Coventry and Warwickshire Joint Health Overview and Scrutiny Committee

Monday, 14 October 2019

Minutes

Attendance

Committee Members
Councillor Wallace Redford (Chair)
Councillor Margaret Bell
Councillor Joe Clifford
Councillor Clare Golby
Councillor John Holland
Councillor Jerry Roodhouse
Councillor Rachel Lancaster
Councillor Marcus Lapsa
Councillor Ed Ruane

Officers
Shade Agboola, Director of Public Health
Rachel Barnes, Health and Wellbeing Delivery Manager
Becky Hale, Assistant Director - People
Helen King, Director of Public Health
Nigel Minns, Strategic Director for People

Others Present

1. General

(1) To note the Appointment of Councillor Redford as Chair for the meeting

It was noted that Councillor Wallace Redford would chair this joint meeting in accordance with the terms of reference for the Joint Health Overview and Scrutiny Committee (JHOSC).

(2) Welcome and Introductions

The Chair welcomed everyone to the JHOSC meeting.

(3) Apologies and Substitutes

Apologies for absence had been received from Councillors Ed Ruane and Hazel Sweet (Coventry City Council).

(4) Disclosures of Pecuniary and Non-Pecuniary Interests

Councillor Jerry Roodhouse declared a non-pecuniary interest as a Director of Healthwatch Warwickshire.

(5) Chair's Announcements

The Chair advised that the stroke services item was a formal consultation on a service reconfiguration, which would be considered after this meeting by the scrutiny committees of both Coventry City and Warwickshire County Councils, before coming back to this body for the determination of the response to the consultation. The other items on this agenda were discretionary items.

(6) Minutes of the previous meeting

The Minutes of the JHOSC meeting held on 20 March 2019 were accepted as a true record and signed by the Chair.

2. Public Speaking

Mr Dennis McWilliams and Professor Anna Pollert had given notice of questions to the JHOSC. The questions are attached to the minutes at Appendices A and B respectively. The Chair responded that a written reply would be provided to the questions after the meeting.

3. Coventry and Warwickshire Strategic Five-Year Health and Care Plan 2019/20 - 2023/24

Sir Chris Ham, Independent Chair of Coventry and Warwickshire Health and Care Partnership (HCP) presented the five-year strategic plan for consideration and comment. Sir Chris summarised the key points of the draft plan and the work undertaken to date. Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs) were required to create five-year strategic plans, setting out how systems would deliver the commitments in the NHS Long Term Plan. There was an expectation that STPs/ICSs would bring together member organisations and wider partners as they developed and delivered the plans. A key principle was that the plans should be owned locally.

The draft plan was submitted and feedback was being sought prior to 15 November 2019, when the final plan would be submitted to accord with national timescales. The summary priorities of the draft plan were confirmed. Sir Chris referred to the process involved in developing the former STP and the different approach undertaken for this document, working with local Healthwatch organisations and building on the work of the two local health and wellbeing boards. The work on prevention and promoting health and wellbeing were referenced particularly and the plan sought to align with these aims. A priority was the aspiration to integrate health and care around patients and populations, with an asset-based approach to health and wellbeing, involving all sectors. There was an aging population who had complex needs that required joined up services. There was a wish to work differently and to engage more. Sir Chris outlined the three strategic priorities in the plan for the next five-year period being to promote healthy people, build stronger communities and

develop effective services. He referred to the four 'places' across Coventry and Warwickshire and approximately 80% of the Plan's ambitions would be delivered in place, rather than across the system. There would be local partnership arrangements for each of the places. For complex services, a system-wide approach would still be required. He highlighted the focus on urgent and emergency care and the pressures these services faced year-round, as well as mental health services, cancer care, stroke and maternity & young people services. Money was a further challenge and whilst additional government funds were being provided to the NHS, there was an increasing and aging population who required more services. The financial constraints for other organisations was a further driver for partnership working.

Sir Chris referred to staffing aspects and the shortages in some areas. Investing in the workforce, to recruit, retain and train staff was a further priority. He closed by reiterating the points on prevention and giving young people the best possible start in life. The aim was to have a more resilient urgent and emergency care, strengthened general practice, out of hospital care and social care. The draft plan was informed by a focused engagement exercise, details of which were provided. The understanding of population needs was drawn directly from the local joint strategic needs' assessments (JSNA). The plan had been developed by the senior responsible officers for each of the workstreams, with involvement from stakeholders across the system. Clinicians had been engaged fully in developing the plan and the supporting clinical planning templates. Questions and comments were submitted, with responses provided as indicated:

• In the previous STP, it had identified a saving need of £267m. There was a need for increased funding to provide services for the area's aging population. The reference to funding cuts in the STP was really about addressing a gap in funding between identified need and the resources available. There would be a continued growth in funding to the NHS locally, but this would not be sufficient to meet anticipated service demands. The local NHS spent about £1.4bn annually. It was perceived that efficiencies could be achieved to make better use of this money and the other assets available.

• Life expectancy had effectively stalled and it was suggested that the plan make reference to how this would be addressed. This point was broader than for the UK alone, affecting countries who were not experiencing austerity. It was against the backdrop of the significant improvements made previously. Perhaps the limit on life expectancy had been reached, unless there was further advancement of medical science.

• The place-based approach was welcomed as there were differences between Coventry and Warwickshire and within areas of Warwickshire itself. There would need to be further disaggregation to each local area. Sir Chris agreed that the plan did work at the micro level, being based on JSNA data.

• A view that JSNA boundaries did not align geographically with the boundaries of organisations or elected members' areas.

• Reference to the finance assumptions and the underlying deficit of £101m. The eight finance principles were welcomed with further information being sought on the governance principles.

• Productivity and efficiency were raised. This showed an efficiency requirement of £119.4m and the need for a different approach to achieving savings. This was linked to the previous section on the approach to engagement and co-production. Previous documents had similarly referred to these aspirations, but they hadn't materialised and further information was sought on how work with the voluntary and community sector (VCS) would be approached. Sir Chris acknowledged the financial gap and underlying deficit, whilst reminding of the partnership's status and that financial accountability remained with the CCGs and trusts. NHS bodies were working hard themselves and with partners to address the financial aspects. There were opportunities for efficiency for example in medicine optimisation, collaboration and reducing duplication. In responding to the points on co-

production, he made reference to the work with Healthwatch as a body that brought together many smaller groups, but acknowledged that the NHS could do more and learn from local authorities in working with the VCS.

• It was questioned how the system learned from feedback and could become more transparent and accountable. It would be helpful to see this referenced in the document. Some people were fearful of making complaints in case it impacted on the treatment they received. Sir Chris wished to reflect on this point, to provide a more reasoned response.

• Providing additional services at GP surgeries to reduce reliance on accident and emergency (A&E) and outpatient appointments. Coventry's population comprised 33% of people of black and minority ethnicity (BME). It was noted that a higher proportion of the BME population attended A&E. There could be more cohesion. Sir Chris referred to the 18 PCNs being established, which were groupings of GP practices to address workforce challenges and meet the growing needs of the population. These organisations were still developing in the main, although some were better established.

• Reference to the difficulties caused by the 2016 STP document which led to rumours about the closure of maternity services and A&E at the George Eliot Hospital. Clarity was sought that there would be no such closures arising from this review. This also had an impact in recruiting and retaining staff.

• Some of the positives in the report were noted in regard to maternity services, notably the 23% reduction in still births and the 17% of women now having a single midwife throughout their maternity, which was valued – 5 – especially for those with difficult pregnancies. Sir Chris Ham confirmed there were no plans to close maternity units. The staffing challenges provided the rationale for working together, rather than in isolation. There was a major piece of work being led by CCGs on how to improve maternity services.

• Reference was made to the key risks and mitigation measures in relation to workforce. There were no plans to increase the workforce numbers, at the same time as reducing agency staff numbers. This implied that existing staff would be asked to do more and could impact on the quality of service provided. The implications of Brexit were raised. The detailed risk register would be welcomed and it was perceived that there was not sufficient funding within the system. Sir Chris agreed with the points on workforce and funding pressures. Staff were working hard to deliver the best services they could, but there was mounting evidence to show the impact this was having on frontline staff. This was why the workforce aspects were referred to extensively in the report. On agency staff there was a need to reduce reliance on them where possible, given the high costs of using agency staff.

Resolved

That the Joint Health OSC:

1) Notes the process for developing and engaging on the draft Plan; and

2) Considers and comments on the draft Plan ahead of final submission by 15 November 2019.

4. Developing Stroke Services in Coventry and Warwickshire - Public Consultation

This item was introduced by Adrian Stokes, Accountable Officer for Warwickshire North and Coventry & Rugby CCGs. The aim of the proposals was to improve stroke services, which were part of both CCG plans and the health and care system improvements identified under the previous item. It had been shown that current local stroke services could achieve better health

outcomes for patients and more effective and efficient services. The analysis of current services showed considerable unwarranted variation and inequity.

Options for the future delivery of stroke care had been co-produced and appraised through a process involving extensive professional, patient and public engagement. Adrian Stokes referred to this engagement over the last four years and the current public consultation process underway on the proposed future stroke pathway. Detailed clinical engagement had also taken place and clinicians were in attendance. The report stated that the preferred future stroke pathway would improve the quality of outcomes and clinical care and remove the current variation in access to care. This proposal was for a whole stroke pathway improvement. He also referred to the bed modelling and service delivery in the home. A lot of work had been undertaken on the preventative aspects. Mr Stokes referred to the plans for a hyper acute stroke unit (HASU) and the subsequent rehabilitation support. It was believed this review was the best solution for the whole stroke pathway. He outlined the learning from the earlier engagement phases and the changes to the proposals, especially for additional ambulance support and workforce aspects.

The Pre-Consultation Business Case (PCBC) was submitted to NHS England and its panel granted provisional assurance, subject to some minor amendments. These amendments had subsequently been completed and the consultation document had been signed off by all local CCGs. The consultation document had been provided as an appendix to the report. The financial implications were reported. This proposal represented an investment of nearly £3.1 million. He outlined how the public consultation would be undertaken between now and 21 January 2020, with a formal pause over the Christmas holiday period. Dr Gavin Farrell outlined his involvement in the review as a clinician over the last five years. He referred to the work on early discharge and support in the home, with the excellent outcomes from this initiative in terms of reduced disability for patients and social care cost savings. The proposed review had been clinically led and sought to design the best outcomes from stroke in both the acute and community phases of the pathway.

Questions and comments were submitted, with responses provided as indicated:
• There was recognition of the extensive consultation undertaken to date and the investment being made in stroke services.
• An earlier concern was how the predicted reduction in the number of stroke cases had been modelled and further information was sought about the proposals for community based atrial fibrillation (AF). Early access to the HASU and AF were both stated as ways in which the number of strokes would be reduced.
• There would be some public concerns about transport and accessibility to the HASU at UHCW, especially for relatives wanting to visit a patient. The concerns for relatives and visitors was acknowledged, but it was considered this would be offset by bedded rehabilitation being closer to home.
• It was noted that investment had been made to commission additional services from West Midlands Ambulance Service (WMAS). Members questioned how well WMAS had been engaged in these proposals and they had been involved extensively and would be present at the public consultation events. The additional funding was to ensure WMAS could achieve the required response times.
• Where patients were in hospital with another condition and then suffered a stroke, it was questioned how they would be treated and whether they would be relocated to the HASU. If a patient suffered a stroke whilst in hospital, their treatment would be prioritised on the basis of the dominant condition. There would still be stroke physicians at both Warwick and George Eliot Hospitals, as these would be bedded rehabilitation sites.

• An assurance was sought that ambulance response times and access to the UHCW site could be achieved. Access for WMAS via School Lane was referenced particularly. Adrian Stokes would ask WMAS to provide a formal response to give this assurance to members. He added that there was a streamlined approach at UHCW so when the patient arrived, they were transferred to the HASU as soon as possible. Some patients were already being transferred to UHCW within four hours for treatment. Access to the site was much better following the introduction of revised parking arrangements.
• The rotation of specialist staff across the sites was discussed. The recruitment and retention challenges were acknowledged especially for acute stroke consultants. The model proposed was an exemplar and it was hoped this would be attractive to staff. Good training and rotation across sites were proposed as part of the vision and this should assist with staff retention.
• If the proposals were approved, there would be implementation of the community services first, to ensure that the modelling, bed numbers and patient flow were correct, before the acute centralisation took place.
• The decision on acute centralisation would be subject to further consultation as part of a staged and monitored process. This clarity was welcomed to avoid any rumours developing that services were being reduced.
• With regard to the report's recommendations, it was not yet possible for the joint committee to provide its formal response. There were some minor aspects to resolve and members would need to see the consultation feedback before submitting their views. It was confirmed that each council's health scrutiny body would review the proposals in detail, before reaching a conclusion at a further JHOSC meeting.
• The WMAS transfer times were a crucial aspect and there were differences between the city of Coventry and a predominantly rural county like Warwickshire, it being questioned if the timescales could be achieved. A meeting with WMAS was required. It was confirmed that WMAS would be involved in the consultation meetings.
• The location and timing of the consultation meetings was raised and these needed to be easily accessible so people could contribute to the review.

Resolved
That the Joint Health OSC:

1. Notes the pre-consultation business case and consultation documentation.

2. Provides its formal response to the consultation following the further discussion of the issues raised above.

5. Coventry and Warwickshire Partnership Trust - Inpatient Bed Review

A report and brief presentation was provided by Dr Rob Holmes with contributions from Dr Sharon Binyon and Jed Francique. This briefed the JHOSC on the programme of inpatient service development and reconfiguration to develop a high performing mental health acute and urgent care pathway in Coventry and Warwickshire. The programme was one of the workstreams of the Mental Health programme of the Coventry and Warwickshire Health and Care Partnership (HCP). A number of key principles had informed the programme and these were detailed in the report.

A range of projects had been initiated to enhance community-based urgent care to offer triage, assessment and treatment of patients with mental health issues in a responsive and timely

manner. CWPT was continuing to review and develop its plans to provide a clearer and more focused set of services across the mental health inpatient sites, being the Caludon Centre in Coventry, St Michael's Hospital in Warwick and the Manor site in Nuneaton. These plans were clinically driven to support the appropriate specialisation and effectiveness of services. It would reduce the need to send some patients out of area to receive their treatment.It was recognised that meaningful stakeholder engagement was essential for the development and finalisation of the plans.

Questions and comments were submitted, with responses provided as indicated:
• The focus on mental health services was welcomed. There were some gaps in provision in the north of the Warwickshire and it was hoped this review would address them. • Parallels were drawn to the previous item on the review of stroke services, again proposing the centralisation of acute services in Coventry with community services in other locations. There was a need for meaningful consultation with the provider taking on board the feedback received. Furthermore, the community services needed to be established before the acute service changes were implemented.
• Reference was made to the 'Housing First' initiative in Coventry that sought to assist homeless people. A member asked if there were good links to other 'wraparound' support services. CWPT had embedded two specialist nurses in the P3 project in Warwickshire. Meetings were planned with Coventry City Council to explore how those organisations could work together more cohesively. There was a broader aspect in terms of developing housing solutions. Some progress had been made, but more could be done. There were models of support elsewhere in the country where local authorities and mental health service providers were working together on housing projects.
• It was noted that CWPT wanted to work collaboratively, but at the same time it was configuring its services around specific sites. Given the earlier references to place based working and PCNs, it was questioned how this review would align.
• Dr Holmes spoke about the work with PCNs, which were at different stages across the county. Dr Binyon explained how the five year plan referenced mental health services through its work streams and the additional monies allocated to acute liaison and crisis services. There were plans in place to utilise this and anticipated future funding for primary care services. A comparison was drawn to the stroke review and the rationale for short term specialist inpatient care and then more community-based treatment afterwards.

Resolved
That the Joint Health OSC notes the briefing.

6. Merger of the Clinical Commissioning Groups

A report was introduced by Gillian Entwistle, Chief Officer, South Warwickshire CCG, who also provided a brief presentation to the Joint Committee. She clarified that the CCGs were considering options at this stage and hadn't decided to merge. The local health commissioners were considering how best to support the move to an Integrated Care System (ICS) and how organisations would need to change. An outline was given of the process to date and the current position of the three CCGs. Whilst members in South Warwickshire supported a merger, the governing bodies of the other two CCGs had requested further assurances before reconsidering this matter in November 2019. Continuing engagement would take place with stakeholders. Should there be a consensus for full merger, the detailed application would be developed for consideration

by NHS England with a view to the merger being effective from 1 April 2021. There was a financial requirement for CCGs to reduce internal running costs by 20% in the next year.

Questions and comments were submitted, with responses provided as indicated:

• There were merits in having a single CCG, but may be concerns that localised issues were masked because the reporting was at a broader level. The data needed to be shown at local levels to highlight specific concerns. The same points had been made by local GPs. Local data would still be reported and there would be four places rather than the current three CCG areas. Additionally, data could be compiled at the PCN level.

• Concerns had been raised at the last County Council health scrutiny committee on some aspects of CCG performance, resulting in a further meeting with CCGs to explore this. CCG representatives apologised for their lack of attendance at the recent meeting.

• Reference was made to the anticipated housing growth across Warwickshire from local plan data. It was questioned if services were expanding at the required rate and confirmed that population growth data had been modelled into the five-year plan. The Chair closed the discussion noting that the further meeting with the CCGs had been arranged. The CCGs would be asked to give a further update as their proposals for review were finalised.

Resolved

That the Joint Health OSC notes the briefing.