minutes

Nottinghamshire County Council

Meeting HEALTH AND WELLBEING BOARD

Date Wednesday 11th January 2012 2pm – 4.07pm

membership
Persons absent are marked with `A'

COUNCILLORS

Reg Adair
Mrs Kay Cutts
Martin Suthers OBE (Chair)
A 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
A Anthony May - Corporate Director, Children, Families and Cultural Services
Represented by Derek Higton

Dr Chris Kenny - Director of Public Health

CLINICAL COMMISSIONING GROUPS

Dr Steve Kell - Bassetlaw
Dr Raian Sheikh - Mansfield and Ashfield
A Dr Mark Jefford - Newark & Sherwood
Represented by Dr Nigel Marshall
Dr Guy Mansford - Nottingham West Consortium
Dr Jeremy Griffiths - Principia, Rushcliffe
Dr Tony Marsh - Nottingham North & East

LOCAL HEALTH WATCH

A Jane Stubbings (Nottinghamshire County LINk)

PCT CLUSTER

Ms Kate Davies - NHS Nottinghamshire County

OFFICERS IN ATTENDANCE

Chris Holmes	-	Democratic Services
Cathy Quinn	-	Associate Director Public Health

MINUTES

Minutes of the last meeting held on the 9th November 2011 having been previously circulated were confirmed and signed by the Chairman.

APOLOGIES FOR ABSENCE

Apologies for absence were received from:-

Anthony May	(Personal)
Councillor Alan Rhodes	(Personal)
Jane Stubbings	(Illness)

MEMBERSHIP

It was reported that Kate Davies had been appointed to replace Dr Doug Black for this meeting.

It was also reported that Anthony May was being represented at this meeting by Derek Higton and Dr Mark Jefford by Dr Nigel Marshall.

DECLARATIONS OF INTEREST BY MEMBERS AND OFFICERS

David Pearson declared a personal interest in Agenda Item 4 as he had been appointed Chair of the Mansfield and Ashfield NHS Clinical Commissioning Group.

STRATEGY AND COMMISSIONING INTENTIONS

(a) Newark & Sherwood Commissioning Group

Dr Amanda Sullivan Chief Operating Officer from the Newark & Sherwood Clinical Commissioning Group gave a presentation to the Board on their vision for healthcare and commissioning intentions. She reported that engagement events had taken place in December and that positive feedback had been obtained. They had obtained an insight from the public into existing problems. With regard to Newark Hospital, they wanted to move to a vibrant future. She pointed out that people had started to value the increase in out patients services. She stated that public events had been held in December in Newark, Southwell and Ollerton to canvass the public's views and the following overall priority rankings had been obtained from these events: 1 = heart and circulatory disease, 2 = dementia; and 3 = respiratory disease.

With regard to Newark Hospital the priorities identified were firstly, expansion of outpatient services, secondly telemedicine link between the Minor Injuries Unit at Newark and A & E at Kings Mill, and thirdly rapid access to specialist clinics. The actions for the Clinical Commissioning Group were to improve

care for people with long term conditions and to improve the value for money to deal with increasing demographic demand.

A comparison of the breakdown of healthcare expenditure in 2011/12 compared with the projected spend in 2014/15 showed that a few percentage points shift in expenditure to the community could give a much more efficient and effective service for patients.

(b) Mansfield and Ashfield NHS Clinical Commissioning Group

Dr Raian Sheikh and Deborah James from Mansfield and Ashfield Clinical Commissioning Group gave a presentation to the Board. They indicated that there was excellent alignment between the registered and resident populations of the area. They explained that the Group were clinically led with a lay chair and two lay members who were linked to their Citizens Reference Panel. There was a nurse and secondary care Board member and an innovative joint clinical executive with Newark & Sherwood Clinical Commissioning Group and Sherwood Forest Hospital Trust. Their strategic priorities had been developed in response to identified health needs and these were currently being consulted on. The top 3 strategic priorities identified were firstly, care of the elderly in the community, secondly planned care, and, thirdly mental health and substance misuse. They emphasised the need for partnership working and that it was essential to stop silo working and forge relationships. They stressed the need for local democratic legitimacy for decision making as there were tough decisions to be made. They indicated that the Citizen's Reference Panel consisted of 20 members. They referred to their links with the Mansfield Area Strategic Partnership and had met Mansfield District Council and Ashfield District Council.

(c) Bassetlaw Commissioning Group

Copies of Bassetlaw's Clinical Commissioning Group's strategy and commissioning intentions were circulated to Board members.

Steve Kell gave a presentation to the Board on the Bassetlaw Commissioning Organisation. He indicated that they were a first wave pathfinder and had merged with the Primary Care Trust in July 2011. They had a delegated budget from the South Yorkshire and Bassetlaw Cluster and had shared management with Doncaster Clinical Commissioning Group. They referred to the national priorities of which the top 3 were firstly Dementia, secondly older people (local care homes focus), and thirdly carers. They outlined local priorities which were firstly the assessment/treatment centre implementation which was sited next to A & E were a rapid assessment involving nurses and doctors set a discharge and a multi disciplinary care team decided what would happen after 48 hours. The second priority was the I Tracker project which tracked real time and it was hoped to extend this to social care and the community. The organisations were hoping to go live in October 2012.

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

- the 3 reports were welcomed which showed a diversity of approaches. The dash of realism in paragraph 6 of the Newark and Sherwood report about there not being sufficient resources was also welcomed.

- The last presentation had listed national priorities and it was wondered if the other Groups had taken account of these. Mansfield and Ashfield stated that the national priorities were at the heart and were implicit in the plan.

- a lot was said about partnership and patient views which were seen as important but what happened when they came up with the wrong answers for example the end of care life was seen as a low priority but was something we had to do.

- it was good for the Clinical Commissioning Groups to talk to each other and it was wondered if this was the only opportunity for that. It was explained that the Clinical Leads from the Commissioning Groups met at least every two weeks and there were also links with the City cluster.

- Nothing had been mentioned about the time frame of the proposed plans. In making the plans there was a need to consider refreshing them and taking account of new priorities both at local and national level. It was explained that the plans ran though to 2014/15.

- at strategic level inequalities were seen as important to address and also from the county perspective. From a local level however was it an issue where we had got the analysis right. Dr Guy Mansford stated that they had re-assigned budgets on a needs basis to try and address inequalities

- the Mansfield and Ashfield strategic plan was seen as very accessible and the glossary very helpful.

- a question was asked about the age group of the people who were engaged in the consultation. Amanda Sullivan stated that there had been a range of ages although more were aged over 50. She was surprised that elderly care of life had not been more prominent in the responses.

- where did domestic violence fit into the strategies.

- Bassetlaw CCG was trying to carry out public engagement differently in a tight timeframe. They had consulted all stake holders and had a list of priorities which fitted in with their own. Next year they wanted to do this over a longer timeframe.

- discussions were at an early stage and that we were currently revising the strategy and the joint strategic needs analysis. It was noted that this was a practical problem

- the national strategy around carers had been mentioned but that in the presentations they had been silent on carers and the question was asked whether this was implicit or whether it was an issue which needed to be picked up. It was pointed out that the data indicated that there were 80,000 carers in Nottinghamshire and that it was a significant issue.

- there were many references to partnership working in the documents which referred to the local authority and there was a need for clarity on this in a two tier area.

- there were a lot of services which the County Council provided with adult services and also with children. Whilst there was good individual thinking there was a need for more integration.

- Children's Centres treated the whole family and it was disappointing that they were not reflected in the plans. The need to work together was emphasised. It was hoped that the Clinical Commissioning Groups would reflect that they did not need to do everything as there was little point in setting up new organisations.

- the emphasis in the plans on children & young people needed to be increased. There also needed to be a reference to social economic factors.

- It was important that success criteria were set and to set achievable targets.

- There was a need to develop a greater mutual understanding of the services provided by health and local authorities. The Health and Wellbeing Boards had been established because of a lack of integration.

- The holistic approach from Mansfield and Ashfield was welcomed.

- Differences in life expectancy should be targeted.

- It was important not to replicate what the Primary Care Trusts do. There was a need to clarify unnecessary clinical pathways.

- It was important that the process was transparent. It was reported that Bassetlaw Commissioning Group had held their first committee meeting in public yesterday.

RESOLVED 2012/001

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

HEALTH PROTECTION IN NOTTINGHAMSHIRE NEEDS AND ARRANGEMENTS

Jonathan Gribbin, Consultant in Public Health and Dr Vanessa MacGregor, Consultant in Communicable Disease Control, Health Protection Agency introduced the report on the importance of health protection. They added that the resilience to health threats needed to be seen in a wider context. They stated that there were a wide range of players. They referred to the local

resilience forum and emphasised the need for close liaison with partners. They stated that there was a need to ensure that health protection arrangements were appropriate during the current period of transition.

During the discussion which followed the following points were raised:-

- the priorities of the Department of Health were with communicable diseases. There was reactive work around cases and controlling outbreaks of disease. Reference was made to the recent outbreak of legionnaire's disease in a prison and the need to find the source and the need to reassure the public.

- there was felt to be a lot going on behind the scenes and it would be helpful to have a collective agreement on vaccinations. The question of vaccinations needed for travelling abroad was raised. It was clear what vaccinations were needed for travel and that these needed to be obtained privately and it was the individual's responsibility to get them.. Reference was made to people who had travelled abroad and had not taken precautions against getting malaria.

- it was noted that the Public Health Observatory which had provided valuable data was being subsumed in Public Health England.

- in response to a question as to who was responsible for monitoring death rates it was explained that the Primary Care Trusts currently monitored death rates and that this would be going to Clinical Commissioning Groups, maybe with a hosted solution.

- the term health protection could be looked at widely and could be extended to the work place but this was not part of the usual parlance.

- there was a need to look at prisoner's health as often prisoners did not receive treatment when they were released from prison.

- in response to a question as to whether whooping cough was covered. It was stated that there had been an increase in cases, not just in Nottinghamshire but across the country. There was a cyclical pattern which last peaked in 2008. It was explained that there was no strategy for treating adults and that the disease could be treated with antibiotics. Children were at high risk and vaccination was promoted for pre school children. It was pointed out that the children centres could be used to encourage vaccination take-up

- there were changes in responsibilities for public health nationally and there should be a local examination to ensure we are prepared.

- immunisation rates in Mansfield & Ashfield were lower than the rest of the county. This problem had been bought to the attention of all practices. Jonathan Gibbin stated that he was aware of different Hepatitis C cases in the north compared with the south and they were exploring options for different commissioning groups.

RESOLVED 2012/002

That the arrangements currently in place to address health protection needs in Nottinghamshire, and the following actions highlighted in the report and appendices: be endorsed:

1) **NHS reforms**
   - Provide the Board with an assessment of any implications for Nottinghamshire County which arise from guidance to be published about the governance, commissioning and delivery of health protection functions.

   - Consider the forthcoming guidance from the Department of Health about the future organisational location of health's Emergency Planning function.

2) **Childhood Vaccination and Immunisation**

   - Work with GPs, practice nurses and staff, health visitors, midwives and others to systematically promote best practice across the County.

   - Closer working with Nottinghamshire County Council colleagues tol provide an opportunity to secure more timely information about school roles, to support the HPV vaccine programme amongst school girls aged 12-14 years.

3) **Seasonal influenza**

   - Work closely with general practice colleagues to promote the best practice approach within primary care.

   - Co-location with Nottinghamshire County Council will provide an opportunity for closer collaboration to secure a high level of uptake of the vaccine amongst colleagues in social care.

4) **Tuberculosis**

   - Monitor implementation of the recently approved TB policy. Review arrangements for screening of neonates for BCG vaccination across Nottinghamshire.

5) **Hepatitis B and C Viruses**

   - Maintain provision of targeted Hepatitis B harm reduction advice and prevention, pending publication in 2012 of NICE guidance on best practice for promoting testing.

   - Address actions highlighted in the recently published East Midlands Hepatitis C Action Plan, including a review of access to treatment services in the north of the county.

6) **Human Immunodeficiency Virus (HIV)**

- Implement the recently developed Nottinghamshire County HIV Strategy.

7) **Sexually Transmitted Infections (STIs)**

- Monitor use of the recently launched sexual health service for young people (Beeston, and West Notts College).
- New National Strategy for Sexual Health is due Spring 2012; await this to prioritise further action. In the meantime, continue work with primary care to provide effective contraception in the community, including intra uterine devices and sub dermal implants.

8) **Healthcare Associated Infection**

- Execute the action plan which was developed recently in response to the increasing cases of *Clostridium difficile,* including rigorous monitoring of all cases to ensure effective management of the patient and that investigations into each case highlight common themes.

9) **Pandemic Flu**

- Review and update the Pandemic Flu Plan to incorporate the revised planning assumptions and escalation procedures which are set out in strategic guidance received from the Department of Health in November 2011.

JOINT STRATEGIC NEEDS ASSESSMENT RAPID REFRESH – UPDATE

Consideration was given to the report which set out the progress on refreshing the Joint Strategic Needs Assessment.

RESOLVED 2012/003

That the report be noted.

UPDATE ON THE HEALTH AND WELLBEING STRATEGY

It was noted that a workshop had been proposed for the 15th February 2012 which would consider the strategy. It was noted that there would be local sensitivities in the report and that the Clinical Commissioning Groups would be part of the local delivery. The importance of the strategy being compliant with equality issues was stated.

RESOLVED 2012/003

1) That the progress made on the development of the Health and Wellbeing Strategy be acknowledged.

2) That the need for a workshop to allow Health and Wellbeing Board members time to discuss and agree which Health and Wellbeing Strategy areas are priority for early action be supported.

STRUCTURES TO SUPPORT THE WORK OF THE HEALTH AND WELLBEING BOARD

David Pearson commented that it was not possible to include everyone involved on the Board and it was proposed to have a separate event which would involve a wider group, the Network. It was pointed out that it was vital that the Board was not seen as a rubber stamp and that it needed to be dynamic.

RESOLVED 2012/004

1) That the Executive Joint Commissioning Group and Local Government and Health Transition Group combine functions of membership to form the Health and Wellbeing Board Implementation Group and report to the Health and Wellbeing Board.

2) That the Health and Wellbeing Strategy (HWS) Editorial Group review its membership and role and combine its functions with the Joint Strategic Needs Assessment (JSNA) Steering Group to become the Health and Wellbeing Strategy, Joint Strategic Needs Assessment and Outcomes Group. This Group will report to the Health and Wellbeing Board via the Health and Wellbeing Board Implementation Group, who will monitor the delivery of Health and Wellbeing Strategy.

3) That robust working relationship be made with the D2N2 Local Enterprise Partnerships, Safer Nottinghamshire Board, District Local Strategic Partnerships or local health strategy groups and future HealthWatch Board. These Boards/ groups should receive the Health and Wellbeing Strategy and have regard to the Strategy in their plans. Conversely the Health and Wellbeing Board should take regard of these plans in the development of the Health and Wellbeing Strategy.

4) That thematic strategic commissioning groups review their terms of reference to link them into the Health and Wellbeing Board's accountability structure.

5) That all commissioning groups review their patient and public engagement in conjunction with HealthWatch (or LINks).

6) That all commissioning groups review their mechanism for provider engagement and Nottinghamshire County Council establishes a Provider and Stakeholder Network to engage a wide range of stake holders. The Health and Wellbeing Strategy, Joint Strategic Needs Assessment and Outcomes Group will provide oversight of this process.

7) That supporting groups become working groups not sub-committees of the Board.

The meeting closed at 4.07pm.

CHAIR M_11jan2012