Time commenced – 18.00
Time finished – 20:00

ADULTS AND HEALTH SCRUTINY REVIEW BOARD

20 April 2021

Present: Councillor Hussain, (Chair)
Councillors Ashburner, Cooper, Froggatt (Vice Chair) A Pegg

In Attendance: Craig Cook, Director of Contracting and Performance
NHS Derby & Derbyshire CCG
Robyn Dewis, Director of Public Health, DCC
Katy Hyde, Involvement Manager
NHS Derby & Derbyshire CCG
Steven Lloyd, Executive Medical Director
NHS Derby & Derbyshire CCG

18/20 Apologies for Absence

Apologies were received from Kirsty McMillan Director of Integration and Direct Services.

19/20 Late Items

There were no late items

20/20 Declarations of Interest

There were no declarations of interest

21/20 Minutes of the Meeting on 2 February 2021

The Minutes from the meeting of 2 February 2021 were agreed as a correct record.

22/20 CCG Updates - COVID 19 Vaccinations Update Restoration and Recovery Update

The Board received presentations from the Executive Medical Director and Director of Contracting and Performance NHS Derby & Derbyshire CCG. The presentations gave an update on COVID 19 Vaccinations and an update on Restoration and Recovery.

COVID 19 Vaccinations Update

The officer informed the Board that the Vaccination Programme in Derbyshire and nationally had been running for over 100 days and Derbyshire had reached 763,400 vaccinations from 19th April, 595,000 plus were first doses and 168,000 were second doses. From Friday 16th to Monday 19th April 2021 36,000 vaccinations had been delivered.

The officer explained that vaccinations had been given in a variety of venues to bring vaccinations closer to communities; there was also the Mass Vaccination Centre at Derby Arena which had two parts, the Primary Care Network led site and the Vaccination Centre. Derbyshire had performed well and compared favourably at a national and regional level in delivering the vaccination programme so far. This was due to its collaborative work with the providers of healthcare and voluntary partners across the system supporting and managing the vaccination process.

The officer explained the phases within the vaccination programme, phase 1 included all people over 50, the clinically extremely vulnerable, their carers, NHS social care workers and Covid at risk. There had been good take-up across all the age groups in this cohort, almost all reaching over 90% take up of vaccinations.

The Vaccination programme was now at a pivot point in that it was entering phase 2 which consisted of the remainder of the local adult population, (Cohorts 10, 11 and 12). The key delivery of phase 2 vaccinations would be through Primary Care Networks (PCNs). There are 15 PCNs in Derbyshire as a whole, and most of the PCNs, including the 5 in Derby have signed up to an Enhanced Services contract to deliver vaccinations to the phase 2 cohorts; three PCNs are still in discussion with the CCG.

The officer then explained that Derbyshire was in a strong position nationally in relation to vaccinations given, being in the top 5 in the country, despite the complexities of the vaccination programme. The officer then highlighted the performance of Derby North and South in comparison with other rural and city constituencies across the country by vaccination age group.

The officer then described how the CCG were tackling vaccine hesitancy in local communities, with the people who are dying from COVID 19 often from the same communities that are vaccine hesitant. The CCG are working to inform and educate these communities with the right information to try and increase vaccine take up. The aim was to tailor their approach so that it works with different communities and issues; it was about engagement, using credible influencers such as community/faith leaders and understanding how communities work. They are developing culturally appropriate communications with diverse, messages and images. They are running “train the trainer” sessions with community leaders, a vaccination session at a West Indian Centre had taken place, working with Disability Direct and other groups to encourage uptake and creating opportunities to offer tailored vaccination services for specific needs like the deaf community.

The officer highlighted the next steps for the local vaccination programme. He explained that regionally they were held in high regard for the work they had

been doing. They were aiming to complete the vaccination programme by national timescales (1st August 2021) and were currently on target. The CCG are looking at Phase 3 boosters and re-vaccination, thinking about when and how, also linking with the flu vaccination programme. They are thinking about what they have learnt through the programme such as collaborative working and how to keep that going. The plan for the longer-term vaccination programme also needs to include an element of business as usual.

The officer gave examples of work in progress which included working with the local authority to vaccinate both registered and self-declared carers. Also engaging further with respected influencers who are in direct contact with communities to encourage take up in vaccine hesitant groups like asylum seekers, travellers, ROMA community, BAME groups), offering mobile pop up sites like a pop-up clinic at the Pakistan Community Centre. The officer highlighted that the homeless community had been targeted and there had been a take up of up 90%.

The Chair welcomed the news that the programme was going well and noted the gap created by vaccine hesitancy; he asked whether the CCG were able to breakdown the vaccination figures by ethnic minority groups in the same way that data had been broken down for the 80-89 year age group. The officer explained that Derbyshire was at the top in terms of work with ethnic communities. National and local data focused on Black, Pakistan and Bangladesh communities and it shows reassurance that these communities are being reached. The biggest lag was in people of African and African-Caribbean groups who are 25% behind the White British population in vaccination take up. The CCG are looking at how to focus on this sector on a pop-up basis. The officer highlighted that only 6% of the Derbyshire people vaccinated with AstraZeneca had missed the second dose compared with other areas where the figure was 18%. For the Pfizer (and BioNTech) vaccine only three per cent missed the second dose. The work we have done in terms of communications and engagement has significantly reduced vaccine hesitancy.

A councillor asked if there had been any impact on uptake of the first dose of Astra-Zeneca, and the officer confirmed the main emphasis had been on the second dose. He explained that at an individual practice level you have queries coming through about ‘is there an alternative that people can use but fundamentally there is not a choice at individual level, this is dictated by national supply. To put it bluntly “it is take it or leave it” but actually the people who leave it are very few indeed. In totality uptake is very solid and very substantial.

A councillor asked the size of the eligible population in Derby City, and the officer confirmed that it was just under 1.1 million. The figure for first doses given was well over half a million, so essentially, we are not over halfway through the programme yet. Immunity will be monitored through the second dose, which was essential. The CCG was making substantial progress with phase 1 with an ambition to get completed in August; the main constraint was vaccine supply. The councillor sought clarification on the eligible group, was it meant to be for all adults over eighteen years. The officer confirmed it was.

Another councillor asked if there was a new variant which affected children and if a vaccine would have to go through a clinical trial process ? The officer gave details of the variants currently in the community. The “Kent” variant had superseded the original variant. It had slightly higher transmission rates and a possibly higher morbidity rate; there was a need to keep an eye on the South African and Brazilian variants. The Indian variant was an unknown in terms of whether the vaccine can block morbidity. We are unsure if vaccines will need to be “tweaked”, but current data gives robust assurance of its effectiveness. Over 50% of the population have anti-bodies to SARS COV 2. The 70 to 79 years group was 90% plus of positive anti-bodies which gave a protective effect; however it was uncertain how long that protection would last. A councillor asked if the vaccines are effective against all the current variant mutations. The officer stated that new variants are classed as “of concern”, where the vaccines might have reduced effectiveness. The aim of vaccination was to reduce the severest effects of the COVID Pandemic, there was nothing to substantially undermine the vaccinations we have got now.

Restoration and Recovery Update

The officer explained the key priorities for Derby and Derbyshire CCG, one of which was our workforce and supporting them; this was a top priority due to the extreme pressures they have been under. On the demand side less than 1% of acute bed space was occupied with COVID patients, we were seeing about 30% occupation, this drastic reduction was due to lockdown restrictions and vaccinations. The CCG was now seeing non COVID volumes starting to return and people are coming back into the system with more complex needs. The 111 service will continue to be used to triage services and the good performance of the discharge service for patients would be maintained. Operations for clinically urgent patients will take place, there will be a focus on high priority care patients who need surgery in a specific timescale, with an aim of bringing the volume of P2 patients down to pre-COVID levels. COVID 19 resurgence risks, new variants, vaccine efficacy remains a significant risk to the NHS and the wider system. However if COVID levels can be kept down to the levels in place, now the NHS will manage the backlog of non-COVID emergency patients needing treatments; it will give space to allow us to operate more. During the second half of this year, going into 2022, other variables would affect performance, like a third wave of COVID plus possible communicable diseases like influenza and norovirus. There was a lot of planning to do for the second half of the year.

There are 5 broad priorities for the year ahead which are:

- The Health and Wellbeing of our staff and taking action on recruitment and retention
- Delivering the COVID Vaccination Programme
- Building on what we have learned during the Pandemic to transform the delivery of services
- Expanding Primary Care Recovery to improve access, local health outcomes and address health inequalities
- Transforming our community and urgent care pathways to prevent inappropriate attendance at Emergency Departments, and improve timely admission to hospital for emergency patients

The absence rate of clinical staff across our providers is around the 5% to 6% rate, which was an expected rate for integrated care services (ICS) at this time of year. A fifth of the absence rate was due to COVID related illness or effects which was expected to increase over time. It was still a significant proportion of staff who are likely to be off due to COVID issues.

Another challenge what has been seen over the last four years was an increasing number of staff absent due to mental health related issues; the CCG was yet to see the adverse mental health perspective of our clinical workforce which remains a risk to recovery. There was work ongoing across providers to look after their staff, investment in wellbeing initiatives such as a lot of decompressing and reflection time, enabling staff to take accrued annual leave for rest and recuperation, radical regrading of Occupational Health service offer for staff to allow them access to psychological support.

The officer then highlighted the pressures being seen in Urgent and Emergency Care. Over the last 12 months all types of hospital demand was reduced due to COVID. The CCG are now starting to see a resurgence of volume in demand. To put this into context, in March 2021 the CCG saw more patients in the Emergency Department than in March 2020; the pandemic would have had some effect on numbers, but there was quite a sizeable increase on the January/February position. The key message to understand was that the impact was not just about volume but about complexity of care. Patients who have not been able to access their long term condition review in primary care perhaps are suffering more exacerbations of chronic conditions, with the knock on effect that the CCG are starting to see more of those patients coming back into the Acute Sector.

A robust forward improvement programme was in place and was being overseen by the Joined-Up Care (JUCD) Urgent Care Delivery Board which was aiming to improve urgent and emergency care pathways. Funding has gone into integrated urgent response offers for patients, services such as NHS 111, thinking about the offer for Urgent Treatment Centres, across the County investing in facilities in peoples communities to make care a lot closer to home, and to help people to access services quickly.

The officer highlighted the work being done in Acute Admission Avoidance, if patients do have to go into hospital they are treated in a quick, efficient and effective manner. Also, the positive elements which were put into place over the last 12 months on the discharging side of pathway; the CCG still need to keep focusing on those also.

There was a new initiative called “Team Up” which ensures clinical teams can link and work together. Patients, GP, community therapist, nursing mental health nurse, the wider adult social care staff working as one team of people proactively supporting a patient in their home, as opposed to the reactionary care offering of the hospital. A lot of new investment was going into that initiative across Derbyshire which it was hoped to have in place before the winter period.

Colleagues will be aware of pressures in Elective Care being reported in the press and at previous meeting at the end of February this year. Just under 80,000 patients across Derby and Derbyshire were on a waiting list, just over

7,000 more than in March a significant increase. Just under a third have waited longer that 26 weeks for treatments, and 13% have been waiting more than a year. A lot of work to segment the waiting list to understand complexity, need and time urgency. Over 4,000 patients need to be treated in the next few months and our focus was to treat those patients.

Cancer Restoration was another important priority. There was an historic high of patients waiting for treatment which reached a peak of 800 patients in May, which was a significant issue which needed to be resolved. The numbers were brought down in the summer months, but they started to increase again during the second COVID wave. However, from March there has been a decrease as Cancer pathways have been restored but it was an absolute priority to keep bringing the numbers down. Elective Care perspective means every piece of capacity that we can create needs to be used, every single theatre session, the CCG was focusing on three specialities orthopaedics, ophthalmology, and ENT. Need to maintain some the good practice put into play during COVID, like how much care could be delivered to patients without them coming into hospital for example like patients with low level vision issues who might have gone to the hospital, the CCG invested in optometry capacity in primary care, which will be maintained as good practice going forward. The NHS requisitioned the use the private hospital sector, Nuffield and Belborough Hospitals, for patient care over the last 12 months and they will continue to be used. One of the big constraints to good elective care performance was patient access to diagnosis, a lot of backlogs that have built up will have to go through a diagnostic process. Over the next 12 months will be increasing community diagnostic provision.

Another focus was Primary Care, most PCNs are targeted on delivering the vaccination programme. However, PCNs are also turning their attention to delivering business as usual. Some of the key aspects are a focus on Adults with Learning Disabilities, ensuring they have health checks; the children's vaccinations programme, getting it up and running again; diagnosis of cancer, screening programmes, flu vaccination, supporting care homes.

The officer then outlined the next steps which included maintaining progress, understanding risk and review of patients on the waiting lists; interface of primary care and hospitals to ensure pathways are synchronised and flow as efficiently as possible. Medium term recovery plans. Synchronicity between primary care restoration, hospitals restoration and health and community restoration to ensure the overall system was effective.

The Chair thanked the officer for providing a comprehensive overview of what was happening in the hospitals. He thanked all colleagues working in the health sector, for doing their best under very difficult time, providing care to people who needed treatment and medical interventions. He then stated that his understanding was that waiting times were lengthy before the onset of COVID, and that had been happening over months and years in a steady way, and because of COVID they increased further. It does not matter how well you were organised at a local level; without additional regional resources it would be difficult to shift the backlog which had been accumulating already and had now increased significantly. Do you see, without additional resources coming from government and co-ordination at that level, that we will be in a position to bring the backlog back down to a reasonable proportion.

The officer confirmed from a planned elective care perspective we entered the pandemic with a mismatch between demand coming into the system and the capacity. The pandemic has exacerbated that position. In terms of recovery it will certainly take two years or more; the problem won't be solved overnight. Through recent announcement from Government the CCG has an elective recovery fund which was targeted at restoring volumes of elective care. In the pandemic the need was seen to join services together; in the medium team we will see a much more effective use of the capacity we have in place. Intersection of choice, new money coming into system for better recovery elective care and capacity resource to be used effectively. Sufficient resource was available to deliver elective care ambitions for this financial year. What's needed for the following years was another matter.

A councillor asked about NHS 111, and explained that GP services are still overwhelmed by people finding it difficult to contact their GP. She asked if the uptake of NHS III and Walk in centres had increased? The officer stated that in terms of NHS 111 the numbers have been high, and there had been investment into that service which was being used. The Urgent Treatment Centres, of which there were five across the County, and one in Derby City, the CCG had not seen the level of recovery of patients going to those centres as had been seen going to A & E. The question was are those services fit for purpose, do they need to re-purposed so that they are used more. In summary NHS 111 was being used but UTCs still need to be used more.

The councillor explained patients can access NHS 111 to get an appointment at the walk-in centre, but they think that the walk-in centre was for homeless people or people without GPs. People don't realise they can access this service even if they have a GP. The officer confirmed that communications need to be improved; there were numerous entry points for care and the flow through systems in the NHS should be made simpler and be better signposted.

The Board resolved to note the two presentations

23/20 The Anticipated impact of COVID on the Community

The Board received a report and presentation from the Director of Public Health (DoPH), Derby City Council which provided an update on the anticipated impact of COVID on the community.

The DoPH explained the current COVID case situation up to 10th April 2021, and that the data would be updated on the 21st April. Good progress had been made with the numbers of cases, there were 57 cases of COVID 19 in Derby, a rate of 22 cases per 100,000 of the population which was at a similar level to that of September 2020. Although not all the tests go through to be tested for the Kent variant, it was in around 95% of tests that do go through. so, it was the dominant variant in the City and across the country now.

The DoPH then explained that as the pandemic has progressed there has been an increased understanding of COVID as a condition, and the correct

treatment for that has improved greatly. There has been an increased understanding of the disease process, with the role of inflammation in the disease, excellent discovery of a steroid treatment, dexamethasone was available, it was a reasonably priced drug and has worked well to reduce the impact of COVID for those people admitted to hospital. Other rare and more expensive drugs could be used to reduce inflammation included Tocilizumab.

There was a clotting risk identified with COVID, there have been concerns around the Astra-Zeneca vaccine and clotting risk and you will have heard in some explanations that, even if there was an association between clotting and vaccine, there was a much stronger association with COVID infection and clotting. People admitted to hospital with the infection need drugs to prevent clotting; Heparin injections could be used for this symptom.

There was also better understanding in place to assist with patients breathing, like “Proning” (placing people on their front so that it was easier for them to expand their lungs); also how non-invasive ventilation could be used, such as oxygen or positive airway pressure through using a mask.

The insufficient evidence of the effectiveness of Antibiotics if there is no bacterial infection associated, the use of Plasma, trials taken place which have not shown any evidence effectiveness also Hydroxychloroquine was highlighted. There was ongoing research in this area to look at any further treatments that may be of effect.

The DoPH then talked about what might lay ahead. There was a huge amount of uncertainty, highlighting the issues which may create this uncertainty, such as the vaccination programme and immunity. She explained that although the vaccination uptake was good, there are still a significant number of people who had not been fully vaccinated. It was unknown how long the immunity would last from the vaccination, there was a lot still to learn. In undertaking a relaxing of the measures, we need to see how well the population continue to follow the restrictions and guidance in place. Everyone has had a difficult year and want to get back to normal as soon as possible. However, it was important to follow the restrictions in stepwise manner. There was some uncertainty about details of Step 4 of the roadmap current plans in June. All we know is that there is plan to relax legal measures but we don’t know what other guidance or other measures will be in place at that time. When we relax in June the population will not be fully vaccinated which puts us in a position of risk. Those people unvaccinated are probably those who are mixing the most either out socialising or working outside of the home; a risk remains that the unvaccinated population may be a trigger for a further wave of the coronavirus.

The DoPH then stated that there was uncertainty about the impact of seasonality which was another factor; Sage (Government scientific experts) have done some modelling on when a further wave of coronavirus could be expected. However, it was good to think positively that the virus could die down in the summer and flare up again in the winter (seasonality). Looking back at last summer there was a lot of socialising and there was no vaccination available but the numbers of cases remained quite low, so there was hope for the same situation this summer, but there was always uncertainty about the impact.

The DoPH then explained that there was uncertainty about any appetite for changes in timeline or measures; for example if we get to May or June and see a resurgence of the virus, whether there will be political of societal will to return to any measures as the population was now keen to move on. Variants of concern are also an issue; the more that the virus circulates in the population, the more it multiplies, the higher the risk of creation of variants of concern. Development of variants have been seen in countries where it is spreading vigorously such as Brazil and India, so this needs to be closely monitored.

The DoPH explained the possibility of a third wave, SAGE have done some modelling and are fairly convinced there will be a third wave which could be as large as the first wave, especially if an increase in the numbers of COVID cases occur earlier in the summer when vaccination levels are less complete. If we follow the measures and guidance in place and hold back the increase in viral transmission, whilst increasing the vaccination of the population we may reduce the size of the wave, but there was a lot of uncertainty around that and it was also dependent on what the rest of the country does, as well as Derby. The DoPH was expecting that the numbers of cases would be low until late May.

The DoPH highlighted that it was predicted that 60-70% of hospital admissions and deaths would be those people in Group 1, even though they would have received two doses of vaccine; no vaccine was 100% effective so it was important to maintain the measures in place. It was likely that we will see a lot of variation in cases and deaths across Derbyshire, but also between counties and regions. Inequality was driving the transmission of the virus and vaccine uptake significantly. Those communities who are more deprived or with populations mixing more socially or out at work and with lower uptake of vaccine, were more likely to get outbreaks.

The DoPH described the possible impact of COVID on the community, there was no data as yet for the City itself, but national work has been done. Marmott undertook a COVID 19 review “Build Back Fairer” which looked at some of the key impacts

- Mortality from COVID has been affected by underlying health conditions, deprivation, inequality, living conditions, occupation, and ethnicity. All these things have added together to increase vulnerability of individuals, along with those individuals who are male and those who are older
- Children have suffered significantly both from the impact of COVID in the community and from measures taken to reduce the spread. There was an increase in child poverty, there are concerns about the impact on mental health, possible exposure to abuse or witnessing abuse, and youth unemployment was significantly affected
- Containment and isolation have impacted on many behavioural issues such as smoking, alcohol intake, obesity has increased, mental health has deteriorated, and those at risk of violence/ abuse have increased.

There was further national data from Public Health England looking at national survey data on wider impacts of COVID-19 on health. Mental Health was an

issue; there was an increase in anxiety, depression and loneliness and a decrease in life satisfaction. However, there was an improvement in air quality as you would anticipate as people moved around less, but this may reduce back to the position before the Pandemic as people begin to move around again. There had been a decrease in the consumption of alcohol for 18 to 34-year olds but an increase for 35 to 54-year olds. There was increased alcoholic specific mortality, significant alcohol intake and the impact on health of that. However, the number of people who had quit smoking without help had increased, but Public Health were expecting an increase in inequality in quitting of smoking, those from more affluent groups quitting more and those from more deprived groups less. There has been an impact on life expectancy from the increase mortality for COVID.

The DoPH explained that over the coming year Public Health would continue to respond to the pandemic, whilst anticipating a further wave and the work needed to reduce that. A lot of work linking in with inequalities and vaccine uptake had been undertaken. Public Health continue to monitor the accessibility of testing in the City, both Symptomatic and Asymptomatic testing. They had recently taken on local zero contract tracing which was immediate contact tracing undertaken by the local area; cases are passed to us immediately and we try to contact all of those positive cases, which enables us to have the local discussion and understand peoples challenges if they need support to isolate. Public Health are continuing to review emerging local data to see what the impacts are for the City and to prioritise their response. There was a national dashboard available with data on the wider impact of COVID on health, but the current data only reports up to 2019. There was national direction for Public Health programme, and ring-fenced funding transferred to local authority for managing obesity and for alcohol misuse. Public Health are continuing with that work whilst looking to assess the impact on Derby and Derbyshire from COVID.

A councillor asked whether there was data available on increased poverty because of COVID restrictions to stop the spread of the coronavirus. The DoPH explained there was no data available at present, but there were concerns about the unknown impact of furlough, such as increased job losses through that time. The councillor then asked whether relaxing COVID restrictions measures on 17th May could cause a rise in cases by the end of May. The DoPH explained that the case rates are expected to be low until the end of May but we know that if the data looks good, measures could be relaxed in May, it would take about 3 weeks to see the impact fully of that. which would be towards the beginning of June.

There was an interdependence between the implementation Vaccination Programme and relaxion of measures which highlighted the need for speed of the vaccination programme and the need for people to remember the COVID protection measures (social distancing, hand washing and face coverings); the better these measures are followed the further we push out the increase in rates and the lower any peak will be.

Another councillor asked, if there was a rise in cases in Derby and Derbyshire; could any local action be taken or was there a need to wait for national guidance to come through which would take two weeks. The DoPH explained that the national legislation was prescriptive, there were limited areas that we

could act on locally. However, we can engage with local businesses, building up relationships and giving guidance and advice when we have seen issues. The legislation locally mainly relates to particular premises or events rather than a population impact.

A councillor then asked how “Test and Trace” was going in Derby and Derbyshire. The DoPH explained that there was good access testing in the City with four symptomatic test centres; capacity was available to get a test and the results are coming through quickly now. Asymptomatic tests at home were available for everyone. Contact tracing was now being undertaken locally; when the positive result was given it goes straight through to the health team who are making phone calls, the main issue of not being able to contact being that people were ill and in hospital or the contact details are incorrect. If they are unable to contact people then PPOs will visit the property to encourage people to engage in an early conversation on 1st or 2nd day after diagnosis, rather than seven or eight days later.

Councillors felt that there was a good opportunity to control the spread of COVID now as the numbers of cases were low in Derby, making it easier for tracking and tracing purposes. When it starts building up into the hundreds then it becomes more difficult and it would mean much more resource would be needed. The DoPH agreed it was a good opportunity but also explained that one of the biggest issues, both in Derby and nationally, was that some people would not want to come forward to be tested in case they receive a positive diagnosis and must isolate. The phone call was a good opportunity to establish whether there were any barriers to the person isolating.

The Board thanked the DoPH and staff for their excellent work.

The Board resolved to note the report and presentation.

24/20 Childhood Vaccination and Update on data

The Board received a report and presentation from the Director of Public Health (DoPH), Derby City Council which provided an update on data for Childhood Vaccination.

The DoPH explained that the key purpose of the presentation was for the Board to consider progress and to provide reassurance on childhood immunisation since the meeting held on the 4th February 2020, and to update the Board on planned changes to the Public Health system.

The DoPH explained that although the Adults Scrutiny Board were planning to seek assurance about childhood immunisation through the Derbyshire Health Protection Board this Board had only met once since the last Adults Scrutiny meeting. The frequency of the meeting was reduced, and the work has been realigned to the COVID Health Protection Board, but the meetings would be re-established, and the Scrutiny Board would be provided with a further update. The work that we conduct around childhood immunisation was with the Screening and Immunisation Team, which was a team from PHE who are based within NHS England; they are the commissioners of the Childhood Vaccination Programme. The staff in the team were re-allocated to respond

to COVID and were only back in their substantive role towards the autumn of last year. National Public Health functions are currently undergoing reorganisation so there are discussions around the responsibility for screening and immunisation sitting with the local integrated care system, rather than outside of that with NHS England; we are not clear where the PHE teams will sit in future. Finally, with Public Health, anticipating publication of a National Strategy on immunisation, which had been expected to be published in spring 2020 but was still awaited, it had not been possible to establish any local actions.

The DoPH then presented a graph showing national data looking at Diphtheria, tetanus, pertussis, polio, Haemophilus influenzae type b (Hib) and Hepatitis B vaccinations up to 6 months of age. These are the vaccinations delivered to babies at 2, 3 and 4 months. The blue line indicated the numbers of vaccinations given to babies during 2019 nationally and we can see the figures for 2020, there were some variations, some changes but actually it was really well maintained, Practices maintained their focus and parents of really young children were engaged with local health services. With the MMR immunisations between 12 and 18 months of age there had been a dip in performance during weeks 11 to 15 but this was not a significant impact.

A further graph showed the Derby coverage data for various different vaccines, Diphtheria, Meningitis and MMR; these are doses and different age period. The DoPH explained that in 2019/20 performance was around or just below the English average. Looking at the latest data in quarter 3 for last year, the figures were relatively well maintained, which was really reassuring news as it showed the Children's Vaccination Programme had been relatively well preserved. However, there was a lot of work to do around the second vaccination for MMR in 2019/20. Derby was at 83.8% of the uptake of the 2nd vaccination by five years, the 2nd vaccination was important to ensure there was maximum immunity in the population. The latest data was at 82.3% so there was still a lot work to do.

The DoPH highlighted the opportunities for the Childhood Vaccination programme:

- The transfer of PHE/ NHSE responsibilities for commissioning vaccination programmes – still awaiting strategic direction to see exactly what the implications will be
- Learning from extensive COVID vaccine inequality work, good learning that can be transferred through the other vaccination programmes
- Development of stronger working relationships with communities.

A councillor asked if there was greater hesitancy amongst ethnic groups regarding childhood vaccinations, if there was something embedded in culture or tradition then it would show up for other vaccinations. The DoPH explained that there were different issues relating to different vaccinations and populations, there have been concerns around the nasal flu vaccines for children. There are many factors involved in the reduced take up of vaccines, sometimes it was the accessibility of services, of everything that is happening in family lives at the time of the vaccination. Relationships between parents and medical staff are intense in the first three months of a baby's life; as children get older the contact between medical staff and families reduces.

A councillor queried whether a Rubella vaccination was delivered to girls at the age of 10 and 15 years. The DoPH confirmed that Rubella was now covered in the MMR vaccination. She queried why there were no teenagers in the graph. The DoPH explained there was a Tuberculosis vaccine, but it was now delivered to babies either living in a risk area or with relatives at risk, so it was now a targeted vaccine programme. A cervical cancer prevention vaccination was also delivered at school to girls and boys which was delivered in year 8 to 9. It's usually given at school but last year Derbyshire Health Services delivered this vaccine by using a mobile vaccination programme "drive through"; the uptake was good for people with cars, and they were now waiting to see the full impact and whether there were any inequalities aspects that needed to be picked up. That was the school age vaccination programme along with pre-University booster as well.

The Board resolved to note the report and presentation.

25/20 Work Programme and Topic Review

The Board considered a report of the Strategic Director of Corporate Resources presenting the proposed work programme of the Board for the remainder of the 2020/21 municipal year.

The Chair explained that the Board had decided to investigate issues arising from the spread of COVID at the time and the impact on older residents particularly, those in residential care for a Topic Review. The Board had thought they might be able to speak to residents and carers to get their perspective on the issue. However, this had been difficult due the spread of COVID. However, the Board do need to conclude the Topic Review, so they asked if the DoPH could put together a report or briefing which covered the initial period when the first COVID cases were identified in Derby, and perhaps comment on Derby's readiness. By the time we heard about the first case in China we knew it would be heading our way. The first case of COVID was identified in China in mid-December, and the first case came to Derby at the beginning of March, so we had approximately eight weeks to prepare, if we had acted promptly. But we were slow to react and put some preparation in place. Could the DoPH provide a story around these events, ultimately the focus would be around could we have done better, and perhaps make some recommendations where we could have done better to improve the situation for everyone.

Ideally the topic review should have been concluded in this meeting and a report taken to Cabinet early next municipal year, but the focus was on containing the COVID virus, so the Topic Review was of a lower priority overall.

A councillor suggested that the Board needed to understand the timescales. Derby did not have a case before March, but we all know that COVID was here way before March but, before we received national guidelines, we could not act. Can we have a review on the timescales coming in from national government. Could we have done anything before the national guidelines came in, were we relying on central government and they were slow to act ?

Could we tell a story as to how the whole thing unfolded, nobody knew a pandemic was coming or how hard it was going to hit. We need to establish what happened, how it happened and if we could get some legislation put within the city boundaries. If a third waves does come can we act before the national guidelines come in, can we pre-empt national guidelines with local legislation ? Another councillor warned that when doing analysis there was a need to avoid hindsight. Look back at what you've done and failed to do.

The DoPH confirmed that a presentation/summary or briefing could be put together, and stated that actually in March last year there was no information about cases in the City, and that was a very important aspect to around where we were then and where we are now and the detail we now know.

The Chair said the aim to conclude the Topic Review at the meeting in June which will allow us to pick another topic to review. The expectation was that each Overview and Scrutiny Board completes at least one review a year.

1. **The Board requested that the Director of Public Health bring a briefing to the first meeting of the next municipal year covering the initial period when the first COVID cases were identified in Derby and comment on Derby's readiness.**

2. **The Board resolved to note the contents of the report.**

MINUTES END