WEST YORKSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE
20TH JULY 2021

PRESENT: Councillor Greenwood – Bradford Council (Chair)
Councillor Baines MBE – Calderdale Council
Councillor Clark – North Yorkshire County Council
Councillor Glentworth – Bradford Council (as substitute for Councillor Hargreaves)
Councillor Hutchinson – Calderdale Council
Councillor Latty - Leeds City Council
Councillor Marshall-Katung – Leeds City Council
Councillor Rhodes – Wakefield Council
Councillor Smaje – Kirklees Council
Councillor Swift – Wakefield Council
Councillor Ramsey – Kirklees Council

1. **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Councillor Solloway (North Yorkshire) and Councillor Hargreaves (Bradford Council), (Councillor Glentworth as substitute).

(Councillor Baines MBE left at 12:42 hours).

(Councillor Glentworth left at 12:52 hours).

(The meeting closed at 13:05 hours).

2. **ELECTION OF A CHAIR AND DEPUTY CHAIR**

Mike Lodge, Senior Scrutiny Officer (Calderdale Council) opened the meeting and advised that a Chair and Deputy Chair of the Committee be elected for the West Yorkshire Joint Health Scrutiny Committee for the 2021/22 municipal year.

It was proposed that Councillor Greenwood be appointed as Chair, and Councillor Smaje be appointed as Deputy Chair, with a unanimous vote.

IT WAS AGREED that Councillor Greenwood be appointed as Chair, and Councillor Smaje be appointed as Deputy Chair of the West Yorkshire Joint Health Overview Scrutiny Committee for the 2021/22 municipal year.

3. MINUTES OF THE MEETING HELD ON 24TH NOVEMBER 2020, 23RD FEBRUARY 2021 AND 22ND MARCH 2021

IT WAS AGREED that the Minutes from the meetings held on 24th November 2020, 23rd February 2021 and 22nd March 2021, be approved as an accurate record.

4. PUBLIC DEPUTATION

There was one public deputation received from Jenny Shepherd, who attended the meeting and read the following:

The Health and Care Bill is bad for NHS patients and for NHS staff. It would reduce the government's obligations to secure NHS care for us all - potentially making the government non-compliant with its duty to provide an effective framework for protection of the right to life. And it seems set to worsen the current NHS front line staff shortage, by threatening national agreements on wages, terms and conditions of employment, deregulating NHS professions and introducing flexible staff

redeployment across NHS organisations, based on "learning" from redeployment of nurses and doctors during the Covid-19 pandemic.

We understand from previous JHOSC meetings that you're not allowed to question government policy and legislation, simply to scrutinise whether local organisations are implementing them in the best interests of the NHS and the public. So, when considering the WYH governance arrangements to be put in place (should the Bill get through Parliament in its current state, which we doubt), we ask you to bear these points in mind: The Bill is bad for patients. It reduces the government's obligation to secure NHS care for us all. This is indicated in Part 1, 15.1 and Schedule 3, para 3, new section 82B. These clauses mean that if Parliament enacts this Bill: (a) there will no longer be a statutory duty on any body to arrange provision of secondary (i.e., hospital) medical services – only a power for Integrated Care Boards to do so; (b) Integrated Care Boards will only have a "core responsibility" for a "group of people" in accordance with enrolment rules made by NHS England. This evokes the US definition of a health maintenance organisation which provides "basic and supplemental health services to its members" (Clause 14 -People for whom integrated care boards have responsibility, and new section 14Z31). But the NHS is meant to be a universal service for everyone. These and other measures in the Bill raise the question of whether it complies with the government's duty to provide an effective framework for protection of the right to life. (This obligation is imposed by Article 2 European Court of Human Rights.) The consequence could be a systemic or structural dysfunction in hospital services that result in a patient being denied access to life-saving emergency treatment.

The Bill is Bad for staff. There is nothing in the Bill about NHS front line staff's national agreements on wages, terms and conditions of employment - but there is plenty about how the postcode-lottery Payment Scheme for the new Integrated Care Boards will impose strict spending limits. This new NHS postcode-lottery funding system undermines the economic basis for national agreements on wages, terms and conditions of NHS staff. Staff pay at around 65% of NHS is the biggest bit of NHS costs so there will be pressure on Integrated Care Boards to vary it (and terms and conditions) according to how their area's funding allocation is set by NHS England.

The Bill would also deregulate NHS professions [Explanatory Notes 210140en.pdf (parliament.uk), p. 37] – with serious implications for the quality of care, as well as the employment status, pay and terms and conditions of a range of NHS workers. Prof. Kailash Chand, an Honorary Vice President of the British Medical Association, has tweeted: 'The core thrust of the new reforms is to deprofessionalise and down skill the practice of medicine in this country, so as to make staff more interchangeable, easier to fire, and services more biddable, and, above all, cheaper.'[Prof Kailash Chand OBE FRCGP on Twitter: "This needs wide publicity…. We can't afford to take our eye off this! https://t.co/cgSPkHudr7" / Twitter]. The Doctors' Trade Union, the British Medical Association, has already rejected the Bill.

5. THE HEALTH AND CARE BILL – GOVERNANCE IMPLICATIONS

The Health and Care Bill had been published and was to be presented to this Committee due to its significant implications for the West Yorkshire and Harrogate Health and Care Partnership (WYHCP), and the commissioning of health and care

services in West Yorkshire. It would also impact on the role of this Scrutiny Committee and the way in which it operates moving forward.

A report was prepared and circulated prior to the meeting by Stephen Gregg (WYHCP) and Ian Holmes (WYHCP) who attended the meeting and gave a presentation highlighting the key changes, issues and implications, and partnership responsibilities including the strategic direction of travel, and the strong emphasis on collaboration rather than competition. It was agreed that Members receive a copy of the presentation following the meeting.

Members commented on the following issues:

- Councillor Hutchinson suggested that the Bill was quite permissive and vague in lots of areas – particularly around conflicts of interest where providers were involved in board meetings. For some time, the integrated boards and partnership-level boards allowed profit-making bodies and organisations to sit on these boards, as well as being awarded contracts for their work, which could often be very high value and long duration contracts, without abiding by public contracts legislation. The new governance arrangements will be very complex, and much of this will be influenced by the constitution. Councillor Hutchinson advised that his understanding was that this was going to be drawn up by the Integrated Commissioning Board and be reported into the Partnership Board. What input was Scrutiny going to have on this? In response, Officers advised that they were hoping to get a first draft to the Partnership in September, with an opportunity to consult much further and wider on this work from September 2021 – April 2022, and Scrutiny would absolutely be welcomed to contribute to the emerging constitution as part of that wide consultation. In addition, there would be new statutory guidance as part of that and c embedding this into systems was another part of this work – however, there was lots of work to do before that stage. At this stage, they needed to ensure the appropriate arrangements were in place to ensure any conflicts of interest were effectively managed.

- Councillor Smaje asked for confirmation with regards to the constitution, that not just health bodies would be discussing these issues before September, and that the local authorities would be able to contribute prior to September? The were two aspects to the Bill – health, and care, and it needed different partners at the table. In respect of governance, there was a section that stated a 'duty to have regard to the wider effect of decisions' – and how did this feed into the governance? In terms of health inequalities, had scrutiny's comments been taken into account in the memorandum of understanding? How were they going to get new voices into the governance structure? And in terms of the 5 Year Plan, which was to be updated by each financial year, would this be refreshed whilst in shadow form? And how would that refresh be done? And could you expand on the range of governance models? In response, Officers advised that it was each Clinical Commissioning Groups (CCG's) responsibility to consult, and they had taken this responsibility from the start and the work would continue to be co-produced. Much of the work was already underway through Governance Officer level, local authorities, Healthwatch, race and inequality groups, Scrutiny, and other providers, etc. and these all report into the various partnership groups, which would then report to the Partnership Board for full

inclusivity. The work should absolutely be co-produced and one of the best ways to address the issues outlined by Councillor Smaje is ensuring partners are listened too, as well as people at place and local level. This is not just focused on health or social care, but also the wider determinants, including things such as climate and inequalities, etc. There would also be opportunity to look at health inequalities under the 'top ten' priorities of WYHCP and the constitution would set that out really clearly – this would be an overriding ambition. WYHCP welcomed the views on how they could best ensure co-production in terms of how the partnership could best be inclusive in the way it represented voices in the communities etc. There were a huge number of pressures in the system currently, especially around future design and the pandemic; and a judgement would need to be taken as to when to 'refresh' the 5 Year Plan at the right time, whilst balancing the competing requirements. In terms of place governance arrangements, the 5 broad areas were absolutely committed as outlined in the report. With regard to the governance arrangements, it would be good to have Scrutiny involved in this as much as possible and Health and Wellbeing Boards should all be involved as part of this work, and Members sought assurances that the 5 Year Refresh work wouldn't be 'drowned out' given current pressures.

- Councillor Swift suggested there was considerable emphasis in the report on the fact that scrutiny would continue to occur at place level to a substantial degree and would expect existing providers to continue to attend scrutiny at that level. There was a risk that things could become nebulous, and potentially a risk that communication could become one way, when responding to local level. What would WYHCP envisage at place level, that had some degree of accountability and autonomy? In response, Officers advised that the scrutiny function level at place level is important, as that would be a delegated function. There should also be a place of NHS accountability, and officers agreed with this being important – and ensuring this works through arrangements or sub-committee arrangements, so that this accountability will be there as it is now.

- Councillor Latty commented, that there must be checks and balances in place to ensure the 'big voices' did not 'drown out the little voices', for example: Leeds being a big place sometimes received criticism that it "swamps the field",. So, what are we doing to ensure this is an identity and not a ranking? In response, Officers advised that, we have 5 very different places across WY and setting out what those place arrangements are, will be quite different, however arranging things that work for those places within those arrangements, was key to getting this right. WYHCP had worked really hard to build something that didn't feel like Leeds was drowning the system, for example. It was felt there had been a good job in managing this to date and that the partnership works very well, with good representation across the piece. The key would be to do a good job of guarding this work and building upon it at Partnership Board, to ensure something that is representative of place and the sector. It was hoped that this was not how it was felt to other areas, as it was definitely something that was felt to not be the case within the system. Councillor Latty commented that it was good we were aware of this.

- Councillor Rhodes commented on the following issues: She supported the comments Councillor Hutchinson made on commissioning and felt it was

important to have transparency, as mentioned by Officers in the presentation. In terms of the paper going to the Partnership Board in September, it was important that this Committee received this early – as it was not just here to scrutinise, but also for overview, at every stage. In terms of the memorandum of understanding that had been mentioned by Councillor Smaje, Scrutiny had commented on this but Councillor Rhodes could not see a time when this had made a difference. This was a process that had been in place for 5 years, and heavily promoted, but looking at this example for the future, what achievements had been made from these plans? They had been greatly put to the test (in terms of the pandemic, staffing levels, future workforce, etc.) but seen as this was the panacea for the future, there was a multi-layer of committees, accountability and responsibility had been mentioned.

- Councillor Rhodes asked, could WYHCP advise how citizens voice, transparency and openness would take place? How were they seeking the views from various bodies and what was meant by citizens voice? And how was this going to be managed? Would the consultation be public, and were the public aware? It was important to ensure all of this was incorporated as the constitution was being built at this stage. If this work was down to local areas, how were they going to fit into this and ensure it was as inclusive as possible with partners? What was being done to address those inequalities referenced in the presentation? And in terms of the involvement of Healthwatch and other organisations, those bodies were scrutinising the work on behalf of half of the public – so, what about the other half? And finally, what had happened in the 3 years prior to the exceptional circumstances everyone had faced (pre-Covid); there needed to be confidence going forward that we would be doing better.

- In response, Officers advised that citizens voice was discussed at the Governance Group last week and work was ongoing with places to develop a set of arrangements to ensure public view, which was key to this work. There had been discussion around running various focus groups as well as proxies such as Healthwatch, etc. which would fully support this work. This was an illustrative process, and the first draft of the constitution would just be an initial scope, but all conversations would be key in developing this work and moving it forward. In addition, inequalities was the ‘golden thread’ running through all of the work, including the ‘top ten’ priorities and running through the ambitions and work involved. The Improving Health Population Group met prior to and during the first part of Covid, and much of the outcomes were achieved from this through the work in places; this is not something that has just been done as an Integrated Care System, this was about working with places as to how this work happens – and it was really important in how that message comes across, for example: tackling some health inequalities issues in covid, housing, etc. One of the big things that has been done as a collective in West Yorkshire in February 2021, was the launch of the Health Inequalities Academy, which was the first in the country and is an opportunity to share good practice, learn so that the same mistakes are not made that might have been in the past and to capitalise on some of the successes, which can there be shared across the place. There needs to be a concrete understanding across all organisations around what this is, so that everyone is starting from the same place, and WYHCP are promoting fellowships to achieve this. Officers advised they would share a presentation detailing more of this work for Members of the Committee.

These are things that are front and centre, especially health inequalities – which is one of the ambitions and going forward this is paramount and something that needs to be looked at as we look at everything. The question should be how this affects inequalities within the population and communities; and most of this work is happening across our places already, with organisations involved.

- Councillor Rhodes asked, how were WYHCP dealing with the future of the Bill and what input collaboration is there between organisations – and what is determined for the reset agenda for health, because there was a massive issue of backlog in the community, so where does this fit in and reset? In response, Officers advised that ultimately, it's the same partners doing the same work; there is one element looking at the reset on elective care and recovery from Covid – with the inequalities work feeding in, the same as the composition of waiting lists, and those who waiting longer, e.g., deprived groups. . Officers advised that the emphasis and challenges post-pandemic and developing a plan for 'getting back on track' were the key areas – they had been through those plans at place level and coming together as a wider system at WY level. Everyone was keen to get the number of operations and a level of activity as it was pre-pandemic and currently the aggregate levels were around 85-90%, which has been a huge effort for those staff involved. Plans were in place to further increase those levels of activity moving forward, however there were increasing pressures around urgent and emergency care at present, in addition to Covid demand – there was no intention to commit to plans whilst dealing with exceptional levels of unplanned care.

- Councillor Clark said that – the only part of North Yorkshire that would be included under West Yorkshire, would be Craven. How would this be managed in terms of representation and how would it work in practice? In response, Officers advised that the perception of GP's who work between Bradford and North Yorkshire has been very positive with regards to Craven, and those great established links and partnership work that is already in place, would continue. There were already conversations ongoing with staff across the various sites to ensure this is not an issue and Craven is well-represented by the CCG. Often in situations such as these, areas are at the forefront of professionals' minds when being represented as a place, and given that these areas involve organisations such as, Airedale and Bradford Teaching Hospitals, these organisations are well aware of how important it is ito keep those relationships strong. This was not new, and there are other areas that have these challenges, but we are starting from a good position. Officers advised that Harrogate hospital has lots of links to WY hospitals, especially Leeds and there should be a close relationship between these hospitals. What needed to be done in terms of the governance was to establish those boundaries, but also to ensure a meaningful footprint and ensure collaboration across the piece; and in terms of the name 'West Yorkshire and Harrogate', this would be something that would be taken into consideration.

- Councillor Hutchinson suggested that lots of the decisions would be binding on the rest of the partnership, and for efficiency, transparency and scrutiny to take place, Members needed all bodies to publish their agendas, minutes and reports – to be transparent with their decision-making so that it could be effectively scrutinised. It should also be noted that Freedom of Information (FOI)

requests apply to all these organisations and there are processes that require responses to these; however often the issue of commercial sensitivity around many subjects makes the scrutiny job more difficult. The other question was around workforce planning, an issue that had been reviewed and mentioned before, but providers had been careful not to get involved in clinical training etc. and this was not a sustainable option and continues to be a key problem within the NHS. In response, Officers advised that this was something they were working through and it would be useful to get a view on. In terms of transparency, this would be built into the governance and on the issue of FOI's, this was not something WYHCP could respond to for others.

- Councillor Smaje reiterated Councillor Hutchinson's point regarding Joint Committees being transparent. This work should not distract from providing the services people need, and the needs that were required now, which would have changed slightly due to Covid, and she agreed we needed collaboration throughout the system and to be looking at the whole process from Overview and Scrutiny Committee. Councillor Smaje advised in addition to this work, she would also be interested in knowing how, where and when dental services fit into this – and this was something we would need to review at a future meeting.

- Councillor Katung-Marshall thanked Councillor Rhodes raising the importance and prioritisation of the inequalities work. In reference to the presentation in reports, there were disabilities and gender referred too, but not ethnicity – given the significant impact on BAME communities because of Covid, and recent reports on maternal death rates, it was important that this information be included. In response, Officers advised that these had just been two examples pulled out in the presentation, but there were many others which would be shared in the full report and Officers provided an update on the race inequalities issues and the diversity and leadership work which had been undertaken in the last 12 months. Officers agreed these were significant issues, and there had been a lot of work happening across the system, which had been recognised and these would happily be shared with this Committee for information.

The Chair, Councillor Greenwood, advised that a letter had been sent to the Secretary of State following the last meeting of this Committee and no response had been received. She asked if Members would be agreeable for the letter to be sent to the new Health Secretary in the hope of a response, which was agreed.

IT WAS AGREED that:

(a) the reports be noted;

(b) the presentation shared at this meeting, be shared with Members of the Committee;

(c) the work on health inequalities be shared with Members of the Committee; and

(d) the Chair be requested to send an updated letter to the Health Secretary following comments made by Members at this meeting.

6. COVID-19 UPDATE

Toni Williams (Consultant, Public Health England – Yorkshire and Humber), Pat Keane and Dr James Thomas attended the meeting and provided an update on Covid-19 issues that had West Yorkshire-wide implications, including the following:

- Daily Covid-19 cases nationally continued to rise and were rising rapidly which had been evident since stage 3 of the roadmap.
- Approaching approx. 50,000 cases in England, and 240,000 of those were in the last week, which was a rate of around 426 per 100,000.
- Excluding the wave last winter, (as we weren't testing) we are approaching the same kind of level of infection when we entered the January 2021 lockdown.
- Rates vary across the country, but all parts are seeing increase. North East particularly high, followed by North West. This had been consistent around the pandemic and links to health inequalities.
- Cases were higher in younger adults – 10-19ears and 20-29 age groups. Less uptake of the vaccine in the lower 20's and also seeing a rise in cases of those less likely to have had two doses of the vaccine.
- The number of patients in hospital with covid is a lot lower than it had been previously, but it is starting to increase again. The vaccine is starting to weaken the links between infection and illness.
- Deaths within 28 days have not yet translated from the very high case rate due to the vaccine programme.
- Similar patterns across the 5 places based on last year. Approximately 400-700,000 per population in terms of cases. The speed of the cases can change rapidly. Some areas are approaching double the rate since January 2021, and some are just above. The figures will be higher than the Autumn and January waves.
- In previous waves the case increases have tracked regardless of age group, however this time the case rates are significantly higher in under 60 population compared to last time. There are rate rises and increases in over 60 population, but much slower than other age groups.
- Patients in hospitals is also increasing again, but again – not levels of hospital activity for covid in the previous 3 waves due to the vaccine programme. This is 14% higher than November peak. Number of deaths lower than normal time of year, Covid deaths account for approx. 5-10 per week, and this has been maintained since coming out of third lockdown.
- Over 1.5m people in West Yorkshire have had first dose and 1.8m have had second dose. There is a big push for those who haven't received their second dose, or a vaccine, to take this up when offered.
- All the data is publicly available on UK Dashboard.

Members commented on the following issues:

- Councillor Hutchinson asked about the different variants of the coronavirus. How many cases were we experiencing in West Yorkshire and were they following any particular trend? And if they did take off, had we plans in place to stop that from spiralling? In response, Officers advised that there were a number of variants being monitored closely at the moment. Some were 'variants

of concern' and some were 'variants under monitoring', the first – when detected, and the UK had one of the best surveillances in the world, meant enhanced testing, vaccine roll-out and contact tracing. In terms of number of cases by specific variant, this was not something they had to hand but it was known that the 'delta' variant was the most dominant variant in West Yorkshire, and we had seen a rapid rate of this at around approx. 4-6 weeks. This was the variant that takes over quickly. It was difficult to get lab test results rather than testing in the real-world settings, in terms of how variants respond to vaccine. There were plans in place to deal with emerging variants, surge testing, the impact of the vaccine etc. and it was important to highlight that the best way to tackle this, was to bring infection rates down globally.

- Councillor Hutchinson emphasised the need to share the difference in Covid-related symptoms for the different variants, for example: headache, fatigue and blocked nose were a sign of the 'delta' variant but did not feature on the symptoms pages for the public to check. In response, Officers advised that this was a wider decision-making process in terms of Government guidance and independently led advice, however they would urge anyone who was experiencing any symptoms or feeling unwell, to book a PCR test regardless.

- Councillor Marshall-Katung commented on the news that 12-15 year olds and the 'a few months before' 18 year olds would be vaccinated; what is the clinical justification for this? In response, Officers advised that it would be those 12-15 year olds only in specific circumstances (for example, those who would experience significant illness as a result of contracting disease, who may have other conditions making them vulnerable, or those living with vulnerable adults), and in terms of 18 year olds – this was about bringing the times forward slightly to ensure all adults are vaccinated or given the option of vaccination as soon as possible. Again, this was a Government decision, based on independently led advice and not something Public Health England could control. In terms of providing some justification around those decisions, we know that for adults, the consequences of getting Covid are significant, however for children, the benefits of the vaccine is different, however this announcement given yesterday, takes us a little bit further forward.

- Why were 16-18 year olds not being vaccinated? In response, Officers advised that this is a Government decision based on independent advice. In terms of the rationale it would be due to the implications of covid on children rather than adults, just as with other illnesses – children are not vaccinated the same way as adults etc. Although covid is currently spreading rapidly, it was not causing significant illness in that (younger) population.

- Councillor Smaje asked a about the testing capacity, how this was coping and how on a WY basis they were going to encourage people to come forward for vaccines; and also ensure second doses are taken up? Would there be any changes in the static vaccination programme? And how were plans going for the booster jabs in the autumn? In response, Officers advised that the vaccine programme was an NHS lead, and this would require a response from the NHS specifically on that issue. There was work ongoing in all 5 places to ensure this work was being rolled out, taking forward the learning and Public Health England were using lots of techniques with communications – for example,

providing behavioural insight to ensure take-up of vaccination and reaching people with those messages. Each area had community champions for the vaccine and it was about ensuring the use of these champions in each of the places. Community testing was holding up, despite recent media reports which might have said otherwise, however there were high results of testing across WY which was positive. Public Health were not hearing of any major issues with regards to testing at present, and there would be times when it was more difficult, but generally speaking – the testing capacity was holding up.

Pat Keane (Senior Responsible Officer for Emergency Care across WYHCP) attended the meeting and gave a presentation, which included the following information:

- System pressures – 0-5 years and 20-29 years significant issues in respiratory conditions in the early years, earlier in the year than normal which is having a significant impact on emergency care.
- The impact was being felt in staff absence and resilience due to test, trace and isolate, for example: parents having to stay home with children who had been contact traced by school, etc.
- Figures of Covid were approaching the January peak, however the impact of this has been mitigated by vaccination.
- The WY&H Strategic Health Co-ordination Group had been re-established for best use of capacity and making best use of the activity across the system.
- In terms of 999 capacity, the last 3 years comparison had shown an increase in recent months. Increase in acute and illness, some of this was believed to be due to unmet demand, such as: stroke, heart attacks, etc.
- The national position for 111, showed an increase (25% in the last few weeks) for advice and support.
- A&E attendances were at record level across many of departments, there was a mix of younger people attending – and an increase in children with respiratory illnesses, not necessarily linked to covid etc.
- Recovery (around elective work) was starting, but the differences between now and last year was that they were seeing the demand, with young children becoming ill with other diseases associated with transmission and impact on staffing and recognising the staffing pressures this causes. They were looking at ways of coping with this at place level, as well as WY&H level.
- Ensuring collaboration across the piece, especially in terms of discharge and taking a collective approach to clinical risk.
- Services did not feel that they had yet seen the peak of these collective issues and risk, so it was about ensuring people were in the right environment and receiving the right care, at the right time.
- There was lots of work going on together in WY&H but there are significant pressures across the places.

Members commented on the following issues:

- Councillor Greenwood asked a question around the impacts on children and young people, and the links between those areas where there are health inequalities, and what was being done to address this? In response, Officers advised that there was a correlation between those areas where there are health inequalities, and also where there are children and young people whose

family are in need of additional support, for example: children do not become seriously ill with covid, but if you are a parent or carer of a child, you might need support with anxiety around how to deal with this and where to go to get care, support, etc.

- Councillor Rhodes commented on a report she had been sent regarding ambulances and the queues waiting outside hospitals, for example: emergency vehicles having heart and "resuss" patients on-board, and are unable to get them into A&E. Is this a consequence of covid, as a result of the number of beds required? Or a consequence of staffing levels? Were patients being prioritised as they were queuing up at the hospital? In terms of the ways forward and staff isolating as contacts, those nurses and care workers were now going to be considered (if they have had a double dose of the vaccine and confirmed through PHE that they were negative from covid), were there any updates on this news? In response, Officers advised that guidance came out yesterday from NHS England, that for those staff who were 'pinged' to isolate, they would be able to get a PCR test, and Lateral Flow Test, and then are able to go back to work, which is different than previous guidance. The key aspect here was in staff getting a negative PCR test and doing a lateral flow test (LFT) prior to their return. Each organisation, Trust or GP Practice etc. would have an Infection Control Lead, who would help control this and align the guidance. They would also be able to bring in Public Health leads and local government if needed, for example, in GP Practices, etc. There have been no changes to A&E and ambulances, however there were a high number of calls being received and transferring people to Emergency Departments, as well as the pressures on beds. Organisations had converted back from covid 'red' and 'green' areas as there had not been a need, but hospitals were now looking to reinstate this due to the pressures and capacity. The Ambulance Service had been extremely busy in recent weeks, and they were aware of the issues – there had been several meetings with Yorkshire Ambulance Service around this. In addition to the pressures, call-handlers had also had to isolate, similarly to the circumstances at hospitals, so the new guidance was welcomed in terms of those staff who tested negative on a PCR being able to return to work.

- Councillor Rhodes commented on people's perception of the two doses of vaccination and the messages being reinforced that this did not mean 100% immunity from coronavirus – there were too many mixed-messages, both through public understanding and organisations being really clear to push the point that you could still contract covid, but it would not be as severe as before vaccination. In response, Officers advised that they were guided by national guidance and national policy; however, from an NHS perspective, PPE would continue to be used in settings and patients would be asked to wear face masks until at least the end of September. Through any forums, they continued to share these clear messages, including that all vaccines do not have 100% coverage or immunity from the disease, but would have an impact on the difficulties of the disease. We needed to be aware of this but also ensuring those Public Health messages were reinforced, as they had been since day one, around be cautious, take the vaccine when you're offered it, hand washing, wearing masks, etc.

- Councillor Hutchinson advised that the vaccine is only effective against Covid, and that in the winter we saw a reduction of the Norovirus from previous years, however this has been increasing recently. In response, Officers advised that the same principles of good hygiene – hand washing, distancing etc. had helped with many illnesses in the last year. Messages were being shared with staff, ensuring that if people were sick, they stayed at home. Norovirus was a quick spreading illness and if outbreaks did happen in emergency care settings there were good Infection Control Procedures (ICP) in place to manage this. There were things everyone should be doing routinely as a population, but experts in the hospital and expectations around ICP were key in the hospitals and health care settings. This focus should be maintained whatever disease is in place.

- Councillor Smaje commented on access to Primary Care, and the potential impact on Secondary Care and staff pressures etc. in emergency departments as a result of this. Was access to services being discussed so that people did not feel like they could go to certain places to get help, and ensure we were not creating a bigger backlog? In response, Officers advised that was paramount and how they approached this was through a 'gearing up approach', so they were supporting people with care through community settings, pharmacists, websites, specialist, and acute services, etc. There were lots of conversations ongoing in practices, in places and with colleagues. In addition, Officers advised that General Practice had changed a lot in the last 15 months and there was a need to support the different methods, such as online, telephone, face-to-face, etc. moving forward. If people weren't able to access due to pressures and demand, this where there were impacts on the system elsewhere. GP access had always been an issue for some time, but this has impacted even further as a result of the pandemic. Some learning was positive, for example, more patients have been seen due to telephone appointments, and more people have been seen by the most appropriate professional, however it was appreciated that this was not always the case for everyone and work was being done to look at this.

Members thanked the officers for their presentations.

IT WAS AGREED that the report be noted.

7. REVIEW OF TERMS OF REFERENCE

The Joint Committee was asked to consider revising the current Terms of Reference, and where necessary, to update and/or amend them, ensuring consistency with the proposals in the Health and Care Bill 2021.

Mike Lodge, Senior Scrutiny Officer (Calderdale Council) advised that the Scrutiny Officers would work with the Members of this Committee to incorporate and support any changes made and bring them forward to a future meeting for consideration and final sign-off.

IT WAS AGREED that the West Yorkshire Scrutiny Officers would work with Members of this Committee to incorporate changes to the Terms of Reference for consideration outside of the meeting, and that the final version would be brought to a future meeting of this Committee for approval.

8. NIGHTINGALE HOSPITALS

It had not been possible to arrange for this item to be arranged for this agenda. It was proposed that the Committee nominated a working group of three or four members to consider the matter, and report back to a future meeting of this Committee.

Councillor Clark proposed that the Chair of the Committee be involved in this work. Mike Lodge, Senior Scrutiny Officer (Calderdale Council) would co-ordinate the progression of this work.

IT WAS AGREED that Councillors Clark, Greenwood and Smaje be appointed to the working group on Nightingale Hospitals, and report back to a future meeting of this Committee.

9. WORK PLAN AND NEXT STEPS

The Senior Scrutiny Officer, Calderdale Council suggested that Members may wish to consider any items they wished to discuss at future meetings for inclusion in the work programme.

Following the earlier discussion on Governance, Members may also wish to consider a meeting prior to September to consider the ongoing work. It was proposed that Mike Lodge, Senior Scrutiny Officer (Calderdale Council) arrange a meeting for the Chair and Deputy Chair with Ian Holmes (West Yorkshire and Harrogate Health and Care Partnership), to look at timescales in further detail.

A request had been made by Bradford Council to take a wider look at Dentistry Services across the region, and Members agreed that work should be undertaken to pull this item together.

Councillor Hutchinson commented on the future workforce plan and the need to assure ‘buy-in’ from providers in order to support this work moving forward. He commented on the previous work which had been undertaken and the challenges this had presented. There was a need to look at how the workforce plan, at a West Yorkshire level, should be incorporated to the new ways of working (as outlined in the meeting today) and how scrutiny can best use its powers to encourage organisations to focus more closely on this issue. Members agreed that this item would be brought to a future meeting of this Committee.

IT WAS AGREED that the Senior Scrutiny Officer would develop the work plan in line with comments made at this meeting and scheduled future meeting dates which would be shared with the West Yorkshire Joint Health Overview Scrutiny Committee.