Minutes of the meeting of Health, Care and Wellbeing Scrutiny Committee held in Conference Room 1 - Herefordshire Council, Plough Lane Offices, Hereford, HR4 0LE on Monday 27 July 2026 at 2.00 pm

Board members present in person, voting:

Councillor Polly Andrews (substitute member)
Councillor Pauline Crockett (Chairperson)
Councillor Dave Davies
Councillor Richard Thomas
Councillor Rebecca Tully (Vice-Chairperson)

Board members in attendance remotely, non-voting:

Note: Board members in attendance remotely, e.g. through video conference facilities, may not vote on any decisions taken.

Others present in person:

Zoe Clifford	Director of Public Health	Herefordshire Council
Councillor Carole Gandy	Cabinet Member Adults, Health and Wellbeing	
Hilary Hall	Corporate Director Community Wellbeing	Corporate Services
Henry Merricks-Murgatroyd	Democratic Services Officer	
Matthew Millward	Head of PMO and Programme Manager	Herefordshire and Worcestershire Health and Care NHS Trust
Badri Padmanabhan	Consultant in Public Health	Herefordshire Council
Scott Parker	Director of Operations and Transformation	Herefordshire and Worcestershire Health and Care NHS Trust
Danial Webb	Statutory Scrutiny Officer	
Charlotte Worthy	Intelligence Unit Team Leader	

Others in attendance remotely:

21. APOLOGIES FOR ABSENCE

Apologies for absence were received from Cllr Kevin Tillett, and Cllr Mark Dykes.

22. NAMED SUBSTITUTES

Cllr Polly Andrews was present as the named substitute for Cllr Kevin Tillett.

23. DECLARATIONS OF INTEREST

No declarations of interest were made.

24. MINUTES

The minutes of the meeting held on 27 April 2026 were confirmed as a correct record.

Resolved: That the minutes of the meeting held on 27 April 2026 be confirmed as a correct record.

25. QUESTIONS FROM MEMBERS OF THE PUBLIC

No questions were received from members of the public.

26. QUESTIONS FROM MEMBERS OF THE COUNCIL

No questions were received from councillors.

27. ADULT MENTAL HEALTH REHABILITATION REDESIGN - UPDATE

The committee considered a report on the Adult Mental Health Rehabilitation Redesign – Update item.

The principal points of the subsequent discussion are summarised below:

1. The Herefordshire and Worcestershire Health and Care NHS Trust provided an update on its adult mental health rehabilitation service redesign programme. It was noted that the programme had been developed over a two-year period and sought to ensure that people received the right care, in the right place and at the right time.

2. The committee heard that the trust currently operated three inpatient mental health rehabilitation units across Herefordshire and Worcestershire, providing 33 beds in total. Rehabilitation services are intended to support people to develop the skills required to live as independently as possible, with level one rehabilitation focused on daily living and functional skills and level two rehabilitation providing more intensive clinical stabilisation.

3. It was reported that the preferred option is to establish a community rehabilitation team for level one rehabilitation, reduce the number of rehabilitation beds from 33 to 18, and procure level two rehabilitation beds from external providers. The trust considered that this would enable it to support a greater number of people in their own homes and communities, with the proposed community service expected to support up to 135 people.

4. The committee was advised that the option appraisal had involved clinical modelling, expert panels and engagement with staff, local authority and integrated care system colleagues, the voluntary and community sector, public health, and people with lived experience. It was noted that the process had been paused during 2025 to consider new potential providers of bedded facilities, although this had not changed the preferred option.

5. In response to questions about the planned closure of Oak House, the trust clarified that Oak House is a rehabilitation unit rather than a secure unit. It was confirmed that the proposals would not affect the secure mental health bed provision at Stonebow. The trust stated that the resources currently used for Oak House would instead support a community rehabilitation offer, although bedded rehabilitation capacity would remain available in Bromsgrove where required.

6. The committee noted the trust's view that public-health modelling indicated that the proposed model should reduce the need for out-of-area rehabilitation placements. However, concerns were raised regarding access for Herefordshire residents required to attend a Worcestershire-based unit, particularly for people without access to a car and for their families and support networks. The trust acknowledged that detailed transport arrangements had not yet been developed and would require further work.

7. Members also raised concerns about the practical delivery and affordability of community provision in a rural county, including the availability of housing to support discharge and recovery. The trust advised that the proposal is intended to be cost-neutral, with staff from units proposed for closure offered opportunities within the community rehabilitation team. It was added that the trust had experience of a similar model through its hospital-at-home service.

8. The trust explained that a detailed implementation and transition plan would be developed only if the proposal passes the next assurance stage. This would include staff training and redeployment, a phased transition period during which both services could operate, and work with partners to address housing and wider support needs. The committee heard that joint work between Herefordshire Council and the Integrated Care Board under section 117 funding is important in providing appropriate housing and community support for eligible people.

9. In response to questions about level two rehabilitation, the committee heard that there are currently no dedicated level two rehabilitation beds in Herefordshire or Worcestershire. The trust advised that people requiring intensive clinical stabilisation are presently placed out of county or supported through alternative arrangements within acute mental health services. The proposed approach would seek to secure appropriate provision from external providers as close as possible to Herefordshire and Worcestershire.

10. The committee noted that engagement with people with lived experience had influenced the programme. It was reported that feedback had led to a pause in the programme to explore an alternative opportunity and to a revision of the approach used to assess options. Staff feedback had been mixed, reflecting concerns about the proposed changes, but the trust stated that it was maintaining regular communication and engagement with affected staff.

11. The committee emphasised the importance of ensuring that the proposed model was integrated with partners including from within adult social care, as well as voluntary and community sector organisations. The trust confirmed its intention to develop the operating model through partnership working across localities.

12. The Director of Public Health welcomed the involvement of public health teams and people with lived experience in the programme. It was stressed that the next stages of development must avoid widening inequalities in access to services or outcomes, including the wider effect on families and carers.

13. A committee member expressed concern that the proposals could reduce the quality of rehabilitation provision available to Herefordshire residents and be driven primarily by financial considerations. In response, the trust stated that the preferred option was based on national best practice and was intended to improve outcomes and quality, rather than generate savings. It was added that the proposal would be subject to independent clinical scrutiny and, if implemented, monitored through appropriate performance measures and service-user feedback.

14. The committee noted that the next stage would be a visit from the Clinical Senate in August 2026, followed by consideration of its findings by the trust and the Integrated Care Board and an NHS England assurance gateway. Subject to the outcome of these processes, a 12-week public consultation is expected to take place in early 2027.

15. It was agreed that the committee would receive a further update following the public consultation, provisionally in July or August 2027, and that further information arising from the discussion would be provided in advance of the committee's next meeting on this topic.

28. HEREFORDSHIRE'S JOINT STRATEGIC NEEDS ASSESSMENT AND NEIGHBOURHOOD PROFILES

The committee considered a report on Herefordshire's Joint Strategic Needs Assessment and Neighbourhood Profiles.

The principal points of the subsequent discussion are summarised below:

1. The Director of Public Health introduced the item and explained that the Joint Strategic Needs Assessment (JSNA) is a statutory, ongoing assessment of the health, care and wellbeing needs of Herefordshire's population. It was noted that, alongside the countywide summary published on a three-year cycle, the JSNA included themed needs assessments, dashboards and other products to inform strategic planning, commissioning, monitoring and evaluation.

2. The committee heard that the JSNA considers the wider determinants of health and wellbeing, including housing, employment, transport, social connections and the local environment, rather than health services alone. It was noted that health services accounted for only part of the factors influencing health outcomes.

3. The Lead Public Health Intelligence Analyst reported that the neighbourhood profiles had been developed to provide an area-based understanding of need, complementing the countywide and topic-based JSNA products. The profiles are intended to support the national neighbourhood health agenda, with Herefordshire identified as one of the first-wave neighbourhood health sites.

4. The committee was advised that the profiles were designed to be accessible to a wide range of users, including primary care networks, commissioners, council and partnership services, voluntary-sector organisations and other stakeholders. Their purpose is to identify opportunities for prevention and reducing inequalities.

5. It was explained that four neighbourhood areas had been defined using existing localities and primary care network footprints: Hereford City, East, South and West, and North and West. The two Hereford City primary care networks had been combined because their registered populations overlapped, while the profiles would also enable analysis of differences within each wider neighbourhood area.

6. The committee heard that the profiles had been developed as narrative and graphic products, interpreting and triangulating available evidence rather than presenting a comprehensive list of data points. A full North and West profile and draft summary profiles for all four areas had been included in the agenda papers, with members invited to comment on whether the profiles accurately reflected the story of each area.

7. In relation to Hereford City, it was noted that the area has the highest population density and contains both some of the most and least deprived areas in the

county. Significant inequalities exist within the city, including a difference of around five years in male life expectancy between some areas, alongside higher smoking rates and avoidable mortality than elsewhere in Herefordshire.

8. The East neighbourhood was reported to have generally positive outcomes, including higher life expectancy, healthier lifestyles and strong communities. However, members heard that area-wide outcomes could mask local need, with Bromyard Central and Ledbury Central identified as areas experiencing deprivation and higher emergency hospital admissions.

9. It was noted that South and West is geographically diverse, encompassing better-connected locations such as Ross-on-Wye as well as remote rural areas including the Golden Valley and the Black Mountains. While health outcomes were generally positive, the profile identified barriers to physical and digital access to services, housing-related issues including fuel poverty and excess cold, and particular health challenges in parts of Ross-on-Wye.

10. The committee heard that North and West also contained significant internal variation. Particular communities in Leominster appeared repeatedly across measures of need affecting children, families and working-age residents, while Ridgemoor and Grange were identified as the two most deprived local areas in Herefordshire, with Ridgemoor among the 10% most deprived areas nationally. It was also noted that six of the county's ten areas with the greatest geographical barriers to services were located in North and West.

11. The Cabinet Member Adults, Health and Wellbeing highlighted the limitations of national deprivation measures in rural areas, particularly where car ownership could be essential because of limited public transport. It was suggested that this could obscure the financial pressures experienced by residents who needed to maintain a vehicle in order to access employment, services and everyday necessities.

12. It was emphasised that the purpose of the profiles is not to compare neighbourhoods against one another but to understand each area in its own context. It was noted that variation within the four neighbourhood areas, including urban-rural differences and concentrated pockets of need, is often more significant than the difference between neighbourhoods.

13. The committee considered an example concerning digital exclusion in Leominster Grange. The area had been identified as being at high risk of digital exclusion, principally because of skills and confidence rather than broadband availability; analysis of deprivation, working-age need and social and private rented housing had helped identify opportunities for targeted action.

14. The Consultant in Public Health explained that the profiles would provide an evidence base for partners to identify local priorities and develop appropriate interventions. The profiles remained in draft and would be developed further, shared with wider stakeholders and updated as further intelligence became available, including local analysis relating to falls.

15. In response to a question about changes since the last JSNA, it was noted that life expectancy has stalled in comparison with the national position, healthy life expectancy has declined, health inequalities remain significant, and the prevalence of multiple long-term conditions is increasing. Officers identified smoking, immunisation uptake and falls prevention as three immediate countywide prevention priorities, to be considered further at neighbourhood level.

16. Members discussed the importance of sustained smoking cessation support, including reducing inequalities in smoking prevalence, and welcomed the focus on falls prevention. The committee heard that smoking prevalence was around 10% and that Herefordshire was on track towards the target of reducing this to below 5% by 2030. A newly established Falls Network, jointly chaired by adult social care and public health representatives, was reported to be considering partnership work on falls prevention.

17. In response to questions about the geography used for the profiles, officers explained that the four areas followed existing primary care network footprints and had been selected pragmatically to support neighbourhood health planning. It was acknowledged that the profiles must continue to distinguish between the differing needs of market towns, rural areas and smaller communities within each neighbourhood.

18. The committee highlighted the potential value of the profiles in informing discussion on transport, access to services and neighbourhood health planning. Officers confirmed that the profiles are intended to begin conversations at primary care network level about local priorities and service design.

19. It was also agreed that officers would provide further information on the One Herefordshire Partnership.

20. A committee member identified the need for targeted health information and prevention activity for communities with different language needs, particularly in relation to smoking. Obesity and late dementia diagnosis were also raised as important issues. Officers confirmed that, while these were not among the three initial neighbourhood health prevention priorities, both remained significant longer-term priorities for the county.

21. The committee discussed the interpretation of deprivation data. It was explained that the Index of Multiple Deprivation used nationally produced measures across seven domains. It was noted that the profiles would first be shared through primary care networks but should subsequently be made available to a wider range of partners.

29. ADULT SOCIAL CARE BUDGET OUTTURN

The committee received a verbal update on the Adult Social Care budget outturn item.

The principal points of the subsequent discussion are summarised below:

1. The Corporate Director Community Wellbeing reported that the 2025/26 revenue budget outturn for Community Wellbeing was a net overspend of £3.7 million, after applying a contribution from the budget resilience reserve. This included £0.9 million of undelivered savings, while the principal amount of the overspend was increased demand across domiciliary care, residential care and nursing care, including increased need among people leaving hospital.

2. It was noted that demand for formal care and support had increased significantly during the first half of 2025/26 and had only partly reduced during the second half of the year. The committee heard that early indications for 2026/27 were more positive, with weekly demand broadly in line with the budget provision and below the levels experienced during the previous year.

3. The Corporate Director Community Wellbeing advised that there is an increased focus on supporting people at home and through supported living, where appropriate, rather than relying on residential and nursing care. It was also

reported that delivery of the 2026/27 savings programme was underway, with first-quarter savings profiled for delivery having been achieved, and the value of undelivered savings from the previous year reduced by £300,000.

4. The committee was advised that the directorate has established structured process for budget oversight, savings delivery and challenge. These included dedicated workstreams and monthly meetings involving the directorate leadership team, finance colleagues and the Cabinet Member.

5. In response to a question about whether expenditure is achieving better outcomes, the Corporate Director Community Wellbeing stated that the service sought to support people in their own homes or supported living settings where this best met their needs. It was noted that feedback was collected through the People's Voice survey following assessment and support-planning interactions, and that this information was used to identify both improvement opportunities and positive outcomes.

6. In response to a question on the quality of domiciliary care, the committee heard that feedback was sought from people receiving care and that the council's quality and review team undertook spot checks and spoke to providers and residents. Where safeguarding concerns arose, work was undertaken by safeguarding and quality teams to address concerns relating to individuals and providers in a timely manner.

7. The committee discussed the cost of people who had previously funded their own care falling below the capital threshold and becoming eligible for council support. The Corporate Director Community Wellbeing advised that this normally created a cost pressure of around £0.5 million, which was considered during budget-setting. It was reported that work was underway to improve the offer to self-funders, enabling earlier engagement, more timely assessment and better planning for continuity of care.

8. The Cabinet Member Adults, Health and Wellbeing noted work to increase awareness of technology-enabled care through stands at community hospitals. It was reported that events had been held at Leominster and Bromyard, with further events planned. The purpose was to help residents, families and staff understand how technology could support people to remain safe and independent at home for longer.

9. The committee considered how the outcomes of technology-enabled care would be monitored. It was advised that referral forms recorded how individuals had heard about the service. It was noted that this information could help establish whether technology had reduced or delayed the need for formal adult social care support and build an evidence base for its effectiveness for particular cohorts and conditions.

30. WORK PROGRAMME 2026-7

The Statutory Scrutiny Officer presented the draft work programme for the Health, Care and Wellbeing Scrutiny Committee.

It was agreed that the arrangements for completing the task and finish group report would be discussed further in a separate meeting.

31. DATE OF THE NEXT MEETING

The date of the next meeting is Monday 14 September 2026, 2.00 pm.

The meeting ended at 4.30 pm **Chairperson**