health and Social Care Devolution – Locality Plan

Geoff Little and Joanne Newton spoke about "recommendations and vision".

GL opened by talking about sustainability in Health and Social Care in terms of:

i. Outcomes for residents
ii. Financially
iii. Long term functioning of services
iv. Social movement for change and self care
    a. Attitudes, behaviours, etc
    b. GM as a whole
    c. Institutions

The Locality Plan is to be finalised by December, and there ought to be a draft version by the end of June with detail on outcomes sought by the Comprehensive Spending Review. There will be one plan for Manchester, incorporating the three CCG districts.

The draft will be available by July and discussed at the board's July meeting.

It was proposed and agreed that there will be a Locality Plan from each of the 10 GM districts.

GL referred to a “bold, radical and broad plan for action” which “needs to relate to economic productivity as well as health.”

There would be a broad range of sub-sections to the plan, e.g. public health, social care, mental health, etc.

MCC should “capture the benefit of devolution for outcomes and spend in the city”, argued GL. Plans should be looked at in “more than qualitative evaluation”, such as a full cost benefit analysis and “tracking of financial indicators”.

In response to some concern about the amount of work being generated, GL said that this was about “strengthening meetings, not creating new ones.”

GL outlined hope and expectation that the leadership could lead “as one set of institutions in the city.”

JN then outlined the GM process:

i. Strategic direction
ii. Transformation proposals
iii. Financial plan and ‘enablers’

She said that this was about consolidating the existing strategy, rather than starting from scratch and that there was a finances workstream attached to this:

- Health outcomes
- Services
- Financial sustainability
- Supporting self-reliance

A new Director of Health and Social Care is currently being hired.

Assuming 2% growth and a proportionate share of the £8billion for GM devolution, MCC believes it will still be left with “a gap of £165million”, which is a “big challenge” and will have disproportionate effect on services.

The strategy outlines benchmarks and suggests reducing spending on hospital care and increasing spending on social and primary care.

The meeting was then opened to the board. One stated the need to “get right” relations between the various partners involved.

Another member asks where the budget for the “social movement” [presumably the attitudes, behaviours and self-reliance] elements will come from, and suggests that his organisation could take the work on.

GL answered that that work wont be funded by any one part of the budget but that it will fall “on us all collectively”.

One member then pointed out the need to develop community assets and another insisted that the strategy needs to “not lose sight of” the important roles played by housing and the third sector.

GL insisted that getting ahead of the curve needs more spending.

JN said that it “was not just about slowing the financial gap, but improving health,” something, she said, at which Manchester has not been good compared to other councils.

The chair said that the board’s July meeting was the last chance to discuss before the draft was submitted and suggested developing a Manchester community strategy.

6 . One Team – Place Based Care
The Living Longer Living Better: Commissioning specification for 2020

Ed Dyson talked about the “place concept” which was “a big change in the way professionals deliver care.”

Living Longer, Living Better shifts focus from organisational boundaries to place and requires a more anticipatory approach. It would require a system, rather than a collection of services. It would have to go from being affordable to being sustainable. It would need to connect Health and Social Care to communities and community assets, he said.

Public, commissioners and providers have contributed and there is widespread support for the model, but it is difficult and complex to implement.

There aims to improve mental health services, “the diagnosis and disease approach need to work with a person centred approach.

GPs and primary care providers need to connected through partnerships.

The conversation is opened to the board.

One member discusses the “need for a broader scope” that is “far more integrated.” He mentioned that the model would need all commissioning resources, not some, and suggested Withington Community Hospital as the site of a “hub” for integrated care.

The chair then mentions the morning’s news that Manchester would be implementing the government’s plan to keep GP surgeries [and possibly other things] open 7 days a week.

ED states that there needs to be a strong interface between district, general and community practice. There are 12 areas which have 7 to 10 GP practices.

One member asks how “communities of identity fit with communities of place.”

Another member says there needs to be a communications strategy for patients and asks where dentists, opticians and pharmacists fit in.

ED says that a communications plan for patients is being put together to increase engagement.

He addresses the questions of communities of place and identity. His team are trying to understand communities and the micro-level. The aim is to deliver specifically targeted services in the city on a central/north/south basis.

He says his team will find their way through the implementation and that desired outcomes include a focus on equality for different groups.

He addresses the question of dentists, opticians and pharmacists. He says these areas are getting more connected in provider partnerships, and more could be done bring them in, “every delivered in the community should be in scope.”

One member points out that the Health and Social Care Act doesn’t allow the commissioning of dentists, etc. Another member adds that this doesn’t make sense to the public, “we can do everything, except your teeth, eyes, etc.”

7. Complex Dependency and Troubled Families

Julie Heslop and James Binks discussed progress on the two programmes.

JH said the programme had been renamed to reflect a more aspirational, confident approach, “not just in how we work but in the changes within our system” and the “broader, deeper cohorts” of people the programme is targeting. This “connects to the aspirations of the health and wellbeing board”.

- Systems
    - Mental health } How to connect to local offer?
    - Vulnerable individuals

JB said the team is working on an evidence base to support the key elements of the model:

- Integrated
- Lead worker
- ‘Whole family’ focus as well as individuals.

Local evaluation shows positive impact on lives. Evidenced, for example, in reduced number of “police call outs” and the number of people being “helped into work”. The programme will be evaluated every 6 months.

GM worked closely with DCLG in the design of the national programme.

The programme targets 27,200 families across GM, including 8,000 in Manchester, it was not made clear how these figures were arrived at. MCC expects to receive ‘attachment funding’ for this work.

Changes in national evaluation shift focus “from specific outcomes to broader improvements.” A new GM outcomes framework also “aims for greater consistency.”

JH said the aims, objectives and philosophy were the same as in the One Team approach, which is seeking to unite colleges, national employment services and Troubled Families employment advisors.

Expanding the range of partners “means a broader pictures of what [outcomes] we’re going to get.”

JB said the tea is working with GPs and frontline key workers, “we’re not starting from scratch but there’s more than we can do.”

Want to reduce “social-related demand on active services “(GP, A+E, etc.

“We need clearer pathways for professionals to get specialist support.”

One member mentioned the “significant” waiting lists for alcohol services in the city.

JB said that there needs to be “priority access for Troubled Families and Complex Dependencies cohorts.” MCC should also “build on the good practice of GPs” such as in the Fit for Work pathway, which GPs claim to have been a big help.

One member asks what monitoring there is on the ‘good quality employment’ area of the work. “How do we know it is delivering meaningful benefits?”

Another pointed out the need for a good cost-benefit analysis methodology.

Another member said that it was good to see single people now mentioned in the Early Help offer and said that mental health services need to be better linked with early help.

The chair welcomes the different definitions around outcomes and points out that tax credits “help families with children.”

JB said that the local and national cost-benefit analysis methodologies would be shared with the board.

8. Impact of Poor Mental Wellbeing

This was a brief point, with a short presentation to the board from David Regan.

There are some "bold" statistics that show Manchester as being well behind in mental wellbeing at the national level.

One member asks why north Manchester is considerably further behind. The board is uncertain but generally agree that factors such as its relatively young population, deprivation and high unemployment will be factors.

DL added that there are social factors and issues of independence and control over one's own life.

The chair added that we often see a high proportion of mental health issues in wards with large, older, "cheap" housing.

He went on to say that 46% of local areas are among the most deprived in the country. He said that this was based on data that can be 7 years old and warned against basing decisions on out of date data.

9. Quality Premium for Clinical Commissioning Groups

Mike Eeckelaers presented about the quality premium measures.

The quality premium scheme will aim to meet measures that are set 80% at the national level and 20% locally.

Differences between CCGs reflect differences in choice, and all are good choices.

Addressing Appendix 1, one member suggested that "this isn't a statement about improving methodology, it's about paying someone to do something for us."

ME agreed.

10. Implementation Plan for Public Health Services

This looked at plans to redesign a number of public health services in Manchester.

The chair introduced a member of the public who wished to speak. He reminded the room that public concerns will be considered by the board but that it was not a negotiating body.

Caroline Bedale, Senior Public Health Development Advisor in the Manchester Mental Health and Social Care Trust and a Unison steward, spoke to “make sure [the board is] aware of what’s happening in health and wellbeing services.”

The redesign amounted to a “drastic reduction” in health and wellbeing services which “cannot lead to a positive impact.”

The real impact of “cuts and uncertainty” had demoralised staff and this has a negative impact on the health of the people of Manchester.

Said the report was very positive and insisted that the board “be honest” regarding the effects of redesign.

Her service has been broken up and put out to tender, she pointed out “irony” of the number of staff being cut given the service’s priority of helping people into work.

She accepted that ultimately this was the government’s decision but argued that MCC could have offset cuts with “small increases in council tax or business rates.”

Cuts were not based on effectiveness; her service had surpassed its targets.

While, because of public concern, mental health has been relatively protected given the cuts elsewhere, the loss of 60 staff meant reduced specialism in the service, “where will expertise come from?”

The health and wellbeing gap is likely to get wider, the devolution deal discusses health but the services that provide for health are being cut.

She reasserted her point that the report was “over-optimistic” and that it “glosses over the impact of drastic cuts.”

The chair responded by saying that the expected growth, based on a government formula, “didn’t come to pass.” MCC’s budget has been cut, and that includes public health.

MCC taking over responsibility means a significant difference in the distribution of money.

The Director of Public Health responded by saying “what we’ve done in the last 20 years hasn’t worked” and that it’s “right to change the way we do things.” He discussed efficiencies, a holistic approach and said that the redesign was the right thing to do.

One member discussed the locality plan.

One member formally acknowledged CB's concerns, said she supports and asset-based approach, which is "incredibly positive" and says that engaging communitis is the right thing to do.

Another member accepted "difficulties in commissioning" but argues that the service "shouldn't put money into what doesn't work."

The chair said that "the services we inherited" were "input-driven, not output-driven. More changes were to come these needed to be dealt with sensitively.

I have endeavoured to give a complete and accurate record of the meeting.

Ben Godfrey
Manchester Green Party
10th June 2015