ITEM 04

Time commenced – 18.00
Time finished – 20:35

ADULTS AND HEALTH SCRUTINY REVIEW BOARD

15 June 2021

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

In Attendance: Andy Harrison, Derbyshire Healthcare Trust
Mick Burrows, NHS Derby and Derbyshire CCG
Gareth Harry, Derbyshire Healthcare NHS Trust
Geoff Neild, Derbyshire Healthcare NHS Foundation Trust
Louise Swain, NHS Derby and Derbyshire CCG
Michael Hammond, University Hospitals of Derby and Burton
Robyn Dewis, Director of Public Health, DCC
Kirsty McMillan, Director of Integration and Direct Services (Adults)

01/21 Apologies for Absence

Apologies were received from Andy Smith, Strategic Director Peoples Services

02/21 Late Items

There were no late items

03/21 Declarations of Interest

There were no declarations of interest

04/21 Minutes of the Meeting on 20 April 2021

The Minutes from the meeting of 20 April 2021 were agreed as a correct record.

05/21 Improving Mental Health Inpatient Facilities in Derby

The Board received a report regarding improving the mental health inpatient facilities in Derby. The report was presented by the Senior Responsible Officer, Acute Care Capital Programme Derbyshire Healthcare NHS

Foundation Trust and the Programme Director, Dormitory Eradication Derbyshire Healthcare NHS Foundation Trust.

The officer informed the Board that this item was originally brought to the February meeting to discuss changes to local inpatient (hospital based) mental health services. Plans were discussed to improve local facilities through national funding which had been identified to make sure that the services provided locally could meet national standards.

Since the February meeting confirmation of the level of investment allocated to Derbyshire to make improvements has been received. £80 million has been identified from this national funding to replace old buildings with two new units of 54 beds on two sites, one in Derby and the other in Chesterfield. The funding must be used, and buildings must be in place by 2024.

National policy details the following "must do" improvements; Mental Health wards should consist of single rooms each with an en-suite bathroom where possible; nobody should have to travel outside of their local area to receive acute mental health care.

The Board were informed that the development at Kingsway Hospital would be a new 54 bedded male facility, three wards of single ensuite rooms. The development at the Chesterfield Royal Hospital site would also be a new 54 bedded facility with single ensuite rooms, across three wards; this would support men, women and non-binary patients and will replace the Hartington Unit on the site.

The officer stated that in addition to seeking support for the national funding for the two schemes, the Trust was looking to obtain local capital funding from the Joined Up Care Derbyshire (JUCD) system for a refurbishment of the Radbourne Unit in Derby to provide 34 female single rooms across two wards to completely eradicate dormitory style wards and at the Kingsway Hospital site a new Psychiatric Intensive Care Unit (PICU) for 14 men together with eight new beds were planned in an "acute-plus" unit for women. The Board were informed that no beds would be lost in the developments.

The Board were informed that the Trust has plans in place to liaise with the internal and external stakeholders with an opportunity for public and other interested parties to share their views through a survey which was planned for July and August 2021.

A councillor was concerned that there would be no loss of beds once building had been completed, also would the wards still be used for Mental Health Services. The officer confirmed that a decant programme had been designed. The planned refurbishment of Audrey House would enable 10 beds to move from the Radbourne Unit to Audrey House, to facilitate refurbishment in the Radbourne Unit during the nine-month period they would only be down 2 beds.

Another councillor highlighted the need to establish more acute mental health facilities locally, it was recognised that when people have to be placed outside the County for treatment it would mean relatives would have to travel a longer distance to visit. Councillors were aware of the need for more local mental

health beds and welcomed the opportunity to improve services. The councillor then asked if 14 Psychiatric Intensive Care Units (PICU) Beds would be enough to place people who are currently place out of the County. The officer confirmed that modelling indicated that 14 beds would be sufficient to meet the needs of Derbyshire. Currently 16 patients are placed outside of Derbyshire in PICUs and 0-2 patients in the Acute area. They were aiming to locate them as close as possible to Derbyshire, and to put in place a transport facility for relatives. The councillor suggested that a sentence could be included in the recommendation to the effect that, for an interim period, where patients have been placed out of county their carers should be offered assistance to visit their loved ones if they have problems travelling to see them. The process should be facilitated as carers should be able to visit their relatives.

Another councillor queried how consultation with residents would take place, particularly around Kingsway. The officer confirmed that engagement with residents would be part of the engagement plan over the summer months, particularly with those nearby the site. The councillor then asked why the Audrey House Rehabilitation Unit was not being used as this was a very important service. The officer confirmed there was an alternative unit on the Kingsway site where there were sufficient beds available for current demand.

A councillor noted from the report that the national funding received was less than initially hoped for and there had been a need to reconfigure services. How had the services been reconfigured? The officer explained that if more funding had been available then having the new build on the Kingsway site would have meant that they did not need to re-utilise the Radbourne Unit, however, the £80 million was a fantastic investment for Derbyshire.

The Board resolved:

1. **To note the opportunity for the improvement of Mental Health Care Facilities in the City and County particularly previously absent Psychiatric Care Facilities.**

2. **To recommend where patients had been placed outside the County their carers should have assistance to enable them to visit their loved ones.**

06/21 London Road Wards 1 & 2 and Cancer Services – Update Report

The Board received a report regarding the London Road Community Hospital Wards 1 & 2. The report was presented by the Director of Business Improvement and Transformation Derbyshire Healthcare NHS Foundation Trust.

The Board noted that the University Hospitals of Derby and Burton (UHDB) had written to the Derbyshire Healthcare NHS Foundation Trust (DHcFT) to formally request the use of Ward 1 on the London Road Community Hospital site on an interim basis.

The Board were asked to support the temporary changes to the services provided at Ward 1, London Road Community Hospital (LRCH). It was planned to move the ward's current mental health in-patient services to the Kingsway Hospital site so that Ward 1 can accommodate urgently needed cancer and Lymphoedema services. Additional space was needed for clinical services because of social distancing needs due to the Pandemic, there was also a growth in the waiting list for the service. If the move of the mental health services becomes permanent, then an engagement/consultation process will take place.

The Board were informed that the date for the move of the mental health in-patient services was 16.06.21, and that the services would be closer to other mental health services on the Kingsway site. Communications would be developed to inform patients of the change.

A councillor recognised that there was currently a large backlog of people awaiting treatment but sought reassurance that the move would not be at the expense of the quality of life and care for mental health patients. The officer stated that the services/offer are better facilitated at Kingsway and the surroundings are also superior to London Road, parking was free. It was felt that a move to the Kingsway site would be a better experience for both visitors and carers. The officer confirmed that the move was an interim one and then explained that the Board had been previously informed about the longer-term plans for a 60-day consultation to permanently transfer the Ward 1 service to Tissington House at the Kingsway Hospital site. These plans would be brought back to the Board at a future date when they wanted the move to be permanent. A councillor asked about timescales for consultation after the temporary move. The officer confirmed that it would be imminent after the move, looking at months rather than years. There was a need to plan a consultation.

Another councillor asked whether there was a regular bus service to the Kingsway site. The officer confirmed that bus routes were excellent, and there was just a ten-minute walk from Uttoxeter Road to the site. It was planned to undertake a travel analysis to understand the impact on carers and patients. The officer acknowledged that it was not a perfect interim solution as some people would be affected, and as part of a more permanent move there would be a need to have the views of more people. Currently no issues had been raised by carers, but they would be supported with funding if transport was a problem. A councillor asked if it would be possible for the shuttlebus from the London Road site to make a detour to the Kingsway site. The officer confirmed it was not far in distance, however the increased time taken to travel the route might cause issues, but the option could be explored.

The Board resolved:

1. **To note the report and**

2. **Noted the future opportunity to discuss longer term plans for a 60-day consultation to permanently transfer the Ward 1 service to Tissington House on the Kingsway site.**

07/21 London Road Community Hospital Transformation Project – Wards 4, 5 and 6

The Board received a report regarding the London Road Community Hospital Transformation Project, Wards 4, 5 and 6, which was presented by the Assistant Director for Joint Community Commissioning at Derby and Derbyshire CCG (DDCCG) and the Strategic Improvement Programme Manager – Unplanned Care at University Hospitals of Derby & Burton (UHDB).

The officers explained that prior to the Pandemic Wards 4, 5 and 6 provided short term rehabilitation nursing beds. An Independent review of people's needs was undertaken in 2018/19 which highlighted that not enough people were being discharged home, too many were remaining in a hospital bed. A Clinical Audit undertaken in 2019/20, concluded that assessment and discharge planning for patients could take place in a venue that would be a better match for a patients final discharge destination and would reduce the number of days in a hospital bed, it would also reduce the harm often caused by longer stays in hospital as they can lead to worse health outcomes for patients, and can increase their long-term care needs. The Audit highlighted that approximately 80% of patients did not need a community hospital bed.

Following the outbreak of COVID 10 in March 2020 the National Health Service England/Ireland (NHSE/I) published a document entitled COVID 19 Hospital Discharge Service Requirements which included agreement for Continuing Healthcare (CHC) funding processes to be simplified and funded by NHSE/I. The Royal Derby Hospital focused on discharging patients from Wards 4,5 and 6 to enable these wards to re-purposed to support the COVID 19 response. Within three weeks all three wards at the London Road facility were empty.

Thus, an opportunity was created for the existing discharge strategy and plans to be reviewed and for a new model of care "Home First" to be put in place. "Home First" sometimes called 'discharge to assess', 'safely home' or 'step down' is where people who are medically fit to be discharged and do not need to stay in an acute hospital bed, but may still need care services, can be provided with short term, funded support to be discharged to their own home (where appropriate) or another community setting. An assessment for longer-term care and support needs can then be done either in the home or community setting and at the right time for the person.

Funding was invested in areas that the Trust wanted to develop. Home Care Delirium Support was boosted to enable patients to be cared for in their own homes. A Dementia Palliative Care Team and a high-level specification for a Nursing Hub to deliver supportive care were launched. The changes were aligned with existing strategies with the aim of meeting patients needs more effectively. Existing staff could be trained to a higher level giving them job security and allowing Adult Social Care Staff to work with the NHS staff. Patients needs would be met in a safe environment.

The officer explained that the new delivery model enhanced what was currently being delivered. The presentation gave an idea about allowing

patients to be discharged home rather than going to a Care Home or to Wards 4,5 and 6. It was too early to assess but the new model seems to work and it allows people with more complex behavioural needs to be supported in their own homes. Home calls are available overnight and more care staff are being supported and given training to manage the needs of people with challenging behaviour. The Case Study work undertaken looked positive. An example was given of a frail, elderly person who had an infection which caused delirium who was discharged home with initial support for 20 days, 4 calls per day by carers which was eventually reduced to 1 call of 30 minutes per day.

The officer explained that the CCG did not need to contact Regulators or hold a full-scale Gateway Review, but they do need to engage with local stakeholders such as the Scrutiny Board to provide information about the changes. Engagement had taken place in the City and County, also with staff in integrated services, and with the patients and people in the communities. Patients experiences have been collected and audits have been undertaken with patients to better understand their needs.

A councillor asked whether the changes to Wards 4, 5 and 6 to help the COVID crisis had enabled faster discharges. The officer confirmed that there had been challenges in discharging patients during COVID, but they were now in the position to make more effective decisions. Another councillor raised concerns about patients being discharged to their own homes when there was a shortage of care workers. It was usual for patients to be passed on to the private sector within two weeks, sometimes they return to hospital. The officer confirmed that there was a recruitment problem as the work was not highly paid, it was difficult and demanding and a special skill set was needed. A trial project had been undertaken with DCC Managers to recruit an additional 60 care workers; funding was available but only fixed term contracts could be offered. It was a challenge, but the greater the investment the more robust it will be, patients' needs can be met, and their recovery would be better, and they would be able to remain in their own homes.

A councillor asked whether patients outcomes could be monitored. The officer explained that work was ongoing in partnership with a Senior Public Health Analyst at DCC who had designed a suite of outcome measures to monitor what had happened to patients both pre and post-operative.

Another councillor stated that the local authority does not employ Care Workers. The officer explained there was a distinction in terms of Care Workers in that the enhanced Pathway 1 provision (intermediate care and reablement services provided in a patient's own homes) is provided by local authority staff and long-term Home Care Packages are provided by the private sector. Some Care Workers were employed by DCC and work in the Pathway 1 area. Training was provided for Pathway 1 workers and it was the intention to provide training for "Home First". A councillor asked whether the CCG would be funding training for private sector care staff as the private sector would not provide funding support from their profits.

The officer highlighted that the care pathway was not just about discharge but about care to avoid going into hospital in the first place. If a patient has come into a hospital with complex health and social care needs, they would be discharged into a Community Hospital. Pathways are a period of assessment

which was better undertaken in a patient's own home, where they can rehabilitate. A councillor was concerned about relying on Care Workers and was sceptical of the training which would be provided. Another councillor highlighted that the scheme proposed was a Managed Hospital Discharge Scheme which had been in place some 20 years ago. An older person goes into hospital, has an intervention, the hospital looks at the best care option going forward. In most cases Home Care is sufficient, in other cases they are assessed elsewhere and provided with a costly Care Package, once the discharge team has made the decision the financial burden would pass to the local authority. Care at home is financially assessed and can be prohibitive, more thought needs to be given after the first few months. The officer confirmed that there would not be a passing of responsibility for the patient. If a patient has social care needs, they will need to be referred to the local authority, if joint needs they would be met by both the NHS and the local authority, if just health needs then by the NHS. The officer explained that the project was not about long-term care, the assessment would allow the NHS to make the best decision as to care needs for the patient. If there are complex needs, then the decision would be made by a Panel. For normal Care Home needs the family will decide. The concern that the councillor raised would not have an impact as the assessment would only be for a very short period of care. The best decision for care for the patient would be better made in the patient's home. The councillor re-iterated that discharge arrangements where possible need to get people discharged to their homes which was the first option, the concept had been in place for 30 years. The officer agreed but emphasised that the NHS were trying to provide a better process. Patients with complex needs are difficult to look after in their own homes and they were previously being put into Community Hospitals but with this scheme they could access care and remain in their own homes while being assessed.

Another councillor queried how the communications were being made about the transition and change amongst the agencies, how are you making sure they are getting the communications. The officer explained that they are trying to make the discharge a multi-agency process rather than being a hospital decision; it was to be a multi-agency decision, agencies working to the same principle and pathway planning will enable a better decision to be made.

A councillor asked how many beds would be lost because of the new process. The officer explained that beds were being lost but that it was a gain of alternatives rather than losing beds, the councillor repeated the question how many beds would be lost. The officer confirmed that the number of beds in the 3 wards totalled 76, those 76 beds are now not open, they are not there anymore, it was a change of resources. The councillor asked what the wards would be used for and why wouldn't those beds be re-purposed, at the moment there was no permanent loss of beds. The Councillor then asked about people who do need hospital beds, the officer explained that there was provision through Derbyshire Healthcare Services there was a total of 96 beds across the county that are available as Community Hospitals Beds. The Councillor stated that none of those beds are in Derby and asked what would happen to people who have no family to help or have an inadequate home. The officer stated that pathway 2A beds are available which are residential beds but not nursing beds they are at Perth House, although they do not have

medical input, they are 24 hour cared for beds, there are also residential nursing home beds with 24 hour health support and social care in reach.

A councillor suggested the following recommendation. The board appreciates that for many patients with delirium or dementia being in a homely position and or family setting is beneficial, however the Board is concerned that many people do not have adequate home provision to return to, that home care resources may be stretched to the limit or may be inadequate and we note that the number of hospital beds per head of population was already at a bare minimum. We had some anecdotal evidence rather than statistical and rigorous evidence of the benefit of this care. So therefore, the Board would recommend that further evidence of the adequacy of post transformation of care be provided especially relating to those who do not have support and that all the local outcomes are reviewed prior to any closure of wards or beds.

A councillor asked if the recommendation could be shortened. Another councillor asked if the officers would be coming back to the next meeting as the Board would like to keep track of the position. The officer confirmed that this was their engagement and stakeholder management; and the Adults Board was important in the process for them. They suggested that they could bring the information outlined above back to the next meeting in October.

A Councillor suggested reducing the recommendation to read “The Board would like to see further evidence of the adequacy of service post transformation of care be provided and all the outcomes locally are to be reviewed prior to any closure of wards and the loss of those beds”.

After some discussion it was agreed that officers should return to the meeting in October with further evidence of the adequacy of service post transformation of care and that all the outcomes locally should be reviewed. An officer asked what was meant by local outcomes reviewed. The councillor explained that in the report that national evidence says that it has these benefits, but we have not had a lot of detail on local outcomes.

The officers were also asked to use fewer initialism and less non numerical references with no reference back in the written report. It was suggested that a glossary could be provided.

The Board would like to see further evidence of the adequacy of service post transformation of care. All the outcomes locally are to be reviewed and an update report is requested for the October meeting.

08/21 Learning from COVID

The Board received a report and presentation from the Director of Public Health (DoPH), and the Director of Integration and Direct Services (Adults) The presentation gave an overview of the Learning from COVID.

The Chair had invited the officers to come this meeting to give a brief report or update on learning from COVID following the fact that it had not been possible to generate the topic review as planned by the Board last year.

The DoPH confirmed that at the last meeting she had taken the action from the meeting to particularly consider the beginning of pandemic and how well Derby City Council were prepared. In the narrative today she would cover National and local planning, the progress of Pandemic, the impact on the population and areas for consideration for future topics

The DoPH explained that the first cluster of cases in Wuhan were on 31st December 2019, it was two weeks until the first case arrived outside of China in Thailand on the 13th January. The first COVID case in the UK was on the 23rd January, which was a young person and mother from China, it was very much contained and there was a large response to individual cases. On the 30th January WHO declared a Public Health Emergency of international concern. The first confirmed case in Derby was on 6th March, it was a hospital in-patient, information regarding the case was held by Public Health England (PHE) who had contacted Derby Public Health to inform us of the case but gave no further information. On the 11th March the World Health Organisation (WHO) declared a Pandemic. This was the first pandemic to be declared that affected the UK since the 2019 Swine Flu Pandemic. In mid-March the number of cases in the UK became such that PHE were struggling with contact track and trace. It quickly became clear from the national data that a similar response as the one for Swine Flu would not be appropriate and a first lockdown on 26th March was declared. Over that three-month period (January to March) there was initially a slow realisation then a rapid response. On reflection we were prepared nationally and locally for an influenza pandemic, which was an entirely rational response. In the past we had experienced the 1918 flu pandemic, and the Swine Flu pandemic 2019, so we were expecting an influenza pandemic probably from avian or other animal source. There were local and national influenza pandemic plans in place, and they were led through the local Health Resilience Partnership as a part of emergency planning, and this was also the national process. Also looking back at other public health emergencies of international concern such as Ebola, Zika and SARS, the fact that the WHO declared an emergency of Public Health of international concern did have not impact on us in this country; it was an international issue and it was not necessarily going to impact on us in this country. So previous experiences of pandemic influenza and emergencies of international concern did not get to UK. Swine Flu in 2019, was also very much an NHS and Health Protection Agency response to treat and vaccinate individuals. Initially anti-viral medication was given to people who were positive and then it was rapidly declared a pandemic in April by September/ October there was a vaccination. It is a very different response to treat influenza to a Novel virus such as COVID 19 and we were unsure of how to treat at the time it arrived.

Locally Public Health Authorities were not given information about individual cases, only information about the number of cases in the City so we knew when new cases were diagnosed. Public Health worked with the University Hospitals of Derby and Burton (UHDB) and were able to access their data to look who the cases were, and to learn who was most vulnerable and at risk. This helped us to understand what we needed to do with the local population. It was an incredibly challenging time, the process was all being nationally led, data was held nationally as was contract tracing and there was a national test and trace process established with national guidance around that. We were

able to look at local data and the national guidance we had and interpreted them so that we could assist our internal services and partner organisations. As a part of that process there was a lot of media engagement such as radio, television, and the local papers to disseminate information and guidance. However, over time there was increased data sharing and around summer last year we began to receive detailed information about cases so we rapidly progressed from knowing very little about cases to knowing individual details of those people and to develop a local track and tracing team, and to have conversations with people to identify contacts. From this week we can follow up with the contacts. However, we were not originally set up to undertake contract tracing, it was never envisaged when PHE was developed from the Health Protection Agency. All health protection functions such as contact tracing, identification of infectious diseases and following up with clusters and outbreaks were all led by PHE and the Health Protection Agency. We are looking now at what our role in the future will be. A local Incidence Management Team involved all partners locally including the Police, Infection Control Team from the hospital working with care homes, appropriate Directors within Council such as Social Care and Education were all in the team and could share information, there was key input from Environmental Health colleagues. Relationships and contacts were developed, and we gained a clear view of what was happening in the City. Key learning has helped in managing any situations that have developed. There were Groups, relations and structures set up that could meet quickly if there were issues that needed to be managed with Schools, Care Homes, and the University. Early in the pandemic an outbreak response plan was developed in which these groups and structures were described, only when we implemented them did, we understand how they worked, so we learnt from live experience. There is a huge amount that we can take forward to the future, learning about the importance of those relationships and how we can manage such situations in the future.

Since the beginning of the pandemic Public Health have been tracking numbers in the various local authorities including West Midlands. Early on Derby's case rates reflected those in the West Midlands rather East Midlands. The cases shown on the slide are our CIPFA neighbours; they are similar Local Authorities and have a local population with similar characteristics to ours. There is a lot of information about the risk and prevalence of virus relating to population, also about chance and geography. Derby tracked with Walsall closely until early spring when they moved above us. Bolton moved upwards at the end as the Delta Variant started to spread which was different to other local areas, Medway was very impacted by the Kent variant, they were tracking quite low but then they took off to the top of the pack. Reflection about populations shows what was similar but also that geography and chance about contacts and where the variants are and where they come into the UK also have an effect.

Reflecting on deaths, data from 2020 shows that there were 2,750 death registrations in the Derby City, 400 had a confirmed COVID 19 cause of death, and 16 had COVID 19 as the only cause on the death certificate others had contributory conditions. Deaths have been strongly linked not only to those other conditions and the health inequalities including deprivation, ethnicity, and social circumstances such as crowded housing and the occupations of individuals.

The DoPH talked about the impacts of COVID and lockdown on the health of the population in the City. There was a significant impact on Mental Health, Long COVID, there were changes in risk factors such as a decrease in smoking initially, but smoking in the most vulnerable groups did not decrease, alcohol is a risk people are now drinking more. Obesity there was now information about childhood obesity, changes in NHS delivery from physical to virtual delivery, an increase in waiting lists, Health inequalities etc.

The Director of Integration and Direct Services (Adults) talked to the Board about possible future COVID related topic reviews that could be undertaken. The Care Home Topic Review could be reconsidered and take place at a later stage and with revised terms of reference, as learning about the experience of families and residents was not feasible during the pandemic. It was highlighted that access to the NHS significantly changed during 2020 and lots of areas of activity ceased completely, the NHS was now in a restoration phase of trying to re-open and catch up on services.

Other options for a Topic Review suggested were Primary care access to GPs, other areas of primary care, acute care (operations). Most of the NHS and Adult Social Care contribution was around the vaccination programme. Specific areas focused on by the DoPH and Director were vaccination for higher risk groups, people exposed to more inequalities. Generally what COVID has exposed is the impact of health inequalities which made the difference to survival. The Board could consider taking a general look at health inequalities.

A councillor asked whether the University was undertaking vaccination rather than the NHS. The DoPH confirmed that the vaccination campaign was now NHS delivered but this may change in the future. Currently when young people go to University the Practice they register with will check vaccinations to be sure they are up to date. In future this might be a good opportunity to include the COVID vaccination in questions. Currently it is organised and delivered in a central programme which was imminently due to deliver the vaccination to 18 years upwards.

A councillor stated that part of idea of the Topic Review last year was to see what lessons could be learnt locally. If in 5 years' time an unexplained infection arose again, he thought that the country and Derby would go through the same process again, wait and see to understand the virus and it's effects, carry on with normal life etc. A National Review when it has been put in place will look at things in much more depth. Locally in Derby there was not much we could have done differently, unless we could put things in place earlier than nationally. For instance, Care Home residents could not be kept in hospitals as the beds were needed for COVID patients. The DoPH reflected that they perhaps should not be looking at things through the lens of flu, pandemic Flu impacts working age adults, older people are not so significantly affected, during the 1918, Flu Pandemic working age people were dying. The key learning was not to look at things though pandemic flu, step back and see if there are any other characteristics.

A councillor wanted to explore the sharing across different disciplines and agencies and asked how that would be embedded in our processes in future,

as it was a good thing to have learnt and should be retained. The DoPH agreed that it had been key, the main part had been the relationships established. Relationships had been developed with parts of council we did not know so well, with the University and established with the schools through the Schools Team. There are now routes of communication and the ability to have early conversations that were not in place before.

The Director of Integration and Direct Services (Adults) stated that she had met worked with more people in the last 18 months than in all of her time in Derby previously. They were thrown together but connections have lasted, working with people in a crisis was galvanising, but what would be challenging now would be ensuring that organisationally all the partners don't return to their own worlds. A lot of new rules had been put in place nationally, to enable people to work together such as information governance, working time directives. Once the rules revert back to normal barriers could return.

Another councillor asked whether there was still vaccine hesitancy and whether it was more prevalent in certain age groups. The DoPH stated that they have not got complete coverage in vaccination programme there are still individuals still who need to be vaccinated. There was a working group set up to try and understand why people do not take up vaccines. The group communicates with the community and community leaders to try and understand the issues, it was not always about physical access, there are other causes for example confidence in the vaccination and who was providing it. However, the Programme is doing well nationally but there was a need to keep an eye on the younger age groups, but the response has been positive so far.

A councillor noted that 16 of total number of deaths had COVID as the only cause of death and asked if the officers were aware of any particular home care and social care needs for people with long COVID. The Director of Integration and Direct Services (Adults) explained that it was too early to say. Clinics have been set up but as yet an increase in cases in Social Care has not been seen.

A councillor asked if the DoPH and the Director of Integration and Direct Services (Adults) were able to make one recommendation to Council from the Topic Review for them to be on the alert for in future. Another councillor agreed with the suggestion and stated that, what had happened had been tragic and we would not want to see it happen again, it was vital that lessons are learnt. The DoPH and the Director of Integration and Direct Services (Adults) were thanked for their input tonight and for all the work done over a difficult and traumatic year.

The Board resolved to note the report and presentation.

09/21 Item for Information – Sinfin Health Centre Development

The Board noted that a report for consideration would be brought to the meeting in October 2021.

The Board resolved to note the contents of the report.

10/21 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 2021/22 municipal year.

The Board discussed and suggested items to be included on the Work Programme for 2021/22 and agreed they would like to have an additional meeting of the Board during this municipal year due to the number of items suggested for the Work Programme.

The Board agreed to undertake the deferred Topic Review – Arrangements put in place by hospitals when discharging patients to Care Homes. The Chair had examined the scope and terms of reference previously provided and had discussed with officers as to why the Topic Review had been deferred. It was felt that nobody could have anticipated the Pandemic continuing in the way it had when the initial Topic Review was agreed.

The Board agreed that Care Homes were a key area and there was a need to know from a local perspective what had happened in Care Homes. They agreed to return to a slightly reconfigured Topic Review on Care Homes as they felt they needed to know from a local perspective what had happened in Care Homes. The Board agreed that Care Homes had been a key area for discussion in the Pandemic and it was necessary to scrutinise for future learning.

The Board resolved to note the contents of the report.

MINUTES END