MINUTES of a meeting of the **SHADOW HEALTH AND WELLBEING BOARD** held on 29 November 2012 at County Hall, Matlock

PRESENT

Councillor A I Lewer (in the Chair)

D Bailey	Derbyshire LINk
H Bowen	Chesterfield Borough Council
Councillor J Burrows	Chesterfield Borough Council
Dr D Collins	North Derbyshire Shadow CCG
Dr A Dow	Tameside and Glossop Shadow CCG
Councillor C A Hart	Derbyshire County Council
B Laurence	Derbyshire County Council
A Layzell	Southern Derbyshire Shadow CCG
Councillor B Lewis	Derbyshire County Council
D Lowe	Derbyshire County Council
R Marwaha	Erewash Shadow CCG
E Michel	NHS Tameside and Glossop
Dr A Mott	Southern Derbyshire Shadow CCG
C Newman	Hardwick Shadow CCG
J Pendleton	North Derbyshire Shadow CCG
B Robertson	Derbyshire County Council
Councillor R J Wheeler	South Derbyshire District Council
M Whittle	NHS Commissioning Board

Also in Attendance – J Cox (Derbyshire County Council), Councillor S J Ellis (Derbyshire County Council), Councillor G Farrington (Derbyshire County Council), E Wild (Derbyshire County Council)

Apologies for absence were submitted on behalf of A Gregory, Councillor C W Jones, Dr S Lloyd, S Savage, I Thomas and Councillor Ms A Western

52/12 **MINUTES** **RESOLVED** that the minutes of the meeting of the Board held on 27 September 2012 be confirmed as a correct record.

53/12 **DERBYSHIRE CCG'S COMMISSIONING STRATEGIES** The Board received a presentation from each of the CCG leads to demonstrate how their proposed Commissioning Strategies supported the delivery of the Health and Wellbeing Strategy. Each lead provided an overview of what their Groups had undertaken to develop their Commissioning Strategies, and what needed to be achieved prior to the documents being finalised and signed off early next year. The Groups had engaged as widely as possible, and each detailed their priorities, and the next steps.

The CCG leads were asked about the current position with regard to the authorisation process. North Derbyshire CCG had recently had its visit, and had been 100% authorised. South Derbyshire CCG had had 49 red indicators prior to the visit, but these had all now been approved. Tameside and Glossop CCG had had 66 red indicators, but this had now dropped to 14 after the visit. Erewash CCG had had 34 reds, but had cleared these by the end of the visit, although there were still a few small issues to complete. Hardwick CCG was in the final wave of authorisation, and was due to have its visit on 18 December. An update would be provided to the next meeting. It was felt that it would be useful to have a presentation from M Whittle on the role of the NHS Commissioning Board Local Area Team.

54/12 **EAST MIDLANDS AMBULANCE SERVICE CONSULTATION** It was reported that a consultation document had been circulated by East Midlands Ambulance Service (EMAS) regarding a major service reconfiguration, and the County Council would be responding to this. A number of consultation meetings had been held across the county.

Improvements to the service were needed, as EMAS had not been meeting its response time targets, and had consequently been fined. It also needed to find £30m worth of savings. The Board was informed that EMAS was proposing to close all fourteen existing ambulance stations in Derbyshire, as these were considered not fit for purpose, and replace these with two hub stations at Chesterfield and Derby and 26 Tactical Deployment Points around the county.

Some concern was raised as to whether the proposed service would meet the needs of residents in the south of the county and those in High Peak. However, there was a general agreement that something needed to be done. D Lowe and Councillor A Lewer would be meeting with the Chief Executive of EMAS, and a formal response to the proposal would be submitted. R Marwaha offered to produce a briefing paper as to the current situation, and this would be circulated to members of the Board.

The consultation period ended on 17 December 2012.

55/12 **WINTERBOURNE VIEW** The Board was informed of the joint actions being undertaken by the local NHS and Adult Care to address the concerns raised by the treatment of people with learning disabilities at Winterbourne View private hospital.

Two reports had been considered by the Adult Care Board, Adult Care's Senior Management Team and Hardwick CCG/Derbyshire Cluster Board. These outlined the continuing action that was being taken by local agencies to minimise the use of out of County private hospitals for people with learning

disabilities, and to review and return wherever possible to Derbyshire, people currently placed out of the county.

It was stated that there were currently over 20 people who were in private hospitals out of the county, and the priority was to bring these back into Derbyshire. Work was taking place with Hardwick CCG to re-commission services locally for people with learning disabilities. Adult Care was also responsible for over 100 people in residential care outside the county, and it was the intention to reduce this. It was felt that there needed to be a model for accommodation, care and support, and a strategy for people with learning disabilities. Hardwick CCG now had a nurse in post to look at this work.

RESOLVED to receive the report and seeks further reports updating about progress on this topic.

56/12 **ADULT CARE BOARD TERMS OF REFERENCE** It was reported that the Adult Care Board, which was accountable to the Shadow Health and Wellbeing Board, had been operating with draft Terms of Reference. These had now been reviewed at the Adult Care Board and had been amended to reflect the Board's responsibilities and activities. In addition, the membership of the Adult Care Board had been reviewed to reflect the changes in the structure of the local NHS. The proposed Terms of Reference were presented.

RESOLVED to agree to the proposed Terms of Reference for the Adult Care Board.

57/12 **HEALTH NEEDS OF VETERANS** Recent media attention on troops returning from conflict had renewed the interest in the duty of care owed to serving personnel and veterans. The Military Covenant aimed to enshrine this duty of care in law, and had highlighted a specific group of people who could have very specific health needs. The four key principles of the Military Covenant for service people, their dependants and veterans were that they suffered no disadvantage, they were able to manage their lives as effortlessly as anyone else, they received continuity of public services, and they could expect proper return for sacrifice. Regarding healthcare for veterans, the wording of the Military Covenant was stated, and as a result there had been a number of legislative initiatives to ensure that support for veterans remained a focus.

At a local level, Armed Forces Community Covenants were intended to complement the National Military Covenant. The aim of the Community Covenant was to encourage local communities to support the Service community in their area and promote understanding and awareness amongst the public. All local authorities in Derbyshire had recently signed a Joint

Community Covenant along with representatives of the Armed Forces, Service Charities and the business community.

The 2008/09 NHS Operating Framework had required PCTs to provide an effective transition of care from Defence Medical Services to the NHS and to ensure that commissioned mental health services were culturally sensitive to the needs of veterans. Subsequently, the revision to the Operating Framework for the NHS in 2010/11 had identified the provision of appropriate treatment for veterans as one of two areas that had been given insufficient emphasis in Strategic Health Authority plans. Strategic Health Authorities had been charged with ensuring continuity of this work during the NHS transition period.

The Operating Framework for the NHS in England 2012/13 stated that Strategic Health Authorities should continue the work of the Armed Forces Network in delivering the principles of the Armed Forces Covenant until April 2013. The requirements were that the Ministry of Defence/NHS Transition Protocol should be implemented, and following April 2013, the new structures would need to take responsibility for addressing veterans' health needs.

In line with the latest NHS Operating Framework, ten Regional Armed Forces Networks had been set up across the country. The East Midlands Armed Forces Network had been launched in 2011, and the purpose of the network was to oversee work which was being carried out to help veterans, service personnel and their families. The East Midlands Armed Forces Network was currently active, and work up to now had been around 'troubleshooting' health and housing issues, with a focus on personnel who were in service but faced transitions from area to area. Nottingham City NHS, which led the network, wanted to re-launch it in the New Year, and this could be with the new CCGs.

It was estimated that there were approximately four million veterans, about half of whom had left the Services before 1960. In addition, there were 5.4 million spouses, partners and dependants. It was suggested that there were just over 50,000 ex-Armed Forces personnel living in Derbyshire. Around 60% of all veterans were aged over 65, and accounted for such a high proportion of that generation that they were not generally recognised as having distinctive health needs. Armed Forces families, spouses, partners and dependants of Service personnel needed to register to receive healthcare through the NHS in the same way as all other UK residents, but as a mobile community they encountered problems registering with GPs, NHS dentists and accessing NHS treatment, as they had often moved by the time they had reached the top of waiting lists for an appointment.

Since 2008, NHS priority treatment had been extended to all veterans with a Service related injury or illness, although priority was not given over

patients with more pressing clinical needs. Research had found that few veterans received this level of service, and 81% of GPs knew nothing or very little of their responsibility to provide it. There was therefore the issue of identifying those who were entitled to priority treatment.

Recent research confirmed that service personnel were at greater risk of developing mental health problems than the general public, and research had also identified that alcohol misuse was a problem in UK Armed Forces personnel and veterans. Heavy drinking was also closely correlated with smoking, and slightly poorer subjective mental and physical health.

In terms of next steps, one issue was informing local policy. Social care and public health policy impacted on a variety of areas where there was a clear need for service provision for the Armed Forces community, including alcohol treatment, mental health care provision for those struggling with their combat experiences, and elderly veterans requiring home adaptations to remain independent. There was currently no clear information on veterans and the wider ex-Armed Forces community in Derbyshire and their specific health needs. This made it difficult to inform social care and health policy, and it would be appropriate for this to be considered as part of the development of the Joint Strategic Needs Assessment. If military veterans disclosed their status, this should be recorded to allow clinicians to assess whether their condition was related to their service and to refer in line with the commitments made in the Armed Forces Covenant.

There were also two key areas where immediate action could be taken to better serve the needs of veterans and their families around accessing healthcare and NHS priority treatment. In September 2011, the Department of Health had launched an e-learning package to help GPs understand the issues impacting on the health of those serving in the Armed Forces, Reservists, the families of those services, the bereaved and veterans. GPs who completed the course would be more likely to be able to identify a veteran and address their needs more appropriately. GPs would be encouraged to access the e-learning package. There was also a need to ensure that health practitioners were fully aware of the rules regarding eligibility for priority treatment, and it was proposed to work with CCGs to assist in ensuring that GPs were aware of NHS priority treatment.

RESOLVED to (1) note the key health issues affecting Armed Forces veterans; and

(2) agree the actions set out.

58/12 **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 Board development session to be facilitated by the LGA would be held on 18 December 2012. This session would focus on one of the key priorities identified at the first session – How to have serious conversations about difficult changes ahead.

The HealthWatch Project Development Group had completed the engagement process to help determine what the new local HealthWatch service should focus on. The findings were being collated in a report that would be circulated to interested parties.

It had been agreed to recruit an 'Implementer' to assist with the setting up of HealthWatch Derbyshire as a new not for profit organisation. Following a tender exercise, the Council had appointed an organisation called Exact to assume this role. Exact was now leading on recruiting an executive board before assisting new board members in the development and setting up of the new HealthWatch organisation. The opportunity to join the Board had been advertised across Derbyshire. The County Council had written to the hosts of Derbyshire LINk to advise that the contract would end on 31 March 2013, and it was planned that the new HealthWatch Derbyshire organisation would work with the LINk hosts to ensure a smooth transition of activity.

The DoH had published the technical refresh of the 'Public Health Outcomes Framework' (PHOF) on 20 November 2012, at the same time as the PHOF Data Tool for England. This contained the first set of baseline indicator data and could be viewed at www.phoutcomes.info. Building on the framework published in January 2012, the PHOF data had been produced by the network of Public Health Observatories in England. The PHOF set out overarching objectives for public health, the desired outcomes and the indicators that would help to understand how well public health was being improved, protected and the extent to which inequalities were being narrowed. The tool contained data for 39 public health indicators split over four domains – improving the wider determinants of health, health improvement, health protection, and healthcare public health and preventing premature mortality.

The updated versions of the PHOF document and the DoH's press release could be found at www.dh.gov.uk/health/tag/phof/. The publication of the frameworks, including the Adult Social Care Outcomes Framework, constituted a structure for measuring improvement across the system.

The Chief Medical Officer's Annual Report (volume 1) had been published recently, and this contained information, charts and maps covering demography, mortality, morbidity and wellbeing, risk factors, social determinants of health, and healthcare. Three priority areas that were highlighted this year were liver disease, variable access to healthcare, and the importance of strengthening surveillance and intelligence systems.

59/12 **DERBYSHIRE LINK** D Bailey reported that the HealthWatch Board would be in place by the end of the year, and it was agreed that there would be an update to the next meeting as to who would be represented on the Board.

60/12 **DERBYSHIRE COMMUNITY HEALTH SERVICES** Some concern was raised regarding changes that were taking place across the county relating to a reduction in the number of beds at hospitals and, it was stated that members of the public were concerned over the lack of information relating to this. It was stated that there would be a presentation by the DCHS to ensure that the public were aware of the changes that would be occurring.

61/12 **ILKESTON FAMILY CENTRE** R Marwaha reported that a press release had been circulated regarding the closure in February 2013 of the Ilkeston Family Centre. The press release would be distributed to members of the Board.