HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview & Scrutiny Committee held on Tuesday 14 July 2020 at the Virtual Meeting - Web ex meeting.

PRESENT:

Cllr Collette Finnegan	Cllr Helen Molyneux
Cllr Terry Hale	Cllr Dilys Neill
Cllr Stephen Hirst	Cllr Nigel Robbins
Cllr Paul Hodgkinson	Cllr Brian Robinson (Chair)
Cllr Martin Horwood	Cllr Jill Smith
Cllr Steve Lydon	Cllr Pam Tracey MBE

Substitutes:

Cllr Iain Dobie for Suzanne Williams

In attendance:

NHS Gloucestershire Clinical Commissioning Group (CCG)/ One Gloucestershire Integrated Care System (ICS)

Mary Hutton – Accountable Officer and ICS Lead
Ellen Rule - Director of Transformation and Service Redesign
Becky Parish

Gloucestershire Hospitals NHS Foundation Trust
Deborah Lee – Chief Executive
Peter Lachecki – Chair
Simon Lanceley- Director of Transformation

Gloucestershire Health and Care NHS Foundation Trust
Ingrid Barker – Chair
Angela Potter, Director of Strategy and Partnerships
Paul Roberts

Gloucestershire County Council
Sarah Scott Director Public Health
Margaret Willcox – Director Adult Social Care
Cllr Tim Harman, Cabinet Member for Public Health and Communities
Cllr Carole Allaway Martin, Cabinet Member for Adult Social Care Commissioning

Apologies: Cllr Brian Oosthuysen
Cllr Robert Vines
Cllr Suzanne Williams

1. APOLOGIES FOR ABSENCE

See above.

2 DECLARATIONS OF INTEREST

No additional declarations were made.

3 MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting held on 14 January 2020 were agreed as a correct record subject to the amendment of a typo at 7.1 where it should read: 'enabling active communities'

4 PUBLIC REPRESENTATION

4.1 The Committee welcomed Dr David Willingham who was a Cheltenham Borough Councillor to make his representation as detailed below:

I am making this public representation to HOSC in respect of my continued concern about the reported Covid-19 death rate in the "Alstone and St Mark's" Middle-layer Super Output Area (MSOA) which has the formal designation of "Cheltenham 007". Online mapping published by the Office of National Statistics, suggests that as of 31st May 2020, there have been thirty-two (32) Covid-19 related deaths in this MSOA. My further analysis of dataset from which this mapping visualisation was derived, shows that this is the highest number of Covid-19 deaths for any MSOA in not just Gloucestershire, but the whole Southwest region, and equal fourth highest number of Covid-19 deaths in the whole of England and Wales. My analysis also shows that in April 2020, Covid-19 was the leading cause of deaths (59%) in this MSOA.

Dialogue with the Director of Public Health for Gloucestershire County Council has suggested that "This MSOA has 9 care homes with 264 beds. This is much higher than the MSOA average of 3 care home with 80 beds. When cross-referenced with our local registration data there is a high match between areas with a high number of care homes and deaths we are aware of in care homes."
The communities that I represent, the bereaved families of the deceased, and families with relatives in care homes deserve both answers and reassurance.
I am therefore making this public representation to request the HOSC investigate what factors led to the high death rate in the Alstone and St Mark's MSOA, and if, as suggested, the majority of deaths were in care homes, what the causal factors that lead to this tragically high death-rate were.

If there were systemic failures at any level, whether national, regional or local, then it is imperative that these are quickly identified so that remediation can occur. This feeds into the second part of my request which is to ensure that in the event of

resurgence of Covid-19 as lockdown measures are eased, the community that I represent, can be confident that there is sufficient understanding and preparedness that there will not be a repeat of the conditions that led to the high localised mortality rate.

My focus as a Borough Councillor is predominantly on the ward I serve and represent, as it has suffered the worst impact of this virus. However, I recognise that it is clearly in the best interests of the county if other MSOAs in Gloucestershire with statistically significant elevated Covid-19 mortality rates also have similar investigations performed.

I trust that HOSC will agree that it is in the public interest for this to be investigated in as open and transparent way possible, so that the communities that I represent can understand what happened, and also get a reassurance that the understanding gained from this investigation is being used to inform the current response and will be used to inform any future response as part of any Local Outbreak Control Plan response if one needs to be implemented anywhere in Gloucestershire.

4.2 The Chair thanked him for raising those points with the committee. He stated that he was sure members shared his concern about the high level of Covid-19 related deaths in his ward. The Committee would want to understand the challenges and learning points from Covid-19 later in the year from a strategic viewpoint and members would take on board the concerns raised when shaping the item as part of work planning.

4.3 Sarah Scott, Director of Public Health, thanked Dr Willingham for raising his questions and she provided some information regarding the way in which the MSOAs information was collated, emphasising that these areas were larger than traditional wards. She recognised that these areas often had variations in infection rates and there were certain factors which could make people more vulnerable to severe illnesses than others. A range of information continued to be monitored on a daily basis to help provide a better picture of incidents of Covid-19 and the impacts on communities. Where care homes were suspected of suffering from an outbreak, contact was made by Public Health England, risk assessment taken and advice and support given. GCC and the CCG Integrated Brokerage Team were in daily contact with care homes offering support. Members noted that there was a Local Outbreak Management Plan. Some deaths were attributed to Covid-19 as a secondary cause, and it was important to fully understand the data. The deaths referred to had been in relation to two of the nine care homes in the area. Care homes were particularly at risk as they house a group of people who were known to be vulnerable to the Covid-19 infection. Each care home had been offered guidance and training on the use of infection prevention and control techniques and the correct use of PPE. There had not been an issue with the supply of PPE in the County. The Public Health team would be discussing with Public Health England colleagues to better understand what had happened in this particular circumstance.

13.4 Margaret Willcox, Director of Adult Social Care, provided detail on the active work carried out with the Gloucestershire Care Providers Association around free

webinars and additional support. Every care home had received an uplift in funding since April with Cabinet agreement to continue this through to September as required. A detailed report had been provided to Adult Social Care and Communities Scrutiny Committee and this would be circulated to Members.

4.5 The Committee noted that all members had received a letter from REACH who wished to raise significant concerns about Gloucestershire Hospitals NHS Foundation Trust's intention to request a 3 month extension in respect of temporary emergency measures already in place. Members would keep this information in mind when considering item 5 on the agenda.

Robert Arnold outlined the concerns which were articulated in the letter including the statistic that 20% of elective surgical patients who got Covid-19 died within 30 days according to the British Medical Journal. He suggested that these concerns applied locally. The safety concerns he outlined included the continuation of major elective surgery at Gloucestershire Royal Hospital against national advice; the transfer of arterial vascular surgery from Cheltenham General to Gloucestershire Royal; the potential mixing of elective and emergency surgical patients; and the removal of emergency theatre at Cheltenham General. REACH suggested that all elective surgery be transferred to Cheltenham General, that there be a robust consent policy for surgical patients, and the reopening of emergency theatre at Cheltenham General.

4.6 Deborah Lee stated that the Trust would respond fully in writing to the REACH letter. The focus of the emergency service changes was on ensuring the safety of services in light of the challenges presented by the COVID-19 pandemic and to promote public confidence in services so that patients who needed access to healthcare, felt able to attend hospital. She went on to say that the changes had been developed by clinicians who had the safety and wellbeing of their patients at the forefront of their minds. She noted REACH's concerns about the risk of transmission of the virus between emergency and elective patients and confirmed that there had not been a single episode of in hospital transmission of COVID-19 since the changes had been made. It was explained that 'blue patients' were those patients confirmed to have COVID-19 and they were never cared for in an area with those awaiting elective surgery. Elective patients were only admitted after having a negative swab result at which point they would be labelled as 'green patients'. Those of uncertain status, or confirmed positive, were managed in separate areas and wards, until a negative result was confirmed

The Chair thanked REACH for bringing the matter to members' attention and stated that this would help inform members' discussion of the main items on the agenda.

5. COVID-19 TEMPORARY SERVICE CHANGES

5.1 The Committee received a report to update members regarding the Covid-19 incident response and proposals for the temporary substantial variation and

development of Health Services in Gloucestershire that were required to meet the ongoing operational requirements. The Committee was asked for further support for changes with details provided in line with the locally agreed Memorandum of Understanding. Ellen Rule introduced the report.

5.2 This related to two service changes, the temporary reconfiguration of Emergency General Surgery to Gloucestershire Royal Hospital from Cheltenham General Hospital (temporary change enacted on 1 April 2020 and the temporary closure of The Vale, Dilke & Tewkesbury Minor Injury Units (enacted on 22 March 2020). Members had been notified of the initial temporary changes by email at the time.

5.3 The Committee understood the two-phase incident response where it was necessary to radically reprioritise and reshape services. Phase 1 had been about moving at pace to ensure services were safe, with short term actions taken so that Covid-19 patients were handled safely. Now the Trust was in phase 2 where Covid-19 was still in circulation but the rate of infection had changed and the degree to which the Country was 'locked-down' had changed. It was noted that throughout this a number of factors have arisen that have and continue to significantly affect productivity of health and care services; these include the need for increased levels of infection prevention and control in all services, the challenge presented in caring for those safely in the shielded and vulnerable categories and continuing higher levels of staff sickness. In addition the Trust was modelling scenarios with regards to potential winter pressures and a potential second peak to ensure services were in a safe place to respond.

5.4 The changes proposed would be up for review in September 2020 with HOSC meeting on the 15th September.

5.5 The Committee recognised that there was some overlap between the emergency service changes enacted in response to Covid-19 and the Fit for the Future proposals due to be brought to public consultation later in the year. This presented a complex message to the public and stakeholders.

5.6 An extensive public engagement had been carried out in relation for Fit for the Future in late 2019 and it was proposed that the programme would be re-established in the autumn. There would be clarity around the changes that had been enacted as part of the temporary incident response and ensuring that no presumption existed regarding the medium to long-term proposals.

5.7 Winter planning proposals had not been completed and that would come to Committee in September.

5.8 Simon Lanceley Director of Strategy, provided members with a run through of the pro-forma for Emergency General Surgery emergency service change. He explained that as a result of centralisation of emergency surgery services, five of the extreme risks have been reduced. He highlighted the patient benefits and case study outlined within the pro-forma and emphasised how these actions removed the rota challenges.

5.9 In response to a member question, it was explained that carrying out a pilot during a pandemic was not the right thing to do. This was about temporary service change with any future permanent changes coming through the Fit for the Future programme. It was suggested that confidence could be taken from the fact that some of the areas of change to make things safe were changes that the Trust had been thinking about making for a while. Deborah Lee reiterated that the main driver for temporary change was handling the impact of the pandemic, but that there was still the opportunity to learn throughout. It was emphasised that in September the Committee would be able to clearly see the difference between the temporary service changes and the medium to long term changes that would be consulted on.

5.10 Members discussed the scepticism that was out there in the general public, where there were suggestions that temporary service changes would go on to be made permanent. In addition some members expressed concern that media reports suggested that Gloucestershire Royal were struggling as the only A & E in the County. Officers emphasised that Cheltenham A & E would be reinstated following the temporary period and it was explained that this statement had been made a number of times and would continue to be repeated. Members understood that any permanent changes would need to be consulted on and this was planned as part of the Fit for the Future programme. In relation to A & E performance it was explained that there an been some initial issues related to power cuts and road closures, but that those teething issues had been dealt with and things had settled down considerably. The performance was strong with the example given of no 12 hour trolley breaches and the fact that patients were not transferred from Cheltenham to Gloucester in the middle of the night as had been suggested.

5.11 In response to queries on the Flu Jab it was explained that planning was underway and that there would be new challenges. It was suggested that the measures around social distancing and hand washing might have a positive impact on the incidences of Flu.

5.12 One member expressed concern about plans to launch the Fit for the Future consultation during a pandemic.

5.13 One member asked the questions raised by the REACH presentation relating to why elective surgery had not been moved to Cheltenham General, why the emergency theatre at Cheltenham General had been closed and would a Type 1 A & E be restored at Cheltenham General following the end of the temporary service changes.

5.14 In response it was stated that the Type 1 A & E would be restored at Cheltenham General at the cessation of the temporary period. In relation to concerns on transmission of Covid-19 in hospitals, it was explained that once the bed base had changed due to social distancing and the temporary measures had been put in place, this had stopped. The General Surgery change had been due to long standing workforce issues. Changes made on 9 June had been to address the risk of virus transmission and that was from when the cross-infection figures had been taken. For Cheltenham there was still out of hour's theatre available if a patient that required surgery was not well enough for transfer to Gloucestershire Royal.

5.15 Members were informed that the changes relating to Vascular surgery were in relation to transmission risk and the need to create three separate entry pathways and this could not be done in isolation. The focus was on ensuring the whole emergency service model was safe.

5.16 In response to a question it was emphasised that those patients at Gloucestershire Royal were not exposed to greater risk. The changes enabled Covid-19 patients to be treated in isolation. With regards to concerns about the risk to elective surgical patients of contracting Covid-19, it was stated that 46 patients (predominantly emergency patients) had contracted Covid-19 in the early phase of the pandemic while in the Trust's care which was less than 0.2% of patients. 11 of these had died. This was a sad situation and reflected the fact that many of these patients were in a vulnerable group. This was a position reflected across the Country and the Trust had responded and learned from this and their approach was now part of a national pilot. She restated that since the temporary changes were enacted there had been no cases of in-hospital transmission.

5.17 Angela Potter introduced the second pro-forma within the papers which was in relation to Minor Injury Units. There had been no incidents or complaints as a result of the temporary changes. The Trust were looking to move four units to an 8am to 8pm opening, but would not be in a position to open the other three units within the three month time period. The risks were outlined within the document.

5.18 Members commented that they would be interested to see the analysis, once completed, around why the number of people visiting units had significantly reduced during this period.

5.19 The Committee noted the pro-forma's and the plans for the continuation of the temporary changes without further comment. The minutes of the meeting would reflect the concerns raised and the variety of views. Members welcomed a further update in September as the Trust moved towards consultation of medium and long term changes as part of Fit for the Future. The Trust were able to extend the temporary service changes for a further three months.

6. FIT FOR THE FUTURE UPDATE

6.1 Members noted the timeline outlined within the previous item for Fit for the Future and confirmed that they would receive the pre-consultation business case proposals at the meeting on 15 September 2020.

6.2 It was explained that the Trust was working on the detail during July before meeting NHS England improvement in August and then in September launching the consultation with public boards and HOSC. In November there would be a Citizens Jury and then implementation would be planned for the new year (subject to consideration of outcome of consultation and any Citizens' Jury recommendations). While it was recognised that the short term challenges around Covid-19 needed to

be considered, it was still felt that long term planning and consultation on those plans were needed. Throughout the process there would be opportunity for reflection and consideration of current challenges and how that might change long term plans.

6.3 One member asked how the consultation would be publicised and carried out. It was explained that members would receive a detailed consultation plan, but it was acknowledged that traditional methods were unlikely to be relied upon in the current circumstances. The consultation would include online discussion forums, short surveys, polls and conversations with training being carried out on the systems and processes to support this. Members understood that the CCG had been working closely with Gloucestershire County Council with the recent allocation of grants and funding through the Digital Innovation Fund.

7. GLOUCESTERSHIRE CLINICAL COMMISSIONING GROUP PERFORMANCE REPORT

7.1 Mary Hutton presented the performance report explaining that there was some updated information. This included a recent rise in Emergency Department activity but still below pre-covid levels as well as a 4.9% reduction in category 1 ambulance calls. There was also a focus on discharge.

7.2 In relation to cancer referrals, these had been well below the previous year's levels for May and June but for July was back up to 100%.

7.3 In response to a question on ambulance response times in rural areas, it was explained that there had been new investment to provide more vehicles on the ground in 2020 as well as an investment in first responders. This was not an area the CCG was taking lightly.

7.4 There was some discussion around pathology services particular in Cirencester and members was reminded that phlebotomy services across the county were being delivered through GP surgeries in their own practices which should allow them to be more responsive. There would be no changes to the timeline and process for obtaining results.

7.5 In response to questions on waiting time at Gloucestershire Royal compared to Cheltenham, it was stated that Gloucestershire Royal Hospital performance during the pandemic was very strong and comparable to the previous year. One member expressed concern and stated that the poor performance in Gloucester was striking.

8. ONE GLOUCESTERSHIRE ICS LEAD REPORT

8.1 The Committee noted the report.

8.2 It was explained that a survey had been issued for those that had been volunteering during the Covid-19 pandemic asking for their experiences and asking if they would like to volunteer again. One member emphasised the importance of utilising the experience in this area.

9. GCCG CLINICAL CHAIR/ ACCOUNTABLE OFFICER REPORT

9.1 The Committee noted the report.

9.2 One member noted the actions that had been taken to support care homes and asked whether there were any national systemic failures in this areas that had been identified and fed back to Government. In response it was explained tat issues had been identified of staff moving between care home and the need for PPE training and that all that learning was being fed back into the national work. It was also explained that a number of care homes had staff that did not have good use of the English language and that they had been unable to interpret guidance. One member called on the need for greater regulation of care homes.

9.3 Members were asked to fill in the survey within the papers on Covid-19 and pass the link on more widely.

9.4 One member asked a question about the previous mention that locally the Public Health team did not have access to the patient details of local cases of Covid-19 to enable outbreak management. This was confirmed as correct by the Director of Public Health. Instead, she worked closely with the South West Public Health England Team who did have access to this data to manage outbreaks. There was also a question on spare capacity at local testing sites. With regards to testing, there was spare capacity due to the relatively low numbers of Covid-19 in the County. This spare capacity was available should there be a second peak, but the Public Health team was also in discussions with regards to how this resource could be best utilised.

CHAIRMAN

Meeting concluded at 12:35