HEREFORDSHIRE COUNCIL

MINUTES of the meeting of Health and Wellbeing Board held at The Board Room, Wye Valley NHS Trust Headquarters, Stonebow Rd, Hereford HR1 2ER on Thursday 26 November 2015 at 2.00 pm

Present: **PM Morgan (Herefordshire Council) (Chairman)**
(Vice Chairman)

Mrs J Davidson	Director for Children's Wellbeing
Mr P Deneen	Healthwatch Herefordshire
Samuels	Director of Adults Wellbeing

In attendance: Councillors

Officers:

37. APOLOGIES FOR ABSENCE

Apologies were received from Diane Jones MBE, Professor Rod Thomson, Dr Andy Watts, Councillor JG Lester, Jo-anne Alner and Jacqui Bremner.

38. NAMED SUBSTITUTES

Alan Exell, NHS England, attended as a substitute for Jo-anne Alner. Gwen Ellison, Clive Hallam and Phil Shackell attended as public health representatives for Prof Thomson.

39. DECLARATIONS OF INTEREST

None.

40. MINUTES

The minutes of the meeting held on 15 September 2015 were approved as an accurate record of the meeting.

41. QUESTIONS FROM MEMBERS OF THE PUBLIC

None received.

42. CHILDREN'S SAFEGUARDING UPDATE

The Board was provided with an update by the director for children's wellbeing and the head of safeguarding and review.

The board had responsibility to understand outcomes in this area and this report provided an overview. More detail would be presented to the safeguarding board and the health and social care overview and scrutiny committee. The focus was for the board to consider priorities and work to be commissioned. The key points of the report were:

- positive improvement, for example, steps being taken to increase adoptions for children with complex needs, with recruitment and marketing to increase placement opportunities;
- the multi-agency safeguarding hub (MASH) processes were improved. Of the 500 contacts into MASH each month, half met the threshold for care. Domestic violence was a key feature of many referrals, with many of the 247 children on

child protection plans being under the category of emotional harm as a consequence of domestic violence. There is a high level of understanding and awareness of the issues but there are resource implications. For example, there were no child protection plans relating to sexual abuse 12 months ago, but now there are more than 20 due to an increased awareness of child sexual exploitation;

- achievements have been made in overcoming recruitment difficulties for social workers and the social work academy was bringing home-grown professionals to the service. Agency workers have reduced to 29% of the workforce which is improving outcomes for children. There was also some planned recruitment for high calibre overseas social workers. In the meantime, casework progression would be slower than hoped.

The director of adults and wellbeing confirmed that an adult safeguarding update would be included in the board's work programme.

Board members made the following comments and observations in response to the update:

- whilst safeguarding could be improved, the hard work and good intent be noted;
- problems in relation to social care and skill mix were recognised;
- court outcomes may lead to a reduction in children coming into care and services would need to look at how children make the transition into adolescence;
- the report highlights the extent of the problems such as domestic abuse and that greater awareness was leading to an increase in reporting, especially from children who are more confident to report what is happening in their life;
- the current situation was well-understood by providers and commissioners and the service was in a better position than previously, but inspections focused on the current picture rather than where services were heading and expected to see improvements compared with previous visits;
- it was recommended that both the children's and adults' safeguarding boards be asked to look at the gaps in commissioned services for mental health as this has an impact on safeguarding;
- it was critical to have a shared vision and be clear on priorities and to be sure that collectively ambitions for children are high enough so that all professions were reminded of their responsibilities;
- commissioners have made mental health and safeguarding their top priorities and the profile of children's services is also much higher on council agendas, with more training for groups such as school governors.

RESOLVED
That the health and wellbeing board review progress and identify any further actions necessary.

43. HEALTH & WELLBEING STRATEGY MENTAL HEALTH UPDATE

An update was provided by the programme manager for children and mental health, which is priority 1 for the health and wellbeing strategy. It was reported that services had come a long way and progress was being made, with partners and agencies taking ownership and 10 actions developed into plans.

An overview of activity and successes included:

- developing social networks - a pilot in Ross with mental health and primary care bringing communities together for self-help and management. This would be reviewed in April to report on the feasibility of extending this across the county;
- In Leominster, adults' services were working with the Alzheimer's Society to create a community-led support hub which would open in January as a pilot

which would be the subject of international study through the University of Worcester;
- CAMHS research through the children and young peoples' partnership with young people to identity how to make a good transition process to support recovery;
- 70 practitioners met through the children and young peoples' partnership to talk about mental health, led by young people, some of whom were in recovery. Plans were to hold another meeting in February for children's mental health week;
- First cohort of graduates from Exeter – staff employed by CLD and 2gether who are undertaking post-graduate training using skills and interventions with young people. This was successful and there will be a new cohort next year in order to grow the workforce to provide local interventions;
- Adults – 1200 people accessing new support; there is confidence that awareness was taking effect. There were 500 new diagnoses of dementia and new support was proving beneficial.

Challenges remained as needs were complex and there were interdependences such as emotional resilience linking to safeguarding. Resources were limited but were being secured. Commissioning was taking an evidence based approach and partners were signed up to reporting on key performance indicators. There was good progress, with ambition to achieve more.

In response to the update, board members made the following comments and observations:
- waiting list for CAMHS was now 4 weeks compared with 6 months and with triage in place. Some people are seen within 24 hours of referral with the focus now on prevention rather than crisis;
- there was a move to an outcomes based model, testing with stakeholders for their views to inform commissioning;
- paediatric liaison was a priority and the urgent care pathway was being redesigned to look at reducing self-harm. Changes were also being made for on-site services to be available over 24 hours for children, with additional staff cover.

In terms of factors that influenced the success of the project that could be translated to other areas, it was identified that a key factor was joint working to identify outcomes for the target population, taking an holistic point of view. Compared with other areas, there was opportunity to start afresh with mental health to model future work, so this was one area where agencies can talk collectively about joint working and the programme was governed by outcomes that people said they wanted.

RESOLVED
THAT:
(a) The mental health plans, milestones and challenges identified within appendix 1 are reviewed to assess the degree to which they are achieving the mental health priorities within the health and wellbeing strategy; and
(b) The board identify any additional actions needed to secure improvement.

44. HEALTH AND WELLBEING STRATEGY - URGENT CARE PATHWAY UPDATE

The report highlighted the clinical commissioning group's aspiration to improve the urgent care pathway as the number of routes in to care could be confusing. Whilst there was a main focus on A&E waiting times, that was just one indicator of a positive experience and the impact on urgent care had an impact on surgery. The intention was for people to be seen more quickly and locally and to ensure that they know where to go for care. There was opportunity to review some provider contracts in 2016. Outcomes would consider the whole care pathway including preventive work.

The sharing of records was a factor in joining services up to provide a better care pathway with more visible information between professionals, although information governance and safeguarding issues were taken into consideration.

Feedback was also that people wanted to live independently for as long as possible. This would be a factor in selecting providers who could meet that outcome such as through prevention work. This approached was mirrored in NHS policy and so there was more evidence that this was the right direction.

A workshop was being planned for clinicians to consider three work strands:

- 7-day primary care to reduce the need to come to A&E. Data suggested that the GP was the first port of call and the impact of this on other providers needed assessing;
- locality based services and realigning community services – providing opportunity to move to public centred care to get best outcomes;
- building in integrated care and understanding the link with intermediate care and primary care.

Board members made the following comments and observations about this update:

- communication was important for communities to have an idea of what they could access and opportunity to re-engage on the new model;
- there was a disconnect which needed review to ensure that walk-in centres had access to records;
- if it were the preferred approach to meet public demand for 7-day access to primary care, there would need to be a review of capacity and implications for other provisions;
- no decision had been made regarding decommissioning other services and any such decisions would be the subject of consultation;

In terms of a timescale, if the CCG needed external assurance that the proposals were clinically sound, this would add 3 months onto the process and so implementation could be next summer.

The CCG was commended for the considerable engagement on this matter; there were different models to provide this pathway but it was believed that the public would welcome the improvements.

It was acknowledged that consultation could always be improved upon and there would be investigation into whether the responses could be analysed by age group.

It was noted that clear outcomes were evident and that this was helpful to the success of the project.

RESOLVED
THAT:

(a) the integrated urgent care pathway plans (at appendix 1) are reviewed; and

(b) the board identifies any areas for further focus or additional actions to secure improvement.

45. HEREFORDSHIRE CHAIRPERSON'S PROTOCOL

The board was asked to consider and approve this protocol which was designed to ensure that boards were in sight of each other in terms of work covered.

It was noted that the protocol showed clarity on how the different boards worked, and made sure that priorities were addressed without duplicating work.

RESOLVED
That the principle of the protocol be approved and the Board provide comments to enable the protocol to be developed and signed off by the Chairs of the respective Boards.

46. APPROVAL OF BETTER CARE DATA SUBMISSIONS - REPORT TO FOLLOW
(Pages 9 - 30)

The director of adults and wellbeing presented the submissions which were a quarterly requirement, and the board's approval was sought to submit the data.

The headlines were that:

- the falls response team had a significant impact on A&E, with evidence that people needed support but this did not have to be in hospital and it was a better outcome if hospital admission could be avoided;
- reablement had improved and was significantly better than previously reported, having significant impact on long term quality and duration of life. It was key that this was significantly better than previously;
- the NHS number was used as the primary identifier and there was progress on open APIs (application programme interfaces), allowing systems to talk to each other;

The submission was supported by board members, with the following comments:

- given the need to deliver savings it was disappointing to see the comment contained in the submission's narrative regarding development of the better care plan;
- the range of services continued to work well and effectively within the constraints although health funding implications were not fully understood. The CCG was currently overfunded against allocations and was in a financial recovery situation, but this did not mean that organisations were not striving to get best value;
- a contributing factor was that drivers through the different routes were not yet as fully aligned as they needed to be. Significant progress had been made in 18 months in securing single approach nationally and guidance was not coherent for either the council or the CCG, but as there was now a single integrated national team, there was confidence that guidance will be meaningful for both health and social care sides;
- there had been discussions nationally with significant work at that level to bring everything together but there were still pressures. It was hoped this submission was a fair representation and that progress would be made in the next report;
- the board meetings needed to be aligned with the submission dates so that they could be approved in good time.

Further to approving the submission, further information was requested regarding the matter of the CCG being overfunded given the rurality and demographics of the county. It was clarified that with the current funding formula, the CCG is over target although the county's rurality, age, age mix and deprivation was considered. Health funding was split into 3 groups, those being CCGs, primary care, and specialised services which are commissioned regionally. There was to be a change in the funding formula to be announced on 17 December which should take into account the greater rurality. There was a commitment to move CCGs to their fair share of allocation by April so funding for Herefordshire may reduce although it was unclear if this would be accurate or better/worse. It was anticipated that there would be a move to fair share allocation in the next two years.

It was suggested that a financial report be commissioned to show changes in funding for the next year and into the future.

As regards budget announcements from the Chancellor of the Exchequer this week, it was understood that the national budget was to grow in 2017-18 by £1.5billion but it was not clear where this would come from. The expectation was that the greater proportion of the CCG budget would to the better care fund although there was no firm evidence to this effect. It was further understood that better care fund plans would lead to full integration of health and social care by 2020 although the meaning of this was unclear although this was the way forward in the government's view. It was hoped there would be more central guidance later in December.
It was recognised that intervention at an early stage was beneficial provided that admissions were tracked and monitored to ensure they were appropriate and best value was essential whatever the government's policy.

RESOLVED
That the Health and Wellbeing Board approve the Better Care Fund (BCF) quarter two report in order to submit to NHS England.

47. HWB WORK PROGRAMME

The board considered the work programme and it was agreed to include a finance report in January 2016 and to ensure that meeting dates were aligned to the better care fund submission dates.

RESOLVED
That the work programme be adjusted as discussed.

TRANSFORMATION PROGRAMME UPDATE

A paper had been circulated previously from public health on the medium and long term solutions on funding shortfall and continuation of the transformation programme. The key points of the update were:

- plans to look at the devolution programme and existing funding programmes along with suggestions received from Ernst and Young for transformation;
- general discussions on transformation had taken place between accountable officers from partner organisations such as Wye Valley Trust, the CCG and 2gether. They were meeting fortnightly and held two separate away days which identified key principles to build capacity and resilience and to develop a strong safe and vibrant community in order to maximise health and wellbeing and its impact on the economy. Alternative solutions in areas such as urgent care were being considered under the principle of independent living and maximising recovery;
- it was expected that the report on the work would be completed by the end of December;
- achievement of the work included sharing resources and posts across services and to look at developing two proposals on devolution and models of care to present to NHS England and the development agency to improve outcomes for Herefordshire people;
- There was still more to do on this and the work streams would be refreshed next week.

Discussion took place regarding devolution and it was noted that Herefordshire was expecting to submit a devolution proposal in January 2016. There were protocols regarding health procurement at national level and which impacted on flexibility and freedom in regard to areas such as back office providers and so freedom on this would be requested. A further request would relate to the ability to negotiate a 3 to 5 year

settlement to assist longer-term planning for funding. The intention was to compliment local health and social care strategy to achieve maximum benefit and to identify the benefits for a potential devolution bid and the opportunities it would hold.

The meeting ended at 4.09 pm **CHAIRMAN**