minutes

Nottinghamshire County Council

Meeting HEALTH AND WELLBEING BOARD

Date Wednesday 2nd May 2012 2pm – 4.05pm

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
Anthony May	-	Corporate Director, Children, Families and Cultural Services
Dr Chris Kenny	-	Director of Public Health

CLINICAL COMMISSIONING GROUPS

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

LOCAL HEALTH WATCH

Jane Stubbings (Nottinghamshire County LINk)

PCT CLUSTER

A Dr Doug Black - NHS Nottinghamshire County

OFFICERS IN ATTENDANCE

Chris Holmes	-	Democratic Services
Cathy Quinn	-	Associate Director of Public Health
Dr Mary Corcoran	-	Public Health Consultant
Penny Spice	-	Adult Social Care, Health and Public Protection

ALSO IN ATTENDANCE

John Wilderspin - Department of Health

MINUTES

Minutes of the last meeting held on 7th March 2012 having been previously circulated were confirmed and signed by the Chairman.

APOLOGIES FOR ABSENCE

Apologies for absence was received from Cllr Alan Rhodes (Personal), Dr Guy Mansford, Dr Tony Marsh and Dr Doug Black.

DECLARATIONS OF INTEREST BY MEMBERS AND OFFICERS

None.

STROKE AND PHYSICAL DISABILITY INCLUDING LONG TERM CONDITIONS

Dr Mary Corcoran, Public Health Consultant and Penny Spice from Adult Social Care, Health and Public Protection Department gave a presentation to the Board on provision in health and social care for both stroke and other long term neurological conditions, especially those causing physical disability.

They stated that the estimated annual number of strokes was due to increase and there was a need to plan for this. They referred to the National Stroke Strategy which had been issued in 2007 and refreshed 3 years later. The aim was to get everyone having a stroke admitted to a specialist unit, with 80% of patients spending 90% of their time in a stroke unit. An early supported discharge scheme was to be started in the south of the county. The Mansfield and Ashfield Scheme had been very successful. For management of TIA's (transient ischemic attack – mini stroke) clinicians in all parts of the county were to see high risk people. New clot bursting drugs were important and access to brain scans could tell whether patients would benefit from this drug. The main delay in patients receiving treatment was in them not realising they had had a stroke.

Case studies were used to highlight approaches to tackling strokes.

The presentation went on to outline long term neurological conditions. These could be sudden onset conditions e.g brain injury; intermittent and unpredictable conditions e.g epilepsy or migraine. They could also be progressive conditions e.g Parkinson's disease; or stable conditions with changing needs due to development or ageing e.g essential tremor. Again case studies were used to highlight services to people with long term conditions. They outlined social care support which was provided.

They concluded by outlining what had been achieved so far. In terms of strokes there were stroke units and pathways at acute hospitals. A full early supported discharge scheme was in place or being piloted in the north of the county with a partial scheme in the south. There were TIA clinics at acute trusts and access to thrombosis across the county. Stroke ability sessions were held across the county except in Bassetlaw. Hopes for the future were a full early supported discharge scheme in the south of the county and integrated rehabilitation support after hospital discharge. There was also a wish for improved support for patients with communication problems. With regard to long term neurological conditions what had been achieved so far was a pilot for personal health budgets. There was also start (short term assessment and re enablement team), specialist nurses and telecare. The hopes for the future were personal health budgets in place and integrated patient pathway development.

During the discussion the following points were made :-

- There was a need to pull together the 3 outcomes framework. Whilst these were reviewed at Clinical Commissioning Group level comparative data should be reviewed by the Board as well.

- A question was raised about the reliability of the estimated number of people having strokes. It was explained that some patients would not appear on the stroke data as they would appear in statistics for another condition e.g diabetes.

- Clarity was needed about which hospitals had stroke units, given the issues about services to Newark Hospital. It was explained that stroke units were at provider Trusts which in the case of the Newark area was at Sherwood Forest Hospital.

- The main delay to patients receiving treatment for strokes was in them not being sure what was wrong. Once the surgery or ambulance service was contacted there was no delay. Often a patient had a mini stroke or a TIA and went to see a doctor at their convenience without realising what had happened. There was a need to emphasise and publicise the FAST test.

- Due to the number of providers involved there was a need for an integrated information strategy to be in place to ensure information was shared.

- A lot of data existed about people in hospital and the costs. Costs were an issue going forward and it was known good outcomes can be achieved in the community at a lower cost.

- The provision of personal budgets in adult care had taken a massive technical and cultural change and it was necessary to get clinicians to understand personal budgets. It was explained that the Department of Health had a project group working on this drawing on the experiences from adult services. Personal budgets will be offered to patients with continuing health needs and continuing care assessment nurses would be dealing with them.

- There was a need for one assessment, one care package and one funding agreement with access to long term physio's which could be at day centres. There was a need to review the assessment process so that it was joined up.

- For stroke recovery gentle exercise had been found to be beneficial. The social side of being in a group had also been found to be important to avoid isolation.

The Board thought that more work was needed on considering how the County Council, Primary Care Trusts and GP Commissioning Groups work together on these services. It was agreed that a further report should be brought back to the next meeting with proposals.

RESOLVED 2012/012

(1) That the following actions be supported:-

Stroke

- Full implementation of the early supported discharge scheme in the south of the county.
- Implement integrated rehabilitation support after hospital discharge.
- Provide improved support for people with communication difficulties.

Long Term Neurological Conditions

- Implement personal health budgets for people with long term neurological conditions.

(2) That a further report be brought to a future meeting as to how the County Council and the Primary Care Trusts engage with the Clinical Commissioning Groups to ensure the needs of people with physical disability, and long term neurological conditions are effectively and jointly addressed.

TERMS OF REFERENCE FOR THE HEALTH AND WELLBEING IMPLEMENTATION GROUP

Consideration was given to the proposed membership, purpose and responsibilities of the Health and Wellbeing Implementation Group. It was reported that it was proposed that the core membership be increased to include 2 GP leads from the Clinical Commissioning Groups.

RESOLVED 2012/013

(1) That the terms of reference of the Health and Wellbeing Implementation Group be endorsed.

(2) That it be noted that the core membership of the Implementation Group will include 2 GP leads from Clinical Commissioning Groups within Nottinghamshire.

NOTTINGHAMSHIRE HEALTH AND WELLBEING STRATEGY 2012-13

Chris Kenny introduced the report on the development of the Health and Wellbeing Strategy. He indicated that the strategy would be underpinned by a work programme to identify specific actions. He also stated that Clinical Commissioning Groups would also produce commissioning action plans.. He added that the work on outcomes was not yet completed and would be brought to a future Board meeting. It was proposed to constantly update the strategy so that it did not become out of date.

During the discussion the following points were made:-

- Having actions in the strategy was of critical of importance. It was stated that a report on integrated commissioning and how this related to actions would come to the next Board meeting.

- Reference was made to aim in the ambitions for people to have 'happier lives' and whether this was measurable and should be included. Others felt that happiness was a relative concept and it was appropriate to strive for. It was pointed out that there was a national requirement to measure satisfaction of service users and quality of life.

- The document contained many references to joined up working and there was a need to explain how this would work and which organisation was responsible for leading. It was noted that Clinical Commissioning Groups were autonomous bodies and there would therefore be differences in different parts of the county.

- There was a need to inspire people to make necessary changes to practices and consideration needed to be given as to how communication of the strategy and actions would take place to bring this about.

RESOLVED 2012/014

(1) That the process followed in the development of the Health and Wellbeing Strategy be endorsed.

(2) That the Health and Wellbeing Strategy for 2012-13 be endorsed.

(3) That the County Councils Policy Committee be requested to ratify the Health and Wellbeing Strategy.

(4) That a follow up report be presented at the Board's September 2012 meeting outlining the action plan developed and progress being made on the implementation of the Health and Wellbeing Strategy.

JOINT STRATEGIC NEEDS ASSESSMENT

Chris Kenny reported orally on the refresh of the Joint Strategic Needs Assessment.

The importance of communication to both the public and GP's was stressed. It was pointed out that the Board would increase its credibility from actions coming out of its decisions. The Board had to be a catalyst for change and the Implementation Team needed to challenge the current system.

RESOLVED 2012/015

That the report be noted.

HOLDING BOARD MEETINGS IN VARIOUS LOCALITIES

It was suggested that meetings of the Board should be held in the various Clinical Commissioning Groups localities. This would enable patients and staff to be aware of the Board's work. It was pointed out that there were certain legal requirements which needed to be met for public meetings.

RESOLVED 2012/016

That it be agreed in principle that alternate meetings of the Board be held in the various Clinical Commissioning Groups localities.

WORK OF THE NATIONAL LEARNING SET FOR CHILDREN AND YOUNG PEOPLE

Anthony May outlined the work that had been done as part of the learning set of children and young people. This was to ensure that Health and Wellbeing Boards made an effective contribution to improving health and wellbeing outcomes for children and young people. Copies of the poster which had been produced was circulated. This gave details of the key success factors, key strategic questions and challenges for Board's, and signposts to resources.

RESOLVED 2012/017

That the report be noted

The meeting closed at 4.05pm.

CHAIRMAN