HEALTH AND WELLBEING PARTNERSHIP BOARD MEETING
WEDNESDAY, 8 SEPTEMBER 2010

Minutes of a meeting of the Health and Wellbeing Partnership Board held in Committee Room A, Civic Centre, Glebe Street, Stoke-on-Trent on Wednesday, 8 September 2010

PRESENT:-

Tony Oakman (Chair), Tina Cookson (NHS Stoke-on-Trent), Zafar Iqbal (NHS Stoke-on-Trent), Councillor Hazel Lyth (Cabinet Member for Adult Social Care and Health), Lynn Kemp (NHS Stoke-on-Trent - Non-Executive Director), Sajid Hashmi (Voluntary Action Stoke-on-Trent), Gill Brown (Voluntary Sector Chief Officers), Rebecca Bowley (Supporting People), Margaret Lilley (Stoke-on-Trent LINk), Mandy Donald (Community Health Services / Older People's Partnership Board), Steve Wellings (Independent Chair of Safeguarding Vulnerable Adults Board), Irene Abbotts (Learning Disability Partnership Board), Lorien Barber (Mental Health Partnership Board), Sue Tams (Mental Health Partnership Board), Mark Palethorpe (Physical and Sensory Disability Partnership Board), Judy Kurth (Local Strategic Partnership), Adrian Hackney (North Staffordshire Combined Healthcare Trust - representing Fiona Myers), Nigel Bennett (Stoke-on-Trent PCT), Paul Trinder (NHS Stoke-on-Trent) and Nathan Dawkins (Secretary)

1 APOLOGIES

Apologies were received from Fiona Myers (sent representative), and from Councillor Bowers, Councillor Daniels, Karen Saunders and Will Boyce.

2 HEALTH INEQUALITIES STRATEGY

Nigel Bennett submitted the draft Heath Inequalities Strategy to the Board for its approval, recommending that the Board's Performance and Commissioning Sub-Group monitor progress against the actions in the Strategy.

As an area with high levels of deprivation, Stoke on Trent faced significant problems, with people in the City more likely to smoke more, drink more, be overweight and eat less fruit and vegetables than most of the rest of the country. Life expectancy was two and a half years lower than the national average, with significant ward variations.

The Draft Health Inequalities Strategy set out key areas for action that reflected these challenges, building on the findings of the Marmot report 'Fair Society, Healthy Lives'.

A vision for a healthy Stoke on Trent was set out in Section 2 of the Strategy, which included the goal of saving half of a million life years by 2015. For each additional year of life expectancy, only 8% could be attributed to the direct medical interventions of the NHS. The wider determinants of health such as housing, poverty, the environment and lifestyle had a proportionately greater impact on the reduction of health inequalities.

He reported that the Strategy had been brought to the Board before (18 November 2009), since then being subject to a number of rewrites. A formal consultation event was held in July 2010, with feedback received from a number of partners, and the draft strategy had been widely circulated amongst partner organisations.

Gill Brown stressed the need to sign off the Strategy at this meeting, following the numerous delays and revisions thus far.

Steve Wellings highlighted the issues around safeguarding, seeking reassurances that this would be addressed within the Strategy.

Resolved (i) – That the Board approve the Heath Inequalities Strategy.

Resolved (ii) – That the Performance and Commissioning sub-group of the Board be charged with monitoring progress against the Action Plan within the Strategy.

3 ALL AGE ALL CAUSE MORTALITY

Paul Trinder submitted a briefing paper on All Age All Cause Mortality to the Board, for information.

He explained that All Age, All Cause Mortality (AAACM) measured the total number of deaths from all causes of disease among people of all ages, presenting the numbers of deaths as a rate (per 100,000 population). Separate rates were reported for males and females.

AAACM was typically presented using three years pooled data (to overcome year on year fluctuations). However, when the indicator was set up nationally as part of the Vital Signs monitoring exercise, single year targets were agreed.

Due to the different age/sex structures of areas, it was not possible to directly compare mortality rates.

In Stoke-on-Trent, based on current trends, rates were falling, although both male and female AAACM remained marginally off track to hit their respective 2011 targets.

Gill Brown questioned if, in future, providers would be asked to commission services to achieve the AAACM target.

Tony Oakman questioned whether adopting AAACM as a target would lead to an increased focus on early preventative measures.

Resolved – That the Board note the measure of All Age All Cause Mortality.

4 QUARTER ONE (2010/11) LAA PERFORMANCE REPORT

Karl Robinson submitted the Quarter 1 performance data for the HCOP block of the LAA, which had already been discussed in detail at the HCOP Performance and Commissioning Sub Group.

He summarised the performance against each of the block's nine LAA indicators, where three indicators were on target (greens – NIs 121, 136 and 141), one was just off-target (amber – NI 53), and four indicators were not on target (reds – NIs 8, 56, 122 and 135). Performance data against the remaining indicator (NI123) was not yet available.

He explained that, while some indicators appear to have fallen during quarter one, this was a common trend each year due to the nature of the indicator calculation method, and was likely to improve exponentially throughout quarter two and three. This applied in particular to NIs 53, 123 and 135.

Further information, including action plans, was provided for each of the indicators that were currently underperforming.

5 LSP CHAIRS GROUP FEEDBACK

Tony Oakman updated the Board on the business covered at the recent meeting of the LSP Chairs Group, focussing on developments over the Area Based Grant (ABG).

He circulated the final figures for ABG reductions, as agreed at the last of Board Members. Looking forward, every plan owner/delivery lead had been asked to review their spending, accounting for monies currently in their budgets, and assessing the potential implications of any further reductions in ABG funding.

Gill Brown expressed concerns that the uncertainty over future funding, and the inability to commit budgets or commission services, may lead to voluntary sector organisations having to downsize operations, or in the worst case scenario may see them running into financial difficulties.

6 IMPLICATIONS OF THE WHITE PAPER - EQUITY AND EXCELLENCE: LIBERATING THE NHS

Tina Cookson gave a presentation based on the government's White Paper - Equity and Excellence: Liberating the NHS.

Key milestones were:

- Provider separation - April 2011
- GP Consortia (shadow form) - April 2012
- NHS Commissioning Board (shadow form) - April 2011
- GP Consortia (real) - April 2013
- Strategic Health Authorities abolished - from April 2013
- PCTs abolished - from April 2013

Several points for discussion were highlighted:-

Creation of 'Healthwatch England', located in CQC, as a consumer champion. Local LINKS to become local Healthwatch (funded by and accountable to local authorities).

NHS would be held to account against clinically credible and evidence based outcome measures. NICE quality standards would inform the commissioning of all NHS care and payment systems.

GP Commissioning Consortia would be placed under a statutory basis, with weighted capitation funding. Every GP practice must be a member of a consortia, which although not subject to a minimum size, must be large enough to manage risk.

Local Directors of Public Health would be jointly appointed by local authorities and the Public Health service.

Local authorities would be required to establish "health and wellbeing boards", or utilize existing strategic partnerships to take on the function of joining up the Local NHS, Social Care and health improvement. These new arrangements would supercede the functions of Health Overview and Scrutiny Committees.

All NHS Trusts must become Foundation Trusts, while all providers would have a joint licence, from CQC and Monitor.

In terms of immediate actions for the PCT (NHS Stoke-on-Trent), it was already in the process of divesting its provider arm, reducing staff at a management level and making plans for the transition period.

Board Members made the following comments (answers provided, where appropriate, by NHS Stoke-on-Trent):-

- Deregulation may lead to multi-national healthcare companies entering the market, but this might not mean more choice at a local level for patients, and may lead to the deconstruction of a nationalised health service, and the return of 'postcode lotteries'.

  (in response to this point Tina Cookson explained that NICE pathways would ensure consistent care journeys nationwide)

- In order for deregulation to work, customers would need to be able to intelligently interrogate the options in the market. A major shift in culture would be required for this to work.

- Uncertainty over how public health issues would be affected – do not want to lose the public health focus of the NHS.

  (in response to this point Tina Cookson explained that public health had been given some protection and excluded from the cuts that the PCTs were expected to make)

- Would GP Consortia continue the PCT's funding and good work on the prevention agenda, and the community involvement/engagement agenda?

- Would GP Consortia continue to work closely with and fund the voluntary sector?

- How would GP consortia engage with the adult safeguarding agenda?

- From the local authority's standpoint, the worst case scenario would be if the local authority held all the responsibility for the health agenda, but none of the funding.

- One of the key challenges would be over governance and accountability of GP consortia – ensuring that the provider and commissioning roles were kept separate, and properly audited and scrutinised by the appropriate bodies.

- The affect on the health inequalities agenda – GPs may gravitate towards practices in more affluent areas.

  (in response to this point Tina Cookson commented that this would not be a new phenomenon, and was already happening)

- LINks expressed concerns over the 'professionalisation' of their role, and the proposal to make them accountable (as Healthwatch) to the local authority.

- Lack of clarity and transparency in the dual CQC and Monitor inspection regime.

- Concerns over the transition period, and how the continuation of services would be ensured during the interim period before the final abolition of PCTs.

Summing up the debate, Tony Oakman and Tina Cookson reported that the White Paper would be brought to the a joint meeting of the PCT and City Council Corporate Directors for discussion, and thereafter to the PCT Board. A formal response would be made in response to the White Paper consultation, which would include the comments by Board Members at this meeting.

7 FINANCIAL POSITION UPDATE

Tony Oakman reported that the City Council was working on the assumption that government funding would be cut by 25%.

To prepare for the cuts work was already underway restructuring the City Council's services, including reducing the number of directorates from six to four. A public consultation was underway, and early budget proposals were being brought to the overview and scrutiny committees.

Tina Cookson reported that NHS Stoke-on-Trent was facing similar budgetary pressures. Work was already underway on the decommissioning process, and the PCT Board had made a commitment to continue supporting the City Council during the transition process.

8 ANY OTHER BUSINESS

Board Members gave their thanks to Mark Palethorpe, for his dedication and hard work over the years.

Tony Oakman (Chair)