Herefordshire Council

Minutes of the meeting of Adults and wellbeing scrutiny committee held at Council Chamber, Shire Hall, St. Peter's Square, Hereford, HR1 2HX on Monday 2 March 2020 at 2.30 pm

Present: **Councillor Elissa Swinglehurst (chairperson)**
Councillor Jenny Bartlett (vice-chairperson)

Councillors: Sebastian Bowen, Helen I'Anson, Tim Price, David Summers and Kevin Tillett

In attendance: **Councillors Pauline Crockett (Cabinet member - health and adult wellbeing)**

Officers: **Democratic services officer, Democratic services manager, Deputy solicitor to the council and Assistant director all ages commissioning**

39. APOLOGIES FOR ABSENCE

All committee members were present.

Apologies were noted from Dr Ian Tait of NHS Herefordshire Clinical Commissioning Group, Christine Price and Ian Stead of Healthwatch Herefordshire, and Stephen Vickers (Director of adults and communities) and Mandy Appleby (Assistant director of adults social care) of Herefordshire Council.

40. NAMED SUBSTITUTES (IF ANY)

There were no substitutes.

41. DECLARATIONS OF INTEREST

No declarations of interest were made.

42. MINUTES

In response to a question from a committee member about an undertaking given by representatives of NHS Herefordshire Clinical Commissioning Group and Wye Valley NHS Trust to provide further information in relation to the data on attendances at Minor Injury Units, the democratic services officer advised that there had been some correspondence following the last meeting but a definitive statement which could be circulated to committee members was awaited.

Resolved: That the minutes of the meeting held on 13 January 2020 be approved as a correct record and be signed by the chairman.

43. QUESTIONS FROM MEMBERS OF THE PUBLIC (Pages 13 - 14)

A question received, a supplementary question asked at the meeting, and the responses provided are attached as appendix 1 to these minutes.

44. QUESTIONS FROM COUNCILLORS

No questions had been received from councillors.

45. BRIEFING PAPER ON NHS CONTINUING HEALTHCARE (NHS CHC)

The chairperson said that the purpose of this item was for Herefordshire NHS Clinical Commissioning Group (CCG) to report on progress since NHS Continuing Healthcare (NHS CHC) was last considered by the committee on 20 September 2018; minute 15 of 2018/19 refers. Linda Allsopp, associate director of nursing and quality, and Nikki Warman, head of CHC, were invited to introduce the briefing paper on behalf of the CCG.

The principal points of the introduction included:

i. NHS CHC was a package of care that was funded solely by the NHS for an individual that had been assessed as having a 'primary health need'; the associated test focused on nature, complexity, intensity and unpredictability.

ii. There was a national framework, updated in October 2018, and the CCG's CHC process was fundamentally a whole system approach, working with local authority colleagues in terms of assessing an individual's need and whether that goes beyond the responsibilities of the local authority.

iii. This update focused on NHS England key performance indicators, including:

- The target was being met in Herefordshire and Worcestershire for making a decision on eligibility within 28 days of a referral.
- The target was being met for no more than 15% of assessments taking place in an acute hospital setting; there was an expectation that no assessments would be undertaken in this setting but fast track referral for an individual entering the terminal phase of life could be accepted.
- The target was being met for accepting all appropriately completed fast track applications.

iv. In line with the national framework, only when there was deemed to be a change in healthcare need would a review of eligibility take place.

v. As part of the merger between the Herefordshire and Worcestershire CCGs, the CHC policies would be reviewed to ensure that systems were working as efficiently as possible to provide quality of service to all patients.

The chairperson drew attention to the recommendations made at the 20 September 2018 committee meeting and invited officers to provide appropriate updates:

a) a small number of senior social workers be upskilled to ensure that there is a common understanding of the medical terminology when dealing with disputes

The assistant director all ages commissioning advised that interactions between the council and the CCG on CHC were progressing well. The associate director of nursing and quality advised that adult social care employed social workers to work on CHC and there were positive working relationships. The head of CHC added that the joint training of multidisciplinary teams on the national framework was being explored.

b) *the CCG be requested to commit to seeking to lift Herefordshire out of its current position of 6th from the bottom in the national CHC eligibility by 50k population and to report its progress against this commitment at a future adults scrutiny committee*

c) *the CCG be called back to the committee to report on progress made against their action plan recommendations in six months' time*

d) *the CCG be requested to influence the report of the NHS England to be a system review and to include the local authority within that review*

The chairperson noted that, in response, the CCG had committed to '*share the outcomes from the NHS England review with the local authority and the committee once it has been received and reviewed by the CCG internal governance processes*' and would '*raise the issue of LA* [local authority] *engagement in NHS England review*'.

The head of CHC advised that NHS England had reviewed performance in October 2018 and it was understood that the outcomes of the review had been shared with the local authority. The assistant director all ages commissioning was not aware that this report had been received and requested that it be sent to him.

Referring to recommendation d), the chairperson questioned the involvement of the local authority in the review in terms of triangulation of experience. The associate director of nursing and quality advised that NHS England had undertaken a 'deep dive' into eligibility within Herefordshire and no anomalies were identified which caused them to be concerned; a commitment was given to share the report. The chairperson observed that such reviews could be perceived to be too insular and there was a need for a more partnered approach.

The chairperson, referring to concerns expressed by the committee in 2018 and by members of the public subsequently about the drop in the figures during 2016, queried why Herefordshire appeared to be an outlier in terms of comparator areas. The associate director of nursing and quality said that: the CCG was regulated by NHS England; CHC was for people with exceptional health needs; and the CCG was striving to apply the framework fairly and consistently, involving local authority colleagues within the assessment and review processes.

The chairperson questioned whether self-funders were at an additional disadvantage and were vulnerable to slipping between the various processes. The head of CHC said that all nursing homes were required to notify the CCG of all new admissions and about any individual that had a significant change in need, and this would trigger consideration for CHC. The associate director of nursing and quality outlined the funded nursing care review and CHC checklist processes.

Attendees were invited to ask questions and make comments, the key points included:

1. In view of capacity issues, a committee member questioned whether the CCG was training non-clinicians to undertake appropriate duties usually undertaken by nurses, or to train nurses to undertake appropriate duties usually undertaken by doctors, such as perinatal mental health referrals.

   In terms of CHC, the associate director of nursing and quality said that there was strict guidance within the national framework about the health and social care professionals involved in multidisciplinary teams. Scott Parker, director of performance, said added that the NHS was looking at other roles which could be undertaken by non-clinicians, including within Primary Care Networks, to release the time capacity of nurses and doctors. On the issue of perinatal mental health, it

was reported that a service was being designed and commissioned to support patients who were between basic and high levels of need, and this piece of work could be shared at an appropriate time.

2. The vice-chairperson asked whether the CCG was confident that everyone who was eligible to have a CHC review was picked up within the diverse systems and not just through hospital pathways.

   The associate director of nursing and quality: reiterated points about the timing of reviews, with assessments made when long term health needs were clear, and the fast track referral process; advised that the systems were supported through training on when it was appropriate to refer an individual for a CHC assessment; said that the CCG would only become aware of an individual when a checklist was received to request an assessment; and reported that the CCG was working on communications around CHC eligibility.

3. Referring to the CCG Governing Body paper of 28 May 2019 on the Herefordshire and Worcestershire Sustainability and Transformation Partnership draft operational plan 2019/20 which identified savings targets from CHC, the vice-chairperson questioned whether the need to make savings was the most important driver.

   The associate director of nursing and quality emphasised that the CCG had statutory responsibilities and said that any savings would be delivered through efficiencies within the provider market, for instance by working jointly with the local authority to reduce variances in the costs of care packages.

4. The vice-chairperson commented that the presentation of figures in terms of percentages made it difficult to understand the position in terms of the Herefordshire population and suggested that it would be helpful to understand the position for Worcestershire also.

   The associate director of nursing and quality reported that the Worcestershire CCGs were also required to submit data to NHS England. It was also reported that a monthly quality and performance meeting for Herefordshire and Worcestershire had been introduced. In response to a question from a committee member, the associate director of nursing and quality clarified that this was an internal meeting which challenged delivery around CHC and considered learning from appeals and complaints, and said that a briefing paper could be provided.

5. Referring to recommendation b) and to the questions from a member of the public, a committee member considered the responses provided to be inadequate, and asked for an explanation of the reasons why CHC eligibility in Herefordshire was consistently below the national average and what would be done about it.

   The associate director of nursing and quality: reiterated that the national framework had to be applied fairly and consistently; said that a local appeal process had been introduced, chaired by an independent person and involving people who had not had prior dealings with the relevant case, before going to NHS England; reiterated that a review had been undertaken by NHS England in 2018; and commented on the process to identify people with primary health need, with regular reviews to ensure that the package of care met that need.

   The committee member expressed concern that the responses did not address the specific reasons for the position in Herefordshire, especially considering that population demographics would suggest that CHC eligibility might be expected to be higher than the national average.

The associate director of nursing and quality said: it did not necessarily follow that there would be a correlation between demographics and eligibility for CHC; the national framework was followed, the CCG could not make individuals eligible if they were not eligible; it was important to ensure that there was a process for referring people for an assessment; and the involvement of local authority colleagues in assessment and dispute processes was reiterated.

The chairperson said that it would be helpful to have a deeper understanding, as the numbers suggested that Herefordshire was an outlier statistically and it was significantly adrift of comparator areas. It was not considered that the committee had been provided with the narrative for the reasons behind this.

The assistant director all ages commissioning suggested that the CCG and the council should work together as partners to produce statistics which showed, based on current demographics: the anticipated levels of CHC that would be expected; the levels that Herefordshire was actually achieving; the levels that Worcestershire and relevant comparator areas were actually achieving; and provide compelling rationale for any similarities or differences. It was acknowledged that the perception of Herefordshire being an outlier needed to be addressed. The associate director of nursing and quality said that the CCG was happy to do this; it was noted that there was a cohort of patients not eligible for CHC but who did have needs above what core services could provide. The chairperson welcomed this suggestion.

6. In response to a question from a committee member about the target for no more than 15% of assessments taking place in an acute hospital setting, the associate director of nursing and quality clarified that NHS England expected there to be an alternative discharge pathway in place, so that an individual had a period of time to recover from their acute illness.

7. The cabinet member – health and adult wellbeing commented on the need to explain to individuals why they were not eligible for CHC and what other options were available to them.

8. The chairperson questioned whether there were statistics on the total number of appeals and the number of appeals that were successful.

   The associate director of nursing and quality confirmed that this information was recorded; for 2019, 690 referrals into the CHC service had been received, with 15 appeals. It was noted that there was a local dispute resolution policy to manage disputes between the CCG and the council around eligibility.

9. The chairperson also questioned the signposting and advocacy that was available, particularly for self-funders and / or their carers.

   The associate director of nursing and quality advised that: NHS England had been leading on a strategic improvement programme to ensure that materials were available to explain CHC to the general public; as part of the quality and performance meeting, a communications group had reviewed the letters sent out to individuals to explain CHC eligibility; and the multidisciplinary teams signposted people to resources, including advocacy services, to support people through the CHC process.

   In response to further comments from the chairperson, the head of CHC advised that individuals were informed of their right to appeal the CHC outcome and were signposted to Beacon, an independent information and advice service on CHC.

10. The vice-chairperson sought clarification that, as assessments were not being made in an acute hospital setting, health and social care teams were following up to ensure that assessments were being offered rather than making assumptions about patients being part of different pathways.

    The director of performance commented that it was better for people to go back home following acute episodes of care and for assessments to be made there in their normal environment. The joint discharge team worked across health and social care, and referrals were passed through to appropriate teams. In addition, community based teams were trained to understand when referrals should be made around CHC and other kinds of eligibility.

    The vice-chairperson sought assurance that the training did not result in teams erring on the side of caution in terms of the number of referrals. The director of performance suggested that this assurance could be provided in the next paper.

11. Referring to the jointly commissioned 'Herefordshire Continuing Healthcare Review: Final Report' by Angela Parry in June 2018, the chairperson drew attention to the review observation that '*CCG colleagues accept that changes to practice went ahead without ongoing discussion with the Council which may have resulted in budgetary implications and relationship difficulties*'. It was questioned why the local authority had not been involved in that change, particularly given the possibility of pressure being moved to other parts of the system.

    The chairperson also drew attention to the review recommendation for '*Clarity from the CCG that there has been change to the CHC approach in Herefordshire and clarity for the Council as to where, within the process, this change has taken place. This will give the Council and understanding of why numbers have fallen so dramatically.*' The chairperson said that this did not appear to have been taken forward and considered it essential to arrive at a mutual, joint understanding of needs and how best to meet them.

    The director of performance suggested that these matters could also be picked up in the next report but did comment that joint working well in the local system, with senior level involvement in the Herefordshire Integrated Primary and Community Services Alliance Board, and collaboration would be further developed through the Primary Care Networks and other initiatives. The assistant director all ages commissioning confirmed that good progress had been made and there was an opportunity for partners to work more closely from an operational commissioning perspective.

There was a short adjournment to prepare draft recommendations. The resolution below was then discussed and agreed by the committee.

Resolved: In collaboration with Herefordshire Council, where appropriate, it be recommended to the clinical commissioning group:

(a) To provide a rationale, with data (in numbers), as to why Herefordshire is not achieving the expected levels of NHS Continuing Healthcare when compared with other clinical commissioning group and local authority comparator areas.

(b) To follow up the request from the adults and wellbeing scrutiny committee on the commitment to provide responses to the recommendations set out in the jointly commissioned Parry report.

(c) To provide details on the numbers of NHS Continuing Healthcare appeals and the number of successful appeals before and since 2016.

(d) To explain how the various discharge pathways are able to pick up the patients where NHS Continuing Healthcare is deemed, or not deemed, to apply and how further assessments of NHS Continuing Healthcare are triggered.

(e) Where there are changes to services that are likely to impact on the wider system, that partners are engaged in conversations at the earliest opportunity.

46. PERFORMANCE MONITORING - NHS HEREFORDSHIRE CLINICAL COMMISSIONING GROUP

The chairperson said that the purpose of this item was to consider a report on performance monitoring by NHS Herefordshire Clinical Commissioning Group (CCG), as requested by the committee following consideration of 'The future of the Herefordshire and Worcestershire Clinical Commissioning Groups consultation' item at the 24 June 2019 meeting; minute 7 refers. In addition, details of the One Herefordshire priorities and outcome measures had been requested by the committee following consideration of the 'One Herefordshire and Integration Briefing' item at the 18 October 2019 meeting; minute 17 refers. Scott Parker, director of performance, was invited to present this report on behalf of the CCG; presentation slides had been circulated in a supplement to the agenda.

The principal points of the presentation included:

a. The differences between Appendix 1 (CCG performance dashboard 2019/20) and Appendix 3 (presentation slides) were partly due to variations in timing and the distinction between CCG data (for services provided for the population of Herefordshire) and Wye Valley NHS Trust data (including attendances by patients from Herefordshire, Wales, and elsewhere).

Arrangements for performance oversight

b. With the merger of the four Herefordshire and Worcestershire CCGs, assurance was provided that performance information for Herefordshire (and the other constituent areas) would still be recorded and there would be an oversight structure which would consider quality, performance and finance, overseen by the Governing Body.

c. A brief overview was provided of the development of Primary Care Networks, including oversight by a local performance forum.

d. It was reported that there was a Sustainability and Transformation Partnership (STP) performance forum, involving system partners with collective ownership and responsibility for the delivery of performance.

Presentation slides

Urgent care

e. Accident and Emergency (A&E) four hour waits performance (c. 76%-78%) was below the national target (95%) but performance for the most severely unwell patients was stronger.

f. For overall performance, Wye Valley NHS Trust was c. 14-16th out of the 21 trusts in the West Midlands. It was reported that there were challenges with substantive post fill but vacancies were being managed and recruitment plans were in place.

g. Within national guidance, there was a 92% general and acute bed occupancy benchmark and it was one of the functions of the A&E delivery board to achieve this.

h. In order to achieve 92% acute bed (general and acute) occupancy there was a projected bed gap of approximately 20 beds. The bed gap was being closed through opening additional beds and initiatives to support reduced length of stay. It was reported that Wye Valley NHS Trust was performing well at 'zero day' length of stay, i.e. working with the patient to help them to return home, avoiding the need for admission to an inpatient bed.

i. Ambulance conveyance was a key challenge for the system, with Herefordshire having the highest conveyance rate for West Midlands Ambulance Service (WMAS). The causal factors, including geographic size and population sparsity, and alternatives to conveyance were being examined for the purposes of service design.

Cancer waiting times

j. The all cancer two week wait referrals position had improved (from c. 91% to c. 94%) and was now above the national target (93%).

k. The breast symptomatic two week wait referrals position had improved significantly (from the low 30s% to high 90s%). It was commented that this reflected the challenges for small general hospitals in running services that were reliant on small numbers of consultants. It was reported that the STP was considering how to deliver such services across the larger footprint of the Herefordshire and Worcestershire CCG, as well as regional propositions.

l. The 62 day cancer wait for receiving first definitive treatment (c. 74-75%) was below the national target (85%) and plans were in place to improve the pathways.

Referral to treatment (RTT) waiting times

m. The RTT 18 week wait for treatment position had improved (to c. 81-82%) but was below the national target (92%) and work was ongoing to manage the waiting list and improve performance. The potential role of the Primary Care Networks in supporting people to consider their treatment options was outlined.

n. The system performed well in terms of diagnostic six week wait, and above the national target (99%).

o. A lot of work had been undertaken to avoid 52 week wait breaches, with the majority of breaches occurring at providers out of county or as a consequence of patient choice.

Dementia diagnosis and IAPT (Improving Access to Psychological Therapies)

p. It was reported that dementia diagnosis was a challenge in both Herefordshire and Worcestershire, and work had been commissioned with NHS Digital to understand how both counties compared to comparator areas; this was expected back in May / June 2020. Mitigating factors included rising age profiles and issues specific to rural areas.

q. The IAPT access rate had improved but was below the national target (22%) but there were other metrics which indicated that the service was performing well; the recovery rate was one the highest in the country. A backlog had been cleared and it was anticipated that the target would be met towards the end of 2019/20.

One Herefordshire draft outcomes framework

r. It was reported that the draft outcomes framework, Appendix 2 to the report, defined a range of ambitions and system level outcomes. Reflecting the differences in constituent areas, work was being undertaken on the best measures for the different populations; it was expected that the final version would go through governance processes in April / May 2020. The outcomes framework would provide an anchor point and an overview of the beneficial impacts.

The chairperson asked for clarification on Delayed Transfers of Care (DToC), as the figures provided in the report showed performance below the target (<=3.5%) but it was understood that there had been substantial improvement over the past year. The director of performance advised that the figures for Herefordshire, unlike other areas, pooled acute hospital and community hospital numbers; for December and January the figure for the acute hospital was c. 2.3-2.4%, whereas the figure for community hospitals had risen to c. 18%. The assistant director all ages commissioning advised that Herefordshire Council presented the figures as actual numbers rather than percentages, and a massive improvement had been achieved; with a target of 416 days of accumulated delay, this was 470 days in January 2019 but had reduced to 353 days in December 2019. He added that this strong performance was mainly due to the work of the discharge teams, and collaborative approaches to minimise admissions to hospital and supporting people to return home as soon as possible. The chairperson suggested that there was a need for joined up understanding and consistent presentation.

The chairperson asked how the cohort of Herefordshire residents accessing healthcare through NHS Wales were reflected in the performance data, especially in terms of the potential impacts on health outcomes. The director of performance explained the escalation process to manage DToC and the assistant director all ages commissioning outlined some of the challenges for domiciliary care in the Welsh system. The chairperson asked whether there was a way to capture data generally for this cohort and compare it to that for residents in the rest of the county. The director of performance said that the governing bodies did recognise and consider the key differences between patients in the English and the Welsh systems.

Attendees were invited to ask questions and make comments, the key points included:

1. In response to questions from a committee member, the director of performance advised that: a written response would be provided on mental health needs and provision for 2 to 4 year olds; assurance would be sought from Worcestershire Health and Care Trust about how the voice of the people of Herefordshire would be represented following the transfer of mental health and learning disability services from Gloucestershire Health and Care NHS Foundation Trust (formerly 2gether NHS Foundation Trust); and, in terms of cancer call-backs, it was recognised that consultant capacity was limited and it was reported that innovations used elsewhere were being explored, such as advanced nurse practitioner led clinics.

   The committee member expressed concern about the appropriateness of certain procedures being undertaken by less qualified or experienced health professionals. The director of performance acknowledged the specific example but the general issue was the need to free up consultants to focus on activities that were most

pertinent to their skill sets; a commitment was given to provide a further update on this.

2. A committee member: expressed concern about the high number of metrics not meeting the required targets; suggested that a lean systems thinking approach should be taken to the whole A&E service; questioned whether the temporary closure of the Minor Injury Units in Leominster and Ross-on-Wye impacted upon the number of ambulance conveyances; and commented that assurances provided before the County Hospital was built that bed capacity would be sufficient had been too optimistic.

   In response, the director of performance noted the challenges in terms of population pressures and current funding settlements. He emphasised the work being undertaken to explore alternative services to meet the needs of the population; demand for urgent services appeared higher than expected, even taking into account the demographic shift. It was reported that initial analysis showed that current ambulance conveyances were appropriate, so there was a need to examine as a system what could happen earlier to avoid or delay situations occurring. It was anticipated that, with the development of Primary Care Networks and the rapid response service, more people could be supported to be safe and well in their communities. It was reported that Herefordshire had received capital funding to support additional beds and this would have a positive impact.

   In response to a further question, the director of performance advised that GP led triage systems worked well in certain areas with limited GP access but trials at Wye Valley NHS Trust showed that the number of patients presenting with primary care sensitive conditions were low. Reference was made to the out of hours service provided by Taurus Healthcare and to the NHS 111 service which could book appointments for patients at GP practices. Reference was also made to the correlation between proximity to a hospital and attendance at a hospital.

   The assistant director all ages commissioning emphasised the importance of demand management and shifting resources into the community to reduce the number of people requiring A&E support, with references made to homecare and hospital at home services.

3. The vice-chairperson considered the performance dashboard for the Worcestershire CCGs to be better than the Herefordshire dashboard; the latter using red, amber, green (RAG) ratings but with less statistical narrative. It was questioned how the information would be presented for the Herefordshire and Worcestershire CCG from 1 April 2020, especially where there were differences in the data being collected and presented currently.

   The director of performance advised that an integrated report was being designed, around the principles of special cause variation, and confirmed that the performance for each constituent area would be presented.

4. A committee member expressed concern about the lack of consultation over the closure of ambulance stations in the county and it was questioned whether this reflected a reorganisation of the ambulance system.

   The director of performance advised the committee that: ambulance services were commissioned on a regional basis to deliver against performance trajectories as a total organisation; in view of travel times to rural areas compared to urban areas, community first responder and defibrillator schemes could support equitable outcomes; the contract with WMAS included clear indicators for rural counties around clinical outcomes for patients; the Herefordshire Integrated Primary and

Community Services Alliance Board and One Herefordshire were responsible for local response models; and, whilst he was not aware of the decision-making process around the closure of the Ross-on-Wye ambulance station, it was understood that assurances had been provided that there would not be any change in terms of crew availability.

In response to a further question about consultation, the director of performance reported that the regional commissioner was based in Sandwell and an impact analysis had been undertaken.

5. Referring to the One Herefordshire draft outcomes framework, a committee member questioned why various metrics were blank currently.

   The director of performance said that the framework was still in development, with consideration being given to measures and metrics that related realistically to specific NHS Long Term Plan aims or system level outcomes.

6. Referring to RTT waiting times and the comment made about supporting people to consider their treatment options, a committee member questioned whether this could lead to a perception that people might be talked out of treatment.

   The director of performance said that it was important to recognise that different procedures would have different outcomes for different people. Therefore, conversations would be patient specific to ensure that they could arrive at an informed choice about procedures and alternative interventions. In response to a further question, the director of performance acknowledged the need for the system to ensure that such conversations were built into its processes.

The chairperson commented on the value of challenge around improving performance and, in particular, welcomed the significant improvement in the breast symptomatic two week wait referrals position; adding that this demonstrated what could be achieved where there was focus and resource to address a particular issue.

Resolved: In collaboration with Herefordshire Council, where appropriate, it be recommended to the clinical commissioning group:

(a) That a consistent set of system figures are used going forward (e.g. Delayed Transfers of Care), including comparative data for Herefordshire and Worcestershire.

(b) That it ensure that the new integrated dashboard moves away from the current RAG rating system and moves to the wider statistical narrative provided in the Worcestershire performance dashboard, with Herefordshire based performance commentaries provided.

(c) The outcomes of the cohort of residents being treated under the Welsh system be included in the dashboard figures.

47. COMMITTEE WORK PROGRAMME

The chairperson drew attention to the following: an additional meeting in April 2020 was proposed; provisional meeting dates for 2020/21 were noted; and, in view of committee members' expressed interest, an informal briefing would be arranged on the transfer of responsibility for the delivery of Herefordshire's mental health and learning disability services to Worcestershire Health and Care NHS Trust.

The vice-chairperson suggested that, in view of previous discussions about frailty and about ambulance conveyances, that an item be added to the work programme on ambulance services. The chairperson suggested that this could be in the form of a briefing on broader urgent and emergency care pathways.

In response to a comment from a committee member, the assistant director all ages commissioning said that he understood that draft organisational structures for the Herefordshire and Worcestershire Clinical Commissioning Group had been prepared and this could form part of a future work programme item.

A committee member felt that the rationale and justification for the closure of ambulance stations, resulting from decisions at a regional level, should be explored in more depth. The chairperson acknowledged the point and said that the format and timing would be considered as part of the ongoing review of the work programme. The assistant director all ages commissioning suggested that this could be accompanied by the mapping of commissioning decisions, as it did not appear that all stakeholders had been consulted.

Resolved: That

1. **Officers, in consultation with the chairperson and vice-chairperson, be authorised to update the work programme accordingly.**

2. **The provisional meeting dates for 2020/21 be agreed.**

48. DATE OF NEXT MEETING

The next scheduled meeting was Monday 6 April 2020.

[Note: due to the coronavirus outbreak and related social distancing measures, this meeting was cancelled subsequently]

The meeting ended at 5.28 pm **Chairperson**

Questions from members of the public to the adults and wellbeing scrutiny committee

2 March 2020

The following question relates to agenda item 7, NHS Continuing Healthcare (NHS CHC). The associated documents can be viewed via the following link:

NHS Continuing Healthcare (NHS CHC) report

Written question submitted in advance of the meeting

From: Andrea Davis

Why do Herefordshire CCG's figures for CHC eligibility continue to be consistently below the national average for CHC eligibility per 50k of population?

Response provided in advance of the meeting

Chairperson of the adults and wellbeing scrutiny committee

Thank you for your question. The question has been put to the responsible health body and the following response has been provided on behalf of NHS Herefordshire Clinical Commissioning Group (CCG).

> **From: Linda Allsopp, Associate Director of Nursing and Quality**
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> *It is essential to note that there may be variations between CCGs, STPs and Regions when compared against each other. This could be due to a wide variety of reasons including (but not limited to) the age dispersion within the local population, variations between geographical areas in terms of their levels of health needs, and the availability of other local services for example step down beds, intermediate care, rehabilitation services, and other CCG community services.*

Supplementary question asked at the meeting

From: Andrea Davis

Given that CHC is a legal entitlement, it is inherent in the functions of this committee to understand the mismatch and to be able to explain the underlying trends. Trisha O'Gorman (the head of NHS CHC at the Department of Health) stated that there is an almost a complete overlap between CHC eligibility and the definition of disability under the Equality Act. Is there a correlation between CHC eligibility and the numbers of those considered disabled? And can you clarify further the reasons for the low eligibility rates in Herefordshire overall?

Response provided at the meeting

> **From: Linda Allsopp, Associate Director of Nursing and Quality**
>
> *The CCGs across Herefordshire and Worcestershire are regulated by NHS England. We follow the national framework for NHS Continuing Healthcare, which is a primary health need test approach, looking at the four key indicators of an individual's needs; that is nature, complexity, intensity and unpredictability. We are regulated by NHS England in*

terms of an appeals process which goes through a local appeal process, leading to an independent review process. Really, the national framework is our Bible that we have to follow. We work in partnership with our local authorities colleagues, they are included in multidisciplinary meetings and if we have any disputes around eligibility, our local authority colleagues are part of that dispute resolution process.