Herefordshire Council

Minutes of the meeting of Adults and wellbeing scrutiny committee held online on Wednesday 24 March 2021 at 9.30 am

Present: **Councillors Elissa Swinglehurst (Chairperson), Jenny Bartlett (Vice-chairperson), Sebastian Bowen, Helen I'Anson, Tim Price, Alan Seldon and Kevin Tillett**

In attendance: Councillors Pauline Crockett (Cabinet member - health and adult wellbeing), David Hitchiner (Leader of the Council) and Felicity Norman (Cabinet member - children and families)

Officers: Mandy Appleby (Assistant director for adult social care operations), Ben Baugh (Democratic services officer), Kate Coughtrie (Deputy solicitor to the council), Jenny Preece (Governance support assistant), Paul Smith (Assistant director all ages commissioning) and Stephen Vickers (Director for adults and communities)

Invitees: David Mehaffey (NHS Herefordshire and Worcestershire System), Ian Stead (Healthwatch Herefordshire), Dr Ian Tait (NHS Herefordshire and Worcestershire Clinical Commissioning Group) and Simon Trickett (NHS Herefordshire and Worcestershire Clinical Commissioning Group)

35 APOLOGIES FOR ABSENCE

All committee members were present. Apologies for absence had been received from the following invitees: Councillors Graham Andrews, Paul Andrews and Phillip Howells (members of the children and young people scrutiny committee); Councillor Yolande Watson (cabinet support member adults and communities); Chris Baird (director for children and families) and Amy Pitt (assistant director talk community programme) (Herefordshire Council); Susan Harris (Herefordshire and Worcestershire Health and Care NHS Trust); Nisha Sankey (Taurus Healthcare); and Jane Ives (Wye Valley NHS Trust).

36 NAMED SUBSTITUTES (IF ANY)

There were no substitutes.

37 DECLARATIONS OF INTEREST

Councillor Bartlett declared an ‘other’ interest in agenda item 6, NHS White Paper: integration and innovation (minute 40 refers), due to attendance at Integrated Care System executive forum meetings, and clarified that she had not been present at a recent meeting where the White Paper had been discussed and she maintained an open mind on the proposals.

38 QUESTIONS FROM MEMBERS OF THE PUBLIC

No questions had been received from members of the public.

39 QUESTIONS FROM COUNCILLORS

No questions had been received from councillors.

40 NHS WHITE PAPER: INTEGRATION AND INNOVATION

The chairperson advised that this additional meeting had been convened to consider the report on the 'NHS White Paper: integration and innovation' from NHS Herefordshire and Worcestershire Clinical Commissioning Group (CCG). It was noted that members of the children and young people scrutiny committee had also been invited to participate in the meeting, in a non-voting capacity.

David Mehaffey introduced the report, the principal points included:

i. The NHS White Paper 'Integration and innovation: working together to improve health' (hereafter 'White Paper') would bring forward measures for a statutory integrated care system (ICS), comprising an ICS Board and an ICS Health and Care Partnership; this would replace the Sustainability and Transformation Partnership (STP).

ii. The focus was on improved outcomes to health and wellbeing for the population and tackling health inequalities by bringing together local authorities, NHS bodies, primary care, voluntary sector and other bodies.

iii. The proposals would not affect the role of the Health and Wellbeing Board; it was acknowledged that there would need to be a clear relationship between the board and the ICS Health and Care Partnership to ensure that they worked together well.

iv. The CCG would be abolished and replaced by NHS Herefordshire and Worcestershire ICS, with its board made up of local partners.

v. The competition rules would change, giving commissioners more discretion over procurement processes.

vi. A number of functions currently commissioned from NHS England in the Midlands region would be delegated to the ICS, such as local pharmacy and dentistry services.

vii. The partners would retain their organisational financial statutory duties but would also be required to have due regard to the balance of the whole system.

viii. The reforms were due to be implemented in April 2022. It was noted that there was a strong history of partnership working locally and the new arrangements represented 'a continuation of that journey' which would enable partners to work together in a more integrated way.

ix. The local system was one of eight, out of forty, involved in supporting the development of national guidance.

x. Attention was drawn to the ‘benefits to the population in Herefordshire’ identified in the report and it was noted that integrating services would result in people experiencing care that was more joined up and digitally enabled; it was anticipated that a single clinical record would make a significant difference.

xi. It was reported that, since the merger into a single CCG, NHS Herefordshire and Worcestershire CCG had made significant additional investment in Herefordshire and further investments were planned as the system moved into the ICS arrangements.

Simon Trickett reminded the committee that the White Paper set out proposals and would be subject to the formal legislative process in Parliament. He said the proposals would tidy up and consolidate the work that had been undertaken locally on integrated care in recent years, removing some of the barriers around procurement, and enabling partners to work collaboratively to design services.

Dr Ian Tait considered that the White Paper represented a permissive approach from the NHS, emphasised that not everything had to be done at the system level, and said that the new arrangements were based on partnership in the most genuine sense, involving individuals, communities, clinicians and members of staff working in health and care, and managerial and governance structures.

The director for adults and communities said that it was important to recognise that this was an evolution of the work that was already ongoing and encouraged the scrutiny committee to explore the ‘place’ issues for Herefordshire as thoroughly as possible, including the interface with the Health and Wellbeing Board; it was noted that the board membership had been expanded in recognition of the need to consider population health and wellbeing collaboratively. He added that, whilst there was detail to be worked through, the proposals should be viewed positively.

Ian Stead said that Healthwatch Herefordshire supported the development of the ICS and was keen to see that Herefordshire benefitted from improvements to services, adding that collaborative working between Herefordshire and Worcestershire had helped to secure investments in mental health services. He highlighted the need to ensure that the patient and public voice was heard strongly and taken into account in the decisions that were taken, and to develop the role of the Health and Wellbeing Board.

The chairperson welcomed the positive comments about the direction of travel but noted that the details would be crucial. Reference was made to the Centre for Governance and Scrutiny (CfGS) document on ‘The scrutiny perspective on the Government’s health and care White Paper’, including: the suggestion about ‘building scrutiny into the ‘duty to collaborate’’; and the concern expressed that ‘it is proposed to remove [scrutiny’s] power of referral to the Secretary of State…’. The chairperson felt that: there should be a role for scrutiny to be able to raise issues of public and local concern; the COVID pandemic had accelerated structural, organisational and cultural changes and it was hoped that the new arrangements should not lead to unnecessary disruptions; the movement from competition to collaboration in commissioning was positive but, referencing a view expressed by The King’s Fund, it would be important to mitigate against the risk that contracts were automatically handed out to incumbent providers, with the potential to diminish diversity within the marketplace; and the wider

determinants of health and wellbeing involved a range of council services, beyond the adults and communities directorate, and it was suggested that the potential extent of collaboration and integration would need to be expressed.

In response, Mr Mehaffey: acknowledged the importance of the wider determinants of health and wellbeing and said that the ICS would enable NHS bodies and the whole of the council to work together; patient choice was an important principle of the White Paper and commissioners would retain the right to recommission services if patients were not getting a good service or adequate choice from a current provider, but would not be forced to do when this was not required; Herefordshire was considered to be in a good position in terms of 'place' and the organisational and cultural approach to collaboration; it would be interesting to see how the issue of the proposed broader powers for the Secretary of State would develop; and the role of scrutiny in holding system partners to account was valued.

The assistant director all ages commissioning commented that competition had helped to drive innovation and the proposed legislation would allow this to continue, with the opportunity to retain what is good and to transform what is not in a collaborative way; some of the unintended consequences of the existing legislative obligation to competition were outlined.

The vice-chairperson posed a number of questions about: the interaction and governance arrangements for the ICS Board and the ICS Health and Care Partnership, including local authority representation; the potential for joint scrutiny committees involving Herefordshire and Worcestershire local authorities; and whether place-based delivery considered fully the challenges and costs of providing services in rural areas.

In response, Mr Trickett: advised that the White Paper expected the NHS ICS Board to include local authority representatives but he recognised that there was work to do during the course of the year on the arrangements, including around the role and relationship between the Herefordshire and the Worcestershire health and wellbeing boards and the ICS Health and Care Partnership; commented on the ongoing role of scrutiny in terms of the local accountability of health services, noting that this would be at a place level in the main but there may be occasions when a service change across both counties could involve wider dialogue; acknowledged the need for clarity about the definitions and roles of all bodies to minimise the potential for duplication; and reported that, broadly speaking, the budgets for Herefordshire and for Worcestershire were managed separately but opportunities had been taken to move money around where this was possible to meet particular needs, such as the investments in local primary care services in Herefordshire.

The chairperson of the children and young people scrutiny committee welcomed the formalisation of what was already happening to some degree. However, whilst noting that the power to review plans for substantial variation would be retained, expressed concern about the possible removal of the power of referral to the Secretary of State given the potential for differences of opinion about what constituted substantial variation in services, the nature of the consultation or engagement, or the appropriateness of the decisions taken. Mr Trickett said that he was not aware of anything which would take away a scrutiny committee's ability to make that referral if due process had not taken place. Mr Mehaffey added that the point was about the Secretary of State having the power to take intervention without a referral.

The vice-chairperson of the children and young people scrutiny committee asked what was being done proactively to ensure that the new arrangements worked as well as possible for local people and queried the future of Public Health England. Mr Mehaffey explained that: this was a White Paper, with all the normal processes and opportunities to engage during the passage of the paper through Parliament; the concept of the health and care partnership body had emerged following an initial draft of the paper, perhaps to bolster the balance between local accountability and central control; and Public Health England would be replaced by a new national institute for public health.

Committee members were invited to ask questions and make comments, the principal points arising from the debate included:

- A committee member commented that: the merger of Herefordshire Council and the former Herefordshire Primary Care Trust, and attempts to integrate services and back office functions, had been undermined by subsequent NHS reforms; it was positive that local authorities were being consulted but it was questioned to what extent the new arrangements were a foregone conclusion; there were similarities with the former Herefordshire and Worcestershire County Council; the retention of the power of referral to the Secretary of State and other safeguards would be essential to ensure that Herefordshire was treated equitably, especially in the rural areas; and no mention had been made about how the two different funding mechanisms for the NHS and for local authorities were going to cope with working together, and the plans might to succeed if this was not addressed.

  Mr Mehaffey said that it was recognised that there was a balance to be achieved between national expectations and local priorities, and the CCG had worked hard on partnership working and to deliver integration with the council. He commented on the principle of subsidiarity in the system, where improvements would be delivered at a place level and would only be delivered at a system level where there was a compelling reason to do so. Mr Trickett agreed that, whilst the Better Care Fund helped to deal jointly with some issues, a national funding solution would help integrated care to move forward more quickly.

  Dr Tait said that: the opportunities for collaboration outweighed the understandable and real risks that had been described; in terms of rural areas, the NHS had duties in terms of quality and equity; there had been benefits to Herefordshire arising from the single CCG for the two counties; the greater costs of service in Herefordshire were recognised; a proper funding solution for social care was an absolute must to maximise the partnership approach; the key role of scrutiny was supported; the wider determinants of health and wellbeing were important and this approach provided a realistic opportunity to deliver something that added value; and he had been invited to lead the arrangements for the future ICS Health and Care Partnership and the committee's comments would be taken into regard.

- A committee member commented that: the NHS was highly valued but challenges remained around funding; it could be concluded that the existing legislative framework had not worked; clarification was sought on references in the report to 'those in need of bespoke health or social care'; clarification was also sought on 'direct action to address a number of key health and well-being risks, such as by

addressing pre-watershed food advertising issues, improving food labelling standards, mandating calorie-labelling on alcohol and the strengthening the approach to water fluoridation.'; and scrutiny should be allowed to retain its powers.

Mr Mehaffey advised that: the 'direct action' referred to would be undertaken at a national level and noted the linkages to some of the determinants of health and wellbeing; 'bespoke health or social care' was about trying to tailor care around the entire needs of an individual in a more organised way.

The chairperson suggested that the identified 'direct action' at a national level could provide a springboard for system partners to work collaboratively on tackling health inequalities at a local level.

- The vice-chairperson drew attention to the suggestion in the CfGS document that health scrutiny powers might include 'Requiring the agreement between ICSs and local scrutiny functions on modes of communication and engagement – reflecting the fact that in different areas, to meet different needs, different models of health scrutiny might be necessary. This will also allow councillors to plan to focus their attention on those matters of greatest public contention, adopting a more targeted approach to their work. It will also provide for the ICS to provide support and resources for necessary joint scrutiny, and to facilitate working between ICS scrutiny, place-based health scrutiny, local Healthwatch and place-based scrutiny of HWBs and the delivery of public health priorities'.

  The vice-chairperson asked for clarification on the point made in the report (agenda page 14) that there would be 'More opportunities to form joint committees and other joint working arrangements to support the delivery of integrated care'.

  Mr Trickett said that the White Paper intended to create a specific legal mechanism for the ICS to form a joint committee with a provider trust, adding that this was prohibited under current legislation; it was noted that Section 75 agreements (under the NHS Act 2006) enabled arrangements between NHS bodies and local authorities.

  The director for adults and communities considered there was more work to be done on the broader context of partnership working where this was less proscriptive at a placed based level, particularly around the roles of the Health and Wellbeing Board and the ICS Health and Care Partnership and the associated interface, in order to ensure that the system was as effective and integrated as it could be.

- A committee member commented on the potential for the council to explore the integration of some services or areas of responsibility to mirror the new arrangements for health. The tangible benefits of a single clinical record were noted and it was questioned what other benefits a Herefordshire resident might see using health services in the future.

  Mr Mehaffey explained that the establishment of Primary Care Networks had resulted in GP practices working together more collectively to deliver a wider range of services to patients in each geographic area. In many PCN areas, one

practice was leading on the COVID vaccination programme and this had enabled much quicker rollout than would have been the case if individual practices were delivering vaccinations to their own patients.

Mr Trickett said that a key principle of the integrated care agenda was wrapping care around the patient, with health and care professionals working cohesively to meet their needs. Consequently, the number of 'hand offs' between different teams should be reduced. He added that this should make the system more efficient and result in better outcomes.

The director for adults and communities outlined the work on integrated discharge pathways and the reinvestment in community services to move people out of hospital more swiftly and back home with a reablement level of support from an integrated health and social care system, connected to the Talk Community offer. He reported that adult social care services had been aligned to the Primary Care Network areas which would help to provide a better integrated offer at a place level. He also explained that population health needs could be looked at on a locality basis, rather than as a county as a whole, and teams could be asked to respond to particular challenges and priorities. He concurred that the real test was the difference that integration and innovation made to the end user.

- The chairperson acknowledged the value of a seamless, wraparound service but noted the additional difficulties for Herefordshire residents living close to the border with Wales, especially in terms of information sharing between providers in England and Wales.

  A committee member commented on previous, unsuccessful NHS IT projects and said that the benefits of the new arrangements, particularly for people living on geographic or system boundaries, would not be realised without alignment.

  Mr Trickett recognised the need for the arrangements to work for all residents of Herefordshire, including those who were registered with GP practices in Wales. It was noted that the proposals would bring arrangements in England closer to those operated in Wales. He added that the point would be raised at a national level.

  Mr Trickett said that, out of necessity during the pandemic, significant progress had been made on information sharing and IT systems in health and care. He added that the digital development programme for Herefordshire and Worcestershire had attracted £13 million of national funding.

Observations were invited from cabinet members, the main points included:

- The cabinet member – health and adult wellbeing commented that the discussion connected with the County Plan, the Talk Community programme, and the refreshed membership of the Health and Wellbeing Board. The interface between Health and Wellbeing Board and the ICS Health and Care Partnership was questioned further.

  Mr Mehaffey commented that some ICS areas involved numerous local authorities and health and wellbeing boards, and a health and care partnership body could

take a view across the whole of the relevant ICS. With there being two health and wellbeing boards in Herefordshire and Worcestershire, there was a need to consider the business to be transacted through the different bodies. He added that this may include occasional joint meetings of the boards to look at cross-system issues, albeit the majority of the work would still be undertaken by each board individually.

- The cabinet member - children and families noted that there was support for the continuation and enhancement of the collaborative approach and the potential benefits that could be realised through a single clinical record. It was questioned how the patient and public voice would be heard, particularly in terms of children and young people. It was also questioned how public health initiatives, especially for preventative work around the wider determinants of health and wellbeing, would be managed and funded between the system partners going forward.

  Mr Mehaffey said that: it was important to listen to what works and what does not work for people and commented on the positive relationship with the local Healthwatch bodies; tackling the wider determinants of health and wellbeing was critical and this would be supported through the improved engagement between health and care, and through better joined up data on population health and wellbeing needs; and tackling health inequalities jointly was a key area of focus, adding that the COVID vaccination programme having shone a light on health inequalities and the relationship between access to services, take up of services, and outcomes.

  Mr Stead commented on: the commitment of Healthwatch to support the process where it could do so and to encourage partner organisations to undertake engagement themselves; and, although mindful of the need to avoid slowing the pace of change where it was needed, further thought would be needed to get the balance right between engagement and consultation.

- The Leader of the Council: welcomed the discussion; emphasised the importance of local involvement; considered that the needs of the two counties were different and it was essential to maintain local accountability and reporting; reflected on his experiences in attending ICS meetings where he had found it difficult to have a voice as an elected local authority representative given that it predominantly involved health professionals; questioned the concept of an ‘independent’ chair from both health and local authority perspectives, and suggested that consideration could be given to a local authority deputy chair; and said, apart from on the Better Care Fund, there had not been significant conversations about overall finances and opportunities to use resources in different ways.

  Mr Trickett: commented on the good level of attendance and engagement from Herefordshire Council in ICS meetings; said that the themes around the local authority voice and democratic accountability would be fundamental questions to address during the year, especially as the White Paper envisaged the creation of a new statutory body with its own legal responsibilities; considered that there were some similarities between Herefordshire and Worcestershire, adding that there were collections of communities with different needs and which required different packages of services; and acknowledged the need for conversations on the overall financial picture to feature as part of the work on the ICS; and, although

further details were awaited on the process nationally, he anticipated that the independent chair would be a job that would be advertised and people would apply for, and hoped that it would attract interest from people in both counties and from a variety of backgrounds.

The committee discussed draft recommendations and agreed the following resolution.

Resolved:

a. **It be recommended to the emerging Integrated Care System that proposals be developed, for consideration and agreement by the local authorities, in terms of the 'duty to collaborate', both at the place-based level and in terms of joint scrutiny involving the local authorities, to ensure that modes of communication and engagement are defined clearly.**

b. **That scrutiny maintains a distinct function within the duty to collaborate and that acceptable parameters be agreed, including ongoing information sharing.**

c. **That clarification be provided about the power of scrutiny committees to make referrals to the Secretary of State and, if it is potentially at risk, that the system be encouraged to lobby for the retention of this power and for enhanced local accountability generally.**

d. **That the developing Herefordshire and Worcestershire Integrated Care System (ICS) governance arrangements (including the relationships with and degree of autonomy of the Health and Wellbeing Boards, the arrangements for the different ICS boards, and how the voice of public / service users will be heard) and funding mechanisms be presented to the scrutiny committee during 2021/22.**

e. **That the intentions to explore the wider determinants of health and wellbeing and local population health needs, to consider opportunities for the integration and alignment of services, and to work collaboratively on tackling health inequalities at a local level, be supported.**

f. **That consideration be given to the experience for residents who live on geographic and / or system boundaries, especially in terms of seamless data sharing between relevant bodies.**

41 DATE OF NEXT MEETING

Monday 29 March 2021 at 2.30 pm

The meeting ended at 12.05 pm

Chairperson