Health and Adult Social Care Overview and Scrutiny Committee

Wednesday 24 March 2021

PRESENT:

Councillor Mrs Aspinall, in the Chair.
Councillor James, Vice Chair.
Councillors Sam Davey, McDonald, Nicholson, Parker-Delaz-Ajete, Mrs Pengelly (substitute for vacant post) and Tuohy.

Apologies for absence: Councillors Tuffin

Also in attendance: Councillor Kate Taylor (Cabinet Member for Health and Adult Social Care), Craig McArdle (Strategic Director for People), Anna Coles (Service Director for Integrated Commissioning), Rob Sowden (Senior Performance Officer), Dr Paul Johnson, Jo Turl and Sian Bunce (NHS Devon CCG), Fiona Peck (NHS Devon CCG), Ruth Harrell (Director of Public Health) and Amelia Boulter (Democratic Advisor).

The meeting started at 10.00 am and finished at 12.50 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.

78. **Declarations of Interest**

There were no declarations of interest made in accordance with the code of conduct.

79. **Minutes**

Agreed the minutes of the meeting held on 27 January 2021.

80. **Chair's Urgent Business**

The Chair reported that she recently attended the Health and Wellbeing Board meeting in which Dental Health was being discussed. Dental Health would be pursued further to ensure that Plymouth was made a priority. The Chair felt that the response from NHS England was disappointing, despite how forcefully concerns were put forward. The next steps to take a political route.

81. **Health and Adult Social Care System Performance Report**

Rob Sowden (Senior Performance Officer) provided an update and referred to the report in the agenda pack. It was highlighted that:

- there had been an increase in outbreaks within care home settings which peaked at the end of Jan but pleased to report that the numbers were now lower, however outbreaks were still happening;
- referral to treatment time pressures reports a decline in the percentage of people seen within 18 weeks;
- there were positive outcomes for people that have receive reablement.

Questions from members related to referral to treatment times and whether a breakdown on specialisms could be provided so that the committee would have a greater understanding on the largest impacts on waiting times for residents.

The Committee noted the Health and Social Care System Performance Report.

82. **General Practice Update and Econsult**

Dr Paul Johnson, Jo Turl and Sian Bunce (NHS Devon CCG) were present for this item and referred to the report in the agenda pack. This report sets out progress made in respect of the Plymouth Primary Care Prospectus, Devon System Primary Care Strategy and additional information requested by the committee concerning the use of the e-consult online consultation system.

The vision was that primary care in Devon would offer each local community a wide and flexible range of information, support and services to enable people to live happy healthy lives.

To do this, they must address a number of challenges. Increasing demand, difficulties in recruitment and retention, estates and IT. The strategy outlines five priorities that will revolutionise general practice. The 5 Pillars are:

- Better Access
- Workforce
- Population Health Management
- Primary Care Networks
- Infrastructure

Questions from Members related to:

- The concerns that Healthwatch shared with the committee on Econsult and what was on the horizon to make Econsult more user friendly?
- The number of GPs and have we lost any GPs?

The Committee welcomed the opportunity to view before the launch on digital inclusion.

The Committee noted the General Practice Update and Econsult.

83. **Restoration and Recovery of Services**

Fiona Peck (NHS Devon CCG) was present for this item. It was highlighted that the report provides an update on the NHS Devon CCG programme for Elective Care Restoration, as part of the Devon Phase 3 Restoration Plans. The national Phase 3 guidance (Third Phase of NHS Response to COVID19, dated 31 July 2020) set out an expectation that systems would restore elective activity to:

- 90% of 19/20 levels by October for elective inpatient, day case and outpatient procedures
- 100% of 19/20 levels of MRI, CT and endoscopy procedures (by October)
- 100% of last year's levels for new and follow-up outpatients

The Elective Care Cell has been broken into 4 workstreams to support the delivery of the Phase 3 and Adapt & Adopt:

- Management of GP referral processes
- Pathway development and GP and patient communication
- Outpatients
- Surgical Restoration

This programme focusses on the following priorities and this is incorporated into the Elective Care Cell's workstreams for delivery:

- Theatres - Prepare regional core principles based on national Infection Prevention Control (IPC) guidelines to support systems with practical implementation of relevant measures, including lessening PPE and Cleaning requirements and enabling local decision making to downgrade PPE according to risk.
- CT MRI - Prepare regional core principles based on national IPC guidelines to support systems with practical implementation of relevant measures.
- Endoscopy - Prepare regional core principles based on national IPC guidelines to support systems with practical implementation of relevant measures, including settling time on COVID negative AGP.
- Outpatient - Prepare regional core principles based on national IPC guidelines to support systems with practical implementation of relevant measures. For outpatient transformation, adapt and adopt work complements and helps with rapid implementation of the existing National Outpatient Transformation Programme.
- There are targets to be delivered against each of these priorities and the CCG is required to report weekly to NHSEI against all of these targets.

Questions from members related to the elective work stream and who sets the priority? A breakdown of elective surgery and waiting list for each specialism would be useful information for this committee to receive.

The Committee noted the update on the Restoration and Recovery of Services and agreed to receive a further update in July 2021.

84. **Covid and the impact on health inequalities**

Ruth Harrell (Director of Public Health) provided an update and reported that that covid-19 has an unequal impact across the population and that this reports aims to highlight the inequalities caused by covid-19. The direct impacts of the disease have been analysed in detail and the causal factors can be summarised as:

- increased exposure
- increased susceptibility (to harmful impacts)
- access to (or making use of) healthcare

The following factors have been found to be very important in identifying risk of poor outcomes from covid-19:

- Age
- Sex
- Deprivation
- Ethnicity

Plymouth has been hit relatively lightly by covid19. The exact reasons for this were likely to be linked to the willingness of people to be tested, to self-isolate and to pass on information about their contacts, and of workplaces, schools etc to stick to covid secure measures to reduce spread; in short, complying with the measures. Everyone did their bit to keep Plymouth safe.

In terms of cases, there was a slight gradient with deprivation, with a slightly higher proportion of cases in the more deprived populations. However, this was slight and may well be skewed by age; younger people were more likely to have to be out and about working, in lower paid and less stable work.

Plymouth's population was mostly white British and so it is difficult to identify any trends in BAME groups from our limited data. However, we would anticipate that the nationally observed trends were likely to be followed.

There were many indirect impacts of covid-19 and they can be summarised as;
Impacts on…

- Mental health and wellbeing
- Health behaviours (smoking, alcohol, diet and physical activity)
- Lived experience (especially for vulnerable groups and potential increases in childhood trauma)

Impacts of changes to…

- Access to healthcare (reduced screening and diagnosis, delayed care)
- Income (recession leading to unemployment and more unstable work)
- School and education (impact of learning from home)
- Built and natural environment (this has been a positive, with green spaces throughout the city being used more to support wellbeing)

It was clear that almost all of these have the potential to impact differentially; there was certainly the possibility that the impact of covid-19 would widen inequalities.

These issues were known and planning was underway to try to mitigate these as much as possible. A detailed Mental Health Needs Assessment was almost complete, and would be shared once agreed with partners.

Questions from members related to:

- How do we work collaboratively to help with health inequalities? Were health inequalities widening or reducing throughout the covid pandemic? BAME community and uptake of the vaccination programme.
- Engagement with the Chinese community?
- The Thrive Programme.

The Committee noted the Covid and the impact on health inequalities report.

85. **Work Programme**

The Committee discussed the following areas of focus for 2021-22:

- Homelessness – developing a prevention plan;
- Community Empowerment Framework;
- Integrated Care System – Plymouth Local Care Partnership;
- Learning from Covid, (support to the care home market and how to develop training and support in a sustainable way);
- Workforce (retention and career pathways);
- ED and improvement work the hospital is undertaking – on-going proactive work increase access to crisis support and minimise attendance at ED.
- Mental Health/CAMHS;
- Dental Health;
- NHS 111 Service (CQC Report and review the action plan);
- Alliance Contract.