MINUTES of a meeting of the **SHADOW HEALTH AND WELLBEING BOARD** held on 26 January 2012 at County Hall, Matlock

PRESENT

Councillor A I Lewer (in the Chair)

D Briggs	Derbyshire LINK
Councillor J Burrows	Chesterfield Borough Council
Dr D Collins	North Derbyshire Clinical Commissioning Group
Councillor C A Hart	Derbyshire County Council
Councillor C W Jones	Derbyshire County Council
Dr S King	High Peak Clinical Commissioning Group
B Laurence	Derbyshire County Council/Derbyshire County PCT
Councillor B Lewis	Derbyshire County Council
Dr S Lloyd	Hardwick Health Clinical Commissioning Group
D Lowe	Derbyshire County Council
E Michel	NHS Tameside and Glossop
Councillor C R Moesby	Derbyshire County Council
Dr A Mott	Southern Derbyshire Clinical Commissioning Group
J Pendleton	North Derbyshire Clinical Commissioning Group
B Robertson	Derbyshire County Council
W Sunney	Hardwick Health Clinical Commissioning Group
I Thomas	Derbyshire County Council
T Thompson	NHS Derbyshire Cluster
Councillor R J Wheeler	South Derbyshire District Council

Also in Attendance – J Cox (Derbyshire County Council), Councillor S J Ellis (Derbyshire County Council), Councillor G Farrington (Derbyshire County Council), J McElvaney (Derbyshire County Council), S Pintus (Derbyshire County PCT), A Pritchard (NHS Derbyshire), and D Timcke

Apologies for absence were submitted on behalf of Dr A Dow, A Layzell, Councillor P Makin, and S Savage

1/12 **MINUTES** **RESOLVED** that the minutes of the meeting of the Board held on 24 November 2011 be confirmed as a correct record.

2/12 **JOINT STRATEGIC NEEDS ASSESSMENT** An update was provided on the process and timetable for the development of the Joint Strategic Needs Assessment (JSNA) in Derbyshire. The JSNA had been a statutory requirement for upper-tier local authorities and primary care trusts since 2008, and the Government expected it to have a strengthened role, and alongside Health and Wellbeing Strategies, would be 'the pillars of local decision making'.

Health and Wellbeing Boards were due to become statutory in April 2013, and at this time would take on the statutory responsibility for undertaking the JSNA and Health and Wellbeing Strategy. Recent guidance had identified a number of key aspects for the Health and Wellbeing Board in shaping an approach to the JSNA.

There was an expectation that Health and Wellbeing Boards should take action now on refreshing the JSNA and developing Health and Wellbeing Strategies, and should emphasise the role of the Health and Wellbeing Board in local leadership, integration and the engagement of key stakeholders. It was proposed that the Board adopted an 'outcomes-based approach', and local authorities, NHS Commissioning Boards and Clinical Commissioning Groups would need to take due regard of the JSNA and Health and Wellbeing Strategy when drawing up their commissioning plans. The Director of Public Health would act as the 'lynchpin' between local health and local authority services, and there would be a clear shift in the focus of the JSNA from not only identifying need but also as a tool to analyse available assets and resources. Draft guidance on the JSNA and Health and Wellbeing Strategies would be released in January 2012, and indicative timetables had been suggested, proposing that a JSNA refresh commenced in January 2012, priorities identified in April 2012, and the strategy to be developed in May 2012.

In terms of the approach in Derbyshire, the current core data set underpinning the JSNA was being refreshed and cross checked with the indicators in the three national outcome frameworks. The Health and Wellbeing Strategy was adopting the life career approach reflected in the national strategy, and it was important to enable an understanding of the health and wellbeing challenges in Derbyshire in an accessible form for all.

The JSNA steering group was currently consulting on and developing a template that would tell the story of health and wellbeing in Derbyshire, and a number of examples would be used to highlight the variation across Derbyshire, and it would be possible to focus on predominant issues facing a particular population group. These snapshots would be developed using key expert input and include inequalities and vulnerability as relevant. The number of narratives produced using an agreed template would be determined by relevant stakeholders, and the approach would be complemented by summary geographical or local district spine profiles.

It was the intention to make the Derbyshire Observatory a one stop portal for all information on health and wellbeing, and the development of Instant Atlas was important to enable people to explore the different aspects of health and wellbeing. It would be necessary to develop relevant geographies within Instant Atlas to allow use by different organisations and

communities, and a 'where I live' feature would be developed to enable users to bring together information to develop a snapshot of health and wellbeing.

The main aim of the JSNA in telling the story of health and wellbeing was to inform the priorities for action and allocation of resources. The JSNA would identify the main health and wellbeing needs for different populations and local areas, and the Health and Wellbeing Board could then prioritise these.

Each refresh of the JSNA should be a mixture of core data sets and filling identified gaps. It was stated that the core data set would evolve, but should cover the three outcome framework indicators. The JSNA Steering Group would identify gaps and develop a prioritised work programme. It would also be possible to develop joint working arrangements where appropriate with Derby City.

It was noted that asset mapping was a new expectation of the JSNA process, and national guidance suggested that an asset could be anything that could be used to improve outcomes. Others referred to asset mapping as identifying the skills, strengths, and knowledge of communities. A piece of work had been carried out in North East Derbyshire, and had engaged local people and locally elected representatives. People had been asked what assets they valued in their local community that contributed to health, and the results had identified a range of important resources, and it was felt that this could be carried out across the county.

It was important to engage the public in the JSNA and Health and Wellbeing Strategy, and rather than asking what the needs were, it could be possible to present local communities with the identified health and wellbeing needs and to ask people about solutions and what positive things were happening in their community that could be built on.

A summary of the process was given, along with a proposed timescale for the next steps. The refresh of data sets and predominant health issues would be identified for prioritisation by the Health and Wellbeing Board in April 2012; the Instant Atlas would be available in May; further work on evidence and resources would be completed for identified priority areas in June/July; and by September, an approach to asset based assessment would have been developed for agreement by the Board.

RESOLVED to endorse the approach to the JSNA and to mandate the JSNA Steering Group to develop and implement the proposed action plan for the JSNA.

3/12 DERBYSHIRE HEALTH AND WELLBEING STRATEGY DEVELOPMENT: PROPOSED HIGH LEVEL PRIORITIES At the last meeting

of the Board, the Health and Wellbeing Strategy Group had been tasked with developing a small number of high level priorities around which the full strategy could be developed. The priorities needed to be those with clear benefits and would need to be linked with clear outcome indicators. The Task Group had reviewed existing plans and priorities, the evidence base for effectiveness and cost-effectiveness had been taken into account, and the views of the Strategy Reference Group had been sought. From this, a proposed list of high-level priorities had been developed, and these were detailed, along with the relevant indicators from each of the three outcome frameworks.

Key strategic aims across all priority areas would be to improve health and wellbeing by **reducing health inequalities,** to **strengthen investment in evidence-based prevention and early intervention** and for all partners to deliver **high quality care that promoted privacy and dignity along with robust safeguarding processes**:

- Improve health and wellbeing in early years. Every child fit to learn and attain the highest levels of literacy. **Focus on early identification and intervention of vulnerable children and families (including children with disabilities)**
- Develop lifestyle services to prevent and reduce harmful alcohol consumption, obesity, physical inactivity, smoking and sexual ill-health. **Focus on preventing and reducing alcohol misuse, obesity and physical inactivity**
- Promote the independence of all people living with long term conditions and their carers. **Focus on providing community based support and care close to home including increased use of evidence-based telehealth and telecare**
- Improve emotional and mental ill-health and provide increased access to mental health services. **Focus on improving access to the full range of evidence-based psychological therapies (services that offer treatments for depression and anxiety disorders and other complex mental health problems)**
- Improve health and wellbeing of older people and promote independence into old age. **Focus on strengthening integrated working (pathways/referral mechanisms etc) between health and social care providers and housing-related support services (Las/registered social landlords/voluntary sector)**

Once agreed, the high level priorities would form the framework around which the full Strategy would be developed. The Strategy Task and Reference Groups would continue to work with the Health and Wellbeing Board in developing the strategy by June 2012, and feedback would be sought throughout the process. This would be closely linked with the ongoing development/refresh of the JSNA, and with emerging commissioning plans of

partner organisations. The publication of the final strategy in June 2012 would ensure that it could be a core part of partner's planning cycles for the 2013/14 year onwards.

The Board was in general agreement of the proposed high-level priorities, but commented on a number of issues that it was felt should be included, particularly drug/substance misuse, and the reference to telehealth and telecare, which could be broadened to self care. The document would be subject to further stakeholder consultation and the comments raised would therefore be considered.

RESOLVED to approve the proposed high-level priorities, taking into account the comments made, and to note the plans for developing the strategy.

4/12 PUBLIC HEALTH OUTCOMES FRAMEWORK 2013-16 The Board was presented with an overview of outcomes and indicators from the Public Health Outcomes Framework, which had recently been published. There were 66 indicators, and these would be public health outcomes from 2013. Of these, 29 were ready, but a number were classed as 'placeholder', which meant that these were the least developed indicators. It would be the responsibility of the County Council to show where improvements had been made, in partnership with the Health and Wellbeing Board.

5/12 OBESITY SERVICES IN DERBYSHIRE: COMMISSIONED SERVICES AND FUTURE STRATEGY ISSUES Obesity was a significant risk factor for many diseases that resulted in long-term ill health and disability, with a resource impact upon health and social care. Obesity provided a key link between disease and lifestyle topics, and as a result, obesity was now emerging as the key health improvement priority.

The national strategy A Call to Action on Obesity in England and the preceding Public Health white paper proposed that Tier 1 local authorities would take on responsibility for commissioning weight management services from April 2013.

Details were provided of the overweight and obesity rates as measured in Derbyshire in 2009/10 for Reception and Year 6 children. It was noted that obesity rates had almost doubled between Reception and Year 6, which reflected that national trend. However, there was a significant variation of obesity prevalence across the county. It was also estimated that there was approximately 190,000 adults in Derbyshire who were overweight or obese, and one of the challenges was that obesity was not generally perceived by the public as a problem.

A number of local services had been introduced and amended, based on a growing evidence base as to the most effective methods of prevention and treatment. In terms of the current approach, NHS Derbyshire County had taken an innovative approach to commissioning weight management interventions, and this included universal breastfeeding training for health workers and Children's Centre staff, investment in a targeted peer breastfeeding support service for the most disadvantaged wards, investment in the universal prevention programme Five60 for all primary school children, integration of the specialist weight reduction service into the Healthy Lifestyle Hub model, and development of the psychology led Tier 3 weight management programme for the morbidly obese.

With regard to early years and childhood obesity, Derbyshire wide levels of childhood obesity were lower than the population of England as a whole, although there were areas where childhood obesity was higher than the national average. In line with national trends, childhood obesity was increasing, which suggested that there needed to be a strengthened interagency approach. Details were given of the prevention and weight management initiatives – breastfeeding, maternity services, paid peer support, health visiting services, Healthy Start, HENRY (health exercise nutrition for the really young), National Child Measurement Programme, Five60, and the Family Weight Management Programme, which was a pilot that would target obese children and young people and their parents/carers. Evidence had indicated that parental participation was key to facilitate a change in family lifestyle choices, as the majority of obese children had at least one obese parent.

For adult obesity, Derbyshire had significantly worse levels than the population of England as a whole, and the Derbyshire Obesity Pathway outlined the services within the county that had been commissioned to combat obesity. In terms of prevention, details were given of the schemes that had been established – Walking for Health Programme, Active Derbyshire Partnership, Derbyshire 2012 Olympic legacy, and health trainer and health champion programme. For weight management, the Healthy Lifestyle Hub had been launched, and in recognition that not everyone would want to access traditional leisure services, providers had been commissioned to offer six available activities, including walking and activities suitable for older people. There was also the Health Referral Scheme and Waistwise, which had been incorporated to deliver in the Hub. It was anticipated that over 3,100 people would successfully complete the Healthy Lifestyle Hub programmes over the current year.

The Tier 3 Specialist Weight Management Service was a psychology led service for the morbidly obese, and an aim of Tier 3 was to reduce the number of people progressing to bariatric surgery by providing an alternative successful weight loss method. It was stated that the service had been

adapted to treat the client over a longer period of time to achieve the target weight loss goal and embed sustainable lifestyle behaviour change.

There were two interventions that were highlighted, but fell outside of the responsibility being transferred to the local authority. The first was prescribing, and from 2009/10 to 2010/11 there had been a reduction in prescribing. The second was bariatric surgery, which had also seen a reduction.

The way forward was discussed, and included developing a strategic framework. A number of principles underpinned the strategic approach, including highlighting and challenging the public perception of obesity, early intervention, parents who were obese shaping the environment in which their children grew up, consistent messages about food and physical activity, and that responsibility was with everyone.

A number of comments were raised by the Board, including that early intervention was key, and that it was essential to have a co-ordinated approach across all organisations. It was stated that it was the role of the Board to ensure that its views were delivered across organisations, and it was agreed that it would be useful to deliver this to the Children's Trust Board.

RESOLVED to (1) endorse the importance of the early years, including the key roles of health visitors, the importance of antenatal intervention, strengthening the links between maternity services and the Healthy Lifestyle Hub model;

(2) support development of obesity programmes to explore further support for weight management through intense family support models; and

(3) consider the possibility of a Commission or similar approach within Derbyshire to gather views and evidence to determine what can be done locally and to help engage wider stakeholders to encourage acknowledgement of responsibility towards obesity.

6/12 **CLUSTER LOCAL INTEGRATED PLAN** Following the annual publication of the Operating Framework, all PCT Clusters were required to develop and submit to the Department of Health a single system-wide Integrated Plan which included PCT Cluster Plans, CCG Plans, Public Health transitional plans, Provider activity planning and Quality Outcomes and Measures. This would reflect a range of requirements, performance challenges, and feedback.

The timeline was presented to the Board, and it was stated that the Plan would be developed with local authorities prior to final sign off on 31 March 2012.

RESOLVED to note the report and to receive a copy of the Derbyshire Local Integrated Plan at a future meeting.

7/12 DERBYSHIRE CLINICAL COMMISSIONING GROUPS UPDATE An update was provided on the progress in establishing CCGs in Derbyshire. The required pace of development of CCGs had increased significantly, with an expectation that each would enter a full 'shadow' year carrying out all functions from April 2012, ready for authorisation from September/October 2012 through to March 2013.

The Cluster Strategic Health Authorities were carrying out a series of Gateway Reviews of CCGs, and these were currently scheduled to look at configuration and capacity to perform all functions, governance and leadership. At the first Gateway, each CCG in the Midlands and East SHA had been given a rating, and High Peak CCG had been asked to consider its future as it was considered that it would be very difficult to fulfil all the statutory functions with a small population and resultant management cost available. It was stated that the Group had discussed this, and had agreed that it would not pursue authorisation as a standalone CCG, but would look to join an existing CCG as a locality. The preferred option was North Derbyshire CCG, and it was hoped that this would be confirmed shortly.

There was an expectation by both Strategic Health Authorities that all configuration issues would be resolved by the end of January, so that CCGs could be confident on which geographical basis they were moving forward.

Draft guidance had been issued on the make up of CCG governing bodies, and how the three key roles of the Chair, Accountable Officer and Chief Financial Officer would be identified and appointed. Consideration was being given to the roles of Chair and Accountable Officer, and it was unlikely that a post of Chief Executive would exist in the new commissioning structure.

In terms of next steps, the authorisation process was expected to be a combination of a number of elements – pre-application submission, application form with documented evidence of track record, 360 degree feedback from key partners and stakeholders, and site visit. Authorisation was currently expected to be in a series of 'waves' on a monthly basis from July (with a decision in October) through to October (with a decision in January).

RESOLVED to note the ongoing development of CCGs within Derbyshire and the expectations around the authorisation process.

8/12 DERBYSHIRE CLINICAL COMMISSIONING GROUPS' COMMISSIONING INTENTIONS FOR 2012/12 The Board was informed of

the NHS Operating Framework for 2012/13, and of the collective and individual commissioning intentions of the Derbyshire CCGs. Each year the NHS was issued with a set of expectations and requirements for the following financial year, and commissioners were required to issue a set of commissioning intentions.

During the next six weeks, contracts would be negotiated with all providers of NHS services which would commit to activity levels and funding from April 2012-2013. The PCT Cluster would also be coordinating a submission to the Cluster Strategic Health Authority detailing how all the targets and requirements of the Operating Framework would be met, along with a financial plan.

RESOLVED to note the national expectations of the local health system for the coming financial year as well as the emerging plans for the individual CCGs.

9/12 PUBLIC HEALTH TRANSITION UPDATE In Derbyshire, the PCT and the County Council had been working together on the transfer of the public health team and its functions, and it was expected that by April 2012, new arrangements would exist in shadow form and by April 2013, full legal responsibility would have been transferred.

In the past six months, planning had been strengthened by the development and work of a Transition Steering Group. This group brought together officers of both organisations, and had developed joint plans across a range of areas. These were detailed, along with progress and any issues arising. There were also a number of specific issues and concerns, and these related to policy development, parallel organisational changes, support structures in the PCT and public health, Glossopdale, links to Derby City and performance management.

In general, progress was good, but lots of detailed work remained around the transfer of staff, IT and contracts. It was stated that 2012 would be a busy period, but it would be important to keep public health services running well, and look at new opportunities that could emerge from the transition process. The public health team in the PCT worked closely with a number of stakeholders, and it was noted that these links would need to be protected through the transition process.

RESOLVED to note the progress made towards the transfer of public health responsibilities to the council, and to support the general approach being taken.

10/12 UPDATE ON THE NHS 111 IMPLEMENTATION IN DERBYSHIRE In July 2010, the Government had stated its commitment to a

national roll out of the new NHS 111 service. The aim was to develop a coherent 24/7 urgent care service that made sense to patients when making choices about their care. This would incorporate GP out of hours' services and provide urgent medical care for people registered with a GP elsewhere. The service would be more accessible by introducing a single telephone number.

There was a requirement to have full coverage throughout England by the end of March 2013, although this could be through a pilot project initially with full procurement to follow. This was the approach being adopted in Derbyshire, with a pilot working with Derbyshire Health United, the current out of hours GP service, with formal procurement due to be completed by October 2013, based on learning from the pilot. The national NHS Direct telephone number would be discontinued by April 2013.

North Derbyshire CCG was leading the work on behalf of all CCGs in Derbyshire. The pilot had a phased implementation, and the first phase of the pilot went live on 25 October 2011 in the Matlock, Bakewell and Chesterfield areas of Derbyshire. It was felt that the first phase of the pilot had been very successful, and activity had been within expected levels and had increased gradually since the service went live.

The 111 service was being implemented in four phases – Bakewell, Matlock and Chesterfield in October 2011, the rest of North Derbyshire from 20 February 2012, Derby City in March 2012, and the rest of southern Derbyshire in August 2012.

NHS111 would replace the existing health information and assessment service offered by NHS Direct on 1 April 2013, although it was likely that the NHS Direct service would stop earlier than this in some areas. In Derbyshire, discussions were taking place around the possibility of stopping the service from September 2012, and this would allow the moving of funding from the existing NHS Direct service to support the NHS111 pilot.

Derbyshire had chosen to pilot the service with the intention to have a procured joint NHS111 and Out of Hours service in place by October 2013. It was the intention to hold a workshop in April 2012 to consider what other services could be attached to 111 to make a more integrated resource for all people.

RESOLVED to note the progress being made on the implementation of NHS111.

11/12 **HEALTH AND WELLBEING ROUND-UP REPORT** A round-up of key progress in relation to Health and Wellbeing issues and projects was given.

The second reading of the Health and Social Care Bull had been completed in the House of Lords on 12 October 2011, and the Bill had then been put forward to a committee of the whole House for line by line examination, which had taken place on 21 December 2011. Further line by line examination of the Bill was yet to be scheduled.

At the beginning of January, the Department of Health had announced that the new start date for the establishment of the local HealthWatch was April 2013. The local work to prepare for procuring HealthWatch would continue, and it was expected that LINk funding would be extended locally until the end of March 2013. The Department of Health had also announced that there would be a small amount of funding in 2012/13 for the start up costs of establishing the local HealthWatch, and that HealthWatch England would be operational from October 2012.

Work had been undertaken to identify existing mechanisms for engaging stakeholders in the work of the Health and Wellbeing Board, and further work was to be undertaken to clarify existing mechanisms and to identify ways for stakeholders to access information and be more engaged in the work of the Board. A further report would be presented to the next meeting of the Board outlining a comprehensive plan. In the meantime, a further meeting of the Stakeholder Engagement Forum had been planned for the end of March, with the primary focus being to gain feedback on the draft priorities for the Health and Wellbeing Strategy.

At its meeting on 12 January, the Adult Care Board had agreed to establish a limited number of joint commissioning priorities for 2012/13. A task and finish group had been set up, and the proposed priorities would be considered at the next Adult Care Board, with the final proposals being submitted to the Health and Wellbeing Board.

Community Budgets for troubled were currently running in 16 areas of the country. The County Council was participating in the roll out of Community Budgets as a Phase 2 area, and had recently consulted with partners through the Derbyshire Partnership Forum about developing an approach and plan for Derbyshire to be in place from April 2012. The development of a Community Budget for troubled families presented an opportunity for partners to review, reshape and redesign services. Plans were likely to focus on the piloting of the project in a small number of geographical communities across the county in the first instance.

A new Troubled Families Team at the Department for Communities and Local Government had recently been established. A new Troubled Families initiative had been launched by the Team, and this was similar to existing Family Intervention models. £448 million was available nationally to support

the scheme, which would provide 40% of the total costs. The remaining 60% match funding would be sought from local authorities and their partners. All upper tier authorities had been asked to put plans in place before the end of March 2012 to ensure that the scheme was operational from 1 April 2012. A key piece of work to be undertaken as part of the scheme was the identification and mapping of families of families who met established criteria by February 2012, and this would ensure that there was an accurate understanding about the extent of such families in Derbyshire. Work to establish how feasible this was within the county was currently taking place with key agencies, and this was likely to inform any decision about participation in the Troubled Families initiative from April 2012 onwards.

A Child Poverty Needs Assessment had been produced, and had been presented to the Children's Trust Board. Having identified in some detail the scale of child poverty in Derbyshire, and its implications in terms of health, wellbeing and achievement, work would move into the next phase. This would involve looking at what was already in place for supporting children and families in poverty, talking to a range of stakeholders, and developing a strategic approach to taking further action within the resources available.

The Derbyshire Alcohol Advisory Service was a county-wide service where all referrals for Tier 2 and above were received and then allocated to a service Tier. The Derbyshire Drug and Alcohol Partnership Board had recently received a report from Jane Bethea, Speciality Registrar in Public Health, which assessed equity of access to the Service. A brief summary of the findings had showed that older patients over 60 years of age had poorer equity of access, the more affluent individuals had poorer access, and there were wide variations in referrals by GPs and by geographical area. This report had made a number of recommendations for further investigation and action, and these were to be considered by the CCGs.

A number of important policy documents had been produced recently, and these were highlighted.

RESOLVED to note the report.