Rutland Shadow Health and Wellbeing Board

Tuesday 23rd October 2012, 2pm in the Council Chamber, Rutland County Council (RCC)

1. INTRODUCTION AND APOLOGIES FOR ABSENCE

Cllr Emmett is involved in the Corby bi-election and therefore CC stood in as chair for this meeting. CC Chaired the meeting on behalf of Cllr Emmett.

Those present were:

Carol Chambers	Director for People, RCC (Chair)	**CC**
Jill Haigh	Senior Manager Health, Wellbeing and Commissioning	**JH**
Peter Marks	Director of Public Health	**PM**
Dominic Cox	Chief Operating Officer, East Leicestershire & Rutland Clinical Commissioning Group (ELRCCG)	**DC**
Andy Ker	Locality Lead for ELRCCG	**AK**
Carol Underwood	Head of Support Services at Spire (on behalf of Katy Sagoe)	**CU**
Christine Stanesby	Rutland Local Involvement Network	**CS**
Cllr Roger Begy	Leader of RCC	**RB**
Liz Rowbotham	Director of Quality, National Commissioning Board	**LR**
Karlie Thompson	Assistant Director of Operations, Leicester, Leicestershire and Rutland Division of East Midland Ambulance Service (EMAS).	**KT**

Apologies were received from Jane Clayton Jones, Dave Briggs and Cllr Emmett.

2. MINUTES OF THE MEETING HELD JULY 2012

2.1 The minutes were accepted as a true record of the proceedings.

3. MATTERS ARISING

3.1 JH noted that little progress had been made around Well London and implementing something similar for Rutland. RCC leadership team received a presentation on the subject; there is an appetite for this type of work locally. Cathy Ellis has been to visit the project. JH suggested that the next step is to consider how it might look in Rutland however at present focus has been on public health coming into Rutland and developing the Health and wellbeing strategy. JH proposed bringing something to this board in the new year. RB recommended not getting it lost in the budget process as if you leave it too late there may not be any funding. **JH**

4. DECLARATIONS OF INTEREST

4.1 The following declarations of interest were noted:

RB – Sits on the Leicestershire Partnership Trust (LPT) shadow council of governors, as of the next meeting he will not have this role.
KL – Her father is the Practice Manager of Uppingham Surgery.

5. CONSULTATION "BEING THE BEST AMBULANCE SERVICE" PROPOSALS

5.1 EMAS is currently out for formal consultation on the "being the best strategy" from 17th September until 17th December. The chair recognised that this will impact Rutland and the board welcomed the opportunity to hear more. See **attachment 1** to the minutes for KT's presentation.

5.2 EMAS is also consulting on a management restructure to reduce management costs; proposals have been pulled together with staff from across the division.

5.3 EMAS hasn't looked at its ways of working for some time so this is seen as a great opportunity.

5.4 The main emphasis of the changes is around two Hubs ("Superstations") to work out of Leicestershire; this is where the majority of their vehicles will be housed.

5.5 There will be community ambulance posts which are small stations; it is suggested that these be moved into other public sector buildings in order to reduce costs such as energy bills etc, examples of where such facilities might be house is within local authorities, fire stations, police stations; KT noted that EMAS is already starting to speak with partners about possibilities. There has been no decision as to where these will be yet; this is a listening exercise and EMAS wants to hear the views of stakeholders.

5.6 The proposed arrangements will mean that ambulances will only usually touch the station 3 times to incorporate a meal break with a very limited amount of waiting at stations, shift patterns will change.

5.7 It is about changing the way EMAS responds and it is not a money saving exercise; EMAS is trying to be smart about what resources are deployed. EMAS is looking at best practice and expects to see a 5% increase in performance against targets. Any savings made will be used to create super stations and community hub posts.

5.8 A map demonstrated that there are 66 existing stations versus the 131 community hubs that are proposed.

5.9 KT has consulted over 100 groups/meetings and there has been lots of media coverage. All responses will be analysed and pulled into a themed report. Changes made will be implemented over the next 3-5 years.

5.10 KT invited questions from partners:

- *AK struggled to understand how response times will increase in Rutland as there is no improvement in terms of the number of*

hubs in this area. AK further noted that ambulance wait times are far too long. KT stated that she is keen to understand how EMAS can develop pathways and improve things from each partner's point of view and experience; we need to work together as a healthcare community to put the right resources on the road. KT is happy to go into more detail and discuss further with AK. **KT** **AK**

- *How will you stop ambulances from being stranded in the City?* There are initiatives in the City Centre to limit this, for example pool vehicles and bikes within a 3 mile radius of the centre; EMAS is looking at how they stop resources from rural areas being drawn into city incidents.
- *PM understands the concept but agreed with AK that there is very thin provision in Rutland. How will EMAS make a 5% increase in performance and what does this mean? PM expects there will be winners and losers. Has staff health and welfare been considered; without the stations where are staff going?*
  KT responded:
  a) Meal breaking will be at the community ambulance posts, staff will be involved in developing the hubs and posts.
  b) Quite a common concern is staff having to drive further to pick up the ambulance; KT confirmed that this is being considered.
  c) 5% increase in performance is an estimate, Leicester city, Leicestershire and Rutland is the best performing area in the East Midlands.
  d) There won't be "winners and losers", improvements will benefit rural areas.
  e) EMAS is commissioned to achieve response in 8 minutes 75% of the time, at least 78% of the time they are above target.
- *CU recommended that they consider sheltered housing sites as hubs*; KT is keen to talk this through with CU. **CU** **KT**
- *RB was keen to see the rural performance figure as he expects that this is a different reality.* KT confirmed she could provide stats that discount the city performance. RB's feedback from ward members is that the community is not happy about the current ambulance waiting times. KT suggested that the perception versus reality is an issue. **KT**
- RB raised concern around staff in rural areas having a significant drive at the start and end of every shift to pick up the vehicle e.g. 12 hour shift with a 1 hour drive each way is not acceptable. KT noted that there are options being considered e.g. man in a van

delivering vehicles, whether the ambulance has to be returned after each shift etc, a solution is being developed.

- EMAS sees the loss of patient transport as a shame; it is something that the service didn't want to lose although it hasn't affected performance. EMAS does work in partnership with the new provider. EMAS will fight to get the service back when the opportunity arises (PTS is the new provider).
- EMAS is exploring options with the fire and police around first response. The police station on station road has been offered to EMAS as one hub location.
- DC is keen to understand how the CCG cam work together to reduce the demand, the CCG has just started having discussions around ambulance call triggers. Discussions are on going with the Emergency Care Network to take pressure off CCGs, KT suggested meeting with DC to move this forward. KT can arrange for clinicians to work around the assurances we need with DC. **KT DC**
- CC questioned how sustainable the solutions are for a growing population and the changing demands (e.g. ageing population), how is this being future proofed? KT noted that we need to do things differently through working with partners on new ways to increase efficiency and ensure resources are used in the best way. Such changes should mean there is increased flexibility as populations change.
- The chair suggested that a formal response from the Health and Wellbeing Board is recommended. It was queried how EMAS will be built into future discussions with the board in order to improve services, this is a challenge for the future. KT is more than happy to attend HWB meetings and EMAS will be working more closely with CCGs. **KT**

It was agreed that KL prepares a draft response based on the comments and questions raised during this meeting. **KL**

6. JOINT HEALTH AND WELLBEING STRATEGY

6.1 There was a further development session held a few weeks ago, this was a helpful session with lots of discussion around what the strategy should look like.

6.2 Graham Johnson (consultant) will be offering some support to develop the document.

6.3 JH introduced a draft health and wellbeing strategic statement which aims to meet the government's requirement, it was seen as important not to rush to get a strategy in place too soon.

6.4 JH proposed that there be a number of further strategy development sessions led by graham Johnson (consultant) and JH. Buy in to these sessions from board members is crucial. The following was noted:

- DC questioned the timing? Without a solid strategy in place how will this board influence commissioning decisions etc?
- DC's concern is that organisations are going into planning processes over the next 2-3 months, and clarity and direction is need for other organisations, a bit more expansion is required on the statement.
- RB agreed that partners need to work in the same direction; it will be a question of supporting each other.
- JH noted that the Integrated Commissioning Group (ICG) should address some of these concerns.
- DC proposed that a more definitive direction by Christmas would be useful.
- PM thinks we need to do it right rather than quickly; however recognise that it won't fit in with CCG timing. Priorities are still very broad and these do need streamlining to give more guidance to the CCG, the other issue to consider is that we will need to look at what is going to be decommissioned.

6.5 JH suggested that we need to come to a compromise, is there anything we can do through the ICG to satisfy some of DCs concerns? JH is keen for an understanding around how much detail the CCGs and commissioning board requires to influence decisions:

- LR suggested that commissioning decisions will be made by Feb/Mar 2013.
- The ICG terms of reference approval is required today so that this group can then be set up. The first meeting can then take place in November or December.
- PM queried whether it would be easier to capture what we can, and justify which ones are the important issues and which ones we are not so keen on e.g. where it impacts on less people or evidence that it works.
- LR - the focus on what is in the strategy needs to be on areas where there is added value to the partnership, this shouldn't stop having the development sessions.

6.6 Partners agreed that we need a pragmatic decision on something that helps to shape year. DC suggested that a couple of people get together a couple of times (this might involve some people from the ICG), PM recommended 2 meetings back to back (ICG and Strategy). This work is to be circulated to the HWB electronically for approval.

6.7 It was agreed to utilise development sessions for the longer term strategy.

6.8 The Strategic Statement was approved in principle; the ICG to come up with a number of more streamlined priorities. **JH**

7. HEALTHWATCH

7.1 JH provided a verbal update on what progress is happening locally with Healthwatch; there is a requirement to have this set up by April 2013. **JH**

7.2 Rutland is working with Leicestershire but on a different procurement timeline.

7.3 Meetings have taken place with CAB, LINk, Communities Of Practice and RCC.

7.4 LINk is undertaking its own consultation and this will feed into the Healthwatch vision.

7.5 It was agreed that JH bring the Healthwatch specification for partners to see to the next Board meeting in February. RCC may opt for the grant aid option in the first year as there might not be time to go down the procurement route, this would give RCC time to prepare for procurement in time for the second year.

8. INTEGRATED COMMISSIONING GROUP (ICG)

8.1 The board received a report outlining a proposal for an ICG to form in Rutland; this would be a subgroup of the HWB with two main aims:
1. Oversee the management of relevant areas of existing joint NHS and local government investment.
2. Look at new opportunities for greater alignment between health and social care expenditure, greater resource efficiency and potential decommissioning plans.

8.2 JH noted that the Complex Needs Group never formed, from further discussions in the senior officer group it was suggested that the ICG in Leicestershire works and this was a structure that would be beneficial in Rutland.

8.3 JH invited the board to comments on proposed ICG:

- DC suggested he attends these meetings
- Do we need Children & Young People influence on this group
- At present JH is the RCC lead on this group at the moment, membership needs to include colleagues that can influence and commit resources
- Membership was noted as a bit thin
- “Senior representation” needs defining

8.4 JH to circulate a revised membership. **JH**

8.5 JH to go ahead and set this group up. **JH**

9. CLINICAL COMMISSIONING GROUP UPDATE

9.1 DC - In terms of the CCG authorisation process, ELRCCG had a site in September, this was a positive outcome for all. It was examined on various aspects; areas for improvement that were identified included the Long term strategy, specifically with providers. The output will come in December, it was challenging but it went very well. The chair congratulated the CCG on the progress that it has made to date.

10. PUBLIC HEALTH TRANSITION ASSESSMENT

10.1 The board was provided with a copy of the assessment which was submitted on 10th October identifying the position reached in this locality with regard to the transition of the public health function from PCTs to the Local Authority.

10.2 No feedback has been received as yet although PM is confident that Rutland is not an area that will come under scrutiny.

10.3 All public health contracts are to be transferred by the end of March; the main issue will be Rutland having such a small grant, solutions to these problems are being developed.

10.4 RB is working as part of SPARSE, challenging why rural authorities are getting such a small amount of the budget. E.g. Leicester City gets twice the figure per head of population than both Leicestershire and Rutland. The Department for Public Health does seem to be listening to the feedback that they are getting.

10.5 The lowest allocation areas may well get an adjustment to the funding currently allocated. Rutland won't know what allocation we are given until mid December.

10.6 PM reassured the board that they have plans to manage the pressures if necessary (in the first year). This report was taken through cabinet last week.

11. DIRECTOR OF PUBLIC HEALTH (DPH) – ANNUAL REPORT

11.1 The DPH traditionally produces an annual report; this will become a statutory function of the DPH and a statutory responsibility for the Local Authority to publish it.

11.2 There are many issues around the ageing population both now and in the future for health, thus PM decided to have this as the focus for this years report.

11.3 Issues around mental health in old age are considered within the report.

11.4 PM noted that this report in for Leicestershire and Rutland, as the function moves to Local Authorities there will be a Rutland specific report.
11.5 JH recognised that it was good to see Rutland case studies reported in the document.
11.6 CS took this to LINk this morning.

12. EMERGENCY PLANNING IN THE NHS

12.1 There is a responsibility to ensure that plans are in place local authorities to have a local health resilience partnership (Rutland is part of the Leicestershire Resilience Forum), a new group has been formed and is aligned to LRF.
12.2 A report was provided to update the board where Rutland is, an assurance workshop held recently demonstrated that Leicestershire and Rutland is ahead of other areas and the report assures that the group is on track. Peter Marks continues to chair this new group.
12.3 LR noted that Trish Thompson is in post, and is aware that she will co chair.
12.4 The board noted the development and partners agreed that they were assured.

13. HEALTH PROTECTION

13.1 There is a proposal to set up a health protection board in Leicester City, County and Rutland; this will be set up on the same footprint as LRF and would become a sub group of each of the relevant Health and Wellbeing Boards.
13.2 This will help us have that assurance that all of the requirements are being met. It is proposed that one of the DPH chairs the board.
13.3 The membership is still being finalised. A LINk representative will be considered, it maybe that there is one representative from across the areas to attend.
13.4 Questions and comments were invited:

- JH – noted that this needs to be added to the HWB substructure. Reports six monthly to this board. **KL**
- Partners were happy with the proposal. Rutland would like its own representatives there.

14. CARERS STRATEGY

14.1 Partners were asked to note the contents of the carers' strategy. This is a Leicester City, Leicestershire and Rutland strategy that Rutland has

signed up to.

14.2 A Strategic action plan is now being worked on; this will form some of the work of the ICG.

14.3 AK noted that carers support is picked up in the integrated commissioning plan for the CCG.

14.4 The action plan will to go to the ICG, it will be necessary to have discussions about how we manage these processes.

15. BOARD SUBGROUP UPDATES

15.1 A report was supplied outlining the progress of the Staying Healthy subgroup –

- A very small pot (Community Grant Scheme) is going to the community and voluntary sector; RB noted that this is very useful, exactly how to spend this is still to be determined.
- There is a lot of work going on to sort out sexual health service provision; JH and PM continue to have discussions on this.
- Findings suggested that alcohol has a bigger impact on sexual health than drugs.

15.2 Children's Trust:

- The Children, Young People and Families Plan has been finalised, Trust partners hope to see priorities and key points in the CYPF plan included in the Joint Health and Wellbeing Strategy when this is developed.
- The Trust also anticipates that any other issues around Children and Families go to the health and wellbeing board, including safeguarding, troubled families and mental health. The work on children's centres needs feeding into the strategy also.

16. ANY OTHER ITEMS WHICH THE CHAIR HAS DECIDED TO TAKE AS URGENT

16.1 CC suggested that as a formal board we consider how we are going to take questions from the public in future. However the current procedure is that the board invites questions or comments that members of the public wish to raise with the board, these need to be received at least one week in advance of the next meeting, questions were received from Mark Bush which the chair wished to answer:

- He recognised that this board is fighting its way through bureaucracy; *Mr Bush questioned how the board is going to measure performance? E.g. what success will look like?*

  The Board will have regular item outlining performance indicators so that we can review progress against priorities. PM noted that there will be a series of public

health outcomes frameworks etc so the board will be benchmarking against this, this will be public information.

- *How will you deal with things in the press?*
  CC noted that the Board will want publicity as this a huge and unusual transition. We have engaged with stakeholders and providers to get to the stage we have got to and we will continue to do this in the future. The ICG will need to take on board the views of providers and commissioners.
  DC noted that the focus thus far had been on engagine local providers e,g. University Hospital Leicester and Leicestershire Partnership Trust but we do hope to make broader connections with Peterborough as well as the South Lincolnshire CCG to develop discussions and get to grips with contracts and how we influence contracts and how these are dealt with.
- Mr Bush noted was interested to hear from the Ambulance Service at today's meeting. Acute hospitals are being encouraged to get involved in HWBs so may be present at future meetings.

16.2 LR noted that by 12th Februrary 2013 more services will be transferred to the local area team director, this might be Trish Thompson, LR will let KL know when this is finalised. Trish would be the person attending future board meetings. **LR** **KL**

17. DATE OF NEXT MEETING

17.1 Tuesday 12th February 2013, 2pm in the Council Chamber

The Meeting closed at 16.01