HEREFORDSHIRE COUNCIL

MINUTES of the meeting of Health and Wellbeing Board held at Committee Room 1, The Shire Hall, St. Peter's Square, Hereford, HR1 2HX on Tuesday 20 September 2016 at 2.00 pm

Present: **PM Morgan (Herefordshire Council) (Chairman)**
Dr Dominic Horne (NHS Herefordshire Clinical Commissioning Group) (Vice Chairman)

Prof Rod Thomson	Director of Public Health
J Davidson	Director of Children's Wellbeing
Mr P Deneen	Healthwatch Herefordshire
Ms J Bremner	Healthwatch Herefordshire
Mr M Samuels	Director for Adults and Wellbeing

Officers: **Amy Pitt, better care fund joint commissioning manager**

81. APOLOGIES FOR ABSENCE

Apologies were received from Cllr JG Lester, Diane Jones, MBE (NHS Herefordshire CCG), Simon Hairsnape (NHS Herefordshire CCG) and Jo-Anne Alner (NHS England).

It was noted that Jo Melling would be attending in future as the NHS England representative.

82. NAMED SUBSTITUTES

There were no substitutions.

83. DECLARATIONS OF INTEREST

None.

84. MINUTES

RESOLVED
That the minutes of the meeting held on 19 July 2016 be approved and signed by the chairman as a correct record.

85. QUESTIONS FROM MEMBERS OF THE PUBLIC

None.

86. BETTER CARE FUND 2016-17 QUARTER ONE PERFORMANCE REPORT

The better care fund joint commissioning manager presented a report on the performance of the better care fund against the plan for the first quarter of 2016/17. The return for quarter one had already been approved under delegated authority by the director for adults and wellbeing, in consultation with the CCG accountable officer, in order to meet the timescale for submission to NHS England.

The following key points were highlighted:

- non-elective admissions were on track. Rapid access to discharge was redesigned on block contract arrangements through the CCG. There were some ongoing issues in relation to delayed transfers of care (DToC) with no indication of immediate improvement and an uplift of £55k had been made available to support improvements in performance
- performance in relation to the number of placements in residential care homes remained the same and the target was reduced from last year in line with regional trends
- a unified contract for residential nursing had been developed and over 100 care homes had submitted bids following extensive engagement and consultation. The benefit to providers is that the council pays the gross amount for care so providers are not affected financially if an individual does not pay their top-up contribution, which would be collected by the council. It was not considered that the risk and cost to the council of this arrangement was significant. For individuals, the impact was that the potential was removed for providers to act unethically in attempting to increase fees charged to service users, although it was noted that this had not been a particular issue locally. Providers were now being assessed using the quality assessment framework.
- the section 75 agreements that supported the BCF legal framework had been combined to make a single agreement across children's and adults' services with effect from 1 October 2016, as agreed by Cabinet.
- in terms of financial implications, there was a 40% increase in the unit price paid for NHS funded nursing care, putting pressure on the budget for the CCG. This was as a result of national policy change and not a local issue.
- it had been possible to cap the risk share for each BCF partner by reducing the client cohort. The risk is set at 13% of the contribution to that cohort for each partner and reviews of clients were picking up. The situation was to be monitored on a monthly basis.

The chair observed that although performance had not reduced, there were no significant improvements and asked how this could be addressed, and what the health and wellbeing board could do to help.

The director for adults and wellbeing explained that the BCF formed only 10% of the directorate's budget, and much less of the CCG budget, which was not of sufficient scale to change behaviour. He suggested that one solution might be to count the protection of adult social care element of the BCF budget in with business rates, such that it was received direct by the council rather than as a transfer from the CCG, but there were tensions associated with this. Where the BCF had made a difference in other areas, it was where it formed a larger proportion of the adult social care budget. To do this would require closer working and this was the direction of travel for joint commissioning work. There was a whole system approach but with a small fund. The alternative would be to produce plans for full integration, and this may be the way forward. The national context was that the NHS was looking at 2-year plans, with guidance for this becoming available in the next few days, and although ministers were engaged with integration, there was a knowledge gap within DH around social care.

The vice-chairman commented that the rate of change for the NHS made it hard to plan over two years.

Referring to the section 75 agreement, the director for adults and wellbeing explained that it presented some difficulties in governance such as differing rules for delegation of decisions between the council and the CCG. A way forward was being developed to address this which would be shared with cabinet members. The chair emphasised the

need to ensure this work happened in order to remove barriers to the effective management of the BCF.

Discussion took place regarding the help to live at home project which updated the arrangements for domiciliary care. Therapy led interventions were being considered for initial reablement rather than using the domiciliary care market through commissioning and use of rapid access to assessment and care (RAAC) beds. It was recognised that this formed part of the frailty pathway, which included long term conditions and children, and supported integration.

The director of public health asked about the key areas to focus on for improvement and how to overcome slower performance. The BCF joint commissioning manager explained that cultural change played a big part in improved performance and there needed to be a shift for services to be considering discharge as soon as someone started to receive care. Greater focus on DToC and RAAC beds would help release funds for community-based care so that people could go home sooner.

The director of public health commented on closer inspection of any evidence of links between causative factors for particular conditions and whether prevention work would assist the situation.

Healthwatch commented on the need for more proactive contingency planning with carers to prevent admissions. It was important to make best use of resources and evaluate the effectiveness of provision. It was observed that patients from Wales used Herefordshire services and there were disconnects between English and Welsh social care systems. It was noted that Powys had a significant impact on DToC and this needed investigating as there was no specific reference to Powys in the BCF, although charges were made back to Powys to cover cost of care. However, an action plan was needed to address this so that out of county assessments could be made to enable care closer to home. It was suggested that the additional funding for DToC could be used in improving performance in this area as a matter of priority.

In considering BCF performance and making the link to the wider context of understanding the integration agenda and the sustainability and transformation plan (STP), Healthwatch commented on public engagement and awareness and that it was not helpful for the NHS to expect consultation on the STP within a very small timescale. Healthwatch was supporting engagement on this and developments were happening both in terms of social media and face to face work. The health and wellbeing board had an oversight role on the development of the STP and there was more that could be done to contribute to the local plans, including closer working with the Worcestershire health and wellbeing board.

The director of children's wellbeing reminded the board that it had a statutory role in ensuring plans were in line with the health and wellbeing strategy. The director for adults and wellbeing commented that NHS England seemed unclear about the role of health and wellbeing boards and whilst they intended them to sign off the STPs, in practice they were expected to take a less directive role. A meeting of the board before submission of the STP on 21 October would ensure that the board fulfilled its governance role against the health and wellbeing strategy.

RESOLVED

That, in light of the information within the better care fund (BCF) 2016-17 quarter one return, as reviewed, and in the context of the wider integration and STP agenda, the board meet to review and comment on the STP prior to its submission on 21 October.

87. UPDATE ON PRIORITY THREE OF THE HEALTH AND WELLBEING STRATEGY

The director for adults and wellbeing introduced the update by explaining that there was a change in approach from one that was centred on how conditions were defined to one based on what a person's needs were. To achieve this, teams were less focused on being condition or cohort specific and were instead more based on geography. There was therefore no single strategy for older people as they were not a specific cohort.

The BCF joint commissioning manager highlighted the key areas of work and the drivers to the approach in terms of delivery of services to enable people to support themselves:

- A key work area was the help to live at home project as a redesign of home care services which was to be presented to Cabinet for approval in October and if agreed, would mean dedicated providers for those needing more intensive support
- The approach would seek to address some operational challenges faced by providers by focusing on viable geographic areas
- The council would choose the providers for each area so that the service users would know who their providers were and how care would be provided
- The Golden Valley area would have a slightly different approach, making use of its community hub and using one provider for each pathway rather than a number of providers

A Healthwatch representative commented on the costs and the governance issues associated with volunteering despite the sector not attracting funding. He asked what could be done to reduce the burden for volunteers in order for them to make a bigger contribution to the community. In the discussion that followed, it was noted that there were misconceptions by some professionals of the reliability of services provided by volunteers, when in reality many volunteers were very committed to their role. However, volunteer input could be better directed, perhaps through Herefordshire Voluntary Organisations Support Service (HVOSS), to where the need was. There was no formal way for volunteers to find out what was needed in their communities or for it to be easier for them to support their neighbourhood without unnecessary bureaucracy.

On the matter of housing, it was noted that accessibility and schemes for extra care were being considered through the possibility of providing housing stock with room to accommodate a carer, and pursuing social housing provision within planning applications. Commissioners were looking at this via analysis of need in order to inform planning decisions. There was no funding to provide housing and it was important to work with registered social landlords about what was required as well as consider fuel poverty issues.

The director for children's wellbeing noted some good progress on outcomes against the strategy, noting that direction was clearer.

A number of areas were identified by board members that would support better outcomes against this priority area:

- public health services such as active here and diabetes prevention and the contribution of GPs to wider prevention issues and supporting people in the right way
- a whole systems approach to discharge to avoid commissioning silos
- falls responder service to help reduce admissions
- links between public health and warmer homes to support people to consider different providers in order to reduce heating bills
- better use of the WISH service to raise peoples' awareness of the services and support available

- greater use of the principle of making every contact count
- greater involvement and engagement of the voluntary sector
- development of support within communities, families and of personal responsibility for self-care
- development of skills in the use of direct payments

RESOLVED
THAT:

(a) it be confirmed that progress to date was supporting delivery of the health and wellbeing strategy; and

(b) approaches to remove any barriers to success or further improve rate of progress be identified as summarised above.

Ofsted joint inspection

The director of children's wellbeing informed the board that there would be a joint inspection of the area by Ofsted and CQC of special educational needs and disability arrangements over five days next week (week commencing 26 September 2016).
She thanked Jacqui Bremner for her assistance in organising sessions with parents and carers, and invited board members to note a parents' webinar to be broadcast on Wednesday evening, 28 September.
The inspection was welcomed as this was a priority in the children and young people's plan which would benefit from external review, which would include education and health care outcomes including short breaks, early years and the full range of disability. A narrative report would follow after the review.

The meeting ended at 3.57 pm **CHAIRMAN**