Adult Social Care & Health Overview & Scrutiny Committee

Date: Wednesday, 30 September 2020
Time: 10.00 am
Venue: Microsoft Teams

Membership
Councillor Wallace Redford (Chair)
Councillor Margaret Bell (Vice-Chair)
Councillor Helen Adkins
Councillor Jo Barker
Councillor Sally Bragg
Councillor Mike Brain
Councillor John Cooke
Councillor Andy Jenns
Councillor Christopher Kettle
Councillor Keith Kondakor
Councillor Judy MacDonald
Councillor Pamela Redford
Councillor Jerry Roodhouse
Councillor Kate Rolfe
Councillor Tracy Sheppard

Items on the agenda: -

1. General

(1) Apologies

(2) Disclosures of Pecuniary and Non-Pecuniary Interests

Members are required to register their disclosable pecuniary interests within 28 days of their election of appointment to the Council. A member attending a meeting where a matter arises in which s/he has a disclosable pecuniary interest must (unless s/he has a dispensation):

- Declare the interest if s/he has not already registered it
- Not participate in any discussion or vote
- Must leave the meeting room until the matter has been dealt with

- Give written notice of any unregistered interest to the Monitoring Officer within 28 days of the meeting Non-pecuniary interests must still be declared in accordance with the Code of Conduct. These should be declared at the commencement of the meeting.

(3) Chair's Announcements

(4) Minutes of previous meetings 5 - 30

To receive the minutes of the committee meetings held on 24th June & 23rd July and of the special meetings held on 30th July & 19th August 2020.

2. Public Speaking

3. Questions to Portfolio Holders

Up to 30 minutes of the meeting is available for members of the Committee to put questions to the Portfolio Holder: Councillor Les Caborn (Adult Social Care and Health) on any matters relevant to the remit of this Committee.

4. Progress in Restoration and Recovery of Services in Warwickshire 31 - 46

A clinical commissioning group update on the restoration of services and proposals for developing a case for change regarding the potential relocation of neuro-rehabilitation beds.

5. Covid-19 Position and Recovery

A presentation to outline the Covid-19 recovery work and a briefing from the Director of Public Health on the position on Covid-19 in Warwickshire.

6. One Organisational Plan Quarterly Performance Progress Reports 47 - 60

The One Organisational Plan reports will be submitted for the end of year 2019/20 and at quarter one of 2020/21.

7. Work Programme 61 - 70

To review the Committee's work programme for 2020/21.

Monica Fogarty
Chief Executive
Warwickshire County Council
Shire Hall, Warwick

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Disclaimers

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Disclosures of Pecuniary and Non-Pecuniary Interests

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The public reports referred to are available on the Warwickshire Web
https://democracy.warwickshire.gov.uk/uuCoverPage.aspx?bcr=1

Public Speaking

Any member of the public who is resident or working in Warwickshire, or who is in receipt of services from the Council, may speak at the meeting for up to three minutes on any matter within the remit of the Committee. This can be in the form of a statement or a question. If you wish to speak please notify Democratic Services in writing at least two working days before the meeting. You should give your name and address and the subject upon which you wish to speak. Full details of the public speaking scheme are set out in the Council's Standing Orders.

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Adult Social Care & Health Overview & Scrutiny Committee

Wednesday, 24 June 2020

Minutes

Attendance

Committee Members
Councillor Wallace Redford (Chair)
Councillor Clare Golby (Vice-Chair)
Councillor Helen Adkins
Councillor Jo Barker
Councillor Margaret Bell
Councillor Sally Bragg
Councillor Mike Brain
Councillor John Cooke
Councillor John Holland
Councillor Andy Jenns
Councillor Pamela Redford
Councillor Jerry Roodhouse
Councillor Andy Sargeant

Other Members
Councillors Les Caborn (Portfolio Holder), Mark Cargill, Keith Kondakor, Kate Rolfe, Izzi Seccombe OBE and Pam Williams.

Officers
Shade Agboola, Jane Gillon, Jak Lynch, Nigel Minns, Isabelle Moorhouse, Louise Richardson, Sushma Soni, Paul Spencer and Gereint Stoneman.

Partner Organisations
Chris Bain (Healthwatch Warwickshire)
Councillor Clifford and Vicky Castree (Coventry City Council)
Gill Entwistle (South Warwickshire CCG)
Rose Uwins (Warwickshire North and Coventry & Rugby CCGs)

Members of the public
Dr. Sharon Hancock
Councillor Jacky Chambers
Professor Nick Spencer
Professor Anna Pollert
Mr Martin Drew

1. General

(1) Apologies

None.

(2) Disclosures of Pecuniary and Non-Pecuniary Interests

None.

(3) Chair's Announcements

The Chair advised that an additional meeting of the committee had been scheduled for Thursday 30th July 2020 commencing at 10.00am. This would consider proposals from the clinical commissioning groups (CCGs) for the recommencement of services post-covid and to receive an update on the CCG merger proposals.

The Chair reported on the proposal to expand the terms of reference of the Horton Health OSC. It had agreed to amend its scope to be able to scrutinise a masterplan for the Horton Hospital. In order to do this, it may require all three councils to agree the revised scope within their health scrutiny powers.

(4) Minutes of previous meetings

The minutes of the committee meeting held on 19 February 2020 were approved as a true record.

2. Public Speaking

Seven public questions were submitted. The questions are attached at Appendix A to these minutes and summaries of each item and responses are provided below.

Question from Dr. Sharon Hancock

Dr Sharon Hancock had submitted a question on test, trace and Isolate and the support contacts were being offered in the Coventry, Solihull and Warwickshire (CSW) beacon area.

Dr Shade Agboola, Director of Public Health (DPH) provided a verbal response. Strong links had been established with the voluntary and community sector and she spoke about the support being provided to those who needed to isolate, which would continue to be built upon. This included practical support e.g. with shopping. There were plans for an engagement session with neighbourhood level groups and making best use of community development workers was also touched on. Further details would be provided later in the meeting on the outbreak control plan. Specific work was being undertaken with homeless people and victims of domestic abuse.

Question from Councillor Jacky Chambers

The DPH was asked to report on progress made so far in making test data from the national test and trace system (pillar two) available to local public health teams; how quickly test results were being returned, and whether or not this information had been used to identify and investigate recent outbreaks in the county.

Shade Agboola responded that significant progress had been made. There was direct access to the pillar two data at both the county and district/borough level. She spoke about test turnaround times which were between one to three days for pillar two tests. The data on incidents/ outbreaks was provided in a variety of ways, including through Public Health England (PHE), the national test and trace service (NT&T) and in relation to an outbreak amongst police officers, from the police themselves. It was expected that the NT&T service would report more data as it gained momentum. Reference was also made to the good working relationships with schools, which ensured that early notification was received, often before the NT&T service reported cases.

Question from Professor Nick Spencer

Professor Spencer spoke of plans amongst retired GPs, public health and community doctors and nurses, to establish a locally based contact tracing initiative, sensitive to and embedded within local communities. He asked if the DPH would meet with them to discuss how their expertise could be deployed to contribute.

Dr Agboola confirmed she was happy to meet with Professor Spencer and colleagues. She described the local role in the test and trace programme, managing complex cases and compared this to the role of the NT&T service in dealing with non-complex contact tracing. Local authorities had a brief from national government which included the development of outbreak control plans. To date existing resources had been utilised to respond to outbreaks, working in conjunction with PHE. The additional government funding may need to be used to provide increased capacity, especially with the easing of lockdown measures. Dr Agboola spoke of the local Health Protection Board, which was meeting weekly and confirmed the composition of this board.

Questions from Professor Anna Pollert

Professor Pollert submitted a question about CCG deficits, but acknowledged that this could be deferred, as it was not Covid related. She asked if the Committee would investigate how the CCGs would deal with these deficits.

Professor Pollert asked a second question which concerned Covid19 and the government system for control of it. She asked the DPH, supported by the committee to do all in their power to work with local health professionals and volunteers to reach, test, trace and isolate local residents with a Covid19 infection. She reiterated the points from Professor Spencer, acknowledging that the DPH had agreed to a meeting with individuals seeking to establish a locally based contact tracing initiative.

Dr Agboola confirmed she was happy to explore working with local health professionals and volunteers, also the local responsibilities for responding to complex cases and producing the Outbreak Control Plan. There had not to date been a requirement for large scale contact tracing. This could change as lockdown measures eased.

Question from Dr Gordon Avery

Dr Avery had submitted a question asking whether there was a way people could help to make a full local contribution to the management of the test, trace and isolate scheme in Warwickshire.

Dr Agboola acknowledged that this was similar to previous questions and reiterated the points made including the willingness to meet with local health professionals and volunteers.

Question from Mr Martin Drew

Mr Drew asked if the DPH and the committee would investigate how GPs could be brought into the Covid19 response making comparison to notifiable diseases. He also asked if Warwickshire GPs were receiving Covid19 antigen test results and if not, what the DPH could do about this.

Dr Agboola responded that the involvement of local GPs would be investigated. One suggestion made was use of local GPs to increase local testing capacity. An options appraisal for testing was currently in production. It was not yet clear if Warwickshire GPs were receiving Covid19 antigen test results. However, it was understood that this was planned. She made an offer to discuss how best GPs could be involved whilst recognising the increasing demands on primary care.

The Chair noted that a further question had been received without adequate notice being provided. This had been forwarded to officers for consideration. He thanked the public participants for their questions.

3. WCC Covid Recovery Approach

A report was introduced by Nigel Minns, Strategic Director for People Directorate, to provide an overview of the Council's approach to recovery from the Covid-19 pandemic. A key aspect was the development of a recovery plan which would be submitted to Cabinet for approval in September. This Committee's comments were sought on the approach to the development of the recovery plan.

Following its approval there would be an ongoing scrutiny role, particularly over the longer-term delivery phase. This would feature in the planned review of the scrutiny function.

The key elements of the recovery approach were summarised within the report and provided in more detail in the appended report approved by the Cabinet on 11 June. This set out the three phases to recovery. The Council was now in the foundation stage and an outline was given of the key focuses and the output for the recovery plan being presented to Cabinet in September.

The report included a section on the focus of the response and plans for recovery. The Council had worked flexibly and adapted in many ways to ensure that key services were delivered, and people were supported to cope with the effects of Covid19. Examples were provided of the responsiveness and actions taken by Public Health, Adult Social Care and People Strategy and Commissioning for services within the remit of this Committee.

As the Council moved into the delivery phase of its recovery plan, there would be a role for this committee to consider aspects of recovery relevant to its remit, particularly health and social care

and aspects of community recovery. It was proposed that further reports be brought to the Committee for its consideration.

Nigel Minns focussed on key sections of the report, giving examples of the work undertaken over the last three months. He referred to the isolation arrangements for Covid patients leaving hospital before retuning to a care home setting. He referred members to the appended Cabinet report and the recovery principles set out within it. There were close working arrangements with health colleagues and the voluntary sector on the recovery actions.

The following questions and comments were received with responses provided as indicated:

- In response to a question from the Chair, Nigel Minns gave an outline of how the County Council had assisted care home providers especially with the provision of personal protective equipment (PPE). Reference was made to a webpage containing further information. This link would be provided after the meeting and can be viewed here. A workforce recruitment plan had also been established, leading to over 100 additional staff being employed. Finally, he spoke about the financial offer to care providers to meet all additional costs associated with the pandemic. The government infection control fund was passported to care providers within a week of receipt. This had already exceeded £4.1m and was continuing to increase. A further update on distribution of funding, including the second tranche of £2.7m of government funding would be provided shortly. The Chair considered a good response had been provided by the County Council to care homes and by its officers generally. This sentiment was echoed by several members during the debate.
- Data was sought on the number of Covid positive patients going from George Eliot Hospital into intermediate care and whether any had needed to go back into hospital. The data would shared after the meeting. No patients had needed to return to hospital.
- The sustainability of the measures implemented was raised, especially the support for homeless people and provision of transitional care. On hospital discharge, the work undertaken over the last two years had helped. Good joint working arrangements had been established, with relationships improving still further during the pandemic. There was joint work on planning the recovery processes. It was hoped that the guidance in place currently would remain similar after the pandemic. There had been terrific support for homeless people across all areas and good joint working between agencies. There was a wish to sustain this if possible and announcements were awaited from central government on funding and arrangements. It was agreed that a letter be sent from the committee to offer support for the continuation of the current measures implemented.
- More information was provided on the priorities for reinstatement of services. This included commissioned services, respite, support for people with disabilities and domestic abuse services. Many services such as sexual health services had continued to operate virtually, but reinstating face to face services was a priority.
- Some issues were beyond the County Council's direct remit. Examples were the decisions on reopening of pubs, restaurants and schools. There was a need to work with other local authorities and the private sector. Officers assured there were good joint working arrangements for example on recovery, town centre planning and members were referred to a section of the Cabinet report which detailed this joint work. It was questioned how local councillors could contribute and the impacts for the business sector were also referenced. Key messages from the pandemic remained in terms of enhanced hygiene and social distancing. This was key to preventing a second wave of the pandemic. An outline was given of key messages within the Outbreak Control Plan.

- It was agreed that reducing health inequalities was a key aspect and this would be the chosen topic for the annual DPH report, anchored by the experience from covid. The pandemic had emphasised the health divide between the north and south of the county. The Outbreak Control Plan would also come into the public domain from the end of June.
- Covid cases in residential care homes was raised with recognition of the way the County Council had responded to a 'spike' in cases.
- The committee's work programme included an item on the long-term sustainability of the care home market. It was hoped this would be included in the cabinet working groups as a recovery aspect.
- Similarly, the mental health difficulties for some people in coping with the lockdown, respite arrangements, telephone support services and the potential for social prescribing were mentioned as further areas for consideration.
- The points raised on respite and care home sustainability were recognised as key priorities. There may remain public nervousness on being admitted to a care environment and currently there were high vacancy rates. There was national work through the government and ADASS on sustainability of the care home market.
- Healthwatch Warwickshire had undertaken a project on access to primary care services for homeless people. It was hoped that the current flexibility and relaxation would be continued after the pandemic, so homeless people continued to have easier access to services. The committee was asked to monitor this, which the Chair agreed to do. Gill Entwistle of South Warwickshire CCG agreed with the points raised and offered to pursue this with Healthwatch after the meeting.

Resolved

That the Committee:

1. Receives and notes the County Council's approach to Covid19 Recovery, as set out in the report and appendix.

2. Comments as set out above on the specific issues relevant to the remit of this Committee that should be considered in the development of the Recovery Plan to be submitted to Cabinet in September.

4. **Test, Trace, Isolate**

Shade Agboola, Director of Public Health gave a presentation to the Committee, which had also been provided to the Covid19 member engagement board held the previous week. This outlined the Outbreak Control Plan, its aim, the eight key priorities and respective roles of national and local government especially in regard to contact tracing. The presentation included Covid19 case number estimates, the sub-regional response arrangements and the governance structure for Warwickshire. Detail was then provided on each of the eight priority areas:

- Community engagement to build trust and participation
- Preventing Infection
- High risk settings and communities
- Vulnerable People
- Testing Capacity

- Contract Tracing
- Data: dynamic surveillance and integration
- Deployment of capabilities including enforcement

The presentation concluded with resource requirements and priorities. The following questions and statements were submitted, with answers provided as indicated:

- People who were infectious but not symptomatic. Currently only people with symptoms could request to be tested. Work was ongoing with Public Health England (PHE) to see how this could be addressed, so those who potentially could be contagious were tested.
- It was planned to provide pillar two test data to elected members along with the pillar one information. Sharing this data periodically with the public would help to ensure appropriate behaviours. It was asked if this data could be disaggregated for each district/borough area. Officers confirmed that the numbers of cases were small.
- The number of cases at the George Eliot Hospital (GEH) seemed disproportionately high. It was questioned if these were community acquired cases or could have been transmitted at the hospital. The number of cases at GEH was reducing. Research had shown a mixed picture with some cases being transmitted in hospital. A postcode breakdown was awaited on the location of residents who had acquired covid in the community.
- A comparison was sought on the proportion of cases acquired at GEH to those in other hospitals. Frequent and detailed information was provided, which confirmed that the rate at GEH was higher. A video had been posted on the County Council's website to show the measures implemented to control infection at GEH.
- In response to a related question about the four wards involved at GEH, the DPH stressed that people should not be discouraged from going into hospital.
- Decisions about local lockdowns and how they would be triggered. It would be crucial to give the correct messages to the public and elected members, as community leaders would be able to provide information in their locality. It was expected that lockdowns would be required, but the size of the lockdown area was presently unknown. The DPH advised that this was currently not under the control of the local authority.
- It was questioned if plans were being put in place in anticipation of such powers being granted. Lockdown action plans would be developed for each part of the beacon area.
- Arrangements for the rollout of antibody testing were questioned. It was available to NHS and some social care staff. However, this was not the solution as it did not give a clear guide to how long the immunity would last for or if it would be effective if the virus mutated. It did help with managing workforce pressures though. It was important that people did not become complacent. Monitoring of staff who had returned to work after receiving a positive antibody test for further symptoms was a further point raised.
- It was questioned why the nightingale hospitals had not been used to provide capacity at existing acute trusts and to isolate covid patients. The DPH agreed to take this point away and report back.

The Chair thanked Dr Shade Agboola for the extensive work being undertaken and for the information provided to members at the meeting.

Resolved

That the Committee notes the report.

5. Questions to the Portfolio Holder

Councillor Les Caborn advised that he had written to the George Eliot Hospital Trust to support the Director of Public Health and ensure that everything possible was being done.

A question was submitted regarding covid deaths, the higher proportion of people affected from BAME communities and the links to social and health inequalities too. It was questioned if this could be added to the work programme. Councillor Caborn referred to the new Health, Wellbeing and Social Care Covid Recovery Group. Such items could be included within its remit. There was an aim to embed all the learning from the pandemic in designing future services. The Chair suggested that this could be added to the Committee's work programme too.

6. Work Programme

The Committee reviewed its work programme.

The Chair suggested that an update be sought from UHCW on actions outstanding from its previous Care Quality Commission inspection. He proposed that more use be made of briefing notes to keep the committee updated and acknowledged the suggestion under the previous item regarding covid deaths and the higher proportion of people affected from some communities.

Changes were being made to healthcare in response to the covid pandemic. In terms of future funding for health services, reference was made to developer contributions and it was suggested an item on where these monies would be allocated would be useful for the committee. The Chair suggested a briefing note for all members in the first instance.

The Warwickshire North Place Board had received a presentation on smoking in pregnancy. The data for the north of the county showed that one in five expectant mothers smoked. A briefing with data and the actions being taken would be useful.

Chris Bain of HWW spoke about the expected legacies of the pandemic. Examples included increased waiting lists and the mental health impacts for people either anxious to return to work, or spending lockdown whilst suffering from a mental health condition. The Chair commented that use of more briefing notes would provide additional capacity to keep the committee informed.

Resolved

That the Committee updates its work programme as outlined above.

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Chair

The meeting closed at 11.55am

Appendix A

Question from Dr. Sharon Hancock

In order for 'Test, Trace and Isolate' to succeed in preventing a second wave of the Covid 19 pandemic, it is essential to have a high degree of compliance by contacts. 14 days self-isolation is a challenge particularly for those on low incomes or with caring responsibilities. What support are contacts being offered by the Coventry, Solihull and Warwickshire Beacon?

Question from Councillor Jacky Chambers, North Warwickshire Borough Council

Statement: More than half the Tests for Covid 19 are now carried out through the National Test system of drive-in centres, mobile units, or postal home testing kits (described as 'Pillar 2' tests).
One of the priority actions described in the Sub regional briefing paper circulated to members was to ensure that the results of these tests were returned quickly and in a form which could be used by local public health teams to respond rapidly to local needs and outbreaks.
Recent media coverage (June 17th) of the sharp rise in the number of patients admitted to the George Eliot Hospital for Covid 19 gave the impression that calls to 111 are the main source of community based information about population transmission – rather than the number of Covid +ve cases reported in the national system.

Question. Now that Warwickshire County Council has been selected as a BEACON authority to work with the national leaders on Outbreak Control Plans, could the Director of Public Health report what progress has been made so far in making test data from the national Test and Trace system (Pillar 2) available to local public health teams; how quickly test results are returned, and whether or not this information has been used to identify and investigate recent outbreaks in the county.

Question from Professor Nick Spencer

Statement:

Primary care and public health professionals in Sheffield and Calderdale (see https://www.communitycontacttracers.com/projects/) have established local community-based contact tracing initiatives which have contributed positively to contact tracing sensitive to, and embedded in, local communities. By contrast, in the CSW Beacon Test & Trace Plan, which interestingly appears to have omitted 'isolate' from its title, tracing of contacts of individuals in the community is being carried out by cold callers recruited by the outsourcing company, Serco, with no involvement of primary care or community-based tracers. Contact tracing and follow up to ensure isolation are skilled and sensitive processes and the use of remote callers with no local knowledge and no clear plan for follow up is destined to fail.

Question:

As a group of retired GPs, public health and community doctors and nurses, we are proposing to establish a locally-based community contact tracing initiative working with primary care practices and local volunteers. Will the DPH consider meeting with us to discuss how our expertise can be deployed to contribute to a locally-based sensitive and embedded initiative?

Questions from Professor Anna Pollert

CCG Deficits.

Statement: SWCCG has a £26 m deficit
Coventry and Rugby and North Warwickshire CCG has a £17.9 m deficit.

Question: Will WCC ASCHOSC investigate how the CCGs will deal with these deficits?

Covid 19.

Statement
I want to indicate to councillors that the government is failing to control Covid 19 in that its testing and tracing system fails to find the majority of Covid 19 cases.

The **Office of National Statistics** **estimated that, at any given time between 31 May and 13 June 2020, the number of people with COVID-19 in the community in England was 33,000. 'Community'** in this instance refers to private households, and it excludes those in hospitals, care homes or other institutional settings.

But the official figure for the UK government test and trace scheme for England between June 4th and 10th was only 5,949 people who tested positive for coronavirus . See Guardian June 18th.

Although this is not for exactly the same time period as for the ONS (one week, not two weeks), this is a tiny fraction of the estimate by the ONS. This disparity means that the majority of people with COVID-19 are simply not being reached by the UK government test and trace system.

And of this 5,949 of diagnosed cases, the New Scientist and other media report that less than three quarters were contacted by the NHS Test and Trace (SERCO run) contact tracers (New Scientist: Latest coronavirus news as of 5 pm on 18 June).
The UK government's contact tracing scheme for England only reached 73 per cent of people diagnosed with coronavirus between 4 and 10 June, government figures revealed today. **This falls short of the 80 per cent target recommended by the government's Scientific Advisory Group for Emergencies (SAGE) for the second week in a row.**

In addition, not everyone contacted by NHS Test and Trace was reached quickly enough. Only 75 per cent of people who were contacted were reached within the government's target of 24 hours. 8.6 per cent of people were only contacted after 72 hours, when the chance that an infected person has already spread the virus is high.

Question Will the DPH, supported by WCC ASCHOSC, recognise the failures of the government system and do all in its power to work with local health professionals and volunteers to reach, test, trace and isolate local residents for COVID 19 infection?

Question from Dr Gordon Avery

I, along with many other public health professionals recognise that the Government has created many problems for the NHS by centralising management and privatising services. In the case of the Covid-19 pandemic we also recognise that they have broken international rules set by the World Health Organisation for the control of Communicable Diseases. The management of such diseases should be carried out by skilled, well trained locally based teams and led by a Regional or Local Director of Public Health. The Coventry, Warwickshire, Solihull Beacon system, while appearing to be a local one, is, from its description to councillors, dependent on the centralised Deloite testing station which people must drive to and which, as far as we know, still does not provide test results to GPs and Public Health. It is not based on accessible, walk-in test centres, as it should be, and is the case in other countries where the virus is successfully suppressed.

We are very concerned that the delays and mistakes made by the Government in getting this programme up and running is a real threat to the people of Warwickshire and Coventry. We are even more concerned about the possibility of a second wave of of the Covid-19 pandemic if concerted action is not taken very soon as 'Lockdown' is eased.
We wonder whether there is any way we can help to make a full local contribution to the management of the Test, Trace and Isolate scheme in Warwickshire especially as the Government has just abandoned the long awaited tracing App.

Question from Mr Martin Drew

Subject: Reinstate role of the GPs in tackling the Covid 19 pandemic

Statement.
There is an established, statutory, locally based **public health** system for tackling notifiable diseases. GPs are pivotal in this process. Patients' trust and their GP's knowledge of health history are very important in diagnosis. GPs are also experienced in cooperating with local Public Health and other local agencies.

A patient with symptoms contacts their GP. If a **notifiable disease** is suspected, GP tests, sends it to their local Public Health Lab, advises patient to isolate and GP notifies Public Health. Test results are returned within 24 hours. If confirmed Public Health organIses tracers to track patient contacts. This tried, tested and trusted system involves close cooperation and local knowledge. It has been successfully used widely in Europe.

However, **in the case of Covid 19**, the Government sidelined this legal process with a centralised, fragmented un-evaluated system. GPs are bypassed because NHS 111 **and the testing centres** did not notify GPs of suspected cases. GPs weren't allowed to test, so confirmed cases were not recorded. Furthermore many results from independent testing companies and lighthouse laboratories went missing and many swab tests were false negative due to poor tester training. Until recently no testing was done in the community, all tests were confined to hospitals. This is probably a major contributory factor for the huge number of excess deaths and the catastrophic toll in care homes.

Reliable local testing together with effective use of tracing data are key. The advent of autumn and winter months will be a critical time if there is a second Covid wave together with the usual increase in flu cases. Expert diagnosis by GPs and swab samples taken **by** trained nurses is vitally

important to ensure higher quality results compared with those produced by the likes of Deloitte or home test kits.

GPs play no role in the Coventry, Solihull and Warwickshire local pilot Beacon programme for test and trace. **They should be brought in.** GPs and Local Public Health need to take back control and should be funded accordingly. There are willing retired health professional and many of the 7000 Warwick/Leamington Mutual Aid volunteers should be deployed for **community** contact tracing.

Question: Will the local Director of Public Health and ASCHOSC investigate how GPs can be brought into the Covid 19 response - as they should have been in the first place?

Adult Social Care & Health Overview & Scrutiny Committee

Thursday, 23 July 2020

Minutes

Attendance

Committee Members
Councillor Helen Adkins
Councillor Jo Barker
Councillor Margaret Bell
Councillor Mike Brain
Councillor John Cooke
Councillor Andy Jenns
Councillor Keith Kondakor
Councillor Wallace Redford
Councillor Kate Rolfe
Councillor Jerry Roodhouse

1. General

(1) Apologies

None.

(2) Disclosures of Pecuniary and Non-Pecuniary Interests

None.

2. Election of Chair

Councillor Margaret Bell proposed that Councillor Wallace Redford be Chair of the Committee and was seconded by Councillor Jo Barker.

There were no other nominations.

Resolved

That Councillor Wallace Redford be elected Chair of the Adult Social Care and Health Overview and Scrutiny Committee.

3. Election of Vice Chair

Councillor Helen Adkins proposed that Councillor Margaret Bell be Vice Chair of the Committee and was seconded by Councillor Andy Jenns.

There were no other nominations.

Resolved

That Councillor Margaret Bell be elected Vice Chair of the Adult Social Care and Health Overview and Scrutiny Committee.

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Chair

Adult Social Care & Health Overview & Scrutiny Committee

Thursday, 30 July 2020

Minutes

Attendance

Committee Members
Councillor Wallace Redford (Chair)
Councillor Margaret Bell (Vice-Chair)
Councillor Helen Adkins
Councillor Jo Barker
Councillor John Beaumont
Councillor Sally Bragg
Councillor Mike Brain
Councillor Andy Jenns
Councillor Keith Kondakor
Concillor Judy MacDonald
Councillor Pamela Redford
Councillor Kate Rolfe
Councillor Jerry Roodhouse

Other Members
Councillors Les Caborn (Portfolio Holder).
Councillor John Holland

Officers
Shade Agboola, Jane Gillon, Carl Hipkiss, Isabelle Moorhouse, Deb Moseley, Paul Spencer and Pete Sidgwick.

Partner Organisations
Chris Bain (Healthwatch Warwickshire)
Councillor Joe Clifford (Coventry City Council)
Gill Entwistle and Anna Hargrave (South Warwickshire Clinical Commissioning Group (CCG))
Sarah Raistrick and Laura Fratczak (Coventry & Rugby CCG)
Adrian Stokes and Rose Uwins (Warwickshire North and Coventry & Rugby CCGs),

1. General

(1) Apologies

Councillor John Cooke, Councillor Tracy Sheppard replaced by Councillor John Beaumont (Nuneaton and Bedworth Borough Council). Vicky Castree (Coventry City Council), Becky Hale (Assistant Director) and Nigel Minns (Strategic Director).

(2) Disclosures of Pecuniary and Non-Pecuniary Interests

Councillor Keith Kondakor declared a non-pecuniary interest as he was in discussions with a clinical commissioning group (CCG) regarding the provision of a new doctor's surgery in Weddington.

(3) Chair's Announcements

The Chair welcomed new members to the Committee and thanked retiring members for their service. He confirmed that Councillor Margaret Bell had been appointed as the Committee's Vice-Chair, also paying tribute to Councillor Clare Golby for her support as Vice-Chair.

The Chair provided an update on two actions raised at the previous meeting. The first concerned the council's Covid-19 response and the 28 patients discharged to stepdown care at the Myton Hospice and Ellen Badger hospital. A response on test, trace, isolate was also provided, which concerned the lack of use of the nightingale hospitals to provide capacity at existing acute trusts and to isolate Covid-19 patients. A councillor commented that this matter was about infection control and the isolation of Covid-19 patients in the nightingale hospitals. The Chair offered to refer this matter again for a further response.

The Chair added that there would be a standing item on the committee's agenda on Covid-19 going forwards.

2. Public Speaking

None.

3. COVID-19 Service Changes

Adrian Stokes spoke to a circulated report and presentation. COVID-19 had created an unprecedented situation, which the Coventry and Warwickshire health and care system had responded to with significant pace.

The response to COVID-19 was being managed in four phases:

- Phase 1 – Service change (immediate response to COVID-19)
- Phase 2 – Restoration (6 weeks from May to July)
- Phase 3 – Recovery (to March 2021)
- Phase 4 – Reset (2021/22)

The covering report explained the role of the Reset Co-ordination Group (RCG) to oversee the Restoration, Recovery and Reset Programme. It listed the correspondence and guidance from NHS England and Improvement (NHSEI), which had been adopted, alongside the local decisions taken, with fast-track transformation initiatives, resilience measures and the need to suspend some services, whilst delivering other services virtually.

Looking to the future, maintaining the transformation would assist with meeting the short to medium term challenges of restoration and recovery, whilst providing for reset of the local health and care system to be more effective and sustainable.

The presentation included slides on:

- Context
  - Ongoing backdrop of Covid-19
  - Starting v stopping
  - Productivity paradox
  - Partnership working strengthened
  - Locking in innovation
- The Health and Care Partnership graphic
- A flowchart showing the phased approach to restoration, recovery and reset
- Phase two priorities
  - Essential services
  - Test, track & trace
  - Care homes
  - Mental health
- Takeaway messages
  - All phases happening simultaneously =
  - complexity
  - Level 4 response running into winter
  - Partnership working – “fleet of foot”
  - Communication is key

Anna Hargrave gave a precis of the circulated report, speaking about the service changes required, key learning points, the ability to respond quickly and the impact of these changes on communities. Currently, a period of evaluation of the quality and equality impacts of the required changes was taking place. This included drawing on the survey by Healthwatch Warwickshire (HWW) and through targeted work with specific groups. This would lead to the next phase of planning to look at service restoration, addressing inequalities, needs assessment and the establishment of a system-wide group to focus on addressing inequalities. It would include discussions with the NHS workforce and undertaking risk assessments for staff deemed at risk. There was a need to understand the impacts of Covid-19 and to lock in changes, whilst being mindful of both quality and equality.

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

- Ensuring that the revised provision included traditional face-to-face services, as well as making use of technology. Some patients value the relationship with their GP and/or would be less comfortable discussing certain conditions remotely. This reflected the feedback

commissioners had received and there was no target percentage for virtual appointments. This was about offering a choice and maintaining a balance.

- Noted that there had been 80,000 GP appointments online.
- Questions about the impact of the pandemic, in terms of waiting lists, demand and capacity. This was an area for further detailed research, with a suggestion to undertake such research via a small group of councillors.
- A point about developing stronger communities with healthier lifestyles, so people were more able to cope when subsequent viruses occurred. It was asked how the NHS would make use of the HWW survey in designing future services and ensuring the patient voice was included.
- Covid-19 had found any weak spots in infection control. Hospitals, especially George Eliot Hospital (GEH), had made improvements and transmission rates were now virtually at zero. It was important not to lose the learning from what had been put in place.
- A concern about demand and capacity, with reference to some hospital waits being over 52 weeks. It was questioned how this would be addressed.
- Covid-19 had highlighted health inequalities in some areas and amongst some sections of communities. It was suggested that a report be provided to a future meeting of the committee, to identify inequalities and the strategies proposed to address them.
- Reference to a presentation at Nuneaton and Bedworth BC from GEH. Covid-19 test results were being received within 2 hours which assisted with infection control. Having such turnaround times at all hospitals would be helpful, especially during the winter period.
- An update was sought on staff changes within the local health workforce.
- Mental health was a significant issue. Data was sought on the numbers of people requesting help and whether there were any backlogs in services.
- The impact of wider determinants of health such as poor diet and lack of exercise. There is a need to encourage healthy lifestyles to provide resilience.
- Context that there were only four patients with Covid-19 in the three Warwickshire hospitals. This had been the approximate number over the last 10 days. A concern at the slow pace of service recovery given the low number of Covid-19 patients in hospital. There were several reasons for this comprising lost capacity, due to the need to separate patients with Covid-19, infection prevention and control (IPC) slowing service delivery and emergency admissions were now operating at a higher than normal level. These all impacted on routine elected procedures.
- Praise for the comprehensive recovery and restoration plan. The points on addressing health inequalities were welcomed, it being suggested that when this item was revisited, it should cover both service provision and health outcomes.
- From the HWW survey, many people had said they received lots of information, but poor communication. There could be barriers to communication, examples being for deaf people, or those who were visually impaired. Information needed to be timely and accessible.
- Many respondents to the HWW survey listed mental health as the top priority. Examples were given of the types of issues people were experiencing. When determining future commissioning, there was a need to consider the legacy of mental health issues and the number of new cases presently unknown to the health sector.
- The Chair asked for HWW to share its survey findings. An offer was made to discuss the survey findings at a future committee meeting.
- Reference to winter pressures, the number of flu cases that were often seen and if this coincided with a spike in Covid-19 cases, it was questioned if there was staffing capacity both for the acute and nightingale hospitals.

- Adrian Stokes summarised that some of the questions above concerned performance data such as waiting lists and GP appointments. This was available at a granular level for each speciality and across each hospital site. The suggestion for a separate session to discuss this was useful. The current data showed many positives, examples being reductions in waiting times for diagnostics and the cancer pathway.
- Anna Hargrave responded to the points about inequality and mental health concerns. Commissioners did not want to prejudge what was needed and had met with HWW to discuss how best to engage, including with the voluntary and community sector (VCS). It could not be assumed that the previous service offer would deliver improvements, and this was an opportunity to reset, also to look at how to communicate and the role of the VCS was critical in supporting local communities.
- On IPC, there was concern that reverting to previous arrangements would result in future problems. It was questioned if there was scope for innovation to make IPC more efficient, to reduce lost capacity. Any advances in IPC should be kept under review.
- Several members emphasised the importance of IPC. A suggestion to have a further briefing note or session on IPC, to examine the lessons learned. There were links to stronger communities, in responding both to Covid and future viruses. A need for collaborative innovation and connection between the NHS, the different tiers of local government and the VCS. The VCS could provide infection control locally and investment was needed into communities to do the IPC on the ground, which in turn linked back to inequalities in communities.
- A question if changes would be made to the flu pathway, given the similar symptoms initially. This would be important, especially during the winter period and would present additional challenges when patients presented at hospital. Speedy diagnosis and effective streaming were key. Triage arrangements were also raised, including work with the 111 service on ‘talk before walk’ and planned messaging to encourage take up of the flu inoculation.
- Discussion about Covid-19 diagnosis and pathways for treatment when people arrived at the A&E department. It was suggested that people should be directed to the Nightingale hospitals instead and only be transferred to a regular hospital if they didn’t have Covid-19. A particular concern was patients who were not showing symptoms.
- The Nightingale hospitals had been procured nationally in response to the pandemic and operational protocols were needed. Further aspects discussed were staffing, the need for a system to be put in place, the potential for Covid type viruses to occur for many years to come and the need to ensure that other services were not impacted.
- There were member observations about living with Covid and similar pandemics, the findings that primary care services were now being used more reasonably, but similarly some people may be deterred from visiting NHS services. The elements on reset were referenced and there would be key learning for example on integrated care. There is a need to encourage people to be tested and to give the public confidence that hospitals are safe to use.

The Chair confirmed that he had noted the various issues raised and he thanked the speakers for the information provided.

Resolved

That the Committee notes the presentation.

4. The Future of Health Commissioning in Coventry and Warwickshire

A report was introduced by Sarah Raistrick to inform the Committee of the future of health commissioning in Coventry and Warwickshire, the proposed structural changes to the clinical commissioning function and the committee's support was sought to the application to create a single, merged Clinical Commissioning Group (CCG) in Coventry and Warwickshire.

Background was provided on the NHS long term plan, which outlined a new service model and as part of this, the formation of integrated care systems (ICS). The CCGs had considered how to support the move to an ICS and following a period of engagement, a case for change was developed, outlining the options available, which were reported.

It was noted that options which involved the strategic direction of the CCGs were reserved to the member organisations, who were asked to vote on their preferred option. Detail was provided on the process undertaken. The outcome of the vote was decisive in all three CCG areas, with members choosing the option of full merger. The next steps in this process were reported and CCGs were preparing to apply to NHS England and Improvement for authorisation to become a single merged organisation. If the application was successful, the three CCGs aimed to become a merged organisation by April 2021. Ongoing engagement with stakeholders and the population was an essential part of this process.

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

- It was questioned if the deadline for the merger was realistic. There was confidence that it could be achieved.
- How could a merged Coventry and Warwickshire CCG (C&WCCG) give more local support? Detail was needed to evidence this. The allocation of funding across the merged CCG also needed clarifying, as there were differing needs in each of the areas and a concern that funding might not be distributed equitably.
- Dr Raistrick referred to health needs and inequalities for Coventry and Warwickshire as a whole, desired outcomes using an example of improving diabetes targets and the differing interventions that would be needed across each 'place' to achieve the target.
- Adrian Stokes added that funding allocations would remain for each of the places they were earmarked for, for the next five years, subject to any financial changes imposed by the Treasury post-covid.
- This response gave reassurance, but conversely there was a need to address known inequalities and funding would be required to do this.
- A comment that average data for Warwickshire was generally good, but it hid issues in specific areas and there was a need to examine granular data for local areas. As a health and social care partnership local data was used, such as that from the joint strategic needs' assessments (JSNA) and primary care networks (PCNs). It was equally important to maintain good outcomes in areas doing well.
- Adrian Stokes reminded that CCGs needed to reduce their running costs by 20%. The merger proposals would remove duplication and some overheads, avoiding the need to cut staffing in more vital areas.
- Delays in making changes could have a financial implication. Examples were the lengthy processes for review of CCG estates and the stroke service reconfiguration.
- A member submitted questions on the number of lay members that would be appointed to the C&WCCG, spoke about people moving into Warwickshire but staying registered with

GP's in Coventry and wanted to see how the new organisation would be more efficient before he could offer support to the proposal.

- Sarah Raistrick stated the need to balance of good governance and decision making. Where reviews affected all the Coventry and Warwickshire area, such as the stroke service review, the decision needed to be considered at various levels by three CCGs currently. A single body would provide more streamlined decision making. The new CCG would be mindful of needs from a place-based approach in each of the local places. It was hoped to reduce both overheads and the speed of decision making, which was something the committee could hold the CCG to account on.
- Chris Bain advised that HWW would remain neutral on the merger proposal and was mindful that most patients were unaware of what a CCG is or does. HWW would monitor inequalities in service provision and outcomes. It wanted to ensure these were addressed and that the patient voice was included at every level of the structure.
- Sarah Raistrick spoke on lay membership. The new constitution was being prepared with an aim to increase lay membership above the statutory level. There were two strong lay members currently who championed addressing inequalities and ensuring the patient voice was heard. Links with Healthwatch, both in Warwickshire and Coventry were referenced and there was a wish to hear the patient voice at all levels.
- The proposal was for three voting lay members and four voting GP representatives on the new C&WCCG. Reference was made to the statutory requirements and the template constitution which could have been used. Specialist advice was being taken in preparing the constitution for the proposed C&WCCG including for an extra lay member to that required. A councillor did not feel able to support the proposals without seeing the detail. Adrian Stokes added that there was the opportunity for wider engagement via the Health and Wellbeing Board (HWBB) and place boards. Other members shared the concerns about reductions in lay representation, especially when viewed across the whole area and the need to ensure that Warwickshire was adequately represented. For the first term of office of the new governing body, there would be three Warwickshire GPs and one GP representing Coventry.
- A view that the key driver for the review was financial, and whilst this would lead to efficiencies, there were concerns about the loss of local knowledge, due to the size of the organisation.
- Comment that this change was being driven by NHS England and it would happen. It was different to a service review like that for stroke services. Reference to the importance of the place plans and that for Rugby was being progressed. The HWBB had a key role in setting the strategy and would be the body to be held to account and scrutiny.
- Comments about the potential for a reduction in front line staffing, that a larger CCG would not necessarily make decisions more quickly and concerns at the potential for service closures. A sense that more information was needed before offering support.
- Adrian Stokes asked if a further session on place would be useful. He outlined the developing arrangements in Rugby and Warwickshire north, considering both were working well, with a local focus. He confirmed that the savings were targeted at back office rather than front line services. The Chair agreed this additional session would be useful to respond to the issues raised.
- Reference to PCNs. There was a perceived lack of patient voice, due to clinical leads not having an effective dialogue with patients. This forum could enable discussion of very local service issues. Sarah Raistrick responded that PCNs had really taken off giving local ownership to address needs in each area. She referred to her own local network meetings, which were well attended, also the attendance at councillor forums to pick up any health

issues raised. PCNs were keen to work with HWW and local councillors. The councillor stated the same approach was not being taken in his locality. This would be pursued after the meeting and referred to the GP lead.

The Chair sought views on the report recommendation, providing a summation of member feedback. More information was required to enable the committee to offer its support to the proposals. The CCGs had offered to attend a further meeting to speak on the place aspects. He asked if members wished to take up this offer before making a decision on this matter. A range of views were submitted and it was concluded that a further meeting should be arranged in the near future.

Thanks were recorded to the CCG representatives.

Resolved

That the Committee arranges a further special meeting in the near future to give consideration this matter, especially to the place aspects and that the concerns and comments raised by the committee as outlined above are reported to the CCGs.

……
Chair

The meeting closed at 12:05pm

Adult Social Care & Health Overview & Scrutiny Committee

Wednesday, 19 August 2020

Minutes

Attendance

Committee Members
Councillor Wallace Redford (Chair)
Councillor Margaret Bell (Vice-Chair)
Councillor Helen Adkins
Councillor Jo Barker
Councillor Sally Bragg
Councillor Mike Brain
Councillor John Cooke
Councillor Judy MacDonald
Councillor Pamela Redford
Councillor Jerry Roodhouse

Other Members
Councillors Les Caborn (Portfolio Holder for Adult Social Care and Health).

Officers
Shade Agboola, John Cole, Jane Gillon, Becky Hale, Carl Hipkiss, Nigel Minns, Deb Moseley, Paul Spencer and Pete Sidgwick.

Partner Organisations
Chris Bain (Healthwatch Warwickshire)
Councillor Joe Clifford and Victoria Castree (Coventry City Council)
Anna Hargrave (South Warwickshire Clinical Commissioning Group (CCG))
Sarah Raistrick and Laura Fratczak (Coventry & Rugby CCG)
Jenni Northcote, Adrian Stokes and Rose Uwins (Warwickshire North and Coventry & Rugby CCGs),
David Eltringham (Warwickshire North Place Executive)

1. General

(1) Apologies

County Councillors Andy Jenns, Keith Kondakor and Kate Rolfe. Councillors Chris Kettle (Stratford District Council) and Tracy Sheppard (Nuneaton and Bedworth Borough Council.

(2) Disclosures of Pecuniary and Non-Pecuniary Interests

None.

(3) Chair's Announcements

The Chair welcomed everyone to the meeting.

2. Public Speaking

None.

3. The Future of Health Commissioning in Coventry and Warwickshire

The committee gave initial consideration to this item at its special meeting on 30 July. It was agreed to hold a further meeting, with a particular focus on the 'place' aspects. A copy of the previous report had been provided as background.

A two-part presentation was commenced by Anna Hargrave of South Warwickshire CCG. The presentation covered the following areas:

- The role of the clinical commissioner to plan, determine and prioritise, purchase and monitor services.
- How our system fits together, showing the population sizes and purposes of the different levels from the primary care network through to region. The aim was to provide 80% of activity at 'place level. Some aspects had to be provided over the larger system footprint.
- Why merge? Key aspects were developing place, more efficient decision making, administrative savings, staff recruitment and retention and better access to new opportunities and funding.
- Our current position, showing the engagement undertaken, the application to NHS England in September and the plans for a continued dialogue.
- Importance of place. At the place level, at least 80% of service transformation would happen and decisions be made on how money was spent. This would focus on local populations and support better engagement.

David Eltringham, Chair of the Warwickshire North Place Executive delivered the next section of the presentation along with Jenni Northcote. Jenni worked jointly for the Warwickshire North CCG and George Eliot Hospital, having a key role in coordinating planning at the place level. Dr Rachel Davies had hoped to co-present but had clinical commitments. She was the GP and primary care representative on the place executive. This part of the presentation covered:

- Context about the place, showing the profile of the area and the organisations involved in the place executive. This body had no legal standing and each organisation retained their respective accountabilities. Time had been spent in building relationships and understanding the roles of each organisation.
- Plan on a page, showing the vision, aim, the current state and that desired, with detail on a range of topics.
- A graphic showing the model of integrated care, which puts the patient and population at the centre.

- A diagram showing ‘how we work together – connecting from PCN to system through place’. Mr Eltringham explained how the various aspects were connected from PCN’s, which aimed to deliver neighbourhood priorities, through to priority programmes of work to deliver at the place level. A new aspect was delivery assurance, following the requirement by government to establish a reset board. The accountability and oversight aspects were also reported, together with the more strategic role envisioned for the merged CCG.
- Jenni Northcote spoke to the slide ‘How we work together – areas of focus’. This took existing information from a variety of sources to provide six areas of focus. The focuses are urgent and emergency care, long term conditions, mental health, wider determinants of health, community capacity and maternity, children & young people. An emphasis on working collaboratively at the place level and adding value. Examples were given for each area of focus to show how this is working in practice across the local system.
- Benefits at Place. The key benefit of local place working is the collective approach to delivering services within the resources available.
- Examples of what we are doing. A reiteration of the collaborative approach at place level.
- Case Study: hot hubs – implementation at place level. The response to Covid-19 showed how organisations had worked together in providing capacity to safely see patients in primary care settings who were suspected to have Covid-19.
- Key messages – a summary slide on the good progress made to date, the relationships developed, next steps in Covid-19 recovery and development of the Integrated Care System (ICS).

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

- A concern about the slide showing the opportunity to reduce costs of delivery and whether this meant service cuts. In response, it was stated that there was duplication in the system and the potential to be more efficient. An example was reducing reliance on the A&E department by providing alternate services. There was a financial budget, but this was an opportunity to move staffing and funding to achieve efficiencies.
- Clarity was sought on how this would work. Using the example of back problems, clinicians could deliver services such as physiotherapy at the local GP surgery or another facility. This would reduce costs. A related concern was the ability of smaller surgeries to accommodate additional services. Adrian Stokes added that the place executive provided a multi-agency forum to agree the best solution for service delivery.
- Members recognised the quality of the presentation and the merits of the place approach. There was good work being undertaken in Warwickshire North Place, which was appreciated.
- Improving health outcomes and reducing health inequalities should be the overall objectives.
- End of life care needed to be referenced in the documents. This would be actioned.
- A question why there needed to be a single CCG overarching the place executives and what the benefits were of joining the CCGs together. The critical issue was funding and further detail was sought on the criteria that would be used in allocating funding to each place to give adequate resources, whilst also addressing health inequalities.
- Anna Hargrave spoke of the challenges of coordinating activity across the three CCGs, an example being capacity to maintain elective activity, whilst also responding to spikes in Covid-19 cases. It was about ensuring connected and coordinated services, also improving health outcomes for key aspects like cancer and stroke services. From the local authority

perspective, working with three CCGs was not ideal as each CCG may have slightly different arrangements in place. Another benefit would be joint commissioning arrangements, due to there being less organisations. It is about making planning more efficient at the system or strategic level, with delivery at the place level. Adrian Stokes added that CCG running costs needed to reduce by 20%. There was a choice on how to achieve this but moving to a single body would reduce the costs and the potential impact on services delivered at place. He reiterated that the funding allocations would remain at the same locations. There were additional benefits of the CCG covering a coterminous area, for example in attracting additional funding.

- Councillor Caborn was the scrutiny chair when the health structure changed from a primary care trust to the three CCGs. The Council was not supportive of that change and he was supportive of the move to a single CCG. He added that the graphic in the presentation needed to make reference to the Health and Wellbeing Board, which would be actioned.
- A point on ensuring that the strategic decisions match what is needed at the place level.
- There was concern that the larger CCG would have less local engagement with reference made to the links between such engagement and recruitment/retention of staff.
- Chris Bain of Healthwatch made a plea for the patient voice to be lodged in the system. The establishment of the ICS by February was effectively a deadline to ensure that it was in place by then. Also, he urged that inequalities were given a higher profile in the ICS.

The Chair thanked the presenters and he considered that they had addressed all the points raised by the committee, when it met previously. He referred members to the report recommendations.

Resolved

That the Committee supports the proposed changes in the structure of the Clinical Commissioning Groups in Coventry and Warwickshire.

……
Chair

The meeting closed at 11:10a.m.

Agenda Item 4

Warwickshire Adult Social Care & Health Overview & Scrutiny Committee
30 September 2020

Progress in Restoration and Recovery of services in Warwickshire

1 Purpose of the Note

1.1 To update the Warwickshire Adult Social Care & Health Overview & Scrutiny Committee regarding the potential relocation of Neuro-rehabilitation Level 2b Beds from University Hospitals of Coventry and Warwickshire (UHCW) to South Warwickshire Foundation Trust's (SWFT) Central England Rehabilitation Unit, located at Royal Leamington Spa Hospital, and the current temporary closure of the Stratford Minor Injuries Unit and Ellen Badger First Aid Centre to support our response to COVID-19

1.2 To seek the support of the Warwickshire Adult Social Care & Health Overview & Scrutiny Committee to develop a case for change to consider the benefits of these service changes for our local population, prior to making a decision regarding the current arrangements.

2 Recommendations

2.1 For the Warwickshire Adult Social Care & Health Overview & Scrutiny Committee to support NHS Coventry and Rugby Clinical Commissioning Group, in collaboration with UHCW and SWFT, to undertake the process to develop a full Decision-Making Business Case regarding the future location of the Neuro-rehabilitation Level 2b Beds.

2.2 For the Warwickshire Adult Social Care & Health Overview & Scrutiny Committee to support NHS South Warwickshire Clinical Commissioning Group, in collaboration with SWFT, to undertake the process to develop a full Decision-Making Business Case regarding the future of the Stratford Minor Injuries Unit and Ellen Badger First Aid Centre as part of a wider look at urgent and emergency care services in South Warwickshire.

3 Background and Information

3.1 COVID-19 created an unprecedented situation, resulting in a national state of emergency and the greatest health and care challenge of our time. The Coventry and Warwickshire health and care system responded to this challenge at significant pace.

3.2 The three Clinical Commissioning Groups (CCGs) in Coventry and Warwickshire delivered both the nationally mandated changes from NHS England and Improvement ('NHSEI'), as well as local decisions, so that together we provided an effective and robust response to COVID-19 and deliver as many services as possible during this time.

3.3 The response to COVID-19 is being managed in four phases:

- Phase 1 – Service change (immediate response to COVID-19)
- Phase 2 – Restoration (6 weeks from May to mid-June)
- Phase 3 – Recovery (to March 2021)
- Phase 4 – Reset (2021/22)

3.4 In many areas, it was essential to fast-track transformation initiatives to enable delivery of as many services as possible. The areas of major innovation are fully aligned with our strategic ambitions outlined in the NHSE Long Term Plan; our local Five Year Plan and align with key messages from various engagement activities with local people.

3.5 The NHS has now in Phase 3 - Recovery. We attended Scrutiny Board at the end of July to give an overview of the governance; scope; objectives; and, progress to date on the Coventry and Warwickshire "3Rs" programme.

3.6 As we look to the future, maintaining the transformation will not just enable us to meet the short to medium term challenges of restoration and recovery, it provides a sound basis to reset our health and care system to one that is more effective and sustainable.

4 Assessment of Service Change

4.1 As part of our Recovery we have had to consider what services are being restored and, if they are, are we returning them to the pre-COVID-19 model or in a new way that reflects the significant transformation that has taken place across our services.

4.2 For any NHS Provider service change which has been undertaken in response to COVID, we have used the NHS England and Improvement Impact Assessment Tool (IAT). The IAT (Appendix B) has four phases. In June we undertook Phase 1 which is an initial 'Sort and Sift' of the service changes which have been undertaken

4.3 The initial Sort and Sift exercise puts the service changes into two categories:

- Restoration: Service changes that are not viable as a permanent solution.
- Recovery: Service changes that are viable for consideration as a permanent change.

4.4 Following initial Sort and Sift exercise, the following services were put into the Recovery Category. These were then subject to evaluation in Phase 2 of the IAT during July so that we could make a better assessment of their viability as a permanent solution.

5 Level 2b neuro-rehabilitation beds

5.1 Prior to the COVID-19 pandemic 12 Level 2b neuro-rehabilitation beds were located at UHCW. These beds are commissioned by Coventry and Rugby CCG on behalf of the three Coventry and Warwickshire CCGs and are the only Level 2b neuro-rehabilitation facilities in Coventry or Warwickshire.

5.2 These beds are used for patients requiring post-acute, specialist rehabilitation at a level less intensive than patient with very the highest acuity. Commonly 2-4 therapist disciplines are involved per patient and the length of stay for each patient is usually 1-3 months, though some may stay up to 6 months. The conditions treated cover:

- Traumatic brain injury
- Hypoxic brain injury (lack of oxygen)

- Complex neurological conditions e.g. Guillain Barre Syndrome
- Acute neuro-behavioural conditions (typically on an interim basis whilst awaiting other units).

The service meets the needs of individuals who typically may be a risk to themselves due to reduced safety awareness, need to understand how their abilities have changed and will be experiencing substantial physical disability.

5.3 In addition to the care provided by Consultants in Rehabilitative Medicine, Junior Grade Doctors and Nurses, patients are supported by a range of Allied Health Professionals including Physiotherapists, Occupational Therapists, Speech and Language Therapists, Dieticians as well as Clinical Psychologists and Social Workers.

5.4 Following inpatient rehabilitation, patients are usually discharged home, where they will continue to receive specialist community rehabilitation services. The full patient pathway for Specialised Neurorehabilitation can be found in Appendix A.

5.5 As part of our emergency response to COVID-19, the decision was taken on 18 March 2020 for these beds to be moved from UHCW to the Central England Rehabilitation Unit (CERU), a dedicated rehabilitation facility which is part of Royal Leamington Spa Hospital, located on Heathcote Lane in Warwick and provided by SWFT.

5.6 This move was undertaken in line with the national directive on 'urgent response' from NHS England and Improvement on 17 March; identifying the need to free-up the maximum possible inpatient and critical care capacity and prepare for the anticipated large numbers of COVID-19 patients, as well as support staff, and maximise their availability.

5.7 Moving these beds increased acute bed capacity at the UHCW site and ensured that rehabilitation patients continued to receive high-quality neurorehabilitation in an appropriate, infection controlled environment.

5.8 Since 19 March 2020 to 31 August 2020, 31 patients have been admitted.

5.9 The evaluation in Phase 2 of the IAT was undertaken during July, so that we could make a better assessment of the change to the service as a permanent solution. This process is now complete and both SWFT (CERU) and UHCW would like to explore the scheme further. They believe that, by siting the beds within a specialist rehabilitation unit it could lead to:

- Improved treatment outcomes - potentially physical and/or cognitive as relevant
- Improved in-patient experience
- Reduced Length of Stay
- Reduced exposure to infectious patients e.g COVID-19, flu, viral pneumonia

5.10 This means that the proposals now move into Phase 3 in order to ascertain if there is system wide support to progress developing a full decision making business case.

6 Stratford-upon-Avon Minor Injuries Unit and Ellen Badger First Aid Centre

6.1 The Minor Injuries Unit is located at Stratford-upon-Avon Hospital and is open 9am to 5pm, seven days a week. The First Aid Centre is located at Ellen Badger Hospital in Shipston-on-Stour and is open 8am-6.30pm Monday-Friday.

6.2 Both units treat minor injuries and illness only, such as sprains and strains, wound care and minor burns and scalds. They are staffed by Nurse-Practitioners and do not have doctors on site. The Minor Injuries Unit in Stratford Hospital has X-ray available Mon – Fri only.

6.3 Attendance at the Ellen Badger First Aid Centre has been decreasing in recent years. On average attendances have decreased by approx. 35% year on year. Based on the 2019 attendances the unit saw one patient every 2.5 days.

6.4 Prior to COVID-19, work had started to relocate Shipston Medical Centre from its existing site to the Ellen Badger hospital to support integrated care.

6.5 Attendance at the Minor Injuries Unit at Stratford Hospital increased by approx. 8% year on year until 2018 and then fell in 2019. The average number of attendances at Stratford in 2019 was just under 23 per day.

6.6 In 2019, as part of the redesign of urgent care services as outlined in the Long Term Plan, NHS England announced that all sites delivering urgent care, such as Minor Injuries Units and Walk-In Centres must all become Urgent Treatment Centres, meeting a set of criteria including being GP-led, open for at least 12 hours a day and equipped to diagnose and deal with many of the most common ailments people attend A&E for. This move is designed to end the current potentially confusing range of options and simplify the system so patients know where to go and have clarity of which services are on offer wherever they are in the country. Units which are unable to fulfil these criteria will change their function to become other primary health care services.

6.7 The Minor Injuries Unit at Stratford Hospital does not currently fulfil the criteria to become an Urgent Treatment Centre. Prior to the start of the pandemic, South Warwickshire Clinical Commissioning Group and SWFT had begun the process of understanding the potential options available.

6.8 As part of our emergency response to COVID-19, the decision was taken in March 2020 for both of these units to be closed temporarily. This allowed South Warwickshire NHS Foundation Trust to redeploy the workforce to support our urgent and emergency care at Warwick Hospital.

6.9 Due to continued management of the COVID-19 incident staff are currently continuing to be redeployed to the Warwick site and therefore the change is likely to extend into winter.

6.10 The evaluation in Phase 2 of the IAT for these services was undertaken during July, so that we could make a better assessment of the changes to the service. This process is now complete and SWFT would like to explore the changes further as part of a timely look at how urgent and emergency care services are delivered for South Warwickshire residents, taking into account

- The standards required for urgent treatment centres and the other models of primary care services available
- Other developments in the national and regional model for delivering urgent care to help reduce pressure on Accident and Emergency Departments.

6.11 This means that the proposals now move into Phase 3 in order to ascertain if there is system wide support to progress.

7 Next steps

7.1 As per the IAT framework, at this stage this service changes being brought forward into Phase 3 are still proposals and the purpose of Phase 3 is to ascertain if there is system wide support to progress to Phase 4.

7.2 If there is support for us to progress these service changes the CCGs, working together with UHCW and SWFT, would mobilise the resource and governance structures to develop a case for change for each service.

7.3 These case for change documents will apply NHSE Service Change Guidance (2018) and work though the development of a robust clinical case for change, including working with patients, staff, the wider public and stakeholders to understand the impact of any changes on them.

7.4 The case for change would be subject to all statutory guidelines regarding service transformation and change.

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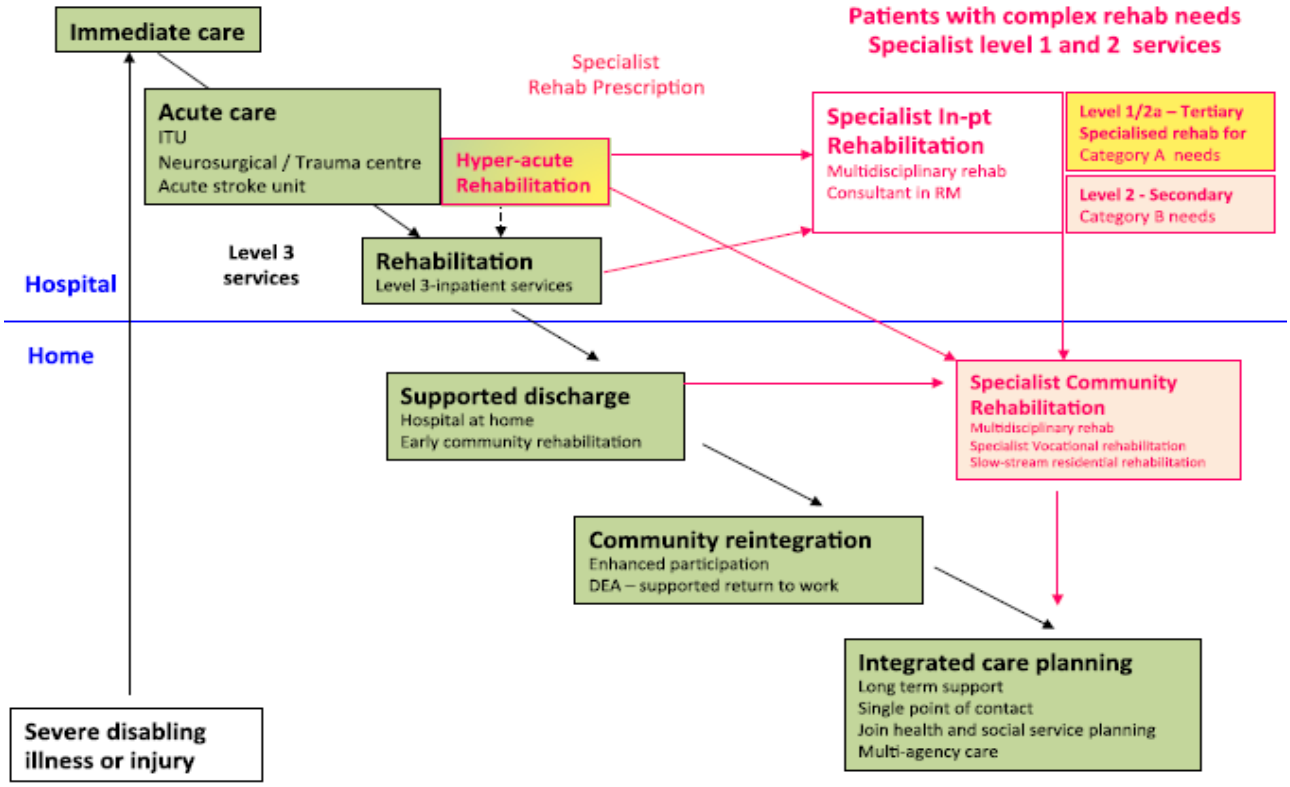
APPENDIX A

Pathway for Patients Suffering Significant, Acute Neurological Injury or Illness



Source: '*Specialised Neurorehabilitation Service Standards*,' British Society of Rehabilitative Medicine, 2019

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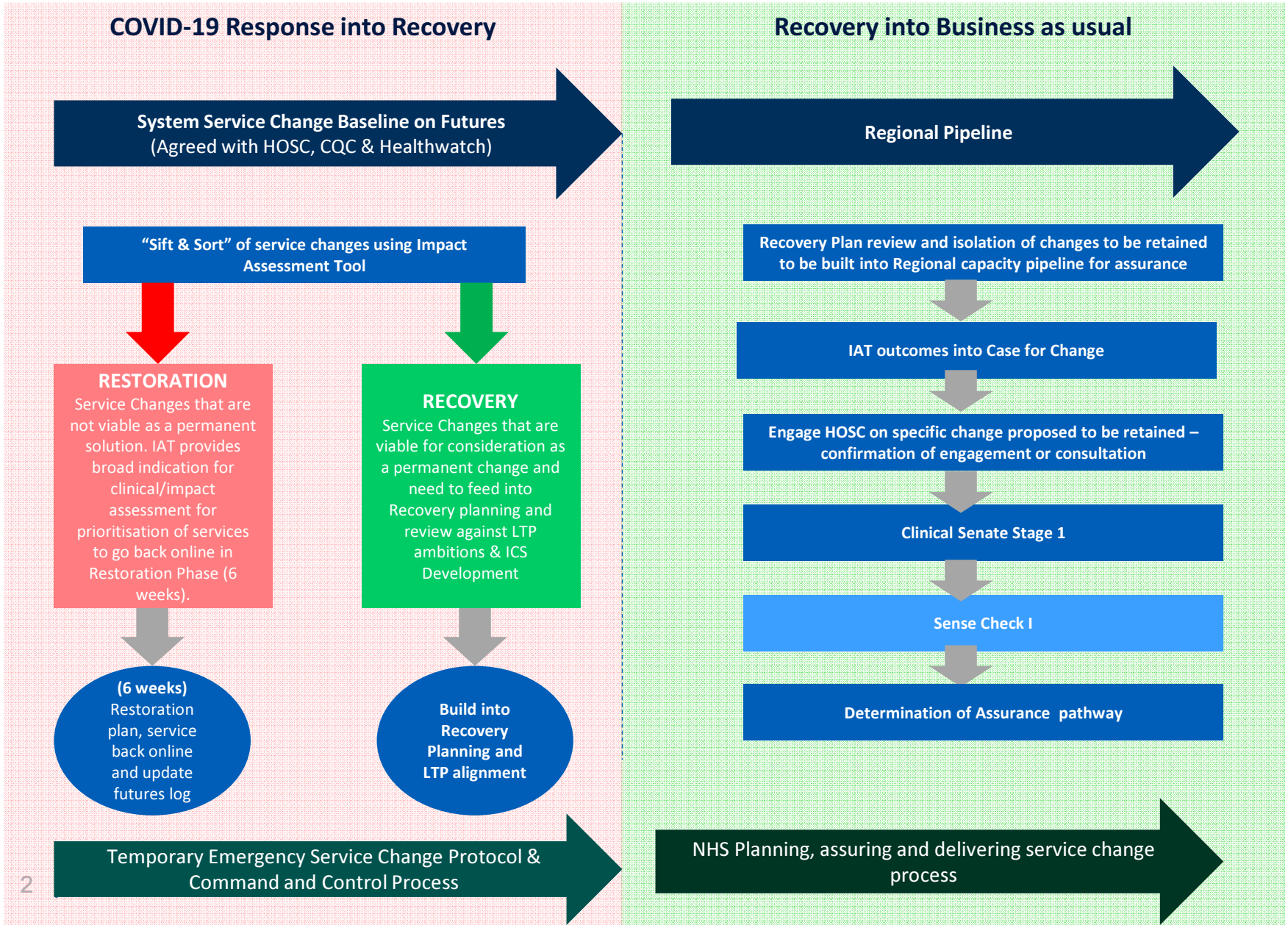
Restoration & Recovery Planning: Impact Assessment Framework for Service Changes during COVID 19

Version: 4.0

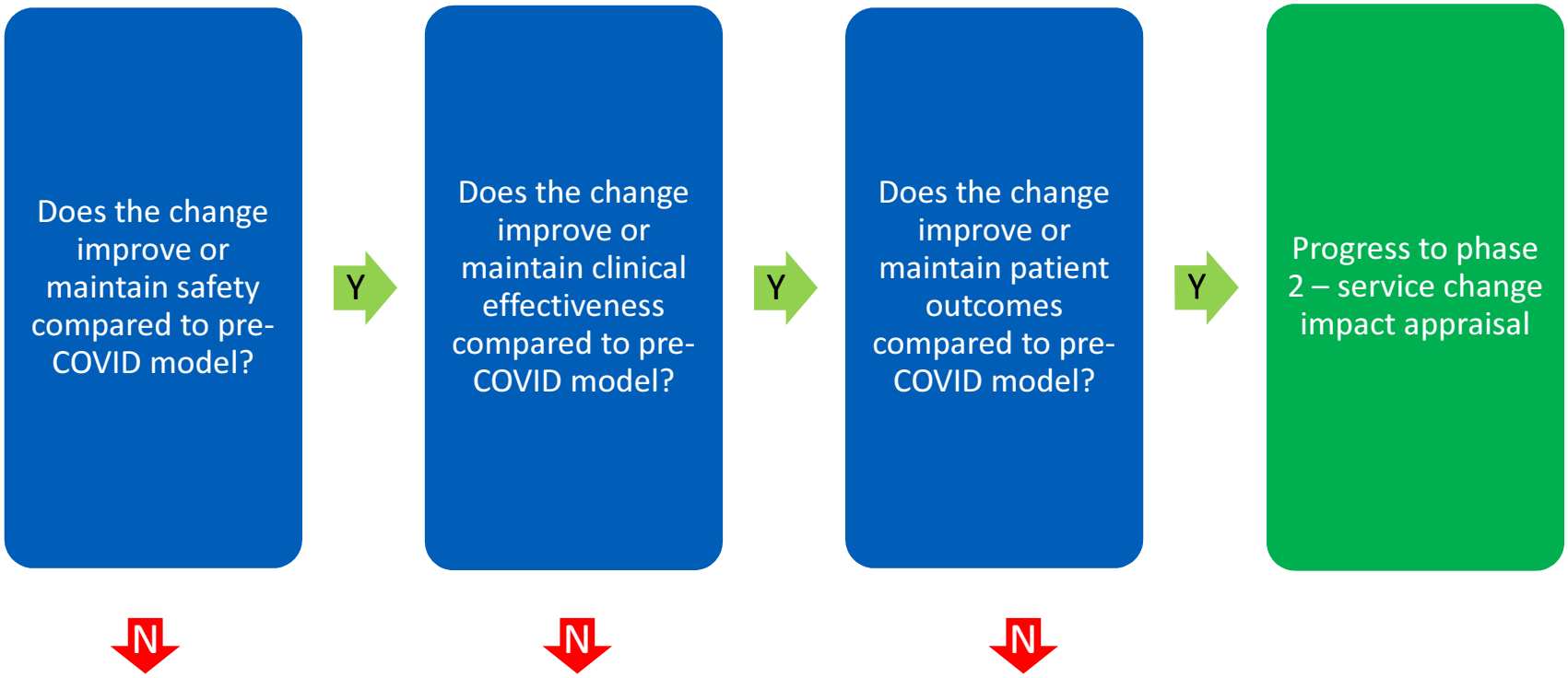
NHS England and NHS Improvement

Midlands Impact Assessment Tool & Processes



Phase 1 – Critical Tests
(to exclude non viable long term solutions)

This first cut will review viability of COVID-19 changes that may be considered for a longer term solution providing patient safety, clinical effectiveness and patient outcomes are improved or maintain pre-COVID provision as a foundation.

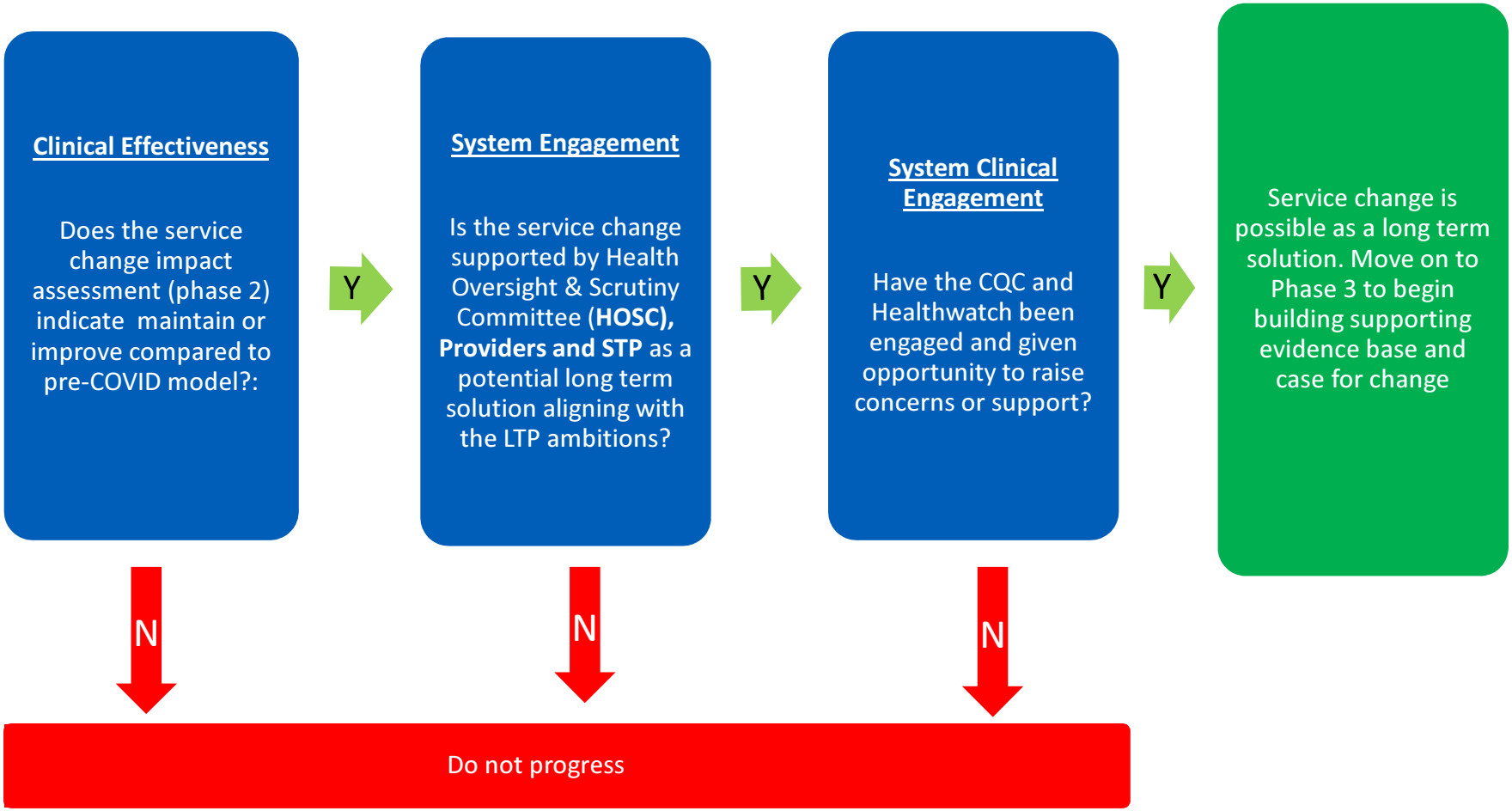


Phase 2 – Service Change Impact Appraisal

		++ve	+ve	Similar/ Unknown	-ve	--ve
Align with detailed QIA	Duty of quality	2	1	0	-1	-2
	Patient outcomes	2	1	0	-1	-2
	Level of safety	2	1	0	-1	-2
	Patient experience	2	1	0	-1	-2
	Patient Choice/ Access	2	1	0	-1	-2
	Impact on equality	2	1	0	-1	-2
Strength of evidence/ Plausibility		2	1	0	-1	-2
Level of clinical effectiveness		2	1	0	-1	-2
Alignment with national policy including NHS LTP		2	1	0	-1	-2
Cost		2 (much lower)	1 (lower)	0	-1 (higher)	-2 (much higher)
Workforce Demand/ Sustainability		2 (much lower)	1 (lower)	0	-1 (higher)	-2 (much higher)
Impact on other clinical services		2	1	0	-1	-2
Impact on neighbouring systems		2	1	0	-1	-2
TOTAL SCORE						

Phase 3 – System Engagement & Alignment

Those changes showing positive scores should now be tested against the three deal breakers below before proceeding to supporting evidence base as a foundation for the case for change. All changes showing potential for retainment should be shared with system partners for support and agreement to progress development. System engagement invested early will support the assurance process and give indication of public engagement of consultation requirements of HOSC, should the change be retained.



Phase 4 – Outlined Evidence for case for change (1/3)

Phase 4 develops the evidentiary base for a Case for Change and includes Key Lines of Enquiries used in a Clinical Senate proforma for a Stage 1 review in an aim to reduce duplication in the development of COVID service changes and enable preparatory work for a Sense Check 1 as part of the standard Service Change Assurance gateways.

Below is a diagram describing the alignment between Phases 2 and 4 of this tool and the base requirements of a Sense Check 1.

Service Change Tests/Sense Check I requirements	PHASE 2 - Impact Assessment Tool	PHASE 4 – Outlined evidence/case for change
Clear clinical evidence base	Duty of Quality Patient Outcomes Level of Safety Level of Clinical effectiveness	KLOEs 3, 4, 5, 6, 10, 15, 17
Patient and public involvement	Patient Experience	KLOEs 18
Impact on patient choice	Patient Choice and Access	KLOEs 12, 18
Support of clinical commissioners and system	Impact on neighbouring systems	KLOEs 7, 20
Financial plan (capital and revenue for commissioners and providers)	Cost	KLOEs 21,
Where reduction in hospital beds – alternatives	*Specific to changes that see a reduction in bed base numbers*	
Consultation plan		KLOEs 24
Public Sector Equality Duty and inequalities duties	Impact on Equality	KLOEs 12, 19
Implementation arrangements	Workforce demand/sustainability	KLOEs 9, 22
Fit with STP and Long Term Plan	Alignment with National Policies and LTP ambitions	KLOEs 2, 11, 13, 14, 16, 17
Impact on performance	Impact on other clinical services	KLOEs 8,

Phase 4 – Outlined Evidence for case for change (2/3)

KLOE	Evidence Requirements	Evidence Summary
1	Summary of the current position in respect of the services covered by your proposals	
2	Case for why proposals for change need to be considered	
3	Proposals for change – describe the clinical model	
4	Describe and quantify the benefits	
5	Extent to which local clinicians and communities believe the proposals will deliver real benefits	
6	Describe and evidence the impact the proposals are expected to have on the safety, effectiveness and experience of care	
7	Impact the proposals are expected to have on the sustainability of affected and related services (including those in other health economies)	
8	How the performance of current services will be sustained through the lifecycle of the reconfiguration programme	
9	How outline plans will be implemented	
10	Impact of estates changes on safety, effectiveness and experience of care	
11	How proposals reflect up to date clinical guidelines and national and international best practice e.g. Royal College Reports	
12	How the proposals reflect the rights and pledges in the NHS Constitution	

Phase 4 – Outlined Evidence for case for change (3/3)

KLOE	Evidence Requirements	Evidence Summary
13	Alignment with local joint strategic needs assessments, commissioning plans and joint health and wellbeing strategies	
14	How proposals meet the current and future healthcare needs of patients	
15	Clinical risk analysis and associated mitigation plan	
16	Demonstrate good alignment with the development of other health and care services	
17	How proposals support better integration of services	
18	Issues of patient access and transport	
19	How proposals will help to reduce health inequalities	
20	Does the options appraisal consider a networked approach – co-operation and collaboration with other sites and/or organisations	
21	Is the service change affordable and sustainable across all health organisations?	
22	Links to other work streams, including specialised commissioning	
23	What alternate or emerging options are there to this service change?	
24	Have the HOSC been engaged and formally advised on the consultation or engagement requirements of the local population?	

Agenda Item 6

Adult Social Care & Health Overview & Scrutiny Committee
30th September 2020

One Organisational Plan Quarterly Progress Report: Period under review: April 2019 to March 2020

Recommendation

That the Overview and Scrutiny Committee:

(i) Considers and comments on the progress of the delivery of the One Organisational Plan 2020 for the period as contained in the report.

1. Introduction

1.1. The One Organisational Plan (OOP) Year-end Performance Report for the period April 1st, 2019 to March 31st, 2020 was considered and approved by Cabinet on 9th July. The report provides an overview of progress of the key elements of the OOP, specifically in relation to performance against Key Business Measures (KBMs), strategic risks and workforce management. A separate Financial Monitoring report for the period covering both the revenue and capital budgets, reserves and delivery of the savings plan was presented and considered at the Cabinet meeting held in June 2020.

1.2. This report draws on information extracted from both Cabinet reports to provide this Committee with information relevant to its remit.

One Organisational Plan 2020: Strategic Context and Performance Commentary

2.1 The OOP 2020 Plan aims to achieve two high level Outcomes:

- **Warwickshire's communities and individuals are supported to be safe, healthy and independent**; and,
- **Warwickshire's economy is vibrant and supported by the right jobs, training, skills and infrastructure**.

Progress to achieve these outcomes is assessed against 64 KBMs.

Outcome	No. of KBMs
Warwickshire's communities and individuals are supported to be safe, healthy and independent	23
Warwickshire's economy is vibrant and supported by the right jobs, training, skills and infrastructure	12

In addition, to demonstrate OOP delivery by ensuring that **WCC makes the best use of its resources,** a total of 29 KBMs are monitored.

As the Organisation continues to transform, this is the first full year performance report that will be reported against the new Commissioning Intentions Performance Framework. The new measures included in the Framework provide a sharpened focus on performance linked to the Organisation's priorities. Detailed performance has been visualised utilising the functionality of the Microsoft Power BI system.

Due to the WCC response to the ongoing Covid-19 pandemic the collection of the year end performance was delayed. There are also some KBM's where commentary has not yet been provided by Service areas, as Corporate Board directed that commentary wasn't required due to changing priorities.

2.2 Of the 64 KBMs, 9 are in the remit of this Overview and Scrutiny Committee. At year end, 33% (3) KBMs achieved target while 45% (4) KBMs are behind target. The remaining 22% (2) KBMs are not applicable as a target has not been set.

Chart 1 below summarises KBM performance by outcome.

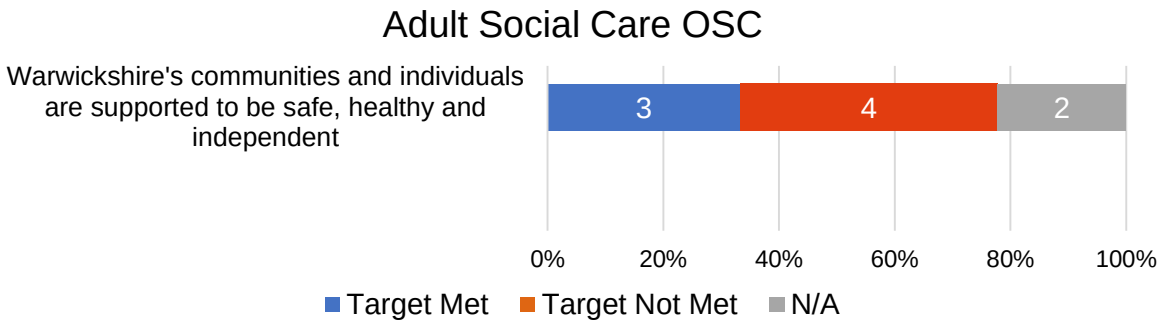


Chart 1

2.3 Of the 33% (3) KBMs achieving target, there is 1 of particular note:

- No. of permanent admissions to residential or nursing care (under 65) as the year-end target has been met, 57 compared to a target of 60.

2.4 The full set of KBM's form the basis of the 2020/21 performance framework and therefore forecast performance projection for the next reporting period is included in this report. As targets have yet to be agreed the projection is based on measure owners current understanding of forecast performance levels. Chart 2 below illustrates the forecast performance projection over the forthcoming reporting period.

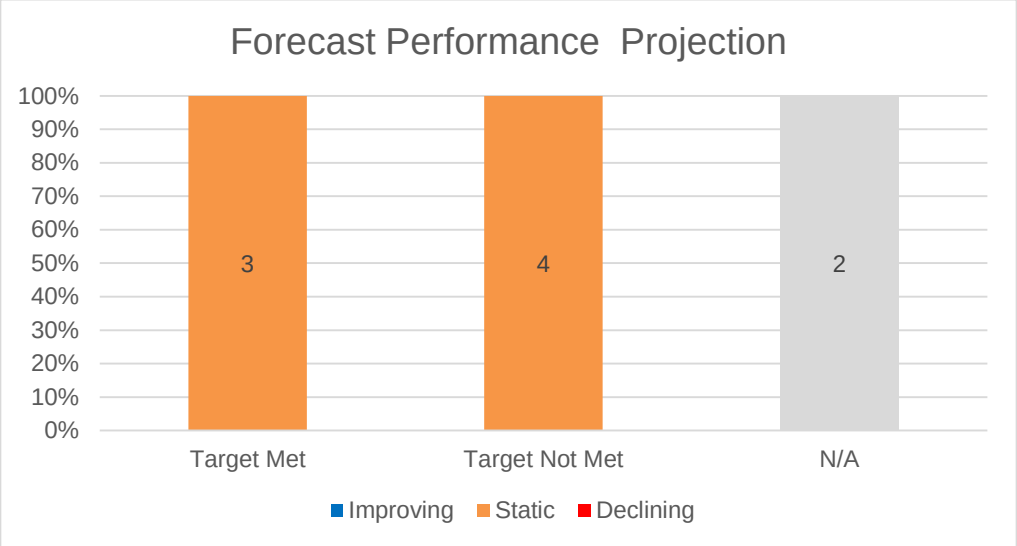


Chart 2

Of the 9 performance measures, 8 KBMs (including the 4 not on target) have a forecast projection to remain static over the next reporting period. 'No. of individuals receiving a WCC commissioned service placed outside of Warwickshire' has a projection of N/A as the data is not yet provided.

The table below highlights the KBMs, including remedial action being taken, where forecast performance is projected to remain underperforming and static:

Measure	Remedial Action
Warwickshire's communities and individuals are supported to be safe, healthy and independent	
% of placements for adults in provision of Good or Outstanding quality as rated by Care Quality Commission	The team will continue to work with all commissioned and spot purchase providers. Those who have experienced a reduction in ratings will be given priority to ensure they return to an acceptable quality. The team have and will continue to work virtually (unless a physical visit is urgent or essential) using an iterative process to quality assurance and ensure they have evidence to assure services are safe and effective. It should be noted that due to timescales between Care Quality Commission (CQC) inspections it can take several months for increases in quality to be reflected in CQC ratings, therefore there may be a delay in the required upward trajectory. This will be especially significant during the next quarters as during the pandemic the CQC and Quality had halted completing one-site quality visits to providers. As on-site visits restart there could be delays in rating changes even when work has been completed with providers and there has been an improvement in quality. This is as priority may be given to assuring those provisions where negative feedback has been given and concerns raised.

% of Women who smoke at the time of delivery across Warwickshire	WCC commissioned a Smoking in Pregnancy (SIP) review on behalf of the Coventry & Warwickshire Local Maternity System (LMS). The Review report and its recommendations now completed and beginning to be disseminated to key strategic forums. The main recommendations include: developing a comprehensive Coventry & Warwickshire Tobacco Control Programme (TCP); implementing a systematic approach to smoking cessation within maternity services and across the LMS based on evidence-based BabyClear approach; co-produce a new model of specialist smoking in pregnancy services; Recruiting a strategic Smoking Free Pregnancy Programme Manager to work across the LMS and within the TCP.
No. of people with a learning disability or autism in an inpatient unit commissioned by the CCG	Arden Transforming Care Partnership (TCP) was significantly over its targets at March 2020. Based on this performance, Arden Transforming Care Programme is in escalation with NHS England (NHSE). An escalation meeting was held on 17 June 2020 with the NHSE's Regional Director. An action plan has been created to reduce admissions and to ensure discharges take place. 2020/21 monthly targets have been agreed with NHSE to give a path to achieving the March 2021 target of 8.
No. of permanent admissions to residential or nursing care: over 65	Continue with strengths-based practice across Adult Social Care. Supporting people to identify their strengths and the support they have available from their personal networks or the wider community will allow them to be independent for longer.

2.5 Comprehensive performance reporting is now enabled through the following link to Power BI full OSC Year End Performance Report.

The Adult Social Care & Health OSC Exception dashboard contains details of those measures that are of significant note where good performance or areas of concern need to be highlighted.

There is a further dashboard split by the 2 high level Outcomes. The Year End Full Dashboard provides a summary of performance for all KBM's within the remit of this Committee.

Financial Commentary – relevant finance information taken from Cabinet report

3.1 Revenue Budget

3.1.1 The Council has set the following performance threshold in relation to revenue spend: a tolerance has been set of zero overspend and no more than a 2% underspend. The following table shows the forecast position for the Services concerned.

	2019/20 Budget £'000	2019/20 Outturn '000	Revenue Variance £'000 %	Retained Reserves £'000	Financial Standing £'000
Adult Social Care	148751	148141	(610) -0.41%	610	0
Due to annually increased one-off funding from government, demand management and effective collection of client contributions, there was an underlying ongoing underspend of circa £1.5m a year, which has been right sized for 2020/21. A one-off increase in the bad debt provision has reduced this underspend in 2019/20. There remain growing pressures in budgets for Older People in Residential Care, especially a growing number of complex cases where mental health is also involved, and in the area of Supported Living for Younger Adults.					
People	33,374	32,461	(913) -2.74%	913	0
Last year saw financial pressure in the support service for drug and alcohol misuse due to demand for detox/inpatient services, increased support for homelessness and staffing overspends within Public Health. These increased pressures were offset by underspends elsewhere within the Service including staffing underspends following the restructure, reduced expenditure for accommodation with support and non-payment of the contract incentive for Sexual Health services.					

3.2. Delivery of the 2017-20 Savings Plan

3.2.1. The savings targets and forecast outturn for the Business Units concerned are shown in the table below.

	2019/20 Target £'000	2019/20 Actual to Date £'000	2019/20 Outturn £'000
Adult Social Care	2,240	2,240	2,240
People	2,820	2,625	2,625
Shortfall £0.195m. Drugs and Alcohol £0.536m shortfall due to cost pressures arising from the increase in prescribing costs (both medications and prescribing) for this demand led service. This is partially offset by £0.341m overachievement of savings on staffing costs and overheads within the Service			

3.3 Capital Programme

3.3.1. The table below shows the approved capital budget for the business units and any slippage into future years.

	Approved budget for all current and future years (£'000)	Slippage from 2019/20 into Future Years £'000	Slippage from 2019/20 into Future Years (%)	Current quarter – new approved funding/ schemes (£'000)	Newly resourced spend included in slippage figures (£'000)	All Current and Future Years Forecast (£'000)
Adult Social Care	3,663	0	0	(3,350)	0	313
People	6,178	30	1	(1,221)	10	4,967

4. Supporting Papers

4.1 A copy of the full report and supporting documents that went to Cabinet on the 9th July is available via the following link and in each of the Group Rooms.

5. Environmental Implications

None specific to this report.

6. Background Papers

None

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Adult Social Care & Health Overview & Scrutiny Committee

30th September 2020

Council Plan 2020-2025 Quarterly Progress Report: Period under review: April 2020 to June 2020

Recommendation

That the Overview and Scrutiny Committee:

(i) Considers and comments on the progress of the delivery of the Council Plan 2020 - 2025 for the period as contained in the report.

1. Introduction

1.1. The Council Plan Quarter 1 Performance Report for the period April 1st, 2020 to June 30th, 2020 was considered and approved by Cabinet on 10th September 2020. The report provides an overview of progress of the key elements of the Council Plan, specifically in relation to performance against Key Business Measures (KBMs), strategic risks and workforce management. A separate Financial Monitoring report for the period covering both the revenue and capital budgets, reserves and delivery of the savings plan was presented and considered at the same September Cabinet meeting.

1.2. This report draws on information extracted from both Cabinet reports to provide this Committee with information relevant to its remit.

2. Council Plan 2020 - 2025: Strategic Context and Performance Commentary

2.1 The Council Plan 2020 – 2025 aims to achieve two high level Outcomes:

- **Warwickshire's communities and individuals are supported to be safe, healthy and independent**; and,
- **Warwickshire's economy is vibrant and supported by the right jobs, training, skills and infrastructure**.

Progress to achieve these outcomes is assessed against 64 KBMs.

Outcome	No. of KBMs
Warwickshire's communities and individuals are supported to be safe, healthy and independent	23
Warwickshire's economy is vibrant and supported by the right jobs, training, skills and infrastructure	12

In addition, to demonstrate Council Plan delivery by ensuring that **WCC makes the best use of its resources,** a total of 29 KBMs are monitored.

As the Organisation continues to transform the Commissioning Intentions Performance Framework was developed and implemented in October 2019 providing a sharpened focus on performance linked to the Organisation's priorities. As part of this transformation several changes to measures were proposed for Cabinet to agree to ensure that the Framework remains fit for purpose and supports delivery of the priorities. The subsequent revised Commissioning Intentions Performance Framework which will be reported on from Quarter 2 can be accessed using this link.

Detailed performance for Quarter 1 for all current KBMs has been visualised utilising the functionality of the Microsoft Power BI system.

2.2 At Quarter 1 there has been an improvement in overall performance compared to the 2019/20 year-end position. Several measures, however, have been impacted by the Covid-19 pandemic and as a consequence there is little or no sign of improvement in these areas. These are fully detailed in 2.5.

2.3 Of the 64 KBMs, 9 are in the remit of this Overview and Scrutiny Committee. At Quarter 1 all KBMs are available for reporting and 78% (7) KBM's are on track and 22% (2) are not on track. This is an improvement from the year-end position when 33% (3) KBMs achieved target while 45% (4) KBMs were behind target.

Chart 1 below summarises KBM status by quarter since the introduction of the Commissioning Intentions Framework.

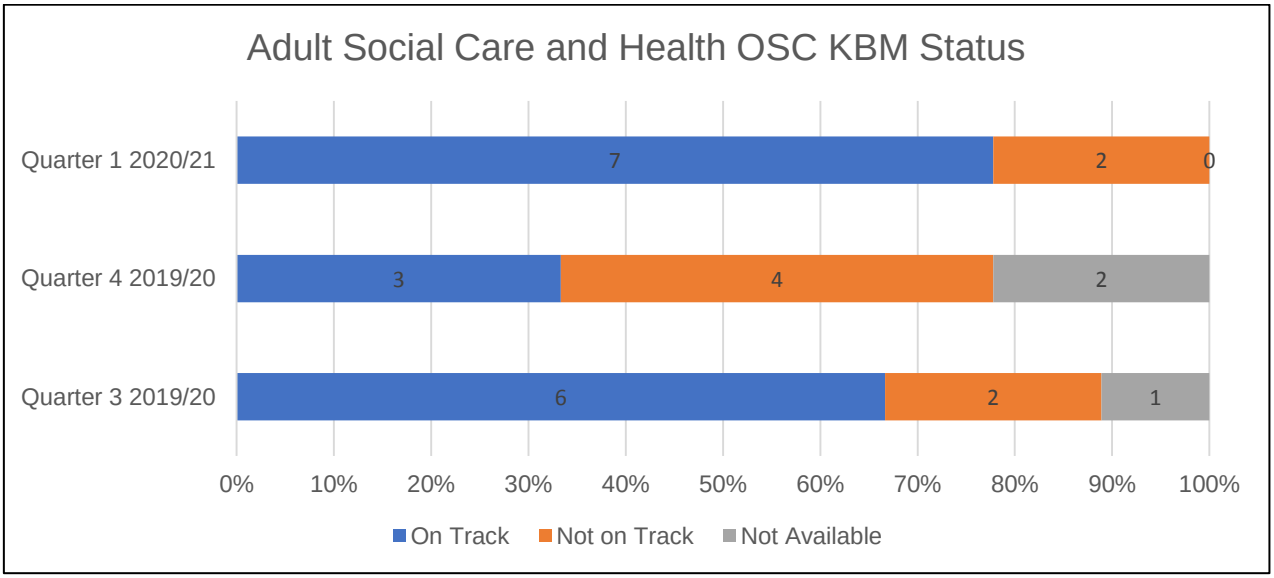

Chart 1

2.4 Of the 66% (6) KBMs which are On Track, there are 2 of note:

- No. of permanent admissions to residential or nursing care (under 65) as at Quarter 1 the number of people under 65 entering permanent residential care has reduced this quarter compared to the same period last year. The full impact of Covid-19 is not known at this time on this performance measure as some customer moves may have been delayed due to the need to minimise spread of infection and customer choice. Health and Adult Social Care are working together to manage any nursing placements and at this time there are no potential transfers of these customers; ; and,
- No. of permanent admissions to residential or nursing care: over 65 as at the Covid-19 pandemic and the Hospital Discharge Protocol put in place by the Government since March 2020, has impacted permanent residential admissions to Residential Care for Older

People. On the one hand there are more individuals entering Residential Care directly from Hospital, balanced, with these individuals not remaining in these placements long term. There are fewer individuals entering from the Community due to safety concerns around Residential Care, therefore, the service could see a sharp rise as infection rates reduce and media messages change. Warwickshire, has also seen high volumes of deaths within this.

2.5 The 2 KBMs that are Not on Track at Quarter 1 are included in Table 1 below and details the current performance narrative, improvement activity and explanation of projected trajectory:

Warwickshire's communities and individuals are supported to be safe, healthy and independent
% of placements for adults in provision of Good or Outstanding quality as rated by Care Quality Commission
Current performance narrative: The downward trend in the number of placements in Good and Outstanding registered provision is of concern. The factors which can contribute to this value are complex and there is not currently a clear picture of the root cause of this reduction. A combination of previously 'good' rated homes being downgraded to 'requires improvement', placement of customers into 'requires improvement' homes and the length of time before 'requires improvement' homes are reinspected to return them to 'good' ratings are the most likely drivers for this negative trend. The Contract Management and Quality Assurance Team will be working with Business Intelligence to undertake a 'deep dive' into this indicator and identify which factors are the most significant and then develop a detailed action plan to reverse the trend. It should be noted that the impact of Covid-19 on CQC inspection timelines is likely to delay reversing this trend, therefore the action plan will include alternative measures to ensure that there is movement in the right direction as soon as possible. Improvement activity: Throughout Covid-19 the Contract Management and Quality Assurance Team have employed a variety of innovative solutions to allow QA activity to continue in a safe and supportive way. Through weekly calls, virtual visits, ongoing monitoring of intelligence and data the Team have been active in identifying and resolving quality issues within homes during this very challenging times. It should be noted that due to timescales between CQC inspections it can take several months for increases in quality to be reflected in CQC ratings, therefore there may be a delay in the required upward trajectory. This will be especially significant during the next quarters as during the pandemic the CQC and Contract Management and Quality Assurance have halted completing physical quality visits to providers. Explanation of the projected trajectory: Not on track - remaining static Taking into consideration current trends and remedial action, performance over the next period is expected to remain static or possibly slightly reduce due to the current pandemic and the ability to complete quality assurance as previously undertaken. As the service progresses through the reporting quarters and changes to how quality audits and CQC rating information is gathered becomes embedded the service should begin to see a rise in the percentage of good or outstanding quality rated providers.

No. of People assisted to live independently through provision of Social Care equipment
Current performance narrative: Quarter 1 activity levels have decreased due to the impact of Covid-19. This has been a national trend. June activity levels show a good recovery with levels close to those of pre-Covid-19 Reasons for a reduction in demand are likely due to: • hospitals stopping routine work - no elective surgery, for example hip replacements who need equipment post operatively; • patients not returning home with the usual needs for daily living equipment; ; • occupancy in care homes has reduced as a consequence of Covid-19, which has led to a reduction in requests; and • services only offering emergency provision not doing routine work to minimise entry to customer homes, for example District Nursing, Occupational Therapy. Improvement activity: Please note this service is demand led. The service has been fully operational throughout the Covid-19 pressure period and continues to do so. WCC continues to work with Millbrook (provider) to ensure service continuity through ensuring appropriate staffing and stock levels. All Social Care practitioners are aware of the availability and accessibility of the service. Explanation of the projection trajectory: Not on Track- Improving Based on trend information performance over the next quarter is expected to recover.

Table 1

The Covid-19 pandemic has adversely impacted on both of these measures and the improvement activity has not seen the expected result due to extra pressures and demand of the pandemic on services. Improvement activity needs time to embed and positive results to be realised.

All other 7 indicators have stayed static in their performance or have made improvements across the quarters. Notably, No. of people with a learning disability or autism in an inpatient unit commissioned by the CCG has moved to being On Track at Quarter 1 from Not Being On Track at year-end.

2.6 Chart 2 below illustrates the forecast performance projection over the forthcoming reporting period.

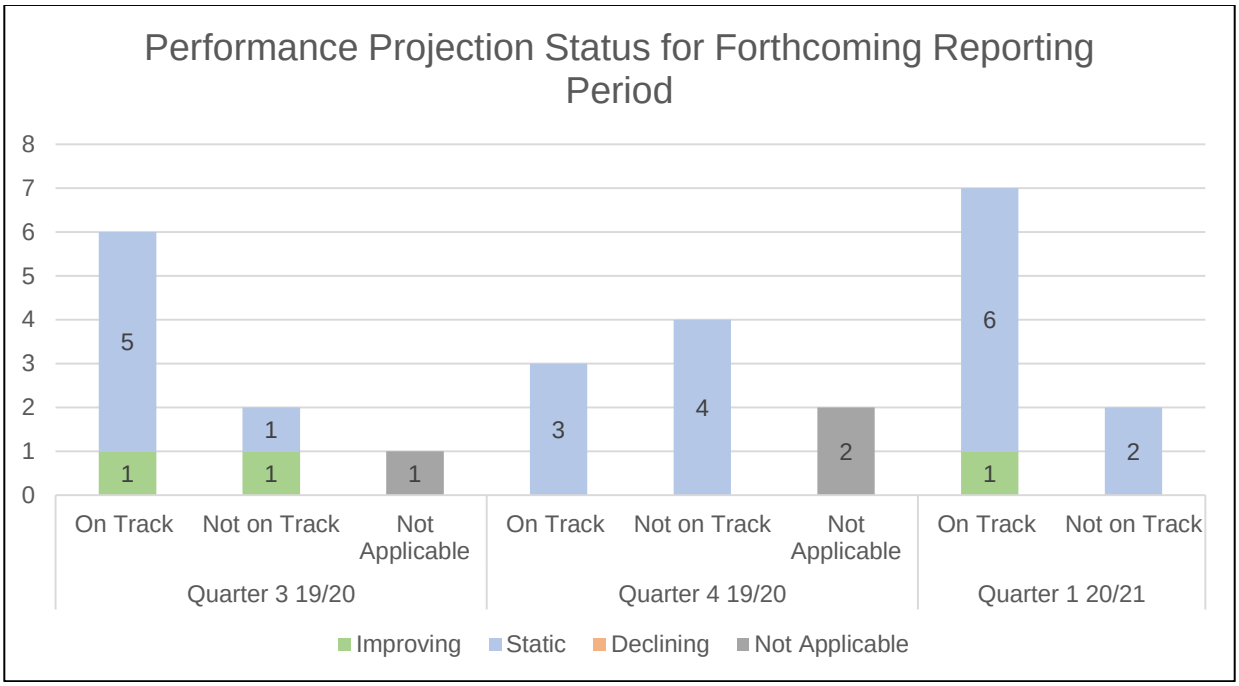

Chart 2

It is forecast that over the next period overall performance will remain similar to Quarter 1 with 7 of the 9 KBMs remaining with a status of On Track over Quarter 2. It is forecast that the 2 measures reported as Not on Track at Quarter 1 will have the same status at Quarter 2.

2.7 Comprehensive performance reporting is now enabled through the following link to Power BI. The Quarter 1 2020/21 Full Dashboard provides a summary of performance for all KBM's within the remit of this Committee.

The Adult Social Care & Health OSC Quarter 1 2020/21 Exception dashboard contains details of those measures that are of significant note where good performance or areas of concern need to be highlighted.

Financial Commentary – relevant finance information taken from Cabinet report

3.1 Revenue Budget

3.1.1 The Council has set the following performance threshold in relation to revenue spend: a tolerance has been set of zero overspend and no more than a 2% underspend. The following table shows the forecast position for the Services concerned.

<table>
<tr><th></th><th>2020/21 Budget £'000</th><th>2020/21 Outturn '000</th><th>Revenue Variance £'000 %</th><th>Retained Reserves £'000</th><th>Financial Standing £'000</th></tr>
<tr><td>Adult Social Care</td><td>158,006</td><td>166,332</td><td>8,326
5.27%</td><td></td><td>8,326</td></tr>
<tr><td colspan="6">• The Covid-19 related forecast includes £3.846m financial support to Adult Social Care providers to assist them in managing the pressures of Covid-19;
• In addition, the Covid-19 related expenditure includes a forecast of £4.700m to be incurred on discharges. This is forecast to be wholly offset by a corresponding reimbursement of £4.700m from the £1.3bn Covid-19 Health Grant;
• There is a potential risk resulting from Covid-19 that may see expenditure on Adult Social care increase over the longer term. This has not been included as a forecast within 2020/21 – but is highlighted as a risk in Section 3.4.;
• The Disabilities Service are forecasting a £1.987m overspend due to increasing costs and numbers of packages relating to supported living and an increase in home care packages relating to individuals with drugs and alcohol dependency;
• Mental Health is showing a pressure of £1.762m across all areas due to increased numbers of clients particularly in residential and supported living and in the north of the county;
There are also underspends being forecast for the following:
• Older People – a refined analysis of client contribution income has led to an increase in the income forecast of £2.953m;
• There is an underspend of £1.836m on residential nursing both due to a significant reduction in demand and as the NHS are currently picking up some of these costs during the Covid-19 pandemic, and an underspend of £0.642m as a result of reduced demand for equipment to aid independent living</td></tr>
<tr><td>People</td><td>34,017</td><td>33,791</td><td>(226)
-0.66%</td><td></td><td>(226)</td></tr>
<tr><td colspan="6">Despite a small overspend on one contract due to increased Covid related demand, there is a net underspend primarily as a result of reduced spend on commissioned services across a range of contracts.</td></tr>
</table>

3.2. Delivery of the Savings Plan

3.2.1.The savings targets and forecast outturn for the Services concerned are shown in the table below.

	2020/21 Target £'000	2020/21 Actual to Date £'000	2020/21 Forecast £'000
Adult Social Care	400	213	400
People	0	0	0

3.3 Capital Programme

3.3.1. The table below shows the approved capital budget for the Services and any slippage into future years.

	Approved budget for all current and future years (£'000)	Slippage from 2020/21 into Future Years £'000	Slippage from 2020/21 into Future Years (%)	Current quarter – new approved funding/ schemes (£'000)	Newly resourced spend included in slippage figures (£'000)	All Current and Future Years Forecast (£'000)
Adult Social Care	0	0	0%	0		0
People	100	4,587	28%	4,515		4.615
Funding agreements for Dementia Friendly environments are in place for 3 projects. Funding is to be paid in 2 instalments- initial payments in 20/21 & final payments on completion- this will likely be in 21/22 due to delays relating to Covid-19.						

4. Supporting Papers

4.1 A copy of the full report and supporting documents that went to Cabinet on the 10th September is available via the committee system.

5. Environmental Implications

None specific to this report.

6. Background Papers

None

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Portfolio Holders	Cllr Les Caborn, Adult Social Care & Health; cllrcaborn@warwickshire.gov.uk

Agenda Item 7

Adult Social Care and Health Overview and Scrutiny Committee
30 September 2020

Work Programme

1. Recommendation(s)

1.1 That the Committee reviews and updates its work programme.

2. Work Programme

The Committee's work programme for 2020/21 is attached at Appendix A for consideration. The programme was reviewed by the Chair and Party spokespeople at their meeting on 11 September. A copy of the work programme will be submitted to each meeting for members to review and update, suggesting new topics and reprioritising the programme.

3. Forward Plan of the Cabinet

The Cabinet and Portfolio Holder decisions relevant to the remit of this Committee are listed below. Members are encouraged to seek updates on decisions and identify topics for pre-decision scrutiny. The responsible Portfolio Holder has been invited to the meeting to answer questions from the Committee.

Date	Report
12 November 2020	Mid-year performance progress report.

4. Forward Plan of Warwickshire District and Borough Councils

This section of the report details the areas being considered by district and borough councils at their scrutiny / committee meetings that are relevant to health and wellbeing. The information available is listed below. Further updates will be sought and co-opted members are invited to expand on these or other areas of planned activity. Due to the Covid-19 pandemic, many committee meetings have been cancelled.

Date	Report
North Warwickshire Borough Council	
	In North Warwickshire, the meeting structure is operated through a series of boards with reports to the Community and Environment Board. There is a Health and Wellbeing Working Party and a Warwickshire North Health and Wellbeing Partnership (covering both North Warwickshire and Nuneaton and Bedworth). There have been no updates published since March.
Nuneaton and Bedworth Borough Council – Health Overview and Scrutiny Panel	
	The Borough Council held a special meeting of its External Overview and Scrutiny Committee on 21st July to discuss COVID-19. This session involved representatives from Public Health England, Public Health Warwickshire, Warwickshire County Council, George Eliot Hospital, the Police and the local MPs, to discuss the effects of COVID-19 in the Borough.
Rugby Borough Council – Overview and Scrutiny Committee	
	The Borough Council has a Communities and Resources OSC. Looking at its website, the scheduled meetings for this committee were cancelled for July and September.
Stratford-on-Avon District Council – Overview and Scrutiny Committee	
	The Committee's work programme includes updates on the impact of the Covid-19 pandemic and the associated work of the Council.
Warwick District Council – Overview and Scrutiny Committee	
	From the work programme in August, the former Health Scrutiny Sub-Committee has ceased. The Overview and Scrutiny Committee will meet next on 29th September. At its November meeting, a report on air quality management is scheduled.

4.0 Briefing Notes

4.1 The work programme at Appendix A lists the briefing notes circulated to the committee. Members may wish to raise questions and to suggest areas for future scrutiny activity, having considered those briefing notes.

5.0 Financial Implications

5.1 None arising directly from this report

6.0 Environmental Implications

6.1 None arising directly from this report

Appendices

1. Appendix A Work Programme

Background Papers

None

	Name	Contact Information
Report Author	Paul Spencer	01926 418615 paulspencer@warwickshire.gov.uk
Assistant Director	Sarah Duxbury	Assistant Director of Governance and Policy
Strategic Director	Rob Powell	Strategic Director for Resources
Portfolio Holder	n/a	

The report was circulated to the following members prior to publication:

Local Member(s): None
Other members: Councillor Wallace Redford

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Adult Social Care and Health Overview and Scrutiny Committee
Work Programme 2020/21

Date of meeting	Item	Report detail
Every Meeting	Covid-19 Updates	At the committee's meeting on 30th July 2020, the Chair advised members that there would be a standing item on every agenda until further notice, to provide for updates to members on Covid-19.
30 September 2020	One Organisational Plan Quarterly Progress Reports	The One Organisational Plan (OOP) Year-end Performance Report for the period April 1st, 2019 to March 31st, 2020 was considered and approved by Cabinet on 9th July. This report provides an overview specifically in relation to services within the committee's remit. There is also the quarter 1 progress report for 2020-21.
30 September 2020	Covid-19 Update	The theme for this meeting is to provide an outline on Covid-19 recovery work and a general briefing from the Director of Public Health on the position on Covid-19.
30 September 2020	CCG Update Progress of Restoration and Recovery of services in Warwickshire	The Committee will receive an update regarding the potential relocation of neuro-rehabilitation beds and to consider the development of a case for change.
18 November 2020	Mental Health	At the Chair and party spokesperson meeting on 11th September, it was agreed that the focus for the November meeting would be on mental health, to include the Healthwatch survey of patient experience during the Covid-19 pandemic and also evidence from commissioned services, the increases in service requests and people needing support.
Date TBC	Covid-19 – BAME Communities and Social/Health Inequalities	At the Committee's meeting on 24th June, it was agreed to add this to the work programme. This report concerns the higher proportion of people affected from BAME communities and the links to social and health inequalities too. For information an item was considered on this subject by the Health and Wellbeing Board on 15th September.
	Primary Care Networks	At the Chair and Spokesperson meeting on 21 January, it was agreed to replace a proposed update on GP Services with an item on Primary Care Networks (PCNs). Linked to this is the item below on pharmacy services. This item was deferred from the 29 April meeting which was cancelled.
	Pharmacy Services	At the Committee meeting on 6 March 2019, it was agreed that an item be added to the programme to receive an update on pharmacy services. The key aspects raised previously were:

		• Confusion over the services provided in each pharmacy and where patients should present, e.g. for minor ailments. Pharmacists have different levels of experience and expertise and local signposting is needed. • Through PCNs, it is planned to provide a broader and more integrated range of services including closer collaboration with pharmacy. • There is a healthy living pharmacy programme, supported by the County Council. In Warwickshire, 80% are healthy living pharmacies which deliver health, wellbeing and other services.
	West Midlands Ambulance Service and the Paramedic Service	At the Chair and Spokesperson meeting on 21 January, it was agreed that this item be added to the programme to receive an update from West Midlands Ambulance Service and the paramedic service, their priorities and performance on response times. Linked to the item will be an update on the 111 Service, which is also provided by WMAS. The original scope for this aspect was how they refer people to health services; how they link in with the relevant CCG; how they know where services are commissioned; also what they do about patients with no transport who are referred to an out of hours Service for example in the early hours of the morning.
	Merger of the Coventry and Warwickshire Clinical Commissioning Groups (CCGs)	This item has been discussed at two special meetings of the committee held on 30th July and 19th August.
	Alternate Provider Medical Services Contracts	A motion was debated at Council on the retendering of Alternate Provider Medical Services (AMPS) contracts. It was agreed that this matter be brought back to the committee for further consideration and was originally intended to bring an item to the February 2020 meeting. WN and C&R CCGs are undertaking the procurement process and details are awaited on the full position will be known on the APMS contracts. On that basis the Chair has agreed to defer the matter pending the outcome of the procurement exercise.
	George Eliot Hospital (GEH) - Care Quality Commission (CQC) Inspection	GEH had an unannounced visit from the CQC in December 2019. Members asked in both the January and February committees when it would be able to discuss the CQC report and associated action plan. It was confirmed that the CQC had given notice of certain 'must do' and 'should do' actions. The CQC report has been published and contact was made with GEH with a view to the item being considered at the cancelled April Committee.
	Coventry and Warwickshire Strategic Five-Year Health and Care Plan	The Joint Coventry and Warwickshire Health OSC received a presentation from Sir Chris Ham on 14 October 2019 ahead of the deadline for submission of the draft Coventry and Warwickshire Strategic Five-Year Health and Care Plan to NHSE&I. It would be useful to programme a date for this item to come to the ASC&H OSC.
	Out of Hospital Programme.	Suggested by Councillor Parsons at a Chair/Spokes meeting.

	Mental Health and Wellbeing George Eliot Hospital (GEH) - Care Quality Commission (CQC) Inspection	This item was added to the work programme in June 2018, with the item scheduled for the November Committee. Further discussion at the Chair and Party spokesperson meeting on 29 October 2019, when the item was deferred. A revised date and scope for this review area needs to be agreed.
	Better Health, Better Care, Better Value (BHBCBV) – Proactive and Preventative Workstream	Suggested by Councillor Margaret Bell. The Proactive and Preventative work stream of the STP. The suggestion is to find out more: What is happening; what is the plan; how is it to be funded; when will we see results?
	Review of the Adult Transport Policy	Cabinet approved a revised Adult Transport Policy on 25 January 2018. This has been suggested as an area for the Committee to review after 12 months of implementation.
	Local Commissioning of Services	Suggested by Councillor Mark Cargill. A pilot scheme has been undertaken in Alcester.
	Coventry and Warwickshire Partnership Trust	Suggested by Healthwatch. There has been a re-inspection of the CWPT by the Care Quality Commission. Originally planned for the Trust to present its progress against the action plan to the January 2018 meeting, which was considered to be too soon for the Trust to have implemented actions from the CQC review. Suggestion to have a written update and then programme for a formal report to provide assurance that the 'must do' and 'should do' recommendations are being implemented.

BRIEFING SESSIONS PRIOR TO THE COMMITTEE

Date	Title	Description
Date to be Set	Admiral Nurses	Cllr Redford is minded to ask representatives of Dementia UK to provide a briefing session on the work of Admiral Nursing.
20 November 2019	Assistive Technology Developments.	***This item was postponed.*** Officers would like to share the positive outcomes of the project on assistive technology and the self-help tool "Ask Sara" to enable people to remain independent in their daily lives. This briefing will enable councillors to be informed and assist in promoting the information with their constituents.
25 September 2019	Older People Adult Social Care Market	This briefing session will provide context ahead of the consideration of a formal report in the Committee meeting.
3 July 2019	None	
6 March 2019	Access to Primary Care Services for Homeless People	Healthwatch Warwickshire will provide an interim report on their project on access to primary care services for homeless people. WCC has a project mapping such services. This will be a joint briefing session from both WCC and HWW.
30 January 2019	Direct Payments and the introduction of Pre-payment cards.	At the Chair and Party Spokes meeting in October 2018, it was agreed to have a briefing session prior to this meeting on direct payments and the introduction of pre-payment cards.
21 November 2018	None	

26 September 2018	Dementia Awareness	A detailed report and presentation was provided in September 2017. The Committee agreed to consider the additional work being undertaken through Warwickshire's Living Well with Dementia Strategy (2016-2019), the potential areas of focus being timely diagnosis and support in acute/residential housing with care settings.
11 July 2018	Presentation on developing Fire and Health/Social care agenda.	A presentation from Officers of the Fire and Rescue Service on the support they are providing to the work of Social Care.

BRIEFING NOTES

Date Requested	Date Received	Title of Briefing	Organisation/Officer responsible
24/06/20		The Warwickshire North Place Board had received a presentation on smoking in pregnancy. The data for the north of the county shows that one in five expectant mothers smoked. A briefing with data and the actions being taken would be useful.	Director of Public Health
24/06/20		At the June Committee meeting, a request for more information about the use of developer contributions from Section 106 planning funding to fund additional health services. A briefing note was requested on where these monies would be allocated. Raised by Councillor Golby.	Clinical Commissioning Groups
21/01/20		Home Environment Assessment and Response Team. The Chair and party spokespeople agreed on 21 January to move this item from the work programme and to receive a briefing note instead. The briefing is expected to be available in April 2020.	
21/01/20		Adult Social Care Strategic Review. The Committee received a presentation at its meeting in September 2019. The Chair and party spokespeople agreed on 21 January to move this item from the work programme and to receive a briefing note instead.	
21/01/20		The review and redesign of Warwickshire Employment Support, a service for adults requiring learning support and those with autism. The Chair and party spokespeople agreed on 21 January to move this item from the work programme and to receive a briefing note instead. The briefing is expected to be available in April 2020.	
21/01/20		Local Suicide Prevention Plan. This item was scheduled for the meeting on 20 November 2019. At the Chair and Spokesperson meeting on 21 January, it was agreed that this update be provided via a briefing note. The County Council has an approved suicide prevention plan; it has a higher number of suicides than for comparative councils and has received extra funding from NHS England for two years to start implementation of the suicide prevention strategy.	

20/11/19	14/11/19	One Organisational Plan Quarterly Progress Report – Quarter 2. This item was scheduled for the November committee meeting, which was deferred. It was agreed that the report be circulated electronically to members of the committee. The report was duly circulated on 14 November.	

TASK AND FINISH GROUPS

ITEM AND RESPONSIBLE OFFICER	OBJECTIVE OF SCRUTINY	TIMESCALE	FURTHER INFORMATION
Health Inequalities and the Impact of Covid-19	Proposed at the Chair and Spokesperson Meeting on 11th September 2020.		
Joint Health Overview and Scrutiny Committee	This is the first of the joint committees, working with Coventry City Council to focus on Stroke Services.	Completed January 2020	A series of meetings took place involving the joint HOSC and individual health OS committees, between October 2019 and January 2020.
Maternity and Paediatric Services	The Committee agreed this TFG area at its meeting on 15 September. The detailed scoping of this area is still to be determined.	Review starts after completion of the GP Services TFG.	A briefing was provided to the joint meeting of this Committee and the C&YP OSC held on 28 January 2020.
GP Services	The Committee agreed this TFG area at its meeting on 15 September. The report of the TFG presented in May 2018.	May 2018.	The review report was approved by Cabinet in June 2018 and submitted to the Health and Wellbeing Board in September 2018.

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