Adult Social Care & Health Overview & Scrutiny Committee

Thursday, 30 July 2020

Minutes

Attendance

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

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

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

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

Warwickshire County Council

1. General

(1) Apologies

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

(2) Disclosures of Pecuniary and Non-Pecuniary Interests

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

(3) Chair's Announcements

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

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

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

2. Public Speaking

None.

3. COVID-19 Service Changes

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

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

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

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

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

The presentation included slides on:

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

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

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

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

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

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

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

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

Resolved

That the Committee notes the presentation.

4. The Future of Health Commissioning in Coventry and Warwickshire

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

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

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

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

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

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

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

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

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

Thanks were recorded to the CCG representatives.

Resolved

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

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Chair

The meeting closed at 12:05pm