Health and Adult Social Care Overview and Scrutiny Committee

Tuesday 27 June 2023

PRESENT:

Councillor Murphy, in the Chair.
Councillor Dr Mahony, Vice Chair.
Councillors McNamara, Nicholson, Noble, Penrose, Reilly, Ricketts, Salmon (Substitute for Councillor Harrison), Tippetts (Substitute for Councillor Stephens), Tuohy and Ms Watkin.

Apologies for absence: Councillors Finn, Harrison and Stephens.

Also in attendance: Councillor Mary Aspinall (Cabinet Member for Health and Adult Social Care), Councillor Mrs Terri Beer, Nicki Collas (Future Hospitals Program Manager, University Hospitals Plymouth NHS Trust), Ruth Harrell (Director of Publish Health), Ross Jago (Head of Governance, Performance and Risk), Chris Morley (Interim Locality Director, NHS Devon), Amanda Nash (Head of Communications, University Hospitals Plymouth), Helen Slater (Lead Accountancy Manager), Rob Sowden (Senior Performance Advisor), Gary Walbridge (Head of Adult Social Care and Retained Functions), Elliot Wearne-Gould (Democratic Advisor) and Stuart Windsor (Future Hospitals Director, University Hospitals Plymouth NHS Trust).

The meeting started at 2.00 pm and finished at 4.50 pm.

Note: At a future meeting, the Panel will consider the accuracy of these draft minutes, so they may be subject to change. Please check the minutes of that meeting to confirm whether these minutes have been amended.

1. **Appointment of a Chair and Vice Chair for the Municipal Year 2023-24**

The Committee agreed to-

1. Note the appointment of Councillor Pauline Murphy as Chair and Councillor Natalie Harrison as Vice-Chair for the municipal year 2023-24.

2. Appoint Councillor Dr John Mahony as Vice-Chair for this particular meeting, due to the submission of apologies by Councillor Natalie Harrison.

2. **Declarations of Interest**

There was one declaration made:

Name	Minute Number	Reason	Interest
Councillor Will Noble	9	Was employed by University Hospitals Plymouth NHS Trust	Registered Personal.

3. **Terms of Reference**

The Committee agreed to note the Terms of Reference for the Health and Adult Social Care Overview and Scrutiny Committee.

4. **Minutes**

The Committee agreed the minutes of the meetings held on the 8 February 2023 and 10 March 2023 as a correct record.

5. **Chair's Urgent Business**

There were no items of Chair's Urgent Business.

6. **Quarterly Performance And Financial Update For Health And Social Care, And Risk Monitoring Report**

Councillor Mary Aspinall (Cabinet Member for Health and Adult Social Care) introduced the report and highlighted the following points:

a) The report provided a comprehensive overview of some of the key performance and activity metrics that were used by the Council and its Partners, including the Integrated Care Board (ICB) and Livewell Southwest;

b) The information within the report was used operationally and strategically by officers and senior managers across all organisations to ensure the best possible outcomes for people using the health and social care system.

Rob Sowden (Senior Performance Advisor), Helen Slater (Lead Accountancy Manager) and Gary Walbridge (Head of Adult Social Care and Retained Functions) delivered the report, and highlighted the following points:

c) Referral demand for Livewell Southwest's services had remained steady and staff had been working to reduce waiting lists, evidenced by a decline in waiting lists for adult social care support and adult social care occupational therapy;

d) Nearly 90% of people referred into social care would not go onto receive long-term adult social care support, so it was important to have alternative long-term care in the community, supported by the Care for Plymouth model;

e) The number of people in the community waiting for a domiciliary care package had reduced despite a general increase in demand;

f) On average in 2022/23, 66% of people left the reablement service with no ongoing needs, which was the most desired outcome;

g) There was a challenge in relation to long term admissions and placements into residential and nursing care in 22/23 with admissions of people aged 65

and over increasing by 57%. Work was being undertaken with partners to better understand the factors behind this;

h) The number of people in receipt of a supported living package was increasing, but the waiting list remained low;

i) The number of people in receipt of direct payments was increasing, which was positive as it allowed people to spend money on care they wanted to receive. Plymouth was expected to level the benchmarking averages by the end of the financial year 2023/24;

j) Safeguarding outcomes were fed into the quarterly Plymouth Safeguarding Adults Board. There had been a drop in cases requiring a full investigation in 2022/23, which had been attributed to an in-service review with partners to ensure best quality of the investigation process;

k) 96.9% of people in 2022/23 who were subject to abuse and thus a safeguarding investigation, had seen their safeguarding personal outcomes achieved partially or fully;

l) Section 42 of the Care Act related specifically to safeguarding and set out the responsibilities and duties of the Council. A Section 42 inquiry would occur when the concern was significant enough to be investigated to ensure the safety of the person in question;

m) Complaint numbers were monitored on a monthly basis but had remained relatively static;

n) The Adult Social Care survey had been completed in February/March 2023 and Plymouth had consistently outperformed its similar local authorities, as well as the national and regional averages;

    i. The results had shown a high satisfaction rate, and high levels of feelings of choice and control;

    ii. Results had also shown an underperformance against a KPI that measured how easy people found to access information and advice;

o) There had been an upward trend in carers assessments since June 2022;

p) A considerable amount of work had been undertaken within the carers commissioning service to seek improvements;

q) There was an improving long term trend within 'no right to reside' data (the number of people who experienced delayed discharge) at University Hospitals Plymouth, but the average length of stays within hospitals had remained relatively static since October 2021;

r) There had been a reduction in the number of hours lost to ambulance handovers however, data showed that the percentage of ambulances that

were delayed over 15 minutes exceeded 80%, and the number of patients waiting for more than 12 hours in the Emergency Department was above average.

In response to questions it was reported that:

s) Efforts would be taken to improve readability of data within future reports;

t) Councillor Aspinall had received concerns from residents regarding challenges communicating with the Council and would address this through the Ageing Well agenda. Challenges faced by those who were digitally excluded would be investigated. Issues around communication had been an ongoing issue, and would remain a priority to be included in the business plan;

u) Analysis of complaints across the Council was regularly undertaken and recommendations from the LGO were recorded and analysed to identify trends and levels of improvement, all of which were then reported back to the corporate management team and mitigations were applied as necessary;

v) LGO recommendations relating to Health and Adult Social Care would be brought to the next meeting of this Committee;

w) There were 99 residential and nursing care homes, and 6-8 domiciliary care providers that the Council worked closely with within the city. Reviews were regularly undertaken into the procurement of services to ensure best value;

x) Details of the procurement and monitoring of these services would be brought to the next meeting of this Committee, to provide members further information on procurement, approach and mechanisms;

y) Individual care arrangements were made through a brokering service that aimed to best match people to the most appropriate providers. A significant amount of work was undertaken by the Council to ensure people received the best possible quality of care;

z) Anyone who was not satisfied with the care they received was encouraged to contact their provider in the first instance, who were obliged to look at each complaint, and respond. However, if this was not satisfactory or achievable, the public were able to contact the Council directly;

aa) There had been concerns raised over the inconsistent standard of care received from varying providers. Issues surrounding the procurement and standards of care would be brought to the next meeting of this Committee;

bb) Data regarding waiting times for domiciliary and supported living packages would be included in future reports;

cc) Although data showed that ‘the number of people who were satisfied with the amount of control they had over their daily lives’ was above the national

average, it had declined over several years and would be addressed in forward planning;

dd) Social Care had seen an improved position due to various improvement schemes run over the winter period. It was now necessary to exit some of these schemes and return to the usual business model however, it was vital to maintain the current standards achieved. Workforce challenges also showed signs of recovery, and would help sustain the improvements made;

ee) People waiting for domiciliary care were triaged using a Red, Amber, Green (RAG) rating, with red being most in need of support. This list was periodically reassessed to ensure the rating was still relevant and appropriate, as it was recognised that people's situations changed over time;

ff) Oversight and support was provided by NHS England at a national level to understand the drivers behind the challenges being experienced in the Emergency Department, and to ensure that the most effective actions were being taken. This focussed on the flow of people through the hospital and how people could be better supported by other services within the community.

The Committee agreed to-

1. Note the Health and Adult Social Care Performance report;

2. Add the following items to the work programme for the next meeting:

    i. LGO recommendations relating to Health and Adult Social Care;

    ii. Procurement and standards of domiciliary care.

Helen Slater (Lead Accountancy Manager) introduced the Adult Social Care Finance Report and highlighted:

gg) The adult social care budget for 2022/23 was just over £85 million, the biggest revenue budget within the Council, and had underspent at £83.22 million. This underspend had been used to meet pressures within Community Connections relating to homelessness;

hh) Domiciliary care and direct payments were the highest pressure areas, which were offset by an increased client and joint funding income, and additional grant funding;

ii) In 2023/24 the budget was uplifted by £7.582 million following modelling on expected demand and having taken into account an increase in the national living wage and inflationary increases. However, there had been an increase in delivery plan savings targets of £3.712m, so the net increase was just £3.870 million;

jj) The two largest saving targets related to managing demand across the care provider market and ASC package reviews, as well as transition packages for people going from Children's Social Care into Adult Social Care. Additional income was expected through direct payment clawbacks;

kk) Care package expenditure was the highest at over £103 million;

ll) The main contract of the service was with Livewell for social care with a budget of £7.6 million;

mm) There was a new provider of community equipment for 2023/24 with a contract of £1.54 million;

nn) CRAG was the nationally set charging framework for people in residential and nursing care.

In response to questions it was reported that:

oo) There had been an 8.5% uplift in the budget for residential and care home fees but it was important to be cautious when comparing Plymouth's market to those of neighbouring authorities because of significant differences in geography and location.

The Committee agreed to note the report.

Ross Jago (Head of Governance, Performance and Risk) introduced the Risk Management Monitoring Report and highlighted that:

pp) There were 22 strategic risks on the corporate register, six of which were red, and one of these fell within the remit of the Committee –'the lack of adult social care workforce and growing fragility in the adult social care market', which was improving;

qq) There were a number of amber risks including risk number eight which referred to health inequalities and life expectancy. It was recommended that the Committee read the Plymouth Report, which fulfilled the requirement for a joint strategic needs assessment, and was due to be considered by the Health and Wellbeing Board;

rr) Risk number 10 referred to adult social care reforms, which the Committee had been diligent in looking at over the previous 12 months.

The Committee agreed to note the report.

7. **No Right to Reside Update** (Verbal Report)

Gary Walbridge (Head of Adult Social Care and Retained Functions) provided a verbal update on the position of the criteria for no right to reside, and highlighted that:

a) No right to reside was a national criteria for measuring the number of people who were in a hospital bed, who no longer needed to be;

b) Plymouth remained at 5%, meeting its target of 5%, with Devon and Cornwall at 5% and 10% respectively;

c) The numbers had been relatively stable and Plymouth was the second best performing system in the South West.

8. **Better Care Fund Plan**

Gary Walbridge (Head of Adult Social Care and Retained Functions) and Chris Morley (Interim Locality Director, NHS Devon) introduced the Better Care Fund Plan report and highlighted:

a) The Better Care Fund (BCF) was the only mandatory policy to facilitate integration between health and social care, providing a framework for joint planning and commissioning;

b) The BCF's core objectives were to:

   i. Enable people to stay well, safe and independent at home for longer;

   ii. Provide the right care in the right place at the right time;

c) The BCF also set out shared objectives which included:

   i. Improving discharges;

   ii. Reducing pressures on urgent and emergency care;

   iii. Supporting social care to achieve goals;

   iv. Supporting intermediate care, unpaid carers and housing adaptations;

d) The plans were submitted to NHS England for initial approval, and would need to go to the Health and Wellbeing Board for approval by 31 October 2023;

e) Investment had been made in community services to support individuals to stay at home for as long as was possible;

f) The BCF allowed officers to evaluate systems that had been introduced on a short term basis to support issues such as discharges, and what potential long-term solutions could be implemented;

g) The schemes that had been introduced would be rolled forward, but would be subject to an evaluation to consider delivery and impact;

h) There were five key metrics, determined by national planning guidance that formed the basis of monitoring performance against the BCF plan:

   i. Avoidable Admissions;

   ii. Falls;

   iii. Discharge to Usual Place of Residence;

   iv. Residential Admissions;

   v. Reablement;

i) In 2023/24, the Government would be providing £600 million to enable local areas to build additional adult social care and community-based reablement capacity and reduce delay discharges and improve outcomes for patients;

   i. The allocation for Plymouth was £3.341 million (£1.81 million to PCC and £1.528 million to NHS Devon Plymouth Locality) but it would be agreed jointly how best to utilise the funding to maximise the impact and support more people to stay at home;

j) The Plymouth BCF 2022/23 investments totalled £37.8 million.

In response to questions it was reported that:

k) A national tool had been released which enabled staff to analyse the number of people who were in hospital and the number of people who were being discharged each month, and to undertake analysis to make the service more effective;

l) The short-term nature of previous investments had led to a complicated discharging system and ways of simplifying these and integrating these were being investigated;

m) Services were reviewed to limit duplication and ensure the best use of resources;

n) Affordable admissions related to wrap around care in the community to stop as many people from going into the emergency department and potentially being admitted to hospital, as well as working with individuals who are regular attenders of the emergency department.

The Committee agreed to note the report and the monitoring of progress.

9. **Future Hospitals - Derriford Urgent & Emergency Centre**

Stuart Windsor (Future Hospitals Director, University Hospitals Plymouth NHS Trust), Nicki Collas (Future Hospitals Program Manager, University Hospitals Plymouth NHS Trust) and Amanda Nash (Head of Communications, University Hospitals Plymouth) introduced the Derriford Urgent and Emergency Care Centre item and highlighted the following points:

a) In December 2022, the business case for Phase 1 was presented to the Joint Investment Committee and was approved. It had now also had approval from the Secretary of State;

b) The full business case would be submitted in the months following the meeting;

c) Derriford Hospital was a complex estate, sat in a complex system and so the team had wanted to ensure they were aware of the available opportunities and took an incremental approach to development with a long term plan for the estate as a whole;

d) Phase One was to address the Urgent Emergency Care building which had received funding from the New Hospitals Programme;

e) The second phase of work would focus ensuring there was the right capacity for work that needed to be done in the hospital environment whilst taking the opportunity to take services out of the hospital into the community where appropriate;

f) The third phase would focus on Derriford's role as a specialist service provider across the peninsula and the importance of ensuring there was the right capacity to deliver services at present and to cope with future changes in demand;

g) The fourth phase would focus on women's and maternity services being reconfigured to ensure the right services were in the right place with the right capacity;

h) The fifth phase would link in closely with phase one and would focus on the creation of an integrated children's hospital that allowed a flow from the emergency department to paediatric and other children's' services;

i) The final phase would focus on maintenance within the hospital and ensuring the correct bed capacity;

j) The phases could occur concurrently and would be broken down further to ensure maximisation of funding opportunities;

k) Crowding was a significant and complex issue which had escalated quickly and formed the basis of the case for change for phase one of development;

l) Within phase one of the scheme, the opportunity had been taken to remove one of the highest clinical risks around interventional theatre capacity for

neurosurgery, by building additional conventional theatre capacity that could be used for both emergency cases and planned cases;

m) A developer, Willmott Dixon, had been appointed and work was underway to finalise designs and the full business case;

n) Enabling works were underway and £50 million had been secured from the new hospital programme to being works, which would include the re-routing of underground services and the building of a fracture clinic;

o) The main contract works would commence in early 2024 and were due to take 2.5-3 years to be completed;

p) A new walk-in entrance and separate ambulance entrance would be created on level 6;

q) Level 7 had been designed to have patients diagnosed, treated and returned home within a 24 hour period, and the floor would also have a short stay ward, imaging facilities and smaller emergency department rooms for examinations and consultations;

r) Level 8 would include four new interventional radiology suites, adjacent patient recovery facilities and would be linked to the existing hospital to improve patient safety;

s) Level 9's primary use would be emergency surgery facilities with 5 new operating theatres as well as administrative offices and welfare facilities for staff;

t) The team were aware of how disruptive schemes like this one could be to both patients and staff and understood the importance of communication with stakeholders both in and out of the hospital, particularly in reference to access;

u) The team would work with the contractors to undertake work when the hospital was least busy, implementing traffic management and ensuring off-site construction was carried out where possible to minimise the construction on site;

v) 40 new beds had been added to the system through the discharge assessment unit and a number of schemes were underway across the site to increase bed capacity;

w) Stakeholder engagement had been conducted since 2018 and there was a comprehensive Communications and Engagement Plan which covering phase one of development;

x) The team were learning from and sharing best practice, and were developing messaging and innovative materials (virtual reality dome to show staff the

development) as well as maintaining strong support from MPs and partners;

y) Engagement was being carried out beyond the Plymouth boundary as the hospital supported people from other areas of Devon as well as areas of Cornwall;

z) Patient feedback regarding future service provision highlighted increased staffing, mental health provision, community care, access and car parking, and wellbeing of staff and environmental concerns;

aa) Full works were expected to begin in March 2024 after the approval process and final completion was expected in December 2026.

In response to questions it was reported that:

bb) Considerable stakeholder engagement had been undertaken that had helped shape plans for the new buildings and services that would be delivered;

cc) There was a process in place to carry out formal consultation, if required where there was significant service change, usually used if a service was being lost, but this was not the case;

dd) The project was bound by planning consent restrictions in terms of the hours that they could work, but the team tried to carry works out around the activity in the hospital and were advised via the network of clinical leads appointed to support the project and services, such as neurophysiology, would be moved away from the construction zone if deemed necessary;

ee) An updated sustainable transport plan was currently under consultation with staff at Derriford and a new plan was due to be published by the end of 2023;

ff) The team were working with partners to identify additional off-site parking to support parking for both staff and patients;

gg) A plan had been produced on how car parking would be handled at certain sites across the full site and there was a plan to construct a further multi-storey car park as part of the next stage of large scale development to ensure no capacity is lost. Car parking provision would be reported as part of the New Hospital Programme updates at future Committee meetings;

hh) A shuttle bus was provided to the hospital from the disabled car park. It was recognised that further action was required to ensure it was running on a more permanent basis, with increased reliability;

ii) Planning consent had been granted for the building, and security and contractors were in place for the project to be completed by its 2026 deadline;

jj) While the project was part of the Government's New Hospital Programme, the new building would be attached to the existing hospital. The total cost of

the project was over £150m, and the allocation made to Plymouth would be received following submission of the full business case;

kk) The movement and creation of services had been based on data around where more capacity was needed on a one, three, five and 10 year basis to ensure improvements were long term.

The Committee agreed:

1. To recommend that the Chair of H&ASC write a letter of support on behalf of the H&ASC OSC, providing support for the New Hospitals scheme at Derriford;

2. That the project did not require further public consultation in relation to health service provision however, statutory planning consultation would be required.

10. **Community Diagnostics Centre Update**

Stuart Windsor (Future Hospitals Director, University Hospitals Plymouth NHS Trust), Nicki Collas (Future Hospitals Program Manager, University Hospitals Plymouth NHS Trust) and Amanda Nash (Head of Communications, University Hospitals Plymouth) introduced the Community Diagnostics Centre Update and highlighted that:

a) A report by Sir Mike Richards in 2020 had proposed the introduction of a series of diagnostics centres to address the diagnostic capacity issues across the country. The Government had launched a programme with plans to create a number of standardised diagnostic centres across the country;

b) A diagnostics centre had already been established in Devon at the Nightingale Hospital. While the Plymouth diagnostic centre was originally intended as a branch/ spoke of this Devon hub, Plymouth's unique challenges had inspired the development of a business case for a Plymouth hub in its own right;

c) The bid had been successful and £25 million had been designated to create a community diagnostics centre in the city centre, close to some of the most deprived areas of the city;

d) The centre would increase diagnostic capacity across the city, improve productivity and efficiency and reduce heath inequalities;

e) It would include consultation rooms to increase efficiency alongside a variety of diagnostic tests, including those deemed to be a priority locally and the team were working in partnership with Plymouth City Council to develop the design;

f) The centre would be built at Colin Campbell Court and a condition of the approval was to delivery temporary diagnostic capacity by the end of

September 2023 via a mobile unit;

g) The team were working closely with the strategic development team to ensure that any development there would complement future development;

h) The site had excellent access by public transport and supported the trust's aims to achieve net zero carbon emissions as access was not limited by car ownership;

i) Services would include CT scanners, MRI scanners, X-ray rooms, ultrasound rooms and an audiology suite as well as the requirements for echocardiography, electrocardiogram, blood pressure monitoring, pacemaker checks and spirometry over 3,500 sqm;

j) The project was expected to open by 1 April 2025 and would deliver the following additional annual capacity by the end of 2025/26:

    i. 34,000 CT Scans;

    ii. 9,000 MRI Scans

    iii. 39,000 Ultrasound Tests

    iv. 9,000 X-Ray's

    v. 2,000 Audiology assessments;

k) A project board had been established with the Council, there were weekly working group meetings, and engagement would be carried out with patients and members of the public.

Councillor Mary Aspinall (Cabinet Member for Health and Adult Social Care) added;

l) The project came under Councillor Mark Lowry's (Cabinet Member for Finance) portfolio, but they would work closely together on this project;

m) It would benefit some of the more deprived communities in Plymouth by bringing services closer to them, but the services would be available to all.

In response to questions it was reported that:

n) A condition of the bid was to have the temporary mobile unit on site from September 2023, but there would be a clear break between the building site and the mobile unit, though the exact location was yet to be determined;

o) The award of the £25 million for the centre did come with conditions that the team were working with partners on to meet;

p) This project was different to the Health Hub originally destined for the site, but it would utilise the site and funding to create this centre and the ambition was still to make it a health village.

11. **Motion on Notice - Defibrillators**

Ruth Harrell (Director of Public Health) introduced the agenda item and highlighted;

a) A motion on notice on defibrillators in Council-owned Public Buildings (specifically the Council House) was raised at the 30 January 2023 meeting of the City Council and was subsequently referred to the Health and Adult Social Care Overview and Scrutiny Committee;

b) The installation of defibrillators was not one organisations' responsibility;

c) A defibrillator could be used to give a jolt of energy to the heart which could restore its rhythm and needed to be delivered with CPR, but if used quickly could increase the chance of survival for people who suffer a cardiac arrest;

d) Defibrillators were quick and easy to use and did not require training;

e) The use of defibrillators was relatively low, with only around 30 cardiac arrests in Plymouth's public spaces per year. It was impossible to know where one might be needed, but the British Heart Foundation had recommended placing them in areas with high footfall, and where the demographic was made up of people at a higher risk of cardiac arrest;

f) The cost of a defibrillator was approximately £2,000, with relatively infrequent and low cost ongoing costs of checks as well as pad and battery replacements;

g) Hospital Trusts across the country were building a database, called 'The Circuit', of the locations of defibrillators in order to direct people when they made a 999 emergency call;

h) After looking at British Heart Foundation guidance and the location of Plymouth City Council buildings, it had been concluded that a number of the Council's sites already had defibrillators, and where there wasn't one, there was on in close proximity;

i) Five areas were identified where action could be taken to increase the number of defibrillators, one of which included one in the proximity of the Council House and Guildhall, the Guildhall being the preferred location;

j) Some defibrillators were only available at certain times of day, so one recommendation was to encourage the owners of those sites to make access to the defibrillators 24/7;

k) Funding was sometimes made available to the voluntary and community sector for defibrillators, so it would be important to identify this and promote it to those in the city to increase the number of defibrillators across the city;

l) 'Restart a Heart Day' was held in the middle of October each year which promoted defibrillators and CPR training and so it would be important to promote this.

Councillor Mrs Terri Beer, who submitted the motion on notice, added;

m) Every minute was crucial when someone was suffering a heart episode and having a defibrillator nearby could save valuable minutes;

n) The aim of the motion was to ensure all Council buildings, used by the public and by staff, had a defibrillator;

o) A former councillor had recently experienced a heart attack at a community centre, and through the critical early use of a defibrillator, along with medically trained members of the public and CPR, had survived;

p) The recommendations were welcomes, but it was still felt that a defibrillator should be installed in the Council House.

Councillor Mary Aspinall (Cabinet Member for Health and Adult Social Care) added:

q) She would be happy to revisit the reasoning behind the decision to put a defibrillator at the Guildhall rather than the Council House;

r) She welcomed the recommendations and advised some would be taken to the Health and Wellbeing Board, where more partners attended.

In response to questions it was reported that:

s) The subject could be raised in an all members briefing to better educate Councillors, and CPR training could be offered as part of this as well;

t) The possibility of installing a defibrillator in Plymstock Library would be looked into, though the reason it wouldn't have been listed as a site would have been that it either already had one, or was in close proximity to one;

u) Community Grant funding could be used to purchase defibrillators.

The Committee <u>agreed</u>:

1. To recommend to the Cabinet Member for Health and Adult Social Care that - Plymouth City Council commission defibrillators at the locations identified which included the Guildhall;

2. To recommend to the Health and Wellbeing Board that –

i. PCC works with partners to promote 'Restart a Heart Day' which takes place on or around 16 October each year;

ii. PCC works with partners to promote CPR training;

ii. All defibrillator owners across Plymouth are encouraged to register their defibrillators on The Circuit - the national defibrillator network;

iii. All defibrillator owners across Plymouth suitable for public access should consider whether access could be widened to 24/7, if not already;

iv. PCC promotes schemes to access funding for publicly accessible defibrillators amongst communities;

v. PCC works with partners to provide defibrillators at St Budeaux library and Southway library.

12. **Tracking Decisions**

Elliot Wearne-Gould (Democratic Advisor) presented an overview of the tracking decisions log, and highlighted that:

a) Following the past three meeting of the H&ASC OSC, there were a significant volume of tracking decisions to be considered and actioned. While many of these had received replies, a meeting between the Chair and relevant officers would be convened to review the progress of actions, and agree further steps;

b) Many tracking decisions had been updated since the publication of the agenda, and therefore more actions were completed than appeared before the Committee. These updates would be provided to the Committee;

The Committed agreed to note the tracking decisions document.

13. **Work Programme**

The Committee agreed to add the following items to the Work Programme:

1. Procurement of Domiciliary Care;

2. Local Government and Social Care Ombudsman Recommendations;

3. Updates on the progress of the build at Derriford Hospital as part of the New Hospitals Programme.