Luton

Item No:
2.1

Health and Social Care Review Group Meeting

Minutes
4 August 2021 at 6.00 pm

Present:

Councillors Underwood (Chair), Agbley, Akbar, Campbell and Moore

Co-optees Present:

Patricia Lattimer (Healthwatch Luton)
Stephanie Power (Healthwatch Luton) (Via MS Teams)

34. Apology for Absence (Ref: 1)

Resolved: An apology for absence from the meeting was received on behalf of Councillor Petts.

35. Minutes (Ref 2.1)

That the minutes of the meeting of the committee held on 21 June 2021 be taken as read, approved as correct records and signed by the Chair.

36. Chair's Update (Ref 2.1)

The Chair gave an oral update on certain proposed developments in the working practices and working relationship between HSCRG and the Health and Wellbeing Board, as summarised below.

Health and Wellbeing Board

In addition to meetings with the Corporate Director for Population Wellbeing, the HSCRG Chair would regularly meet with the Chair of the Health and Wellbeing Board and key portfolio holders to discuss key matters and how they link to the work of HSCRG.

As part of this work, a table had been produced to assist in the thinking on what items should be in the work programme for the HSCRG, the Executive and the Health and Wellbeing Board. The paper had been circulated to all partners for information.

Some update reports to HSCRG would cease, replaced by the Chair's verbal update, as appropriate.

Integrated Care System

The Health and Social Care Bill is at the Committee Stage in Parliament. This would put the Integrated Care System (ICS) on a statutory footing. The Bill also provided for the Care Quality Commission to assess how local authorities deliver adult social care and changes to the way ongoing care was co-ordinated when patients were discharged from hospital. The Bill was likely to return to the Parliament in November and HSCRG would look at some of the wider implications at a future meeting

At BLMK level, the ICS would be looking to set up in shadow form from late Autumn 2021. The Council's involvement in the ICS would need to be considered by Executive and HSCRG would have an opportunity to review this before it went to Executive. The Chair of the ICS, Dr Rima Makarem, would remain in place. The Chief Executive's role would be subject to a national advertisement process.

Joint Strategic Needs Assessment Update

Given that the Business Intelligence Team had been supporting COVID and also the recent Ofsted visits, there had not been capacity to progress the JSNA data analysis. An additional analyst was currently being recruited. The JSNA would also need to include consideration of the wider impacts of COVID on health inequalities and further work was being undertaken on this. The updated JSNA would come to HSCRG for consideration.

Population Wellbeing Action Plan Update

The Population Wellbeing Strategy needed updating to reflect the changed position from the COVID pandemic. The priority was to update the strategy and then amend the Action Plan. The Updated Strategy and Action Plan would come to HSCRG for consideration.

The Health and Wellbeing Board had developed a recovery plan and this had also been circulated to HSCRG.

Resolved: That the Chair's update be noted.

37. Covid-19 Update Report (Ref: 7)

The Corporate Director, Population Wellbeing presented the report on Covid-19 update (Ref: 7), updating HSCRG on the latest situation in Luton.

The latest figures showed that infection rate in Luton was below the national average at 275 per 100,000 population and declining. However, she advised that there was still a high prevalence of Covid infection in Luton and hence the need to keep pushing the key

messages around regular testing and ‘hands’, ‘face’ and ‘space’ and wearing face masks in crowded places.

In view of the additional symptoms associated with the new Delta variant, the council was changing the key messages on what was expected and what people needed to think about, which were due to be re-issued imminently.
Testing was continuing in St George’s Square, community centres and via the testing bus. More people were also picking the lateral flow test kits for home testing twice a week. Testing take up was good.

The council was waiting for national guidance update from the government on how to proceed, but continued to put resources into testing and to encourage people to take up vaccination.

In terms of vaccination, the BLMK CCGs Director of Primary Care informed HSCRG that residents continued to come forward for the first dose of the vaccine and young people were being encouraged to take up provisions of the offer of the vaccine, as the most effective way to deal with Covid-19 infection.

In the previous few days, effort had also started to encourage more pregnant women to be vaccinated, as there was now a significant evidence base of the adverse impact of Covid-19 on them. Progress was slow and ways of providing more encouragement to pregnant women to come forward was being considered. Vaccination sites were shown on the website.

Whilst the Primary Care Network had completed their work on vaccination, community pharmacists were achieving some success providing vaccination and were popular with residents.

Dealing with questions and comments, clarification and further information was provided, with key points recorded, as set out below.

At 275 per 100,000 population, infection rate was lower in Luton that the English average, representing a 21% reduction from the previous week.

In terms of vaccinations, provisions included walk-in facilities, along with all the normal booking process and the targeting of hard to reach and vulnerable people.

In the coming weeks, 16 and 17 years old would be eligible for the vaccine and work was underway on the communications methods to encourage them to come forward. Healthwatch Luton’s involvement offer in this regard was noted and would be considered. The council was working with the CCGs Primary Care Director on how to encourage and get more of the population of Luton, including young people to take the vaccine. A meeting to discuss the marketing campaign particularly directed at young people was due to take place the following week.

Vaccine take up in Luton would be measured against council areas with similar demographics. More information would be available for HSCRG to consider and ask questions, when the detailed plan was developed.

Luton had a young population. GP Practices needed to ensure that data in their registers were up-to-date, as Luton also had a more mobile population, which meant there was a time lag between Luton and national data. Luton was doing slightly better.

Collaborative working with partners was continuing to target interventions for particular age groups. There was also an opportunity to work with colleges and the university to offer the vaccine to young people. Any different ideas from members were welcomed to boost the current offers of the vaccine bus, pop up centres and the successful use of community pharmacists. It was important to get as many people vaccinated, as possible.

The message to young people about the different symptoms of the Delta variant and the fact they could be asymptomatic and still infect other people had been published, including the message that it was important to get vaccinated to protect their family members and elderly relatives.

National figures showed that people admitted to hospitals who needed ventilation were mostly those who had not been vaccinated. Exact figures for the L&D Hospital was not readily available. Figures also showed that it was people who had not been doubly vaccinated who were in hospitals.

Resolved: That the update on the impact of the COVID-19 pandemic on the health of the population of Luton be noted.

38. Updates on the provision of NHS Dental Services in Luton (Ref: 8)

David Barter Head of Commissioning NHS England and NHS Improvement, East of England presented the report (Ref: 8), updating HSCRG on the provision of NHS Dental Services in Luton. He was accompanied by Tom Norfolk, a General Dental Practitioner and Lead Dental Clinical Adviser for NHS England and NHS Improvement, East of England.

Key points covered were as summarised below.

Dental services were suspended during the pandemic, as dental practices were considered potential super- spreaders of Covid-19. In Luton, two Urgent Dental Care Practices provided services to meet the urgent needs of patients.

Following the NHS England and NHS Improvement's Chief Dental Officer announcement, dental provision was restored in June 2020, based on clinical need and taking account urgency of needs, un-met needs of vulnerable groups and capacity.

Although dental practices were re-opened for service, capacity was significantly reduced due to the need to clean the kits and surfaces between patients. Whereas, practices used to treat between 25 to 30 patients per day pre-Covid, they were currently treating only 5 to 7 patients per day to ensure their safety and that of the clinicians.

Between June to December 2020, Dental Practices delivered 20% of their contractual obligations. For April to September 2021, they were expected to increase delivery to 60% of their contracts to the same standard operating procedures, with usual professional infection controls in place.

Following the Chief Dental Officer's guidance, dental services were being prioritised based on needs, which meant patients having to wait longer for routine check-ups.

The three pillars of the current strategy, signed off a year previously, were to increase access, reduce inequalities and improve outcome for patients. Previously dental practices performance were measured in terms of units of dental activities, which did not benefit patients.

In line with the Department of Health requirements to increase access and reduce inequalities, a workforce strategy had been developed to widen the skill mix of the workforce in dental practices. This would be similar to what GP Practices had already put in place, providing opportunities for dentists and other healthcare professionals to undertake important prevention work and improve outcome for patients.

Dealing with members' questions and comments, David Barter and Tom Norfolk provided clarifications and further information, with key points recorded, as set out below.

The 60% target for delivery of services was a national minimum for the first two quarters of 2021/22. The standard operating procedures did not allow more patients to be seen. The Chief Dental Officer was expected to announce the target delivery for the third and fourth quarters of the current year imminently. Depending on the situation with Covid-10, dental practices were likely to be required to see more patients.

The 60% target related to the quantity of activities required to be delivered, not the quality of service. The NHS contract required all dental practices to deliver the same high quality service. Many practices, particularly those with multiple dental chairs in use, were delivering higher level of activities than the 60% minimum target. Delivery level was also dependent on whether practices had outside windows and extractor fans for ventilation purposes.

All dental practices had to learn new approaches, as the particles sprayed from their drills were apparently of the perfect size to spread the Covid-19 virus. Practices needed to be extra safe before seeing the next patient.

No records were kept of people attending hospital A&E for lack of access to dental services. Patients contacting providers of primary care and the NHS 111 service would be directed to an emergency dental practice, which was part of the contract.

A three months dental trauma pilot, believed to be the first in the country, was in place covering Luton and surrounding areas. It was provided by a number of volunteer dentists in the region, some with high tech equipment, including high resolution scans to provide the best timely care to patients. The pilot was being run in close working relationship with primary care providers, A&E, the ambulance service and schools. Although the pilot was in its early stage, close working showed that not all cases needed to go to A&E and those that did, would be referred to the pilot after initial trauma treatment, e.g. stitching.

It was re-iterated that no records were kept of patients going to A&E for lack of access to dental services. There was a system through the NHS 111 service and the Urgent Care Centre, for patients who needed urgent dental care to be referred to the two very active dental practices in Luton seeing patients with urgent needs.

It was expected that the new dental strategy would formalise the long-term process, including the work of the pilot in Luton, with patients being referred to Dental Practices by e-mail.

Roll out of services would be in segments. Provision of dental check-ups was not part of the contract yet, but some practices had check-ups as 10% of their contracts. The process needed to be updated to enable the 111 service to sign-post patients to be seen and treated.

As most dentists had been re-deployed during the pandemic to administer Covid vaccination, the new strategy would aid recovery of dental service, help increase access, reduce health inequalities and provide better value for money.

Due to the three months data lag, performance figures against the 60% activity target was not currently available, but could be shared with members in due course.

Resolved: (i) That the update on the provision of NHS Dental Services in Luton be noted

(ii) That members' comments and concerns be considered during the process of recovery and reinstatement of dental services in Luton

(iii) That the committee's thanks to David Barter and Tom Norfolk for their informative report and responses to members' questions be recorded.

39. Oral Health Needs Assessment (OHNA) (Ref: 9)

The Senior Integrated Commissioning Manager presented the report (Ref: 9), updating and informing members on the Oral Health Needs Assessment (OHNA) and development of the Oral Health Action Plan for Luton.

Key points covered were as set out below.

Poor dental health was an indication of poor health in general. Through the OHNA, Public Health had identified that Luton had one of the highest prevalence of tooth decay in five-year-old children in England and the East of England region. Severity of tooth decay in that group of children was also above the national average.

The OHNA also found that a greater of proportion of dental decay was clustered in children in the more densely urban populated areas in Luton, with Challney, Saints, Biscot and Dallow as the most affected wards followed by Farley and South wards.

Nationally, there was a significant relationship between ethnicity and dental decay. Luton data indicated that children from some ethnic minorities experienced poorer oral health outcomes, with higher prevalence and more severe tooth decay, compared with their white British counterparts.

The Oral Health Improvement strategy and action plan and commissioning of oral health services for early years would target tooth decay prevention work in young children, in a whole system approach.

There was evidence that informed interventions, including supervised tooth-brushing, provision of toothbrushes and toothpaste to vulnerable families and water fluoridation protected children against tooth decay.

There was also evidence of a relationship between tooth decay and healthy weights, linking it to food policies and the focus on healthy lives. Breastfeeding was also linked to better outcome on oral health.

A member commented that Luton had a history of children going to hospital for extractions and questioned why there had not been any improvement over the years.

Members were informed that historically the needs assessment indeed showed poor oral health in children in Luton. Services were looking to widen their reach, with the community dental service working with 26 schools and nurseries to train staff to spread the key messages about tooth brushing and advising families about ensuring children go to the dentists. Health visitors were also working with families to get the message across for children younger than 5 years old.

Link workers were focusing on oral health in children, to overcome the difficulties engaging with early years settings. The Early Years Alliance was running starting well programmes focusing on pre-birth to 2½ year olds in Dallow and Farley wards, which would be further extended to other wards. Part of their programme was on oral health.

As historically the situation had not been improving, that was why there was an action plan in place, which it was hoped would make a difference.

On the issue of how the effectiveness of the communications campaign was measured, members were informed that evaluation was through the Public Health outcome framework and the Public Health oral health surveys. The commissioned services, through the Early Years alliance, also had part of their performance indicators on how well they were getting the key public health messages across.

The Chair further commented that it was important to measure the effectiveness of the information campaign to improve health outcome.

Resolved: (i) That the contents of the Oral Health Needs Assessment to inform the key priorities and actions, with focus on inequalities, be noted

(ii) That the development and implementation the Oral Health Action Plan to deliver key recommendations from the needs assessment, with the overall aim of improving oral health and reducing health inequalities in Luton be supported.

40. Healthwatch Luton Update on MH Patient Views - RAR (Ref: 10)

Lisa Herrick, the Healthwatch Luton (HWL) Project officer presented the report (Ref: 10), updating HSCRG on the progress of the mental health recommendations, actions and review (RAR) table provided to ELFT on mental health patients' views, as set out in the report.

She said the intention of the report was to bring attention to the feedback gathered from over 200 people and ask HSCRG to keep at the forefront the progress of the recommendations.

Key points highlighted included safeguarding concerns submitted to the Luton Adult Safeguarding Board and ELFT safeguarding team relating to self-harming and certain behaviours displayed by in-patients on the wards.

HWL was also due to take part in a multi-agency audit planned for the autumn 2021.

HSCRG was also asked to note that pre-Covid, HWL would have already been back to the wards to conduct reviews, but was finding it more of a challenge to get in-patients feedback from the wards due to Covid and was getting information from people in the community about their relatives, who were in-patients.

The Corporate Director, Population Wellbeing concurred with the comments in paragraph 10 of the report about the need to join-up several initiatives being conducted by different services and better co-ordinate these to ensure there was no duplication and that services were working well together and making use of the best resources. She added that there was evidence from the council's work on Covid about an increased demand for mental health packages and it was right and important that HWL had focused on and flagged up mental health in its report.

Resolved: That the Healthwatch Luton report on the progress of the mental health recommendations, actions and review table provided to ELFT on mental health patients' views be noted.

41. Primary Care GP Access and Primary Care Access Group (Ref: 11)

The BLMK CCGs Director of Primary care presented the report (Ref: 11), providing an update on the work being overseen by the Primary Care Access Group.

To put it in context, she explained that primary care access included primary medical services and GP services

She recognised that residents did not always know how to access their GPs, some due to not having registered with a GP Practice or were registered, but still did not find it straightforward. The clear message to residents was for them to ring their GP Practice if they know the number and if not, ring the NHS 111 number, if in need of health care. They should not ring 111 to make an appointment.

If in need of urgent health care, the 111 service would help them navigate to the right service, including obtaining an appointment to see a GP.

In terms of urgent dental care, she re-iterated the earlier information provided to members at minute 38 (item 8 above) of two very active dental practices providing urgent dental care in Luton during the pandemic.

Working with Healthwatch Luton, she was aware from residents' feedback that they could not always get an answer from their GPs on the telephone. The advice was to then ring 111 if in need of urgent medical care and they would be spoken to by a clinical staff, if necessary.

Regular users, including people with mental health issues, should already know how to guide themselves through the care pathway and if they arrived at A&E, they would seen by Mental Health Liaison Service team located there.

She said that primary care was about systems workings and would welcome a discussion on how to manage people's expectations. She added that In the East of England, contacts with primary care clinicians had increased by 31%, although the figure for Luton was not readily known.

In terms of the Primary Care Access Group, she said that membership of the group included Healthwatch, the CQC and members of the local medical committee. The broad range of the membership was necessary, in acknowledgement that there were issues with primary care and the need to work together on them.

The GP survey, in relation to which some members had been in touch with her, was one aspect of the CCG looking at primary care, with about 200 responses received. It was but one indirect measure of the service.

In the aims and objectives of the group, there was a solution to the immediate problem. In the GP survey, problems with the bottom 5 Practices were already known and the CCG was working to support them with their various issues. As telephony was one of their issues, the digital programme was part of the system engagement for this group.

The population health management programme was being used to target children with respiratory issues, with the primary care team working closely with the children health and social care teams, as these children often had other complex needs.

As already mentioned, in Luton people who could not access primary care would often go to A&E. The advice was to ring 111, but the CCG was aware that at worse, only about 13% of calls were answered within the 60 seconds target. At best 60% of calls were being answered within 60 seconds. Work was underway to find out the reasons for the disparity, such as staffing issues or high demands. For Bedfordshire, including Luton the 111 service was sometime dealing with 700 calls within a 24 hour period, which was considerably more than before the pandemic. People were being advised how they could help themselves and there were fewer 111 calls from care homes than before the pandemic, probably due to more collaborative working.

Dealing with members' questions and comments on primary care access, clarifications and further information was provided, with key points recorded as, set out below.

In terms of concerns over access issues, it was explained that there were 26 GP Practices in Luton working within five Primary Care networks and the CCG had no concerns over any contractual issues with any of them. These Practices worked collaboratively together, supporting each other, as required to address any issues at any one Practice. The value of the Primary Care Networks working together was very evident in their response, working on the Covid-19 vaccination programme.

The CCG had invested in primary care infrastructure, supporting GP Practices, e.g. in terms of buildings and investing in GP contracts and employment of diverse clinical staff, e.g. social work link workers and community pharmacists. The services provided by the multi-disciplinary teams, e.g. on frailty, working with the employment and the housing teams, with Healthwatch involvement, was a good example of collaborative working. For example, the

quality of service provided by the musculoskeletal team was of the same quality with that offered at the hospital and people should not feel they needed to go to A&E. It was a matter of managing people's expectations

The Primary Care Networks also supported education and training of staff, including receptionists, who offered the first experience for patients, some who might not be regular users and families with complex needs.

All patients had to register with one of the 26 GP Practices, where they would normally receive services. The Practices worked collaboratively, with some specialising in certain areas, e.g. diabetes, which would be on offer for the whole network. This was done in dialogue with the Patients Reference Group to meet the needs of patients.

Some services rotated between the Practices to provide a stronger service, recognising there were access issues.

The value of the Primary Care Networks was very evident providing services, e.g. for residents of care homes, who were offered the services of community pharmacists and the discharge team when they left hospital.

The point raised by the HWL co-opted member was accepted, that it was important that when patients were discharged from acute mental health units, they had a named person they could contact and were guided to services they could access, if needed. The point was also taken that there was a need to ensure people did not think the 111 service was purely for GP access, as it also offered access to other services, including a mental health worker.

In relation to the messaging about the 111 service and GP appointments, members were informed that the 111 service was promoted in various ways, including through public posters. Work was also done with the A&E Delivery Board to ensure a consistent and clear message, that if a patient arrived at A&E who did not need emergency attention, they would be re-directed to the primary care Urgent care Centre at the hospital.

It was also re-iterated that if anyone could not get an answer from their GP Practices, they should call 111 and would get an appointment with a GP if needed or re-directed to the right service. All GP Practices needed to nominate a number of bookable slots for use by the 111 service.

Members were also reassured that if anyone needed an urgent appointment, they would get one that day, as it was a contractual obligation. While they could ring 111, the GP Surgeries were still responsible and expected to deal with calls and offer urgent appointments if clinically required. They were also required to provide good access for patients with long-term conditions, such as diabetes. The 111 service could also book non-urgent appointments.

It was accepted that some people who had not used the system for a few years would not know what to expect. There was therefore a need for constant and clear messaging and the largest cohorts being targeted to make progress were children, people with mental health issues and care home residents.

The Primary Care Director proceeded with the second part of her report, on the GP Community Pharmacy Consultation Service, outlining key points from the report.

She said that the service was another good example of the collaboration between the GP Practices and local pharmacists, who were highly trained and qualified, providing a good resource for Luton residents. Her role was to facilitate and encourage primary care networks to get involved in the pilot.

The evidence-based service had been piloted nationally and considered best practice, providing a service for minor illnesses that could be dealt with by the local community pharmacists.

One month since the start, Lea Vale Medical Group, one of the biggest in Luton had recently joined in the pilot and it was hoped that all 26 GP Practices would sign up, which would be a good sign that the primary care network was developing and providing an excellent service.

She added that she was hoping that dental practices would join the primary care networks, as they were already doing some good work in Luton with the care homes.

She re-iterated that Community Pharmacy Consultation Service was a good example of access to primary care.

The Corporate Director, Population Wellbeing suggested that members submit the more detailed questions that people with long-term conditions were raising with them about access to their GPs to the CCGs' Director of Primary Care, in advance of future meetings to enable her to research and provide more in-depth answers to HSCRG.

She commented that residents' expectations still appeared to be that they would eventually speak to or see a doctor when they called their GP Surgery, whereas the reality was that they could be better provided for by another clinician, e.g. a physiotherapist. She suggested that the Director of Primary Care should consider what sort of information she could provide to HSCRG for members to use to spread the right messages in the community.

The Director of Primary Care agreed with the suggestion, which would fit the agenda for HSCRG and give her and the CCGs' clinical lead the right platform to address these issues.

The Corporate Director suggested that depending on the questions and the areas covered, the Director of primary Care could decide on the agenda item and provision of the appropriate report, which was agreed.

Resolved: (i) That the update on the work being overseen by the Primary Care Access Group be noted

(ii) That HSCRG members be requested to submit by e-mail via the Democracy and Scrutiny Officer, any questions on Primary Care/ GP services to the BLMK CCGs' Director of Primary Care in advance of future meetings, to enable her to prepare and provide the most informative answers in a report to HSCRG.

42. Resolutions Performance Data Q3 and Q4 (Ref: 12)

The Senior Public Health Manager presented the report (Ref: 12), updating HSCRG about the 'year four' contract review of the ResoLUTiONs drug and alcohol treatment service and to provide assurances that the new service was reflecting the needs of Luton residents.

She said that the report provided data for Quarters 3 and 4 and proceeded to highlight key points of interest from the report, as set out below.

ResoLUTiONs was still operating under Covid restrictions, but were hoping to bring the staff and clients back for face-to-face treatment in September 2021. As a precaution, staff would be assessed, as to who could come in and who should continue to work from home. The same assessment would be carried for clients, prioritising those with the more complex needs to come in for the service.

As there had been good feedback from clients about the benefits of seeing their key workers remotely, there would be an assessment of what worked well, which would be retained, while re-introducing face-to-face treatment, as part of the menu of options.

The service would also be looking to increase its community arrangements, using GP Surgeries, Futures House and similar community facilities to see clients.

In terms of performance, members were directed to Table 1 in the report, which showed the expected performance. The report also showed that ResoLUTiONs was meetings all its targets, except one where they were expected to have successfully completed their work with long existing service users. This was because they had not been discharging people during the Covid pandemic, so that these clients could be given extra support.

In addition to the harm reduction and blood borne virus work, although not in the report, the service was also running Covid vaccination clinic at ResoLUTiONs, encouraging take-up of the vaccine by those clients who had not already been vaccinated.

In terms of the ethnicity of service users, Change, Grow, Live (CGL) the providers was planning to join many of the virtual groups together, so that clients did not only speak to others in their own area, but perhaps in an area like Tower Hamlet. This would enable groups to be formed using specialist languages, which should provide clients the opportunity to get services in their own languages.

Members were informed that the service was also looking at co-location of ResoLUTiONs staff, putting some of the Drugs and Alcohol staff in with mental health services and adult social care, with cross training offered between these services, which it was hoped would improve partnership working.

Towards the end of September or in early October 2021, a new venue was opening up in Luton for the young people service opposite Matalan in Caste Street. The same co-location approach would also be used and there had already been discussions with the New Family Partnership, the Mental Health and Emotional Wellbeing Service, CHUMS and with the children and adolescent mental health services (CAMHS). This should also improve partnership working and cross training of staff.

Dealing with members' questions and comments, further information was provided, as set out below.

Information on the TREE (Tackling, Reducing and Ending Exploitation) Project was not readily available and would be provided to the Chair directly.

It was confirmed that multi-agency working was the approach taken, as drug and alcohol issues could not be addressed by ResoLUTiONs alone.

The Corporate Director, Population Wellbeing commented that some additional funding from the Covid-19 Contain Outbreak Management Fund had been targeted and allocated to ResoLUTiONs, where a need had been identified.

The Senior Public Health Manager confirmed the funding was being used to recruit two substance misuse workers to work within adult social care, where there was a need for support on both alcohol and substance misuse work.

Resolved: That the update from the contract review of the ResoLUTiONs drug and alcohol treatment service be noted.

43. Draft Work Programme 2021-22 (Ref: 13)

Members considered the work programme, which was agreed as per the report.

Members were requested to submit their questions from their constituents on 'Primary Care GP Access and Primary Care Access Group' for the CCGs Director of Primary Care's consideration in good time prior to the next meeting, via the Democracy and Scrutiny Officer.

This was agreed initially for the standing item on 'Primary Care GP Access and Primary Care Access Group' and if successful, could be extended for other regular update items on the HSCRG work programme.

Resolved: (i) That the Democracy and Scrutiny Officer (DSO) be authorised to update and amend the work programme, adding and reviewing items for each meeting in consultation with the Chair of the committee

(i) That HSCRG members be requested to submit any questions from their constituents on 'Primary Care GP Access and Primary Care Access Group' for the CCGs Director of Primary Care's consideration in good time prior to the next meeting, via the Democracy and Scrutiny Officer. (Note: If successful, this approach might be extended to all elected members of the council)

(Note: (i) Cllr Campbell left the meeting at 7.00 pm, at the end of Item 10;

(ii) The meeting ended 7.45 pm)