Herefordshire Council

Minutes of the meeting of Adults and wellbeing scrutiny committee held at The Council Chamber - The Shire Hall, St. Peter's Square, Hereford, HR1 2HX on Thursday 25 January 2018 at 10.00 am

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

Councillors: CR Butler, MJK Cooper, PE Crockett, CA Gandy and D Summers

In attendance: **Councillors WLS Bowen, E Chowns and MD Lloyd-Hayes**

Officers: **Herefordshire Council: M Samuels and S Vickers**
Healthwatch Herefordshire: C Price and I Stead
NHS Herefordshire Clinical Commissioning Group: H Braund, S Hairsnape and I Tait
Wye Valley NHS Trust: J Ives
2gether NHS Foundation Trust: F Martin and J Melton

26. APOLOGIES FOR ABSENCE

Apologies were received from Cllr RL Mayo.

27. NAMED SUBSTITUTES (IF ANY)

Cllr CR Butler substituted for Cllr RL Mayo.

28. DECLARATIONS OF INTEREST

There were no declarations of interest.

29. MINUTES

RESOLVED:

That the minutes of the meeting held on 16 November 2017 be confirmed as a correct record and signed by the chairman.

30. QUESTIONS FROM MEMBERS OF THE PUBLIC

There were no questions from members of the public.

31. QUESTIONS FROM COUNCILLORS (Pages 11 - 12)

One question was received and is provided, with the answer, in appendix 1 of the minutes.

32. HILLSIDE CENTRE

A presentation was given by the managing director, Wye Valley NHS Trust (WVT) and the director of operations, NHS Herefordshire Clinical Commissioning Group (the CCG). It was explained that some of the information provided had already been shared and it was intended to give more detail and update the committee since the meeting in November. Members were reminded that officers had also attended the meeting in August 2017 and talked through the process, and had taken members' advice on the engagement process from that meeting.

In the presentation, the following key points were made:

- There was a strong body of evidence to support not keeping people in a bedded environment, which included the degenerative impact, and to provide reablement
- In terms of metrics, WVT performance compared well with other areas and as provision of care shifted it was expected to see improvement
- The early supported discharge (ESD) team had transitioned care from other sites as well as the Hillside annexe and was providing high quality community-based reablement including dedicated stroke reablement in order to provide better outcomes. It was important to recognise this if performance were to be improved in addressing length of hospital stays and increasing the number of people who had access to care at home
- 6 additional staff had been recruited with a further 4 sought in the new financial year and there was confidence over capacity to meet the change in service. Double running of provision was in operation during February whilst stepping down the number of people at Hillside for the transition to be effective from 24 February
- There was close working between the health and social care teams to support the transition

The assistant director, operations and support, explained that around £1.2m had been spent on reablement and rapid response services, leading to the council forming the home first service. Investment would increase to £1.5m next year. Where previously around 300 people would have been in receipt of this service, it was expected to increase to around 1000. It was anticipated that this number could grow further as the new service became established.

A member asked what was included in reablement and rehabilitation and whether this included soft exercise. The managing director, WVT, confirmed that the increase in reablement staff included additional physiotherapy input.

Responding to a member's concern over contingency plans in the event that the additional workforce could not be recruited, it was further clarified that there were staff in place. The assistant director added that 6 of the 11 posts in the adults and wellbeing team were being filled with 4 being recruited, and this would be an ongoing recruitment drive.
The member asked whether any staff from Hillside had joined the home first team, or if they had been redeployed elsewhere.
The WVT managing director explained that staff had a choice of vacant posts in the trust and that they were avoiding redundancies. It was not certain whether there had been any resignations as a result of the changes.

A member in attendance sought clarification on the skill-mix of the whole time equivalent number of staff mentioned in the presentation. It was clarified that these were clinical staff and not clerical staff and were additional staff as part of the wider service.
The member commented that experience had shown the difficulties in providing a stable workforce, especially in remote areas. She questioned why these changes had not been announced at the same time as the closure of the walk-in centre. She further

commented that she did not accept the council's response to the situation as she believed it had a duty of care to the population.

The CCG director of operations explained that they were in the flow of the engagement process so were not in position to say that it was the right thing to do and that the two issues were not running in parallel.

A member asked where the additional staff would be based, pointing out the issue of travelling times involved in getting from place to place in rural areas. The managing director clarified that staff would be based at different sites, such as Hereford and Leominster. The member observed, in response, that from Leominster to some of the remote parts of north Herefordshire, travelling could be a challenge in terms of geography and timing, and so it would take up a lot of time travelling from person to person in some areas. Officers acknowledged that it was better to have staff in localities and this was the plan. The director of operations added that they had visited parish councils and talked about transport and getting this network to be effective. She added that GPs were encouraged to work together to look at practical solutions, but the system needed to get better connected.

The member noted that the health centre in Leintwardine, which was currently under used, would be an ideal base rather than Leominster.
The director of operations commented that as the locality projects, such as Kington and Leominster develop, surrounding areas such as Leintwardine would be included.

The chairman commented that there were other market towns to be considered in the developments and asked whether use could be made of the community hospitals. The managing director confirmed that there were already staff out there, so the work was augmenting those teams in order to be distributed as far as possible.

The assistant director, operations and support described how adult social care was distributed and that with regard to home first, this could start to work more effectively on a locality basis to provide a standard level of support for people who need it. He added that staff could work across areas and that with the redesign of the home first service, a new scheduling service supported through mobile devices was being commissioned and this would enable staff to be better located. It was expected this would be in place by the end of February and would involve a care co-ordinator with therapists offering goal oriented support. The design was intended to bring benefits that reduced the distances covered to reach people.

The chairman asked how the disabled facilities grant (DFG) figured in the changes. The assistant director explained that the expenditure was increasing. The Director for adults and wellbeing added that the element of the better care fund allocated to the DFG had tripled and the aim was to establish greater flexibility and a wider range of facilities to provide as this was an area that was proven to make a significant difference and so it was important to ensure that funding was being used and coordinated.

A member commented that parish councils had access to funding to establish community groups such as for soft exercise but they could be difficult to set up. He asked if it would be possible for a package of support for community groups to access to support people coming out of hospital.

The director for adults and wellbeing confirmed that there was a grant scheme which had limited funding. However, the incoming director of public health would be looking at a series of prevention funding to have a more coherent approach. He added that the public health grant was reduced but this work was identified as a priority for the director of public health to ensure organisations could be linked up to work together.

The assistant director described forthcoming developments around operational practice which included the community broker function and locality based support from February to connect earlier for people who did not currently access support. The wellbeing information and signposting service (WISH) was relaunched last week to support access to schemes. He added that where there were gaps were identified by the community brokers this would inform further commissioning of support.

The vice-chairman welcomed the earlier comment raised about the remoteness of areas such as around Leintwardine. He welcome the investment in the home care service. He suggested that parish council meetings were a good way to get messages out about local issues and suggested that those meetings taking place in April and May would be a good opportunity to engage as it was more likely for members of the public to be in attendance.

Discussion took place around how these service developments were all part of a wider piece of work such as discharging people to be assessed at home or care home facility rather than assess in an acute setting, extending the use of mobile technology for community health staff. The standard of mobile and broadband coverage was noted. Members commented on involving communities more as part of the solution and making use of the formal and informal support networks that existed in villages, including good neighbour schemes.

A member asked about home care and what contingencies were in place for people who were at home alone. The assistant director explained that the adult social care pathways were redesigned to discharge to assess using a strengths-based model to assess what people could do for themselves to identify the gaps and assess eligible need that could not be provided any other way. The community brokers would feed into the commissioning strategy to bridge some of the gaps.

The chair of the CCG offered some observations from a frontline clinical perspective, which demonstrated that older people did not want care in hospital and that families wanted to know there was an appropriate pattern of care. Care would be very specific and individualised as some people were very independent in older years, and others more dependent, so it was necessary to assure people that the breadth of need was being met. The system as it stood, had a disabling effect. For example, it was tradition to keep people in bed for 2 weeks following a heart attack, whereas in the USA people were up again very quickly. It was important therefore to avoid the long hospital stays associated with a culture of safety.
The facility at Hillside tried to put professionals together to rehabilitate people but this was artificial because it was not their home with their people around them. Through evidence it was clear that people needed to be cared for at home and some of the work could be done on the acute ward so people could go home sooner. The plan was to make this more consistent for others with frailty and degenerative conditions. In allowing the shift in model it would be something that could be continued for future generations. This was achievable with the right support but it was necessary to be realistic.

A member commented that people were sceptical about changes. She believed it could work but it would be necessary to review it to see it was beneficial. She realised that people worried about going into hospital and in the majority of cases, people wanted to be in their own home with their own people around them to care for them and be with them and whilst this was not possible in all cases, but it would be better if available to more people as long as it was better care than currently in place. The member concluded that it would be good to see the benefits and it was supported with caution, although the implication needed to be better understood.

A member asked about access to exercise facilities such as Halo Leisure during rehabilitation. The CCG chair explained that all patients in the system were offered

cardiac rehabilitation through the trust as this was the most effective intervention, but people then had to sustain the changes. Halo had a charging policy so it was not accessible for all people even with reduced or supported costs.
The member commented that it was important to invest in preventive measures. The CCG chair responded that the medical model was not the only good approach and that the message was that exercise was the best medicine, as it promoted physical stability, helped to prevent falls, and promoted good mental and physical health. The opportunity to socialise was also important.

Members' final comments included that the main concern was the ability to provide individual care plans within resources, and that the timing of these changes were not ideal as people needed to get over the winter.

The chairman reminded members that there was pressure on services all year, although it was different at this time of year with winter pressures and whatever the timing, effecting a change to service provision would present difficulties.

RESOLVED
That:

a) **assurance be confirmed regarding the measures in place to effect changes as smoothly as possible; and**
b) **that an update be provided in 6 months' time**

33. HEALTHWATCH UPDATE

The director for adults and wellbeing introduced the item. In setting some context, he explained that Healthwatch was commissioned by the council and, through the Health and Social Care Act 2012, was the third iteration of arrangements since Community Health Councils were abolished in 2003 that had been established formally to provide a function for public involvement in health.
There had been long standing arrangements in place for such a function through the establishment of community health councils in 1974. Councils were required to commission Healthwatch services from a third sector body, through non-ring fenced funding. The commissioning relationship was complex as it was established on behalf of the system but also the council was subject to review by Healthwatch, and so it was important to maintain the right balance between being an effective commissioner and not disabling Healthwatch's role to hold the council to account. The new arrangements represented a significant step forward in fulfilling this role.

The chair of Healthwatch provided some background to the current arrangement, and explained that the previous iteration of Healthwatch was formed as a subcommittee through Herefordshire Voluntary Organisations Support Service (HVOSS) but was now recommissioned as a standalone organisation. It was an established company, with a new board of directors and a developing team led by a new chief officer. Further appointments to engagement and communication roles were underway. There was still work to do in continuing to improve the performance of the organisation from these good foundations and in continuing to monitor health and care provision. Accountability was established through the formal contract with the council and in the relationship with the public as users of health and social care, in taking their views and helping them to understand what is happening within local services. It was a challenge to maximise engagement but Healthwatch continued to make progress, supported by a valued volunteer network and an established stakeholder group. The Healthwatch chair acknowledged the significant role of volunteers including two who had been co-opted to the board. The Healthwatch chair also acknowledged the support that had been provided by Healthwatch Worcestershire to help establish Healthwatch Herefordshire so that it was able to become a standalone organisation.

The chief officer of Healthwatch gave an account of the work of Healthwatch over the past year, which commenced with asking the public what they thought Healthwatch should focus on. This had identified: GP access; public health and prevention; palliative care; complex conditions; adults social care pathway; and accident and emergency services.
The resulting plan was to focus on two areas at a time, making use of groups and gathering feedback and information, which had led to further emerging issues to be addressed at the same time as the key priorities.
The key point this year would be to evaluate what contact was the most effective and to develop relationships with key organisations to ensure ongoing dialogue to inform the work. An example included working with the CCG about public concerns over Hillside. Positive and more effective relationships were developing in the work to represent patients and the public.

The chair asked about the issues that the public raised the most.
The most frequently cited issue was ear syringing, which was no longer provided as a free service by GPs and which was reported as difficult to access because of price and location of service providers for those who required it. Healthwatch had responded by talking to the CCG and responding with public information about the changes. It was noted that for some people a lack of treatment could have significant impact or impairment especially when combined with other health issues. Conversely, there were people for whom syringing could have serious negative health impact or where it was of marginal benefit. It was also noted that there were elements of self-care that were appropriate for some people, and that the CCG was looking at placed-based provision for those who required essential treatment and could not easily get to Hereford. The CCG offered to provide a briefing note for members on this topic.

The chief officer described the other most frequently raised topics:

For mental health, there had been limited ways in to speak to people so a forum was set up which had identified issues including joining up services for substance misuse and emotional support. This had led to work between Addaction, 2gether NHS Foundation Trust and the CCG. The mental health forum was working well and Healthwatch was supporting the group to be self-directed, with Healthwatch raising issues on its behalf. It was noted that although the initial work with the public did not identify mental health, it came up regularly and was an important issue for Herefordshire. It was therefore important to ensure that any such emerging topics could be included in Healthwatch's work.
The director of engagement and integration, 2gether NHS Foundation Trust, welcomed the feedback that Healthwatch had provided and acknowledged the value that Healthwatch could provide to help address some of the issues. The trust now had link workers in place to connect and build on what Healthwatch had helped to raise.

The chairman welcomed this work.

The Healthwatch chief officer turned to the topic of access to dental services. A focus on children's dental health was to start in March. Feedback had suggested that in some areas such as market towns, not everyone was able to register with an NHS dentist. This had been raised with NHS England to check that there was sufficient commissioning activity, but more exploration of this issue was needed to be clearer on the situation.
The chairman commented on the significant public health concern regarding children's dental health.
The chief officer explained that Healthwatch was asking how people felt about water fluoridation and to promote awareness that children's dental healthcare was free.
The CCG chair declared an interest in the matter as his wife was a dental practitioner in the county and commented that the health and wellbeing board had identified children's

dental health as a priority focus, adding that poor dental health was a marker for health issues in later life.

A member commented that people did not realise that water supplies in the county were not fluoridated and this was not something that people tended to check when looking for a place to live. She added that some people did not want compulsory medication via their water supply, and asked if there had been any publicity on this so that parents could seek to replace it. The member also questioned whether there was evidence to support that, as role models, the public's approach to adult dental care was poor.
The chief officer responded that outcomes from the work were awaited, but some responses suggested that people did not look after their children's teeth and so Healthwatch was looking at numbers who although were registered themselves, had not registered their children, and was working with public health to increase the evidence base.

The director for adults and wellbeing explained that the council had lead responsibility for this matter, and the data for children's dental health stood out in comparison with adults and which indicated surprisingly poor dental health in the county. The public health team had been tasked to look at water fluoridation and although this was not straightforward to address, it was coming up the agenda very quickly. Public health was looking at causes of poor dental health and what the best solution might be, clinically and in terms of practicalities, which would then be brought through the democratic process to ensure the solutions were acceptable to the public. He added to the CCG chair's earlier advice by confirming that this was a priority of the health and wellbeing board to address as a strong indicator of other health issues and also in later life.

A member suggested that there was not always a correlation between fluoridation and dental health because of people moving into the county who had grown up elsewhere, and that consideration should be given to challenging peoples' ethical viewpoints and whether they researched the presence of fluoride in water supplies before they moved somewhere.

On another theme, the member also asked about the diagnosis of autism and whether this related to children or adults. The chief officer confirmed that this referred mostly to adults. The member confirmed that the children and young people's scrutiny committee would be looking at the autism strategy in April.

The chief officer reported on work that had been completed regarding GP access, on which recommendations had been presented to the CCG for response. It was noted that many opinions had been gathered regarding access to primary care which included suggestions to standardise services across all general practices, and to be able to book follow-up appointments in advance. Other feedback referred to the out of hours service, the approach to triage for appointments, access to pharmacies and requests for assistance for people with additional needs when visiting surgeries. A lot of positive feedback had been gathered which highlighted good practices.

In summarising Healthwatch's other projects, the chief officer summarised the following areas of work:
Regarding public health, the chief officer confirmed that a Healthwatch report on palliative care would contribute to regional work around end of life care.
Work on adult social care commenced this week, by identifying service users to hear about strengths based assessment, and conducting a staff survey, which would be reported back to the committee once the outcomes became available in April.
It had been decided to temporarily suspend the accident and emergency project given the current pressures but this will resume later in the year.
For complex multiple conditions there was a series of focus groups to gather views and to find out how organisations worked in an integrated way.

The chair commented on the proactive and dynamic approach Healthwatch had taken to the work and on the importance of hearing from service users.

The vice-chairman welcomed the report and noted the monthly e-bulletins, which he felt were very to the point and clear, as were articles in the Hereford Times such as on dental health. He noted that the work around the priorities had demonstrated that Healthwatch had been very active.

A member particularly expressed support for the work on mental health.

A member remarked on the high level of representation of Healthwatch at different meetings and fora. It was noted that this did not capture all Healthwatch activity and that this would be reviewed to ensure ongoing effectiveness.

RESOLVED
That:

(a) performance of Healthwatch Herefordshire to date be commended;
(b) a report be presented on outcomes from the Healthwatch review of the adult social care pathway and strengths based assessment at a future meeting; and
(c) a Healthwatch performance update be included in the committee work programme for 2018-19.

34. COMMITTEE WORK PROGRAMME 2018

Members were reminded of the workshop that was scheduled for 7 March which would cover public health, how it operates and what the strategies achieve. It was noted that the new director of public health would be in post by then.

A councillor had expressed concern regarding contract management for home care and it was agreed that this be included in the work programme. It was noted that there was a new framework for home care agencies to go through a single contract and quality management process. It was intended that the framework would be an interim step pending development of a new market strategy and which would need to be revisited for new contracts to ensure stability in the market.

With regard to scrutiny of learning disability services, it was noted that the learning disability strategy was under development and that this would embrace all age groups. Members agreed that this might be an opportunity for the committee to work in tandem with the children and young people scrutiny committee to look at the strategy in entirety and officers would make appropriate arrangements for this.

A member pointed out some clashing of timings with CCG meetings and it was agreed to look at this.

RESOLVED
That the updated work programme be agreed subject to the amendments noted.

The meeting ended at 12.14 pm **Chairman**

Questions from councillors to Adults and Wellbeing Scrutiny Committee

25 January 2018

Question 1

Councillor MD Lloyd-Hayes, Aylestone Hill Ward

There has been a great deal of public consternation regarding the proposed closure of the Hillside Centre. There appear to be no emails from the parish liaison officer, the usual conduit for consultation with parishes, nor can I find any reference to it until latterly from the CCG or Wye Valley Trust. How were parish councils or members of the public able to engage if no public notice was issued?

Answer

There was no public notice issued by the council because the Hillside Centre is run by Wye Valley NHS Trust and therefore not a council facility, nor was it a council decision to close the facility.
The council owns the building, and is purely the landlord in this instance. In fulfilling its function to review and scrutinise the planning, provision and operation of health services affecting Herefordshire, the matter has been included on the agenda at this meeting in response to concerns raised, including those made at the last meeting of this committee, about the depth and scope of engagement with the public on this matter.
Material concerns were offset by the broader reforms being proposed about rehabilitation and discharge, which, at the meeting on 16 November 2017, the committee was persuaded, albeit with some caution, provided more appropriate ways to support people to leave hospital.

Supplementary question from Cllr MD Lloyd-Hayes

I am concerned about the consultation process because of correspondence received, and that parish councils were not included, and I feel that the council has a duty to be engaged in the consultation. I request that the proposals be reviewed as they were not shared with the public and patients.

Answer

Herefordshire Council is the landlord.

Additional response to supplementary question from the accountable officer, Herefordshire Clinical Commissioning Group

Advice was followed and contact was made with all parish councils, and they were invited to participate within the engagement process.