Committee and Date	Item
Shadow Health & Wellbeing Board 14 December 2012 9.30 am	**3** Public

MINUTES OF THE SHADOW HEALTH AND WELLBEING BOARD MEETING HELD ON FRIDAY 5 OCTOBER 2012 AT 9.30AM IN THE SHREWSBURY ROOM, SHIREHALL, SHREWSBURY

Responsible Officer Karen Nixon
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PRESENT

Members of the Shadow Board:

Councillor Ann Hartley	Portfolio Holder for Health and Wellbeing (Chair for the meeting)
Councillor Steve Charmley	Portfolio Holder for Health and Wellbeing
Councillor Cecilia Motley	Portfolio Holder for Flourishing Communities/Education and Skills
Dr Bill Gowans	Vice-Chairman, Shropshire CCG
Dr Helen Herritty	Chairman, Shropshire CCG
Dr Caron Morton	Accountable Officer, Shropshire CCG
Sonia Roberts	Chairman VCSA
George Rook	Chairman Shropshire LINK
David Taylor	Corporate Director – People
Prof. Rod Thomson	Director of Public Health

Officers and others in attendance:

Stephen Chandler	Group Manager, Assessment and Eligibility
Councillor G Dakin	Chairman of the Healthy Communities Strategy
Janet Graham	Group Manager, Care and Wellbeing
Carolyn Healy	Partnerships and Health Integration Manager
Councillor M Shineton	ALC representative

28. APOLOGIES

Apologies for absence were received from Councillor Keith Barrow, Harmesh Darbhanga, Dr Julie Davies and Paul Tulley.

29. DISCLOSABLE PECUNIARY INTERESTS

There were none.

30. MINUTES

RESOLVED

That the Minutes of the Shadow Health and Wellbeing Board meeting held on Friday 14 September 2012 be approved and signed by the Chairman as a correct record.

31. INTERIM REPORT ON THE CONSULTATION FEEDBACK FROM THE HEALTH AND WELLBEING STRATEGY

31.1 The Chair thanked Carolyn Healy for such a full report, commenting that pleasingly feedback so far was good. It was now time for Members to reflect and take ownership of this. Slides had been prepared to aid discussion which were welcomed by the Group.

31.2 Carolyn Healy introduced and amplified a report on consultations undertaken on the draft Health and Wellbeing Strategy. Consultation to date showed broad support for the outcomes and priorities within the strategy. Feedback included some very helpful suggestions on how the priorities could be delivered and many respondents expressed a willingness to continue to be involved in developing delivery plans.

31.3 The consultation period ends on 12th October 2012. Responses to date show support for the intentions behind the strategy, the long term outcomes and for most of the priorities. Key areas for improvement highlighted by both the survey consultation and the workshops were that there needs to be more emphasis on the root causes of ill health and recognition of the broad range of partners, including individuals and communities that need to be involved in addressing the priorities. The strategy will also need to achieve the right balance between being ambitious in order to drive change, and having measurable outcomes to track progress. Improving the language and ensuring that there is no jargon (or at least that it is explained) is also important if the strategy is to be meaningful to local people and professionals alike. The following key points were discussed:

31.4 <u>Strategic Ambition</u>

Option 1: The vision and outcomes should be ambitious and aspirational and give a clear direction of travel.

Option 2: The vision and outcomes should be realistic, achievable and measurable.

Option 3: other suggestions by board members.

After some discussion it was generally agreed that the Board wished to achieve a realistic balance between Options 1 and 2.

Some members preferred to be ambitous and reach high. Others preferred to be more realistic about what can be achieved. It was generally agreed that clear outcome measures were required. Lots of visionary ambitions were often long-term, so it was accepted this would not happen overnight, whilst it was agreed it would be good to look towards milestones.

It was noted that the CCG had found that it helped greatly to get back to the fundamentals; in other words "doing the ordinary, extraordinarily well". The overall tena was to be ambitious, but to include more detail about targets and ouputs and to show the direction of travel.

It was agreed that public expectations would need to be managed and that there would need to be a shift in underlying attitudes.

It was highlighted that nowhere in the document was funding or budgets mentioned. It was agreed that it would have to be stated somewhere and that ambitions could only be realised within resource limitations.

It was noted that the County was 'volunteer-rich' and that this needed to be captured within the document.

It was agreed tha the strategy outcomes and priorities would be re-phrased subject to the discussions of the Shadow Health and Wellbeing Board. It was highlighted that there was a potential ambiguity at Outcome 1, which needed to be clarified.

31.5 Cross Cutting Principles

Option 1: Retain as is.

Option 2: Include an additional cross cutting principle relating to Patient Choice.

Option 3: other suggestions by board members.

It was agreed that Option 2 was preferred. The idea of patient choice being articulated much more had come out from the recent workshops. A discussion ensued about what people meant when they used the word 'choice'.

It was agreed that Carolyn Healy would draft something in respect of this and circulate to everyone following the meeting for approval.

31.6 Priority 1: Obesity

Option 1: Retain the word 'obesity' to be clear about the issue that needs to be addressed.

Option 2: Reword the priority to "Increasing the proportion of children and adults that have a healthy weight".

Option 3: change the priority.

It was agreed that Option 2 was preferred. Feedback from young people showed they did not like the word obese and instead preferred the term 'healthy weight'.

Mr Dakin urged the Shadow Board to lobby manufacturers about the labelling of food, to be clearer and consistent with their labels, which was noted.

31.7 Priority 2: Children's Mental Health

Option 1: Retain the focus on children and young people, and on prevention and early intervention, but outline that services for adults and children with existing needs will still be supported and provided services.

Option 2: Remove the focus on children and young people and / or the focus on prevention.

Option 3: other suggestions by board members.

It was generally agreed that early intervention was good and therefore that Option 1 was preferred.

It was noted that recent CAHMS work might be helpful aswell as information from Young MIND. It was hoped to stop medicalising terms and look more to well-being and building resilience. Recently the number of referrals to CAHMS had increased and it was agreed that those working with children needed to be educated when it came to mental issues.

31.8 Priority 3: Dementia

Option 1: Retain the priority but correct some terminology errors in the supporting text and provide more explanation about dementia friendly communities.

Option 2: other suggestions by board members.

Option 1 was preferred. It was agreed to retain the prioriy, but correct the terminology; there were errors in the supporting text. It needed to provide more of an explanation about demetia friendly communities.

31.9 Priority 4: Assistive Technology

Option 1: Reword as "Develop the use of assistive technology, telecare, telemedicine and reablement to enable people to remain independent and connected to their communities" & provide examples and more explanation of the terms, and stress the importance of retaining personal contact to combat loneliness in the supporting text.

Option 2: Reword the priority to "Support people to remain independent and connected to their communities through increased use of traditional and modern technologies and help when they leave hospital.

Option 2 was preferred in principle as long as this was clearly explained and not too technical (it was agreed this was really a wording issue). Members were mindful that taking away the human element was often of concren to some people and that this neded to be borne in mind. It was agreed that Carolyn Healy would re-write this.

31.10 Priority 5: Smoking in Pregnancy

Option 1: Retain the priority.

Option 2: focus on addressing smoking in all groups and all areas.

Option 3: focus on neonatal and post natal support to ensure the best start for all children.

Option 4: change the priority to "Work with partners to address the root causes of deprivation".

Option 5: Make a commitment to address deprivation by focussing on a particular aspect eg, reduce child poverty.

Option 4 was preferred. It was agreed that this priority needs to link into other boards and strategies, and should not sit in isolation.

It was noted that there had been some recent research around the clustering of unhealthy behaviours, particularly in communities living in deprived areas, and that addressing this in a more holistic way may achieve better outcomes.

31.11 Priority 6: Collaborative Commissioning

Option 1: Retain the priority.

Option 2: other suggestions by board members.

It was agreed that Option 1 was preferred.

31.12 Priority 7: Easier Access

Option 1: Retain the priority

Option 2: other suggestions by board members.

It was agreed that Option 1 was preferred.

31.13 General Points to consider

How best can the Health and Wellbeing Strategy recognise the needs of specific groups (autism, sensory impaired, learning disabilities etc)?

How best can the strategy reflect the impact on health of other factors such as transport and education?

Is the balance between individual responsibility and agency responsibility right?

On the one hand it was generally agreed that there was a need to communicate that the strategy encompasses 'all' including specific conditions such as autism, but that it needs to focus on priority areas if there is to be a real improvement in the health of the population. It was also agreed that responsibility for improving health needed to be balanced against what individuals, families and communities can actually do for themselves and where agency support needs to be directed.

32. A MEMORANDUM OF UNDERSTANDING

A joint report by Dr Caron Morton and Professor Rod Thomsonon the Shropshire CCG/Public Health Memorandum of Understanding was receieved and noted.

The CCG and the Public Health Department are committed to improving the health and well being of the population of Shropshire through the development of a creative and dynamic partnership. Priority will be given to reducing health inequalities and to the prevention and mitigation of long terms conditions.

It was considered that this Memorandum of Understanding captures the current relationship as it is. With Public Health becoming a Council responsibility, the Memorandum of Understanding will need to be between the Clinical Commissioning group and Shropshire Council, rather than Public Health.

RESOLVED: That the Memorandum of Understanding be amended and formally signed off by Council in due course.

33 DATE OF NEXT MEETING

RESOLVED

That the next meeting of the Shadow Health and Wellbeing Board be held at 2.00 p.m. on Wednesday 21 November 2012 in the Shrewsbury Room, Shirehall, Abbey Foregate, Shrewsbury.

34 ANY OTHER BUSINESS

Carolyn Healy reported that she often received lots of email and correspondence that may be of interest to Board Members. In future she proposed to encapsulate this into a monthly newsletter/bulletin for member's which was welcomed by all.

Chairman : ……..

Date : ……..

The meeting finished at 11.30 am