HEALTH COMMITTEE: MINUTES

Date: Thursday 25th June 2020

Time: 1.30pm – 3.54pm

Venue: *Meeting held remotely in accordance with The Local Authorities (Coronavirus) (Flexibility of Local Authority Meetings) (England) Regulations 2020*

Present: Councillors, D Connor, L Dupré, M Goldsack, L Harford, A Hay (Vice-Chairman) M Howell, P Hudson (Chairman) L Jones, L Nethsingha and S van de Ven

District Councillors D Ambrose-Smith, S Clark, G Harvey N Massey, and J Taverner

Apologies: Councillors K Reynolds (Cllr Goldsack substituting) M Smith (Cllr Howell substituting)

In welcoming everyone to the meeting the Chairman wished to place on record his thanks for the service provided to the Committee by the previous Democratic Services Officer Dan Snowdon.

300. APPOINTMENT OF CHAIRMAN AND VICE CHAIRMAN

It was noted that the Annual Council in May had appointed Councillor Peter Hudson as the Chairman and Councillor Anne Hay as the Vice Chairman.

301. DECLARATIONS OF INTEREST

Councillor van de Ven declared a non statutory interest under the Code of Conduct in relation to minute 306, Covid-19 Update, as her son worked at Addenbrooke's Hospital.

302. MINUTES – 5th MAY 2020

The minutes of the meeting held on 5th May 2020 were agreed as a correct record.

303. HEALTH COMMITTEE – ACTION LOG

In respect of the responses on care homes one Member expressed disappointment that the responses were very brief and would have liked to have seen more detail, highlighting that she received more information from the local press or hospital updates, the latter referencing the number of discharged patients who had not been tested and requesting that as much information as possible was provided in future responses. The Director of Public Health explained that the information the Member referred to from Addenbrooke's Hospital was not held by the Council as different organisations held different information. Information provided by Care Homes to Public Health included a great deal of confidential, operational information that was not appropriate to be included in a public forum. She did draw attention to more detail in the question and answer appendix to the Log.

The Action Log was noted.

304. PETITIONS AND PUBLIC QUESTIONS

There were no petitions or public questions.

305. CO-OPTED DISTRICT COUNCILLOR APPOINTMENTS

It was noted that:

Huntingdonshire District Council had reappointed Cllr Mrs Jill Taverner with Cllr Mrs Sarah Wilson as her substitute.

East Cambridgeshire Council had reappointed Councillor David Ambrose Smith with Councillor Julia Huffer as his substitute.

Cambridge City had re-appointed Councillor Nick Massey with Cllr Anthony Martinelli as substitute

South Cambridgeshire district Council have not had an annual meeting so Councillor Geoff Harvey remained their member and Cllr Alex Malyon the substitute

306. COVID-19 UPDATE

Given the rapidly changing situation and the need to provide the Committee and the public with the most up to date information possible, the Chairman reported that he had accepted this as a late report on the following grounds:

1. Reason for lateness: To allow the report to contain the most up to date information possible.

2. Reason for urgency: To enable the committee to be briefed on the current situation in relation to the Council's response to Covid-19 for those services for which it was responsible.

Introducing the report, the Director of Public Health provided the most up to date information from the Covid 19 cell which was meeting.

Her oral update included that:

- there had been 2 new Pillar 1 confirmed Covid 19 cases in Cambridgeshire in the latest reporting period 15th to 21st June leading to an updated total of 1243 cases overall. Pillar 1 testing was mainly for residents in care homes and patients in hospitals being carried out in local labs and did not include national testing procedures including drive through and internet testing, but picked up the most serious cases. Two new cases was positive and showed the trend was continuing to fall.

- Overall Pillar 1 cases in Cambridgeshire was significantly lower than the national rate apart from Huntingdonshire, which was similar to the national rate.

- There had been one suspected care home outbreak in the same reporting period and was again positive as being significantly lower than in earlier reporting periods.

- The national statistics for the period March to the end of May also confirmed that death rates in Cambridgeshire were significantly lower than the national average with the statistics for the week ending Friday 12 June showing there had been 4 deaths from Covid 19 in Cambridgeshire. The trend continued to be downwards and reflected the overall national position.

The Director of Public Health highlighted Section 5 of the report titled 'Public Health

Service Response' (wrongly shown in heading as Section 4 but with all subsequent numbered paragraphs showing them correctly as sub paragraphs of Section 5) which detailed the specialist public advice being provided by the Public Health team across the County and the various sub-groups of the Strategic Co-ordination Group.

It was highlighted:

- That a Public Health Advice Cell with membership from Local Authority Public Health, the Clinical Commissioning Group and Public Health England had been created for escalation of more complex issues.

- A public health specialist continued to jointly chair the Local Resilience Forum (PPE) hub with a CCG manager, ensuring that national Personal Public Protection PPE stock was distributed appropriately to health and social care providers.

- There had been ongoing support to public mental health promotion, for a range of voluntary sector and other service providers to continue to support vulnerable populations.

- A stock-take of Covid-19 impact and risk for socially excluded and vulnerable population groups identified a number of priority areas with details provided on who was taking action to address them.

- That at the beginning of June, Public Health England (PHE) had published a review of disparities in risks and outcomes from Covid-19 identifying risk factors for poor outcomes such as age (the strongest risk factor), gender, ethnicity, occupation, long term conditions and socio-economic deprivation with summaries of the review distributed to senior officers and to the SCG.

- The main priority for Public Health as a specialist team since May had been the implementation of the national Test and Trace Programme through development of a Cambridgeshire and Peterborough Local Outbreak Control Plan. This was a nationally required local plan for a local response to manage more complex, local outbreaks working with the Public Health England Health Protection Team and Environmental Health officers and various other NHS colleagues for the control the spread of Covid-19 infection, through identifying cases by widespread testing, and then tracing their close contacts who were then asked to self-isolate for 14 days. The Plan has seven key theme to deliver against listed in paragraph 5.11 of the report. The work of the various agencies was being co-ordinated through Local Health Protection Board. The Plan would be considered at the Cambridgeshire and Peterborough Joint Health and Wellbeing Board meeting on the 29th June for subsequent submission to national government on 30th June. However this was not sufficient on its own to contain Covid-19, and ongoing social distancing and hygiene measures would still be required going forward.
- A Surveillance Group was now meeting daily to look at epidemiological data and local trends.
- An Incident Management Centre had been set up to provide a single point of contact for reporting local outbreaks with the Director thanking Kate Parker for her work on helping setting it up.

- Terms of reference had been prepared for a new member led Local Outbreak Engagement Board drawn from the membership of the Joint Health and Wellbeing Board Core Sub-committee to include the Leader of Peterborough City Council and the Deputy Leader of Cambridgeshire County Council the co-

option of the Chairman of this Committee, the Peterborough Public Health Portfolio holder and a District Councillor with local councillors to be co-opted when there was an outbreak in their local areas. It would meet in public but was not a decision making body, as its main purpose was to impart good communication and provide strong political leadership.

In thanking the Director of Public Health for her presentation update, the Chairman wished to place on record his thanks to both her, who had come back from leave for the meeting and her team for all the hard work and long hours they had undertaken during the present crisis **and asked that this was conveyed on to her staff. Action.** These sentiments were also subsequently reiterated by all Members when asking questions / raising issues on the report.

Issues raised by Members included:

- Why Huntingdonshire Covid 19 figures were consistently poorer? Research undertaken jointly with Public Health England had identified a strong association in some health and social care settings but that there was nothing unique that had been found in Cambridgeshire. Rural areas had issues with the age of the population and those living in poorer conditions. In Cambridge City the risks of higher rates of CO-vid 19 could be associated with higher urban density and a higher concentration of black and other ethnic minority groups and was also an issues in parts of Fenland, due to factors such as poorer quality housing and the difficulty of social distancing.
- One Member referencing page 3 the directly aged standardised rates of mortality data and the flagging up how they were higher in Fenland, suggested that while it was fine to extrapolate the risk factors, as a Committee, there was a need when moving forward and already knowing about areas of deprivation and low investment, to look at the Health and Inequalities correlation issue between how Covid 19 had struck and the way health and inequalities were embedded across the population. This she considered was an area that needed further investigation and was a very important question for the Committee. Officers confirmed that they would be reporting back on this to future meetings as it became more apparent. **Action**
- On the issue of homeless people as an identified at risk group, and the benefits that had been ascertained in terms of moving them off the street into hotel accommodation during the lockdown, one Member highlighted that some Councils were potentially moving them out again as Government funding was for a limited period. Questions were raised during a debate on what could be done to ensure the benefits for them was not lost when lockdown was eased. Val Thomas indicated Public Health were working with various organisations including the CCG in respect of ensuring greater access to services for a number of at risk groups moving forward. Also highlighted was the positive feedback received from rough sleepers across all the districts of the benefits that they themselves perceived from not sleeping rough and the range of support services they had been able to access. It was an agenda item for the next Sub Regional Housing Board with reassurance given that it was a very high priority for the local district councils going forward, who were reporting back on the actions they were taking, while also waiting to hear what additional financial support would be provided from Government moving forward. It was agreed that it would be good to obtain more information on what districts were intending to do going forward, with Fenland referenced as a council that were moving the homeless out of hotel to other accommodation **Action**
- Referencing paragraphs 9,10 and 11 of the report in respect of Test and Trace, one Member expressed her concerns at how successful it could be in densely populated areas when the Government data provided to local councils regarding

outbreaks was restricted to postcodes and not specific addresses. It was clarified that if locally there was an outbreak in a setting, Public Health England and the local Authority would have access to more detail of where the setting was but that individual names and addresses was personal, sensitive information and was handled currently by Public Health England.

- On testing in Care Homes, a Member argued the need for continuous testing asking what was the data regarding frequency of testing in Cambridgeshire Care Homes. In terms of testing the Government had offered testing for all residents and staff in Care Homes by the 6th June. There was ongoing debate among professionals on whether there should be continuous testing in all care homes as this would require a great deal of resource, especially now that the level of sickness had subsided. If an outbreak was now detected as a result of a positive test in a care home, all residents and staff would be tested
- It was highlighted that although the report referenced outbreaks premises such as schools / care homes, there was no detail about outbreaks in such places as food processing factories, of which there were a considerable number in Fenland and East Cambridgeshire. Reference was made to the outbreak at the Princes factory in Wisbech and whether public health were working collaboratively to reduce the risk of such outbreaks. There was considerable discussion regarding this particular outbreak. It was explained that there had been a lot of work undertaken in conjunction with Environmental Health officers in this area, with it being clarified that the outbreak had not been as the result of relaxing of the social distancing rules by the factory. All recommendations had been acted on following a local authority visit and the case was seen an exemplar of best practice of how to deal with an outbreak in this particular setting.
- Referencing a school that was closed down in Suffolk due to an outbreak within a bubble, a Member asked if there had been similar incidents in Cambridge and if a similar approach was or would be followed. In reply details were given of a Schools Cell and a memorandum of understanding that had been agreed between Public Health and the Director of Education to support schools on the action that would be taken. This would be included in the Local Outbreak Plan document. It was confirmed that similar action had taken place in the same type of circumstance and the procedures were working well. Also highlighted was the fact that the Service worked closely with schools in cases where children had been sent home with data being shared on test results.
- Was there any update on the vaccination trials as the media were reporting that there could shortly potentially be a vaccine available that could treat 40 million people? The Director of Public Health cautioned that new vaccines did take time to test and would take longer in lower Covid case areas. Considerably more testing would need to be carried out before any vaccine could be certified to be used on a much wider scale.
- Clarity was sought on how the Trace and Test system would work on settings outside care homes / schools / meat packing plants etc. such as swimming pools and other places where people would gather in large numbers and where it would be much harder to trace, if an individual was later identified as testing positive, especially as there was not currently a phone contact tracing app. Linked to this was asking whether it was possible to close down an area smaller than a district to control a local outbreak. In reply it was clarified that when not looking at a local setting, the main contact tracing would be carried out by the national Test and Trace system. At a local level more resource might be provided from the national Test and Trace system if required. Local authorities currently had no powers to shut down individual streets and the indication was that this was not likely to change. Environmental Health officers had specific powers to close down shops, restaurants or swimming pools if deemed a threat to Public Health. It was considered that residents now had a very good understanding of Covid 19 threats and Public Health, in liaison with local

councils, needed to look at the best ways in a situation like this to continue to communicate the measures communities should take to protect themselves, in addition to any enforcement measures. In reply to a later follow up question, it was confirmed that there been the only case of its type in the County on that scale.

- Following up the fact that Local authorities were not empowered to close down a specific area, a Member highlighted that it was critical therefore for full information to be shared from the national Test and Tracing system to local level in a very short time frame to allow for speedy communication of preventative measures to be targeted to the local population affected. On this, a question was raised regarding providing an estimate on the timescale currently taken for this information to be passed on from the national to local level. In reply, while agreeing that speedy transmission was clearly vital, as there had not been a case requiring such data sharing from the national system, such a timeframe could not currently be given.
- Regarding replying to a query on the resource capacity to be able to a scale up Trace and Testing, the Regional Health Protection Team had the capacity to carry out the bulk of trace and testing work while nationally there were 25,000 people employed. At local level at Level 1, Public Health and Environmental Health Officers would be involved, at Level 2 help could be obtained from teams such as the Sexual Health team. At Level 3 more staff would be required and could involve training up staff such as Environmental Health Assistants. Plans were in place to take over telephone contact tracing and scaling up, but currently this was still being carried out at national level and there was still uncertainty regarding whether it would be transferred to a local level.
- It was highlighted that anti body testing as a means of determining the number of cases in the County was unreliable in that some people testing negative could test positive a day or so later, and others co-vid 19 positive were not being picked up by the test. Following on from this point, the question was raised on whether there was data on the assumed number of covid cases in Cambridgeshire. It was agreed that testing was not the whole answer but Pillar 2 testing data was now becoming available. The Director of Public Health confirmed the test was better in the first three days and was less reliable after that and stated that a better measure of the estimates of covid cases was through sample testing on a regular basis carried out by the Office of National Statistics . In the Country as a whole there were 33,000 positive results which was approximately 1 in 1700 and was considered to be the better estimate measure than counting the number of positive tests. **There was a weekly Public Health England Surveillance report which provided a national map maps on cases identified that the Director of Public Health was happy to share with the Committee. Action**
- A question was raised on what forward planning was taking place to help avoid side by side flu and covid epidemics when the cold weather returned to be able to test whether people had the normal winter bugs like the flu as opposed to Covid 19. The Director agreed that getting local outbreak control plans and systems in place now was essential to help as people begin to develop cold symptoms on what would be a very challenging time including having more testing capacity to be available to help distinguish between the different symptoms. Currently medical experts were still waiting to see the effect of cold on the Covid virus, as this was still generally unknown, as the virus was still very new and had not yet been observed for a whole year cycle.
- Another Member highlighted the importance of currently suspended intervention screening services being restarted as soon as possible, with smear tests cited as one example, to ensure there was not undue added pressures on services going forward from people requiring additional medical treatments as a result of some conditions not having been identified, or treated at an earlier stage. In the discussion the Director agreed there was the need to ensure intervention and

preventative services caught up and did not slip further, citing the importance of continuing with the annual Flue jabs programme for those identified as being in the greatest risk groups. It was highlighted that there had been benefits identified from the lockdown in terms of establishing which services could be effectively provided through virtual consultations, which was likely to influence best practice going forward.

It was suggested that with lockdown about to be relaxed, as a Health Committee, there was a need to acknowledge that there was now a greater risk going forward. The Director of Public Health confirmed that all the scientific evidence was that the virus had not gone away and that the lockdown relaxation was for economic reasons and to allow schools to re-open. There was still the need for people for their own safety to continue to be as careful as possible and to continue to practice good personal hygiene and where possible, still apply the two metre distance rule.

It was resolved:

to note the report.

307. COVID 19 IMPACTS ON PUBLIC HEALTH COMMISSIONED SERVICES

This report detailed how the COVID 19 emergency had impacted on the commissioning process and service delivery of commissioned Public Health services, describing the impact and consequential responses arising from the emergency, along with how services were moving into the recovery or “new normal” stage of the pandemic.

Three procurements at various stages had experienced delays in procurement initiation, new service implementation impacting on the following services: Sexual and Reproductive Health; Prevention of Sexual Ill Health; Drug and Alcohol Treatment; Lifestyle, Primary Care; Healthy Schools, Healthy Workplaces and the Healthy Fenland Fund with report detailing the progress of each services and how the services had adapted to deal with the crisis.

Section 2 of the report set the impacts and delayed timescales in respect of the following joint procurements being undertaken with Peterborough, as well as the how the other services referred to above had adapted their service provision to ensure they were still providing a service to their client groups.

- Integrated Sexual and Reproductive Health (SRH) Services Procurement.
- Prevention of Sexual Ill Health Service.
- Integrated Lifestyle Services.

In terms of recovery / the new normal paragraph 2.14 set out the steps now being undertaken in three key areas:

- The status of services that were stopped and need to resume.
- Service innovation being evaluated to assess outputs and service user acceptability.
- The evaluation of the impact of COVID 19 on services includes the identification of the negative or positive effects upon the more vulnerable or hard to reach groups and any indication of overall impact on health inequalities.

In addition, the financial impact of COVID 19 upon services was also being monitored, although it would take time to fully assess as the service transitioned from emergency into recovery or a new normal.

Questions / Issues raised by Members included:

- That the emphasis in the report was on the financial impact and the governance issues and although learning and development going forward was touched on, there was a need for this to be represented in the recommendations. It was important not to lose the benefits of the volunteer support mechanisms that had grown up locally during the crisis and who would also be ideal for helping with the Test and Trace programme. In reply officers fully agreed with the sentiments expressed and indicated this was being looked at by local resilience forums as there was a lot of commonalty and experience that could be shared as good practice moving forward.
- With reference to paragraph 2.1 and the impact of staff, it would be good to have a better understanding of the Council's response to the effects of the crisis on its staff and also the wider impact in terms of the funding shortfalls.
- A member queried whether there was any data on whether the closure of tier 4 inpatient detoxification settings had resulted in increased deaths or other negative impacts. In reply it was indicated that those on the programme had still received support from staff through visits and the data from drug resulted deaths showed that they were lower during the current crisis.
- A Member highlighted that there had been national coverage of the increase in unwanted pregnancies and abortions during the crisis and asked whether this was also reflected in Cambridgeshire. In reply it was indicated that there was currently a time lag in the data returns for abortions / pregnancies but the officer had not heard anything yet from local practitioners to suggest there was a particular problem, but she would keep a close watch, as it could clearly be a concern going forward.
- One Member wished to pay tribute to those providers who had agreed to extend their current contracts to ensure there was no break in service provision, citing as an example the Prevention of Sexual Ill health provider DHIVERSE, who had required great flexibility from its staff and she hoped that the Committee shared her appreciation and acknowledgement of their efforts. Officers agreed that they fully deserved such praise, as at the end of the day the services had continued and was a great credit to their staff.
- Referencing the Drug and Alcohol Service, one Member highlighted the excellent work undertaken by voluntary groups who helped cover when the main service was only operating from Monday to Friday and suggested moving forward there needed to be a more flexible service provision offer.

In relation to the point made earlier regarding harnessing learning from the Covid experience an additional recommendation was moved and seconded and adopted as a fourth recommendation.

It was resolved to support:

a) The changes to the delivery of commissioned Public Health services necessitated by the COVID 19 emergency and the implications for ongoing service delivery;

b) The financial implications arising from the revised procurement and new service implementation schedule; and

c) Payments to providers in line with the Cabinet Office Policy Procurement Note (PPN) 02/20.

d) Harnessing learning from the experience of Covid 19 including at the most local level

308. HEALTHY CHILD PROGRAMME'S RESPONSE TO COVID-19

This report provides the Committee with an update on:

- The Healthy Child Programme's (HCP) response to the current Coronavirus pandemic with Commissioners and Providers of the Healthy Child Programme (Health Visiting, Family Nurse Partnership, School Nursing and Vision Screening) having worked closely to ensure that families remained supported during the pandemic, whilst keeping staff and families safe. The full details were set out in part 2 of the report (paragraphs 2.1-2.14)
- the integrated work from the Best Start in Life Strategy group during this period as detailed in section 3 of the report (paragraphs 3.1 -3.3).
- the initial approach to the recovery phase as detailed in section 4 paragraphs 4.1-4.2).

Questions / issues raised included:

- Concerns that as a result of the crisis, a large number of children would have missed their vaccinations and asking what was being done to catch up with the back log to ensure there was no epidemic of measles etc. In reply it was indicated this was currently a high priority for the School Immunisation Programme, while data was also being collected from NHS England and Healthy Child providers to help promote the need for parents to get their children immunised.
- As a follow on, a question was raised on what action was being taken to ensure Hard to Reach Groups were included. Officers would be looking at the data from NHS England and to also see the good practice adopted in other areas to help reach such groups.
- On the same subject questions were raised regarding what help could be offered for working parents to obtain appointments outside normal surgery to immunise babies. In response it was explained that baby vaccinations were carried out at GP surgeries, so apart from promoting the service, Public Health Officers had no powers to direct surgeries regarding their opening hours. **There was a request as this was a particular concern to the Committee that this issue should be taken up at the next available CCG liaison meeting in terms of potentially varying GP's contracts to allow / encourage such activities outside of normal surgery hours. Action**
- With reference to paragraph 4.2 of the report the need for a mitigation strategy was wider than missed vaccinations and encompassed issues such as the social isolation of children; the need to get children back to school and domestic abuse in order to protect both the physical and mental health of children. This was something that should be reported on in future update reports. The officer confirmed that this would be undertaken, highlighting that in respect of domestic abuse Healthy Child Programme providers were working closely with Children's Social Care during the lockdown to support those identified as being at risk. In terms of clinically extremely vulnerable groups (children who were shielding) the Royal College of Paediatrics and Child Health (RCPCH) had reduced the criteria of shielded groups for health reasons to allow more children to be eligible to be able to return to school. (See following link (https://www.rcpch.ac.uk/news-events/news/rcpch-releases-guidance-clinicians-shielding-children-young-people)

It was resolved:

To note and comment on the progress made to date in responding to the impact of the ongoing Coronavirus pandemic.

SCRUTINY

309. NHS QUALITY ACCOUNTS – ESTABLISHING A PROCESS FOR RESPONDING TO 2019-20 REQUESTS

NHS Healthcare providers are required under the Health Act 2009 to produce an annual Quality Account report on the quality of services by an NHS healthcare provider and to send to the Health Committee in its Overview and Scrutiny function a copy of their Quality Account for information and comment. While there was no statutory requirement for the Health Committee to respond to the Quality Accounts, statements received from Healthwatch and Health Overview and Scrutiny Committees were required to be included in the final, published version. The report invited the Committee, to agree the process to respond to statements on the Quality Accounts provided by NHS Provider Trusts.

In previous years the deadlines for NHS Healthcare providers to submit their final Quality Accounts to NHS Improvement had not allowed adequate time for the Quality Accounts to be discussed at Health Committee meetings and scrutiny has been conducted through a member task and finish group. Due to the pressures presented by the covid-19 pandemic the deadlines for trusts to publish their 2019/20 Quality Accounts had been revised to 15th December 2020..

It was proposed that a member led task and finish group should therefore be established to review the Quality Accounts and draft a statement of response on behalf of the Committee. Where possible statements would be brought back to Committee to approve the final submission. However if timelines did not allow this, then the Committee was being asked to approve a delegation.

It was resolved:

To note the requirement for NHS Provider Trusts to request comment from Health Scrutiny committees and

a) to note the improvements in the process introduced for responding to Quality Accounts in 2019 and feedback from the Trusts

b) to agree that the Committee should respond to Quality Accounts from the provider trusts:-

i) by appointing the following representatives from the Health Committee to a Task and Finish Group to review those received:

- .Councillor Linda Jones
- Councillor Susan van de Ven
- Councillor Anne Hay
- Councillor Lynda Harford
- Councillor Jill Taverner

ii) receive and comment on statements from the Task and Finish Group if response timescales allow.

iii) if response timescales do not allow full Committee input, to agree to delegate approval of the responses to the Quality Accounts to the

Head of Public Health Business Programmes acting in consultation with the views of members of the Committee appointed to the cross party member led Task and Finish Group.

OTHER DECISIONS

310. HEALTH COMMITTEE AGENDA PLAN AND APPOINTMENTS TO OUTSIDE BODIES AND INTERNAL ADVISORY GROUPS AND PANELS

This repot invited the Committee to review its agenda plan and to consider whether, as it was required to do on an annual basis, to re-appoint the same appointments to outside bodies, internal advisory groups and panels within the Committee's remit, or to consider suggesting any changes.

In relation to the appointment to Cambridge University Hospitals NHS Foundation Trust Council of Governors, currently Cllr Howell and Cambridgeshire and Peterborough NHS Foundation Trust, currently Councillor Graham Wilson, Democratic Services orally that reported that having been approached both had indicated that they would be happy to continue to serve on them if the Committee was minded to reappoint them.

During discussion regarding liaison meetings starting up again the question was raised and why there was never any meetings between Members and CCS. **Officers were asked to look into setting up a meeting with CCS. Action: Kate Parker**

Action: The Chairman requested that officers should look to devising a reporting mechanism for appointees to the agreed outside bodies reporting back to the Committee. There was also a similar request for some form of feedback from the joint liaison group meetings.

Regarding the agenda plan Members made the following comments:

- Highlighting that the Covid -19 Reports ran out after the September Committee. (*post meeting note: Democratic Services have since been asked to add them on all service Committees agenda plans up to December*)
- A county Council Covid readiness Look back Review should be considered for a future meeting.
- There was a request for officers to pick up some of the main points made during the meeting for future reports or for inclusion in future update reports.

It was resolved to:

a) to note the agenda plan attached at Appendix 1 to the report and note that there would be representation from the CCG for scrutiny questions at the 9TH July meeting;

b) To ask officers to schedule for future meetings reports / or include information in existing monitoring reports on the key issues raised at the meeting including;

- In due course in terms of Covid readiness - a review the performance of the Council in responding to the crisis.
- Mitigation measures to protect children's health regarding social isolation including liaison with CCG regarding more flexible GP opening hours to help increase the uptake of children's vaccinations

- Details of the additional work undertaken by voluntary organisation and contractors during the Covid crisis and how this could be utilised going forward
- Details of liaison undertaken with other partners to help safeguard the benefits of the additional services provided to the homeless during the lockdown

c) Officers to devise a reporting mechanism for Members appointed to outside bodies to report back to the Committee

d) Agree the appointments to outside bodies as detailed in Appendix 2 of the officer report; and

e) Agree the appointments to Internal Advisory Groups and Panels as detailed in Appendix 3 of the Officer report.

Chairman