CAMBRIDGESHIRE HEALTH AND WELLBEING BOARD: MINUTES

Date: **21st April 2016**

Time: **14.00 to 15.30**

Place: **Kreis Viersen Room, Shire Hall, Cambridge**

Present: Cambridgeshire County Council (CCC)
Councillors P Clapp, M Loynes, L Nethsingha, and T Orgee (Chairman)
Charlotte Black, Service Director: Older People's Services and Mental Health, Children, Families and Adults Services (CFAS) (substituting for Adrian Loades)
Dr Liz Robin, Director of Public Health (PH)

District Councils
Councillors D Brown (Huntingdonshire) and R Johnson (Cambridge City

Cambridgeshire and Peterborough Clinical Commissioning Group (CCG)
Cath Mitchell (substituting for Dr Sripat Pai)

Healthwatch
Val Moore

Voluntary and Community Sector (co-opted)
Julie Farrow

Apologies: Councillors J Whitehead (CCC), M Cornwell (Fenland), S Ellington (South Cambridgeshire) and J Schumann (East Cambridgeshire); Dr S Pai (CCG); M Berry (NHS England); A Loades (Executive Director, CFAS, CCC) and C Malyon (Section 151 Officer, CCC)

200. DECLARATIONS OF INTEREST

There were no declarations of interest.

201. MEMBERSHIP OF THE CAMBRIDGESHIRE HEALTH AND WELLBEING BOARD

The Board received a report setting out options for change to the Health and Wellbeing Board (HWB) membership. These had been developed by the working group established at the HWB meeting in November, and discussed by the HWB in March and by the Cambridgeshire Public Services Board in April.

At its meeting on 17th March, the HWB had already agreed four of the five changes proposed:

b) Invite 5 representatives for providers (mix of influential non-executive directors and executives)
c) Co-chair or vice-chair arrangements with CCG
d) Board-to-board meetings with Peterborough, explore joint programmes of work
e) Strengthen links with Local Health Partnerships – Integrated Care Boards?.

The difficulty had lain with the first proposal, to reduce local authority HWB membership from 5 County Councillors and 5 District Councillors to 5 elected Councillors (County and District) in total.

Members noted that the CPSB, composed of experienced chief executives from public sector organisations, had confirmed that there was no easy answer. There had been a helpful discussion of HWB membership by the CCC Constitution and Ethics Committee at its meeting on 19th April; the Committee had concluded that the Board should discuss the options, and had delegated authority to the Monitoring Officer, in consultation with the Chairwoman and Vice-Chairman of the Constitution and Ethics Committee and Chairman and Vice-Chairman of the Cambridgeshire Health and Wellbeing Board, to recommend the final proposed membership changes to full Council on 10th May 2016.

Comments at the Constitution and Ethics Committee meeting had been generally supportive of making changes to Board membership, and of retaining five District Councillors. It had been suggested that it might be appropriate to appoint Chairs or Vice-Chairs of the relevant policy and service committees as CCC Board members, and perhaps the Leader and Deputy Leader of CCC; there was also support for appointing the chairs of Local Health Partnerships. It was also clarified that the HWB should not engage in scrutiny, because this was carried out by the Health Committee.

Members noted the proposed options for Councillor membership of the Board:

- Option 1: existing Councillor membership to remain, perhaps increasing CCG membership by one
- Option 2: reduce to four County Councillors and one District Councillor
- Option 3: reduce membership to three County Councillors, but remain with five District Councillors

and also noted the suggestion that the Board hold a development day in June to talk about new ways of working as a Board.

Emailed comments from Councillors Cornwell and Whitehead were read; the points they made included that

- having one District Councillor on the Board had been unsatisfactory in the past; one District representative could not speak for five very different districts, and Option 2 was therefore unacceptable
- even if Integrated Care Boards were to come into existence locally, it was not certain that they would adequately reflect the whole spectrum of health and care
- having a slightly larger Board would not be a problem; District members had been diligent and useful attenders, and their number should not be reduced, neither should the number of County members, where it was important to have a political balance of members under a hung Council
- if Option 3 were to be adopted, the three County members should be either the chairs of the three relevant committees (Adults; Children and Young People; Health) or members of and nominated by those committees.

It was noted that not all chairs of Local Health Partnerships were Councillors.

Speaking as both a member of the Constitution and Ethics Committee and chair of the HWB working group, Councillor Nethsingha said that she would not have any difficulty with maintaining the current number of Councillors on the Board. The starting point of the working group had been that conversations around the Board needed to be more robust and involve more people. Since the group had concluded its work, some strong feedback had been received, particularly from the NHS, about the value of having all five districts represented on the Board, and following conversations after the

Constitution and Ethics Committee, she had also come to agree with retaining five County Councillors.

Other comments in the course of discussion included that

- the CCG was very supportive of the proposal to widen Board membership

- Integrated Care Boards did not yet exist in Cambridgeshire; they were still under discussion, but would perhaps be known by a different name

- Option 1 was the best because it would retain representation from all the Districts, despite the resulting Board being perhaps rather large for difficult discussions

- It was very important to define how the Board functioned; because of the constant changes in the health and wellbeing environment, it was necessary to utilise the help available from such sources as the Local Government Association (LGA), and to look at best practice from other HWBs to see how they tackled the challenges, perhaps utilising peer review

- the development day in June could be a good time to invite somebody to attend from the LGA to attend in relation to best practice and peer support; the day would also provide an opportunity to look at the Board's work in relation to the new Health and Wellbeing Strategy.

The Chairman stated that the Districts each had their own characteristics and priorities, and he did not support reducing the number of their members on the Board. As the Board was a committee of the County Council, it was inappropriate for it to have fewer County than District Councillor members. He therefore supported retaining five County and five District Councillors. This view was supported by the Board by acclamation.

Members went on to consider whether they wished to indicate to Council a view on who those Councillors should be. Points made included that

- it would be useful if District members had a link into the Local Health Partnerships, and prudent to have a link into the County committees
- there was a requirement for HWBs to join up public health, NHS and social care functions, which were executive streams of work for which the three committees were responsible; despite the county officer membership of the Board, there was a lack of a clear Councillor link to the Adults Committee
- it would be better to leave matters as they were, and not be too prescriptive; under the Committee system of governance, the chair's function was to chair meetings, and he/she could not speak for the Committee
- perhaps the Board could offer a sentence supporting nomination of members to the Board who would contribute to its work.

The Chairman summed this up as wishing to offer Council gentle guidance as to whom it would be helpful to have as Board members.

The Board went on to consider a suggestion that it recommend amendment of its standing orders. This question had not been included in the report, but identified when it had been realised that the absence of the Vice-'Chairwoman meant that it would have been impossible, under the present standing orders, to hold a valid meeting of the Board had anything happened to prevent the Chairman's attendance. Members noted that under the current terms of reference, the quorum was five, to include the Chairman/woman or Vice-Chairman/woman. A larger Board perhaps

required a larger quorum, and usual practice for Council committees was that in the absence of Chair and Vice-Chair, those members present selected a temporary chairman/woman for the meeting.

The Chairman proposed, and the Board agreed, to recommend to Council that the quorum be amended to eight, and that Standing Orders be amended to remove the requirement that Chair or Vice-Chair be present and allow the nomination of a temporary Chair.

It was resolved:

a) to agree that the Board's preferred option was Option 1, as set out in section 3 of the report before the Board, under which the existing Councillor membership of the Board would remain at 5 County Councillors and 5 District Councillors

b) to agree the proposal to organise a development session in June 2016 to develop future ways of working, as set out in section 4 of the report.

202. BETTER CARE FUND PLAN 2016-17

The Board received a report setting out the background to the Better Care Fund (BCF) plan for 2016/17 and updating members on further areas for development in the plan. Attention was drawn to the requirement to submit the final BCF plan by 3rd May 2016, and the request for a delegation to the Director of Public Health in consultation with the Chair and Vice-Chair of the Health and Wellbeing Board for completion and approval of the templates.

Members noted that

- the BCF continued to involve creating a joint budget to help health and social care services to work more closely together in each Health and Wellbeing Board area
- the plan was being drawn up in a different environment from that of the previous year, largely as a result of the termination of the UnitingCare contract for the delivery of Older People and Adult Community Services (OPACS)
- the majority of the BCF spending remained within mainstream services, but efforts had been made to set out more clearly which service areas the BCF would be supporting in 2016/17
- for 2015/16, a target of 1% had been set, but not achieved, for the reduction of non-elective admissions, so a fresh look had been taken at what was being done to support the aim of keeping people out of hospital and not needing support from social care services
- a large part of the plan involved the creation of and effective working of integrated teams involving all local partners to offer home-based services and intensive rehabilitation services
- the target for 2016/17 was based on CCG operating plans; the final target figure was not yet known but due to be received from NHS England shortly
- feedback on the draft version submitted on 21 March had been relatively positive; the reason for the 'not assured' rating had been largely because the draft had been unable to include final figures and targets

- the plan for 2016/17 was to be assessed in the context of the local health and care economy, and the risks the local system was facing. The rating would reflect these local conditions.

The Board went on to consider the draft plan as presented in appendices to the report. Points raised and noted in the course of discussion included

- whatever was done to develop the best possible plan, local financial circumstances meant that it would be signed off 'with support' (rather than not being signed off, or being signed off as assured); regionally, no plans had been signed off as assured

- a 5% target for reducing non-elective admissions was ambitious, particularly by contrast with the previous year's unachieved 1% target, and in the light of reduced financial resources; setting such a target could be a recipe for failure

- unlike last year, there was one target across the whole system, and this ambitious target would be contained within other relevant plans; therefore the BCF plan would be likely to be rejected if it were to contain a different target

- the requirement to align figures across the health system was setting up the whole system for a budget deficit, because they appeared to reflect the amount of funding available rather than being aligned with actual need.

  The Director of Public Health raised and undertook to look into the questions of whether the figures used for the BCF applied to both Cambridgeshire and Peterborough together, as the Cambridgeshire and Peterborough CCG would have submitted one figure, and of whether the figures assumed inbuilt growth

- the BCF was not the only mechanism involved in delivering the target, there was also the Urgent and Emergency Care Vanguard, and the five-year Sustainability and Transformation Plan

- it was important fully to engage with primary care, and to encourage people to access primary and urgent care services appropriately, to reduce the number of people simply turning up at hospital emergency departments

- if somebody was actually admitted to hospital on a non-elective basis, it was because there was a problem that required admission

- efforts were being made to offer early intervention to as many people as possible, in order to avoid them reaching the point where admission was required; it was more cost-effective to invest in lower-end services than spend on hospital care

- the aim of making savings by diverting people to other services required prior investment in those services in order to be successful

- investment was being undertaken in the community, including in neighbourhood teams, which had been in place since October 2015. It had been decided to invest heavily in these teams through the BCF, realigning resource in health, social care and the voluntary sector to support the teams to work in a different, more proactive way. It was not a question of cutting services, but of intervening earlier so that people did not need to go into hospital

- the new teams in place needed workforce development. This included workforce development for voluntary organisations, which were vital to the success of these teams and plans; Care Act training for example had included the voluntary sector free of charge. The CCG's representative on the Board acknowledged the point and undertook to convey it to the CCG

- the content of the 2016/17 plan was very similar to that of the previous year's plan, because there had been considerable delay in implementing some of the targets following the end of the UnitingCare contract; anything the Board could do to keep up the momentum for progress would be very helpful

- it had emerged from the aftermath of the OPACS contract that some of the data sharing anticipated had not taken place, which raised the question whether the data sharing being sought by the BCF plan would in fact occur

- Oneview, part of the UnitingCare plans, was not now going ahead, so work was being done on how to link in with neighbourhood teams, including checking what consents would be required for elements of data it was proposed to share. The result arrived at would not be one big technical solution; there was much that could be done within existing systems

- it had been a CCG decision not to proceed with Oneview; GPs had judged that Oneview was not going to provide information that could be viewed by everybody and could give the outcome that had been sought

- a common information hub was being created for the public, which would provide consistent information by whatever route the hub was accessed; anything the Board could do to support the delivery and implementation of these changes would be helpful

- the Health and Wellbeing Board was responsible for the actual Better Care Fund plan, but the targets were system-wide and the responsibility of several bodies.

It was resolved to:

- delegate authority for completion and approval of the Better Care Fund templates to the Director for Public Health in association with the Chair and Vice-Chair of the Health and Wellbeing Board.

203. DATE OF NEXT MEETING*

Board members noted the date of the Board's next meeting:

- 10am on Thursday 26th May 2016, at Bargroves Centre, Cromwell Road St Neots PE19 2EY

Chairman

***POST-MEETING NOTE**
The venue for the next meeting (still at 10am on 26th May) has been changed to **South Cambridgeshire Hall, Cambourne.**