Adult Social Care and Health Overview and Scrutiny Committee

Wednesday 17 November 2021

Minutes

Attendance

Committee Members

Councillor Clare Golby (Chair)
Councillor John Holland (Vice-Chair)
Councillor John Cooke
Councillor Tracey Drew
Councillor Marian Humphreys
Councillor Chris Kettle
Councillor Jan Matecki
Councillor Chris Mills
Councillor Penny-Anne O'Donnell
Councillor Pam Redford
Councillor Kate Rolfe
Councillor Mandy Tromans

Officers

Shade Agboola, Becky Hale, Nigel Minns, Isabelle Moorhouse, Pete Sidgwick and Paul Spencer.

Others in attendance

Councillor Margaret Bell, Portfolio Holder for Adult Social Care and Health
Councillor Jerry Roodhouse, Warwickshire County Council (WCC)
Chris Bain, Healthwatch Warwickshire (HWW)
Mark Docherty and Murray McGregor, West Midlands Ambulance Service (WMAS)
David Lawrence (Press), John Dinnie, Martin Drew, David Passingham, Carolyn Pickering, Anna Pollert, Bryan Stoten (Public)

1. General

(1) Apologies

Councillors Richard Baxter-Payne (Nuneaton and Bedworth Borough Council), Peter Eccleson (Rugby Borough Council) and Judy MacDonald (North Warwickshire Borough Council).
Rose Uwins (Coventry and Warwickshire Clinical Commissioning Group (CCG)).

(2) Disclosures of Pecuniary and Non-Pecuniary Interests

Councillor Jerry Roodhouse declared an interest as a Director of Healthwatch Warwickshire.

(3) Chair's Announcements

The Chair welcomed everyone to the meeting, especially the return after illness of Councillors Kate Rolfe and Tracey Drew. She confirmed membership changes and welcomed new members to the Committee, being Councillors Peter Eccleson (Rugby Borough Council), Chris Kettle (WCC) and Penny-Anne O'Donnell (Stratford-upon-Avon District Council).
A welcome also to Mark Docherty and Murray McGregor, who would be providing an update from WMAS.

(4) Minutes of previous meetings

The Minutes of the meeting held on 29 September 2021 were accepted as a true record and signed by the Chair.

2. Public Speaking

It was reported that five people had registered to speak at the meeting.

Carolyn Pickering, representing South Warwickshire Keep Our NHS Public (SWKONP), submitted a statement and question about Coventry and Warwickshire Integrated Care System (ICS) Public Accountability. A copy of the submission is attached at Appendix 'A' to the minutes.

Anna Pollert, Secretary of SWKONP, submitted a statement and question about Coventry and Warwickshire ICS. A copy of the submission is attached at Appendix 'B' to the minutes.

Mr David Passingham spoke about the Community Hospital Review and specifically in relation to the Ellen Badger Hospital. His address covered the value of community hospitals, the reported and perceived aims and outcomes of the review. He spoke of bed capacity within the NHS and drew comparison to medical provision in other countries. This review should have been holistic, and he listed areas that should have been included. The benefits of the hospital were stated, especially for frail elderly patients. There were wider benefits in terms of local staff skills and environmental benefits through reducing travel requirements for staff, patients and their families. He concluded that the review should have been holistic.

Professor Bryan Stoten also spoke on the Community Hospital Review, providing background on the Ellen Badger hospital. It had been anticipated the hospital would be closed. A league of friends was formed, land adjacent to the hospital was acquired with local funding and a commitment was given by South Warwickshire Foundation Trust for the site to be restored and developed. However, this did not materialise, and further fundraising had since been discouraged. He referred to the review paper, the now stated purpose of the hospital for discharge to assess patients which differed from the original vision for community hospitals to avoid admission to an acute hospital setting. He drew comparison to a similar review in Alcester and the outcome from that review. He similarly expected that there would not be a hospital, but instead a GP surgery at this location. This approach was being repeated and was losing public support.

Mr Martin Drew, representing SWKONP, submitted a statement regarding forthcoming changes to data protection legislation. A copy of the submission is attached at Appendix 'C' to the minutes.

The Chair responded that the matters raised would be considered, and a written response provided to the questions after the meeting. Regarding the ICS the Council was in discussion with health colleagues and was planning to hold a meeting in public, focussed on the ICS. She did not want the concerns raised to be taken out of context, expanding on a few of the points made by speakers about the perceived dismantling of the NHS, the potential benefits which could come from public/private partnerships and referring to a previous community hospital review.

3. Questions to Portfolio Holders

Councillor Jan Matecki asked Councillor Margaret Bell a question on the Prevent Service. An accusation had been made by a member of the public which concerned the disproportionate referral of people with mental health issues or learning disabilities. Context was sought from the portfolio holder on the total number of referrals to the service in the last 12 months and how many individuals had mental health issues or a learning disability. Councillor Bell gave thanks for the prior notice of the question. The detail had been requested and would be provided to Councillor Matecki.

4. Questions to the NHS

None.

5. West Midlands Ambulance Service

The Chair welcomed Mark Docherty, Director of Clinical Commissioning and Murray McGregor, Communications Director from West Midlands Ambulance Service (WMAS).

WMAS had been asked to address members on its review of community ambulance stations. This item had been raised at Council on 28 September and all members of Council were invited to submit questions and lines of enquiry. These were forwarded to the Ambulance Service, with initial written responses provided and circulated to members.

Murray Macgregor spoke initially on the following areas:

- An acknowledgement that WMAS performance in Warwickshire was not good enough, evidenced by the performance data provided to members in the circulated pack. This was disappointing and reflected data from across the country.
- A recent report highlighted cases of harm due to hospital handover delays. The hospitals serving the Coventry and Warwickshire area were not the worst offenders, but there was room for improvement.
- From data there were some 28,500 lost hours of service across the region due to hospital handover delays, impacting severely on the ability to respond to further patients. He spoke of the impact for patients, the risk of harm and for staff, finishing late, affecting their welfare and when they could commence their next shift.
- This was one of the reasons for the decisions around closure of community ambulance stations.

- Previously, response targets were based on the time taken to get to the patient. A detailed review was undertaken in 2017-18 to look at improvements. Using the example of a stroke case, it was not about when the paramedic reached the patient, but when that patient received the specialist treatment in hospital which determined their likelihood of survival and a good outcome.
- Community ambulance stations provided an inefficient system. An outline was provided of the way the hub model operated and staff had an ambulance checked, equipped and ready to use immediately for their full shift. Compared to this, the community ambulance station model had a number of inefficiencies which were explained and equated to 2½ to 3 hours per site per day. It was estimated that the increased efficiency from this proposal would enable response to 5000-6000 extra calls per year.
- There was concern that this change would remove the ambulance cover from Stratford and Rugby. This was not the case and an outline was provided of the operating model. In many cases, patients were treated at the scene and did not need transport to hospital. This meant the ambulance was available in that locality for the next patient. Data showed that ambulances based at a community ambulance stations only attended 5% of cases in their immediate area.

Mark Docherty outlined his background working in the NHS and spoke on the following areas:

- His involvement in a document 'zero tolerance' raising concerns some nine years ago about the implications of delayed hospital handovers for ambulance services.
- Data was provided and nearly 30k hours were lost due to hospital delays, the equivalent of taking 83 ambulances out of service.
- Across the region WMAS worked with 22 hospitals. He used data from Shropshire to show the significant increase in delays of over one hour in ambulance turnaround times. Over the last five years, for that hospital it had increased from 56 to 397 in the first 10 days of November alone. Additionally, the length of waits at hospitals had increased significantly, in one case being 14 hours.
- The matrix used to assess the likelihood and severity of impact of hospital delays. It was considered that hospital delays would lead to patient deaths. This was a significant issue which could not be ignored.
- Covid had been used as an excuse. Whilst it had accelerated the decline in performance, he considered the current position would have been reached within the next one to two years without the pandemic. The issue had been raised with many people over a number of years.
- It was a really difficult position now and the early signs showed it would be a difficult winter period.
- The numbers of calls for service increased year on year. This was the first year WMAS was not delivering its targets or was not even close to them for some patients.
- He spoke of the impact of delays in terms of the number of patients that could be treated by one crew during their shift.
- WMAS did not have staff vacancies, but capacity was much reduced as a result of these reported issues.
- Trainees were attending a much smaller number of patients, which did not give them the rounded experience required. The current position would have long-lasting effects unless a solution was found.

- A local context was provided on the handover delays at the hospitals serving Coventry and Warwickshire. The position was relatively better than for some other parts of the region, although delays were still experienced and there were early indicators of concern. A comparison was made to Birmingham, where the delays were considerably more significant.
- He spoke about capacity, the number of ambulances committed at any time and when there were no ambulances immediately available to respond.
- He concluded that current response times were unacceptable.

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

- The Chair and members welcomed the honest and open approach provided.
- Concerns about the failed performance targets in CV postcode areas.
- In response to points from Councillor Pam Redford, discussion about the endeavours to engage with acute hospitals to address the challenges caused through delays in patient handover, especially for the Accident and Emergency (A&E) department. This was a very complex issue, both in this country and many others. A key contributor was unnecessary occupancy of hospital beds by people who no longer needed acute care. Patient flow was key. Both WMAS and A&E were used inappropriately by many as a first point of care, instead of using primary care services. The responses showed a need to address this strategically throughout the NHS as a whole.
- A comparison to the waiting times at A&E departments, when patients presented, those reported by WMAS and ambulance waits now meant some people were travelling to A&E themselves, rather than wait for an ambulance. WMAS gave patients a realistic appraisal of the waiting times. If people could travel to hospital themselves, it could be argued that they did not perhaps need an ambulance.
- Examples were provided of the initiatives in place, the continual dialogue with acute hospitals, the use of hospital liaison officers and clinical validation to triage patients to the appropriate service. Data on conveyance rates showed the proportion of people using WMAS inappropriately.
- Mark Docherty gave examples of the innovations in the region, notably it had the best trauma service, good outcomes from both stroke and heart attacks and he spoke of the decisions taken in regard to the vehicle fleet. The figures could be bland and he urged that they were treated with caution. If a time target was missed slightly it would be shown as ‘red’ on the data. For serious conditions like a stroke, it was more important when treatment of the patient started to give them the best outcome.
- Resolving the current challenges would require many agencies to be involved.
- There was greater use of emergency services by younger cohorts than previously. True emergencies represented about 10% of WMAS work. If other patients accessed the appropriate health service, this would improve the situation significantly. The Chair urged the press to publicise the message to use WMAS appropriately, also highlighting the demographic data on younger people not using services appropriately.
- Councillor Matecki made points about the closure of community ambulance stations. Only half of patients required transport to hospital, so there was a counter argument for efficiency in having an ambulance in the very south of the county, rather than travelling from Warwick. A comparison was made to a review by the Police to centralise staff, which resulted in a reduction in officer numbers and loss of local services. Assurance was sought that this review would not similarly reduce services in future. Whilst the counter argument was

accepted by WMAS officers, generally crews took their break after attending hospital. There was no reduction proposed in the personnel. In fact the benefits from the revised arrangements would lead to building cost savings which would be directed to front line services.

- Regarding the performance data, a point that a faster response time was likely to lead to the patient receiving treatment more quickly. It was noted that the best response time data was for the area closest to the Warwick hub. Response times for people living close to hospitals were always good, due to the number of ambulances at hospitals.
- Mr Macgregor gave an outline of the different response categories and prioritised approach to focus on the most severe cases. Response times in urban areas were always faster than for rural areas. Mark Docherty added that service demands now meant personnel were rarely at the ambulance hub, even for a meal break. He gave an outline of the process to ensure the vehicle fleet was maintained, equipped and ready to be used. This had been a key aspect in meeting the challenges of the pandemic. He reflected on the benefits of the former community ambulance station model, but this was no longer sustainable.
- Councillor Rolfe shared her personal experience following a heart attack. Whilst the WMAS response took 42 mins, the staff had saved her life and she thanked WMAS and the staff concerned. The Chair thanked her for sharing this personal account and it gave context on the performance 'red' and 'green' indicators.
- Councillor Holland paid tribute to all NHS staff. The current performance wasn't good enough and needed a joint recovery plan involving both WMAS and acute hospital A&E departments. Previously WMAS had said it did not have enough paramedics. With sufficient staff, up to two thirds of incidents could be resolved at the scene, reducing the impact on A&E. Reference also to previous work on quality accounts, a visit to the Warwick hub, and an outline of how the hub model worked with the fleet located to ensure a timely response to calls. Previously, some managers had needed to be operational to add capacity.
- In response, WMAS now had paramedics on every vehicle and was the only ambulance service in the country to do so. It had helped in reducing the proportion of patients who needed transporting to hospital. The crews were now constantly out on jobs. Managers were only deployed for complex situations. On the point about a joint approach to address the current hospital waits, this needed to be much wider than just WMAS and A&E departments, to include all aspects of hospitals, primary care, mental health services and local authorities, to ensure effective discharge to social care.
- Mr Docherty welcomed the challenge and ideas put forward, but these were an 'ideal world' view. He outlined the actual position using an example in Shropshire where every ambulance had been delayed at hospital. As a regional service, ambulances would be diverted from adjacent areas, but the position was worsening. Context was provided that the position in Coventry and Warwickshire was relatively not as bad as for Birmingham. However, the position was much worse than previously. It was important to recognise the rural geography of Warwickshire too, which impacted on response times.
- The WMAS representatives then spoke about the critical time for response to treat a patient in cardiac arrest and the rapidly worsening prognosis. Community support and defibrillators were of significant assistance. Typically, in the UK there was a 7% chance of surviving a cardiac arrest. By comparison survival rates in Denmark were 25% which was attributed to teaching children CPR in schools and a much higher number of defibrillators. They needed to be placed every 400 metres to provide full cover. Reference also to the mapping work with the British Heart Foundation, so that all defibrillators were registered and a request for members to spread this message.

- A sense check on peoples' willingness to do CPR and a request to encourage people to take up such training and learn where their community defibrillator was located.
- Councillor Holland reiterated points from earlier in the discussion, the need for a joint recovery plan and asked that it be considered by the Committee. Mr MacGregor stated that this was much wider than just WMAS and A&E departments, also speaking about the current challenges faced by acute hospitals.
- The Chair spoke of cause and effect, the need for the recovery plan to include all stakeholders and urged a further discussion after the meeting to take this aspect forward. Councillor Holland repeated that he would like an initial report at the next meeting.
- Councillor Mills commented that hospital waits were a longstanding issue and that some people made inappropriate requests for service.
- Councillor Cooke asked how WMAS checked that service requests were appropriate and the potential for a public education video. Mr Docherty replied that public education was difficult and from a previous endeavour had actually increased unnecessary calls for service. An example was used of referrals from care providers 'out of hours' for incidents involving frail elderly people. These often resulted in the person being admitted to hospital, when other services may have been more appropriate, but they were not available 24 hours per day, seven days a week. The situation was exacerbated over the Christmas period, due to the closure of other services.
- Councillor Roodhouse suggested that a task and finish group may be a useful method for discussing the recovery plan. He considered that poor communications had contributed to the public reaction to the operational decision regarding closure of the community ambulance stations. He referred to a WMAS board paper and asked for an update on the regional discussions to address the current challenges. Similarly, an update on the clinical validation teams in call centres was sought. In the Health and Wellbeing Board which preceded this meeting, approval had been given to the Better Care Fund submission. He quoted from that paper on the implications of falls and the significant number which resulted in calls to WMAS. This needed to be picked up as part of the integration arrangements. He considered that WMAS should be involved a lot more in those discussions and that WCC could assist with communications. In regard to the NHS111 service, difficulties were experienced with calls not being answered, so people may then ring 999 instead.
- Mr MacGregor referred to a recent letter from NHS England to acute trusts and others asking them to address delayed hospital handovers, which had highlighted this issue. He reminded of the recent report on patient harm resulting from such delays. The clinical validation team was working well and improving still further. In September it directed lower priority requests to more appropriate services in 12,000 of 20,000 cases where no ambulance was required. In October it was 18.9% of such calls. An outline was given of how this was undertaken through advice or triage. WMAS now had the highest non-conveyance rate in the country.
- On the NHS111 service, Mr MacGregor advised that WMAS was commissioned to handle 1.2 million calls per year but was now taking 2 million calls, causing immense pressure. There was no additional funding for the extra calls. During the height of the pandemic, a clinical decision was taken to focus on the emergency 999 service, using staff from the NHS111 service which had impacted. Extra call handlers had been and would continue to be recruited to address the known problems, even if it put WMAS into deficit. The service was starting to recover as a result of this action. Integration of the 999 and 111 call handlers had taken place and the benefits of this approach were explained. There was a continual increase in calls to the NHS 111 service and the public were now being encouraged to use its online service first or the NHS mobile telephone application.

- Chris Bain thanked the speakers for the clear and candid approach at both this meeting and a previous regional Healthwatch meeting. He agreed that resolving the current challenges required a system-based response. NHS111 and the 999 service were part of that response. HWW was undertaking a survey of those using NHS111, with a focus on carers using the service during the pandemic. Access to GP doctors remained an issue. At acute hospitals there were concerns about bed occupancy levels, lengths of stay and safe discharge arrangements to other services. It needed an ICS response for a joint recovery plan and could not be produced by WMAS alone. It also needed to include the Coventry and Warwickshire Partnership Trust.
- Mr Docherty welcomed these contributions, also praising WMAS staff for their work through the pandemic. Staff were fatigued, fragile and some had received verbal abuse. They needed space and help to recover and WMAS was undertaking a range of actions to improve services and help its staff. He reiterated the increasing volume of calls to the 111 service. Mr Docherty spoke more generally about Covid and influenza, encouraging people to be vaccinated.
- Chris Bain drew a distinction between A&E attendances and admissions. Primary care had a significant role to play.
- Councillor O'Donnell also paid tribute to WMAS for the service provided for a family member. She agreed that the recovery plan needed wide input, spoke about hospital discharge arrangements, the need for better communication and the additional challenges caused by Covid. She was concerned about the lack of experience for trainees. Mr Docherty gave an outline of the different training offers and the option to extend training periods. Examples included a new paramedic masters' degree course, simulation training and hospital placements to get maternity experience. Remote supervision provided another option using technology to connect to hospital-based services to receive guidance where required. Murray McGregor gave a further example of video calls made to multi-disciplinary teams, improving diagnosis, providing prompt treatment or referral to a specialist. Such video technology was also being considered for the NHS111 service and would assist call handlers.
- Councillor Humphreys asked for more information about community first responders (CFR), the total number of people, total hours of service and where they were located. Mr McGregor offered to provide specific information for Warwickshire after the meeting. CFRs were volunteers and WMAS was undertaking a campaign to recruit more, having secured an extra 400 over the last year. Following a review, CFR activity was focussed on areas where they could have most impact, responding to serious medical conditions such as cardiac arrest and stroke. He encouraged councillors to seek to establish a CFR scheme in their communities. Further points were the standard training qualification for all CFRs and their importance in rural communities to provide a timely response.
- Further information was provided about the national category system for prioritising calls for service.
- Mr Docherty reiterated that WMAS was not happy with the current response times. He outlined the WMAS operating model, the allocation of ambulances on a prioritised basis, the potential service demands currently and risks of harm for some patients if no ambulance was available to respond. In very serious cases such as a stroke those delays could result in the patient's death or significant long-term impacts. These delays were directly attributed to ambulances being delayed at hospitals.
- Councillor Kettle questioned if the lower category cases should be considered as a crisis necessitating a 999 call or indeed whether an ambulance should be sent if there were other options for the patient to be transported to hospital more quickly. The officers spoke of the

surge in service demand in the summer. Councillor Kettle asked if there were any aspects the Council should be considering. A concern about the response time data for south Warwickshire which was significantly worse than for some other areas of the county. He also asked what impact the revised arrangements would have for rural areas in south Warwickshire and whether response times would worsen.

- Mr Docherty urged caution in the interpretation of call categories, which were used by WMAS to prioritise the service response. Some people may not clearly express how unwell they were, whilst others could overstate their symptoms, to get more urgent attention. He gave a number of examples to demonstrate this. On rural response times, it was hard if not impossible to meet the seven-minute target for all areas and this could not be guaranteed even if there was a significant increase in crew numbers and the ambulance fleet. The data on response times would continue to deteriorate if the current hospital delays were not addressed. There was a need to have honest conversations. He spoke of wider issues including the age profile of people in rural communities, the impact of deprivation on some communities and there would be a variance in response times for the most rural areas.
- Mr MacGregor spoke about the high number of Covid cases still, but people had ceased to wear face coverings. Wearing face coverings had also contributed to there being fewer flu cases last year. It was known that some people had not received Covid or flu vaccinations, but by following health advice the situation would be better. The NHS was in difficulty and everyone had a role to play in looking after themselves and others.
- The Chair thanked Mark Docherty and Murray MacGregor for their honesty and for responding to members' questions. She considered the opportunity for the wider Council membership to submit written questions was helpful. If there were any further questions, these could similarly be forwarded to the WMAS officers.
- The Chair stated that GPs need to "step up"; opening their doors and delivering the services that they have a duty to. She added that throughout the Pandemic other arms of the health service have risen to the challenge. The same could not be said for GPs. Members of the committee were reminded that a task and finish review of GP services is about to commence. The TFG may wish to include within its remit how GP activity had an influence on wider NHS issues. Some people used A&E services because they could not get a GP appointment. There was an education piece, which should start at school for example with CPR training and correct use of services. The public needed to take more responsibility themselves. They could access services by video call and wearable technology/ augmented reality may be of use too. The Committee would always be a critical friend and whilst some issues may not be agreed on, the open and honest dialogue was valued. To the Portfolio Holder, Councillor Bell, she spoke about discharge support and providing wraparound services on a 24 hours per day, seven days per week basis. This was something that the county council's services should adapt to, to match NHS colleagues. Emergency response systems out of hours were perhaps not as effective as they could be to get people into and out of an acute hospital. The Chair praised the Warwickshire Fire and Rescue Service hospital to home scheme, having seen this operate. It could perhaps be expanded and add capacity to WMAS. It had been established that '999' calls were subjective and that the response time data could be misleading. The Chair asked that details for the defibrillator registration scheme be provided for wider circulation, also speaking on CPR. She closed this item, thanking Mark Docherty and Murray MacGregor for their time and members applauded.

Resolved

That the Committee notes the update from West Midlands Ambulance Service.

6. Community Hospital Review

The Chair sought members approval and then confirmed that this item would be deferred to the next meeting.

7. Work Programme

The Committee reviewed its work programme. Councillor Penny-Anne O'Donnell referred to the GP Services task and finish group, asking if a nuanced approach would be taken as the county had a large geographic area and there would be differing patient experience of GPs. The comments raised would be included.

Resolved

That the Committee notes its work programme.

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Councillor Clare Golby, Chair

The meeting closed at 12:50pm

Appendix 'A'

Statement and Question to WCC ASCHOSC on Coventry and Warwickshire ICS Public Accountability.
Question from Carolyn Pickering

Public Accountability
The UK government's Health and Care Bill will place Integrated Care Systems on a statutory footing. The term 'integration' sounds good, but it conceals a major threat to the future of the NHS. The concept of integration of NHS services, and integration between health (the NHS) and Social Care sound welcome. Who does not want more joined up care? But, contrary to government claims of improvement in our care, the word 'integration' and the jargon around plans for ICSs conceal legislation which undermines the NHS.

1) **Money and Staff.** The Bill to put ICSs into law does not solve the major problem facing the NHS and social care, i.e. chronic underfunding for the past 10 years and understaffing. The bill offers nothing to address that 5.7 million people in England are waiting for hospital treatment.
2) **Fragmentation and rationing, not integration**. ICSs fragment a national NHS into 42 independent ICSs, with their own budgets.

The national NHS pay scale will go and be replaced with a new NHS payment scheme. Thirty-six parliamentarians recently wrote to the minister for health arguing that this will, in effect, give private healthcare companies the opportunity to undercut NHS providers.

The Bill allows for NHS professions to be removed from regulation and this has the potential to impact on the status and, over time, level of expertise of the people who work in the NHS.

The Bill will worsen a postcode lottery as each system will be required to develop a plan within its 'population health management; budget, deciding which treatments to prioritise and which not to prioritise in their given areas. It will lead to increased rationing of services, too, as the Integrated Care Boards (ICBs) running the care systems will have far stricter financial limits each year, and once they have spent the money they have been allocated, patients may have to wait longer or go without treatment. That is a frightening prospect.

3) **Lack of public accountability**.
Councils. There is a real risk that the oversight role of councils - WCC and its committees - will be severely curtailed by the ICSs. The Coventry and Warwickshire ICS plan has room for only 2 local authority representatives. It is unclear as to the future role of the WCC ASCHOSC.
CCGs will be abolished. The Coventry and Warwickshire ICS, as described in WDC paper for Cabinet Nov 4 2021, Item 13, App. 1a, p. 7 cites NHS Coventry Warwickshire (the 'NHS Body') as the 'strategic commissioner' and refers to the Coventry and Warwickshire CCG[1] (the merger of the previous 3 CCGs). But as the King's Fund 'Integrated Care Systems Explained' (May 2021)[2], CCGs will be abolished. Getting rid of CCGs will remove another layer of what little accountability we have left.
ICPs are not required to meet in public or publish their minutes and papers.

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1 tinyurl.com/5crva7r2 'Warwickshire Integrated Care Partnership' - operation for Health and Well Being for South Warwickshire Place.

2 https://www.kingsfund.org.uk/publications/integrated-care-systems-explained

As the HSJ reported (November 4th 2021), the Bill will shortly go to the House of Lords. Among issues to be probed:

- More generally, there could be more probing of where accountability and decision making will lie in the new NHS – between integrated care boards, partnership boards, health and wellbeing boards, places, provider collaboratives, integrated care partnerships, primary care networks, and all the rest.
- Karin Smyth, a Labour MP, former NHS manager with a long interest in health, and member of the bill committee, adds to the list in a piece for HSJ, predicting that "accountability, local clinical leadership of the new bodies, integration with local government and 'safe space' in [the Healthcare Safety Investigation Branch]" are likely to feature prominently in Lords debate.

Will this committee give assurances that you will work to defend the public accountability of the ICS? That is, to probe the accountability problems as highlighted by the HSJ as well as defend the right of Councils, i.e. WCC and Coventry City Council, to have regular oversight and scrutiny of Coventry and Warwickshire ICS policies and decisions, including budgets, levels of care, staff pay, health and social care provision and other matters mentioned here? If these rights are undermined will you seek the support of those you represent as well as the support of MPs, to maintain these vital democratic rights?

Appendix B

Question and Statement to WCC ASCHOSC on Coventry and Warwickshire ICS regarding Cuts and Privatisation.
Question from Anna Pollert
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I would like to focus on the issue of ICSs, funding cuts and privatisation in the forthcoming Health and Care Bill, which will be debated on 22nd and 23rd November, ahead of it Third Reading.

The Health and Care Bill will turn ICSs into legal bodies. The Bill is based on NHS England proposals, derived from the US model of Accountable Care Systems, which aims to spend less on care.

Let me take you back to the WCC Public Interest Debate on Integrated Care Systems, in February 2019, when WCC voted to support a motion that:

This Council believes that an integrated care system focused on communities is the right way forward for the health and wellbeing of citizens inWarwickshire.

A number of SWKONP members contributed to that debate and, while supporting the principle of integration, highlighted the many elements of the ICS plan which the rhetoric of 'integration' conceals.

I hope the Chair can circulate my contribution to that 2019 debate, which, among other things, pointed to what I want to again highlight today, **i.e ICSs, funding cuts and privatisation.**

Since February 2019, things have now moved on. On March 19 2021, Coventry and Warwickshire Health and Care Partnership announced that: "We're delighted to let you know that Coventry and Warwickshire has been officially designated as an Integrated Care System by NHS England."

https://www.happyhealthylives.uk/latest-news/2021/03/19/ics-next-stage-ofdevelopment-for-our-health-care-partnership/

Funding Cuts:
These will be implemented by deregulation of professional standards and by 'population health management':

- The Bill allows the Secretary of State to deregulate unspecified NHS roles currently covered by professional regulation, threatening patient safety and staff development and training.
- NHS England Guidance proposes 'agile and flexible working' with staff deployed at different sites and organisations across and beyond the system. Again, this is a staff funding cut.
- NHS providers will be bound to a plan written by the ICB and to financial controls linked to that plan – population health management. The annual budgets will be based on area-wide targets, rather than providing the care needed by the individuals who live there.
- NHS funding will be delivered through a fixed block payment whose value is determined locally, based on a Payment Scheme in which prices for the same treatment or service vary by area, and according to who is providing it and who is receiving it. The private sector will be consulted on the Scheme.

Increasing privatisation.

- As it currently stands, the Bill allows for big business to sit on both ICBs and their constituent Integrated Care Partnerships (ICPs), with private companies influencing decisions about what health and social care is available in an area, despite the fact that those very same companies will, in all likelihood, be seeking contracts to deliver health and care in that same area. Conflicts of interest are inevitable.
- NHS England has accredited over 200 corporations and businesses, at least 30 US-owned, to help develop ICSs.

Will the proposed government amendment stop privatisation?
Health Minister Edward Argar announced to MPs in September 2021 that the government will amend the bill to *prevent "individuals with significant interests in private healthcare" from sitting on ICBs".*

1) But this does not apply to Integrated Care Partnerships. The Bill still explicitly provides for private sector participation in the advisory ICPs. ICPs, through their various sub-committees can have a significant role in influencing ICB policies and decisions and enhance the position of private company interests.

2) Privatisation can go ahead, but without tendering – a recipe for cronyism. The Bill repeals parts of Section 75 of Andrew Lansley's 2012 Health and Social Care Act, which required Clinical Commissioning Groups to put clinical services out to competitive tender. *But it does not abolish handing out contracts to private companies.* ***NHSE/I has developed a contract, the 'Integrated Care Provider contract',*** *which allows commissioners to award a long-term contract to a single organisation to provide a wide range of health and care services to a defined population*.

Without the Public Contracts Regulations 2015, contracts could be handed out to the private sector without the stringent arrangements one would expect in the awarding of public money. This is a recipe for cronyism, which has been exposed already in the management of the pandemic. Even if the host provider is an NHS body, the Bill does not prevent the setting up of private sub-contract companies, and subcontracting to other private companies.

Question: Will this committee give assurances that in scrutinising the ICS :
It will oppose cuts in health and care spending in an already depleted NHS and care service.
It will oppose private companies, whose priority is profit and not public service, having the power to make decisions about NHS and health and care services in Warwickshire and Coventry.

Appendix C

Statement from Mr Martin Drew

As consequence of Brexit, the UK government's DCMS consultation, Data: a new Direction proposes to change data protection that was covered by GDPR. The consultation process closes, 19/11/2021 yet there has been virtually no publicity about the radical revision of the way our data is used. Far-reaching reforms are proposed to the UK data protection regime with an emphasis on capturing the power of data to drive economic growth and innovation.

As you probably remember there was an attempt earlier this year to use GP patient data for research and NHS planning. This was postponed owing to public concern and the fact that patients' information would automatically be used unless people opted out.
The major revision of GDPR is another attempt whereby patient data will be made publicly available. Organisations and other third parties would be allowed to sell and reuse personal data more freely. Individuals would be exposed to harmful or exclusionary practices when it comes to commercial offers, the provision of services, and other life necessities.
Furthermore, the Government would be allowed to pass new laws and reuse data freely "in the substantial public interest", lacking suitable safeguards. The existing list of "substantial public interests" ranges from "statutory and Government purposes" to "standards of behaviour in sport", and it could be expanded indefinitely.
Lack of accountability that these proposals will produce is a major concern. I believe ASCHOSC has an important role in challenging what is tantamount to the exploitation of our private data.