CAMBRIDGESHIRE HEALTH AND WELLBEING BOARD: MINUTES

Date: 26 July 2018

Time: 10.00-12.00pm

Venue: Kreis Viersen Room, Shire Hall, Cambridge

Present:

Cambridgeshire County Council (CCC)
Councillor Peter Topping (Chairman)
Councillor Mark Howell (substituting for Councillor Samantha Hoy)
Councillor Linda Jones
Councillor Susan van de Ven
Dr Liz Robin - Director of Public Health
Tom Kelly - Head of Finance (substituting for Chris Malyon)
Richenda Greenhill – Democratic Services Officer

City and District Councils
Councillor Geoff Harvey – South Cambridgeshire District Council
Councillor Nicky Massey – Cambridge City Council
Councillor Jill Tavener – Huntingdonshire District Council

Cambridgeshire and Peterborough Clinical Commissioning Group (CCG)
Jan Thomas (until 11.45am)
Jessica Bawden

Healthwatch
Val Moore, Chair

NHS Providers
Ian Walker, Cambridge University Hospitals NHS Foundation Trust
Matthew Winn - Cambridgeshire Community Services NHS Trust (CCS) (from 10.25am)

Apologies:
Stephen Graves – North West Anglia Foundation Trust
Councillor Samantha Hoy – Cambridgeshire County Council
Chris Malyon – Section 151 Officer, Cambridgeshire County Council (substituted by Tom Kelly, Head of Finance)
Dr Sripat Pai – Cambridgeshire and Peterborough CCG
Stephen Posey – Papworth Hospital NHS Foundation Trust
Councillor Joshua Schumann – East Cambridgeshire District Council
Vivienne Stimpson – NHS England
Wendi Ogle-Welbourn – Executive Director: People and Communities, Cambridgeshire County Council
Councillor David Wells - Cambridgeshire County Council

81. APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST

Apologies were noted as recorded above. There were no declarations of interest. In the interests of transparency, the Chairman reported that he had been appointed to carry out a review of a Department of Health programme for integrating care. No conflict of interest was evident.

82. MINUTES OF THE MEETING ON 31 MAY 2018

The minutes of the meeting on 31 May 2018 were agreed as an accurate record and signed by the Chairman.

83. MINUTES - ACTION LOG UPDATE

The Action Log was reviewed and the following updates noted:

i. Minute 11: Sustainability and Transformation Programme (STP) Update Report

Action: To establish whether it would be helpful to arrange a general briefing session on the Sustainability and Transformation Programme (STP) for newer members of the Board.

Update: Cllrs Cornwell, Harvey and Massey to attend a briefing session, details to be arranged direct by the Sustainability and Transformation Partnership System Delivery Unit. Any other Board members requiring this training were asked to advise the Clerk as soon as possible so that this action could be completed.

ii. Minute 78: Living Well Partnerships Update

Action: A Member commented on the integral importance of community safety, stated that there was an almost complete lack of community policing in the rural villages of South Cambridgeshire and asked how this could be factored in to Living Well deliberations.

Update: This issue has been discussed in the South Cambridgeshire Crime and Disorder Reduction Partnership in July 2018. The Local Police Review has now been implemented and had restructured local neighbourhood resourcing to maximise visibility and partnership working. Inspector Paul Rogerson would meet Councillor Van de Ven to provide a detailed briefing.

iii. Minute 78: Living Well Partnerships Update

Action: Refer Councillor Schumann's question about the logic behind putting East Cambridgeshire and Fenland together in one Living Well Partnership (LWP) to LWP officers.

Update: Officers at East Cambridgeshire District Council had followed this up direct on Councillor Schumann's behalf.

84. A PERSON'S STORY

The Manager of the Reablement Service South stated that they offered a life-changing programme of short-term support tailored to meet the individual needs of local people aged 18+ after a hospital stay or referral from a GP or other professional. The Service offered an 'expert friend' to help people (re)learn the skills needed for daily living, to build their confidence and reduce the amount of care and support they needed.

Reablement focused on helping people to do things for themselves rather than having things done for them. The Board heard the story of 'Rose', a local resident in her late 90s who had been living at home independently until she suffered a fall earlier in the year. Even with the support of her daughter she was struggling to cope on her return home, and the Reablement Service became involved in supporting the family. Together they identified the practical goals that 'Rose' wanted to achieve, including cooking and cleaning for herself and making a regular trip to her local town. The Occupational Therapy Service provided some simple personal care equipment and a support worker visited two or three times a day over an agreed period to support 'Rose' in regaining her independence. Although no longer providing direct support, the Reablement Service remained in touch with 'Rose' and with her daughter. The Board was shown a hydration aid call an Ulla as an example of the type of simple devices used by the Service to support independence and wellbeing. This could be attached to a cup or bottle and would flash at regular intervals as a reminder to take a drink.

During discussion of the Person's Story, Board members:

- Commended the Reablement Service's person-centred approach and practical use of assistive technology;

- Asked how support from the Reablement Service was accessed. Officers stated that they worked closely with the Adult Early Help Service and received referrals through that route. Referrals were also accepted from GPs and health professionals, local care networks and community organisations;

- Asked what percentage of service users returned to their former levels of independence following a programme of support. Officers stated that a check was made after three months and by that point around 60-70% of people had regained their previous level of independence. Even when this was not the case the improvements to the quality of an individual's life could be of significant benefit;

- Asked whether there was any difference in outcomes between proactive and reactive referrals. Officers stated that this was not the case as they worked with each individual on a case by case basis to respond to their wishes and needs at that time.

Summing up, the Chairman thanked 'Rose' and her family for agreeing to share her story. The Board were very appreciative of such an illustrative example of the real impact which a personalised approach and the use of relatively simple and inexpensive technology could make to the quality of a person's daily life and their independence.

The Board noted the personal story as context for the remainder of the meeting.

85. BETTER CARE FUND UPDATE

The Chairman stated that the Health and Wellbeing Board had a level of accountancy for the Better Care Fund (BCF) and Improved Better Care Fund (iBCF). Previous reports had focused on the ambition for its use, but this time he has asked for a frank and detailed assessment of what the funds were being used to do, what was working best and what had worked less well.

The Director of Commissioning stated that the Fund comprised two parts. The Better Care Fund had been introduced in 2015 and represented a reorganisation of funding to the Local Authority and Clinical Commissioning Group to create a pooled budget of around £40M. The iBCF had been introduced in 2017/18 and represented new money coming into the system, but was non-recurrent. The iBCF of around £8.3M had to be spent in line with nationally specified conditions relating to meeting Adult Social Care needs, reducing pressures on the NHS including delayed transfers of care (DTOCs) and stabilising the care market. The governance arrangements attached to the funding required that quarterly reports were submitted to NHS England. Local responsibility for day to day oversight of the management of the Fund had been delegated to the Integrated Commissioning Board which met monthly.

Whilst the iBCF funding was non-recurrent the aim was to use it in ways which would enable its impact to continue to be felt in future years. To achieve this it had been planned to invest £3M into housing for vulnerable people, including those with complex learning and physical needs. Due to unprecedented financial pressures on the Adult Social Care budget resulting from increased costs of care and winter pressures these funds had been redirected in-year to mitigate these pressures. However, Cambridgeshire County Council had committed to exploring the potential for capital investment to enable the continued delivery of the vulnerable housing project objectives.

The following points arose in discussion of the report and in response to Members' questions:

- A health service member commented that the Cambridgeshire and Peterborough Combined Authority had made a commitment to investing in healthy places for local people to live. This had included some discussions about supported housing and residential care. Officers stated that there had been some preliminary conversations with the Combined Authority about this, but that there was a need to address the current pressures as well as looking at longer term options;

- Previous practice had led to the public sector competing for finite resources and so driving prices up. The new planned commissioning arrangements would avoid this whilst offering the potential for greater purchasing power;

- An elected member noted that the £3M of iBCF funding used to offset in-year pressures relating to Adult Social Care was non-recurrent and asked how pressures in future years would be funded. Officers stated that a full evaluation of the iBCF was being carried out to see whether the services it had been used to fund were delivering the outcomes being sought. This would provide an evidence base which would be used decide which services should be recommissioned. Where this was not the case investment would be refined or redirected to mitigate the cost of future pressures. Further details on this would be brought back to the Board once the evaluation was complete;

  The Vice Chairman stated that it was important to remember that the money within the BCF/iBCF did not represent the total expenditure in these areas. For example, significantly more money had been spent system-wide in addressing DTOCs so it was important to ensure that all pressures and expenditure were managed in a considered way. Another key area of expenditure for the Clinical Commissioning Group (CCG) was discharge to assess. The acute hospitals and others were committing significant sums to this. Integrated brokerage was absolutely the right

way to go to be clear about how the whole system was working together to meet need.

- The Chairman stated that the use of iBCF funds to create additional housing for those with complex needs had appeared quite a ground-breaking initiative when it was proposed. Given that this money had subsequently been redirected to off-set pressures on Adult Social Care he questioned whether the money was being used as intended. The Director of Commissioning stated that there were currently 120 people with complex needs placed out of county. Of these, 23 had been identified to be brought back within county and corporate agreement to create housing for these individuals had been agreed, subject to approval of the relevant business cases;

- An elected member asked whether the County Council still had an appetite to build residential homes. This issue had been raised previously at the Council's Commercial and Investment Committee and they expressed concern that an opportunity was being missed. Officers stated that the Council had not dropped the ambition to build the housing needed to bring vulnerable people back into the county. It was not intended to own or run residential nursing homes, but to work more strategically with partners delivering this service;

- An elected member commented that assistive technology could provide some simple and cost effective solutions to improving a person's independence or quality of life, as evidenced by the Person's Story at the start of the meeting. However, this needed to be balanced with the potential reduction in personal contact and care with service users. They would be interested to know more about current expenditure in this area, trends, future plans and protocols for deciding its use. Officers stated that significant investment was being made in Reablement and Occupational Therapy teams to maintain a person-centred approach to care;

- An elected member asked whether the housing being created to bring some service users back into the county would be located close to their families or at a location convenient to the Council. They further asked where discussions about this would take place. Officers stated that they would look to place people where it was convenient to them and wherever possible they would be brought back into their original community if this was their wish, subject to meeting the individual's needs. The Vice Chairman agreed to reflect on where conversations regarding need and person-centred provision would best take place;
  (**Action: Vice Chairman**)

- A health service member questioned whether the totality of money to address DTOCs was being spent in the best way given that the figures remained challenging. They felt that the key question was how to get below the 3.5% target. Officers stated that the £8.3M iBCF alone could not solve the issue of DTOCs and that the guidelines for its use covered other important areas too. The BCF/iBCF was having a significant impact on adult social care performance. Although not yet meeting the 3.5% target there had been significant improvements in relation to DTOCs;

- The County Council was a material purchaser of adult social care. When the requirements of Peterborough City Council and the CCG were taken into account they became a significant purchaser with the opportunity to help stabilise the local care market by using capacity effectively and coherently;

- An elected member questioned the difference between planned expenditure of £41k for a dedicated social worker at Cambridge University Hospitals and actual expenditure of around £16k. Officers stated that there was an underspend against some projects. These related mainly to timing or phasing issues or the time taken to recruit staff. In these cases the funds were used to support additional projects not included in the original programme. The Chairman acknowledged this rationale, but stated that the Board would want some assurance that initial aspirations were still being met.

Summing up, the Chairman thanked officers for a very helpful report setting out what was happening. He stated that he did not want to duplicate market provision and welcomed the offer of a further update report including an evaluation of spend, the housing plan and the evidence base around assistive technology. This should also address the Integration and Better Care Fund Operating Guidance for 2017-19 and refreshed expectations for managing Delayed Transfers of Care for Health and Wellbeing Boards for 2018-19 which had been had been circulated to Board members the previous week.
(**Action: Director of Commissioning**)

It was resolved to:

a) note and comment on the report and appendices.

86. DELAYED TRANSFERS OF CARE

The Vice Chairman stated that delayed transfers of care (DTOCs) were a longstanding problem and there was huge focus and drive across the health and social care system to address this. Chief Executives were meeting constantly to address this issue and there was real commitment not just to getting patients out of hospital but also to getting them into the right placement first time. This required a more holistic approach covering the whole of the patient's care journey and not focusing solely on the time spent in hospital.

The Discharge Transformation Director stated that patient discharge was a dynamic and evolving process which needed to be able to react and respond to the changing needs of individual patients. Significant improvements were being made, but there was still lots to do in order to achieve the target of no more than 3.5% of occupied bed days. Recent changes in leadership for the DTOC Programme were reflected in a revised programme structure with a focus on discharge flow. Each hospital now had a dedicated site lead and there was real engagement between partners. A 12 week summer plan had been drawn up to ensure that the decision making process around patient discharge decisions was not compromised when key staff took annual leave. An update on this would be included in the next report.
(**Action: Discharge Transformation Director**)

In the course of discussion, Board members:

- Commented that the report lacked comparative year on year data and asked for some examples of progress. The Vice Chairman stated that in October/ November 2017 Cambridge University Hospitals (CUH) had around 120 DTOC patients compared to 58 the previous week. The target figure was 31 so whilst the number had already been halved the target would require the same level of improvement to be repeated;

- Asked about readmission figures and failed discharges. The Vice Chairman stated that many factors could influence these figures, but they were tracked at patient level and could be reflected in a future report;
  (**Action: Discharge Transformation Director**)

- Commented that the Health Committee had received an assurance in June that DTOC figures at CUH were on a downward trajectory, but that the report noted a significant blip in performance since then (paragraph 3.5 refers). Officers stated that this was due to a change in a senior member of staff which had an unanticipated impact on patient flow. There had been much learning from this and officers were confident the issue had been addressed for the future;

- Noted that the DTOC Programme Board Risk Log remained red (at risk of not being achieved) even after mitigations. The Vice Chairman stated that patient flow was as much a cultural issue as it was a process issue. There was still a constant need to reinforce new ways of working to ensure discharge planning began from the first point of contact. Until these cultural changes were securely embedded the risk of a lapse into previous practice remained a challenge;

- Emphasised the importance of utilising the evidence to be gained from patient experience both now and in the future. Officers undertook to follow this up direct with the Healthwatch representative;
  (**Action: Discharge Transformation Director**)

- Asked about the impact on DTOCs of patients living outside the borders of Cambridgeshire and Peterborough, but being treated in their hospitals. Officers stated that the site lead for each hospital would monitor the number of DTOCs for those living out of county. The Vice Chairman stated that a breakdown of these figures was produced daily and was regularly reviewed;

- Emphasised the importance of the health and social care providers working together to produce a solution and not blaming each other for any short-comings;

- Asked how programme leaders were managing profound cultural change in a period of crisis. Officers stated that the key was ensuring consistency and continuity in their approach to embed the cultural change required;

- The Chairman stated that Appendix 1, which was supposed to evidence performance against trajectory for the first few weeks of the programme, was not good enough. He asked that the table be revised and a clearer version of the information circulated. The Vice Chairman suggested this might use weekly situation report numbers.
  (**Action: Discharge Transformation Director**)

Summing up, the Chairman emphasised the need to keep clearly in mind that DTOCs were not just numbers, but reflected the experience of individual people and their families. The Board welcomed the improvements in performance which were being seen, but needed to see this improvement sustained and embedded. The length and detail of the discussion and the challenge offered illustrated the importance which the Board attached to addressing DTOCs.

It was resolved to:

a) note the Delayed Transfers of Care (DTOC) Governance arrangements;

b) note performance against trajectory;

c) note the main issues and programme risk register.

87. CAMBRIDGESHIRE HEALTH AND WELLBEING PRIORITIES – ACTION PLANNING

The Director of Public Health stated that the Board had identified three priorities for the period to the end of 2019. These were health inequalities, including the impact of drug and alcohol misuse on life chances; new and growing communities and housing; and integration, including the Better Care Fund (BCF) and delayed transfers of care (DTOCs). The Board had already spent time earlier in the meeting discussing the BCF and DTOCs in detail (minutes 85 and 86 above refer), so her overview would focus on the other two areas.

Health Inequalities

The Public Health Reference Group (PHRG), a multi-agency forum comprising key local stakeholders, had met the previous week to discuss how to progress work on health inequalities as its key priority for 2018/19. The discussion addressed scoping issues and what the Group could deliver in the short and longer term. Amongst the key issues to emerge were poverty, homelessness and the pressure on housing, especially within vulnerable groups and the role of the Drug and Alcohol Misuse Delivery Board (DADB), working in conjunction with Living Well and Community Safety Partnerships. Priorities included early help initiatives for young people, children and families and reducing drug-related deaths, addressing barriers which existed across housing and homelessness, mental health issues and the dual diagnosis of alcohol and substance misuse issues.

In discussion, Board members:

- welcomed the focus on early help for children and young people, but commented that the issue of 'county lines' (the criminal exploitation of children by gangs and organised crime to sell drugs, often travelling across county borders) needed to be dealt with first. Officers stated that the DADB would be receiving a presentation on 'county lines' at its next meeting;

- Paragraph 3.3: expressed some concern at the level of expectation being placed on Change Grow Live (CGL) to address socio-economic issues. Officers stated that the Clinical Commissioning Group would be supporting CGL in this work.

New and Growing Communities and Housing

The number and variety of new and growing communities and housing needed within the county created both opportunities and challenges across the public and private sector. The issue had been raised at the Health and Care Executive and other strategic groups. There was a wish amongst health service representatives to see the planning system simplified, whilst planning authorities were seeking simplification of health service provision. An officer report had been submitted to the Cambridgeshire Public Service Board, but no substantive progress had been made. A further report had been requested for October 2018, but there were differing views on how best to make progress. The views of the Board were sought on next steps.

The following comments arose in discussion of the report and the issues raised;

- The Chairman stated that this was a complex issue which was not always particularly well understood;

- A health service representative commented that large developments such as Northstowe required the provision of healthcare infrastructure such as a GPs surgery. However, they were not required to take account of the impact of the new community on wider health care services and infrastructure such as midwifery services and hospital care. They felt this was a policy issue as much as a practical one. The impact on health services of the additional demand created by those living in smaller, infill developments was also not yet taken into account when proposals for these types of developments were considered;

- The Vice Chairman stated that it should be possible to work out iterative liability costs as populations grew. Section 106 money might pay to build a GPs surgery in a new community, but it did not fund the staff needed to work in it or the impact on other healthcare services in the area. She did not feel that the Health and Care Executive Group was the right place for that discussion;

- A District Councillor commented that they were glad this issue had been raised as it demonstrated a dysfunctional way of working. Whilst the impact of small developments and infill housing might seem minimal, the cumulative effect could be significant. They questioned whether a more proactive role could be taken and suggested a case study;
- A District Councillor commented that health service information and figures were not getting to the Districts.

The Director of Public Health stated that the report taken to the Health and Care Executive had been quite operational. What was needed now was a careful analytical look at the system and to get some strong analysis done to take this forward. She undertook to share the information suggested by the Vice Chairman with District and City Council representatives to ensure that these bodies were fully sighted on the work.

Summing up, the Chairman stated that this issue went wider than solely chief executives and asked that the flavour of this discussion should be fed back to them. The Board really wanted to know how they would engage. There was also a role for District and City Council representatives in raising this issue with their respective Councils.

It was resolved to:

a) note progress with progressing action planning for the three priorities confirmed at the HWB Board on April 24th 2018;

b) consider how the Living Well Partnerships might wish to work with the Health and Wellbeing Board and county-wide officer groups on these priorities.

88. CAMBRIDGESHIRE AND PETERBOROUGH SUSTAINABILITY AND TRANSFORMATION PLAN UPDATE – PUBLIC ENGAGEMENT

The Director of Corporate Affairs for the Cambridgeshire and Peterborough Clinical Commissioning Group stated that the public engagement strategy had been refreshed to increase transparency and it was now more of a system communication plan. As part of this the STP Board was hoping to start meeting publicly from October/ November 2018 onward and the minutes of these meetings would be published. The need to do better in relation to public engagement around proposed changes to services was accepted, including the need to be more methodical and to provide feedback to those who were consulted. Amongst the suggestions was a three month formal consultation period for major service changes, but with the option of more targeted consultation where specific groups of service users were concerned. The possibility of holding some place-based events about the STP was also being considered, but there were some reservations that this might raise unnecessary concerns in those areas that local services might be affected. The alternative would be to include sessions about the STP in wider events. Any feedback from Board members on this would be very welcome.
(**Action: All Board Members**)

In the course of discussion:

- The Healthwatch representative commented on the need for on-going input and dialogue. The proposals looked promising and she suggested that it would be helpful to see a collection of shared learning examples in a year's time. She also suggested looking at the methodology of patient involvement so that this focused on patient-sensitive impact points;

- It was noted that Cambridge City Council should be included in the list of local government stakeholders included in the report;

- Paragraph 3.3: A County Councillor commended the principle of ensuring that the patient's voice was heard throughout service change planning and implementation, but questioned how this would be delivered in practice and cautioned about the need to avoid over-promising. The Director of Corporate Affairs acknowledged that including a patient representative on a Panel would not necessarily reflect the full spectrum of opinion amongst patients and agreed to reflect further on this.

It was resolved to:

a) note the strategy for external communication and engagement for the coming year.

89. FORWARD AGENDA PLAN

The Board reviewed the Forward Agenda Plan, noting that the September meeting would be held concurrently with the Peterborough Health and Wellbeing Board. The Chairman proposed that a report on the Cambridgeshire and Peterborough Combined Authority should go to that meeting to help understand the direction of travel in relation to the Health and Wellbeing Board's sphere of interest. This would include exploring what this meant for the Board and how it could contribute. He further proposed a report looking at David Behan's report on integration and best practice to see how lessons learnt could be applied locally.

Two members of the public sought to ask a question without having given the required notice. Officers offered to follow up the points raised outside of the meeting.

It was resolved to:

a) note the Forward Agenda Plan.

90. DATE OF NEXT MEETING

The Board will meet next on Thursday 20 September 2018 at 10.00am in the Council Chamber at Peterborough City Council, Town Hall, Bridge Street, Peterborough PE1 1HF. This meeting will be held concurrently with a meeting of the Peterborough Health and Wellbeing Board.

Chairman