minutes

Nottinghamshire County Council

Meeting HEALTH AND WELLBEING BOARD

Date Wednesday 7th March 2012 2pm – 4.30pm

membership
Persons absent are marked with `A'

COUNCILLORS

Reg Adair
Mrs Kay Cutts
Martin Suthers OBE (Chair)
Alan Rhodes
Stan Heptinstall MBE

DISTRICT COUNCILS

Councillor Jenny Hollingsworth
Councillor Tony Roberts MBE

OFFICERS

David Pearson	-	Corporate Director, Adult Social Care, Health and Public Protection
Anthony May	-	Corporate Director, Children, Families and Cultural Services
Dr Chris Kenny	-	Director of Public Health

CLINICAL COMMISSIONING GROUPS

A	Dr Steve Kell	-	Bassetlaw Commissioning Organisation
	Dr Raian Sheikh	-	Mansfield and Ashfield Clinical Commissioning Group
	Dr Mark Jefford	-	Newark & Sherwood Clinical Commissioning Group
	Dr Guy Mansford	-	Nottingham West Clinical Commissioning Group
	Dr Jeremy Griffiths	-	Principia, Rushcliffe Clinical Commissioning Group
	Dr Tony Marsh	-	Nottingham North & East Clinical Commissioning Group

LOCAL HEALTH WATCH

Jane Stubbings (Nottinghamshire County LINk)

PCT CLUSTER

Dr Doug Black - NHS Nottinghamshire County

OFFICERS IN ATTENDANCE

Chris Holmes	-	Democratic Services
Cathy Quinn	-	Associate Director of Public Health
Barbara Brady	-	Public Health Consultant

ALSO IN ATTENDANCE

Vicky Bailey	-	Principia Rushcliffe Clinical Commissioning Group
Tracy Lee	-	Nottingham West Clinical Commissioning Group
Oliver Newbould	-	Nottingham West Clinical Commissioning Group
Sam Walters	-	Nottingham North & East Clinical Commissioning Group

MINUTES

Minutes of the last meeting held on 11th January 2012 having been previously circulated were confirmed and signed by the Chairman.

APOLOGIES FOR ABSENCE

An apology for absence was received from Dr Steve Kell.

DECLARATIONS OF INTEREST BY MEMBERS AND OFFICERS

None.

STRATEGY AND COMMISSIONING INTENTIONS

(a) Nottingham West Clinical Commissioning Group

Dr Guy Mansford Clinical Lead from Nottingham West Clinical Commissioning Group gave a presentation to the Board on their business plan for 2012/3. He indicated that Nottingham West was different in that it had bigger black and minority ethnic (BME) and Eastern European groups; more elderly; and 3% lived in the 20% most deprived areas. He outlined that in the following areas Nottingham West was the same as other Commissioning groups:

- Some deprivation
- More Elderly
- Hampered by the Treatment Centre contract
- Contract with a dominant Trust
- Mental health contracting
- Public health Issues
- Issues of GP access

The aims of the Nottingham West Clinical Commissioning Group were to:

1. Reduce health inequalities in the local population by targeting the health and wellbeing of people with the greatest health needs
2. Improve the quality of our local health services, particularly around health outcomes, patient safety, access and patient satisfaction

3. Organise services around the needs of local service users wherever possible
4. Maintain and optimise the health of people with long-term or chronic illness living in our community
5. Focus our available resources where they will deliver the greatest benefit to our population

He indicated that the Nottingham West Group stood for:

- Engagement with practices and patients
- Innovation – long list of clinical pathways; peer review of referrals management to weed out inappropriate ones
- Responsible – strong governance; coordinating commissioner for Nottingham University Hospitals NHS Trust (NUH)
- Transformation – concentrate on long-term conditions; care homes, end of life log, admissions log
  - drive transformation with NUH
  - strong support to frail elderly people pathways
  - much to do to get us out of our 'silos' (there was a need to be braver)

(b) Nottingham North & East Clinical Commissioning Group

Dr Tony Marsh, Clinical Lead gave a presentation to the Board. He indicated that Nottingham North & East was a collaboration of 21 practices serving a population of 144,700 mainly in Gedling but significant populations in Hucknall, Broxtowe, and Newark and Sherwood. There is a diversity of skill mix across the Board's membership.

When compared to England there was a higher proportion of people aged 45 and older; together with a lower proportion of children and young adults. Deprivation was less extreme but there was a large deprivation variation. The main causes of death for all ages were cardiovascular disease, cancer and respiratory illness.

Their vision was – putting good HEALTH into practice. Their aims were to:

- Drive up the quality of care in order to improve health outcomes and reduce unwarranted variation
- Commission appropriate models of care for older and vulnerable people with complex needs, ensuring all patients are treated with dignity and respect
- Secure improved chances of a healthy life by targeting our prevention approach for children and young people

He outlined their priorities as:

- Smoking
- Obesity
- Diabetes
- Avoiding inappropriate admissions
- Chronic obstructive pulmonary disease
- Trauma and orthopaedics
- Depression
- Dementia
- Care home admissions
- End of life
- Targeting early years
- Child and adolescent mental health services

Four public events had been held and the emerging top patient priorities were;

- Clinical
    - Health education, promotion and early intervention
    - Care of the elderly
    - Mental Health
    - Long-term conditions

- Non-clinical
    - Partnership working
    - Patient-led
    - Signposting

Patient feedback would inform their plans and priorities.

(c) Principia, Rushcliffe Clinical Commissioning Group

A presentation was given by Dr Jeremy Griffiths, Clinical Lead. He indicated Principia had been established as a Department of Health Social Enterprise Pathfinder in 2006 with 16 GP practices across Rushcliffe with a registered population of 121,619. He gave details of the population of the area. He commented that there were perceptions about the area but it was not all "green and leafy" and that life expectancy was 5.2 years lower for men and 6.9 years lower for women in the most deprived areas of Rushcliffe than in the least deprived areas.

He outlined the governance structure of Principia, Rushcliffe. He gave details of the successes of the group and the awards they had been given.

He gave an example in action of the urgent care support service. This was a 12 month pilot started in March 2011, jointly funded between the Primary Care Trust and the local authority. It delivered short-term care to people who were at risk of having an emergency admission to a hospital or care home due to a combination of medical deterioration and inability to cope at home. Quantitative and qualitative data have been systematically reviewed to assess both the implementation and impact. The evaluation had identified 82 reported avoided hospital admissions. The net savings from the service were £140,000 for Year 1 and the service had been re-commissioned using re-enablement monies.

He stated that the Commissioning Group had added value through:-

- Innovation,
- Strong patient engagement,
- clinical leadership,
- locally focused
- High profile,
- established in local health community,
- history of partnership working

He gave details of how their commissioning intentions had been informed.

During the ensuing discussion on the strategies and commissioning intentions of the 3 Clinical Commissioning Groups the following points were made:-

- There was hardly any mention of Broxtowe Borough Council in the Nottingham West's plans. The Borough Council provide sheltered housing and it was important to link into the Local Partnership Board.

- The sections in the Nottingham West's document about deprivation were unclear about how this would be tackled.

- There was no mention in the Nottingham West's document about out of hours provision. The Stapleford Walk-In Centre has recently closed and there was no reference to this. It was explained that clinical capacity had been increased by improving access to local GPs in the Stapleford area. The impact of the closure of the Stapleford Walk-In Centre had been small.

- It was explained that Nottingham West had looked at care homes with out of hours admissions and had visited them so a dialogue could be held around unplanned admissions. Nottingham North & East indicated that they tried, subject to patient choice, to have all patients in a home registered with one GP, and then establish a relationship with the care staff in the home. It was reported that the LINk were looking at homes which have not yet been inspected by the Care Quality Commission. The County Council inspected care homes and this seemed an area which was not joined up. The County Council and health joined audited homes which had been innovative when it started. The documents needed to be explicit in what was provided rather than implicit. There was a need to demonstrate added value from the Board.

- The Clinical Commissioning Groups from their plans did not seem to be connecting with the County Council and in particular Children's Centres. Principia's plans seem more inwardly looking.

- For people reaching the end of their life there may need to be provision so they can stay at home rather than go into hospital because it is too difficult to remain at home.

- Reference was made to the need for the dominant provider to change to avoid financial crisis. There is a need for them to remodel their services so that there were consultants in the community rather than having wards to fill. It was noted that there was more work needed to be done on this which was an issues which affected everyone.

- It was important to get the structure right so patients knew how to get into the system.

- It was felt that the business plans lacked information about how and when changes would be made. There was also a lack of information about baselines for the changes so that a comparison could be made to see if progress had been made.

- Extended GP opening hours had been discussed e.g. Saturday mornings – were there any plans to look at this? It was not clear how out of hours services were commissioned and how they will change. It was explained that the out of hours services were in the process of

being re-commissioned over the next 12 months. Primary Care Clinicians would be involved but the Primary Care Trust was carrying this out.

- There was no mention of pharmacists in the plans. They can be a good source of directing people.

- There was a lack of information in GP surgeries about what services were available at Newark Hospital which would contribute to a misuse of Accident and Emergency at Kings Mill. There is a need to understand the services offered, elective as well as the service changes were very dynamic.

- There was a need for stronger links to be in place with Districts/Borough Councils.

- Everyone supported collaborative work but everyone wanted to protect their organisation and the challenge was to put collaborative work into practice. There was more public involvement in health than previously and each had their own organisation's view but there was not a cross-organisation view.

- There was a need to prevent a postcode lottery. It was reported that there was a list of services that were not funded across the East Midlands. Some degree of variation was inevitable. There was a lot of guidance from National Institute for Heath and Clinical Excellence (NICE). The understanding of thresholds was not always clear. The local office of the NHS Commissioning Board would have specifications on commissioning which it would be useful to share at some point. This would include pharmacists and dentistry. Clinicians can approach the Primary Care Trust for approval for specific funding on an individual basis in certain circumstances.

David Pearson commented that the ambition and commitment of the Clinical Commissioning Groups were clear and a lot had been achieved in a short time. It was helpful to see the plans include some of the health issues which had been discussed recently at the Board. He summarised some of the key issues to come out of all the presentations so that the Clinical Commissioning Groups could take account of these as they finalised their plans. These were as follows:-

- A continued focus on referencing the Joint Strategic Needs Assessment and the Health and Wellbeing strategies to explain why particular topics are a commissioning priority for Clinical Commissioning Groups.

- Being as clear as possible as to how outcomes will be achieved and what they mean in practice, including shifts in funding to address the priorities. It is recognised that in the current economic climate and with demographic change, there will need to be decisions about priorities which the Board will need to actively engage in.

- As the Board has a responsibility to promote integrated commissioning, plans to identify where a particular outcome will be

achieved in collaboration with others and how would be valuable. This is part of clear implementation plans.

- It is acknowledged that between health and local government there is in excess of £2 billion of public expenditure. It is important that how value for money will be achieved is described.

He indicated that a report was being prepared for all Clinical Commissioning Groups on adult's, children's & the County Council's strategic priorities.

RESOLVED 2012/005

That the comments set out above be taken into account in the preparation of the final strategies.

MENTAL HEALTH AND EMOTIONAL WELLBEING IN NOTTINGHAMSHIRE

Consideration was given to a report which gave information about adult mental health and wellbeing, excluding dementia which had been the subject of an earlier report to the Board.

Barbara Brady, Public Health Consultant gave a presentation to the Board.

She stated that mental health was a state of well-being in which an individual is able to realise his/her own potential, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community. In this positive sense, mental health is more than the absence of mental disorders or disabilities. As such, good mental health is central to the quality of life of the individual and the effective functioning of a community.

Mental health was the single biggest cause of disability in the UK and 23% of the total burden of ill health. There was a strong link with multiple deprivations and there was a big impact on the workload in primary care. She used case studies to highlight approaches to tackling mental health issues. She reported that it was estimated that 3,100 people in Nottinghamshire had a severe mental illness compared to an estimated 86,500 people with common mental health disorders. She explained that common mental health disorders included the following diagnoses; depressive episode, generalised anxiety disorder, mixed anxiety and depressive disorder, phobia, panic disorder and obsessive compulsive disorder.

The local action included developing a local mental health strategy to make sure we are effectively implementing the national strategy. The areas of work included promoting more effective screening for common mental disorders and further development of approaches to self-management

During the discussion it was stated that by promoting positive mental health issues we would improve the emotional health of people. Community cohesion also made a difference. The role of schools was raised and it was explained that the challenge was to have a consistent approach when schools were more self autonomous. There was a programme in schools which had a good impact in primary schools, less so at secondary level. Attempts were being made to pull this together and the Children's Centres had a role to play. Adolescence was a difficult period for many young people and the challenge

was to have joined up working across the county. It was commented that Districts/ Boroughs had a role to play and reference was made as an example of the positive impact of tending an allotment.

RESOLVED 2012/006

1. That the intention to develop a local Mental Health Strategy and associated plan of action to support the achievements of the six national objectives for mental health and emotional wellbeing be endorsed.

2. That the Board ensure that the commissioning plans of the Clinical Commissioning Groups and local authorities take account of the health and wellbeing needs described in this report.

PUBLIC HEALTH OUTCOMES FRAMEWORK 2013-2016

Consideration was given to a report on the proposed Public Health Outcomes Framework published by the Department of Health in January 2012.

RESOLVED 2012/007

That the Board acknowledge the publication of the Public Health Outcomes Framework and endorse local actions to assess Nottinghamshire County and its communities against the indicators in the framework.

TRANSITION FROM LOCAL INVOLVEMENT NETWORK (LINK to HEALTHWATCH)

Consideration was given to a report concerning the continuation of the LINk until the launch of HealthWatch in April 2013. It was explained that the County Council is to receive a specific grant for this which had now been incorporated in government grant to commission an external host organisation.

RESOLVED 2012/008

That the Board note:-

1. the composition of the membership of the future local HealthWatch Board

2. The proposal for a health sector engagement and communication strategy

3. The action plan detailed in appendix A to the report (Local HealthWatch implementation plan)

UPDATE ON HEALTH AND WELLBEING STRATEGY

Chris Kenny gave an oral report updating members on the progress of the Health and Wellbeing Strategy which will be brought to the next meeting.

RESOLVED 2012/009

That the report be noted.

JOINT STRATEGIC NEEDS ASSESSMENT RAPID REFRESH

Chris Kenny reported orally that the Joint Strategic Needs Assessment Refresh was currently being finalised and would be reported to the Network meeting the following week. It would be a web-based process which would be constantly refreshed.

RESOLVED 2012/010

That the report be noted.

PRESENTATION ON TROUBLED FAMILIES

Anthony May gave an oral presentation to the Board on the Troubled Families Programme. He indicated that this was part of the government's agenda and that there were 1,580 troubled families in Nottinghamshire, costing £118.5 million per year according to government's estimates. He explained that the Programme was about turning around lives through getting adults into work, children into school, cutting crime and anti-social behaviour, and cutting costs and saving money. These families had lots of problems and caused lots of problems. They were draining budgets of hard pressed services. The aim was to avoid the risk of children leading the same destructive and harmful lives as their parents. There was a national 3 year programme which provided a limited amount of pump priming money. It required a new relationship.

He reported that in Nottinghamshire we had aligned the leadership of the Programme with the Family Intervention Programme based in Children's Social Care. A commercial analyst post had been recruited to work with partners to verify and identify the 1,580 troubled families in Nottinghamshire. A recruitment process had been started for a person to lead the local programme of action. The next step was to establish a troubled families executive partnership group to verify Nottinghamshire's troubled families and agree the scope of the local troubled families programme with partners and government. A troubled families business plan was to be developed and existing work including Think Early would be aligned with the Programme. A progress report would be brought to the Board.

Board members commented that this work needed to link in with District Councils and Commissioning Groups. It was noted that there was a need to focus down on specific families. At the moment there was not one forum where all the issues were considered. Confidentiality issues would be involved in these discussions.

RESOLVED 2012/011

That the presentation be noted and that a progress report on the programme be brought to the Board in due course.

The meeting closed at 4.30pm.

Chairman