HEALTH SCRUTINY PANEL

A meeting of the Health Scrutiny Panel was held on Tuesday, 19 March 2024.

PRESENT: Councillors J Banks (Chair), M Storey (Vice-Chair), C Cooper, D Coupe, D Jackson, J Kabuye and S Tranter

ALSO IN ATTENDANCE: C Blair (Director) (North East & North Cumbria Integrated Care Board), C Mills (Transformation and Delivery Manager - Prevention) (NHS North of England Commissioning Support Unit), J Quine (Strategic Lead for Population Health, Prevention and Healthcare Inequalities) (NHS North of England Commissioning Support Unit) and M Stamp (Consultant in Public Health)

OFFICERS: M Adams and G Moore

APOLOGIES FOR ABSENCE: Councillors J Walker

23/39 **DECLARATIONS OF INTEREST**

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

23/40 **MINUTES - HEALTH SCRUTINY PANEL - 19 FEBRUARY 2024**

The minutes of the Health Scrutiny Panel meeting held on 19 February 2024 were submitted and approved as a correct record.

23/41 **AVOIDABLE DEATHS AND PREVENTABLE MORTALITY - FURTHER EVIDENCE**

The Health Scrutiny Panel continued to gather evidence in respect of its current review of Avoidable Deaths and Preventable Mortality.

Representatives from the NHS North of England Commissioning Support Unit (NECS) and the North East and North Cumbria Integrated Care Board (ICB) were in attendance to provide:

- key data and information held by the NHS/ICB on Middlesbrough's leading causes of avoidable deaths (those that are either preventable or treatable) and risk factors for ill health;
- information on the role of the NHS and ICB in helping people to make healthier lifestyle choices and treat avoidable illness early on;
- an overview of the work undertaken by the NHS/ICB to reduce the number of avoidable deaths, e.g., healthcare interventions; and
- information on evidence-based best practice that could further contribute towards tackling the local population's major risk factors driving preventable ill health and avoidable deaths.

The Director of Place Delivery advised that two presentations had been prepared for the meeting, one planned to provide information on the North East and North Cumbria Integrated Care Board's (NE&NC ICB) Healthier and Fairer Programme and the second presentation focussed on reducing health inequalities in South Tees NHS Hospitals Foundation Trust.

The Transformation and Delivery Manager explained that the NE&NC ICB's Healthier and Fairer Programme aimed to tackle health inequalities, improve life expectancy and narrow the gap in healthy life expectancy for areas throughout the North East and North Cumbria. The programme also aimed to address the social and economic deprivation that was prevalent in the area.

The Healthier and Fairer Programme was system-wide and involved the NHS and local authorities working in partnership. In terms of the Healthier and Fairer Advisory Group and its workstreams, a joint leadership, co-led approach had been adopted with both NHS medical directors and public health directors. The three workstreams that had been developed included:

1. Prevention (focusing on the modifiable risk factors i.e., alcohol, tobacco, obesity, cardiovascular disease (CVD) and prevention in maternity);
2. Healthcare Inequalities (i.e., Core20PLUS5 (children and young people), Core20PLUS5 (adults), deep end practices, inclusion health and Waiting Well); and
3. Broader Social and Economic Determinants (i.e., the anchor network, poverty proofing, digital inclusion and health literacy).

The principles of the Healthier and Fairer Programme involved creating an evidence-base for informed decision-making by identifying those projects/practices/initiatives that would have the greatest positive impact. For example, an approach had been taken to introduce health champions, which built on the excellent work that had been undertaken during the pandemic. Health champions promoted, identified, and signposted people to health and wellbeing services. It was planned that the health champion approach would be rolled out further across the North East and North Cumbria.

In terms of funding, the NE&NC ICB had received ring-fenced health inequalities funding of £13.6 million for a three year period and funding had recently been secured for a further two years. In addition, it was commented that service development funding had been received from NHS England and there had also been a contribution from the Northern Cancer Alliance. Furthermore, prior to the current year, a significant amount of NECS transformation funding had been provided, which had initially assisted with developing a new model of working and funding the introduction of public health consultants.

The prevention workstream focussed on smokefree and tobacco dependency and a whole system, partnership approach was taken. It was highlighted that the North East and North Cumbria had encountered the biggest reduction in smoking prevalence in any region. Furthermore, the gap between the region and the England average was narrowing. To achieve that, the NE&NC ICB had worked in partnership with Fresh, which was an organisation that worked at a population level to encourage a societal shift around tobacco and alcohol use.

In respect of each NHS hospital trust throughout the region, there were tobacco treatment dependency services for in-patients and maternity services. An incentive scheme had recently been rolled out to encourage pregnant women to stop smoking by providing them with shopping vouchers, which had proven to be popular. A pilot was also being delivered, which focussed on providing support to those who suffered from severe mental illness, to enable them to stop smoking.

In terms of alcohol, the prevention workstream focussed on primary prevention by building a social movement to reduce alcohol harm and increase awareness of alcohol risk. There had been media campaigns conveying that, like tobacco, alcohol could cause cancer. It was explained that alcohol care teams had been introduced into each NHS hospital trust throughout the region. Each alcohol care team involved specialists who supported patients throughout the hospital to reduce, quit or use alcohol more safely. In addition, there were recovery navigators, who focussed on bridging the gaps between secondary care and the community. Furthermore, a programme of alcohol studies had been recently launched to increase staff awareness and a fibroscan referral pathway was being developed to promote earlier detection of liver disease.

The newest prevention workstream focussed on healthy weight and treating obesity. Members heard that South Tees NHS Hospitals Foundation Trust (STFT) was working to develop Tier 3 weight management services, which planned to focus on tackling and addressing inequalities. In addition, it was advised that an injectables pilot was being planned with NHS England. Furthermore, a digital weight management approach had been developed, which focussed on enabling people living with obesity to manage their weight, improve the quality of their life and improve longer term health outcomes.

The Strategic Lead for Population Health, Prevention and Healthcare Inequalities advised that there was a cardiovascular disease (CVD) InHIP project. InHIP stood for innovation in healthcare inequalities programme, which was a national programme funded by NHS England. The programme, delivered by Health Innovation North East and North Cumbria, had identified 3 CORE20 communities:

- Black Africans;

- South Asians; and
- underserved indigenous white groups.

It was explained that CORE20 focussed on the 20% of the population in the lowest deprivation quintile across England. By working with the identified communities, the project had been co-designed to increase engagement with CVD risk assessment, support people in modifying health behaviours and promote access to treatment. It was highlighted that one of the largest causes of preventable death was CVD. The project had been delivered in collaboration with Teesside University Sports Science and the Middlesbrough Football Club Foundation, through the use of a health bus to target health checks in local community hubs with relevant community partners. The health bus had visited Black African churches and South Asian women's groups (Nur Fitness) within deprived wards in Middlesbrough and had parked up outside the Riverside Stadium on match days. Members heard that the project was on track to have engaged over 400 residents that would not have otherwise accessed screening.

Members heard that the Deep End Network was a network of GP practices, which worked within areas of blanket deprivation, where 50% or more of the practice list lived within the 15% most deprived Lower Layer Super Output Areas (LSOAs) as measured by the Index of Multiple Deprivation (IMD). For 2024/25 there were 14 Middlesbrough practices, out of a total of 52 across the North East and North Cumbria. It was highlighted that Middlesbrough had the greatest density of deep end practices in the Tees Valley. It was outlined to the scrutiny panel that the projects supporting Middlesbrough's deep end practices included:

- An immunisation catch-up team undertaking work to increase the low uptake of pre-school immunisations, by providing additional clinics or home visits.
- An opioid and gabapentinoid deprescribing project being delivered for people waiting surgery, in collaboration with the Waiting Well project.
- Funding being allocated to each deep end practice to employ/commission a dedicated link-worker to address the social determinants of health that the practice had identified.

Deep end practices were also provided with the opportunity to become training practices to increase GP recruitment, support networks for administration staff and nursing staff working in deep end practices, and researcher-led patient and community engagement for patients of deep end practices.

In terms of the CORE20Plus5, the CORE20 referred to the 20% most deprived communities nationally. In the area of North East and North Cumbria, over a third of the population lived in deprived communities. Therefore, there were disproportionate levels of deprivation in the region and there were significant disparities in England. The Plus referred to those groups that were marginalised and stigmatised and the 5 referenced five clinical pathways where the greatest amount of health inequalities existed. It was commented that in respect of the CORE20Plus5, there were two frameworks, one for adults and the other for children and young people. For adults, the five clinical pathways were maternity (ensuring continuity of care), severe mental illness (ensuring annual physical health checks), respiratory disease (increasing the uptake of Covid-19, flu and pneumonia vaccination), early cancer diagnosis (ensuring 75% if cases were diagnosed at stages 1 and 2) and cardiovascular disease (hypertension case finding and lipid optimal management). For children and young people, the five clinical pathways were asthma (reducing reliance on reliever medication), diabetes (increasing access to real-time continuous glucose monitors and insulin pumps), epilepsy (increasing access to nurse specialists, especially in the first year of life for children with autism and/or a learning disability), oral health (addressing the rates of tooth extractions in those under 10) and mental health (improving access rates to services for children 0-17).

Members heard that inclusion health was an umbrella term used to describe people who were socially excluded, who typically experienced multiple interacting risk factors for poor health, such as stigma, discrimination, poverty, violence and complex trauma. It was identified that those people experienced significantly poorer health outcomes. There were 16 recognised inclusion health groups within scope of the approach, which included veterans and service personnel; those who had experienced or were at risk of homelessness; those who had experiences of the care system; those in contact with the justice system; the Gypsy, Roma and Traveller (GRT) community; sex workers; migrants and refugees. The Inclusion Health Project was a programme being developed that aimed to identify and support people from those communities that suffered inequalities in terms of access, uptake, experience and

outcomes of healthcare services.

A Member raised a query on the wider determinants of health. In response, the Strategic Lead for Population Health, Prevention and Healthcare Inequalities commented that there was an awareness that gambling, smoking, alcohol and ultra processed foods resulted in ill-health and subsequently required intervention from healthcare services. Wider determinants of health typically created an environment for poor health and poor outcomes. It was commented that often healthcare was about trying to address behaviours and environments that people had been exposed to. One area referenced was advertising, which encouraged behaviours that negatively impacted on a person's health. The Transformation and Delivery Manager commented that there was a growing consensus in the region that further work was required to address the commercial determinants of health. It was commented that, working alongside the Association of Directors of Public Health (ADPH), a commercial determinants of health position statement required development and there was a need to raise awareness throughout the health workforce.

A Member raised concerns regarding the increased use of vapes. In response, the Transformation and Delivery Manager advised that work was being undertaken in partnership with Fresh to create an evidence base on the effectiveness and the potential risks of vaping.

A Member raised a query regarding the CORE20 communities. In response, the Strategic Lead for Population Health, Prevention and Healthcare Inequalities advised that working with the local population to understand and acknowledge the challenges, barriers and complex issues experienced by CORE20 communities was of the utmost importance. Members heard that once that evidence was collected and analysed it would facilitate the delivery of solutions aimed to effectively tackle health inequalities.

A Member raised a query regarding health champions. In response, the Transformation and Delivery Manager advised that further funding would be awarded to support the health champions approach.

A Member raised concerns about smoking outside of hospitals. In response, the Consultant in Public Health advised that each NHS hospital trust had no smoking policies. However, the Director of Place Delivery confirmed that the hospitals were unable to legally enforce against smoking outside.

A Member raised a query regarding vaping prevention work in schools. In response, the Director of Public Health advised that the Team Manager for Substance Misuse had visited schools in Middlesbrough to raise awareness of potential harms of youth vaping. It was commented that although vapes could be an effective tool in supporting smoking cessation, the number of children using vapes had increased significantly and due to nicotine content and the unknown long-term harms, vaping carried the risk of harm and addiction for children.

A Member raised a query regarding access to data in respect of the use of vapes among children and young people. Although there was currently no prevalence data at a local authority level, the Director of Public Health advised that, following the meeting, national statistics would be circulated to the scrutiny panel.

A Member raised a query regarding the injectables pilot. In response, the Director of Public Health advised that injectables had been subject to randomised control trials that had proven their effectiveness. A concern of the NHS was that, as obesity was caused by social and environmental factors, although the injectables were proven to work, introduction of injectables would not tackle those causes. The Director of Place advised that although injectables were an effective treatment, they needed to be used in conjunction with other prevention measures to achieve behaviour change. It was also added that there would be an expectation that the injectables pilot would form part of a weight management programme, which would include regular, potentially prescribed, exercise. It was envisaged that people would need to demonstrate how they were trying to lose weight, by eating a healthy diet and exercising, before being offered the injectables. The Transformation and Delivery Manager confirmed that a holistic, multi-disciplinary approach would be taken.

The Consultant in Public Health provided the scrutiny panel with information on reducing health inequalities in South Tees NHS Hospitals Foundation Trust (STFT).

It was explained that health inequalities were:

- unfair and avoidable differences in health across the population, and between different groups within society; and
- arose because of the conditions in which people were born, lived, worked and aged.

Members heard that health inequalities resulted in poor health being experienced from a younger age, at a higher intensity for a greater proportion of life and ultimately in premature death.

A graph showed that of the 59 most deprived local authority areas across England, Middlesbrough was the third most deprived.

It was explained that the STFT had a Health Inequalities Group. The group was chaired by the Chief Medical Officer and the Director of Public Health South Tees was the Vice-Chair. The group reported to the Quality Assurance Committee and the Clinical Policy Group on a six-monthly basis and information was then disseminated to the clinical leads across the whole of the organisation. There was a number of different groups that fed into the Health Inequalities Group, those included, the:

- Vulnerabilities Group;
- Prevention Group;
- Fairer Access to Working Group;
- Making Every Contact Count Group; and
- Anchor Group.

It was commented that the Prevention Group had a number of different groups feeding into it and those covered areas such as alcohol admissions, treating obesity, smoke-free, population health in maternity, Waiting Well, mental health and veterans.

In terms of the workstreams associated with the Health Inequalities Group, those included:

1. Understanding inequalities in the organisation
2. Addressing inequalities in access, experience and outcomes
3. Opportunities for preventative programmes
4. Identifying and addressing social determinants of health
5. Looking after the workforce and the inequalities in the workforce
6. Partnership working to reduce health inequalities
7. Strengthening the STFT's role as an anchor institution

In respect of understanding inequalities in the organisation, the Business Intelligence Team had developed a health inequalities dashboard, which focussed on patients who Did Not Attend (DNA) or Was Not Brought (WNB) for their outpatient appointment, filtered by clinics and by postcode. The following data/information was outlined to the scrutiny panel:

- There was a clear and significant social gradient in access to all STFT outpatient services.
- The most deprived populations were twice as likely to be unable to attend as the least deprived (16% and 8%).
- There was inequity of access to STFT services between white and non-white populations.
- DNA/WNB rate for all non-white persons was 15% compared with 12% for white.
- For Southern Asian people (the main non-white group), there was a less marked social gradient with high rates across all quintiles (that meant ethnicity impacted on access to services in even the most affluent groups).
- There were marked differences in attendance between age groups, which affected all specialties.
- Children under 4 were least likely to be brought to appointments.
- Older people over 60 were significantly more likely to attend than other age groups.
- The rate of WNB was 23% in the most socially disadvantaged children.
- A working group had been set up to further expand the dashboard, which planned to include additional indictors required by the NHS England and would include key clinical areas set out CORE20Plus5 as well as the collation of data by inclusion

groups.

In terms of addressing inequalities in access, experience and outcomes, there were a number of pieces of work being progressed by the STFT, those included:

- A DNA/WNB Pilot - The pilot focused on paediatrics, maternity and patients with learning disabilities from decile one across selected clinics. The STFT was contacting patients via telephone 2 weeks prior to their appointment to confirm awareness of appointment and identify barriers to attending. A suite of interventions was then offered to encourage attendance, which included hospital transport, reimbursement of travel costs, translator support, rearranging appointment, revisiting the location or type of appointment. It was added that, although the pilot was currently ongoing, initial evidence suggested that the telephone reminder was having a positive impact on reducing DNA/WNB rates.
- Qualitative Maternity - The STFT was working with Teesside University to explore experiences and perceptions impacting on ethnic minority pregnant women, in relation to access and outcomes of their maternity care. Interviews and focus groups were being arranged to gather insights into barriers and challenges, with an aim to understand the reasons for ethnic minority women not seeking antenatal care.
- Travel Reimbursement Scheme - The Travel Reimbursement Scheme was a national scheme. To qualify, a patient had to be receiving benefits or be on a low income. A poster had been developed for STFT reception areas to raise awareness and information on the scheme was provided on the hospital website and by GPs on referral.

In terms of the prevention workstream and the STFT's role in preventing ill-health, information was provided on the following services:

<u>Tobacco Dependency Service (TDS)</u>

- The aim of the service was to offer support to all those admitted to hospital who smoked.
- Since September 22, 1613 inpatients had been reviewed, 1545 (95.79%) were smokers, with 558 (36%) accepting support and 241 (15.6%) referred to community Stop Smoking Services (SSS).
- A mandatory smoking field in the Electronic Patient Record (EPR) had been introduced for inpatients, which triggered automatic referral to TDS and was now live on 15 wards.
- A vaping policy was being developed for staff and patients onsite.
- All staff working in the TDS were now on permanent contracts to ensure the sustainability of service.
- The smoking at time of delivery rate across South Tees was higher than England, however, since introduction of TDS in maternity services there had been a significant decrease from 12.4% in March 2022 to 10.7% December 2023. During 2023, there had been 413 referrals made, with 153 women engaging. Since January 2023, 45 babies had been born into smokefree homes.
- A successful incentive scheme had been put in place, offering successful quitters a maximum of £380 Love to Shop vouchers, across the course of the pregnancy.
- The NE&NC ICB had been successful in securing funding to offer vapes to women and partners, as aid to increase quit rates.

<u>Alcohol Care Team (ACT)</u>

- The aim of the Alcohol Care Team (ACT) was to provide specialist alcohol care for patients with alcohol dependence to demonstrate admission avoidance, reduce length of stay and improve management of withdrawal, in addition to increasing STFT wide expertise, training and early identification of risky levels.
- In its first year, ACT had received 694 referrals from the emergency department and 614 referrals from inpatient services. Most of those referrals were dependant drinkers (however, that was only a fraction of those attending with alcohol-related issues).
- Once the alcohol use disorders identification test (AUDIT C) had been implemented across the STFT to identify those drinking at risky levels, it was envisaged that referrals would dramatically increase.
- The ACT had been working with I.T. to implement a mandatory alcohol field, which

would be used to trigger referrals.
- The ACT was only funded until 24/25 by the NE&NC ICB, therefore, there was a risk if the team was not mainstream funded beyond 2025.
- In terms of next steps, a service review would be undertaken to develop a new model and vision for the ACT.

Public Health in Maternity

- There were healthy weight clinics at James Cook University Hospital (JCUH) and the Friarage Hospital for all pregnant women with a BMI over 40. Healthy lifestyle/diet advice was provided to keep weight between 5-7kg.
- There was a dedicated vaccination nurse JCUH, who worked with Public Health South Tees to increase education/uptake of vaccines in pregnancy (total vaccines given during 2023 Flu - 898, Pertussis - 2271).
- Funding had been secured to deliver a maternal mental health service, which included a midwife and a part-time psychologist.
- Contraception had now been embedded in postnatal care. Midwives/maternity nurses had been trained to fit postnatal implants and doctors had been trained to fit coils, post birth. There was also a robust follow-up service in place with sexual health services (total numbers fitted since May 2023, Coils 56, Implants 82).
- There was a cervical screening drop-in clinic held at the Friarage Hospital for staff members and the public.
- Poverty proofing work was being undertaken to establish a booking pathway, which planned to involve health literacy.

Obesity

- Work was underway to carry out a healthy weight mapping exercise, which included promoting healthy workplaces. The exercise planned to examine the offer for staff, the provision of weight management programmes, the physical environment, access to green spaces, the enabling of active travel and public transport and initiatives aimed at preventing obesity in children and families.
- A working group had been set up to introduce an active hospital approach, which involved STFT staff members and a range of external partners.
- There was a Tier 3 specialist weight management service, which supported 1500 patients per year.
- There was a Tier 4 bariatric surgery service for children.

High intensity users (HIUs) were those who used healthcare more often than, or differently than expected (e.g., for instance they presented to the emergency department five or more times within a year). It was highlighted that HIUs had a significant impact across the non-elective care pathway, ambulance arrivals at the emergency department, visits to the emergency department, emergency admissions and inpatient bed days. It was commented that the HIUs cost an estimated £2.5 billion per year.

Between November 2022 and 2023, 1,446 HIUs had been identified with 11,330 attendances (between 5-66 attendances each). There was a clear link between HIUs and health inequalities, with 55% of HIUs in the 10% most deprived areas. There were two peaks in terms of age, from 20 to 29 years and those over 70 years. HIUs tended to have poor physical health, poor mental health, problems with substance misuse, involvement with criminal justice system and had experienced Adverse Childhood Experiences (ACEs). 50.9% of HIUs were female, 49.1% were male and 89.5% were white British.

Health inequalities funding had been secured to provide a dedicated keyworker based at STFT to deliver a project aimed at reducing the numbers of HIUs. It was commented that work would be undertaken to analyse local data and identify the target group (top 50 attenders). The dedicated keyworker would provide a non-medical approach, which focussed on providing HIUs with social, practical and emotional support. There were over 100 HIU programmes that had been developed and implemented across England and those had reported a 58% reduction in emergency department attendance, a 67% reduction in non-elective admissions, a 71% reduction in ambulance conveyances and a system saving of £432,000.

In terms of the hospital navigator project, violence was a major cause of ill health and poor wellbeing and it strongly related to inequalities. Work was being undertaken in partnership with Cleveland Unit for the Reduction of Violence (CURV). CURV had commissioned STFT to develop a hospital youth intervention programme to support/divert young people (aged 10 to 25) involved in crime. The aim of the project was to provide support to patients admitted with violent related injuries by addressing changeable risk factors. The project planned to use mentoring, counselling and onward referral to community services to help reduce violent re-injury, death, arrest etc. To deliver the project, two navigator posts had been created to work with children and adult presenting at Accident and Emergency (A&E)/admitted with injuries that were result of violence. The STHT had developed a new vulnerabilities group with an aim to co-ordinate/implement three navigator workstreams i.e., HIUs, violence and the ACT. Work was also planned to develop the emergency department dashboard and explore the metrics needed to support the workstreams.

In terms of addressing wider determinants and Making Every Contact Count (MECC):

- A working group had been established and a communications plan had been developed.
- Over 200 staff members across the organisation had been trained in MECC to support patients in respect of the wider determinants of health.
- MECC case studies/examples of good practice had been collated and evaluated.
- MECC STFT wide resources had been developed for patient facing services.
- A STFT MECC regional training film had been developed for maternity services, explaining the damaging effects of smoking.
- MECC was now part of the Trust induction process for new members of staff.
- There had been an official launch of MECC on 15 January 2024, which had involved collaboration between STFT, SERCO and Public Health South Tees and 49 areas had been visited.

In terms of the STFT being an anchor institute:

- Executive anchor leads had been identified across the STFT.
- A health anchor mapping questionnaire had been sent to all the NHS foundation trusts across the region and responses had been mapped against 4 pillars - widening access to good employment and apprenticeships, using buildings and estates to support local health and communities, contracting for local benefit and social value and leadership and partnership working.
- The mapping exercise had identified areas of good practice and gaps in provision that required further development.
- The STFT had widened access to employment by running a successful prospect programme. The programme had resulted in a 82% success rate of participants gaining employment within a 6 month period. Social mobility schemes were also offered to young people from disadvantaged backgrounds as well as a range of outreach activities into disadvantaged communities.
- The STFT had implemented the Green Plan, to become a leader in carbon management. The plan focussed on areas such as waste, clean air through provision of electric vehicle charging points, DR bike and a staff shuttle bus across sites.
- Procurement activities had been undertaken to examine food suppliers and it had been highlighted that the vast majority of food was sourced locally in the North East.
- Future work planned to identify gaps and priorities for action/collaboration, deliver collaborative projects through shared resources and a common approach, align with North East and North Cumbria's Integrated Care System (NE&NC ICS) priorities, develop a Tees Valley anchor network, complete baseline assessments across all anchor institutions and develop a set of metrics.

A Member raised a query regarding the project exploring the experiences of ethnic minority pregnant women. In response, the Consultant in Public Health advised that the research would be completed by the end of March 2024, therefore, it was envisaged that a report containing an analysis of the findings would be available in April 2024. It was commented that, once the report was published, it would be circulated to the scrutiny panel.

It was announced that the Director of Place Delivery was moving to a different role. The Chair expressed gratitude and appreciation for the Director of Place Delivery's valuable input and contributions, which ultimately aimed to improve the health and wellbeing of Middlesbrough's population.

AGREED

That the information presented at the meeting be considered in the context of the scrutiny panel's investigation.

23/42 **OVERVIEW AND SCRUTINY BOARD - AN UPDATE**

The Chair explained that at the meeting of the Overview and Scrutiny Board, which was held on 28 February 2024, the Board had considered:

- the Executive Forward Work Programme;
- an update from the Executive Member for Environment;
- an update on the Local Government Boundary Review 2023/24; and
- updates from the Scrutiny Chairs.

In addition, Members heard that at the meeting on 6 March 2024, the Board had considered:

- the Executive Forward Work Programme;
- an update from the Executive Member for Community Safety; and
- updates from the Scrutiny Chairs

NOTED

23/43 **ANY OTHER URGENT ITEMS WHICH IN THE OPINION OF THE CHAIR, MAY BE CONSIDERED.**

Next Meeting - 22 April 2024

The Chair put forward a proposal to cancel the next meeting of the Health Scrutiny Panel, which was scheduled to take place on Monday 22 April 2024.

Following discussion, the scrutiny panel was in agreement that the meeting should be cancelled.

AGREED

That the next meeting of the Health Scrutiny Panel, scheduled to be held on 22 April 2024, be cancelled.