Adult Social Care and Health Overview and Scrutiny Committee

Date: Wednesday 16 February 2022
Time: 10.00 am
Venue: Committee Room 2, Shire Hall

Membership
Councillor Clare Golby (Chair)
Councillor John Holland (Vice-Chair)
Councillor Richard Baxter-Payne
Councillor John Cooke
Councillor Tracey Drew
Councillor Peter Eccleson
Councillor Marian Humphreys
Councillor Christopher Kettle
Councillor Jan Matecki
Councillor Chris Mills
Councillor Penny-Anne O'Donnell
Councillor Pamela Redford
Councillor Kate Rolfe
Councillor Sandra Smith
Councillor Mandy Tromans

Items on the agenda: -

1. General

(1) Apologies

(2) Disclosures of Pecuniary and Non-Pecuniary Interests

(3) Chair's Announcements

(4) Minutes of previous meetings 5 - 20
To receive the Minutes of the meeting held on 17 November 2021.

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

Margaret Bell (Adult Social Care and Health) on any matters relevant to the remit of this Committee.

4. Questions to the NHS

Members of the Committee are invited to give notice of questions to NHS commissioners and service providers at least 10 working days before each meeting. A list of the questions and issues raised will be provided to members.

5. Menopause Services

Dr Shade Agboola, Director of Public Health will provide a presentation to the Committee on menopause services in Warwickshire.

6. Community Hospital Review 21 - 40

This report provides the Committee with an overview of the purpose, scope and progress of South Warwickshire Foundation Trust's Community Hospital inpatient review. It presents findings of the initial engagement as well as the future plan and indicative timeline for the review.

7. Work Programme 41 - 46

To review the Committee's work programme for 2021/22.

Monica Fogarty
Chief Executive
Warwickshire County Council
Shire Hall, Warwick

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- Declare the interest if they have not already registered it
- Not participate in any discussion or vote
- Leave the meeting room until the matter has been dealt with
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Non-pecuniary interests relevant to the agenda should be declared at the commencement of the meeting.

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

Public Speaking
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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
……..

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.

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Agenda Item 6

Adult Social Care and Health Overview and Scrutiny Committee

Community Hospital Inpatient Review

16 February 2022

Recommendation(s)

Recommendation 1: Adult Overview and Scrutiny Committee to note the scope and progress of the Community Hospital review in Warwickshire including the engagement feedback received to date and the output of the Community and Technical Panel exercises.

Recommendation 2: Adult Overview and Scrutiny Committee to consider the proposals in Table 4 and support further exploration to be progressed on each of the proposals in Table 5.

1. Executive Summary

1.1 This report provides the Adult Social Care and Health Overview and Scrutiny Committee an overview of the purpose, scope and progress of South Warwickshire Foundation Trust's Community Hospital inpatient review and presents findings of the initial patient, carer, stakeholder, and staff engagement as well as the future plan and indicative timeline for the review.

1.2 The Health and Social Care Act 2012, Regulation 23 requires relevant NHS bodies and health service providers to consult a Local Authority about any proposal which they have "under consideration" for a substantial development of or variation in the provision of health services in the local authority's area.

1.3 This report covers the following:

- Community Hospital inpatient provision
- The review of Discharge to Assess services
- Hospital Discharge Policy 2020
- The case for change
- Current utilisation, need and demand
- Engagement findings
- Equality Impact Assessment
- Technical Panel
- Community Panel
- Milestones and next steps
- Conclusion

2. Community Hospital inpatient provision

2.1 Community Hospitals have been established in local, usually rural landscapes for over 150 years. Initially identified as cottage hospitals they were a service for patients in rural communities to access health facilities in a safe and clean environment. Before being transferred to the NHS in 1948 they were funded entirely through fundraising, donations, and volunteering. A new model for community hospital provision was developed in 1970s when primary care and secondary care worked closely to offer a wider range of services from Community Hospital sites.

2.2 Locally, Community Hospitals provide a range of in patient and day treatment services within the South of Warwickshire which include treatments, rehabilitation, and end of life care. Community Hospital provision helps expediate discharges from acute hospital as well as, to a lesser degree, help prevent admissions to acute hospital. These small, bedded units receive medical cover from GP's rather than on site consultant support. They are predominately nurse and therapy led services.

2.3 Within Warwickshire there are 2 Community Hospitals, both in South Warwickshire provided by the Out of Hospital Care Collaborative within SWFT.

2.4 The Community Hospital inpatient facilities in scope of the review are;

- Ellen Badger Hospital in Shipston on Stour which has **16 inpatient beds** and;

- The Nicol Unit at Stratford Hospital which has **19 inpatient beds**.

There are a total of **35 inpatient beds** being reviewed across the 2 sites.

2.5 The bedded offer at the Community Hospitals is broadly split into 2 areas;

Acute Discharge (step down) beds (approx. 90% of admissions)

- Patients who have recently experienced an acute illness and require on going 24 hour medical and/or nursing input, for a short period of time. Patient also require further assessment, therapy and supported discharge planning.

Admission Prevention (primary care step-up) (less than 10% of all admissions)

- Patients with a deteriorating health condition requiring medical or nursing intervention that does not require acute admission but cannot be managed at home.

2.6 Added to this the local profile of the Community Hospital offer is unique at each site. Ellen Badger Hospital predominately provides traditional Community Hospital provision with a focus on rehabilitation whereas the Nicol unit generally supports patients with higher levels of need, they may be frail or at the end of life, Patients are also offered therapeutic interventions such as occupational therapy and physiotherapy.

2.7 Clinical interventions available at each site include; nursing care, therapy assessment and interventions, medical assessments, administration of medication, intravenous fluids or antibiotics (Nicol only), wound management, support with nutrition and hydration, continence care and assessment of mental capacity.

2.8 There is currently no Community Hospital provision in Warwickshire North or Rugby, within these geographical area's patients' needs are met via a mix of primary care, community and acute provision.

2.9 Other services provided from Community Hospital Sites such as minor injuries unit/s or Day Hospital/s are out of scope of this review.

2.10 A separate but interdependent project to redevelop the whole of the current Ellen Badger Hospital site is underway. The results of the Community Hospital Inpatient Bedded Review will be shared with the re-design project team to help inform their plans for phase 2 of the building which includes the current bedded unit on site of EBH.

3. The review of discharge to assess services

3.1 A system wide strategic review of discharge to assess (D2A) services was agreed by all local system partners in 2019. The scope of the review was to understand the current delivery and future requirements for all D2A pathways and services across the county to help ensure that these services are sustainable, resilient, and fit for purpose. This review has been undertaken at a time of unprecedented challenge with the onset of the pandemic and the introduction of new mandatory policy governing hospital discharge pathways and assessment practices.

3.2 The review concluded in 2021 and is now moving into implementation phase. Recommendations within the review are to move towards a more simplified, clear and fit for purpose D2A offer. This includes matching services to demand and where possible supporting people within their own home where it is safe to do so.

3.3 Community Hospitals form part of the D2A Pathway 2 offer within South Warwickshire. This means that the vast majority patients are discharged to the hospital following an acute stay in order that they can receive additional time for recovery, rehabilitation, further assessment, and medical support within a 24-hour care bedded setting. A very small number of admissions are step up from the community to Community Hospital via a GP led referral (less than 10% of total referrals).

3.4 **Table 1:** Coventry and Warwickshire Discharge to Assess Pathway definitions based on new Hospital Discharge Policy[1].

[1] Hospital Discharge and Community Support Policy & Operating Model, Department of Health and Social Care 2021.

Pathway	Ambition	Think	Definition
Pathway 0	50% of people	As Is	Discharge home to usual place of residence with: • no support from health or social care once at home or, • the same level of care as that provided prior to admission (even if with different provider)
Pathway 1	45% of people	Own Bed	Discharge home with new or an increased level of care compared to that provided prior to admission
Pathway 2	4% of people	Interim Bed	Discharge to an interim / temporary step-down bed
Pathway 3	1% of people	Permanent Bed	Discharge to a 24-hour care setting that is likely to be a permanent placement

Table 1 provides a breakdown of the different pathways available to patients at the point of discharge. Community Hospital inpatient beds, being part of pathway 2 should account for no more than 4% of all discharges from acute hospital within the over 65's population.

3.5 Community Hospitals are therefore an integral part of the D2A pathway in South Warwickshire and will be reviewed within the context of this wider service offer.

4. Hospital Discharge Policy 2020

4.1 One of the central policy drivers for the D2A review is the **Hospital Discharge Policy 2020**[2] which sets out responsibilities for NHS Trusts, Community and Acute providers and Social Care.

4.2 In September 2020, the original guidance was mandated as policy with the latest guidance revision being made in July 2021. Social care needs assessments and NHS CHC assessments recommenced with assessments being undertaken in a community setting. Acute settings must 'discharge all persons who no longer meet these criteria [to reside in hospital as soon as they are clinically safe'. Discharges must be on a timescale of within one hour for Pathway 0 and the 'same day' for Pathways 1, 2 and 3.

4.3 The Hospital discharge policy and supporting guidance sets an ambition that a maximum of only 4% of all discharges should be discharged to a D2A pathway 2 bedded service. Instead the policy and guidance states that; *Every effort should be made to follow Home First principles, allowing people to recover, reable, rehabilitate or die in their own home.*

4.4 The approach to a Home First approach to discharge is central to this policy, NHS England campaign to help reduce long length of stays within acute hospital. This policy acknowledges that an individual's own home, or if

[2] Hospital Discharge Service Guidance, Department of Health and Social Care 2020.

required a care home or other 24hr care setting, is best for their recovery and rehabilitation once their acute medical needs have been addressed.

5. Case for change

5.1 The Community Hospital review takes place within the context of wider changes within both health and social care including the development of the Integrated Care System, the development of out of hospital services, the wider availability of discharge to assess services and the prevalence of preventative programmes to help avoid people requiring acute services such as the proactive frailty programme in South Warwickshire.

5.2 Community health / out of hospital services have developed and altered over time and are now able to support much higher levels of patient need with a focus on admission prevention and supported discharge. This includes 2-hour emergency response in the community and greater levels of skill and competency such as the deployment of Advanced Clinical Practitioners. It is therefore important to review Community Hospital provision within the context of this enhanced and broader community offer that can support more patients at home.

5.3 Some patients go to Community Hospitals to die, alongside this we have inpatient and outpatient hospice facilities that could be utilised to a greater degree of impact and benefit, this issue will be considered as the review progresses with a focus on patient outcomes.

5.4 In April and May 2021, a 3-day multi agency audit of patients using the Community hospital inpatient facilities was undertaken. Of the 50 patients using the beds at the time of the audit at least a third of patients at each site were identified as being able to have their needs met at home rather than within an NHS bedded facility. A further proportion (around 10%) were identified as needing a 24 hour care bed in another setting such as a residential care home or hospice bed.

5.5 There are significant environmental and capital considerations required at both Nicol and EBH to ensure these hospital sites are modernised and fit for the future, this will come at considerable cost and it is therefore appropriate to review the service offers to identify future need alongside capital development required.

6. Current utilisation, need and demand

6.1 Pathway 2 bedded utilisation: There were 923 admissions into Pathway 2 Discharge Services in 2020/21 which represents a growth of 2% compared with 2019/20. Admissions into The Nicol Unit and Ellen Badger accounted for 56% of admissions due to offering the largest volume of Pathway 2 beds in Warwickshire.

6.2 **Table 2** - Total Community Hospital admissions between 2019 - 2021:

	Period 2019-20 and 2020 - 21 (combined total)	% of total admissions
Ellen Badger Hospital	434	45%
Nicol Unit	530	55%
Of these admission numbers above 66 of these or 6.8% were GP led step up / admission prevention*. All others were step down from acute. * During the pandemic there have been periods of time where admissions via the step up from community/GP pathway have been closed which may have impacted on the overall usage of this pathway.		

6.3 Typical patient profile across both EBH and the Nicol Unit:

- The average age of patients across all bed bases is 83 years.
- The largest age group of patients is 85 - 89 years.
- 25% of patients accessing community beds are age 90 years or over.
- 4.7% of patients accessing community beds are under 65 years.
- The majority of patients are female (62%).
- 93% of patients identified as White ethnic group whilst 1.6% identified as Asian ethnic group, 0.1% as Black ethnic group, 0.1% as any other ethnic group 4.4% of patients ethnic grouping was not known.

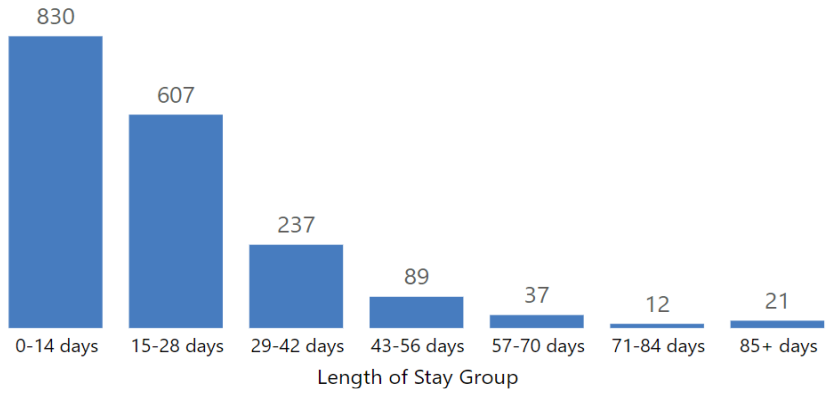
6.4 Patients home address location (home postcode), cumulative data for both sites (January - August 2021), identifies that patients who were admitted into Community Hospitals lived in the following locations:

- Leamington Spa: 23%
- Warwick: 23%
- Stratford upon Avon: 17%
- Kenilworth: 12%
- Southam: 6%
- Alcester: 4%
- Shipston on Stour: 4%
- Henley in Arden: 2%
- Out of area 8.5%
- Not recorded 0.5%

6.5 The average length of stay across both locations is demonstrated in Image 1. The average length of stay across both hospital sites between 2018-2020 is 23 days, this is slightly lower than the national average length of stay for Community Hospitals which is 25 days[3]. There is a small but significant proportion of patients with long length of stays 28 days and over.

[3] Community Hospital Benchmarking, NHS Benchmarking, 2018.

Image 1: length of stay EBH and Nicol 2018 - 2020



6.6 Discharge Destinations for patients that were discharged from Community Hospitals between 2018-19 and 2019-20 are as follows;

- Approximately 70% of all discharges were to the patient's own home.
- 20% of discharges were to a residential / nursing home.
- 5% of discharges were due to the patient passing away (RIP) whilst on the unit;
- Only 0.3% discharges were to a hospice setting.

Engagement approach

6.7 The involvement and engagement of people who have used or may use Community Hospital services is central to and will guide the review process. A stakeholder analysis has been completed to identify key stakeholders and groups who should be targeted as part of the engagement approach.

6.8 The approach to engagement was to primarily target those groups with personal experience of Community Hospital inpatient provision either as a patient or a carer/family member of a patient and/or those who were in a similar demographic group and therefore may use these services in the future.

6.9 These groups were provided an opportunity to complete a survey with questions designed to explore what is important to people about Community Hospital provision and what needs to be considered within the review process.

6.10 SWFT commissioned Healthwatch Warwickshire to distribute and promote surveys to target groups; previous patients, potential patients and wider public and stakeholders. Healthwatch also independently analysed all survey results and published these findings on their website which can be found here; https://www.healthwatchwarwickshire.co.uk/report/2021-09-20/south-warwickshire-community-beds-review

6.11 Healthwatch are particularly skilled in engaging with communities, groups, and individuals within the target group and survey respondents were offered the opportunity to complete a paper based, online or telephone based survey. The survey link was live and accessible for a period of 3 weeks. A list of the groups that Healthwatch targeted for surveying is enclosed as Appendix 1.

6.12 To gain further rich and in-depth insight into current patients experience of Community Hospitals a series of face to face patient interviews were conducted across EBH and the Nicol Unit in June and July 2021. A total of 27 interview were undertaken.

6.13 Patients were selected on the basis that they consented to take part and that undertaking the interview would not compromise their own health or wellbeing. Patient with levels of cognitive impairment were also in scope and able to take part in the interviews with appropriate support and guidance from ward staff. Interviewee's feedback has been included with the survey respondents' feedback and is detailed in section 7 of this report.

6.14 Staff and wider stakeholders who either work at one of the current Community Hospital sites or professionals working closely with or referring to the Community Hospital provision were also asked for their views. This was collected via a survey with space for free text responses. Again, these responses have been collated and are put forward within section 7 of this report.

7. Engagement Findings

7.1 The key themes from the patient's surveys, on ward patient interviews and staff and stakeholder surveys have been summarised and analysed. General themes include:

- ✓ A desire and need to access therapy and/or an increased amount of therapy to aid recovery.
- ✓ The importance of having time to rest, recover and recuperate away from the acute hospital environment.
- ✓ The benefit of social interaction and regular meals and nutritional support to aid recovery.
- ✓ Feeling safe and well supported.
- ✓ Being able to receive visitors whilst recovering.

Highlight points and feedback from specific groups are as follows:

7.2 People with direct experience of Community Hospital inpatient provision:

- 44% of interviewees reported that they were recovering at the community hospital following a fall with most reporting that their overall admission reason being for recovery, rehabilitation or 'bed rest'.

"Physio once a week for bad arthritis in both feet – been bad for many years." (Male, 72, Ellen Badger).

"2 weeks rest for leg – physio as well but mainly rest – then back to specialist as an outpatient." (Female, 85, Ellen Badger).

- Being able to receive 'physio' and support with care needs was highlighted by patients as important factors during their period of recovery.

"Physical care as can't do it for myself." (Female, 85, Ellen Badger).

"Little Exercises – physio comes – need to be supported to get back on my feet." (Female, 86, Nicol).

"They need more people – didn't have enough physio – would have been a faster recovery if there was more physio." (Female, 83, Nicol).

- Support with emotional needs, social interaction (staff and patients) cited as very important with some patients referring to being 'lonely' at home.

"Being around people – improving mental health – was lonely at home and found the experience traumatic." (77, Ellen Badger).

"Company – atmosphere – meeting for supper in the TV room." (78, Ellen Badger).

- Some patients highlighted the personal service received at a Community Hospital was greater compared to large acute setting. Comments around kindness of staff, environment being smaller, homely, and able to accept regular visitors were also key features of feedback received.

- Patients felt the environment of care at the Community Hospital helps aid a good routine as well as receiving regular meals, and hydration.

- Further comments and feedback indicated that Patients are not always clear about why they were at the Community Hospital or what to expect post discharge.

"I think it will be another ward like this." (Male, 50, Ellen Badger).

"No one talks about going home at the moment." (Female, 95, Nicol).

- When thinking about an 'ideal' scenario some Patients would like to re-habilitate at home rather than within a hospital but appear to have some doubts that the right care and equipment would be available to do this.

"Home to live independently – with support from a paid carer if have to but can't afford it." (77, Ellen Badger).

"Ideal would be at home with a package of care because then I can have visitors." (Female, 95, Nicol).

"Ideal would be home with carers." (Female, 74, Ellen Badger).

- Some Patients felt that the Community Hospital offer continuing exactly as it is delivered at the current time would suit their needs best.

"Best to come here rather than home – here physical needs are met and its local." (Female, 88, Nicol).

"Here – physical and medical needs are met until fit to be more independent at home." (Female, 85, Ellen Badger).

7.3 Former patients survey feedback:

Former patients of both community hospital sites were asked what they felt were the main benefits of Community Hospital provision, the top 3 answers were.

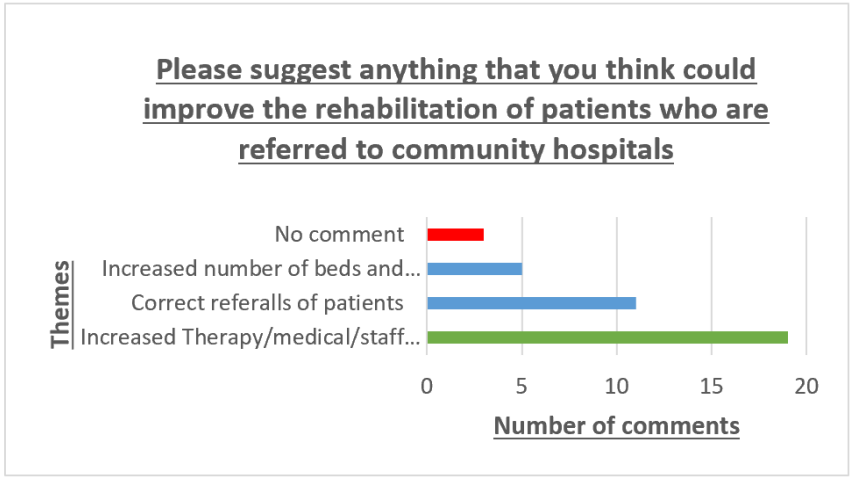
1. Quality of care
2. Rehabilitation
3. Eases transition from hospital to home

7.4 People without direct experience of community hospital provision:

Those without direct experience of Community Hospitals rated the same top 2 benefits as those with direct experience with exception of the 3rd most important area for this group being 'care closer to home' as opposed to 'eases transition from hospital to home'.

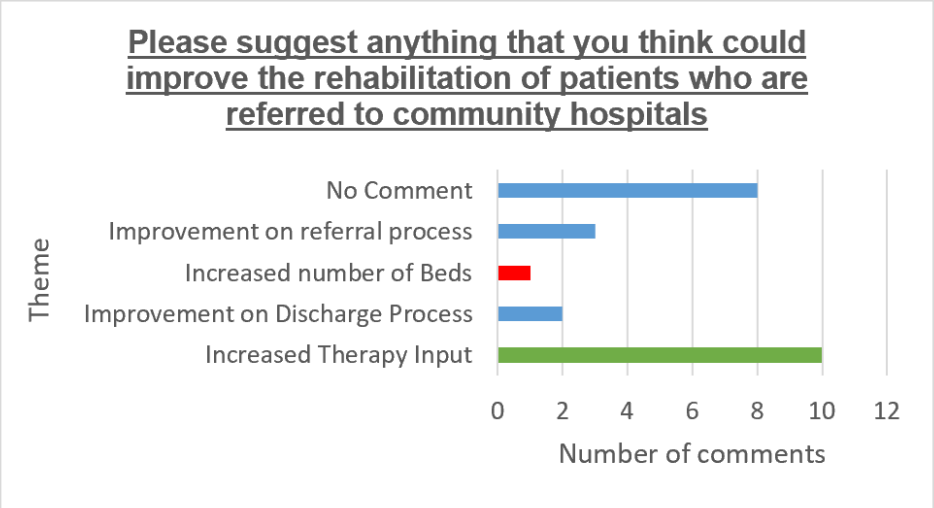
7.5 Staff working at Community Hospitals and/or professionals with knowledge of or referrers to the community hospital provision were asked a range of questions about the current offer and potential future requirements with staff indicating that Increased access to therapy medical support and staff was the areas that could most improve patient experience whilst at the Community hospital.

Image 2: Staff survey response:



7.6 A range of professionals that have knowledge of or refer to Community Hospitals were also surveyed, again access to therapy was highlighted as the area that could most improve a community hospital stay.

Image 3: Professionals survey response:



7.7 Acute staff were asked the same questions as those staff working within community hospitals. 11 acute staff responded to the survey of which 5 felt that between 21-40% of patients could be supported elsewhere e.g. home rather than a Community Hospital inpatient facility. A direct comment from a survey responder: *Many of my patients could go home with a package of care of 4 calls a day and physiotherapy input from the beginning (not 6-8 week wait as is often the case at home). Some would need support at night.*

7.8 Ongoing engagement with key groups as well as the formation of a community panel will help further refine the key themes, in particular this process will seek to fully identify the desired criteria and specific detail of areas identified such as 'increased therapy' and what this should look like within the future community service.

8. Equality Impact Assessment

8.1 A full Equality Impact Assessment has been undertaken to support the review and will be regularly refreshed as the review progresses.

8.2 The review of community inpatient facilities is underpinned by an Equality Impact Assessment (EIA) which also includes the wider determinants of health. At each stage of the review process this EIA will be kept up to date to ensure that due regard is given to the impact of the review on the protected characteristics of current and potential future users of community inpatient facilities as well as the wider determinants of health.

9. Technical Panel

9.1 A Technical Panel was formed in November 2021 to consider the long list of proposals put forward from the public engagement and to consider these against a set of hurdle criteria with a key aim of agreeing viability of each proposal.

9.2 The Technical Panel comprised of the following roles who were identified as having expertise and knowledge around the community bed offer; Nursing representatives, Medical representatives, Governance, Finance, General Manager, Therapy lead, Business Development, Staff Governor, Organisational Development, Social Care and Healthwatch. The meeting was facilitated by The Assistant Director for Operations for Out of Hospital SWFT and the Consultation Institute.

9.3 The hurdle criteria was agreed as follows.

Patient safety & quality	Does the suggestion promote patient safety and clinical quality for patients in south Warwickshire?
Workforce Delivery	Will the workforce be able to deliver the suggestion?
National and local direction	Does the suggestion meet the strategic direction of travel for hospital discharge services?
Affordability	Is the suggestion affordable and sustainable?

The hurdle criteria are a binary part of the process, and each proposal will either meet or not meet the agreed criteria. The Technical Panel used an interactive scoring exercise to capture their agreement/disagreement to each element of the hurdle criteria. Of the 14 proposals originally put forward 5 were deselected as non-viable against the hurdle criteria. (This is reflected in Table 3)

Table 3 Deselected proposals

Proposal	Reason for de-selection
Retain the Community Hospital exactly as is now.	Did not meet hurdle criteria: • National and local direction of travel.
Provide ensuite rooms only	Did not meet hurdle criteria: • National and local direction of travel. • Affordability
Increase the number of community hospital beds	Did not meet hurdle criteria: • National and local direction of travel. • Affordability • Workforce delivery
Cease Community Hospital ‘as is’ and provide support within a current	Did not meet hurdle criteria: • National and local direction of travel. • Workforce delivery

or new care home provision (newbuild or development)	
Reduce the number of Community Hospital 'as is' and provide support within a current or new care home provision (newbuild or development)	Did not meet hurdle criteria: • Affordability • Workforce delivery

The remaining proposals went for consideration to the Community Panel detailed in Table 4 of this report.

10. Community Panel

10.1 In December 2021 a panel of community representatives were convened to consider the inpatient review proposals as derived from the original engagement and Technical Panels subsequent shortlisting.

10.2 Representatives were invited to attend the panel from patient forums, senior citizens groups, hospital league of friends, carers organisations, faith groups, health and wellbeing partnerships, Citizens Advice Bureau, Heath Watch, community support groups, dementia support groups, disability support groups, community and voluntary action (CAVA).

10.3 The panel collectively agreed their 'desirable criteria' these are the things that are important to community panel representatives and the wider communities they represent.

10.4 To present this visually the panel contributed key words to suggest the things that are important to them within the context of the review which is displayed in the word cloud below.

10.5 A key theme for community panel is accessibility of services. Further discussion around this topic revealed that where individuals require

rehabilitative support they feel this should be available in a variety of ways and should be easy to access. Clear communications associated with service offers and support as well as the provision of good quality care were also discussed as very important. The desirable criteria highlighted by the Community Panel will be used to help guide the remainder of the review.

10.6 Furthermore, members of the community panel were asked to 'rank' the remaining proposals in order of preference. These preferences are detailed below alongside the Technical Panels final recommendation once they had been presented with findings from the Community Panel.

Table 4: Community Panel preferences alongside Technical Panels final recommendations:

Proposal	Community Panel preference	Technical panel final recommendation. Should the proposal progress to the next stage?
1. Keep the Community Hospitals as is but change the type of services on offer: • Diagnostics • Frailty Chair A combination of the above or 'other' to be identified service offers alongside BAU or reduced number of Community beds.	1st choice	Yes
2. Continue with some of the Community Hospital beds and invest in homebased alternatives such as package of care or therapy.	2nd choice	Yes
3. Retain the Community Hospital offer but change the location.	3rd choice	Yes
4. Continue with some Community Hospital beds and invest in a virtual ward to support and compliment this.	4th choice	Yes – suggest merge with 2nd proposal as very similar
5. Invest in the hospice service model to divert pressure from Community Hospital of those at the end of their life plus continuation of a proportion of community beds.	5th choice	Suggest deselect for this review and consider within the Hospice review

6. Invest in the hospice service model, cease community beds and invest in an alternative home based model.	6th choice	Suggest deselect for this review and consider within the Hospice review
7. Cease Community Hospital bedded provision and invest in 'own home' alternatives and/or virtual ward.	Least preferred choice	Although in line with HomeFirst policy suggest deselect as a continued need for community beds remains therefore proposal not feasible.

A total of **3 proposals** will be taken forward as part of the review for further exploration this includes merging proposals 2 and 4 and deselecting proposals 5, 6 and 7.

Table 5: Final proposals for further exploration

No	Proposal
1	Retain the Community Hospitals offer but change the type of services e.g: • Diagnostics • Frailty Chair • A combination of the above or 'other' to be identified service offers alongside BAU or reduced number of Community beds.
2	Continue with some of the Community Hospital beds and invest in homebased alternatives such as package of care or therapy and/or a virtual ward in the community.
3	Retain the Community Hospital offer but change the location.

11. Milestones and next steps

11.1 The timeline and expected milestones for the remainder of the review are included as an infographic timeline as Appendix 2.

11.2 The next stage of the review is to fully explore the final 3 proposals. This will be guided by Community Panels desirable criteria, Technical Panel's original hurdle criteria around viability and will be centred around the following key questions.

- ✓ What is the optimal capacity* required?
- ✓ What services are required to wrap around the service/offer?
- ✓ Where should the community capacity be located?

*capacity in this context could be community support (e.g., domiciliary care/care homes) and/or community inpatient beds.

11.3 At this stage of the review HOSC members should consider the planned approach and indicate if it is foreseen that any of the proposals represent a substantial development or variation in the provision of health services in the local authority's area.

11.4 If formal consultation is now triggered the CCG will lead this as the statutory duty to involve and consult ultimately sits with the CCG and then the Integrated Care Board when this forms as part of the Integrated Care System (ICS) later in 2022.

12. Conclusion

A review of Community Hospital Inpatient facilities is underway within Warwickshire. This review is not only timely but also strategically important for the local health and care system. The aim of the review is to understand if the support provided for patients at the point of discharge is being delivered in the right place and at the right time. Learning from the pandemic and wider service and the developments to the out of hospital offer are important points of context for the review. People with direct experience and those that may experience community hospital services are at the centre of this review. The review will conclude with a clear agreement on the future offer within the community. This will be achieved by following the plan described within this report.

Appendices

Appendix 1 - Community groups targeted for survey responses.
Appendix 2 - Community Hospital Infographic timeline.

Background Papers

None

Report Author	Katie Herbert Integrated Lead Commissioner, WCC and SWFT.

Appendix 1 – list of groups targeted via engagement plan.

Age UK Dementia Day Service Manager:
Healthy Ageing Workstream
Dementia Café Tysoe
SVHWP
Alcester HWB
League of Friends
Communities Teams (WCC Newletters)
HWW newsletter
Social Prescribers
Policy Officer Older People
Dementia Cafés WRAP Bishopton
Dementia Cafés WRAP Wellesbourne
CA Over 65's support
WCC Reablement Service
The Gap
SYDNI Centre - older people activities
Brunswick Hub
Shipston Forum
WCAVA - Newletter
Warks District Dementia Group
VASA
Social media and Vol Drivers
WCC development Officers for Community Centres
WALC - Parish Councils
Warwick District Faith Forum
Stratford District Interfaith Forum
Equip
Gypsy and Traveller Team WCC
HWW Volunteers
South Warks PPPG

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UPDATED TIMELINE JANUARY 2022

Gather feedback from previous, current and future patients.

July 2021

Analysis of feedback.

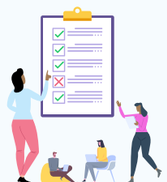
September 2021

Discuss initial thoughts with Health Overview and Scrutiny Committee.

POSTPONED
Rescheduled February 2022

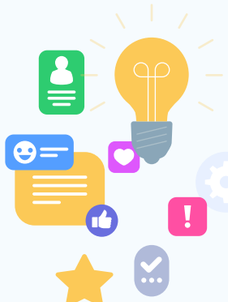
November 2021

Evaluate the key themes and using agreed scoring criteria, refine viable solutions. Work with patient representatives on this process.



November-December 2021

Discuss initial thoughts with Health Overview and Scrutiny Committee.

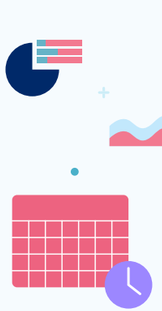


February 2022

Engage Coventry and Warwickshire Clinical Commissioning Group and NHS England & NHS Improvement on the viable solutions, based on the scoring outcomes. Dependent on what this is, establish if full consultation required.

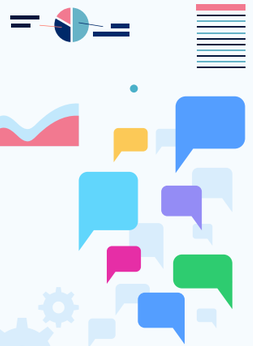
Early 2022

Preparation of full consultation, if required.



Expected to take 1 month

Formal consultation, if required.



Will take 12 weeks

Analysis, deliberation and decision making.

Expected to take 2 months

Implementation phase begins based on agreed proposal.

Expected to take 2-3 months

Recommended proposal in place.

Summer 2022

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Agenda Item 7

Adult Social Care and Health Overview and Scrutiny Committee
16 February 2022

Work Programme

1. Recommendation(s)

1.1 That the Committee considers and approves its work programme.

2. Work Programme

The updated work programme was discussed by the committee's Chair and spokespeople at a meeting on 20 January. The outcome from that discussion is attached at Appendix A to this report.

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 provided for the committee to consider as potential areas for pre-decision scrutiny. Members are encouraged to seek updates on decisions too. The Portfolio Holder, Councillor Bell has been invited to the meeting to answer questions from the Committee.

Date	Report
17 February 2022	Quarter 3 Council Plan 2020-2025 Quarterly Progress Report (April to December 2021)
10 March 2022	Review of Section 75 Partnership Agreement for the Provision of Integrated Mental Health Services between Warwickshire County Council and Coventry and Warwickshire NHS Partnership Trust

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.

North Warwickshire Borough Council (NWBC)	
	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). From the NWBC website, the Board met on 17 January. On this occasion there were no items related to health.
Nuneaton and Bedworth Borough Council (NBBC)	
	The NBBC Housing, Environment and Health Overview and Scrutiny Panel met on 3 February. The agenda included the following items: • Neurodevelopmental Services – An update on the waiting list • Healthwatch Warwickshire – the concerns and priorities for healthwatch.
Rugby Borough Council – Overview and Scrutiny Committee	
	The Borough Council (BC) has a single overview and scrutiny committee with the use of task groups. From the Rugby BC website, the last meeting was held on 22 November 2021 with a further meeting scheduled for 16 February. Looking at the work programme for the committee and task groups, there is a proposed item on the topic of emergency health care provision.
Stratford-upon-Avon District Council – Overview and Scrutiny Committee	
	The Council's Overview and Scrutiny Committee met twice in December, on 5 January and 2 February. From examination of these agendas, there are no recent items linked to health. There is a future item listed (date to be confirmed) for an update on health recovery (COVID) from Coventry and Warwickshire Clinical Commissioning Group.
Warwick District Council – Overview and Scrutiny Committee	
	The Overview and Scrutiny Committee met on 7 December 2021 and 8 February 2022. Looking at the committee's work programme, there are no recent items linked to health. There is an item scheduled for April to call in a report going to Cabinet on the HEART Shared Service update including the implementation of the new IT system.

4.0 Task and Finish Groups (TFGs)

4.1 The GP services TFG held its first meeting on 29 November to consider the scope of this review. The next meeting is scheduled for 28 February.

5.0 Briefing Notes

5.1 The work programme at Appendix A lists the briefing notes requested and circulated to the committee. Members may wish to raise questions and to suggest areas for future scrutiny activity, having considered those briefing notes. In particular, members may wish to comment on the Quarter 2 Council Plan 2020-2025 Quarterly Progress Report (April to September 2021). This was circulated on 2 December 2021. The Quarter 3 report will be submitted to the April committee meeting.

6.0 Financial Implications

6.1 None arising directly from this report.

7.0 Environmental Implications

7.1 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 Clare Golby

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Adult Social Care and Health Overview and Scrutiny Committee
Work Programme 2021/22

Date of meeting	Item	Report detail
10 February 2022	Integrated Care System (ICS)	Discussed at the committee meeting on 29 September. A high-level briefing to be delivered by the Chair and chief executive (designate) of the ICS/ICB.
16 February 2022	Women's Health - Menopause	The scope is to look at services provided in Warwickshire. Include the links to other health issues. In the north of Warwickshire, current services are co-located inappropriately. A need to collate information on current GP services, data and workplace support. Dr Shade Agboola to lead on behalf of both WCC and the Coventry and Warwickshire CCG.
16 February 2022	Community Hospital Review	To provide an overview of the Community Hospital review in South Warwickshire which forms a significant part of the wider Discharge to Assess review.
27 April 2022	Quarter 3 Council Plan 2020-2025 Quarterly Progress Report	This report summarises the performance of the organisation at the Quarter 3 position, 1 April 2021 to 31 December 2021.

BRIEFING SESSIONS PRIOR TO THE COMMITTEE

Date	Title	Description
TBC	Duties Under the Care Act	Suggested by Pete Sidgwick at the Chair and Spokesperson meeting on 7 June. to provide a briefing for the committee on the Council's duties under the Care Act.

BRIEFING NOTES

Date Requested	Date Received	Title of Briefing	Organisation/Officer responsible
7 June 2021	28 June and 29 July	An offer from Healthwatch to provide briefing papers on its role (circulated 28 June) and the carers' survey of lived experiences during the pandemic (circulated 29 July).	Chris Bain, Healthwatch Warwickshire
7 June 2021		Minor Injuries Unit – Stratford. This unit at Stratford Hospital is currently closed. A request for information on when it will reopen.	Rose Uwins, Coventry and Warwickshire CCG
29 September 2021	25 October 2021	Follow up briefing on dementia services, with data on young onset/ early onset dementia and Admiral Nurses.	Claire Taylor, WCC Commissioning
	22 December 2022	Council Plan 2020-2025 Quarter 2 Progress Report. This report summarises the performance of the organisation at the Quarter 2 position, 1 April 2021 to 30 September 2021. Due to a timing issue, it was agreed to circulate the report to members as a briefing between meetings.	Performance, Planning and Quality, together with relevant services in the People Directorate

TASK AND FINISH GROUPS

ITEM AND LEAD OFFICER	OBJECTIVE OF SCRUTINY	TIMESCALE	FURTHER INFORMATION
GP Services – Revisit	A task and finish group (TFG) took place in 2017/18. The committee agreed to undertake a further TFG.	TBC	The TFG has met once and considered the scope. A further meeting of the TFG will take place on 28 February.