DARTFORD BOROUGH COUNCIL

DARTFORD GRAVESHAM AND SWANLEY HEALTH AND WELLBEING BOARD

MINUTES of the meeting of the Dartford Gravesham and Swanley Health and Wellbeing Board held on Wednesday 17 December 2014.

Present:

Councillor Roger Gough – Kent County Council (Chairman)
Councillor Ann Allen – Dartford Brough Council
Councillor Jane Cribbons – Gravesham Borough Council
Councillor Tony Searles - Sevenoaks District Council & Swanley Town Council

Sheri Green	Dartford Borough Council
Anna Card	Dartford Borough Council
Sarah Kilkie	Gravesham Borough Council
Tristan Godfrey	Kent County Council
Terry Hall	Kent County Council
Vicky Wiltshire	Kent County Council
Sue Xavier	Kent County Council
Debbie Stock	Clinical Commissioning Group
Dr Elizabeth Lunt	Clinical Commissioning Group
Cecilia Yardley	Healthwatch
Lee Rose	Kent Fire and Rescue Service

40. APOLOGIES FOR ABSENCE

An apology for absence was submitted on behalf of Andrew Scott-Clark. Terry Hall attended the meeting on his behalf.

41. DECLARATIONS OF INTEREST

There were no declarations of interests.

42. URGENT ITEMS

There were no urgent items.

43. THE MINUTES OF THE MEETING OF THE DARTFORD, GRAVESHAM, AND SWANLEY HEALTH AND WELLBEING BOARD HELD ON 29 OCTOBER 2014.

The minutes of the meeting of the Dartford Gravesham and Swanley Health and Wellbeing Board held on 29 October 2014 were agreed as an accurate record. There were no matters arising.

44. THE MINUTES OF THE MEETING OF THE KENT HEALTH AND WELLBEING BOARD HELD ON 19 NOVEMBER 2014.

DARTFORD GRAVESHAM AND SWANLEY HEALTH AND WELLBEING BOARD

WEDNESDAY 17 DECEMBER 2014

The Chairman summarised the meeting of the Kent Health and Wellbeing Board held on 19 November 2014. He drew attention to a communication from Jeremy Hunt to all Health and Wellbeing Boards about what relationship they should have with providers. The Chairman explained that a view had been taken to restrict the membership of local boards to commissioners as the membership of the boards was already quite large, there were other channels for communicating with providers and Kent was in the vanguard in terms of good commissioner-provider communications.
The Kent Board had received a presentation from Frank Gibbons on progress with delivering the outcomes in the Joint Health and Social Care Self-Assessment Framework for 2013-14. In terms of Winterbourne View there had already been an assessment which focussed on dealing with the needs of service users rather than meeting framework targets.

The main changes introduced by the Care Act 2014 were discussed and the greater needs of Care Workers had been noted and Healthwatch would be making a presentation to the next Board meeting in January.

Resilience issues across Kent had been discussed although it was noted that DGS was better placed than most other areas in Kent, notably Medway, as a result of recent improvements. The minutes of the Local Health and Wellbeing Boards had been noted along with the minutes of the Children's Health and Wellbeing Board and the Emotional Health and Wellbeing Strategy had been discussed.

The DGS Health and Wellbeing Board discussed the current commissioner-provider split and noted that this was complex and imperfect for example Districts were providers in respect of their public health commissioned responsibilities and the County Council in respect of social care. The implications of the Care Act for districts was discussed, particularly housing and environmental health teams. Health staff also found that when Council officers identified customers in this way they were tending to be referred to acute hospital care rather than towards primary care providers or contacts in the voluntary sector who would often be more appropriate points of contact. It was felt that there should be a single route to ensure that referrals were channelled to the practitioners who were best positioned to assist and noted that the voluntary sector often felt frustrated at their lack of direct involvement at an early stage. Some work had already been carried out with the Chairman of the West Kent CCG to undertake a pilot with the voluntary sector whereby referrals would be channelled.

The Chairman felt that the Kent Health and Wellbeing Board would be very interested in examining how District Council's related to the Care Act and to how health and Council practitioners worked with local community agencies. The Board had also been told that Emma Hanson had recently given a presentation on this topic and it was agreed that this should be a future agenda item and that Emma should be invited to deliver her presentation.

45. ACTIONS OUTSTANDING FROM PREVIOUS MEETINGS

The Board received and noted a position statement on actions arising from previous Board meetings. In terms of the inclusion of health needs in future s106 and CIL agreements the Chairman reported that he had raised this with KCC Planning and that this would be an item on the Kent Board agenda in January.

46. KENT FIRE AND RESCUE SERVICE

The Board received a presentation by Lee Rose, Head of Community Safety for the Kent Fire and Rescue Service (KFRS), on the work that the KFRS undertakes and the greater opportunities for KFRS to work with health and community personnel and bodies.

Mr Rose was keen to stress that the KFRS did much more than deal with fires and that there were many services that could be offered to assist other agencies. A key focus was upon prevention and this had seen a reduction in the number of fire related call-outs of 70-80% in the last decade but greater involvement with road traffic collisions and specialist rescue.

The focus on prevention meant that KFRS had developed expertise in identifying people at risk. A lot of work had been done on identifying and working with vulnerable people including young and old people, the disabled, people with mental illnesses, dementia, those at risk of domestic violence, child safety and fire-setters. This had involved working with many agencies, the police, social services, schools, prison and probation services, local authorities, voluntary services and health agencies. KFRS offered training services for dealing with people suffering from dementia and were seen as national leaders in this field, they regularly attended one-stop shops in connection with domestic violence, they had a nationally recognised programme for dealing with fire-setters and visited schools and businesses where they could offer advice on prevention and also business continuity. Fire stations also housed other services and many of the 66 stations across Kent were shared with other agencies such as the police. Key areas were working with vulnerable people, dealing with slips, trips and falls to prevent admissions to hospitals, work with the business community and programmes such as “Firefit” which assisted in tackling issues such as obesity, elder fitness and youth engagement.

Fire Officers were often the first point of contact with people most in need of accessing health and social care as they were seen as readily identifiable and trustworthy. People would often allow fire officers into their homes when they would not allow access to other people. This meant that Fire Officers were uniquely placed to be able to alert other agencies over the needs of individuals who might otherwise not be known to them and it made sense for agencies to tap into their expertise and accessibility as they shared the same customers and for agencies to use the “Fire brand”. In order to do so it was

important to identify how to integrate services, and to remove blockages to this to sieze the wider opportunities available.

The Board discussed how KFRS staff made their referrals and followed up contacts to access the right care path for each customer. It was explained that officers had been trained and also had specific risk criteria which would be applied in each case to categorise the customer and how best to meet their needs. These were directly correlated with, and linked, to specific services. In addition to these reactive interventions the Fire Service also carried out commissioned work whereby it would be asked to undertake particular visits or tasks. An example of this was the 10,000 home safety visits carried out across Kent each year. KFRS conducted 150 such visits per week and ideally would wish to target these on the most vulnerable and at risk-people which greater sharing of information across agencies could assist. The relationship of KFRS and CAMHS was discussed and it was explained that the the two services worked closely together. All of the KFRS's cars now carried defibrillators and were often the first responder. Whereas there were 34,000 ambulance staff dealing with 9.3 million calls nationally there were 53,000 fire staff dealing with 0.5-1 million calls so it made sense to use this capacity.

The Board noted the opportunities for more integrated working with the KFRS, sharing information and reaching the vulnerable people sometimes not otherwise known to health agencies as being in need. In terms of looking at blockages to this it was felt that part of this was a result of the Fire Service being pigeonholed as a reactive service dealing only with fires and also the lack of mature linkages with other agencies. This was contrasted with the experience in terms of community safety where the Fire Service was fully embedded in the Community Safety Partnership and the linkages were well established. It was felt that health agencies could draw upon the experiences of the local authorities and community safety partners in working with KFRS.

The Board was keen to develop closer working and to tap into KFRS services and information, and to promote two way communication. This could help to address issues such as KFRS being unable to follow up patient needs following hospital discharges for example because of lack of information on discharges. The Board was also keen to know the sources from which KFRS received referrals and also to whom it made its own referrals and Mr Rose agreed to provide this data. It was also requested that relevant information be supplied by KFRS to Children's Operation Group (COG) meetings.

It was agreed that CCG and public health officers should meet separately with KFRS to identify opportunities for better integration to exploit the expertise, knowledge and synergies of closer working and to report back to the DGS Health and Wellbeing Board. This could also be linked to the presentation to be given by Emma Hanson, referred to in minute 44. In doing so it was also important to consider how the public access these services and how they know the right people to deal with at each stage of their need from the first point of contact through to its conclusion.

47. HEALTH INEQUALITY GROUPS - AN UPDATE ON PROGRESS ACHIEVED.

The Board received a detailed progress report on the work carried out by the Health Inequalities Groups against identified priorities and how these compared across the areas of Dartford, Gravesham and Swanley.

The Board welcomed the detail of the report but felt that there was a greater need to focus upon outcomes and to highlight the issues of greatest concern or success and how resources were being used. This was considered to be particularly important as many cases involved cross referencing between agencies and there needed to be a clear understanding of the issues. An example of this was the growing gap in life expectancy in different areas which was a major concern but was somewhat lost within the detail of the report. Other opportunities for meaningful benchmarking were discussed and it was suggested that “Mind-the-Gap” might provide a tool for this and that the annual health profiles could also highlight key areas of movement. It was also noted that much of the information in the report was on additional work as opposed to commissioned work, which was already well monitored, and that a lot of data would not be available until the end of the year.

The health prevention agenda was also considered to be key as this was linked to so many health issues, such as obesity and mental health and it was important to understand how successful initiatives such as free gym memberships were in delivering health benefits, but this was not possible from the information in the report. Nor was it possible to assess if services were reaching the right people and people who they would not otherwise reach.

The Chairman stressed that the report was a useful piece of work and interesting in terms of seeing the position in different areas. However for the future he asked if the report could flag up outcome measures and specific key issues for review and decision by the Board.

48. CHILDREN'S OPERATIONAL GROUPS - UPDATE ON PROGRESS ACHIEVED.

The Board received a detailed progress report on the work carried out by the Dartford, Gravesham and Sevenoaks Districts Children’s Operational Groups against identified priorities and outcomes contained in the Kent Health and Wellbeing Strategy relating to children and young people. Progress was compared to national and county performance figures to provide context. The report highlighted areas of good practice, gaps in achievement and where more work could or should be done.

The Board welcomed the report and asked for any significant issues to be highlighted in the progress reports for consideration at future meetings.

49. INFORMATION EXCHANGE

There were no items to be reported.

50. BOARD WORK PLAN.

The Board Work Plan was amended to remove the Urgent Care Review (Feedback) item for the meeting on 11 February 2015 as this was substantially the same item as the Re-commissioning of Walk-in and Urgent Care Services item on the same agenda. An update on Community Services should be added to the agenda for that meeting and Emma Hanson invited to attend and give a presentation.

51. DATES OF BOARD MEETINGS 2015 / 2016

The dates of future Board meetings were noted. Further consideration would be needed over whether to hold a meeting in August and it was suggested that as a start Board members availability should be canvassed.

The meeting closed at 5.19 pm

Councillor R Gough
CHAIRMAN