HEALTH SCRUTINY PANEL

A meeting of the Health Scrutiny Panel was held on Tuesday 11 January 2022.

PRESENT: Councillors D Coupe (Chair), D Davison (Vice-Chair), R Arundale, A Bell, A Hellaoui, T Mawston and D Rooney

PRESENT BY INVITATION: Councillors

ALSO IN ATTENDANCE: C Blair (Director Of Commissioning Strategy and Delivery) (TVCCG)

OFFICERS: S Bonner, C Breheny and G Nicholson

APOLOGIES FOR ABSENCE: Councillors C McIntyre and P Storey

21/111 **DECLARATIONS OF INTEREST**

There were no declarations of interest received at this point in the meeting.

21/112 **MINUTES - HEALTH SCRUTINY PANEL - 6 DECEMBER 2021**

The minutes of the Health Scrutiny Panel meeting held on 6 December 2021 were submitted and approved as a correct record.

21/113 **SOUTH TEES NHS TRUST - BIANNUAL PERFORMANCE UPDATE**

The Chair welcomed the Deputy Director of Patient Safety, Associate Medical Director and Chief Nurse from South Tees NHS Trust to the meeting. The Trust thanked Members their invitation and informed the meeting it had been a difficult year for the Trust.

The Trust had provided more than 4,000 patients with Covid-19. Given current Inpatient levels and increasing infection rates, this was likely to expand. Most of those patients had been treated for the Omicron variant.

As Middlesbrough had the highest infection rate in the Country it was hoped this would help focus people's minds. It was recognised the community in South Tees had been appreciative of health care staff during the pandemic who had performed very well in difficult circumstances.

It was commented that staff in Critical Care continued to treat young people who had not been vaccinated.

The Trust's response to the Covid-19 Pandemic continued to be clinically led with the rapid establishment of a Command and Control centre which assisted service delivery both from a strategic and tactical perspective.

Operationally, Members were advised hospital sites had been separated into red and green pathways, with the latter created for those in receipt of routine and urgent care without risk of contracting Covid-19.

The Trust continued to have daily tactical and strategic meetings to ensure patients continued to receive the care they needed, such as cancer treatments and urgent surgery.

The overarching aim for the Trust was to keep both patients and staff safe.

Members were made aware patient feedback was very positive. Examples included the CQC's 2020 Children and Young People's Survey which showed results had either been maintained or improved upon from the previous year. The results placed the Trust among the

nation's top performers.

Positive results were also seen in the Adult Inpatient Survey which placed the Trust consistently above the national average for inpatient medical care. This was the same for medical care which, despite the impact of Covid-19, remained above the national average. This was a testament to the wider improvement journey the Trust was on.

The Panel heard clinical teams had continued to perform to the highest standards especially those within the cardiothoracic and neurosurgery centres which were among the highest performing in the country.

Over 46,000 patients requiring an overnight stay were cared for by the clinical teams, as well as over 79,000 patients who were able to return home the same day after receiving their clinical treatment.

Emergency and Urgent Care staff had been able to treat over 665,000 outpatients as well as attending to 150,000 urgent and emergency attendances despite the challenging circumstances.

Importantly, Community based staff had delivered more than 1.25 million patient contacts.

Despite the challenges, more than 4,400 babies had been delivered safely which was a testament to the vaccination programme and the efforts of health care staff.

In terms of the Omicron variant; the Trust was keen to emphasise the vaccine was safe and effective. 95% of staff had had at least two doses of the vaccine.

While Covid-19 continued to pre-occupy the health care system, winter pressures were acute. While the Trust was managing well, a toll was being taken on staff and resources. It was emphasised the community could protect themselves and access health services at points other than emergency care, which would help alleviate pressures. Unlike other Trusts, South Tees had not declared a Major Incident which was a testament to the hard work of staff.

The Chair, on behalf of the Panel, thanked all staff across the Trust for their continued dedication and hard work.

A Member sought clarification regarding the numbers of Covid-19 inpatients. It was clarified there were 142 patients across the Trust with seven patients being treated in Critical Care. It was also clarified there was no age breakdown available but from clinicians' experience most of those Covid-19 inpatients were unvaccinated. It was also clarified that while Covid-19 numbers were relatively low this still added pressure to an already stressed system.

The Chair reminded the meeting that caution should continue to be exercised.

A Member queried, due to the lack of opening windows in James Cook hospital, if this posed a problem for effective ventilation and therefore increased risk to staff and patients. It was clarified while areas of the hospital did not have good ventilation the use of isolation areas and effective PPE equipment helped to contain the spread of the virus. It was noted the Trust's Estates Services had played a vital part in a non-clinical role of combatting Covid-19.

A Member queried how rules from the 1st April regarding unvaccinated staff and their entitlement to work, would impact on the Trust. It was clarified 5% of staff in the Trust had received their vaccine. Consequently, the number of staff yet to receive the vaccine was small in real terms. It was also clarified that some staff had been unable to receive the vaccine at the point of rollout but work was underway to ensure those staff received it.

A Member queried if there were any further initiatives to improve vaccination take-up. The Member also commented that recent pop-up initiatives of taking vaccination centres into the community had proven to be very successful.

A Member commented that vaccine take-up was low in her ward and that pop-up initiatives would have benefit there. It was also commented that awareness of the vaccine needed to be stepped up and that consideration needed to be given to none social media users.

The CCG commented they were heavily involved in the vaccination programme and helped to inform where pop-ups should be placed. While there had been positive levels of vaccine take-up prior to Christmas, this had reduced significantly despite there being adequate vaccines and vaccinators. It was also commented that local pharmacies also distributed the vaccine and there was a need to consider over reliance on digital channels. It was noted that any suggestions from Members would be welcomed as this remained a challenge.

A Member commented that a significant obstacle was entrenched religious views.

The Chair thanked South Tees Trust for their attendance and expressed the Panel's thanks for their continued efforts.

ORDERED: That the information presented be noted.

21/114 **HEALTH INEQUALITIES - A PRIMARY CARE PERSPECTIVE**

The Chair welcomed the Secretary of the Cleveland Local Medical Committee (LMC) who provided Members with information relating to how GP Practices could contribute to the Health Inequalities agenda.

Members were advised the LMC was the statutory body representing GPs and GP Practices. The LMC, by extension, also represented Primary Care Networks (PCN) and worked closely with Clinical Directors as part of the primary care collaborative.

One of the primary aims of GPs was to provide cradle to grave care for all. GPs also provided services that overlapped with Urgent Care services as well as undertaking roles to monitor long term illnesses and administer the appropriate medication to manage those conditions.

It was commented that GPs strived to offer better services, and in some cases diversified their service offer, such as Foundations Practice. However it was recognised there were pressures on GP Practices that were not present in the past.

Members were made aware that GPs were essentially individual businesses that received a relatively small amount of the larger NHS budget which equated to £15.9 billion out of £176.5 billion respectively. There were additional funding streams available including weighted funding for age and gender as well as disease prevalence.

There were several challenges facing GP Practices including a reduced number of staff with 1,139 fewer GPs than in the previous years as well a 24% increase in appointments delivered versus 2019. These pressures often led to media stories which could exacerbate the issue.

In light of such longstanding issues Primary Care Networks (PCN) were introduced to try and alleviate them. PCNs were a group of practices working together although additional resource allocation was limited. There were three main PCNs in Middlesbrough with some crossing over with networks in Redcar and Cleveland.

One of the aims of PCNs was an increased focus on population health which included engaging with seldom heard patients and increasing collaboration with community providers. While PCNs were able to secure additional staff and funding to assist with the Covid-19 vaccination programme, it was recognised this affected the main objectives of the PCNs. It was noted that any under spent budgets could be prioritised for deprived areas.

One of the most significant successes of PCNs was the alignment of care home patients to one Practice, as previously this was quite nebulous.

Further positives from the creation of PCNs was the ability for GPs to contribute to complex medical reviews, cancer treatments and social prescribing. It was commented that social determinants of health were more likely to have an impact on health inequalities.

Members were also made aware that 75% of Covid-19 vaccinations had been administered via the PCN model. Similar social trends relating to vaccination take-up had been observed by GPs; namely that lower take-up rates tended to be in more deprived areas.

With regards to Health Inequalities; there was a new requirement for GPs to work with their

communities to try and reduce inequalities and this was planned for a 2021 implementation. However, this was delayed by Covid-19. It was commented that current work pressures were preventing work on this requirement.

However, there were several factors known to GPs that contributed to health inequalities. For example, 10% of service users consumed 40% of practice resource. This was partly explained by the pressures of modern society and the ability for patients to look up symptoms online. There was also a decline in community support that was present previously.

It was commented that screening services, such as heart checks and smear tests, tended to be lower in more deprived communities and it was here that GPs could work to engage more closely with their communities to try and understand those issues better. It was recognised that initiatives that took care into the community such as Heart Checks taken to places of work, had more success than centralised services.

It was commented that some members of the community preferred walk-in facilities rather than making appointments, such as contraceptive access. Members were advised that this service, especially fitting long term contraceptives, had recently been reduced. With family planning clinics no longer offering repeat prescriptions for the contraceptive pill it was commented the impact of this was still to be understood.

While digitisation of services was seen as a benefit, this did not create additional resource for Practices to see patients. Digitisation also negatively impacted patients who did not know how to use or afford the required technology.

There was also a significant number of patients who did not qualify for free prescriptions but who could not afford to pay for repeat prescriptions.

The CCG's Director of Commissioning, Strategy and Delivery (Primary & Community Care) advised the Panel it would be helpful for the CCG to return to the Panel and provide an overview of how the challenges and constraints identified were being addressed by commissioners.

It was noted that while the Covid-19 Pandemic had affected initiatives associated with health inequalities a great deal of work was being undertaken by the CCG, PCNs and the Local Authority.

A Member commented that current funding levels for GP Practices was insufficient to meet demand and that more should be available as social inequalities would only exacerbate health inequalities. The Member also queried what initiatives were in place to recruit more staff to GP practices.

It was clarified that while staff shortages were currently acute there had always been a shortage of GPs locally.

A Member commented that health inequalities was a complex topic and while financial investment would help, social responsibly was also an important factor.

A Member queried if a replacement sexual health service had been installed to replace a previously closed one. The Member also raised concern over recent plans to change prescription services to the over 60s.

A Member queried if the improvements needed for local health services would be realised post Covid-19. While it would require significant discussion and planning, several initiatives had been proposed. For example, hospital speciality doctors working in GP hubs which would enable health services to be taken to communities. However, this would require investment in infrastructure such as premises.

A Member commented on the current messaging used to demonstrate welfare rights and how Primary Care could contribute to that agenda. It was confirmed that an update on this would be brought back to a future meeting of the Panel.

A Member queried if there was data was available to compare funding streams across health and local government areas to make further understand the links between poverty and health

inequalities in different parts of the country. A discussion took place regarding the national funding formula, and funding for Health and Social Care more generally, and how increased funding could actively contribute to the health inequalities agenda.

Members were advised that a key challenge for the health sector was the corollary of an ageing population and the increased prevalence of complex medical needs and manage quality of life effectively.

The Chair thanked the representatives from the LMC and the CCG for their attendance.

ORDERED that:
1. The CCG attend a future meeting of the Panel to discuss how the challenges identified were being addressed from a commissioner's perspective.
2. To understand if a replacement sexual health service was installed to replace the previously closed town centre service.
3. That the information presented be noted.

21/115 **HEALTH INEQUALITIES - AN EDUCATIONAL PERSPECTIVE**

This item was deferred to the Panel's meeting to be held on 8th February 2022.

NOTED.

21/116 **COVID-19 UPDATE**

The Chair welcomed the Public Health Specialist and invited him to provide the Panel with an update on the Covid-19 situation.

The Panel heard that infection rates in Middlesbrough had risen significantly and equated to a 47% increase. Such increases were reflected across the Tees Valley. However, this was in contrast to the previous increase of 246% the week before and infections seemed to be slowing down.

Infection rates were highest with the 20-39 and 40-59 year old age ranges which was affecting front line services as this was working age population. Infections in 0-19s were also increasing, most likely due to the return to school.

While there had been a rise in the number of patients admitted to hospital this was not significant compared to previous waves. A similar picture was found with deaths, in that two had been recorded but this was small compared to previous waves.

Vaccination take up remained comparatively low with areas of higher deprivation experiencing the lowest levels of take-up. It was recognised this was a complicated issue and that work was continuing to address it. Initiatives included pop up vaccination centres in Grove Hill, the Cleveland Centre and the former Debenhams site. Work had also been undertaken with Ayresome Primary School which had offered its premises as a pop-up vaccination centre.

A Member queried if low levels of vaccination take-up could be attributed to delays between individuals receiving their initial dose and subsequent doses. It was clarified that the data could not prove or disprove that hypothesis. Ultimately, there remained a significant proportion of individuals who had not received the vaccine.

A Member commented that, despite discussion about various communication channels to promote the vaccine, they were not apparent. It was clarified the main channels of communication were via social media platforms. However, a lot of work was being done to target specific groups via word of mouth. A discussion took place regarding the optimal communication for those without social media, with suggestions such as posters and printed material being suggested.

The Chair thanked the Public Health Specialist for his attendance.

ORDERED: That the information presented be noted.

21/117 **CHAIR'S OSB UPDATE**

The Chair advised Members about information provided and updates received at the previous meeting of Overview and Scrutiny Board held on 7 December 2021.

NOTED.

21/118 **ANY OTHER URGENT ITEMS WHICH IN THE OPINION OF THE CHAIR, MAY BE CONSIDERED.**

Members discussed groups in the community that were in need of additional resources and investment. Members also discussed the virtues of targeting specific groups for increased investment versus blanket increases for all groups.

NOTED.