London Borough of Hammersmith & Fulham

Health & Wellbeing Board

Agenda

Monday 13 December 2021 at 6.00 pm
3 Shortlands, Hammersmith, W6 8DA
Online Meeting

MEMBERSHIP

Councillor Ben Coleman - Cabinet Member for Health and Adult Social Care (Chair)
Vanessa Andreae - H&F Clinical Commissioning Group (Vice-Chair)
Dr James Cavanagh - Chair of the Governing Body, H&F Clinical Commissioning Group
Councillor Larry Culhane - Cabinet Member for Children and Education
Philippa Johnson - Central London Community Healthcare NHS Trust
Dr Nicola Lang - Director of Public Health
Jacqui McShannon - Director of Children's Services, H&F
Lisa Redfern – Strategic Director of Social Care, H&F
Sue Roostan – Borough Director, H&F Clinical Commissioning Group
Glendine Shepherd – Assistant Director of Housing Management, H&F
Sue Spiller – Chief Executive Officer, SOBUS
DI Luxan Thurairatnasingam – Metropolitan Police
Carleen Duffy – Healthwatch H&F Manager

Nominated Deputy Members
Councillor Patricia Quigley – Assistant to the Cabinet Member Health and Adult Social Care
Councillor Lucy Richardson, Chair, Health, Inclusion and Social Care Policy and Accountability Committee
Nadia Taylor, H&F, Healthwatch Representative

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Date Issued: 3 December 2022

London Borough of Hammersmith & Fulham

Health & Wellbeing Board
Agenda

Item **Pages**

1. APOLOGIES FOR ABSENCE

2. ROLL CALL AN DECLARATIONS OF INTEREST

The Chair will carry out a roll call to confirm attendance. Members also have the opportunity to declare any relevant interests.

If a Member of the Board, or any other member present in the meeting has a disclosable pecuniary interest in a particular item, whether or not it is entered in the Authority's register of interests, or any other significant interest which they consider should be declared in the public interest, they should declare the existence and, unless it is a sensitive interest as defined in the Member Code of Conduct, the nature of the interest at the commencement of the consideration of that item or as soon as it becomes apparent.

At meetings where members of the public are allowed to be in attendance and speak, any Member with a disclosable pecuniary interest or other significant interest may also make representations, give evidence or answer questions about the matter. The Member must then withdraw immediately from the meeting before the matter is discussed and any vote taken.

Where members of the public are not allowed to be in attendance and speak, then the Member with a disclosable pecuniary interest should withdraw from the meeting whilst the matter is under consideration. Members who have declared other significant interests should also withdraw from the meeting if they consider their continued participation in the matter would not be reasonable in the circumstances and may give rise to a perception of a conflict of interest.

Members are not obliged to withdraw from the meeting where a dispensation to that effect has been obtained from the Audit, Pensions and Standards Committee.

3. MINUTES AND ACTIONS 4 - 11

(a) To approve as an accurate record and the Chair to sign the minutes of the meeting of the Health & Wellbeing Board held on 29 September 2021

(b) To note the outstanding actions.

4. PUBLIC PARTICIPATION

This meeting is being held remotely. If you would like to ask a question about any of the items on the agenda, please contact: bathsheba.mall@lbhf.gov.uk

You can watch the meeting live on the Council's YouTube channel: Watch the meeting live on YouTube

5. COVID UPDATE

Verbal

This report will include an update from the Director of Public Health on the boroughs Covid response, and health partners, with particular reference to:

- Flu vaccine uptake
- Covid vaccine uptake
- Support for those with long Covid symptoms

6. PROGRESS UPDATE ON TRANSITION TO THE INTEGRATED CARE SYSTEM

12 - 17

This report will consider governance arrangements and priorities for the Integrated Care System which will be implemented in April 2022.

7. WORK PROGRAMME

The Board is requested to consider items to be included in future meetings.

8. ANY OTHER BUSINESS

9. DATES OF NEXT MEETING

Monday, 14 March 2022

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London Borough of Hammersmith & Fulham

Health & Wellbeing Board

Draft Minutes

Tuesday, 21 September 2021

PRESENT

Committee members:
Councillor Ben Coleman - Cabinet Member for Health and Adult Social Care (Chair)
Dr James Cavanagh - Chair of the Governing Body, H&F Clinical Commissioning
Dr Nicola Lang - Director of Public Health
Jacqui McShannon - Director of Children's Services, H&F
Lisa Redfern – Strategic Director of Social Care, H&F
Sue Roostan – Borough Director, H&F Clinical Commissioning Group
Glendine Shepherd – Assistant Director of Housing Management, H&F
DI Luxan Thurairatnasingam – Metropolitan Police
Carleen Duffy – Healthwatch H&F Manager

Nominated deputy members:

Councillor Lucy Richardson
Nadia Taylor, H&F Healthwatch

Officers and guests: Cheryl Anglin-Thompson, Health Partnership Manager, H&F; Jo Baty, Assistant Director Assistant Specialist Support And Independent Living; Jazz Browne, Chief Executive, Nubian Life; Peggy Coles, Dementia Action Alliance; Jim Grealy, H&F Save our NHS; Merril Hammer, H&F Save Our NHS; Dr Chris Hilton, Executive Director of Local and Specialist Services, West London Trust; Linda Jackson, Director COVID-19 & Lead for Afghanistan Refugees; Paula Linan, H&F Information Advice & Guidance Service Manager; Helen Mangan, Director Mental Health Services, West London Trust; Kate Sergeant, H&F Support Services Manager, Alzheimer's Society

1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Cllr Larry Culhane and Philippa Johnson.

2. ROLL CALL AND DECLARATIONS OF INTEREST

None.

3. MINUTES AND ACTIONS

RESOLVED

That the minutes of the meeting held on 29 June 2021 were agreed as an accurate record.

4. DRAFT DEMENTIA STRATEGY

4.1 Councillor Ben Coleman welcomed the work undertaken co-producing the dementia strategy which supported the intention to become a dementia friendly council and borough. Working collaboratively with residents, community partners and local groups there was a strong commitment to improving services and support for all residents living with dementia and their carers. Acknowledging that it was World Alzheimer's Day, Councillor Coleman thanked the Dementia Strategy Task and Finish Group and commended them for their unstinting support.

4.2 Jo Baty added that the draft dementia strategy had been co-produced with stakeholders most expert in the needs of people with dementia and their carers and represented a renewed hope of becoming a dementia friendly borough . There were currently 570 dementia friends from the Council, CCG, CAN and from local stakeholders and residents. It had been necessary to navigate some difficult conversations with carers, families and stakeholders across the community, private and public sector to examine the key issues they face in delivering and receiving services and support in their respective roles. This evidenced based approach had identified gaps and helped map areas to further develop, utilising online surveys and data evaluation over 16 months . This was a critical opportunity for the ICP to have significant impact on people's lives at a local level and embodied the principle of "nothing about us without us".

4.3 Peggy Coles underlined the importance of a data driven approach to accurately reflect the diversity and demographic of the borough where diagnosis of dementia was the second lowest rate in London at 57.6%. While diagnosis was dependent on self-referral, there needed to be a greater focus on public health messaging and prevention, recognising that dementia was linked to risk factors. Embedding co-production and the establishment of a dementia partnership board, with representatives from community groups, council and NHS, were the key recommendations.

4.4 Providing brief insights on what were perceived as systemic barriers around dementia diagnosis for black and Asian minority ethnic groups, Jazz Brown acknowledged that there was stigma associated with dementia. There was a lack of understanding and of safe community spaces where information was accessible. Previously, community memory outreach groups had achieved a positive success rate with self-referral and diagnosis, but a clinical route was often avoided by choice. Dr Christopher Hilton confirmed that the provision of dementia services fell within the remit of West London Trust (WLT). He welcomed the report and its recommendations and explained that they would be exploring outreach work with organisations such as Nubian Life.

4.5 Paula Linan commented that a great deal had been learned about the work of each organisation represented on the Dementia Strategy Task and Finish

Group and added that a collaborative approach would be very positive for those with dementia and their carers, especially in terms of respite care.
Dr James Cavanagh welcomed the initiative and acknowledged that difficulties in dementia diagnosis were partly attributable to stigma and the lack of effective outreach programmes. However, the report inferred that the prevalence rate was the rate of diagnosis per year rather than the total number of diagnoses.

ACTION: To amend this within the report

4.6 DI Luxan Thurairatnasingam also welcomed the report and agreed that there was stigma about dementia, that it was easier to overlook as it was associated with old age and that people diagnosed with dementia often became invisible. He described the operational difficulties often experienced in policing in relation to for example, reports of missing people. He advocated for a long-term plan with a multi-agency partnership approach.

4.7 Jim Grealy commended the report authors for the clarity and clear focus of the report which was inclusive, empathetic and jargon free. He queried the low rate of diagnosis compared to neighbouring boroughs and referenced the anticipated increase of 42% of those with serious dementia by 2030. The ICP controlled the cost and provision of such services and played an important role in the decision making. Peggy Coles observed that this was a medical condition for which there was no cure. It was important to focus on the clinical response. Lisa Redfern concurred that the role of the ICP was critical, and it was confirmed that frailty was a key area which linked to the ICP work on dementia. Dr Hilton added that the strategy would help guide the development of local services and that the ICS was monitoring the rate of diagnosis.

4.8 Councillor Coleman acknowledged a concern about maintaining a “bottom up” approach. Developing and delivering the aims of the strategy would be guided by a dementia partnership board, and that residents and stakeholders would be integral to the work of the board. The Board discussed representation on the proposed dementia board which could also include a rolling focus group of residents to facilitate greater accountability. It was important that residents were meaningfully involved, and this required careful planning.

RESOLVED

1. That the Health and Wellbeing Board endorsed the co-produced Hammersmith and Fulham Dementia Strategy between the local Council, the local NHS, the voluntary and community sector, our residents, and businesses.
2. That the Health and Wellbeing Board supported the proposed establishment of the Dementia Partnership Board, with representation from the local Council, the local NHS, the voluntary sector, residents, and businesses to oversee the implementation and evaluation of the Dementia Strategy, aligned to the work of the ICP.

5. COVID 19 UPDATE

5.1 Councillor Coleman set out the three elements of the verbal presentation which comprised of: the borough's ongoing response to the pandemic; an update of the flu vaccination and the ICP's role in this, and Covid vaccination.

5.2 Dr Nicola Lang reported that the rate of new cases was 203 per 100,000 people and that this was gradually decreasing and that the rate was consistent with the rest of London. There had been a number of outbreaks in local schools which were being actively managed. Linda Jackson reported that there had been a spike in cases amongst the over 60s cohort, but this had not resulted in a significant impact. The government had recently published its winter plan and the borough was well placed to respond as it continued with vaccination, testing (the highest rate in London), and the contact tracing pilot project. The government had also written to people who were clinically vulnerable and advised that they were no longer required to shield. The borough had continued to maintain contact with this group and currently had no plans to end this support. Generally, the borough continued to maintain low level and essential support.

5.3 Councillor Coleman enquired how well schools where managing, given the widely expected spike in cases at the start of term. Dr Lang responded that the schools had worked well and in partnership alongside Public Health England with an early and interventionist and upstream approach. The Public Health team had taken a proactive approach to prevent outbreaks in settings such as schools and schools with special needs where there were vulnerable groups by implementing mitigating measures such as restricted movement, mask wearing and hygiene control. This had been seamless, and the schools had done a great job.

5.4 Jacquie McShannon felt that this was a measure of how much confidence schools had with the borough's Public Health and Children's Services teams and that they continued to have engage brilliantly and have good contact with the council. Dr Lang regularly met with schools to maintain strong links. Much time and energy had been invested in this work which would remain unfunded by government and supported by the council. The removal of contact tracing was a concern and Dr Lang explained the changes in contact rules for a young person under 18. Schools were having mature conversations with parents about measures and there had been a highly sophisticated response in finding ways to navigate complex public health concepts. It had been heartening to see trained school professionals doing public health work.

5.5 Councillor Coleman enquired about the quality of support offered by government in respect of quarantine hotels and travellers returning from abroad. Linda Jackson explained that there had been one large quarantine located in the borough which had been well supported and organised by the Department of Health (DH). A number of Afghani refugees were being

housed in temporary bridging accommodation. Random checks by council staff indicated that the sites were well run with the exception of one which was being managed by the Home Office resulting in additional work for the council. Linda Jackson confirmed that despite the negotiation of a package of care with the NHS the full cost of the additional work and expenditure would not be covered. Sue Roostan outlined the co-ordinated NHS response to support five bridging hotels across North West London (NWL). This included offering childhood immunisation and Covid vaccination and the intention was to complete this process by the end of the week (24 September).

5.6 Nadia Taylor queried the difficulty in obtaining in person GP appointments and that virtual care was a compromise which should not become the norm as it would not suit everybody. She asked what guidance had been provided to see patients. Dr Cavanagh said that patients should not feel that they cannot be seen. Patients were being triaged over the phone and then a decision taken as to whether an in person consultation was necessary. Access had increased but it was not always appropriate to see patients with Covid. Digital disenfranchisement was a concern and while Covid continued, surgeries were working to maintain appropriate measures. It was possible to be infected despite double vaccination and the surgery had a responsibility to protect both staff and patients.

5.7 Jim Grealy suggested that improved messaging could help address this issue and alleviate anxiety about not being able to have in person consultation. Currently, surgeries seemed exclusionary, patients felt unwelcome, and it would also be helpful to communicate what patient safety measures were in place. Sue Roostan concurred with the communications point and agreed with the need to have clear and consistent messaging to ensure people accessed the correct care pathways. In terms of infection control, it was not safe to have patients in waiting rooms. The Trusts were managing this carefully and the CCG was working in line with this policy.

RESOLVED

That the verbal update was noted.

6. INTEGRATED CARE PARTNERSHIP (ICP) - UPDATE

6.1 Lisa Redfern welcomed the opportunity to provide an update on the work of the ICP and covered the two broad areas of the four campaign groups (health and well-being, frailty, diabetes and mental health) and the work of the PPL partnership. The four campaigns were all at different development stages and of these, the diabetes group was the most advanced. Sue Roostan highlighted that in the context of dementia, reintegration and reablement they had mapped and identified areas where there were service gaps. This was an evolving process and they hoped to report on the deliverables in future. PPL had been engaged to help support and develop the partnership with a

focus on engagement. There were three key themes: how to deliver services, create change and the development of a shared identity. Section 4.5 of the report referred to key findings identified through engagement and the dementia strategy work was a good example illustrating a model of how to engage with people and what could be achieved.

6.2 Merril Hammer referenced the mental health campaign work which she felt took a linear approach compared to the dementia work which had been broader and inclusive. It was observed that if the ICP was committed to being inclusive they needed to address how engagement could be extended to proactively include residents as part of the process. Lisa Redfern recognised the work that was needed and that this point was a key finding by PPL. The ICP needed to build a shared approach to co-production through an assured and well-planned delivery process. The new ICP was emerging, and Councillor Coleman said that this would be the focus at future meetings of the Board and how engagement would be taken forward. In response to a point made by Jim Grealy, Lisa Redfern offered an assurance that the ICP would be responsive and would be able to include within the different campaigns areas of emerging interest. Sue Roostan concurred and referred again to the example of the work on dementia and also, the mental health of children and young people as part of the mental health campaign group. There were so many priorities that an initial and tight focus around four campaign groups and the five key areas was thought to be more flexible and deliverable.

RESOLVED

That the Board noted and commented on the report.

7. FLU VACCINATION - H&F UPDATE

7.1 Councillor Coleman introduced this item and explained that it would also encompass Covid vaccination, jointly presented by Linda Jackson and Sue Roostan.

7.2 Sue Roostan reported that this was a joint piece of work across the ICP, CCG and local authority. Notification of the delivery schedule for the booster programme had been issued and some people had already received text messages, if they were aged 50+ and had immunosuppressed conditions. There were four sites available across the borough: Brook Green Surgery, White Cite Community Centre, West Kensington Tenant's Association Hall and Hammersmith Surgery nominated as the Primary Care Network (PCN) sites. Brook Green and White City would go live shortly.

The local authority and CCG had been campaigning for additional pharmacy sites within the borough which would increase to 11 and so offered an additional 7 sites. The booster programme had commenced in care homes and work was ongoing with CLCH to deliver the vaccine to housebound residents.

7.3 Commenting on the vaccine delivery programme to schools for 12-15 year olds, Sue Roostan reported that national protocols and guidance would be issued that week. It was important to issue a clear, local message that people would not invited to book their booster jabs until 6 moths had elapsed from a second vaccine dose. There had been significant work undertaken to encourage and support vaccine take up with a range of hyperlocal initiatives including a vaccine bus on sites such as Charing Cross hospital and the Claybrook mental health facility. Vaccine uptake for mental health patients had increased although actual numbers were low. Helen Mangan added that vaccine bus had been situated at the site for 5-6 weeks, capturing 12% of the unvaccinated population. There was a long list of patients with a range of issues that meant that an integrated approach was preferable to support vulnerable residents in gaining the confidence to be vaccinated.

7.4 Sue Roostan explained that NWL were recruiting teams of mobile vaccinators as the mass vaccination hubs were being decommissioned and it was confirmed that the intention was to have 100 full time vaccinators for pop ups. The issue of vaccinating those that were house bound was raised, which was distinct from making vaccines locally accessible through pop ups and similar initiatives. Councillor Coleman responded that the borough's needs were not being met and sought clarification about what more could be done to address the low rates of vaccine take up that was historic within the borough. Sue Roostan stated that it was not possible to deliver vaccines at home due to other operational priorities. They had successfully lobbied for additional pharmacies which would soon be operational.

7.5 Merril Hammer expressed concern that H&F, an inner London borough with one of the lowest take up rates nationally, was not receiving greater support. The implications of this had been raised with the board of Imperial College Healthcare NHS Trust. The view of the Trust was to adopt a hyperlocal, street by street approach and speak directly to people who had refused the vaccine. Linda Jackson outlined the H&F approach, which was precisely this, to have local conversations with communities however there was a fundamental lack of trust which extended beyond fear of vaccination. There was a commitment to continue to build upon the work already begun to engage and build trust with cohorts that did not want to be vaccinated.

RESOLVED

That the verbal update was noted.

8. WORK PROGRAMME

In discussing the Board's work programme priorities, Councillor Coleman highlighted the reluctance of many black and Asian ethnic minority communities to be vaccinated and acknowledged that there was an historic lack of confidence or trust of the NHS as an institution within these communities. The Board felt that the following items could be considered at future meetings:

- Long Covid – to better understand the condition and how residents could be better supported in managing it;
- GP surgeries – practices and GPs were under immense pressure and post Covid, patient / GP interactions were challenging, to be considered for the March 2022 meeting.

9. DATES OF NEXT MEETINGS

Monday, 13 December 2021.

Meeting started: 6pm
Meeting ended: 8.24pm

Chair .....

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Legislation will require us to have an Integrated Care Partnership that brings together all partners, and an Integrated Care Board that has statutory responsibility for NHS expenditure. In addition, we will engage the LA Leaders Group and NW London Chairs. The statutory responsibilities of Health and Well Being boards and Overview and Scrutiny Committees remain unchanged

Statutory bodies

NW London Integrated Care Partnership (quarterly)
Chair: Penny Dash

- Develop overall strategy to meet the wider health, public health and social care needs inc. goals to reduce inequalities and economic development (built from local borough based needs assessments, e.g., JSNAs)
- Align purpose, ambitions and strategy of partners
- Challenge all partners to demonstrate progress in reducing inequalities and improving outcomes
- Develop approach to consultation and engagement
- Refer decisions back to Integrated Care Board as appropriate

NW London Integrated Care Board (monthly)
Chair: Penny Dash

- Develop a plan to meet the health needs of the population (based on the ICP's strategy)
- Allocate NHS resources to deliver the plan and deliver financial sustainability
- Establish joint working arrangements to deliver the plan.
- Assure plans and metrics in place to review delivery against strategy
- Agree capital plan for NHS
- Secure the provision of health services
- Hold all parts of system to account for delivery of ICS objectives and ICS programmes (where NHS funds are used)
- Plan for, respond to and lead recovery from incidents
- Support collaborative problem solving and drive transformation

Non-Statutory group

8 LA Leaders & 8 LA CEOs (6 weekly**)**
Chair: Graham Henson

- LA/ICS engagement
- Discuss all major proposals
- Support collaborative system problem solving and improvement

NW London Chairs (monthly)
Chair: Penny Dash

- Engagement of NHS Chairs and LA leaders
- Support collaborative system problem solving and improvement

North West London Integrated Care System

NWL ICS already has four objectives and nine programmes

Four Delivery Programmes*

1. Population Health & Reducing Inequalities in Health
2. Local care including primary care
3. Mental health and care for people with learning disability and autism
4. Acute care:
   - Urgent and emergency
   - Elective: High volume, low complexity, outpatients and diagnostics
   - Specialist Care
   - Critical Care

Four Objectives

A. Improve outcomes in population health and health care

B. Prevent ill health and tackle inequalities in outcomes, experience and access

C. Enhance productivity and value for money

D. Support broader economic and social development

Five Programme Enablers

5. People
6. Research, education & innovation
7. Digital & Data
8. Estate: including new hospitals
9. Corporate services

North West London Integrated Care System

Transition update on delivery and governance

Delivery

- Each programme is defining how it will deliver each of the four ICS objectives and, importantly, how success will be measured meaningfully. This must be agreed by the end of 2021.
- Local authority leadership is particularly welcomed to deliver the fourth objective: to support broader economic and social development.
- Many programmes, for example young people's mental health and prevention of obesity, require good comparative data and joint working between the eight boroughs and between health and care.
- The immediate short-term priority, given the exceptional demand on all services, is to work together to deliver optimum care throughout winter (winter plan) and vaccination.

Governance

- Rob Hurd, ICS CEO starts 6th January 2022.
- Substantive recruitment of two statutory posts in the ICS Executive will commence in January: Medical Director and Chief Nurse.
- The draft ICS Constitution to be submitted 5th December 2021. Regarding membership of the Integrated Care Board (ICB), we will mirror the minimum national requirement e.g. LA CEO x1, NHS provider x1, ICS CEO.
- The legislation is likely to be delayed beyond April 1st 2022, however, we will continue to work as a shadow ICS driving delivery at all times.
- The integrated health and care leadership of borough-based partnerships (BBP) and their detailed delivery plans will be confirmed in the New Year.

The draft composition of the NW London Integrated Care Partnership and Integrated Care Board is set out below

NW London Integrated Care Partnership

(Statutory Partnership body[1]) - Quarterly

- All members of NW London ICS Integrated Care Board (see opposite)
- Local authority Chief Executives (x8)
- Voluntary sector
- Citizen/lived experience, Health Watch
- Brunel and Imperial Universities
- Large local employer

NW London Integrated Care Board

(NHS Statutory body successor to Partnership Board)- Monthly

- Independent chair of NW London ICS
- Non executives up to 4
- Chief executive, NW London ICS
- NHS Trusts
- Place based Partnerships
- Local authority chief executive
- Director of Public Health
- Primary Care lead (a GP)
- Members of ICS executive
- CEO AHSC
- CEO AHSN

We will revisit membership once the legislation has passed Parliament

1 Not yet established

North West London Integrated Care System

Place based partnerships (boroughs) are the engine room to join up care around our population. They are not statutory bodies and the ICB remains accountable for NHS resources deployed at place level

Principles agreed by the Partnership Board

- The ICS will deliver on its objectives (improving outcomes, reducing inequalities, improving productivity and contributing to wider society) through our place based partnerships - by engaging residents, joining up care for and with them, and working through and alongside local communities and partners
- Our place based partnerships include local government (social care and public health), mental health, community and primary care, as well as residents and patient groups
- Like trusts and local authorities, places are part of the ICS and are therefore involved in ICS priority and objective setting through our programmes. In addition, we propose place based partnerships are included in the ICB
- Authority, and commensurate accountability, should be devolved to place in order to:
    - Enable local action within a clear ICS framework of objectives, consistent application of 'what works' and minimum expectations of access and outcomes
    - Enable local tailoring of services to meet the needs of particular populations
- Places will work collaboratively where scale is necessary to achieve a critical mass to get the best outcomes and to minimise variation in the experience, access and outcomes for our resident

NWL places already have delegation and influence and have developed priorities and plans for delivery

Areas that are formally delegated

- Primary care (in particular, locally enhanced services (LES))
- Better Care Fund
- Placements (including continuing health care)
- Anything covered by a section 75 agreement with a local authority

Areas places are involved in decision making

- Minimum standards and service specifications for primary and community care (through the local care board)
- Minimum standards and service specifications for community mental health care (through the mental health programme board)
- Setting of North West London wide priorities and programmes (e.g., diabetes)
- Levelling up of investment in services (i.e., allocation of growth monies; for 2022/23, allocations of money previously received continues)

In addition:

- Members of places (e.g., primary care, community care, social care, mental health) can reallocate monies between themselves locally where they agree this will improve services