Adult Social Care and Health Overview and Scrutiny Committee

Wednesday 27 April 2022

Minutes

Attendance

Committee Members
Councillor Clare Golby (Chair)
Councillor John Holland (Vice-Chair)
Councillor Richard Baxter-Payne (Nuneaton and Bedworth Borough Council)
Councillor John Cooke
Councillor Tracey Drew
Councillor Marian Humphreys
Councillor Christopher Kettle
Councillor Jan Matecki
Councillor Chris Mills
Councillor Penny-Anne O'Donnell (Stratford-upon-Avon District Council)
Councillor Kate Rolfe
Councillor Sandra Smith (North Warwickshire Borough Council)

Officers
Becky Hale, Nigel Minns, Deborah Moseley and Paul Spencer.

Others in attendance
Chris Bain, Healthwatch Warwickshire (HWW)
Councillor Margaret Bell, Portfolio Holder for Adult Social Care and Health
Terry Chikurunhe, NHS England and Improvement (NHSE&I)
Pippa Wall, West Midlands Ambulance Service (WMAS)
Justine Richards, University Hospitals Coventry and Warwickshire (UHCW)

1. General

(1) Apologies

Apologies for absence had been received from Councillor Mandy Tromans and Councillor Pam Redford (Warwick District Council).

(2) Disclosures of Pecuniary and Non-Pecuniary Interests

None.

(3) Chair's Announcements

An update was provided on the South Warwickshire Community Hospital Review. Following further discussion at the Chair and spokesperson meeting it was confirmed that this review was not considered to be a major service reconfiguration. This review would be kept under consideration bu the committee.

The Chair outlined the agenda content, urging brevity in both presentations and questioning, also reminding of the additional documents circulated ahead of the meeting.

(4) Minutes of previous meetings

The minutes of the meetings held on 10 and 16 February 2022 were approved as true records and signed by the Chair.

2. Public Speaking

Carolyn Pickering made a statement and submitted questions concerning the Coventry and Warwickshire Integrated Care System and public accountability. A copy of the submission is attached to the Minutes. Councillor Margaret Bell, Portfolio Holder for Adult Social Care and Health responded. A copy of the response is also attached to the minutes.

3. Questions to Portfolio Holders

None.

4. Questions to the NHS

None.

5. Quarter 3 Council Plan 2020-2025 Quarterly Progress Report (April 2021 to December 2021)

The Council Plan quarter 3 performance progress report for the period 1 April to 31 December 2021 was considered and approved by Cabinet at its meeting on 17 February 2022. A tailored report was submitted relevant to the remit of the Committee. It provided an overview of progress of the key elements of the Council Plan, specifically in relation to performance against Key Business Measures (KBMs), strategic risks and workforce management. A separate financial monitoring report for the period covering both the revenue and capital budgets, risk management and delivery of the savings plan was also provided. Comprehensive performance reporting was available through the Power BI platform.

Councillor Drew sought further information about the number of people who could have remained at home with support rather than going into a care or nursing home. This would be researched to provide an indication to members.

Resolved
That the Committee notes progress on the delivery of the Council Plan 2020 - 2025 for the period.

6. Update on NHS Dental Services

Terry Chikurunhe, Senior Commissioning Manager for NHS England and Improvement (NHSE&I) provided a verbal update to the committee covering the following areas:

- The change in commissioning arrangements, moving from NHSE&I to the new Integrated Care System (ICS).
- Key messages to address public confusion of dental services and the difference in patient lists when compared to GP doctors. Contractually, dentists provided treatment and then retained responsibility for that patient for two years afterwards, unless the patient had periodic 'check ups'.
- The challenges for dentists throughout the Covid pandemic, the loss of services other than some urgent dental care.
- Dentists continued to receive NHS funding throughout this period, providing they maintained services at a level set nationally. NHSE&I had a contractual monitoring role.
- Oral health promotion and work with the new ICS for Coventry and Warwickshire.
- There were 65 dental practices within Warwickshire and five specialist orthodontic practices for children. South Warwickshire Foundation Trust provided secondary care for patients in the County, with George Eliot Hospital providing community dental services. Specialist and complex procedures were undertaken at the Birmingham dental hospital and children's hospital.
- Dental services in Warwickshire performed well when compared to other areas of the Midlands region. However, there were some areas of the County with significant challenges for dental access, with Nuneaton and Rugby referenced. There were challenges in attracting dentists and nurses to work in rural areas. Reference to the work to promote NHS dentist services to practitioners. There were workforce challenges and some dentists chose to treat patients privately, even if the same premises were used for NHS services.
- The planned strategic review of dental services. This would be based on population growth and tackling inequalities in current services.
- Prior to the pandemic, 50 percent of the population accessed NHS dental services, with the other half either using private services or not having access to a dentist.
- The pandemic impacted significantly on access to dentists, mainly due to infection control. Data was provided for Warwickshire. In December 2021, dental access was just below 44% of pre-pandemic service levels. Now the lower threshold for services was 62% of normal service levels, with one in 10 dental practices not achieving this level currently.
- Oral health improvement. Targeted work was taking place in Nuneaton, Bedworth and Rugby to address high incidences of children with tooth decay. A joint approach was taking place to encourage children through programmes like 'brushing for life' where education and toothbrush/paste were supplied. Reference also to training for care home staff so they could look after their residents. A move to more integrated services.
- Fluoridation of water supplies. This was not preferred by all but was beneficial in preventing tooth decay.

A lengthy debate followed with the following contributions and themes:

- The Chair requested that a written summary of the data be provided.
- Further discussion about dental registration and the contractual obligations. After two years of initial treatment, a dentist was not contractually obliged to keep the patient registered.

This was not widely known. People were classed as a dormant patient, unless they attended for a regular check-up. It was confirmed that people would not be removed from registration where they had become dormant through not being able to attend their dentist ,due to the pandemic. Reference also to the NICE guidance, work on the dental contract and through patient groups to ensure that patients were not deregistered unnecessarily.

- A concern about rising living costs and people not attending dentists because of the costs. Whilst NHSE&I was not aware of this issue, some people had not visited their dentist for two years due to the pandemic. Dentists were reporting an increase in the number of more complex cases. From a financial perspective this was causing some dentists to cease providing NHS services.
- Due to the pandemic, the equivalent of a year of dental activity had been lost. Addressing this backlog would take considerable effort and time. There were recruitment issues and staff fatigue too. Programmes were being run to increase capacity.
- The follow up report would include the fee structure for NHS dental services. Some people were exempt from paying NHS fees, including for dental services, subject to meeting specific criteria.
- Alarm that only 50% of Warwickshire's population were using NHS dentists, which implied that the rest were forced to use more expensive private services. This was challenged a patients should not be forced to use private services. If NHSE&I became aware of such activity, contractual sanctions were taken. Some people chose to access private services, but it should be a choice. It was requested that a further report be provided to give a breakdown of data for the 50% of people that were not accessing NHS dentist services.
- A view was sought on the financial viability of dentists in Warwickshire, with reference to the feedback received from some dentists. This was a national issue and was based on the national contract and financing in place since 2006. NHS dentists had continued to receive full funding throughout the pandemic despite the reduction in operational activity. The subsequent report to members would include details of the incremental increases in operational targets for them to continue to receive this funding. It was NHSE&I's view that dentists had been supported through the pandemic. It could be argued that there was a need to revisit the financing due to work and additional costs for infection control. This was an ongoing discussion and had significant financial implications.
- Chris Bain of HWW reported that dentistry was the NHS service which caused patients most confusion. The dental contract was described as impenetrable. Feedback from patients evidenced a reluctance to use NHS services during the pandemic, to redu pressure on services, but this had actually resulted in lost appointments. HWW undertook a survey of dentistry, and the findings were published on its website. It showed a 'postcode lottery' in terms of NHS dentist services, with a lack of access to NHS services in both Rugby and Stratford at the time. The survey was being repeated this year and its findings would be reported to the committee. Private appointments were available at the time in both Rugby and Stratford, which evidenced the exploitation of confusion by some dentists. Referrals to the NHS 111 service did not result in satisfactory responses especially for urgent dental matters. These findings were also available via the Healthwatch website. Enquiries to HWW continued to include many related to dental services. The plans to increase services to address the backlog were not realistic and posed a risk of dentists leaving the service. The points about workforce challenges were known. The reports and assurances from NHSE&I differed from the lived experiences reported to HWW. Chris Bain offered to have further discussions with Mr Chikurunhe after the meeting. There was a need to tackle both inequalities and the postcode lottery. Some people in Rugby had not had dental appointments for over two years and there were concerns especially for children.

- Mr Chikurunhe welcomed the opportunity to work with HWW. He acknowledged the access problems in Rugby and spoke of plans for more investment in dental services for this area. It was known that newly qualified dentists wanted to work privately, rather than provide NHS services. NHSE&I was aware that some practices offered both NHS and private services, offering faster appointment times and treatment privately. Further points about the differing fee structures and dentists wanting to work on a part time basis.
- A comparison to NHS doctors who could also work privately but had obligations to see NHS patients. There were different contractual requirements and funding mechanisms for GPs and dentists, with dentists required to fund their own premises for example. The degree of influence for NHSE&I was much less for dentists than it was for GPs. NHSE&I provided a contract payment to dentists who then configured their services. Chris Bain responded that the funding did include an aspect for facilities.
- A request that HWW provide feedback to the committee following its discussion with NHSE&I. It was suggested that the committee could revisit this topic at a future meeting.
- Some specialist services were only available on a private basis and at significant cost. It was questioned why such treatment could not be provided as an NHS service. Mr Chikurunhe responded that especially where a patient was in pain, they should not be required to pay for treatment privately. Cosmetic procedures were not available via the NHS. An offer to look into a specific case reported. He also outlined the secondary care services available for more specialist procedures. Some people may elect to pay for private treatment, if there were waiting times for treatment on the NHS.
- Members welcomed the plans for training of care home staff speaking about the importance of oral hygiene. This project was being led by dental Public Health colleagues and data would be provided as part of the report back. Reference also to the domiciliary visits which took place for people unable to visit a dental practice.
- A question about the proportion of private dental services and when this became a concern. There was no easy way of measuring this, and it was more about responding to complaints from patients directed to private services, instead of being offered treatment on the NHS. Such dentists were reminded of their contractual obligations. Some patients may choose to pay for private dentistry, but they should not be forced to use private services due to a lack of NHS service. NHSE&I had no right to information held by dentists about their private work.
- Councillor Cooke gave an outline of previous roles as a councillor serving on the health authority and spoke about the charging structures introduced for both dentist and optician services. Issues with NHS dental services had existed for some time and examples were provided to demonstrate this, as well as personal experience of a practice moving to provide only private services paid for via a monthly dental plan. He spoke about the comparative costs for NHS treatment and was concerned at the lack of NHS dental services for children. He considered that the NHS dental contract required updating.
- A question about dentists choosing to provide only private services and the impact for dormant patients who had not visited the dentist for two years. It was confirmed that such dentists were required to give a minimum of three months' notice and to complete the treatment of current NHS patients. The councillor considered this a contributor to the 50% of people unable to access an NHS dentist as many preferred to stay with the same dentist.
- The Portfolio Holder Councillor Bell commented on obligations of dentists whose training was paid at least in part by the public purse. There should be an obligation to treat children on the NHS, free of charge. An update was sought about the infection control requirements, also referring to the impact of the pandemic in limiting the number of patients who could have appointments. Addressing the service backlog would not be achieved if there were the

same requirements for infection prevention measures. She also asked about the transfer to the ICS and what controls it would have, such as to revisit the dental contract.

- Mr Chikurunhe considered the comment about training to be fair and this was an area for Health Education England, which was responsible for dental training. Like other students, most newly qualified dentists had a significant debt to repay. On infection control, he confirmed the additional risks for this service and the measures that were imposed to protect patients and staff. A detailed response would be provided on the rules now in place as this changed frequently. The transfer of dentistry and other services from NHSE&I to the ICS would include additional funding for the ICS. It was a question of how to reconfigure services at both the place and ICS level. However, the current issues would transfer to the ICS. He also spoke about an unsuccessful pilot scheme to align dental contracts to be more like those for GPs. This had actually impeded access to NHS dentists.
- Nigel Minns added that the current problems would transfer to the ICS and would need addressing. There was considerable interest in dental services locally and it would be a clear focus for the new system to address as best as it could within the national framework.
- It was questioned if dentists were required to offer a minimum proportion of NHS appointments. Mr Chikurunhe confirmed that dentists received a payment based on contractual terms, for the provision of NHS services. He outlined the services and t additional challenges due to the pandemic, making it difficult for new patients to receive NHS dental care.

In closing the item, the Chair made a number of points. The dental contract was not helping residents or dentists, who were given a binary either/or choice. The contract dated back to 2006 but there had been significant changes since that time, so it required update. She referred to the contractual requirement to deliver 65% of usual service levels during the pandemic. To address the known backlog, dentists would be required to work above normal service levels. If they chose to cease providing NHS services, it was questioned if the monies provided during the pandemic could be clawed back. She asked if there was a view about the contract review and ministers could be lobbied about this. Reference had been made to a strategic review for Warwickshire and the Chair asked for the timeline for this review. Reference also to the dental education provided previously in school settings. It was questioned if this service was still in place, as a reliance purely on parents may have an impact for some children. The Chair asked about emergency NHS dental treatment requesting that a pathway be provided to show how patients may access the services. These points would be communicated to Mr Chikurunhe after the meeting for the follow up briefir note. He was thanked for his attendance and responding to the Committee's questions.

Resolved

That the Committee notes the update from NHS England and Improvement on dental services and that a further briefing note is sought on the follow up areas outlined above.

7. West Midlands Ambulance Service (WMAS)

(1) WMAS - Performance Update

The Committee received an update from WMAS on 17 November 2021. Pippa Wall, Head of Strategic Planning for WMAS provided an update on performance data since that meeting, through a presentation covering the following areas:

- Incidents, transport and conveyance rates year on year.
- Coventry and Warwickshire hospital handover delays of over fifteen minutes – the total hours by month.
- Operational demand and handover delays.
- Hospital handover delays of over fifteen minutes and cohorting vs operational performance. A series of charts showing the position for priority categories 1,2 and 3.
- Two further slides were provided showing handover delays for University Hospitals Coventry and Warwickshire (UHCW) and for Warwick Hospital. A similar slide for George Eliot Hospital would be circulated.

The Committee was invited to submit questions and comments, with the following points raised:

- Difficulty in reading and interpreting the slides. It was noted that these had been circulated ahead of the meeting.
- The slides showed a concerning position. It was interesting to note that during the peak of the pandemic services were coping but performance had worsened over the last year. The causes were questioned. Pippa Wall agreed that it was a bad position and was difficult for front line staff assisting patients. People were waiting longer for WMAS to arrive, and the situation was unprecedented. An outline was given of contributing factors, including Covid, the recovery work of NHS impacting on other services and people presenting with more acute conditions. There was staff fatigue and sickness, some people were leaving the services and reference to ongoing recruitment as well as continued infection control measures. Ambulance delays at hospitals were also mentioned.
- The data for the most serious (category 1) calls was considered shocking and the trends showed the position was worsening. It was hoped the position would improve. Details were provided of the escalation processes to raise these concerns and the dynamic response approach to address concerns where possible. This situation required a holistic system response as hospitals were similarly facing many challenges.
- The open and honest approach was appreciated.
- Chris Bain of HWW agreed this was a system issue for the ICS. He spoke about separating attendance at the Accident and Emergency (A&E) departments from resultant admissions. There was more chance to influence why people attended A&E and avoid unnecessary attendance. The impact on patients was not covered and should be. Delays could be linked to readmission rates, lengths of stay and impacts on discharge. Chris asked how the situation would be recovered and by who. He was not clear if there were any system plans in place for recovery.
- Pippa Wall agreed on the points about patient impact. WMAS was a data rich organisation and could make more use of this data to give an integrated picture and insightful messages. An increasing number of complaints were being received. She spoke about the monitoring of performance data around impact for patients who were critically ill. This could be researched to provide an answer to the questions raised. Addressing the current position would require action by a number of organisations. Hospitals would similarly have their own action plans and there were national mandates to reduce ambulance handover delays. Pippa spoke of the current delays in some parts of the region and the risks for patients who were waiting for an ambulance to arrive. There was an impact on the call centres too as people sought an update on

the crew's arrival. Reference also to the 111 service and subsequent requests for an ambulance to sent. There were attempts to reduce conveyance to hospital where possible and the proportion of patients taken to hospital had reduced. Also, the 'hear and treat' service resolving issues over the telephone had contributed in reducing conveyance to hospital. However delayed arrivals meant the condition of some patients had worsened.

- The presentation data was difficult to interpret just showing a number of spikes. It should include more context, for example on the impact of a delayed handover or reduced recovery rates. As WMAS was 'data rich' it was questioned what analysis took place to make use of this data. The points were noted. It would be useful to add events such as commencement of the pandemic to the timeline to show causal effect. It was also important to show trend and correlation data. Examples were provided of the information sources available to WMAS, the software system and dashboards which enabled investigation of this data, down to clinician level and the treatment supplied.
- It was questioned how GPs could assist in reducing the attendance numbers at A&E departments. A question about the coordination of individual plans and strategies to address the current situation. Pippa Wall confirmed there were system wide meetings where providers discussed their respective challenges. WMAS wanted to reduce hospital handover delays to improve response times. It did provide information to GP surgeries on patients requesting an ambulance. All parts of the NHS were 'fire-fighting' currently, attempting to address their respective concerns, but it was challenging. The member viewed that this could be addressed by working together to find a solution.
- More information was sought about how call categories were defined and the information provided to the call handler was interpreted. There were significant differences in response target times. An example was used of a case involving a serious incident, where it was felt the wrong call category had been assigned. Pippa Wall responded that the categories were determined nationally and were reliant on information given over the phone. These were highly emotional situations. Call assessors used a nationally assessed script to ask questions in determining the priority of the call.
- A concern about people calling for an ambulance inappropriately.
- An analogy was used to demonstrate the need to 'unblock' the system. There was a need to support social care, to put it on an equal footing to the NHS and include it as part of the system approach to addressing the current problems. Nigel Minns added that the whole system had to work together on this. He spoke about the significant involvement of social care, the daily discharge meetings and the low proportion of people discharged from hospital who needed onward social care. Too much time was spent focussing on the discharge of patients and there should be more of a focus on the patients presenting at hospitals. This did need a system approach, involving the CCGs and primary care. It was taking place, but there was always room for improvement.
- A question on the proportion of hospital beds and wards that were now in use. Reduced capacity impacted on hospital admission efficiency and delayed handovers for WMAS personnel.
- Concerns for dementia patients as family members were not permitted to travel in the ambulance with them. It was agreed that for dementia patients and relatives, transfer to hospital could be challenging and stressful. They were allowed to be accompanied prior to the pandemic and an update would be sought on this aspect, whilst noting the ongoing measures around infection prevention.

- A breakdown was sought in the variance for response times between urban and rural areas, acknowledging that the distances involved may increase the time for the ambulance to arrive.
- Data showing averages wasn't useful. A number of examples were provided of lengthy waits for an ambulance to arrive. Questions about the impact of delays for patients, and if the wrong category was applied by the call handler assessing the urgency of that case, a longer wait could result. From the data available, it was important to look at outcomes, not trends and to monitor the accuracy of the call category allocation.
- Pippa Wall acknowledged the points raised. There had always been a longer response time to reach rural areas, but the current position made this more challenging. There was an audit process of the call handling and summary information could be supplied. The councillor requested more granular performance data. This had been provided on request previously, but given the time taken to produce it, would need to be useful to a wider audience. Data was also available on the national performance standards. The current performance level showed a lot of 'red' indicators where targets were not being achieved. There were occasions when WMAS was not able to provide a service, even in urban areas. The Chair confirmed that postcode-based data had been supplied previously.
- A need to formulate an action plan and to work jointly to address the current position. There had been a worsening performance trend for some years. A solution may be for additional WMAS staff, who could treat patients without needing to convey them to hospital. The member recounted attending the WMAS Hub in Warwick and seeing the operational challenges faced. He quoted examples of good practice such as the active monitoring of ambulances waiting at hospitals. Such timely information was essential to good decision making. It was confirmed there was no spare capacity in the system now. In the subsequent item, an outline would be provided of the initiatives being employed by WMAS to alleviate pressure. Comparatively, WMAS was the most successful ambulance trust in the country, and the position elsewhere was even worse. However, WMAS was struggling to meet targets. There was a strong recruitment and training model, which assisted with capacity.
- A need for preventative work and community services to reduce the need for hospital admissions.
- A councillor shared a personal example to demonstrate the challenges faced and praised the professionalism of paramedics. On arrival after a nine hour wait the staff were concerned that the wrong call priority had been allocated. There was a need for more flexibility in assigning a category as some lives had been lost due to incorrect judgements. For future items, having someone involved in that service area to attend the meeting would be helpful. Warwickshire had an older than average community, with many located in rural areas and there would be more falls. She spoke of the alternate service pathways or a community team to attend for such incidents. Research of 15 parish councils had resulted in a number of similar issues being reported. From the report, it was questioned if the response time data and statements made within the document were accurate. The needs of elderly patients and those with dementia should be taken into account when considering categorisation. The points were acknowledged and would be responded to under the subsequent Quality Account (QA) item. Reference to alternative pathways and engaging community first responders (CFR). These provided a valuable additional resource for situations like the one reported. However, the length of wait was not acceptable and previously would have been an exception. It was known that symptoms worsened due to such delays

compounding the treatment needs and length of hospital stay required. This was impacted by crews being delayed at hospital. The councillor responded that in this case a complaint was urged by WMAS staff.

The Chair gave a summation that 'one size fits all' did not work nationally or within Warwickshire. There was a need for flexibility within the system to take on board local feedback. Also, a need for an end to end reform of the NHS was evident, a need for accountability and improvement in outcomes, and a need to accept the issues within the system.

Resolved

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

At 12:55pm the Chair moved a motion to suspend standing orders to enable the meeting to continue beyond three hours' duration. This was duly seconded and approved by the Committee. A brief adjournment took place for five minutes.

(2) WMAS - Quality Account

A copy of the WMAS draft Quality Account for 2021-22 had been circulated and the Committee was invited to submit questions and comments. Pippa Wall took members through the document, which was accompanied by a presentation of the key areas:

- Update on 2021/22 priorities for:
  - Cardiac arrest management
  - Maternity care
  - Reduction in the volume of patient harm incidents
  - Learning from patient feedback
- Priorities for 2022/23 for:
  - Integrated urgent and emergency care clinical governance
  - Maternity
  - Mental health
  - Utilisation of alternative pathways including urgent community response
- Taking action on last year's comments
- The recent engagement exercise on the draft quality account

The following points were raised, with responses provided as indicated:

- The report made reference to the Commonwealth Games and the 400 frontline staff being deployed to work on the games. There were strong concerns that 'business as usual' would not be maintained. Data was sought on what proportion of WMAS staff this involved. Pippa Wall gave an undertaking to provide this information including why 400 staff were required and what the expected impact would be, together with the cover arrangements. It did sound a significant number and she outlined the reasons for this, including the scale of events, multiple locations and the length of cover needed each day. WMAS would be challenged if it didn't provide resources. The Chair also asked who was funding the service to the Commonwealth Games. A formal response would be provided.

- A series of questions and points were submitted about the incomplete nature of the QA document, with a number of examples quoted. The member felt it would have been better to defer this item until the full report was available.
- Reference to the accompanying presentation. Earlier in the meeting there was discussion about the serious challenges in providing a responsive service for patients, which had not been included in the presentation. WMAS had attended the Committee in November to provide a performance update and at that time described the situation as a crisis. Again, the report made no reference to this, focussing on other areas, such as safeguarding and body cameras. For the public the key issue was a responsive service.
- Pippa Wall responded reminding of the statutory nature of this report which had to be approved and published by June. There was a duty to seek comments from a range of stakeholders and a number of timing constraints with availability of information, such things as avoiding council elections and the requirements for sign-off before publication. The Chair added that this was a draft report. She agreed with the points made about the key issue for patients being a responsive service and questioned the value of producing such QA reports instead of addressing the current service challenges. Pippa Wall confirmed that large sections of the report were mandated. Most people would be concerned about response times, whilst others had raised staff wellbeing and safety.
- Chris Bain noted that all service providers were required to produce these QA documents and he questioned what added value they provided. He clarified some wording in the document which should refer to people who were 'seldom heard' rather than 'hard to reach'. This would be updated. He welcomed the forward objective around mental health, but less so the link to the NHS plan. This should not become an objective but may be a means to achieving objectives and should be distinguished. The point was noted. Finally, the objective of tackling inequalities was raised. This may mean different things to different people.
- Councillor Bell noted that none of the targets included any data. This should state the current and target performance to enable measurement. From the previous session she referred to the low chance of a patient surviving a cardiac arrest. Even if the target was to improve survival chances by just 1% it would give some reassurance. There was ongoing work on ambulance services which would be discussed by the Health and Wellbeing Board (HWBB) with a view to formulating an action plan for improvement. It was a systemic issue which needed joint work to address it.
- A comment that the comparison of the WMAS performance being better than many other areas was sightly irritating. Councillors were concerned about services for Warwickshire patients.
- Further information was provided about the first responders who were volunteers and the urgent community response, which was a national directive. Further clarification would be provided after the meeting.
- The Chair commented that there was a need to involve the key personnel of all organisations, to agree a strategy and direction of travel, to address the reported concerns and focussing on manageable areas at one time. A need to focus collectively on patient outcomes was the critical aspect. She spoke about survival rates which were lower than those in other European countries and feared that this would worsen further. There was an opportunity to shape things for the future through a joint discussion. It was hoped that this would be progressed by the HWBB.

In closing the debate, the Chair thanked Pippa Wall for her attendance for both items.

Resolved

That the Committee notes the WMAS draft Quality Account for 2021-22 and responds as outlined above.

8. More than a Hospital – University Hospitals Coventry and Warwickshire (UHCW) Organisational Plan

The Chair advised that Justine Richards, Chief Strategy Officer had needed to leave the meeting due to its long duration and other commitments. Endeavours would be made to rearrange consideration of the UHCW organisational plan. It was suggested that members comments could be collated, considered by the Chair and submitted to UHCW as there may not be the opportunity to revisit this item at the next meeting in June. Otherwise, a retrospective look at the document may also be useful in providing feedback to UHCW. Another view was to seek a brief face to face meeting ahead of an existing meeting, or possibly to arrange a meeting via MS Teams.

A councillor considered that if reports could not be provided in full that they should be deferred to a future meeting. The Chair reminded of the timing constraints around the Quality Account (QA) document discussed under the previous item. The member reiterated that it could not be considered fully as it was incomplete. Paul Spencer provided background on the detailed consideration given to the QAs previously through task and finish groups working with each provider trust and the two Healthwatch organisations for Coventry and Warwickshire. The QA documents were now circulated and any member feedback was collated and submitted to the Trust.

9. Work Programme

The Committee reviewed its work programme. A suggestion for a further update to be scheduled from West Midlands Ambulance Service. The Chair noted that this would now be pursued through the Health and Wellbeing Board. Further statistical information would be circulated to members in due course. Councillor Bell confirmed she would report back. It was particularly challenging as this was a regional service provider, but this matter would be pursued.

Resolved

That the Committee notes the work programme as submitted.

C. Golby

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Councillor Clare Golby, Chair

The meeting closed at 210pm

Statement and Questions to WCC ASCHOSC on 27.04.2022 concerning Coventry and Warwickshire ICS Public Accountability.
Question from Carolyn Pickering

The new ICB will take responsibility for all health and care decision making for Coventry and Warwickshire local areas in July.
Membership **should** include Councillors from each local authority; representatives from Social Care, Mental Health, Public Health, Community Health, Primary Care, Acute Health, Carers and Trade Union representatives, among other bodies.
Private sector providers of NHS funded health services **should be ineligible** for ICB membership, but there is no evidence that the ICS Chair, Danielle Oum, has committed to prevent private companies from being members of ICBs or the advisory ICPs.

1.Will the Council support the above proposals to demonstrate there is accountability to the public, patients and staff; to ensure openness and transparency in the ICB decision making, including public access to Board papers and Board meetings and to allow public questions?

2. ICPs are not required to meet in public or publish their minutes and papers.Will this committee make every effort to ensure and require that the Coventry and Warwickshire Health and Care Partnership publish in full on its website the planned structure of the ICS and all its minutes and papers?

3. At the meeting of ASCHOSC 17 November 2021, it was said that the Committee was fully aware of the implications of the Integrated Care Systems set out in the Health and Care Bill before Parliament, and that there were plans to address them. So far no information has been given, will this committee reveal what plans there are?

4. Does this committee realise that 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, and it is unclear what the future role of the WCC ASCHOSC will be.

In addition, the fact that CCGs will be abolished is set out in the King's Fund 'Integrated Care Systems Explained' (May 2021). This will remove another layer of what little accountability we have left.

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 relevant matters?
- that if these rights are undermined this committee will seek the support of those you represent as well as the support of MPs, to maintain these vital democratic rights?
- that this committee will reveal its plans to safeguard the provision of health to the local community, as well as maintaining standards of democracy that are expected of a representative body by the community.

Response to Public Question from Councillor Bell, Portfolio Holder for Adult Social Care and Health

The County Council is working closely with the Clinical Commissioning Group (CCG) and the Coventry City Council (CCC) to ensure that it is fully engaged in the governance structures of the Integrated Care System (ICS) and that the Integrated Care Board (ICB) and Partnership (ICP) membership and processes reflect statutory guidance and are open and transparent.

The CCG will, as stated, be abolished and will be replaced by the ICS, a statutory NHS body. The ICB will take on both CCG commissioning responsibilities and some responsibilities currently held by NHSE, thus increasing local accountability for services.
The ICB will meet in public and its papers will be published. We expect that the ICP will do the same.

The two Councils (WCC and CCC) will be represented on the ICB and the ICP. This is a significant increase in the Council's influence as it is not currently represented on the Governing Body of the CCG.
The ICB is an executive board and, in line with guidance, the Councils will be represented by senior officers. The Councils will be represented by both elected members and officers on the ICP.

Unlike some areas of the country, none of the major local health providers are private sector providers. Consequently, there are no plans for any private sector health providers to sit on the ICB or ICP. However, private and voluntary and community sector providers deliver the vast majority of social care in Warwickshire. It would not be appropriate to ban the sector from representation in the ICS.

The role of this committee is unchanged and it will continue to scrutinise the health and care system. In addition, the ICS will have a statutory responsibility to have regard to the Health and Wellbeing Strategy, set by the Health and Wellbeing Board.