HEREFORDSHIRE COUNCIL

MINUTES of the meeting of Health & Social Care Overview and Scrutiny Committee held at Council Chamber, The Shire Hall, St. Peter's Square, Hereford, HR1 2HX on Monday 19 September 2016 at 9.00 am

Present: **Councillor PA Andrews (Chairman)**
Councillor J Stone (Vice Chairman)

Councillors: WLS Bowen, ACR Chappell, CA Gandy, MD Lloyd-Hayes, MT McEvilly, GJ Powell, A Seldon, NE Shaw and D Summers

In attendance: **Councillor PM Morgan, cabinet member health and wellbeing**

Officers: **Jo Davidson, Martin Samuels, Alison Talbot-Smith, Prof Rod Thomson and Claire Ward**

91. APOLOGIES FOR ABSENCE

Apologies were received from Councillors CR Butler and PE Crockett.

92. NAMED SUBSTITUTES (IF ANY)

Councillor WLS Bowen substituted for Councillor PE Crockett.

93. DECLARATIONS OF INTEREST

None.

94. MINUTES

RESOLVED
That the minutes of the meeting of 6 July 2016 be agreed as a correct record of the meeting and signed by the chairman.

Referring to the matter of speech and language therapy (SALT) provision and the committee's recommendation to expedite a review of the same (Item 87, 6 July 2016), the director for children's wellbeing confirmed that this area was the responsibility of the clinical commissioning group (CCG). The CCG had been made aware of the recommendation and were to undertake a review of SALT and occupational therapy services for children and young people. Advice regarding a timeframe for this review was awaited.
Members commented that this review was needed without delay.

95. SUGGESTIONS FROM MEMBERS OF THE PUBLIC ON ISSUES FOR FUTURE SCRUTINY

None.

96. QUESTIONS FROM THE PUBLIC

None.

97. UPDATE ON HEREFORDSHIRE AND WORCESTERSHIRE SUSTAINABILITY AND TRANSFORMATION PLAN AND ONE HEREFORDSHIRE

The programme director for One Herefordshire presented a briefing on One Herefordshire and the NHS sustainability and transformation plan (STP) to provide context and progress to date. The main points of which were:

- Development of the STP commenced in December 2015, with a local footprint of Herefordshire and Worcestershire. Underpinning the STP was the imperative to maximise outcomes through the triple aim of improved health and wellbeing, care and quality, and finance and efficiency.
- STP leadership and governance arrangements were established in March 2016, with proposals being developed in readiness for submission of the final plan to NHS England on 21 October 2016.
- There were differences across the footprint, including mortality and expected outcomes for children, and public health priorities were key in supporting service redesign.
- There was an anticipated shortfall of £84m against a forecast budget of £1.4bn available to NHS commissioners for 2020-21, so providers would have to make efficiency savings year on year. This would require wide engagement and evidence of best practice.
- Emerging priorities were defined as cancer, stroke, maternity, mental health and wellbeing, frailty and dementia, and acute services.
- The plan would address changing ways of working, focusing on the workforce, digital technology, estates, personal care planning, public and patient involvement, leadership and decision making.
- In terms of engagement, subsequent detailed plans would be co-produced with local communities to look at the specifics, and would be subject to scrutiny review
- One Herefordshire provided a specific medium within the county for partners to work together to focus on prevention and ensuring resilient communities. This sought to recognise interdependence across wider public services to achieve common aims, provide a cohesive service and support delivery of the STP.
- New models of delivery and care were being explored, with closer organisational alliances, whilst recognising the complexities of governance and cross working. The alliance approach was based on a memorandum of understanding to support improved outcomes.

The director for adults and wellbeing made the point that it was important to address any tensions in the system and members' views were sought in respect of three particular areas:

- Firstly, the triple aim model was based on sustainability, which encompassed areas that drove the broader wellbeing of the population, such as economic development, education and housing, which in turn enabled the delivery of quality health and social care services. There were finite time and financial resources to achieve this which caused tension and so system change was the only option.
- There was a second tension about connecting appropriately with the public on significant levels of change. Timing and level of detail of this was key. It was important to consider whether to provide a high level of detail on a finished product or whether to involve the public in designing the services in order to develop a more owned and realistic solution. The latter would take longer to achieve and there is a deadline to submit the plan in October, with contracts then signed by 23 December, giving little time for meaningful consultation at this stage of the process.

- A third tension was around the dynamics of the relationship between commissioner and provider and the extent to which there is engagement and cooperation to work together to secure results.
- There were also some tensions between the approaches of One Herefordshire and the STP, and so as a whole, there is no simple solution.

The chairman commented on anxieties raised by the overall picture and noted that the STP had so far been under the public radar, and that this approach was now seen by the NHS nationally as not ideal.

Members raised a number of comments and questions in response to the presentation.

A member commented that more could be made of digital technology within community services to maintain provision. She added that service and role design had an impact on the recruitment and retention of staff, making it difficult to provide services locally. These services may therefore have to be transferred elsewhere, which in turn affects the public's ability to access services. She observed that this would have an adverse impact on engagement with plans for members of the public who were not near to the service provision.

In response, the programme director confirmed that the STP was developed in line with the NHS constitution and in recognition of the public sector equality duty and therefore would not remove peoples' rights in accessing services. There may be some unpopular and difficult decisions but it was important to achieve good outcomes and quality services that are a within a reasonable travel distance.

Thanks were expressed by a member for the work of officers on the positive moves of this plan. He commented on the importance of ensuring that the community was involved as this would encourage people to share information. He added that members played an important role here as there had been past criticisms of jointly managed services and people needed to know that the plan would be successful.

Referring to the earlier observation regarding digital technology in remote services, and drawing upon comparative areas in Wales, another member added that effort was required to attract staff to provide services within localities were they were needed, for example, district nurses in GP surgeries. It was vital to maintain good services within the county to avoid travelling out of the county.

The programme director responded that the use of technology in other remote areas could be investigated to learn more about how it could be better used. The value placed upon local services was recognised and it was acknowledged that "wrap around" GP services could be explored.

The director for adults and wellbeing added that recruitment issues also affected social care provision, observing that the leisure and housing opportunities available within the county, as well as some roles, may not be attractive to mid-career professionals. The impact of this on the feasibility of providing services, including viable on-call rotas and the opportunity for individuals to practise skills for professional accreditation was noted. This was being addressed by looking at redesigning career pathways. The programme director commented further that the STP was often viewed as a threat, but it presented opportunities, for example by sharing on-call rotas and clinical networks across a wider area that sought to provide better services and allow them to be maintained locally. There was an imperative to maximise opportunities for such networks.

A member observed that providers had quality and finance issues and that over recent years the council had changed its approach in order to avoid running deficits. Change was inevitable and significant and the focus needed to be on what was best for the

residents of Herefordshire. He further commented that, being NHS-led and with its governance managed by the CCG, it was difficult to envisage meaningful council involvement.

The director for adults and wellbeing explained that the NHS had sought to engage councils as active partners in the STP, and there was welcome involvement at the planning meetings. There was also active involvement of public health and Healthwatch within the footprint, but although this would influence and inform debate, it had to be recognised that the STP remained an NHS process and budgets related to the NHS rather than the whole system of health and care for adults and children.

The director added that a key aim was to provide counterweight to centralisation of services to ensure locally sustainable services. It was recognised that whereas the STP was mandatory across England, One Herefordshire was a local initiative intended to ensure the best for the county.

In answer to a further question regarding full integration of health and social care by 2020 and how this would be funded in light of the requirement for financial savings, the director explained that this would need additional funding. One-off costs would be met through a national fund of £1.8bn with £50m allocated to Herefordshire and Worcestershire, and the integration process was designed to achieve the level of savings. Savings would be more easily achieved through wider working and maximising the effectiveness of individual contacts by professionals, but presented a significant challenge.

The member responded that the focus should be on strengthening the plans for primary and community services, which would reduce demands on hospital admissions and speed up discharge, and so make services more efficient.

The programme director concurred with this, adding that there needed to be locally oriented services whilst being able to access wider systems. This was particularly relevant for patients with long term conditions whose needs could change daily, with a requirement to move between different types of care.

The member noted the comments made in the House of Commons recently regarding the draft STP not being made public. He expressed concern and disappointment that final plan was to be submitted in October and nothing had been shared with the public and so there was no expectation from public that change was coming.

The director for adults and wellbeing reminded members of the tensions described earlier. National guidance had been clear that the plan was not in the public domain and that there had been new guidance issued which included the expectation of open public engagement. This created tensions over pressing timescales and the need to engage with the public which took time.

A member made the observation that other areas seemed more advanced with the development of their STPs, and that the NHS had not involved councils, which had been challenged by the local government association. He added that communication and leadership was not working effectively within the NHS. Discussion took place around clinicians' reliance on medication rather than prevention and the need to be more honest with people about causative factors of illnesses, such as the link between obesity and high blood pressure. Whilst there may be complexities behind issues such as obesity, tackling such issues and bringing about a change in culture would be a way of supporting success of the STP.

Referring to the recent House of Commons debate on the STP, a member commented that the limited time available would lead to failure of the consultation. She believed that

if this were the case, then it would be regrettable as worthwhile contributions would not be taken into account. She added that there needed to be robust feedback on services and auditing of outcomes to ensure the alliance was working effectively, noting that services were also accessed by people across the border in Wales, where there were differences in NHS structure and practice. Given the rurality and isolation within the county, it was important to recognise the role of cottage hospitals, and also the role of the public in identifying need to ensure community resilience.

The director for adults and wellbeing acknowledged the difficulties associated with consultation on the STP. He reminded members that they had a central role in calling for the scrutiny of the preparation and delivery of the STP.

The chairman proposed an extra-ordinary meeting, to be held in October 2016, to review the draft documentation prior to the plan being submitted.

A member commented the government had acted with arrogance in not being open about the STP. She observed that there had been no reference to the STP in Wye Valley NHS Trust's recent annual report or annual general meeting, which she felt was a missed opportunity. She added that primary and secondary health services had been criticised recently and were in crisis, and so there were benefits in working together, including the third sector, to avoid a silo approach and to increase accountability. Supporting the recommendations, she felt that the STP should have commenced sooner and that there should have stronger leadership from the Department for Communities and Local Government (DCLG).

In identifying initiatives that would support the success of the STP in addressing rural isolation, a member cited the lengthsman scheme, the principles of which could be transferred to a social support role within parishes. He added that the plan needed to be bolder in considering fresh approaches, such as the roles of professionals working locally being extended to support more people within communities, for example, school nurse clinics extending to address parental health. In response the chairman commented that the plan was to support local resilience.

The director for adults and wellbeing added that there were examples currently in consultation, such as the help to live at home scheme. For such schemes the issue of carers' travelling times was important and this was being addressed with providers to minimise journeys between visits. In Herefordshire, the normal minimum visiting time of 45 minutes was longer than in some other areas, which would enable the development of personal assistant roles and better connections to the community.

Discussion took place regarding personal budgets and how people might make better use of them. Communities could be more involved in supporting people, and there were examples of good neighbour schemes within wards which worked well to provide self-help as and when required. The level of uptake of direct payments had increased rapidly over the past year, with around a third of people now using the approach. Nationally there were good outcomes seen through this approach. It was noted that there was mapping software available that could help services to plan travelling and visits more efficiently.

In response to a member's question regarding progress with schools, the programme director acknowledged that this was where there could be a great impact on outcomes, and explained that alliances were being considered to look at where there was added value. The director of public health added that there was close working with the CCG and WVT to shape services, noting that it was important to ensure that schools' workloads were not affected. There were some good examples nationally regarding the linking up of isolated individuals which brought about overall benefits in the community.

Dental health and obesity were target areas, and so the role of school nurses was key here in terms of encouraging lifestyle changes for whole families.

The cabinet member for adults and wellbeing observed that although the STP had a national mandate, it was important to recognise that there was definite scope for services to be improved locally, and caution should be exercised over opposing the STP. However, it was also important to protect good service provision and also to involve the public. The same applied to One Herefordshire, although more of a challenge to achieve. She added that it was necessary to include the private sector in the plan and be better engaged with those providers as they were significant contributors to wellbeing.

Referring to the earlier comment regarding good neighbour schemes, a member noted that despite peoples' willingness to help in their community, schemes had difficulty setting up and recruiting due to regulation around checking volunteers' suitability. Commenting also on the prevention agenda and the recent pilot project on diabetes prevention, she noted that this required participants to commit to a 9 month programme and rigid appointment times, which was not possible for some people, and they were then being rejected from the programme. This may be a barrier to the success of the pilot and to GPs referring people to the scheme. It was noted that there were other ways of working on diabetes prevention such as with practice nurses but that it was important to provide feedback on the pilot.

The vice-chair noted the strength of the voluntary sector, particularly in Leominster, where there was also a strong community hospital. He hoped that as this was working well, that it would not be affected by the STP. It was important to take into account the distance travelled to services as local hospitals performed valuable services and there was concern that national issues would not take this into account, to the detriment of these services.

The programme director explained that the intention would be to try and provide care and services as close to home as possible and keep people living independently, and that there were no plans at this point to close hospitals as locality bases would be needed.

A member reminded the committee that the STP was intended to stop the NHS over spending and it was important to understand how the available money was being used. Concern was expressed that if the plans were driven by central government, rural operational issues would not be recognised. It was therefore critical to make it clear that delivery costs are higher in rural areas compared with urban areas.

In considering the report's recommendations, it was concluded that members must be the voice of public, given the limited opportunity for consultation. The purpose of the extra-ordinary meeting in October would therefore be to review and make suggestions and alterations to the STP before submission on 21 October. It was imperative for the programme team and leadership to attend this meeting, to present the plan and to hear comments from members in order to influence changes to the plan before submission.

RESOLVED

THAT:

(a) the committee note the content of the report;

(b) the committee meet in October to review the STP in order to make recommendations regarding the approach, process and direction of travel prior to its submission on 21 October 2016; and

(c) that the programme director for One Herefordshire provide more information to a future committee regarding One Herefordshire's role in supporting local delivery of the STP

The meeting ended at 11.30 am **CHAIRMAN**