minutes

Nottinghamshire County Council

Meeting HEALTH AND WELLBEING BOARD

Date Wednesday, 16 January 2013 (commencing at 2.00pm)

membership
Persons absent are marked with `A'

COUNCILLORS

Reg Adair
Mrs Kay Cutts
Martin Suthers OBE (Chair)
Alan Rhodes
A 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

	Dr Steve Kell	-	Bassetlaw Clinical Commissioning Group
	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
A	Dr Jeremy Griffiths	-	Rushcliffe Clinical Commissioning Group
	Dr Tony Marsh	-	Nottingham North & East Clinical Commissioning Group

LOCAL HEALTH WATCH

A	Jane Stubbings	-	Nottinghamshire County LINk

NHS COMMISSIONING BOARD

A	Helen Pledger	-	Local Area Team, NHS Commissioning Board

OTHER COUNCILLOR IN ATTENDANCE

Councillor Joyce Bosnjak

OFFICERS IN ATTENDANCE

Barbara Brady	-	Public Health
Paul Davies	-	Democratic Services
Cathy Quinn	-	Public Health
Nick Romilly	-	Public Health
Dr Barbara Stuttle CBE	-	Local Area Team, NHS Commissioning Board
Dr Helen Walsh	-	Rushcliffe Clinical Commissioning Group

MINUTES

The minutes of the last meeting held on 7 November 2012 having been previously circulated were confirmed and signed by the Chairman, subject to the amendment of the penultimate line of page 4 to read "That the use of social media in health promotion be explored…"

APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Heptinstall, Dr Griffiths, Jane Stubbings and Helen Plegder.

DECLARATIONS OF INTEREST BY MEMBERS AND OFFICERS

Dr Jefford declared an interest in behalf of the CCG representatives in the items on Domestic Violence and Carers' Funding Allocation.

DEVELOPING VIABLE OPTIONS FOR SHERWOOD FOREST HOSPITALS AND SURROUNDING HEALTH ECONOMY THROUGH A PARTNERSHIP TRANSFORMATIONAL APPROACH

Dr Jefford introduced the report which updated the Board following the presentation about Sherwood Forest Hospitals Trust to the previous meeting. Reports on the Trust's finances and governance would go to the Trust's Board and then to Monitor. The report also outlined the role and composition of the Mid-Nottinghamshire Integrated Care Transformation Board.

RESOLVED: 2013/001

(1) That the progress under way to secure a vision for sustainable hospital and community based services in mid Nottinghamshire be noted.

(2) That update reports be presented to each meeting of the Health and Wellbeing Board.

TACKLING DOMESTIC VIOLENCE IN NOTTINGHAMSHIRE

Barbara Brady and Nick Romilly gave a presentation on the health and wellbeing dimension to domestic violence. They drew attention to current work by agencies to prevent or respond to domestic violence and identified gaps in current services and the challenges which still had to be met. They responded to questions and comments.

- Cases identified as medium risk could also result in death. This made dealing with the challenges identified in the report all the more important.

- Partnership working should include work with perpetrators. The proposed changes for Probation should be taken into account.

- Training on domestic violence should be widely spread, and include housing workers, for example.

- How was the capacity of services assessed? Was there sufficient administrative support? Could district councils help? - District councils were quite actively engaged. However the NHS could engage more, through its domestic violence representatives.

- The action plan in recommendation (2) should be costed. - Chris Kenny assured the Board that this would be the case.

- Intervention should be at the time of disclosure, not by way of communication back to the victim's GP. - Action would be taken at the time of disclosure. However the GP was seen as having a holistic view of the patient. A high risk case would be referred to MARAC (Multi Agency Risk Assessment Conference). For medium risk cases, there were more gaps in service.

- The role of voluntary organisations should be recognised. - Providing contact details for voluntary organisations could be one of the actions taken.

- The table on page 7 of the report showed a great variation in the numbers disclosing domestic violence. - This reflected the areas served by Sherwood Forest Hospitals midwifery service. The purpose of the table was to show the extent to which domestic violence was under-reported.

- Work should also take place with perpetrators to break the cycle of domestic violence. - This was acknowledged. Probation worked with some perpetrators, but not all.

- Victims included people over 60, where their children might be the perpetrator, and male victims, who did not receive the same level of support as females. - This showed the challenge of measuring the real scale of the problem. If support was tailored to the victim, their gender should not be an issue.

- Another consequence was the impact on children of witnessing domestic violence against a parent. - Services existed to deal with this.

- It was important to share information, and this could over-ride confidentiality issues.

- The MASH (Multi Agency Safeguarding Hub) was an opportunity to link actions together. Agencies were encouraged to report disclosures to MASH, which covered both adults and children, and could help agencies access an appropriate response.

- It was important to develop a proper business case for filling the gaps in service, including the costs to the NHS of domestic violence, and whether funds could be diverted from less effective activities.

- The contract for health visitors and district nurses required that they be trained in domestic violence.

- Serial victims of domestic violence existed, and had low self-esteem. - Specialised support should reduce the risk of repeated violent relationships.

- Low self esteem could be deep-rooted. Children's Centres worked with parents to develop self esteem, by for example encouraging people to return to work.

- Obvious actions should be taken without delay.

RESOLVED 2013/002

(1) That the report be noted.

(2) That approval be given for the Domestic Violence Strategy Group to develop a costed plan of action to address the challenges identified in the report, and present a follow-up report to the Health and Wellbeing Implementation Group in three months time.

EXPENDITURE OF CARERS FUNDING ALLOCATION - PROPOSED PLANS OF NOTTINGHAMSHIRE CCGs

David Pearson introduced the report, which advised the Board that £1.5m was to be allocated from Health to the County Council to be spent on support for carers. The report outlined to proposed uses for the funding, and governance arrangements to ensure its correct use. Mr Pearson observed that the 2011 census had identified 91,000 carers in Nottinghamshire, of whom 23,000 provided more than 20 hours of care per week.

RESOLVED: 2013/003

(1) That the report be noted and the recommendations for the proposed expenditure of the additional £1.5m funding be supported.

(2) That a further report be presented in April 2013 updating on the Carers Strategy and how the additional funding will be used across Health and Social Care.

HEALTH AND WELLBEING IMPLEMENTATION GROUP REPORT

The report summarised progress made by the Health and Wellbeing Implementation Group and the integrated commissioning groups. David Pearson invited the Board's views on how this information should be presented in future. Board members acknowledged the importance of knowing how their recommendations were being pursued. A "you said - we did" layout was suggested, with the Board's recommendations as a starting point. A further suggestion was to link progress to outcomes rather than processes. It was stated that frameworks and output measures were being developed, and indicated that the next report on the Tobacco Alliance would have output measures.

It was observed that Appendix 4 to the report, about tobacco control, did not identify action against illegal and contraband tobacco. The City Council was understood to have two officers dealing with this. Tobacco could be "cut" with dangerous substances. In response, it was pointed out that the County Council also did work against illegal tobacco, and the report did not cover every action being undertaken.

David Pearson observed that overall, considerable progress was being made.

In relation to the establishment of local HealthWatch, it was reported that the County Council's Policy Committee on 16 January 2013 had approved the direct appointment of a chairman and implementer for the HealthWatch board.

RESOLVED 2013/004

That the progress being made to support the work of the Board and the delivery of the Health and Wellbeing Strategy be noted.

ROLE OF DISTRICT COUNCILS IN IMPROVING HEALTH AND WELLBEING

Councillor Hollingsworth introduced the report, which summarised district council activities in support of the Health and Wellbeing Strategy. She indicated that each district council was preparing its own implementation plan, and suggested a stronger recommendation to the Board, as set out below.

Councillor Roberts also supported a stronger recommendation. He stated that the Board could also audit what each district council was doing to meet its area's needs.

David Pearson expressed the Board's thanks to Councillor Hollingsworth, John Robinson and Ruth Marlow for their work. He added that the report was a summary and information for each district was available on request.

In reply to a question about whether any funding went from the county to district councils, Chris Kenny indicated that some of the Public Health Grant was passed to district councils.

The Chairman asked whether district councils were satisfied with the way in which they related to the Board. Councillor Hollingsworth replied that she and Councillor Roberts worked hard to gather all district councils' views. All district councils were invited to the pre-meeting a few days before the Board

met. There had been no complaints, although she was aware that some district councils had asked for their own seat on the Board.

It was agreed to accept the revised recommendation, and therefore it was -

RESOLVED 2013/005

That the Health and Wellbeing Implementation Group be tasked to look at future commissioning models between district councils, CCGs and Public Health to support the Health and Wellbeing Strategy.

AMBITION AND OPERATING PRINCIPLES FOR THE HEALTH AND WELLBEING BOARD

The report summarised discussions at the workshop on 28 November 2012 and proposed an ambition statement and operating principles for the Board. Points made during discussion about the report included:

- The Board had important decisions to take and should wherever possible take its decisions in public.

- The Code of Conduct did not adequately reflect the position of the non-councillors on the Board. It was understood that regulations which were due shortly would address this. There would be a further report to the Board about this.

- CCGs were themselves representative organisations with a large membership. They were not in a position to consult their membership on every issue.

- The role of the Board could be enhanced, given that it was the only setting with this membership, to promote joint working with CCGs and local authorities and ensure that Public Health outcomes were delivered.

- There would be a report to the next meeting about an outcomes framework.

RESOLVED: 2013/006

That the ambition statement and supporting principles be agreed for the time being, and subject to review in the light of the forthcoming regulations.

COMMUNICATIONS AND ENGAGEMENT PLAN

The report proposed a communication and engagement plan for the Board, Joint Strategic Needs Assessment and Health and Wellbeing Strategy. It was suggested that large local employers be included among the collaborators and providers, that the Local Area Team of the NHS Commissioning Board also be included in the plan, and that the plan be reviewed after the Board became fully operational on 1 April 2013.

RESOLVED: 2013/007

(1) That Communication and Engagement Plan proposed in Appendix 1 to the report be accepted.

(2) That a national management trainee or similar project worker provide short-term dedicated support to undertake this work and to provide a presence on behalf of the Board at local events.

(3) That early work be undertaken to coordinate communications and engagement activity across the County Council and with key partners under the overarching plan.

(4) That the Communications and Engagement Plan be initiated by a refresh of the Health and Wellbeing Board website to include more detail about the Board and its members, their remit and work programme.

(5) That the Communications and Engagement Plan be reviewed after 1 April 2013.

PUBLIC HEALTH GRANT AND BUDGET PLANNING UPDATE

Chris Kenny reported that since the report had been written, the Government had announced that the allocation to the County Council for Public Health would be £35.1m in 2013/14 and £36.1m in 2014/15. Options would be reported to the Public Health Sub-Committee in February and the Board in March. He did not anticipate many changes in how the budget was spent in 2013/14, as existing contracts would be carried forward. However there were opportunities to change how the budget was spent in 2014/15. The Board was well placed to consider the options. In reply to a question about linking spending to targets, Dr Kenny referred to the outcomes framework to be reported to the next meeting.

RESOLVED: 2013/008

(1) That the 2012/13 Public Health Budgets in place be noted, and the services that the budget is used to commission, to address the health needs across Nottinghamshire County.

(2) That the information on the planning work undertaken to date be received.

(3) That it be noted that the preferred option for setting budgets for 2013/14 is Option 1 (fund all current pre-commitments only and use the non-recurrent monies to meet in-year cost pressures and financial risks).

The meeting closed at 4.30 pm.

CHAIRMAN