Monitoring Officer
**Christopher Potter**

County Hall, Newport, Isle of Wight PO30 1UD
Telephone (01983) 821000

# Agenda

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| Name of meeting | **POLICY AND SCRUTINY COMMITTEE FOR HEALTH AND SOCIAL CARE** |
| Date | **MONDAY 13 SEPTEMBER 2021** |
| Time | **5.00 PM** |
| Venue | **COUNCIL CHAMBER, COUNTY HALL, ISLE OF WIGHT** |
| Members of the committee | Cllrs J Nicholson (Chairman), M Lilley (Vice-Chairman), R Downer, A Garratt, K Lucioni, C Mosdell and J Robertson |
| Co-opted Members | Chris Orchin (Healthwatch) |
| | Democratic Services Officer: Megan Tuckwell<br>democratic.services@iow.gov.uk |

1. **Minutes** (Pages 5 - 10)

   To confirm as true record the Minutes of the meeting held on 19 July 2021.

2. **Declarations of Interest**

   To invite Members to declare any interest they might have in the matters on the agenda.

3. **Public Question Time - 15 Minutes Maximum**

   Members of the public are invited to make representations to the Committee regarding its workplan, in writing at any time or at a meeting under this item. Questions may be asked without notice but to guarantee a full reply at the meeting, a question must be put including the name and address of the questioner in writing or by electronic mail to democratic.services@iow.gov.uk, no later than two clear working days before the start of the meeting. Therefore, the deadline for written questions will be Wednesday 8 September 2021.

Details of this and other Council committee meetings can be viewed on the Isle of Wight Council's Committee website. This information may be available in alternative formats on request. Please note the meeting will be audio recorded and the recording will be placed on the website (except any part of the meeting from which the press and public are excluded). Young people are welcome to attend Council meetings however parents/carers should be aware that the public gallery is not a supervised area.

4. **Progress on outcomes and recommendations from previous meetings** (Pages 11 - 12)

The chairman to give an update.

5. **Dentistry on the Isle of Wight**

Following on from the last meeting, when the Healthwatch Isle of Wight report on dentistry was considered, it was noted that NHS England/Improvement indicated that it would :-

- work with Public Health England to produce a commissioning Needs Assessment for Hampshire and the Isle of Wight to determine where the recurrent UDA's should be tendered
- work with local networks and professional groups to ensure practice communication is clearer regarding the patient offer
- encourage the Isle of Wight NHS Trust and care homes to introduce Mouth Care Matters

Alison Cross, Senior Commissioning Manager (Dental) for NHS England and NHS Improvement – South East Region has agreed to attend the meeting virtually to provide an update on progress with these issues.

6. **Update on Covid-19**

To receive a brief verbal update on Covid-19 including latest figures on cases, vaccination programme, recovery plans and continuing impact on the delivery of health and social care.

7. **GP Patient Survey 2021** (Pages 13 - 18)

To consider the results of the 2021 GP Patient Survey.

8. **Health in Coastal Communities - Chief Medical Officer's Annual Report 2021** (Pages 19 - 44)

To discuss the findings and recommendations in the national report and the actions that can be taken at a local level to understand and address the issues identified.

9. **Integration and Innovation: Working Together to Improve Health and Social Care For All** (Pages 45 - 54)

To receive an update on the establishment of the Integrated Care Partnership (ICP). The Health and Care Bill which underpins the establishment of ICPs will commence the Committee stage in the House of Commons on 9 September 2021.

10. **Patient Transport**

To ascertain what actions are being taken to improve arrangements for patients having to travel to mainland facilities for treatment.

11. **Updates on Significant Service Issues**

To consider any update on any significant service issue not already covered on the agenda but requiring the formal attention of the committee.

12. **Workplan** (Pages 55 - 56)

To consider the future workplan and to identify any key issues that should be included.

13. **Members' Question Time**

A question may be asked at the meeting without prior notice but in these circumstances there is no guarantee that a full reply will be given at the meeting. To guarantee a reply to a question, a question must be submitted in writing or by electronic mail to democratic.services@iow.gov.uk no later than 5pm on Thursday 9 September 2021.

CHRISTOPHER POTTER
Monitoring Officer
Friday, 3 September 2021

Interests

If there is a matter on this agenda which may relate to an interest you or your partner or spouse has or one you have disclosed in your register of interests, you must declare your interest before the matter is discussed or when your interest becomes apparent. If the matter relates to an interest in your register of pecuniary interests then you must take no part in its consideration and you must leave the room for that item. Should you wish to participate as a member of the public to express your views where public speaking is allowed under the Council's normal procedures, then you will need to seek a dispensation to do so. Dispensations are considered by the Monitoring Officer following the submission of a written request. Dispensations may take up to 2 weeks to be granted.

Members are reminded that it is a requirement of the Code of Conduct that they should also keep their written Register of Interests up to date. Any changes to the interests recorded on that form should be made as soon as reasonably practicable, and within 28 days of the change. A change would be necessary if, for example, your employment changes, you move house or acquire any new property or land.

If you require more guidance on the Code of Conduct or are unsure whether you need to record an interest on the written register you should take advice from the Monitoring Officer – Christopher Potter on (01983) 821000, email christopher.potter@iow.gov.uk, or Deputy Monitoring Officer - Justin Thorne on (01983) 821000, email justin.thorne@iow.gov.uk.

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If you wish to record, film or photograph the council meeting or if you believe that being filmed or recorded would pose a risk to the safety of you or others then please speak with the democratic services officer prior to that start of the meeting. Their contact details are on the agenda papers.

If the press and public are excluded for part of a meeting because confidential or exempt information is likely to be disclosed, there is no right to record that part of the meeting. All recording and filming equipment must be removed from the meeting room when the public and press are excluded.

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http://www.iwight.com/documentlibrary/view/recording-of-proceedings-guidance-note

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# Minutes

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|---|---|
| Name of meeting | **POLICY AND SCRUTINY COMMITTEE FOR HEALTH AND SOCIAL CARE** |
| Date and Time | **MONDAY 19 JULY 2021 COMMENCING AT 5.00 PM** |
| Venue | **COUNCIL CHAMBER, COUNTY HALL, ISLE OF WIGHT** |
| Present | Cllrs J Nicholson (Chairman), R Downer, M Lilley, K Lucioni, C Mosdell, M Oliver<br><br>Chris Orchin (Healthwatch)<br><br>Cllr K Love<br><br>Helen Babington, Simon Bryant, Carol Tozer, Paul Thistlewood, Megan Tuckwell<br><br>Michele Legg, Richard Samuel, Alison Smith (IW CCG), Darren Cattell, Kirk Millis-Ward, Lesley Stevens (IW NHS Trust), Joanna Smith (Healthwatch) |

1. **Minutes**

RESOLVED:

THAT the minutes of the meeting held 1 March 2021 be confirmed as a true record.

2. **Declarations of Interest**

Cllr Karen Lucioni declared an interest as a self-employed Personal Assistant.

Cllr Michael Lilley declared an interest as the chairman of the Voluntary Sector Forum and as a trustee of the Isle of Wight Youth Trust.

3. **Public Question Time - 15 Minutes Maximum**

No written public questions were received.

4. **Update on Covid-19**

The Director of Public Health provided a brief update on Covid-19 recovery plans and vaccinations. The Committee were advised that despite a recent increase in cases of infections (across all age groups nationally and locally), hospitalisations and deaths remained low. A further increase in cases was expected following the

recent relaxation of restrictions, so key activities encouraging cautious optimism were ongoing to prevent the spread of the virus as the vaccination programme continued to be rolled out.

Questions were raised in relation to contact tracing and the rate of vaccination uptake across all age groups. The Chair of the IW CCG provided a brief update on the recently issued guidance around the delivery of a third Covid vaccination to the most clinically vulnerable commencing from September 2021 in conjunction with the flu jab.

RESOLVED:

THAT the update on Covid-19 be noted.

## 5. Adult Social Care

### 5.1 Statutory Complaints Annual Report 2020-2021

The Director of Adult Social Care presented the statutory report which provided information on the complaints received by Adult Social Care during the period 1 April 2020 to 31 March 2021, and the subsequent actions and learning adopted to continuously improve the experience of service users.

The Statutory Complaints Officer drew attention to the findings of the Local Government Ombudsman, the timeliness of complaint handling, and the integrated complaints handling across healthcare services. The Committee were advised that services had not seen an increase in complaints at this time in light of the pandemic.

Questions were raised in relation to the steps taken to seek the views of service users who do not wish to make a formal complaint. The Committee were referred to the results of the 2019/21 national user/carer survey which placed the Isle of Wight in the top 15% of councils.

RESOLVED:

i) THAT the statutory Adult Social Care Annual Complaints Report 2020-21, including the integrated complaint handling practice, be noted.

ii) THAT the staff involved in the handling of complaints be commended on the efficiency of the service provided.

### 5.2 Budget and performance including Care Closer to Home

The Director of Adult Social Care and Housing Needs presented information on the performance and budget for Adult Social Care, Public Health and Housing Needs during the period 31 January 2021 to 31 March 2021, and the committee received an update on Care Closer to Home.

Attention was drawn to information related to integrated discharge arrangements, the Living Well service, the Supporting People programme, the single person homelessness pathway; and the increasing numbers of DoLS applications and individuals permanently in living in care homes. Discussion took place regarding the

budget position and future funding, and it was advised that the service currently projected an underspend.

The Chairman, committee and all health partners paid tribute to the outstanding work undertaken by Dr Tozer and her immeasurable contribution and achievements to the lives of Island residents and wished her well in her retirement.

RESOLVED:

THAT the update on performance and budget be noted.

### 5.3 Care Quality Commission inspection report on Shared Lives IW

The committee received the CQC report which rated the Shared Lives service to be 'Good' across all criteria. The committee congratulated those involved in the service on the outcome of the inspection. The Director of Adult Social Care advised that there were plans to increase the capacity of the Shared Lives team.

The Deputy Chief Executive of the IW NHS Trust provided a brief update on the recent CQC inspection of IW NHS Trust services. It was advised that initial informal feedback had been positive and the inspection report (due to be published in September 2021) was expected to reflect the improvements that had been made.

RESOLVED:

THAT the CQC inspection report on Shared Lives IW be noted.

## 6. White Paper - Integration and Innovation: Working Together to Improve Health and Social Care For All

The Director of Transition and Development for the Hampshire and Isle of Wight Integrated Care System (ICS) presented the report which provided an update on the ongoing development of the ICS following the publication of the Government White Paper in February 2021 which outlined plans to support the development of ICS's as statutory organisations. No questions were raised at this stage and the update was noted.

RESOLVED:

THAT the update be noted.

## 7. Healthwatch

### 7.1 Suicide Prevention and Related Mental Health Provision on the Isle of Wight

The Manager of Healthwatch Isle of Wight presented the report which was developed to reflect the views and feelings of people who had been affected by suicide. It was noted that since starting this piece of work in 2019, positive changes had been underway particularly in relation to improved access to mental health services.

The Director of Mental Health and Learning Disabilities at the IW NHS Trust provided an update on the integrated mental health hub and the 'no wrong door' strategy, to improve access to mental health services. The Director of Public Health referred to the suicide prevention strategy which would be refreshed and presented to the committee when appropriate.

Questions were raised in relation to delayed data and future plans for walk-in community mental health hubs across the Island. The committee explored the possibility of forming a task and finish group on this matter, however it was agreed that the committee would wait for the response from the Health and Wellbeing Board on how it planned to review the strategy.

RESOLVED:

THAT the recommendations contained within the report be supported.

### 7.2 NHS Dental Services on the Isle of Wight

The Manager of Healthwatch Isle of Wight presented the report on dentistry which had been chosen as a priority topic for 2020/21 as the number of people reporting issues within this area had increased rapidly.

Key areas of concern were around inequalities in access to NHS dentists particularly in relation to children. Dialogue with NHS England was ongoing and an oral needs assessment for Hampshire and the Isle of Wight was expected, which would look at the level of provision against the level of need.

RESOLVED:

THAT the recommendations contained within the report be supported.

### 7.3 Healthwatch Isle of Wight Annual Report 2020-21

The Chairman of Healthwatch Isle of Wight presented the annual report. It was highlighted that there had been increased public engagement during the pandemic, which had informed intelligence reports which were regularly shared with health partners to give feedback on patient experiences reflecting current issues.

The Manager of Healthwatch Isle of Wight provided an update on key projects, including work with the Safeguarding Adults Board looking at the possible implications of changes in processes and procedures across a number of agencies during the pandemic. Additionally, Healthwatch were supporting Kings College London in a project looking at what makes an environment 'homely' for people with a learning disability; and was working with the General Medical Council in a pilot project with the aim of improving NHS complaints handling.

The Committee passed its thanks to Healthwatch and the report was noted.

RESOLVED:

THAT the Healthwatch Isle of Wight Annual Report 2020-21 be noted.

8. **Workplan**

Consideration was given to the future workplan, and the Committee and health partners were invited to identify any key issues that should be included. No comments were made at this stage.

RESOLVED:

THAT the workplan be noted.

9. **Members' Question Time**

No written questions were received.

CHAIRMAN

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# POLICY AND SCRUTINY COMMITTEE FOR HEALTH AND SOCIAL CARE – PROGRESS ON ACTIONS AND OUTCOMES 2021/22

| Date | Item | Actions | Comments |
|---|---|---|---|
| **19 July 2021** | | | |
| | Adult Social Care Annual Statutory Complaints Report 2020-21 | The statutory complaints report 2020-21, which included the integrated complaint handling practice, was noted. | Consideration of the Annual Statutory Complaints Report for 2021-22 will be included in the workplan for the July 2022 meeting. |
| | Budget and Performance including Care Close to Home | i. The "Pride in our Practice" strategy would be a key element in arrangements being introduced in 2023 by the Care Quality Commission in its inspection of adult social care.<br><br>ii. The rise in the number of people going into permanent residential care was highlighted.<br><br>iii. The Committee will seek a report at a future meeting on progress with reducing the number of outstanding Deprivation of Liberty Standards assessments.<br><br>iv. The actions being taken to refresh the Care Close to Home Strategy was noted. | The Committee will continue to monitor delivery of the strategy in the lead up to 2023 inspection arrangements.<br><br>The Committee will continue to monitor this matter and look at actions that can be taken to reduce numbers.<br><br>A report on this matter will be included in the workplan for the 29 November 2021 meeting.<br><br>The Committee will continue to monitor the delivery of this strategy. |
| | CQC inspection report on Shared Lives IW | With regard to the Care Quality Commission inspection of the IWNHS Trust it was likely that the report would be published in September 2021 and this would be presented to the committee for discussion. | The CQC inspection report of the IWNHS Trust has not yet been published. |
| | White Paper – Integration and Innovation: Working Together to Improve Health and Social Care for All | The committee to be kept updated on the Health and Care Bill and the implications for arrangements on the Isle of Wight. | There will be a regular update on future agendas. |

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| | Healthwatch | | |
| | a. NHS Dental Services on the Isle of Wight | The report was received and the recommendations fully supported. | A representative from NHS England/ Improvement has been invited to the September 2021 meeting to assist in a discussion about assessing the dental needs on the Island. |
| | b. Healthwatch Isle of Wight Annual Report 2020-21 | The report was received and the Committee congratulated Healthwatch isle of Wight on ensuring that the voice of residents were represented and taken into account by health and social care providers. | A review by Healthwatch of access to GP services has commenced. This covers Hampshire, Isle of Wight, West Sussex and Wiltshire. The Scrutiny Officer attends meetings of the project group. |
| | c. Suicide Prevention and Related Mental Health Provision on the Isle of Wight | i. The report was received and the recommendations fully supported.<br>ii. The response of the Health and Wellbeing Board on the proposed review of the Isle of Wight Suicide Prevention Strategy be awaited before the committee decides what further action is required. | The report has not yet been considered by the Health and Wellbeing Board. |

The latest GP patient survey results are out (Jan 2021 – April 2021):
https://l.antigena.com/l/EQBmpjZS64aTHgK-i-n3YqN1~j15hPuVmU_c2IneDZMSQI2i5h9PswxSXjb5i6MJ2-gCSBr575qv1dzpYN_FwwDlUqnQZaZaWOtfj9LfAZVrkZu4Z~jm7apJk2K6JIWzqFHMJl8qkO7UzBdu1Mbwka1

**Cowes Medical Centre**
200 Newport Road, Cowes, PO31 7ER
**Where patient experience is best**
These are the three results for this practice that are the highest compared to the CCG average.

- 95% of respondents had confidence and trust in the healthcare professional they saw or spoke to during their last general practice appointment
  Local (CCG) average: **96%**National average: **96%**
- 94% of respondents took the appointment they were offered
  Local (CCG) average: **97%**National average: **98%**
- 87% of respondents say the healthcare professional they saw or spoke to was good at giving them enough time during their last general practice appointment
  Local (CCG) average: **90%**National average: **89%**

**Where patient experience could improve**
These are the results for this practice that are the lowest compared to the CCG average.

- 26% of respondents find it easy to get through to this GP practice by phone
  Local (CCG) average: **67%**National average: **68%**
- 20% of respondents usually get to see or speak to their preferred GP when they would like to
  Local (CCG) average: **48%**National average: **45%**
- 40% of respondents were offered a choice of appointment when they last tried to make a general practice appointment
  Local (CCG) average: **66%**National average: **69%**

**East Cowes Medical Centre**
Church Path, East Cowes, PO32 6RP
**Where patient experience is best**
These are the three results for this practice that are the highest compared to the CCG average.

- 93% of respondents say the healthcare professional they saw or spoke to was good at giving them enough time during their last general practice appointment
  Local (CCG) average: **90%**National average: **89%**
- 91% of respondents say the healthcare professional they saw or spoke to was good at treating them with care and concern during their last general practice appointment
  Local (CCG) average: **89%**National average: **88%**
- 97% of respondents had confidence and trust in the healthcare professional they saw or spoke to during their last general practice appointment
  Local (CCG) average: **96%**National average: **96%**

**Where patient experience could improve**
These are the results for this practice that are the lowest compared to the CCG average.

- 15% of respondents usually get to see or speak to their preferred GP when they would like to
  Local (CCG) average: **48%**National average: **45%**
- 41% of respondents find it easy to get through to this GP practice by phone
  Local (CCG) average: **67%**National average: **68%**

- 44% of respondents were offered a choice of appointment when they last tried to make a general practice appointment
  Local (CCG) average: **66%**National average: **69%**

**Newport Health Centre**

22 Carisbrooke High St, Carisbrooke, Newport, PO30 1NR

**Where patient experience is best**

These are the three results for this practice that are the highest compared to the CCG average.

- 95% of respondents felt the healthcare professional recognised or understood any mental health needs during their last general practice appointment
  Local (CCG) average: **88%**National average: **86%**
- 99% of respondents felt their needs were met during their last general practice appointment
  Local (CCG) average: **95%**National average: **94%**
- 99% of respondents took the appointment they were offered
  Local (CCG) average: **97%**National average: **98%**

**Where patient experience could improve**

These are the results for this practice that are the lowest compared to the CCG average.

- 34% of respondents find it easy to get through to this GP practice by phone
  Local (CCG) average: **67%**National average: **68%**
- 18% of respondents usually get to see or speak to their preferred GP when they would like to
  Local (CCG) average: **48%**National average: **45%**
- 42% of respondents were offered a choice of appointment when they last tried to make a general practice appointment
  Local (CCG) average: **66%**National average: **69%**

**Tower House Surgery**

Rink Road, Ryde, PO33 1LP

**Where patient experience is best**

These are the three results for this practice that are the highest compared to the CCG average.

- 82% of respondents find it easy to get through to this GP practice by phone
  Local (CCG) average: **67%**National average: **68%**
- 81% of respondents describe their experience of making an appointment as good
  Local (CCG) average: **70%**National average: **71%**
- 94% of respondents felt the healthcare professional recognised or understood any mental health needs during their last general practice appointment
  Local (CCG) average: **88%**National average: **86%**

**Where patient experience could improve**

These are the results for this practice that are the lowest compared to the CCG average.

- 29% of respondents usually get to see or speak to their preferred GP when they would like to
  Local (CCG) average: **48%**National average: **45%**
- 94% of respondents had confidence and trust in the healthcare professional they saw or spoke to during their last general practice appointment
  Local (CCG) average: **96%**National average: **96%**
- 88% of respondents say the healthcare professional they saw or spoke to was good at treating them with care and concern during their last general practice appointment
  Local (CCG) average: **89%**National average: **88%**

**Esplanade Surgery**

The Esplanade Surgery, 19 The Esplanade, Ryde, PO33 2EH

**Where patient experience is best**

- These are the three results for this practice that are the highest compared to the CCG average.
- 84% of respondents find it easy to get through to this GP practice by phone
  Local (CCG) average: **67%**National average: **68%**
- 93% of respondents describe their overall experience of this GP practice as good
  Local (CCG) average: **83%**National average: **83%**
- 95% of respondents felt the healthcare professional recognised or understood any mental health needs during their last general practice appointment
  Local (CCG) average: **88%**National average: **86%**

**Where patient experience could improve**

These are the results for this practice that are the lowest compared to the CCG average.

- 23% of respondents usually get to see or speak to their preferred GP when they would like to
  Local (CCG) average: **48%**National average: **45%**
- 66% of respondents describe their experience of making an appointment as good
  Local (CCG) average: **70%**National average: **71%**
- 65% of respondents were offered a choice of appointment when they last tried to make a general practice appointment
  Local (CCG) average: **66%**National average: **69%**

**Ventnor Medical Practice**

Ventnor Medical Centre, 3 Albert Street, Ventnor, PO38 1EZ

**Where patient experience is best**

These are the three results for this practice that are the highest compared to the CCG average.

- 80% of respondents were offered a choice of appointment when they last tried to make a general practice appointment
  Local (CCG) average: **66%**National average: **69%**
- 92% of respondents were satisfied with the appointment they were offered
  Local (CCG) average: **83%**National average: **82%**
- 80% of respondents describe their experience of making an appointment as good
  Local (CCG) average: **70%**National average: **71%**

**Where patient experience could improve**

These are the results for this practice that are the lowest compared to the CCG average.

- 40% of respondents usually get to see or speak to their preferred GP when they would like to
  Local (CCG) average: **48%**National average: **45%**

**Argyll House**

West Street, Ryde, PO33 2QG

**Where patient experience is best**

These are the three results for this practice that are the highest compared to the CCG average.

- 82% of respondents are satisfied with the general practice appointment times available
  Local (CCG) average: **65%**National average: **67%**
- 80% of respondents describe their experience of making an appointment as good
  Local (CCG) average: **70%**National average: **71%**
- 88% of respondents describe their overall experience of this GP practice as good

Local (CCG) average: **83%**National average: **83%**

**Where patient experience could improve**

These are the results for this practice that are the lowest compared to the CCG average.

- 49% of respondents were offered a choice of appointment when they last tried to make a general practice appointment
  Local (CCG) average: **66%**National average: **69%**
- 84% of respondents find the receptionists at this GP practice helpful
  Local (CCG) average: **90%**National average: **89%**
- 86% of respondents felt the healthcare professional recognised or understood any mental health needs during their last general practice appointment
  Local (CCG) average: **88%**National average: **86%**

**The Bay Medical Practice**

Sandown Health Centre, Broadway, Sandown, PO36 9GA

**Where patient experience is best**

These are the three results for this practice that are the highest compared to the CCG average.

- 63% of respondents usually get to see or speak to their preferred GP when they would like to
  Local (CCG) average: **48%**National average: **45%**
- 96% of respondents felt the healthcare professional recognised or understood any mental health needs during their last general practice appointment
  Local (CCG) average: **88%**National average: **86%**
- 70% of respondents are satisfied with the general practice appointment times available
  Local (CCG) average: **65%**National average: **67%**

**Where patient experience could improve**

These are the results for this practice that are the lowest compared to the CCG average.

- 49% of respondents find it easy to get through to this GP practice by phone
  Local (CCG) average: **67%**National average: **68%**
- 76% of respondents were satisfied with the appointment they were offered
  Local (CCG) average: **83%**National average: **82%**
- 61% of respondents were offered a choice of appointment when they last tried to make a general practice appointment
  Local (CCG) average: **66%**National average: **69%**

**Medina Healthcare**

16 West Street, Newport, PO30 1PR

**Where patient experience is best**

These are the three results for this practice that are the highest compared to the CCG average.

- 99% of respondents had confidence and trust in the healthcare professional they saw or spoke to during their last general practice appointment
  Local (CCG) average: **96%**National average: **96%**
- 97% of respondents were involved as much as they wanted to be in decisions about their care and treatment during their last general practice appointment
  Local (CCG) average: **94%**National average: **93%**
- 99% of respondents took the appointment they were offered
  Local (CCG) average: **97%**National average: **98%**

**Where patient experience could improve**

These are the results for this practice that are the lowest compared to the CCG average.

- 54% of respondents say they have had enough support from local services or organisations in the last 12 months to help manage their long-term condition(s)

Local (CCG) average: **76%**National average: **74%**

- 29% of respondents usually get to see or speak to their preferred GP when they would like to
  Local (CCG) average: **48%**National average: **45%**
- 60% of respondents describe their experience of making an appointment as good
  Local (CCG) average: **70%**National average: **71%**

**Wight Primary Partnerships Ltd**

Brookside Health Centre, Queens Road, Freshwater, PO40 9DT

**Where patient experience is best**

These are the three results for this practice that are the highest compared to the CCG average.

- 74% of respondents find it easy to get through to this GP practice by phone
  Local (CCG) average: **67%**National average: **68%**
- 68% of respondents are satisfied with the general practice appointment times available
  Local (CCG) average: **65%**National average: **67%**
- 85% of respondents were satisfied with the appointment they were offered
  Local (CCG) average: **83%**National average: **82%**

**Where patient experience could improve**

These are the results for this practice that are the lowest compared to the CCG average.

- 30% of respondents usually get to see or speak to their preferred GP when they would like to
  Local (CCG) average: **48%**National average: **45%**
- 72% of respondents felt the healthcare professional recognised or understood any mental health needs during their last general practice appointment
  Local (CCG) average: **88%**National average: **86%**
- 81% of respondents say the healthcare professional they saw or spoke to was good at giving them enough time during their last general practice appointment
  Local (CCG) average: **90%**National average: **89%**

**St. Helens Medical Centre**

St. Helens Medical Centre, Upper Green Road, St.Helens, PO33 1UG

**Where patient experience is best**

These are the three results for this practice that are the highest compared to the CCG average.

- 87% of respondents find it easy to get through to this GP practice by phone
  Local (CCG) average: **67%**National average: **68%**
- 89% of respondents say they have had enough support from local services or organisations in the last 12 months to help manage their long-term condition(s)
  Local (CCG) average: **76%**National average: **74%**
- 75% of respondents were offered a choice of appointment when they last tried to make a general practice appointment
  Local (CCG) average: **66%**National average: **69%**

**Where patient experience could improve**

These are the results for this practice that are the lowest compared to the CCG average.

- 77% of respondents were satisfied with the appointment they were offered
  Local (CCG) average: **83%**National average: **82%**
- 44% of respondents usually get to see or speak to their preferred GP when they would like to
  Local (CCG) average: **48%**National average: **45%**

- 87% of respondents say the healthcare professional they saw or spoke to was good at giving them enough time during their last general practice appointment
  Local (CCG) average: **90%**National average: **89%**

**South Wight Medical Practice**

The Surgery, Blackgang Road, Niton, PO38 2BN

**Where patient experience is best**

These are the three results for this practice that are the highest compared to the CCG average.

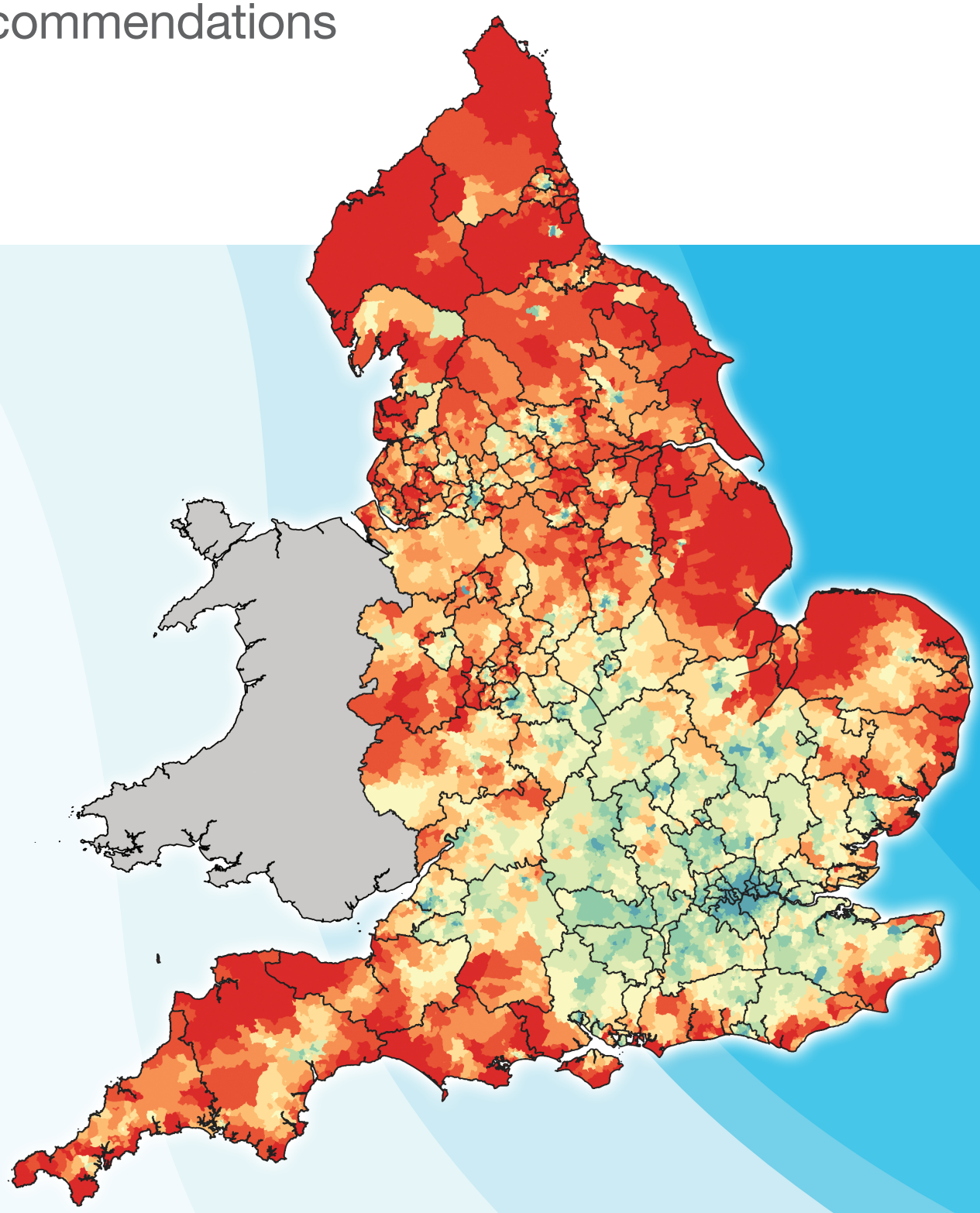
- 89% of respondents find it easy to get through to this GP practice by phone
  Local (CCG) average: **67%**National average: **68%**
- 73% of respondents are satisfied with the general practice appointment times available
  Local (CCG) average: **65%**National average: **67%**
- 91% of respondents describe their overall experience of this GP practice as good
  Local (CCG) average: **83%**National average: **83%**

**Where patient experience could improve**

These are the results for this practice that are the lowest compared to the CCG average. *This practice has scored higher than their CCG average in every question*

# **Chief Medical Officer's** Annual Report 2021

## Health in Coastal Communities – Summary and recommendations



Map showing prevalence of coronary heart disease in England.

# Introduction

The last year has seen the public health focus dominated by combatting COVID-19. With other health colleagues, I intend to write a report on technical lessons learned from COVID-19, but the pandemic in the UK is still evolving rapidly. COVID-19, which has had its greatest effects on those with chronic health conditions, has however reinforced the importance of local variations in health, and the concentration of pre-existing health conditions and chronic disease in certain geographies. It is important we do not lose sight of these enduring health challenges as we face the largest pandemic for a generation. The Chief Medical Officer's Annual Report 2021 concentrates on one of the most important of these challenges: health in coastal communities.

Coastal communities, the villages, towns and cities of England's coast, include many of the most beautiful, vibrant and historically important places in the country. They also have some of the worst health outcomes in England, with low life expectancy and high rates of many major diseases. For example, Blackpool, one of the country's favourite holiday destinations, has the worst life expectancy in the UK despite remarkable efforts by local health and civic leaders.

The central argument of the report is that the health challenges of coastal towns, cities and other communities are serious, and their drivers are more similar than their nearest inland neighbour. This means a national strategy to address the repeated problems of health in coastal communities is needed in addition to local action. If we do not tackle the health problems of coastal communities vigorously and systematically there will be a long tail of preventable ill health which will get worse as current populations age.

There are many reasons for poor health outcomes in coastal communities. The pleasant environment attracts older, retired citizens to settle, who inevitably have more and increasing health problems. An oversupply of guest housing has led to Houses of Multiple Occupation which lead to concentrations of deprivation and ill health. The sea is a benefit but also a barrier: attracting NHS and social care staff to peripheral areas is harder, catchment areas for health services are artificially foreshortened and transport is often limited, in turn limiting job opportunities. Many coastal communities were created around a single industry such as previous versions of tourism, or fishing, or port work that have since moved on, meaning work can often be scarce or seasonal.

Given the known high rates of preventable illness in these areas, the lack of available data on the health of coastal communities has been striking whilst researching the report. Coastal communities have been long overlooked with limited research on their health and wellbeing. The focus has tended towards inner city or rural areas with too little attention given to the nation's periphery. Data is rarely published at a geographical level granular enough to capture coastal outcomes, with most data only available at local authority or Clinical Commissioning Group (CCG) level. As a result, deprivation and ill health at the coast is hidden by relative affluence just inland which is lumped together. The report aims to explore the experiences of local leaders, along with analysis of what data exist, to help us understand the health and wellbeing of coastal communities.

Coastal communities are not homogenous, and each is shaped by its own unique history and culture. They do, however, share many similar characteristics, which should help some common policy responses. A resort town like Blackpool, for example, has more in common with Hastings, Skegness or Torbay than with Preston, just 18 miles inland. Fishing or port communities have particular, shared, challenges. A national strategy informed by these common groups, and underpinned by local actions aligned with a sustained evidence-informed strategy, will help reduce health inequalities in these areas.

The report will highlight the significant strengths in coastal communities along with many exemplary and impressive examples of local work taking place to support the health of local citizens. They should not however, in my view, face the considerable health challenges alone. The vulnerability of these communities is not a new revelation, and the economic problems they face have been highlighted in several recent reports including in relation to the impact of COVID-19 [1,2,3].

Whilst the focus nationally over the summer may be directed towards visitors, with many opting to stay in one of the UK's many beautiful coastal towns, it is important to remember that the coast is also home to millions of people and that the health and wellbeing of these populations has been long neglected and overlooked.

## Report structure

The full report can be accessed via the Chief Medical Officer Annual Reports page on GOV.UK. The chapters included in the full report are outlined below. This document includes the summary of key themes identified and my recommendations.

**Chapter 1** includes 10 case studies written by Directors of Public Health and others who work with and in coastal communities. These case studies range from large port cities, to local authorities covering smaller seaside towns. The case studies provide an overview of the demographic structure of the population and their health and wellbeing outcomes, along with both the strengths and challenges facing their communities. These case studies highlight what local level, place-based working can achieve.

**Chapter 2** consists of analysis by the Office for National Statistics (ONS) using their own granular coastal definition to explore the wider determinants of health including demographic and migration patterns, deprivation, employment, education and housing. Given the limited relevant data available on housing, especially the private rental sector, section 2.8 further explores housing via a case study from Blackpool Council.

**Chapter 3** is an analysis by colleagues from Plymouth University exploring the burden of disease and health service data at a granular level using their own definition of a coastal community.

**Chapter 4** includes analysis by Health Education England (HEE) on the medical workforce in coastal communities and their ambitious programme of reform to overcome some of these challenges.

**Chapter 5** is a summary of flooding and coastal communities written by the Public Health England (PHE) Extreme Events Team. This was raised as a concern by local leaders working in coastal communities.

**Chapter 6,** written by colleagues from Exeter University, explores the benefits of coastal living. The coast has much to offer with research suggesting that there is a protective effect to health and wellbeing from living on the coast.

Running through the report is the fact that coastal communities have multiple, overlapping but addressable health problems. If we are serious about improving the health of the nation, coastal communities are a good place to start.

**Professor Christopher Whitty –** Chief Medical Officer for England.

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# Summary of key themes

## The following are key themes arising from the report.

1. Health and wellbeing in coastal communities.
2. Deprivation and health.
3. Mental health.
4. Migration and demography.
5. Health services and medical workforce.
6. Economy and employment.
7. Education.
8. Housing.
9. Benefits of coastal living for health.
10. Coast-specific issues.
11. Limitations of data and definitions.
12. A strong case for national action.

## Health and wellbeing in coastal communities

Many coastal communities are remarkable and beautiful places but have some of the worst health and wellbeing outcomes in England. Capturing these outcomes accurately has historically been challenging as data are often not available at a granular level and are averaged out with nearby healthier inland towns.

The report demonstrates that coastal communities have a higher burden of disease across a range of physical and mental health conditions (for example Coronary Heart Disease in Figure 1). This is partly driven by age structure and partly by concentration of deprivation, however, even after accounting for these and other factors, there remains a 'coastal excess' of disease. This is true across many conditions and risk factors. Figure 2 plots these 'coastal effects', demonstrating the extent to which, having accounted for all other factors, populations in coastal areas experience higher or lower disease prevalence rates.

Life expectancy (LE), healthy life expectancy (HLE) and disability free life expectancy (DFLE) are all lower in coastal areas and the Standardised Mortality Ratios (SMRs) for a range of conditions, including preventable mortality, are significantly higher in coastal areas compared with non-coastal. The case studies in the report describe a high proportion of people with long term conditions, with one in four people in Morecambe having a limiting, long-term illness or disability (25.0%), significantly more than the national average.

The Director of Public Health (DPH) in Hull, for example, highlights how poor health occurs prematurely and is largely the result of preventable diseases affecting LE and HLE/DFLE – "far shorter lives are spent in far poorer health." This is echoed by the Director of Public Health of North East Lincolnshire who describes people in their most deprived communities "old before their time".

This concentration of poor health and wellbeing in coastal communities also provides a clear and geographically defined target for national action. If we could improve the health of coastal communities, the median health for the entire country would be lifted. Improving health here would mean a significant part of the long tail of lower life expectancy in England would be reduced.

**Figure 1:** Crude GP QOF Prevalence of Coronary Heart Disease attributed to LSOAs: 2014/15 – 2018/19

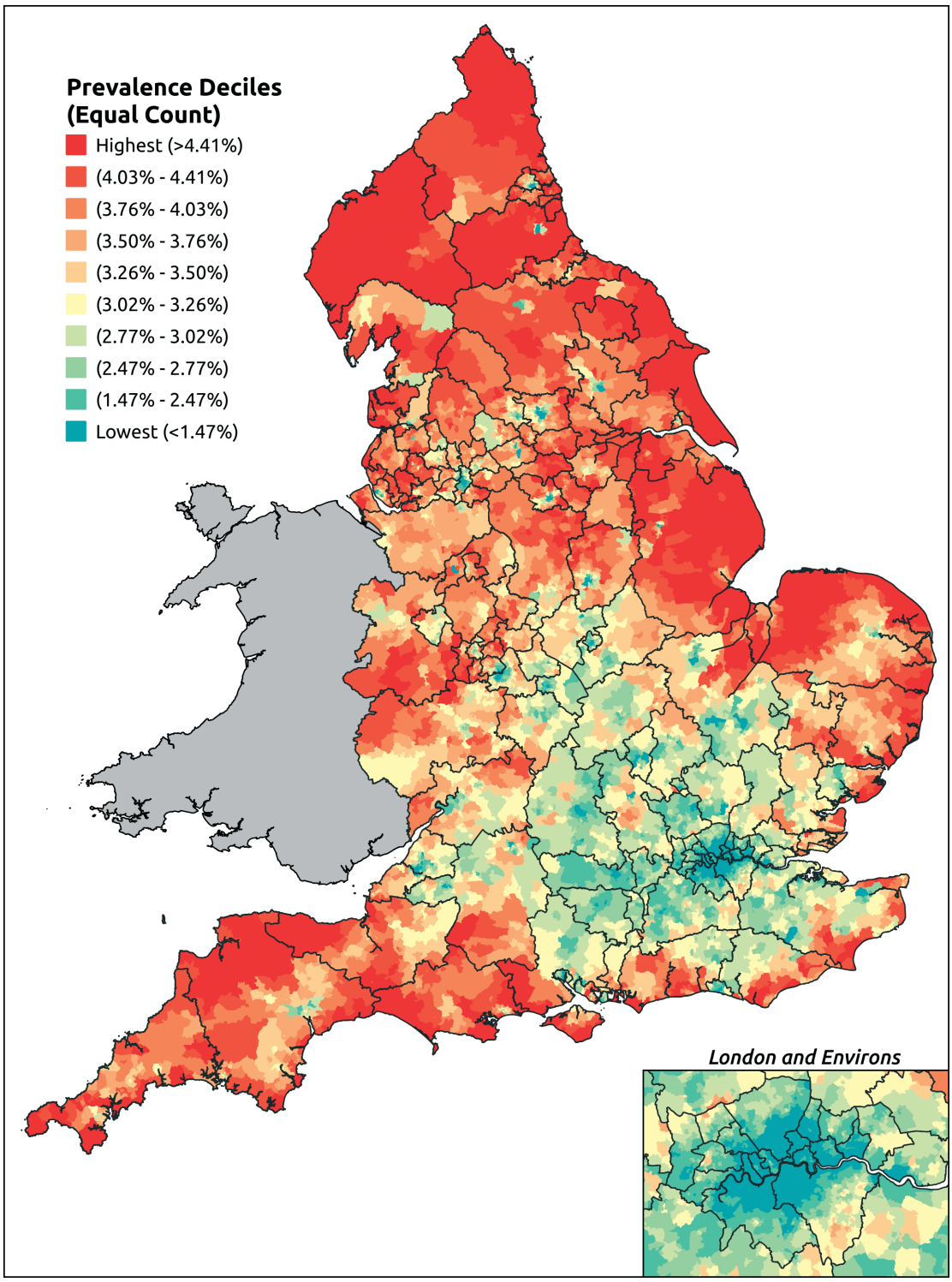
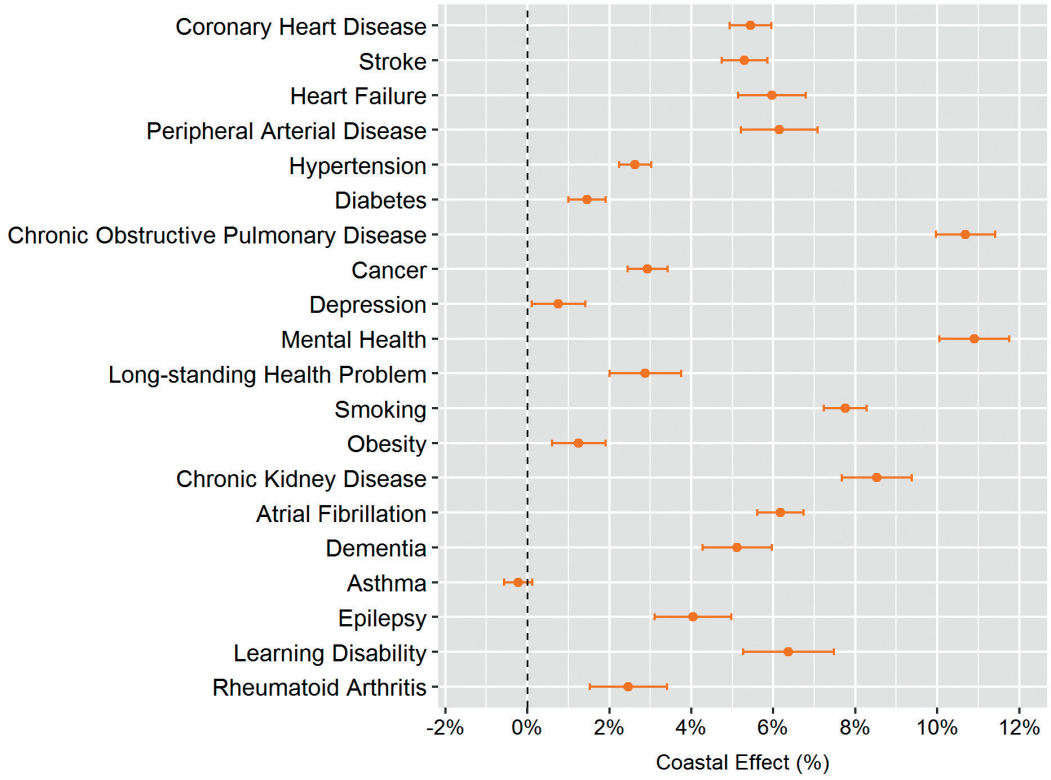


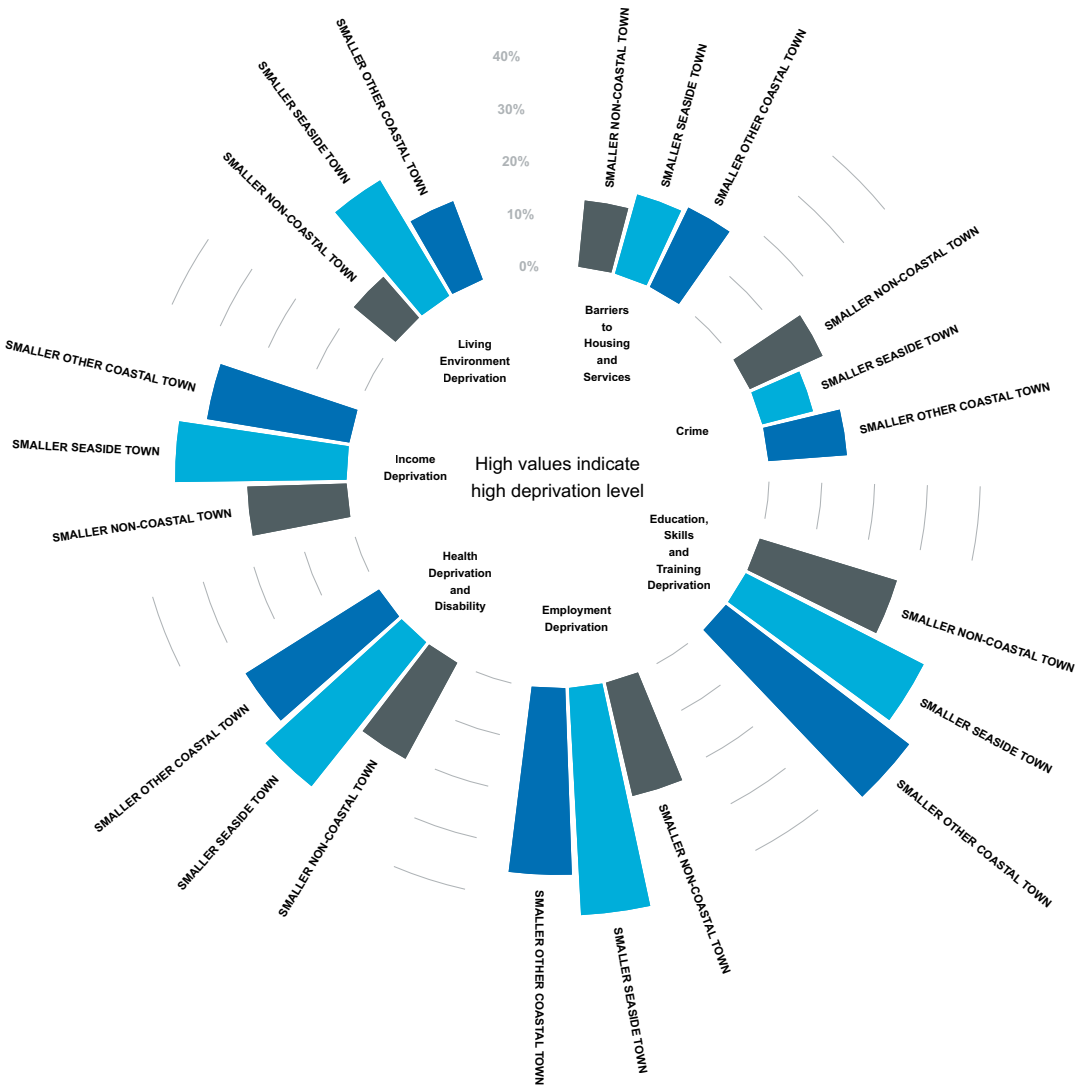
**Figure 2:** Estimates of the 'coastal effect' on the number of patients on selected GP disease registers: 2014/15 – 2018/19




## Deprivation and health

High levels of deprivation, driven in part by major and longstanding challenges with local economies and employment, are important reasons for the poor health outcomes in coastal communities. ONS, in their analysis for the report, found that deprivation was higher in coastal communities compared to non-coastal, with smaller seaside towns and large coastal (non-seaside) towns being especially deprived. Figure 3, for example, shows that smaller coastal towns had a higher share of population living in the most deprived areas of England across almost all domains of deprivation. This is echoed by all case studies in the report, including Blackpool, the most deprived local authority in England and Hastings, the most deprived in the South East.

**Figure 3:** Percentage of small towns' resident population living in the 30% most deprived neighbourhoods in England, 2019




**Source:** Ministry of Housing, Communities and Local Government – English Indices of Multiple Deprivation, 2019, compiled for towns and cities by the Office for National Statistics

Several risk factors which are important drivers of health outcomes have a strong correlation with deprivation. Obesity for example, is higher in those who live in more deprived areas which are often obesogenic environments compared to less deprived neighbourhoods. Peoples' circumstances and environments can make it difficult for them to change unhealthy behaviours[1]. Whether we can be active or eat healthily is impacted by a number of socio-economic factors, such as income, housing, education, access to space and sale of unhealthy foods.

Risk factors, including smoking, are higher in coastal communities, with analysis suggesting an excess coastal prevalence rate of 6.71%. Many coastal Directors of Public Health highlight smoking as a key concern in their case studies. Hartlepool and Blackpool for example, describe that almost one in four women smoke during pregnancy, and in Hull, despite the proportion of women smoking in pregnancy falling, it is still twice that of England (20.6% compared with 10.4%). Despite a downward trend in smoking rates nationally, it is clear geographical inequalities remain, and that targeted intervention to high risk groups and geographies is required.

Excess alcohol use is also commonly raised as an issue by coastal Directors of Public Health. Along with other coastal communities, Morecambe and Hastings have high rates of hospital admission for alcohol-related harm. The Torbay case study highlights worse admissions for alcohol-related conditions compared to the English average and Blackpool has the highest rate of hospital admissions for alcohol-related harm in the country. The report also found that alcohol-attributed admissions in 0-17-year olds were higher in coastal communities.

ONS analysis of alcohol-specific mortality rates found a mixed picture. Large urban areas appeared to have a higher alcohol-specific mortality rate. There was a statistically significant higher alcohol-specific mortality rate in males in large towns (both coastal and non-coastal) compared to smaller non-coastal towns. Mortality figures, however, are unlikely to represent the overall burden of the challenges associated with alcohol and further analysis of alcohol related indicators at a granular level in relation to coastal communities would be beneficial. Improving the ability of Directors of Public Health to input into licensing applications in their local areas is likely to have a significant impact on health outcomes, especially in coastal communities.

Coastal Directors of Public Health outlined substance misuse as a concern. In Hull for example, the estimated prevalence of opiate and/or crack cocaine use is more than twice that of England (18.1 versus 8.9 per 100,000 population aged 15-64 years). These local data are supported by the national ONS analysis which found that the mortality rate due to drug poisoning was higher in coastal towns compared to non-coastal.

## Mental health

Mental health problems demonstrate social gradients in the same way as physical health problems[2].

There is a high burden of mental ill-health illustrated by QOF data in coastal communities. The rates of self-harm among 10-24-year olds were also found to be higher in coastal compared with non-coastal communities.

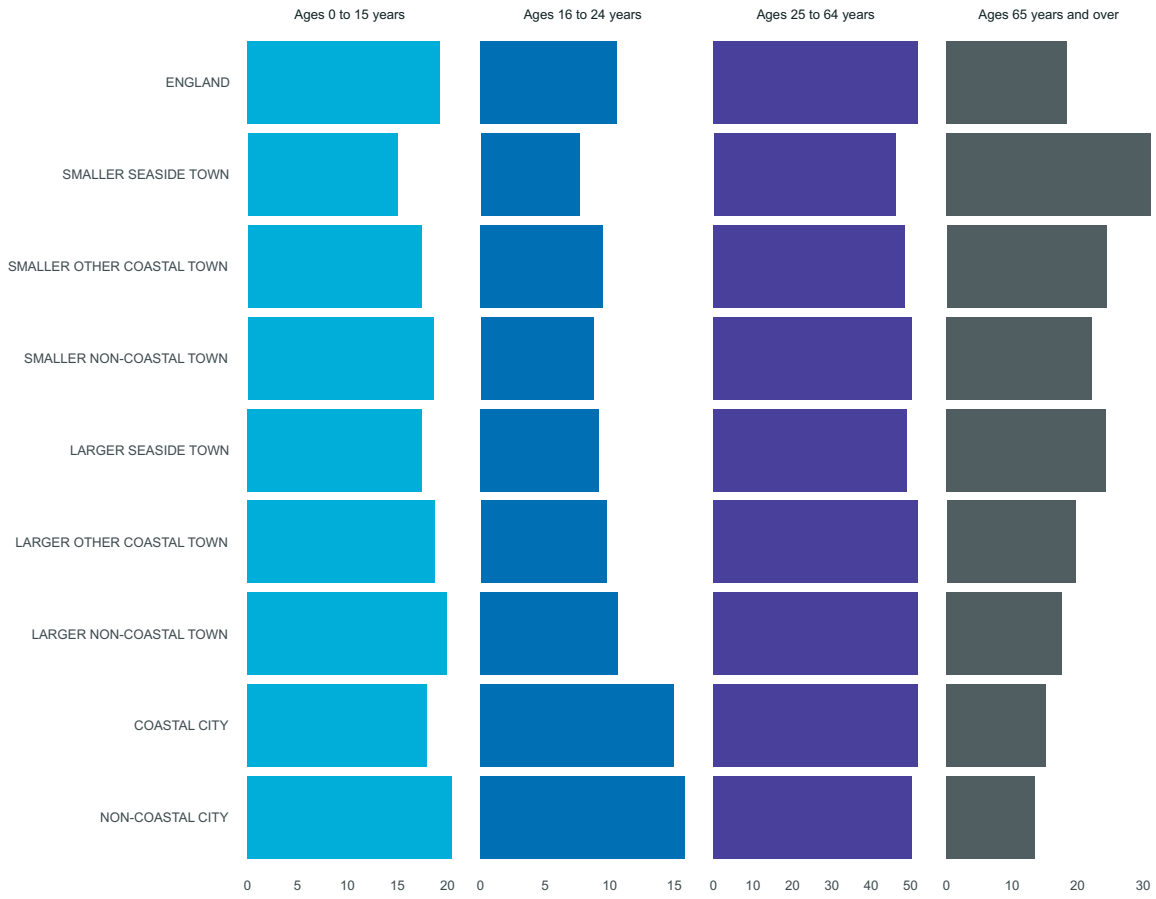
These findings are mirrored by the case studies, with Clacton, reporting the second highest mental health need in the country. According to the case study, patients in Morecambe Bay Primary Care Network are 20% more likely to have depression than the national average, and in Somerset, hospital admissions for self-harm are significantly raised compared to the rest of England and appear to be increasing with time. Hartlepool has a higher prevalence of mental health disorders than the England average for both the 16 years + population and the 65 years + population.

Researchers at Liverpool University have created the Small Area Mental Health Index (SAMHI), which is a composite measure on mental health from multiple sources at lower geographical level (lower super output areas)[3]. This index also shows a coastal pattern of disease which is largely explained by deprivation, migration and age profile of coastal populations.

## Demographics and migration patterns

Coastal communities more often have a higher proportion of elderly residents than the general population, and this is set to increase over the following decades. The ONS analysis found that coastal towns and cities have higher shares of residents in the 65 years or over age group and lower shares in the 0 to 15 years age group (Figure 4). This finding is mirrored in the population pyramids of each case study. This age difference is likely driven by migration out of large cities as people grow older and may also be similarly seen in rural areas.

**Figure 4:** Population by age groups, England 2019



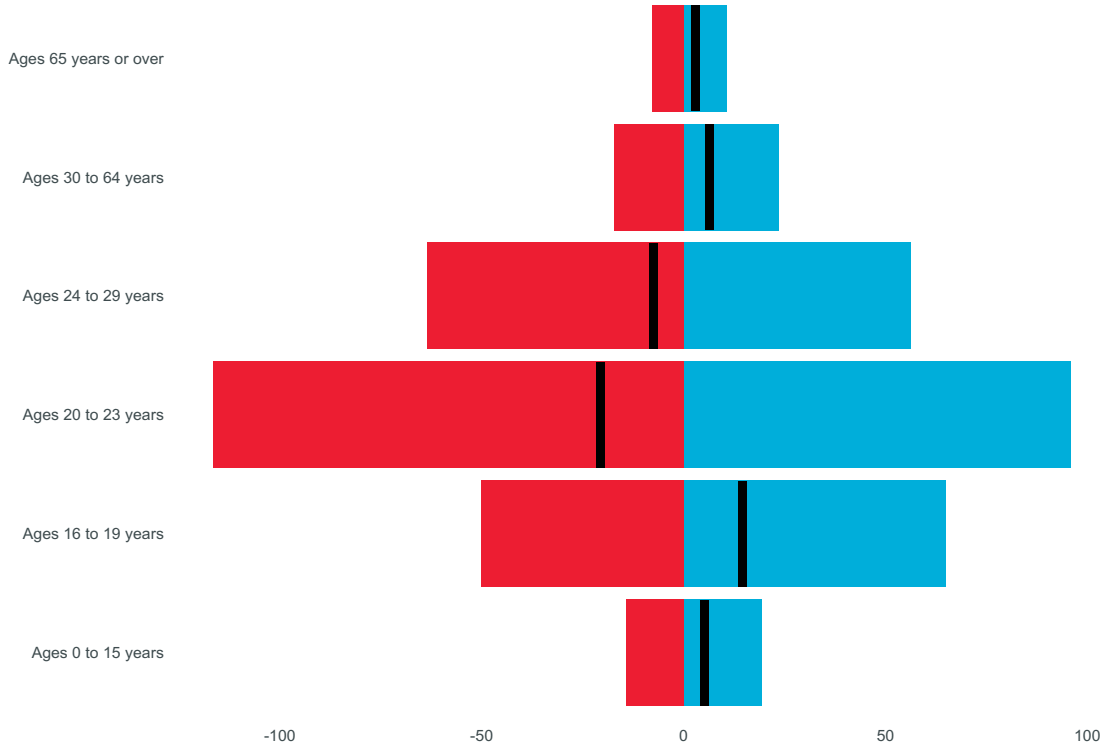

**Source:** Office for National Statistics – Population estimates

## Migration

The case studies and wider literature describe three key populations who migrate to and from the coast. There is an in-migration of the elderly population, retiring to the coast (as they do to other semirural areas). Secondly, some coastal areas including Blackpool, Morecambe and Hastings experience in-migration of a transient, vulnerable younger population driven by the availability of cheap housing. There is also an out-migration of young people in search of employment opportunities not available locally.

Granular migration data below local authority level was not available nationally for ONS analysis. Despite this, analysis at local authority level provides an indication of movement to coastline local authorities (although this may not equate directly to coastal areas, especially in large local authorities with small coastlines). The analysis suggested that coastline local authorities saw a net outflow of two age groups: the 20 to 23 years age group and the 24 to 29 years age group. All other age groups had a net inflow, including the 16 to 19 years age group which is likely due in large part to migration into coastline local authorities with universities or other higher and further education.

**Figure 5:** Net moves from coastline local authorities to inland, by age group (per 1,000 population), England, 2019




**Source:** Office for National Statistics – Population Estimates

Both current and future demographic and migration patterns have public health implications for the burden of disease and service provision in coastal areas. Given the elderly population, considering the needs of older people is essential. PHE highlighted this in their commissioned evidence review of health inequalities in older populations in coastal and rural areas[4]. The review found a paucity of literature in coastal communities. As a result, they are due to publish a further report, in partnership with Age UK, to assist those working in coastal communities to understand the issues affecting older people in previously under-recognised groups, including older men, older people from ethnic minority and LGBTQ communities.

Migration patterns are also relevant to population health and wellbeing. Evidence suggests that triggers for moving in the elderly can include a change in partnership, such as widowhood or a change in health and economic status during the last 12 months[5]. Understanding the *reasons* for migration are likely to be important especially for ensuring appropriate support and services.

## Health services and medical workforce

There is evidence of a significant health service deficit in terms of recorded service standards, cancer indicators and emergency admissions in coastal communities. The reasons for this are unclear, however possible explanations include challenges with the retention of medical workforce and access to services.

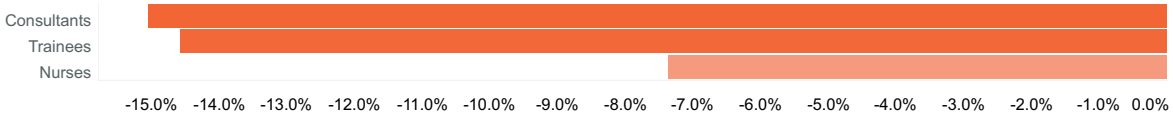
The case studies emphasise that coastal communities, especially those in coastal areas that are also sparse, such as West Somerset and Lincolnshire, face challenges with access to services, but also challenges with service delivery where they struggle to reach the critical mass needed to sustain specific services.

### Medical workforce

Challenges to the recruitment and retention of health and social care staff is a common concern expressed by coastal Directors of Public Health and NHS leaders. Morecambe, for example, describes the challenges of recruiting and retaining General Practitioners and experienced practice nurses, and how these inequalities in primary care provision further compound the health issues within the community.

HEE's analysis for the report found that despite coastal communities having an older and more deprived population, they have 14.6% fewer postgraduate medical trainees, 15% fewer consultants and 7.4% fewer nurses per patient. This is shown in Figure 6.

**Figure 6:** Deficit in consultants, trainees and nurses in coastal communities




HEE is planning an ambitious set of reforms to address these concerns. Their approach to undergraduate reform, along with the review of the distribution of post-graduate medical trainees in coastal areas, will be a step towards reducing the disparities in coastal communities. HEE's approach to generalism is especially welcomed, given the aging population in coastal communities, who are likely to have a greater number of long-term conditions.

## Economy and employment

Employment is a key challenge in coastal communities and impacts health in multiple ways. ONS analysis for the report shows that the unemployment and part-time employment rate is higher in coastal towns. There is also a greater dependency on the public sector for employment in coastal communities.

The drivers of employment patterns in coastal communities are varied. The case studies illustrate that higher levels of unemployment, part time and seasonal work may be due to a decline in traditional industries which were central to the original reasons these communities thrived and grew, such as previous versions of tourism, fishing, engineering and manufacturing. These industries have changed over recent decades and the historical 'purpose of place' has changed. Poor transport connections, peripheral location and long distances to local employers are also a challenge, along with limited awareness of opportunities outside the local area. A person in a coastal community looking to work outside their area has literally half the geographical options of inland towns (the other half is the sea). Lack of diversification in the local economy is problematic; however, some areas have been able to adapt, whilst others, for various reasons, have found this more challenging. These findings are also highlighted by the House of Lords Select Committee on Seaside Towns and the Coastal Communities Alliance[6,7]. North East Lincolnshire's Director of Public Health describes how a third of economic inactivity is due to long-term sickness and is linked to high rates of chronic disease in some of their neighbourhoods.

COVID-19 has had a significant impact on unemployment rates in coastal communities. The case studies suggest that this is due in large part to their reliance on tourism and hospitality, but also the already low levels of employment and opportunities. Increases in unemployment-related benefit claims during COVID-19 were not equal across the country. Areas that started out with higher claimant rates and those with a higher reliance on tourism were hit especially hard[8]. Coastal areas like Blackpool, Devon and Cornwall have been particularly affected. This is supported by other reports, including by the Institute of Fiscal Studies, which found that many coastal areas are notably vulnerable along both health and employment dimensions[9,10]. Whilst the effects of the initial COVID-19 waves will fade, these communities are more vulnerable to economic shocks of many kinds.

Poor employment prospects underpin many drivers of poor health outcomes, and good quality, stable jobs are important in ensuring positive health outcomes. Local areas, however, have embraced various innovative strategies to improve employment prospects, including working with local anchor institutions. The NHS's work on anchor institutions is an example of how the health sector can support this given the NHS and social care are major employers in many coastal communities.

## Education

Poor educational attainment is linked to worse health outcomes over a lifetime[11]. Analyses from the report suggest that children in coastal communities have worse education attainment compared to those in non-coastal areas. This is especially true for progression to higher education. There is, however, disparity between different types of coastal communities as outlined by ONS.

The case studies mirror these findings. In Clacton, for example, the proportion of children achieving a good level of development is statistically significantly worse than wider Tendring, Essex and national comparators, with only 53% achieving a good level of development at age 5 compared with 58% in Tendring and 62% in Essex. Morecambe and Torbay report high numbers of children receiving Special Educational Need (SEN) support, with Torbay emphasising that poor outcomes are often masked by the high performance of pupils in the grammar school system.

The Director of Public Health in Lincolnshire describes how poor educational attainment includes low aspirations that may be tempered by home and community expectations. Access to local higher education opportunities is also harder than for most inland communities. Travel times from coastal Skegness or Mablethorpe to Lincoln are over two hours when using public transport, making on-campus learning unviable for those who need to live at home. Young people often leave coastal areas to pursue higher education given the lack of local opportunities, and the Morecambe public health team describe how these young people rarely return, making recruitment into local businesses and the development of the local economy more difficult.

The Coastal Communities Alliance summarise several reasons for the patterns of comparatively low education attainment in coastal areas which include: a transient workforce with a high percent turnover of pupils; lack of access to further education; lack of employment opportunities and investment in skills development and lack of adaptation to peak and low season patterns of employment[6]. With support from the Coastal Communities Fund, Lincolnshire is piloting courses that are adaptable to the seasonal nature of coastal communities, with the aim of encouraging young people to continue in education that is flexible to their needs.

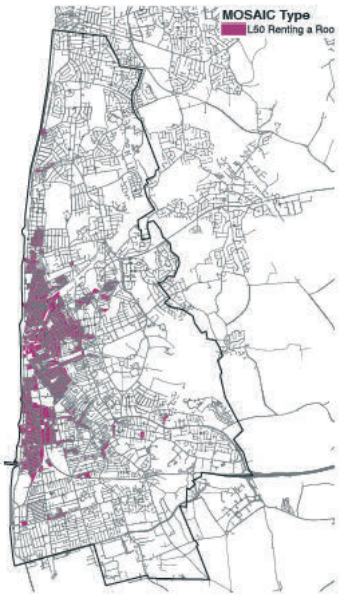
## Housing

Housing, especially the private rented sector and other accommodation including Houses of Multiple Occupation (HMOs) and static caravan parks, is a key issue for coastal communities. HMOs in seaside towns have often been converted from now comparatively cheap former guesthouses, designed for a previous form of seaside tourism. Directors of Public Health and local government leaders raise concerns about the challenges of poor quality, but cheap HMOs, encouraging the migration of vulnerable people from elsewhere in the UK, often with multiple and complex health needs, into coastal towns. This has implications for both service provision and support. Blackpool's Director of Public Health describes the tight relationship between poor quality private rented housing and low life expectancy, with those living in the failing private rented housing of inner Blackpool dying prematurely (Figure 7).

Static caravan parks present a different set of challenges, often being the home for part of the year for older citizens with multiple health needs or migrant workers, but without the service provision designed in to support them.

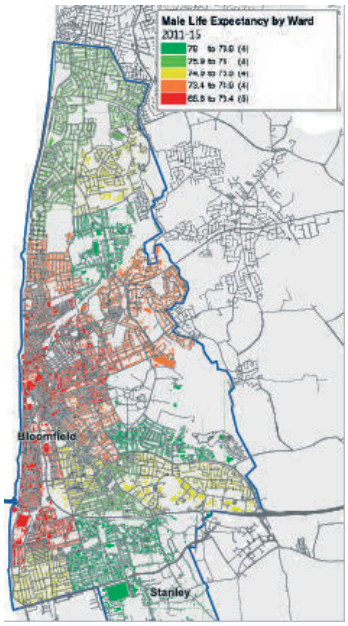
**Figure 7:** Approximate location of HMOs and Male Life Expectancy

**Approximate location of HMOs**




**Source:** Blackpool Public Health Annual Report 2017

**Male Life Expectancy**




**Source:** Public Health England Local Health

## Benefits of coastal living

Although the report demonstrates the many health challenges of coastal communities, paradoxically coastal areas are generally intrinsically healthier. Once socio-economic and demographic characteristics are accounted for, those living closer to the coast report better health on average than their inland counterparts. The report highlights that there are health benefits (both physical and mental) to living near the coast which are not merely the result of selective migration. These may include better access to outdoor spaces for exercise, social contact and lower air pollution. There are also opportunities from new initiatives such as the English Coast Path. These geographical advantages provide a good starting point for many of the changes that need to occur.

## Problems caused by the physical geography of the coast

Flooding is more common in many coastal areas, through combinations of storm surges from the sea, and fluvial (river) flooding as many are built on river outlets of flood plains. Flooding can have a significant health impact both in the short term and long term. Drowning, physical injuries and water contamination may impact in the immediate aftermath, whereas mental health problems, access to health care and loss of employment can have severe long-term consequences. Modelling of future flood risk indicates significant increases in future coastal flood risks with coastal local authorities including Hull, the City of Portsmouth, and Sedgemoor District Council at particular risk. Climate change will exacerbate this risk.

Having half of the surrounding area as sea makes transport, digital connection and wider connectivity more difficult. The time taken to get from coastal communities to major conurbations for work, specialist healthcare, retail and leisure is often considerable, providing a physical reason for some coastal community challenges.

## Limitations of data and definitions

A key challenge for the report has been the minimal research and limited data available at small area geographies. Several key public health indicators were not available or accessible for analysis at lower level geographies. The Directors of Public Health and chapter authors clearly highlight that the granularity of analysis makes a major difference, and that health outcomes in coastal communities can be significantly masked when analysis is at a wider geographical footprint such as local authority or CCGs.

Data from Clacton highlight that a key issue in recognising and understanding the severity and rate of the decline in the area, is that data are usually presented on a wider Tendring footprint, which includes some areas that are relatively affluent. If just the wards identified as Clacton are considered, the level of deprivation around the education and childhood deprivation domains exceed almost all comparators.

A further limitation is that there is no nationally agreed definition or consensus on what constitutes a 'coastal community'. Academics, institutions, and policy makers have adopted a variety of definitions. These range from the narrower specification of seaside resorts, to broader classifications which include every local authority with a coastline or estuary. Each definition has its limitations and there is commonly an element of subjectivity in the categorisation. Certain 'sub-categories', for example, port-towns or seaside towns may sometimes be an appropriate narrower definition depending on the purpose for categorisation.

## A strong case for national action

The UK, and England specifically, is a coastal nation. A high proportion of the worst health and wellbeing outcomes in England are concentrated in coastal communities. The specific health challenges of coastal communities often have much more in common with one another than their nearest inland neighbours, making a national strategy to complement local and regional initiatives a sensible approach. If we could reduce the health disparities in coastal communities, the impact locally would be very positive. Given the scale, improving health in coastal communities means the median health and wellbeing of the whole country would also be lifted, and the long tail of poor health outcomes in the nation would be reduced appreciably. Many of these challenges are amenable to strong, targeted, long-term action. The report highlights many problems, but they are problems to which in many cases there are solutions. We have suggested some specific recommendations for action, but these should be viewed as a starting place. Coastal communities have major public health challenges, and we have a responsibility to meet them.

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# Recommendations

## The report has three key recommendations, and several more specific recommendations.

Lead government departments and organisations are listed where appropriate, but this is not exhaustive, and this work needs a whole of government response.

## Key recommendations:

1. Given the health and wellbeing challenges of coastal communities have more in common with one another than inland neighbours, there should be a **national strategy to improve the health and wellbeing of coastal communities**. This must be cross-government as many of the key drivers and levers such as housing, environment, education, employment, economic drivers and transport are wider than health.
2. The current **mismatch between health and social care worker deployment and disease prevalence in coastal areas** needs to be addressed. This requires action by HEE and NHSE/I.
3. The paucity of **granular data and actionable research into the health needs of coastal communities** is striking. Improving this will assist the formulation of policies to improve the health of coastal communities. Local authorities, ONS and NHSE/I need to make access to more granular data available. Research funders, including NIHR and UKRI, need to provide incentives for research aimed specifically at improving coastal community health.

## Detailed recommendations:

### 1. Develop a national cross-government strategy on health and wellbeing of coastal communities

The strategy should consider cross-government action on the following:

| | | |
|---|---|---|
| **1.1** | Planning for the ageing population in coastal and other peripheral areas, with consideration to migratory patterns, and the potential for a deficit of social care and healthcare workers relative to older populations | Cross-government |

| | | |
|---|---|---|
| **1.2** | Opportunities for joint working from early years through to further education to improve both health and educational outcomes for children and young people in coastal communities | DfE, MHCLG |
| **1.3** | Opportunities for joint working to maximize economic opportunities for coastal communities including maintaining the current focus on the role of the NHS as an anchor institution | NHSE/I, DWP, DHSC, MHCLG |
| **1.4** | Review of incentives in the private rental sector in coastal communities, specifically HMOs which draw a transient vulnerable population to coastal communities | MHCLG, HMT |
| **1.5** | How to mitigate the transport links which make coastal communities more peripheral | DfT |
| **1.6** | Specific plans for major risk factors concentrated in coastal communities – especially high rates of smoking in pregnancy, alcohol and substance misuse | DHSC, NHSE/I |
| **1.7** | Looking at funding formulas which disadvantage coastal communities | MHCLG, DHSC, HMT |
| **1.8** | Making more of the potential health and wellbeing benefits of living in coastal communities | DEFRA, MHCLG |

## 2. Maintain focus on the current and proposed future medical education reforms which includes the geographical redistribution programme

Additional work is required to;

| | | |
|---|---|---|
| **2.1** | Take account of the coastal deficit in the location of new medical schools, and actively recruit in coastal communities to existing medical schools | HEE, DHSC |
| **2.2** | Increase GP and specialty training placements (including public health) in coastal areas | HEE, NHSE/I |
| **2.3** | Increase access of coastal communities to specialist healthcare, including via digital methods | HEE, NHSE/I |
| **2.4** | Build upon learning from the COVID-19 pandemic and HEE's Future Doctor report to strengthen the focus on maintaining generalist skills, which are doubly useful in populations with multimorbidity in peripheral areas further from specialist care | HEE |

| | | |
|---|---|---|
| **2.5** | Review whether current funding arrangements are a disincentive to GP, nursing and other NHS and social care workers moving to coastal areas | HEE, DHSC |
| **2.6** | Consider the wider workforce including social care and other NHS workforce in addition to the medical and nursing workforce | NHSE/I, DHSC |

## 3. Improve data and research into coastal communities

This work should include the following actions:

| | | |
|---|---|---|
| **3.1** | Review the availability, access and applicability of data on health and wellbeing outcomes and their determinants at lower geographical levels. This includes the analytical capacity across the system to collate, analyse, interpret and disseminate the existing data. This needs consideration of data sharing arrangements | OHP, ONS |
| **3.2** | Further multi-disciplinary research is required to understand the multiple drivers of poor health outcomes in coastal communities and test effective interventions and solutions. This requires specific incentives to leading health academic groups by research funders | NIHR, MRC, ESRC |
| **3.3** | Analysis suggests that there may be service level challenges in coastal communities. Further research is required to assess this including reviewing the actual, versus expected disease prevalence and service provision in coastal and non-coastal communities | Health inequalities team in NHSE and DHSC |
| **3.4** | Research on the health and wellbeing of coastal communities should be encouraged in coastal universities where appropriate, for example through civic agreements between universities and local authorities | NIHR, MRC |
| **3.5** | Review migration patterns at lower level geographies to improve understanding of their impact on local communities | ONS |
| **3.6** | Improve joint working between local authorities and academic institutions data sharing arrangements | Research funders, especially NIHR, MRC, ESRC |

| | | |
|---|---|---|
| **3.7** | Given the commonality of interest between coastal areas, learning networks of those leading population health in these areas should be encouraged, linked to academic institutions with an interest in building the knowledge base on health improvements | ADPH |

## Further recommendations

| | | |
|---|---|---|
| **4.1** | Continue work to ensure Directors of Public Health in every Integrated Care System (ICS) are an integral part of the ICS Executive leadership team/ board | DHSC |
| **4.2** | The high rates of excess alcohol use in coastal communities, and specifically issues in resort towns, further strengthens the case that public health should be added as a licensing objective in the Licensing Act 2003 | HO, DHSC |

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# Update on the development of Hampshire and Isle of Wight Integrated Care System for Isle of Wight Council Policy and Scrutiny Committee for Health and Social Care

## Context

1. This paper provides an update on the development of the Hampshire and Isle of Wight Integrated Care System (ICS) and the Isle of Wight Health and Care Partnership. This update builds on the briefing provided at the July meeting.

2. Integrated Care Systems were established to bring together providers and commissioners of NHS services, local authorities and other local partners to plan and improve health and care services to meet the needs of their population. The core purpose of an Integrated Care System is to:

   - Improve outcomes in population health and healthcare
   - Tackle inequalities in outcomes, experience and access
   - Enhance productivity and value for money
   - Support broader social and economic development

3. Integrated Care is about giving people the health and care support they need, joined up across public services.

4. The Hampshire and Isle of Wight ICS serves 1.9 million people living in Portsmouth, Isle of Wight, Southampton and Hampshire, and is one of 42 ICSs in England. In Hampshire and Isle of Wight, NHS, local government and voluntary sector partners have been working together for a number of years to improve and integrate care. For the Isle of Wight, the Integrated Care Partnership brings local partners together to collaborate and to plan and deliver improvements for Island residents.

5. The Health and Care Bill is currently making its way through the parliamentary approvals process. The Bill is intended to further support the development of Integrated Care Systems, and make it easier for partners to collaborate to improve health and care for residents. The Bill will establish ICSs (which are currently informal collaborations) as statutory bodies. The functions currently undertaken by Clinical Commissioning Groups will transfer to ICSs.

6. A key aim is to build on and further strengthen local collaboration between partners – for example on the Isle of Wight – to address health inequalities, sustain joined up, efficient and effective services, and enhance productivity.

7. Since the last meeting of the committee, further guidance has been published by NHS England setting out the requirements, based on the Bill, that ICSs must deliver in readiness for 1 April 2022. These technical documents form the basis on which NHS England will assesses progress within the NHS throughout the remainder of 2021/22. Guidance received to date include:

   - ICS readiness to operate checklist and statement

- ICS people function, HR and employment commitment
- Provider collaborative guidance
- ICS functions and governance guide
- CCG close down and ICS establishment checklists
- Model constitution
- NHS oversight metrics and framework

## Statutory ICS arrangements for Hampshire & Isle of Wight

8. Subject to the passage of legislation, and in line with the requirements set out in the Bill, the statutory ICS arrangements for Hampshire & Isle of Wight will comprise:

    - The **Hampshire & Isle of Wight ICS NHS Body** which leads integration within the NHS, bringing together all those involved in planning and providing NHS services to agree and deliver ambitions for the health of the population. The ICS NHS Body will be responsible for NHS strategic planning and the allocation of NHS resources. It will receive a financial allocation from NHS England and will be accountable to NHS England for the outcomes it achieves for the population of Hampshire & Isle of Wight. The ICS NHS Body will have a unitary board (the Integrated Care Board) with a chair and chief executive, executive and non-executive directors and members from NHS Trusts, general practice and local authorities.

    - The **Hampshire & Isle of Wight ICS Partnership.** This is the forum which brings local government, the NHS and other partners together across Hampshire & Isle of Wight to align ambitions, purpose and strategies to integrate care and improve health and wellbeing outcomes. The ICS Partnership will be established jointly by the NHS ICS Body and the four upper tier local authorities and has responsibility for preparing an 'Integrated Care Strategy' setting out how the health and social care needs of the population of Hampshire & Isle of Wight are to be met, and how the wider determinants of health and wellbeing will be addressed. The ICS NHS Body and local authorities will have a duty to have regard to this Integrated Care Strategy.

9. In order to deliver their core purpose, the ICS NHS Body and ICS Partnership will be supported by strong local place-based partnerships (see section below on the Isle of Wight partnership) and provider collaboratives.

10. Provider collaboratives are partnership arrangements involving at least two NHS Trusts working at scale with a shared purpose and effective decision making arrangements to reduce unwarranted variation and inequality in health outcomes, access to services and experience, and to improve resilience (by, for example, providing mutual aid).

11. Isle of Wight NHS Trust has developed provider partnerships with Solent NHS Trust, South Central Ambulance Service NHS Foundation Trust and Portsmouth Hospitals University NHS Trust to support the delivery of high quality sustainable patient services for Island residents.

## Isle of Wight Place Partnership (Isle of Wight Integrated Care Partnership)

12. Strong local place based partnerships, such as that for the Isle of Wight, are at the heart of the way ICSs work to deliver improvements for residents. Local partnerships have the best opportunity to reflect the needs of their community and design local services to meet those needs.

13. Health and care partners on the Isle of Wight currently work together through the Isle of Wight Integrated Care Partnership.

14. The national guidance for the design of ICSs makes clear that local place based partnerships are key to the co-ordination and improvement of services, and to addressing the wider determinants of health. The Health and Care Bill does not prescribe the local arrangements for place based partnerships, instead providing flexibility for each ICS to agree with local partners the approach that best suits local needs (including the membership and governance), building on existing arrangements. The ICS NHS Body will remain accountable for NHS resources deployed at local level.

15. National guidance sets the expectation that, as a minimum, local partnerships should include primary care provider leadership, local authorities (including directors of public health), providers of acute, community and mental health services, and representatives of people who access care and support. Local partnerships are expected to work closely with Health and Wellbeing Boards.

16. There is now the opportunity to further develop the Isle of Wight Integrated Care Partnership, further strengthening the local partnership arrangements to meet the needs of Island residents. Work is already underway with members of the Isle of Wight Integrated Care Partnership to consider the arrangements that will be best suited to meet the needs of the Island.

## Next steps

17. NHS England has confirmed the appointment of Lena Samuels as Chair Designate for the Hampshire and Isle of Wight Integrated Care Board. Lena currently serves as the chair of the ICS and we are delighted that she will be continuing to support the development of the ICS. Other roles will be recruited to in due course.

18. During Autumn 2021, the statutory arrangements for the ICS and the local place based arrangements – including the Isle of Wight place partnership – will be designed with local partners.

1 September 2021

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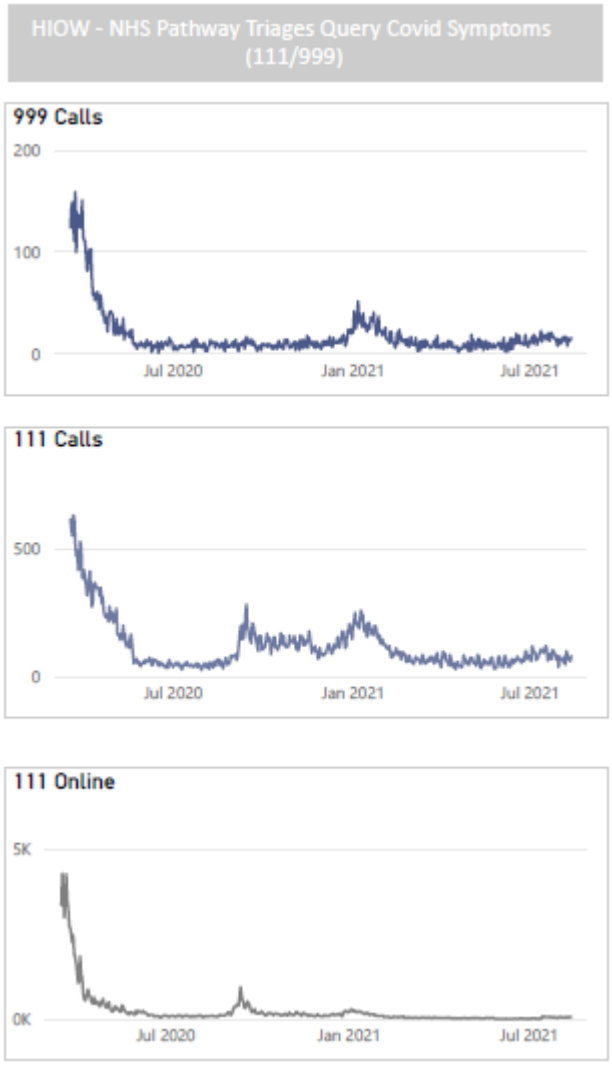
# Hampshire and Isle of Wight NHS response to COVID-19
# Update Briefing for HIOW Overview and Scrutiny Committees/Panels
# September 2021

## 1. Introduction

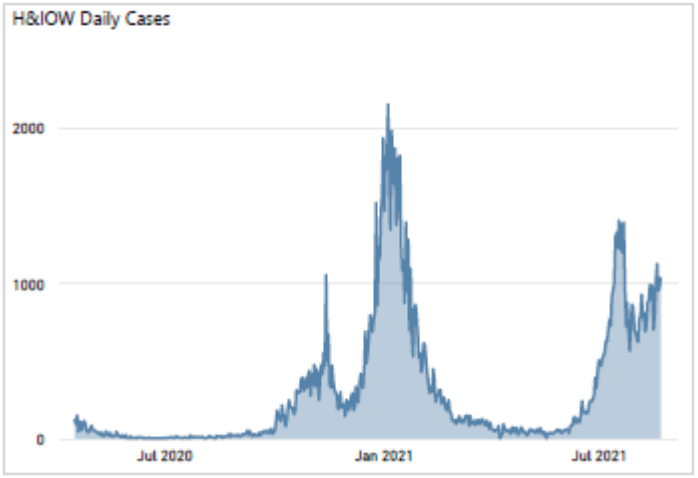
This paper provides an update on the impact to date of the pandemic on Hampshire and Isle of Wight and planning, the COVID-19 vaccination programme and recovery of services, including increases in planned activity.

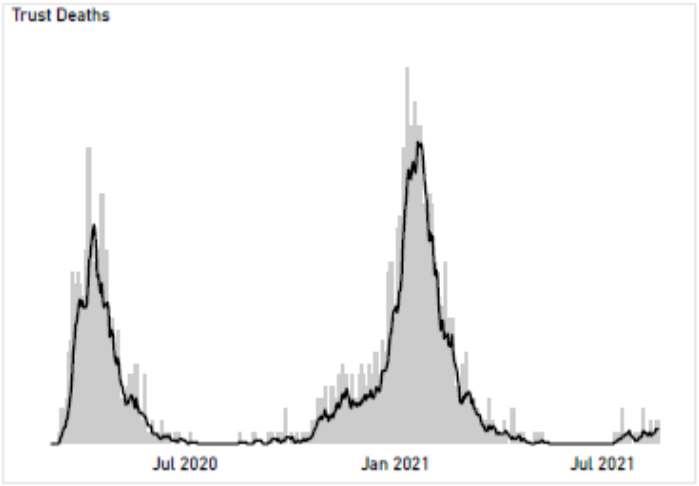
## 2. Impact of COVID-19 in Hampshire and the Isle of Wight

The following graphs show the number of NHS 111 calls, NHS 111 online contacts and 999 calls with potential COVID-19 symptoms.

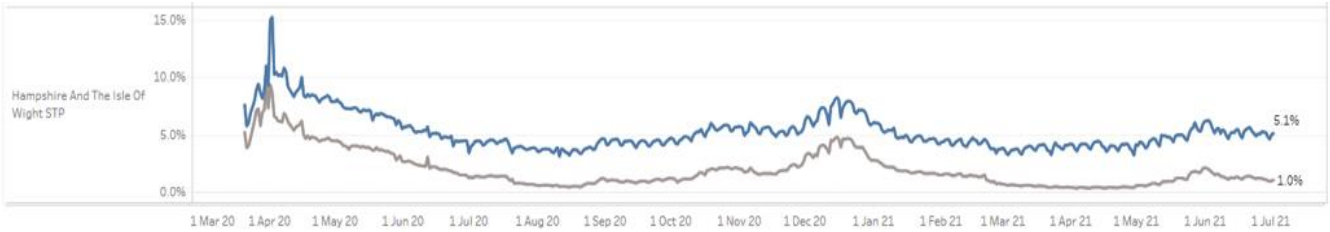


The following graphs show the number of daily COVID cases and the number of deaths in HIOW Acute Trusts due to COVID.




The following graph shows the daily staff sickness rate across Hampshire and the Isle of Wight.




As at 25 August, the staff absence rate is 5.1% for all staff absences, which is an improvement on previous highs of 8.8%. Sickness related to Covid-19 sickness or self-isolation is currently at 1%.

We continue to do all we can to ensure that we are supporting our staff. A wide range of support continues to be available, including mental health and wellbeing programmes and bespoke support for all staff groups.

Our primary care colleagues continue to do incredible work to respond to patient need, both COVID-19 and non-COVID related. This is against the backdrop of increasing demand, and while continuing to play a significant role in the delivery of the COVID-19 vaccination programme across Hampshire and the Isle

of Wight. Face-to face appointments are available for those who need them, and primary care continues to provide access via telephone and online via eConsult where appropriate.

Our community mental health teams continue to work closely together to supported discharge services, early intervention services and keep our patients safe in the community under incredibly challenging circumstances.

The number of patients with COVID-19 being cared for in hospital reduced to very low levels by the end of May (46). Since Covid lockdown restrictions were lifted on 12 July, we have seen numbers rise steadily over the last few weeks. As of 23 August, there were 139 patients with COVID-19 being cared for across all four hospital sites in Hampshire and the Isle of Wight. The largest increase in Covid cases identified in the last 30 days is predominantly in the 15-24 year old age groups.

We continue to work closely with our health and care partners to respond to COVID-19 while also focusing on the continued recovery of services and local delivery of the vaccination programme. We are monitoring the situation closely and ensuring we are as prepared as possible for any potential future impact of the pandemic in our communities, including new variants.

Across Hampshire and the Isle of Wight we have seen a marked increase in non-COVID-19 related demand for care. At present:

- NHS 111 and 999 calls with query COVID-19 symptoms remain comparatively low compared to peak activity during waves 1 and 2 of the pandemic, but 111 calls and 999 calls for non-COVID-19 activity have returned to pre-pandemic levels
- Emergency Department activity volumes have risen to peaks above “normal” levels in June and July – with some days in July being as busy as a normal January period
- Primary care is also exceptionally busy, with ongoing high patient demand and GP practices continue to GP practices continue to work hard to safely deliver care to the population

**3. Recovery of services across Hampshire and the Isle of Wight**

Elective recovery plans have been finalised by all Trusts, and include additional activity in order to deliver the accelerator bid targets we agreed with NHS England – HIOW ICS going further, faster for our patients, and aiming for a peak of 110% activity compared to 19/20 levels

We are currently delivering a higher level of activity than the national standard (95% of 2019/20 activity levels), and current data shows HIOW ICS meeting all accelerator standards, with the exception of Day Case activity.

The accelerator programme has been extended until November and the system will need to continue to meet its target of 110% of activity.

Cancer activity remains strong, with Wessex Cancer Alliance (WCA) 2nd highest nationally and HIOW 4th highest ICS. HIOW continue to exceed the 28 days faster diagnosis standard, however we have seen more challenged performance in June as a result of the expected marked increase in two week wait referrals, which has impacted on 2 week wait and 62 day standards.

A significant programme of investment is underway to sustainably transform mental health services over the next three years for the benefit of our communities, with a particular focus on children and young people.

We continue to work with partners to support implementation of innovative ways to reduce waiting lists wherever possible, while continuing to support on the health, wellbeing and recovery of individuals working across the system.

In response to the challenges presented by the pandemic to the elective care programme in Hampshire and the Isle of Wight, the health and care system continues to work in partnership to:

- innovate, share learning and work with patients to make best use of our existing planned care capacity. This work has included:
    - drawing on insight from national productivity and efficiency tools (such as Get It Right First Time) to maximise patient throughput of, for example, theatres
    - using digital approaches to benefit patient experience and reduce non-value adding activity for example virtual consultations, patient-initiated follow-up and digital pre-operative assessment
    - rolling out best practice pathways of care including the use of 'advice and guidance' to ensure patients are able to access the optimal outcome as rapidly as possible

- create additional capacity - in a co-ordinated and sustainable way that maximises the return on investment. This work has included:
    - accessing capacity in the Independent Sector, creating multi-organisational treatment hubs, and jointly negotiating with providers of capacity to get best value
    - accelerating the creation of a flexible workforce that will be able to support the hub development, administrative support to enhance take-up of independent sector capacity. The workforce element will enable us to build greater resilience into our delivery programme and build a more secure workforce for the future.

## 4. COVID-19 Vaccination Programme

We continue to work in partnership to roll-out the COVID-19 Vaccination Programme locally. We are doing all we can to encourage uptake to ensure as many eligible people in our communities as possible are protected from the virus.

Latest figures published by NHS England and NHS Improvement show that as of 26 August, more than 2.54m vaccines have been delivered across the Hampshire and Isle of Wight Integrated Care System (ICS) footprint.

We are incredibly grateful for the dedication and hard work of our partners, colleagues and volunteers who continue to do all they can to support local delivery of the programme.

### Vaccinating children and young people

At the time of submitting this report, the vaccination programme has been extended to 16 and 17 year olds. At-risk children aged between 12 and 15 years old, who are clinically vulnerable to COVID-19 or live with adults who are at increased risk of serious illness from the virus are also being invited to get vaccinated. This follows changes to guidance from the Joint Committee on Vaccination and Immunisation (JCVI).

On 5 August a letter summarising the guidance and operational next steps was published. All remaining 16 year olds and 17 year olds who are not within three months of their 18th birthday were

then contacted through letters and text messages to be offered one dose of the Pfizer BioNTech vaccine and we continue to promote uptake to these groups and everyone eligible. We await a national update on the plans to offer the vaccine to all 12 to 15 year olds.

**Targeted work to encourage uptake**

Working with our partners we continue to tackle inequalities, addressing individual concerns and circumstances and focusing in specific areas to increase uptake, taking into account demographics such as age, ethnicity and deprivation.

Our outreach work to reduce barriers for people who may be less likely to take up the offer of a vaccine is ongoing, and ranges from walk-ins to pop-up clinics, support for some of the most vulnerable people in our communities and work with community leaders.

We continue to ensure support is in place to support clients of sexual health and HIV clinics to be vaccinated, with appropriate confidentiality arrangements. Clinics have been set up for people receiving support for substance misuse to be vaccinated across the ICS footprint and work is ongoing with local authorities and PCNs to support homeless people to get vaccinated.

Examples of community activity also include the pop-up vaccination clinic held by Solent NHS Trust at Victorious Festival in Southsea for anyone aged 16 and over and a two-day partnership walk-in vaccination clinic at Southampton Guildhall at which approximately 1,700 people were vaccinated on 10 and 11 July. Other recent activities have included walk-in clinics at fire stations across the area and walk-in clinics led by Primary Care Networks, all of which are widely promoted via social and regional media and partners. We are also working with organisers of the Isle of Wight Festival to provide a pop-up vaccination clinic on-site at the event later this month.

We are working closely with our local authority partners to target schools, colleges and universities to encourage more young people to take up the offer of a vaccine as soon as possible.

**Preparing for phase three**

Once we have the vaccinations for all 12-15 year olds underway, our focus is shifting towards the COVID-19 booster doses alongside the flu vaccination programme, while continuing to promote the “evergreen” offer of a COVID-19 vaccination for anyone in Hampshire and the Isle of Wight who is yet to receive their first dose for any reason. We are also continuing to encourage uptake and provide second doses of the vaccine for all those recommended by the JCVI to receive them.

Anyone who receives an invitation for a COVID-19 jab, whether for their first or second dose, is urged to act on this as soon as possible. People do not need to be registered with a GP or have an NHS number to be vaccinated, but it is not yet possible to book an appointment via the NBS without one.

For those not registered with a GP or without an NHS number, walk-in and pop-up sites continue to be available and are promoted both via NHS England and Improvement’s website and the Hampshire, Southampton and Isle of Wight CCG website here. Walk-ins and pop-ups also continue to be promoted via our partners, local and social media.

### Vaccine effectiveness

A study published by the University of Oxford highlights that obtaining two vaccine doses remains the most effective way to ensure protection against the COVID-19 Delta variant. Conducted in partnership with the Office of National Statistics (ONS) and the Department of Health and Social Care (DHSC), the study found that with Delta, Pfizer-BioNTech and AstraZeneca vaccines still offer good protection against new infections, but effectiveness is reduced compared with Alpha.

## 5. Recommendation

The Committee is asked to note this update briefing.

**ENDS**

# Policy and Scrutiny Committee for Health and Social Care - Workplan 2021/22

| DATE | MEETING | DESCRIPTION/ BACKGROUND | |
|---|---|---|---|
| **31 August 2021** | **Informal Briefing** | Induction session, to receive an overview of current issues from Adult Social Care and Housing Needs. | |
| **31 August 2021** | **Informal Briefing** | Induction session, to receive an overview of current issues from the IW CCG. | |
| **1 September 2021** | **Informal Briefing** | Induction session, to receive an overview of current issues from Public Health. | |
| **7 September 2021** | **Informal Briefing** | Induction session, to receive an overview of current issues from the IW NHS Trust. | |
| **13 September 2021** | **Committee** | Dentistry | To consider progress by NHSE/I in relation to dental provision on the Island. |
| | | Integrated Care Partnership | To consider progress with the establishment of the ICP together with any other implications arising from the Health and Care Bill. |
| | | GP Patient Survey 2021 | To consider the results of the 2021 GP Patient Survey |
| | | Health in Coastal Communities – Chief Medical Officer's Annual Report 2021 | To discuss the findings and recommendations in the national report an the actions that can be taken at a local level to understand and addres the issues identified. |
| | | Patient Transport | To ascertain what actions are being taken to improve arrangements fo patients having to travel to mainland facilities for treatment. |
| | | Updates on significant service issues | To consider any update on any significant service issue not already covered on the agenda but requiring the formal attention of the committee. |
| **5 October 2021** | **Informal Briefing** | To receive an update on current issues from the IW NHS Trust. | |
| **7 October 2021** | **Informal Briefing** | To receive an update on current issues from Public Health. | |
| **14 October 2021** | **Informal Briefing** | To receive an update on current issues from Adult Social Care and Housing Needs. | |
| **19 October 2021** | **Informal Briefing** | To receive an update on current issues from the IW CCG. | |
| **29 November 2021** | **Committee** | Integrated Care Partnership | To consider progress with the establishment of the ICP together with any other implications arising from the Health and Care Bill. |

# Policy and Scrutiny Committee for Health and Social Care - Workplan 2021/22

| | | | |
|---|---|---|---|
| | | Safeguard Adults Board (SAB) Annual Report 2019-20 and 2020-21 | To consider the Safeguard Adults Board (SAB) annual report 2019-20. Note: this item was delayed due to the impact of Covid-19 and the annual report for 2020-21 |
| | | Updates on significant service issues | To consider any update on any significant service issue not already covered on the agenda but requiring the formal attention of the committee. |
| | | Deprivation of Liberty Standards Assessments | To monitor the number of outstanding assessments. |
| | | Public Health Strategy | To look at progress with the delivery of the strategy. |
| **27 January 2022** | **Informal Briefing** | To receive an update on current issues from the IW CCG. | |
| **2 February 2022** | **Informal Briefing** | To receive an update on current issues from the IW NHS Trust | |
| **10 February 2022** | **Informal Briefing** | To receive an update on current issues from Adult Social Care and Housing Needs. | |
| **17 February 2022** | **Informal Briefing** | To receive an update on current issues from Public Health. | |
| **14 March 2022** | **Committee** | Integrated Care Partnership | To consider progress with the establishment of the ICP together with any other implications arising from the Health and Care Bill. |
| | | Updates on significant service issues | To consider any update on any significant service issue not already covered on the agenda but requiring the formal attention of the committee. |
| | | Care Closer to Home Strategy | To monitor the delivery of the strategy |
| | | Pride in Our Practice | To monitor the delivery of the strategy |
| | | | |