North Yorkshire County Council

Scrutiny of Health Committee

Minutes of the remote meeting held on Friday, 10 September 2021 commencing at 9.00 am.

A recording of the meeting can be viewed on the Council's YouTube site via the following link - https://www.northyorks.gov.uk/live-meetings

Members:-
County Councillors: John Ennis (in the Chair), Val Arnold, Philip Barrett, Jim Clark, Liz Colling, Zoe Metcalfe, Heather Moorhouse, Chris Pearson, Andy Solloway, Roberta Swiers and Robert Windass.

Co-opted Members:-
District and Borough Councillors: Sue Graham (Ryedale), Wendy Hull (Craven), Nigel Middlemass (Harrogate), Jane Mortimer (Scarborough) and Jennifer Shaw Wright (Selby).

In attendance: County Councillors Caroline Dickinson.

Officers: Rod Barnes (Chief Executive, Yorkshire Ambulance Service NHS Trust), Daniel Harry (Democratic Services and Scrutiny, NYCC), Victoria Turner (Public Health Consultant, North Yorkshire County Council), Wendy Balmain (Director of Strategy and Integration, North Yorkshire CCG), Richard Webb (Director of Health and Adult Services, NYCC)

Apologies: County Councillor John Mann, Hambleton District Councillor Kevin Hardisty, and Richmondshire District Councillor Pat Middlemiss.

Copies of all documents considered are in the Minute Book

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172 Minutes of Committee meeting held on 18 June 2021

That the Minutes of the meeting held on 18 June 2021 be taken as read and be confirmed by the Chairman as a correct record.

173 Apologies for absence

Apologies were received from County Councillor John Mann, Hambleton District Councillor Kevin Hardisty, and Richmondshire District Councillor Pat Middlemiss.

174 Declarations of Interest

There were none.

175 Chairman's Announcements

The committee Chairman, County Councillor John Ennis, welcomed everyone to the meeting.

County Councillor John Ennis thanked all present for being able to attend the meeting at the revised start time of 9am. The change was necessary due to an unavoidable clash with another committee meeting and the constraints on the live broadcast technology which means that two meetings cannot be held at the same time. He said that the meeting would need to finish promptly at 10.55am.

County Councillor John Ennis reminded the committee that the meeting was being held informally and that any formal decisions would need to be taken in consultation with the Chief Executive Officer using his emergency powers.

County Councillor John Ennis read out the following statement so that the status of the meeting was clear to all involved and viewing:

You will have seen the statement on the Agenda front sheet about current decision-making arrangements within the Council, following the expiry of the legislation permitting remote committee meetings. I just want to remind everyone, for absolute clarity, that this is an informal meeting of the Committee Members. Any formal decisions required will be taken by the Chief Executive Officer under his emergency delegated decision-making powers after taking into account any of the views of the relevant Committee Members and all relevant information. This approach has been agreed by full Council and will be reviewed at its November 2021 meeting.

County Councillor John Ennis noted the sad and untimely death of former County Council John Clark. He was a member of the committee up to 2017 as a County Councillor and then more recently in his capacity as a Ryedale District Councillor. He was an active member of the committee and a strong advocate for high quality, accessible health services for the people of North Yorkshire.

County Councillor John Ennis said that the order of the printed agenda had been changed to accommodate the availability of key speakers. The substantive items would now be taken as follows: 8; 9; 10; 7; and 6.

176 Public Questions or Statements

Daniel Harry, Democratic Services and Scrutiny Manager, said that there were six public questions for the committee. The Council Constitution states that public questions are taken in the order in which they are received and the maximum time allocated in total to public questions is 30 minutes.

Daniel Harry read out the first five questions at the request of those people who had submitted them. Scarborough Borough Councillor Richard Maw was present to read out his question.

The answers to the six questions were provided by Lucy Brown of York and Scarborough Teaching Hospitals NHS Foundation Trust and Simon Cox of the North Yorkshire CCG. Neither were able to attend the meeting due to other commitments and so Daniel Harry read out the responses on their behalf.

The responses to the public questions were batched together where there were common themes.

<u>PQ1 - Dr Gordon Hayes – centralisation of specialist services and associated travel times</u>

Scarborough Hospital has seen a huge reduction in local healthcare service provision for the 200,000 residents in its catchment area since York Trust took over in 2012.

One of the services that has been lost is out-of-hours ophthalmology, which I experienced first hand at the end of 2020.

I have previously suffered a torn retina in my eye which required laser repair. Early one Friday evening at the end of last year I experienced sudden onset recurrent symptoms which I had been advised required a fairly rapid ophthalmological assessment.

I telephoned 111 - who advised me to attend my nearest Emergency department within two

hours.

On attending the Emergency department at Scarborough Hospital I was advised there was no longer an out-of-hours ophthalmology service located there and was signposted to York Hospital where our 'local' service was now based.

I phoned the Emergency department at York Hospital prior to travelling over to specifically check there was a duty ophthalmologist available who could see me if I arrived there. This was confirmed.

I was driven to York from Scarborough by a family member (I could not drive myself in the circumstances) where I eventually arrived over an hour later. I checked in at the Emergency department, was subsequently assessed by a nurse, and then waited for over two hours - only to be told in the early hours of Saturday morning that the duty ophthalmologist could not see me then as previously stated, but that they required me to return early the next morning.

I was driven back to Scarborough, arriving home at 2am on Saturday morning - and wearily driven back to York at 8am to get to York Hospital in time for my appointment.

The medical assessment I received when I saw the ophthalmologist was absolutely fine. But the access system and travelling involved (a total of 5 hours and 160 miles) were appalling. I was very lucky to have someone who could drive me to York, and at times when public transport would be difficult if not impossible to find. Many others would not have been so fortunate and would have been unable to access this healthcare.

Could the committee please comment as to whether they feel this is a reasonable, practical and equitable way for Scarborough and East Coast residents to now access a core medical service which has previously been provided at Scarborough Hospital?

Response to PQ1 – Lucy Brown of York and Scarborough Teaching Hospitals NHS Foundation Trust and Simon Cox of the North Yorkshire CCG

The Trust is unable to comment publicly on individual cases.

In general terms, it is simply not viable to provide out of hours or specialist care for every specialty on every site with the resources we have.

With regard to ophthalmology, there has not been a 24/7 on site emergency ophthalmic service at Scarborough Hospital for over 10 years, and shared arrangements have been in place since that time in order to provide a service for people in the Scarborough area. There is a shared on call rota between the York and Scarborough teams, and ophthalmology elective care and outpatient services have been sustained.

There has been continual investment in the East Coast ophthalmic service, including new consultants based at Scarborough, a new Bridlington clinic and a vastly expanded Malton clinic, with significant capital input. We continue to develop the service in order to improve the quality of care for all of our patients.

PQ2 – Catherine Blades – centralisation of services and supporting small hospitals

As a resident of Scarborough I am concerned about the loss of core health care provision in Scarborough and the East Coast. The Trust says that such cuts are partly due to recruitment problems, but also that services need to have an ‘economy of scale ‘citing stroke services, oncology and other services, meaning that our population does not justify providing the services we need. For example, the CCG recently stated that there would need to be a population of 200,000 people and 600 patients a year to justify a Hyper Acute Stroke Unit in Scarborough, which is why they now want to treat all emergency stroke

patients in York, despite concerns about travel times along the A64 which a recent FOI request I submitted revealed to be at the best 55 minutes, but sometimes up to 2 hours, which is outside the NICE clinic, guidelines for treatment of strokes.

Having done some research, I found a document that was due to be the focus of a debate in the House of Commons on March last year, on the funding of Unavoidably Small Hospitals. The document was published by NHS England and written by the Advisory Committee on the Allocation of Resources for Unavoidably small hospitals such as Scarborough. It quotes the Scarborough catchment area as having a population of 194, 000., and also stresses the need to provide services to take into account the health needs , geography and travel time to the nearest other hospitals, The catchment area , for which they provide a map , extends out to Kirkbymoorside, Driffield and Whitby. The population must surely be more than 200, 000 by now.

My question is; Is the CCG recognising the full extent of the population quoted (which would achieve economy of scale to provide services), and are they utilising funding for the whole of this catchment area to provide services at Scarborough Hospital?

PQ3 – Mr R H Ward – concerns about the ability of YAS to support the new hyper acute treatment model due to concerns about its performance

Dear committee members

With regard to the permanent move of stroke services to York Hospital from Scarborough Hospital. At your last meeting councillor Heather Moorhouse had some worries with regard to the transfer of patients and the effects this would have on the Yorkshire Ambulance Service. This in mind I made a freedom of information request to the Yorkshire Ambulance Service for timing of transfer of stroke patients from Scarborough postcodes to York Emergency Department, this for the period April 2021 and July 2021. The response was timely and for my post code YO12 revealed that the quickest time was 56 mins and the slowest 1hour 56 mins. How can this be acceptable when in London and in Manchester HASUs are sited so that travel time for any patient is no more than 30 mins and the national stroke lead Dr Deborah Lowe in her foreword to the last SSNAP report states that time is brain. To follow from this I on Saturday 28th August 2021 had what 111 described as a medical emergency and advised my wife to ring 999 for an ambulance. She was told after giving my symptoms that the ambulance service was at a critical level and they could not say how long it would take for an ambulance to be despatched. We do have a car and luckily my wife can drive so she said she would take me to Scarborough A&E. We were informed that the ambulance service quite frequently has to operate at critical level.

My question is how can the committee allow a new service, temporary or permanent, to be put in place which is going to stretch even further an Ambulance service which is struggling to cope with day to day operation, when it would seem sense to create a HASU in Scarborough, fully staffed and funded properly by York Trust which would take one pressure away from the ambulance service, would bring Scarborough patients in line with the majority of the country by giving them a service they could reach within the 30 mins it seems is deemed important in London and Manchester and not the lottery I would be asked to accept of, you might get there in 56 mins or it could take 1 hour 56 mins? But, we will give you a top class service that will save that part of your brain that is left undamaged after the journey to York.

Thank you for your attention.

PQ4 – Mrs M Ward – centralisation of hyper acute stroke services and travel times to treatment

I write as a lifelong resident in Scarborough to your committee to urge all councillors to hear my utter dismay at Scarborough people losing timely access to stroke services. I am totally

dissatisfied with the prospects of a journey time between 56 mins and 1hr 56 mins. Haemorrhagic strokes are extremely dangerous, although they make up about 10% of cases, in real terms I am being asked to wait up to two hours travelling time before even being delivered to a Hyper Acute Stroke Unit. The rest of cases is where blood vessels become blocked and my brain is being starved of oxygen. I believe my prospects of recovery from such an event to be worsened under these extended travelling conditions. A paramedic in an ambulance can do nothing for me. I live in the YO12 postcode area.

'Time is Brain' a mantra used in stroke care. Without a scan and any medication administered my chances of survival and good recovery are worsened each second and minute that passes by.

Public consultation and reassurance has been virtually zero apart from a few scant emails. The public deserve to know the outcomes for the direct model stroke service in a clear transparent manner for Scarborough stroke patients from 2019 - 2021 and where they are classed as postcoded from. The most recent SSNAP data would also be useful. Anything to offer reassurance. There is talk of some kind of consultation in the autumn - after the final decision has been taken no doubt. It is said there is no viable alternative to the direct model, a HASU on the east coast is most definitely a viable alternative.

I will be looking carefully for our coastal outcomes and results in the coming months.

<u>Response to PQ2, PQ3 and PQ4 - Lucy Brown of York and Scarborough Teaching Hospitals NHS Foundation Trust and Simon Cox of the North Yorkshire CCG</u>

This response relates to the three questions that have been asked on the subject of the stroke service.

In 2015 a change was introduced to the stroke service, and since that time anyone attending Scarborough Hospital's emergency department with a suspected stroke is transferred to York Hospital where they can benefit from the expertise and treatment offered in the Hyper Acute Stroke Unit.

In May 2020, a temporary change was introduced to adopt a direct transfer model. This means that patients suffering a stroke will now bypass the intermediate step of going to Scarborough Hospital's emergency department, and will instead be taken directly by ambulance to their nearest hospital with a hyper-acute stroke unit. This may be York, Hull or Middlesbrough and will be dependent on which is to closest to where the patient is picked up.

The rationale for this is that the most important elements in the initial response to stroke are:

- Prompt recognition of signs and symptoms (as summarised in the FAST mnemonic) and call 999
- Assessment and stabilisation by a trained paramedic crew where an ambulance has been called
- Access to a fully configured and staffed Hyper Acute Stroke Unit (HASU). These units should treat at least 600 patients per year
- Rapid access to CT scan to confirm diagnosis and aid treatment planning including timely delivery of thrombolysis where appropriate.

This change means that patients will now access such a unit directly, rather than going via an emergency department in a hospital that does not have a hyper-acute stroke unit.

This model of care is already in place in many other parts of the country, with The NHS Long Term plan notes the following: There is strong evidence that hyper acute

interventions such as brain scanning and thrombolysis are best delivered as part of a networked 24/7 service. Areas that have centralised hyper-acute stroke care into a smaller number of well-equipped and staffed hospitals have seen the greatest improvements. This means a reduction in the number of stroke-receiving units, and an increase in the number of patients receiving high-quality specialist care.

The current stroke pathway for Scarborough patients brings the quality of care for the Scarborough population closer to the nationally recommended standards. Although in responding to incidence of stroke time is of the essence, national standards, based on clinical evidence, are based on timely delivery of key indicators rather than reference to a golden hour.

Considering the transport times from the Scarborough area to Scarborough Hospital (an average of 22 minutes for the Scarborough Hospital catchment), the time involved in assessment and diagnosis at Scarborough Hospital, likely time waiting for an ambulance to be available for transit to the HASU in York, and then the ambulance journey itself, the new direct admission model is likely to see patients accessing specialist care more quickly than before and thus improve outcomes. The service data shows that in 2019 Scarborough area patients would typically access a HASU within 6 hours. As of the current service even with an average ambulance transfer time of 52 minutes, patients are much more likely to arrive at a HASU within 4 hours.

The ambulance service previously would take patients to Scarborough Hospital and then have to transfer them as emergency patients from Scarborough to York. With the direct admission model the number of total ambulance journeys has reduced and the direct admission model is likely to provide more availability of emergency ambulance capacity. Yorkshire Ambulance Service were fully involved in discussions regarding delivery of stroke services for the Scarborough population and the direct admissions model to York was their preferred option.

<u>PQ5 – Mrs D Gallie – centralisation of services and travel times to specialist services</u>

As a resident of Scarborough I am becoming more and more concerned as to the way we are being treated by York Trust withdrawing scores of services from Scarborough Hospital and all done with a complete lack of any local consultation with residents. We have approximately 200,000 people in the true catchment area, more during the summer months, and what are we offering them?

A lengthy trip to York, Hull or Middlesbrough. Even a 10 minute appointment now requires a trip to some other hospital often taking a day and added expense to many patients.

My own experience is having to drive, on at least 13 occasions, my extremely vulnerable husband, in great pain, over a 1000 miles, in total, to York, Castle Hill (Cottingham), The Spire (Anlaby), Malton, Bridlington and Hull Royal Infirmary for various consultations and treatments. He has a lot of complex medical conditions and nothing is on offer for him in Scarborough now.

What is even more galling is that we live just across the road from Scarborough Hospital.

We are a couple of senior citizens and I don't know how long I will be able to do these drives as I have Osteoarthritis and Inflammatory Arthritis in both ankles which, in turn, cause me great pain as well. Plus imagine how much 1000 miles has cost me in petrol expenses.

Now my question to you, and to the others in the NYCC Scrutiny of Health Committee is: Is this right and is this fair?

It is to be hoped that as a Scrutiny Committee you take your positions seriously and take up

these concerns with York Trust.

Response to PQ5 - Lucy Brown of York and Scarborough Teaching Hospitals NHS Foundation Trust and Simon Cox of the North Yorkshire CCG

The way that health services are organised and have developed over the years, and the resources available to run those services safely, means that we cannot provide all services in all locations and that inevitably people will have to travel to access some services, particularly those of a more specialist nature.

We know that in a large rural area such as ours this can be difficult for patients and their families, and there are several options for accessing support with transport and the associated costs. We are also offering an increasing number of video and telephone appointments where appropriate to avoid the need to travel.

The Trust widely advertises travel support details, including information with outpatient appointment details and on the main page of its website. Both the Patient Transport Service, commissioned by the Clinical Commissioning Group on behalf of patients, and the Healthcare Travel Cost Scheme, administered by the Trust, are extensively used.

These services are specifically designed to support patients who find transport prohibitively expensive due to their financial circumstances and/or because of physical health and mobility issues.

PQ6 – Cllr R Maw – delays at Scarborough A&E, lack of beds at York and impact upon hyper acute stroke treatment

This week I was conducting a mobile street surgery on my ward when I met a lady who had only recently experienced a worrying time at SGH. Julie (not her real name) had been suffering with a heart condition and found herself in A&E. At approx. the same time another lady was brought in by her anxious husband.

On this particular evening there was a shortage of beds. Both patients were to wait out almost the entire night on wooden chairs. At 4am Julie was found a bed whilst her new friend waited, still in her chair.

Julie has no idea what has happened to her fellow patient although she had told her that she was waiting to be taken through to York.

Obviously it is not for anybody here today to comment on any particular case but it does raise the concerns of what care she might have been requiring at York that Scarborough could not provide.

If this other lady had been suffering the symptoms of a stroke, what are the procedures when a suspected stroke patient is brought into Scarborough Hospital A&E by a family member at such a busy time and can these procedures be met 24/7/365?

Response to PQ6 - Lucy Brown of York and Scarborough Teaching Hospitals NHS Foundation Trust and Simon Cox of the North Yorkshire CCG

Patients attending the emergency department, whether by ambulance or walk-in, are assessed and prioritised in order of urgency. In the case of a suspected stroke, under the current pathway ambulances would take the patient straight to the nearest Hyper Acute Stroke Unit, however if the patient has made their own way to Scarborough Hospital they would be urgently transferred to the HASU in York. The procedures for doing this were agreed with the ambulance service prior to implementation of the direct access model, and apply all day every day.

Scarborough Borough Councillor Richard Maw asked as supplementary question, as follows:

It is apparent that waiting times at A&E in Scarborough Hospital are increasing and there are more pressures upon that department, which ten has a knock on effect elsewhere. Is this due to changes/reductions in services elsewhere across the catchment area for Scarborough Hospital?

Daniel Harry said that he would obtain a written response to his question.

County Councillor Liz Colling said that it would be useful to have a future item on a committee agenda regarding unavoidably small hospitals.

County Councillor John Ennis thanked all of the people who had submitted a question or statement for their comments and their contribution. He noted that the committee had carefully scrutinised the changes to the provision of hyper acute stroke services over the past 18 months and at the June meeting endorsed the adoption of the direct admissions model as the only viable option. In doing so, the committee had taken into account NICE guidance, the similar and successful changes made at Harrogate hospital to stroke services, the outcome of the regional review of hyper acute stroke services and information provided by commissioners and providers. The role of the committee is now one of monitoring patient outcomes. An update on this will be provided to the committee meeting in December.

177 Update on the development and performance of the services provided by the Harrogate and Rural Alliance - Report of Chris Watson, Director of Harrogate and Rural Alliance

Update on the development and performance of the services provided by the Harrogate and Rural Alliance

Considered - a presentation by Richard Webb (Director of Health and Social Care, NYCC) and Wendy Balmain (Director of Strategy and Integration, North Yorkshire CCG).

The key points from the presentation are as summarised below:

- The alliance was setup in September 2019
- The alliance delivers an integrated operating model that brings together community health and social care services for adults in Harrogate
- It involves North Yorkshire County Council, Harrogate and District NHS Foundation Trust, Tees Esk and Wear Valleys NHS Foundation Trust, North Yorkshire CCG, and the Yorkshire Health Network Local GP federation
- The annual budget is £49m and there are 400 staff (approximately 50/50 HDFT and NYCC)
- Benefits include reducing duplication, the continued development of the Home First Model and the development of care market
- The co-location of the workforce leads to new ways of working
- It is not the intention to roll out the HARA model to other parts of the county. Each area needs to develop a partnership and model of health and social care delivery that works for them
- Links with the Primary Care Networks are becoming increasingly important
- Local Government Review presents new opportunities as key elements of prevention and early intervention are brought together in the new unitary.

County Councillor John Ennis asked how HARA would fit within the Integrated Care System for Humber Coast and Vale.

Wendy Balmain said that there are four care partnerships within the footprint of the Integrated Care System for Humber Coast and Vale, and one of these aligned to the area covered by HARA.

County Councillor John Ennis asked how HARA had performed and how patient outcomes were measured.

In response, Richard Webb said that the alliance was setup in September 2019, just six months before the first national lockdown. As such, much of its work to date has been dominated by the response to the pandemic. Whilst this has resulted in some new and innovative ways of working that will be continued post pandemic, it has meant that it has been difficult to measure performance overall. Anecdotally, there has been improved working across the local system with better care planning and more timely decisions about care pathways and packages. This will have had a positive impact upon patient outcomes. He said that further work would be undertaken to evaluate HARA and its first 2 years of operation.

County Councillor John Ennis summed up, thanking Richard Webb and Wendy Balmain for attending and noting the positive impact that HARA had locally during a very difficult period of time.

Resolved:-

1) That a watching brief be maintained and that an evaluation of the performance of HARA be brought back to a future meeting of the committee.

178 Yorkshire Ambulance Service response to and recovery from the pandemic - Verbal update - Rod Barnes, Chief Executive, Yorkshire Ambulance Service NHS Trust

Considered - a verbal update by Rod Barnes, Chief Executive, Yorkshire Ambulance Service NHS Trust

Rod Barnes updated as summarised below:

- The service was in a unprecedented position with very high levels of demand
- The service is operating at the highest level of escalation since early July 2021
- All ambulance services are currently struggling with high levels of demand and one has declared an emergency
- There are 3,900 calls a day to the control room at present, with an increasing number of those calls relating to serious incidences
- The activity levels are similar to what you would see in winter and there were 190,000 calls to the NHS 111 line in July alone, which is 20% higher than normal
- The challenges in the system around access to primary care and dental care, amongst others, can lead of an increased ambulance call out
- The need to maintain covid-safe services has meant that the Patient Transport Service has reduced capacity from 3 people per ambulance to 1 person. The number of journey's made, therefore, increased despite there being lower demand
- The requirements upon the NHS for infection control are greater than for the public as a whole and this impacts upon the service provided by YAS
- Additional NHS funding of £5million has been secured for emergency response and this will be invested in more staff for the ambulances and the control room
- Looking ahead, the intention is to bring in an additional 300 staff prior to the busy Christmas period and to develop more defined career paths with the service to aid staff retention
- Work is underway to support staff wellbeing and also to build surge capacity, which will in turn take the pressure off A&E.

County Councillor Heather Moorhouse asked whether YAS worked with the Air Ambulance.

In response, Rod Barnes said that that there was a strong working relationship between the two services.

County Councillor John Ennis asked whether the transport of patients from the catchment area of Scarborough Hospital with a suspected hyper acute stroke directly to York hospital, rather than going to Scarborough Hospital for assessment first, created any operational issues for YAS.

Rod Barnes said that the direct admission model made more sense as it removed delays caused by patient transfer between sites and improved access to specialist treatment.

County Councillor John Ennis thanked Rod Barnes for attending.

Resolved:-

1) That a watching brief be maintained on YAS performance and that Rod Barnes keep the committee informed of any emergent issues of concern.

179 NHS response to and recovery from the pandemic - Report of Wendy Balmain, Director of Strategy and Integration, North Yorkshire Clinical Commissioning Group

Considered – A presentation by Wendy Balmain, Director of Strategy and Integration, North Yorkshire Clinical Commissioning Group.

The key points from the presentation are as summarised below:

- NHS recovery planning has six elements, including developing primary care, supporting and retaining staff, rolling out the vaccination programme and building upon lessons learned from the pandemic and new ways of working
- NHSE returns include regular updates on outlining plans for activity, finance and workforce
- There is a potential efficiency saving requirement of approximately 3%
- Good progress being made with the vaccination programme. As of 27 August 2021, a total of 524,572 second doses had been administered
- Currently preparing for a covid booster programme to be carried out in the autumn alongside an influenza vaccination programme for all over 50s
- Patients on waiting lists for treatment are to be supported through the 'Waiting Well' programme that is being developed
- Patients continue to be prioritised due to clinical need
- Face to face appointments and digital interactions are now exceeding pre-covid levels (in total), albeit that there may be local variations across the county
- Recognise that there is a need to better describe the health system so that people access the right care at the right time
- A programme of support is in place for staff. The staff absence rates for NHS trusts in the Humber Coast and Vale Integrated Care System were on 17 August 2021 an average of 6.2% ranging from 3.8% to 7.7%
- GPs can make referrals to specialist long covid treatment, where there are severe symptoms that persist longer than four weeks after contracting covid 19.

County Councillor Philip Barrett asked what more could be done to enable a wholesale return to face to face appointments with GPs and primary care.

In response, Wendy Balmain said that there is a lot of anecdotal evidence that suggests that some people are having real problems accessing in person appointments and she recognised that this was very frustrating for many people. Wendy Balmain said that she

would raise this issue with colleagues in the CCG who work directly with primary care providers as the issue is likely to be exacerbated during the winter months when people tend to become ill or existing conditions worsen.

County Councillor John Ennis summed up, thanking Wendy Balmain for attending and responding to questions from the committee members.

Resolved:-

1) That Wendy Balmain provides an update on the local NHS response to and recovery from the pandemic, with a focus the potential impact of national funding and policy changes at the committee meeting on 17 December 2021.

180 Update on Covid-19 prevalence in North Yorkshire - Verbal update - Victoria Turner, Public Health, North Yorkshire County Council

Considered – A verbal report by Victoria Turner, Public Health Consultant, North Yorkshire County Council.

Victoria Turner updated as summarised below:

- At 7 September 2021, there had been 53,544 positive tests since 3rd March 2020. The massive expansion of testing of school children may be a factor to consider here
- The 7-day incidence rate (to 05/09/2021) in North Yorkshire was 361.8 cases per 100,000 population, higher than the England rate of 336.5
- At 7 September 2021, there were 143 hospital beds occupied by people admitted from North Yorkshire. 123 people were in general and acute beds and 20 in intensive care beds
- There have been an estimated 441 Covid-19 deaths in hospital of North Yorkshire residents since 1 September 2020 (wave 2). There were 259 deaths in wave 1 (March-August 2020)
- The pandemic has exacerbated existing health inequalities as people with generally poorer health have been disproportionately affected
- Making sure that everyone has had two doses of the vaccine is important as is adhering to the standing advice ‘hands, face, space’.

County Councillor John Ennis asked what surveillance was in place to track the development and spread of new variants of covid-19.

In response, Victoria Turner said that Public Health England regularly send positive PCR tests for genetic sequencing to help identify and assess any new variants. Where variants appear, then there is close working with the local Public Health team to understand the implications and response.

County Councillor Andy Solloway said that more large scale vaccination centres were needed as these were efficient to run and manage and could vaccinate large numbers of people in a short period of time.

County Councillor John Ennis summed up, noting the success of the vaccination programme and the work that Public Health in the county was doing to manage local outbreaks of covid.

Resolved:-

1) That Victoria Turner or Louise Wallace provide a further update at the meeting on the committee on 17 December 2021.

181 Committee Work Programme - Report of Daniel Harry, Democratic Services and Scrutiny Manager, North Yorkshire County Council

Considered – the report of Daniel Harry, Democratic Services and Scrutiny Manager, regarding the committee work programme.

Daniel Harry introduced the report and asked Members to review the work programme and make suggestions for areas of scrutiny for inclusion.

Daniel Harry noted that there were only two more formal meetings of the committee prior to the May 2022 elections. The March meeting may fall within the pre-election period and so the agenda for that meeting may be limited.

Resolved:-

1) That the committee review the work programme
2) That an item on unavoidably small hospitals is added into the work programme.

182 Other business which the Chairman agrees should be considered as a matter of urgency because of special circumstances

There was no other business.

The meeting concluded at 10.50 am.