Access to planned health care within the context of Covid-19 response and recovery planning

Report of the Health Scrutiny Committee (Sub-Committee of the People Scrutiny Commission)

Contents

Executive Summary

Return to contents

The Health Scrutiny Working Group, a cross-party group of elected Members, Chaired by Councillor Brenda Massey, was convened in July 2020 to focus on the effect Covid-19 has had on equitable and timely access to planned health care in Bristol, what the city-wide response has been, and what learning there is to help inform and build resilience for the ongoing challenges and for risks of future pandemics. In August 2020 evidence was heard from 10 participants and the Working Group also considered 9 further submissions. The issues, reflections and responses that came out of the two evidence sessions have been organised across 3 key areas: (i) Communication and messaging; (ii) Communities and support; (iii) Capacity and ways of working.

Significant findings were;

- Despite complex changes being implemented extremely quickly and efficiently to ensure NHS settings were made as safe as possible for patients, many still stayed away due to, for some, not fully understanding information, and fear of catching Covid-19. Members thought that better, more accessible and culturally competent communication was required to support people to attend their elective care appointments and help manage the huge increase of patients on waiting lists.

- Limitations with digital communications were flagged as an issue. This included vulnerable and older people finding it difficult to access services on digital platforms; and some households having limited access to online resources due to a lack of devices and/or broadband. There had been distribution of devices with connectivity to economically deprived households, although this was limited. There was a need, therefore, to tackle digital poverty; and for additional coaching and training to use digital technology.

- Capacity across the health system had been severely reduced with the need to implement infection control measures, impacting the time taken for care, and adding to the numbers of people waiting longer. This demanded a greater focus on community support and resilience.

- The role of Social Prescriber Link Worker was noted as vital to help people navigate the health and social care system, and to free up capacity for health professionals. Members agreed that there should be a greater focus on this role within the context of community-led provision. An approach to welfare and service provision which involved building relationships and enabling capabilities was identified as essential.[1] The positive development of locality-based community health, care and wellbeing services during this period was welcomed and Members thought this should be developed further.

- An awareness of a 'second pandemic' of mental health was raised as a concern; and the Members heard about the Healthier Together joint systems approach as a response to this. Members thought this example of positive collaboration should be encouraged.

[1] Members were recommended Hilary Cottam's 'Radical Help' which includes principles and ideas grounded in on Cottam's relational welfare approach, including the importance of relationships and capabilities.

- There had been an increased and deepened partnership working across the system and with the voluntary sector. This had provided for innovative and quick change, and those working arrangements should remain and develop.

- The social status and importance of health and social care workers increased during this period. Members thought this should be built upon to make the recruitment more attractive, helping to build more capacity. The expertise, dedication and flexibility of the workforce across social care and NHS settings was highlighted and commended.

Introduction

Return to contents

Cllr Brenda Massey, Chair of the Health Scrutiny Committee, convened the Health Scrutiny Working Group, a cross-party group of elected Councillors (also known as Members) in July 2020. The Working Group's focus was the effect Covid-19 has had on equitable and timely access to planned health care in Bristol, what the city-wide response has been, and what learning there is to help inform and build resilience for the ongoing challenges and for risks of future pandemics.

A starting point for Working Group was that a health system working well requires equitable and timely access to effective health care. Covid-19 has shone a light on inequalities, delays and concerns across the health system. The pandemic has also highlighted the positive work already underway across health providers; and it has illustrated the 'art of the possible', how people and partnerships have pulled together and risen to the immense challenge.

In August 2020 evidence was heard from 10 participants and the Working Group also considered 9 further submissions. The findings and recommendations are made in the knowledge this is a fast moving landscape with many changes and challenges to come, and so elected Members, following Centre for Public Scrutiny guidance, have concentrated on consideration of how well partners work together across the system to address people's concerns, and aims for its findings to contribute to smooth, effective decision-making to address blockages, barriers and inequalities.

The Health Scrutiny Committee's priority is to ensure local communities and individuals' needs and experiences inform Bristol's health services; and that those services are effective and safe.[2] Therefore, within the context of how Covid-19 has affected, and continues to affect, Bristol's health and wellbeing, the role of health scrutiny is now more important than ever.

[2] Department of Health (2014), 'Local Authority Health Scrutiny: Guidance to support Local Authorities and their partners to deliver effective health scrutiny'

The purpose of the Working Group

Reflection and Learning

The Working Group would like these findings and recommendations to support the Bristol, North Somerset & South Gloucestershire Clinical Commissioning Group (BNSSG CCG), local health providers, the Council and city partners to reflect and learn from the experience of lockdown so as to:

1. Increase resilience and improve accessibility should Covid-19 remain for the foreseeable future or escalate again, and also for the risk of future pandemics;

2. Help improve timely access to planned health care whilst keeping people safe during the recovery period; and to support people where there are delays.

3. Aim for equitable access to planned health care and support for people from different backgrounds, with all protected characteristics, and for those with economic disadvantages.

How the Working Group investigated and collected evidence for this report

The 3 aims above were framed around the following key questions which were referred to when collecting and reviewing evidence;

1. In your view, observations and experiences, how is the waiting list for planned health care being managed and what are the most successful methods of supporting people in need of, but have not had timely access to, required health care?

2. What can be learnt from the response to Covid-19 in terms of ensuring timely access to planned health care; that people are properly supported if delays occur; and that timely access is equitable for all people with different protected characteristics and socio-economic backgrounds across the city?

Participants and submissions

Return to contents

Members of the Health Scrutiny Working Group heard from 10 participants in person, and received a further 9 written submissions.

Session 1

Christina Gray Director, Public Health, Bristol City Council

Hugh Evans Director, Adult Social Care, Bristol City Council

Lisa Manson, Director of Commissioning, Bristol, North Somerset & South Gloucestershire Clinical Commissioning Group

Mark Smith Chief Operating Officer, University Hospitals Bristol and Weston NHS Foundation Trust

Evelyn Barker, Chief Operating Officer, North Bristol NHS Trust

Session 2

Vicky Marriott Area Manager, Healthwatch Bristol, North Somerset & South Gloucestershire

Rhian Loughlin Regional Learning Coordinator for Social Prescribing (South West)

Ruth Thorlby Assistant Director (Policy), The Health Foundation

Evidence not in person

Ade Williams, Community Pharmacist, Bedminster Pharmacy

Healthier Together Citizens Panel (x8)

Cllr Asher Craig Deputy Mayor, Communities, Equalities & Public Health

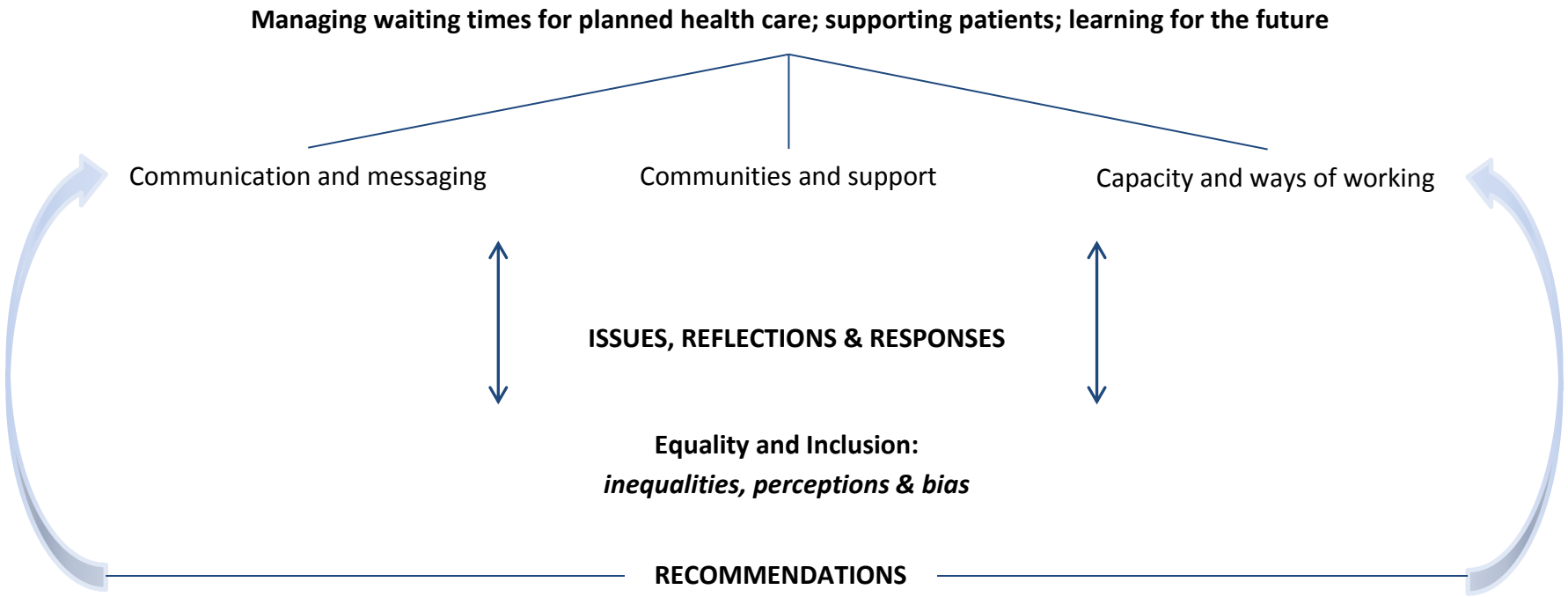
Cllr Helen Holland Cabinet Member, Adult Social Care; Co-Chair of the Health & Wellbeing Board

Findings

Return to contents

The diagram below is a visual representation of what the Working Group has found. Members organised the issues, reflections and responses that arose from the two evidence sessions into 3 key areas: (i) Communication and messaging, (ii) Communities and support, and (iii) Capacity and ways of working.

Members asked questions about patients' support and managing waiting times for planned heath care during the period of lockdown; and, as lockdown restrictions have been relaxed (although with a clear understanding guidance and rules may change quickly), there were reflections on what has worked well and what has been learnt to help increase resilience and generally improve patients' experiences. Members appreciated the relationships and interconnectivity between the 3 key areas, demanding a holistic approach to analysis. Their recommendations are all framed and informed by issues of equality and inclusion.



Communication and messaging

Return to contents

ISSUES	RESPONSES & REFLECTIONS
• Fear of catching Covid-19 in hospital has deterred some people from attending appointments. • Some information needs more clarity, and some should be more culturally or linguistically appropriate for minority groups. • There were reports of people having difficulties navigating the health system. • People still required support whilst face to face contact was reduced. • Limitations with digital communications, including vulnerable and older people had difficulty accessing digital platforms; and some households had limited access to resources due to lack of devices or broadband.	• There is national guidance , public information and local public information about new safety measures, which included separate zones for patients with confirmed negative tests for accessing health care. • Face to face contact had been maintained where necessary (based on risk assessments); and for shielding patients there had been a special pathway, including clearer waiting areas for social distancing. • It was noted that clear, accessible, and more culturally competent communication was required. • Safety measures could prevent family members and carers attending consultations; Members heard that there could be more clarity around how this has been applied. • Patients' feedback and stories were raised as an important source of learning; patients could utilise the Healthwatch share your views page. • Healthwatch document '*North Somerset: stories of shielding or self-isolating, June 2020'* was identified as providing relevant recommendations for clear, age appropriate communication and guidance. • Members heard the Joint School App had supported patients waiting for orthopaedic surgery, replacing services otherwise disrupted by Covid-19. Specialist nurses had kept in contact with patients; and physio-therapy teams contacted patients to take them through the exercises to support them. • Members heard that devices with connectivity had been distributed to economically deprived households, although this was limited and further work was required to address digital poverty; and a need for coaching and training opportunities to use digital technology was recognised.

> *"One of the important things to us is reassuring patients that they are safe coming into any of the NHS facilities, and how we are putting in place changes to make sure we can create as Covid secure environment for patients as possible".*
>
> Lisa Manson, Director of Commissioning, BNSSG CCG

Communities and support

Return to contents

ISSUES	RESPONSES & REFLECTIONS
• There were reports of increased isolation and anxiety during this period. • An awareness of a 'second pandemic' of mental health. • Black, Asian, Minority Ethnic (BAME) communities were more likely to fear hospitals and preferred community-based services. • There was an identified risk of losing local accountability with the evolution to 'Integrated care systems' • Economic disadvantage had come more into focus during this period, with the risk of it becoming worse within the context of an expected economic downturn.	• Public Health and BNSSG CCG co-chaired the mental health and well-being response cell, which took a systems approach (involving clinicians, front-line workers and people with lived experience) to respond to increased demand, including focus on intervention, prevention, and protecting capacity. This work was described as a 'collaborative bid to address the second pandemic in mental health'. • It was noted that Social Prescriber Link Workers have played a vital role to help people navigate the health and social care system; and could free up capacity, including for GPs to focus on medical issues. • There had been a positive recognition that 'health is made in communities'; and that personalised care had become 'business critical' for the NHS. • An approach to welfare and service provision which involved building relationships and enabling capabilities was identified as essential, which would avoid communities being 'managed' by way of top down transactional arrangements.[3] *"It's all about relationships; you can badge it as social prescribing link work, and you can badge it as humans talking to other humans; It's about normalising that in a way that that makes it really straight forward and reduces barriers."* Rhian Loughlin, Regional Learning Coordinator for Social Prescribing (South West) • It was noted that the development of Integrated Care Systems demand a focus on local needs and democratic accountability. • Members were advised that there should be higher investment in community based resources; allocations should be more flexible to target areas of need; and that Covid financial support received by Public Health had been allocated to community development and health champions to reach those most in need.

[3] Members were recommended Hilary Cottam's 'Radical Help' which includes principles and ideas grounded in on Cottam's relational welfare approach, including the importance of relationships and capabilities.

Capacity and ways of working

Return to contents

ISSUES	RESPONSES & REFLECTIONS
• Existing NHS problems exacerbated by Covid-19, including staff shortages. • Covid-19 caused a dramatic fall in planned care to save beds and ICU capacity. • Promoting Covid safety has placed huge restrictions on the NHS and created a lack of capacity. • A greater demand on primary care and adult mental health services within the recovery phase is expected. • Upcoming winter pressures, including flu demands, require strong planning taking into account the extra impact Covid-19 would create.	• Waiting lists were intensified due to fear associated with Covid-19 and a requirement to shield for 2 weeks either side of an operation impacting child care and employment, leading to some n attending. • It was noted that patients who had not engaged in elective treatment weren't referred back to their GPs and so remained on the waiting list. • Whilst routine surgery was stood down, medical staff were trained to work differently; many anaesthetists and surgeons were trained to support medically ill patients. *"Infection control measures have meant reduced capacity within the acute sector, and it is likely the much attention will still need to be paid to the challenges of upcoming Covid-19 waves"* Hugh Evans, Director, Adult Social Care, Bristol City Council • The mobilisation of 'whole system' 'out of hospital' service approaches ('Home-First') during this period was positive, and could address a discharge system that has had challenges. • There had been a positive development of locality-based community health, care and wellbeing services. • An increase and deepening of partnership working across the system and with the voluntary sector was noted. • The contribution of private hospitals was limited, as they relied on surgeons and anaesthetists from NHS, not adding to workforce capacity. *"Although Covid has been very stressful for everybody, there has been a tremendous amount of transformation that has occurred in a matter of weeks; the deepening relationships and the working arrangements we have got in place will now stand us in good stead".* Mark Smith, Chief Operating Officer, University Hospitals Bristol and Weston NHS Foundation Trust • The status of health and social care workers increased; this should be built on to make the recruitment more attractive, helping to build capacity.

Equality and inclusion

Return to contents

ISSUES	RESPONSES & REFLECTIONS
• Communication and guidance was difficult to understand for some people. • Not all households have access to the internet. • Older people have found it difficult to access digital platforms. • Health inequalities persist in the city. • Gaps in data, including ethnicity and mental health.	• It was noted that clear, accessible, and culturally competent communication of information was required. • Members' heard about the national information standard where every hospital records how a patient prefers to receive information, recognising not everyone has access to the internet or is able to use it. • It was noted that devices with connectivity have been distributed to economically deprived households, although this was limited and required further work to address digital poverty. • Coaching and training opportunities to use digital technology were needed to enable access. • Members were advised that community organisations need to be supported during this period to help bring about culturally competent responses and services; and be adequately resourced.

"We know that the contribution of unhealthy weight, smoking, and underlying health conditions have created much higher risk factors in some groups; and whether its Covid or not, if we can address those risk factors in our population, which we all know are associated with inequality, then we will improve health outcomes across the piece"

Christina Gray, Director, Public Health, Bristol City Council

Summing up Return to contents

Despite an array of national and local guidance and information about Covid-19, the Working Group heard that some people have either been unable to access it or it has lacked clarity. Members found that health providers have clearly worked hard to reassure patients, and they have implemented complex changes, including special pathways for vulnerable patients, in a quick and efficient manner. Regardless, and although there have been recent improvements, a great deal of people stayed away due to fear and anxiety of catching Covid-19 in hospital, and decided to not attend their elective care appointment. The huge increase in numbers on the waiting list is partly a result of this with hospitals preferring, for better outcomes for patients, to keep them on the list rather than referring back to GPs due to missed appointments.

It was noted that people from Black, Asian, Minority Ethnic (BAME) communities, and especially Black people, felt inclined to avoid hospital visits due to fear of catching Covid-19, within the context of the knowledge Covid-19 has disproportionately affected BAME communities, with people from Black ethnic groups most likely to be diagnosed, and that death rates from Covid-19 had been highest among people of Black and Asian ethnic groups.[4] Members heard that there was a clear need for a more culturally competent approach to communications and information. Although Covid-19 has shone a light on the need for more cultural competency (as it has also highlighted all structural inequalities), it is relevant and important not just for communications, but for all future policy and service development to ensure health care is available and responds to the needs of the diverse communities across the city.

The Working Group also heard that people with disabilities were also likely to be more fearful of hospitals and preferred community based services. This may be tied to a greater risk in contracting Covid-19 due to extra barriers to social distancing and implementing hygiene measures, including access to regular hand-washing.[5] Due to the fact the largest disparity in how the national population has been affected by Covid-19 was by age[6], it was noted clear and accessible information for older people was vital, as well as ensuring hospital and community services were accessible.

> *"People will be worried and frightened; good care at the moment means someone being in touch with that person to make sure that they are ok, they know what's happening and there is care put in place; it's a worrying and, for some a very painful time, while they wait."*
>
> Ruth Thorlby, Assistant Director (Policy), The Health Foundation

As face-to-face contact needed to be reduced, online communications and service provision was introduced, which although broadly successful, Members were advised about limitations with digital communications including that vulnerable and older people found it difficult to access services on digital platforms; and some households had limited access to online resources due to lack of devices and/or broadband. Face-to-face contact, as well as other methods of communication, was therefore flagged as important for people. Members

[4] Public Health England (2020), 'Disparities in the risk and outcomes of COVID-19'
[5] World Health Organization (2020) 'Disability considerations during the Covid-19 outbreak'
[6] Public Health England (2020), 'Disparities in the risk and outcomes of COVID-19'

heard about the national information standard where every hospital records how a patient prefers to receive information, recognising not everyone has access to the internet or is able to use it.

Members were advised, therefore, that digital solutions to mitigate disrupted services due to Covid-19, including the 'Joint School App' which supported patients waiting for orthopaedic surgery, were just one element of supporting patients needing to wait longer who may be concerned and in pain. Specialist nurses had kept in contact with patients and physio-therapy teams had contacted patients to remotely take them through exercises to support them.

> *"There has been very good close contact with our specialist nurses; a lot of our physio-therapy teams have been contacting patients and taking them through the exercises as well. So, although there are lots of people using it, it's not just all about the app".*
>
> Evelyn Barker, Chief Operating Officer, North Bristol NHS Trust

Elected Members acknowledged the work of Healthwatch, which helped inform the Working Group about the needs, experience and concerns of patients across the area. Recommendations from recent research based on peoples experiences of shielding and self-isolating were reflected upon and it was noted that learning could be applied to Bristol, and Members supported Healthwatch recommendations, including that communication and guidance should be clear and age appropriate.[7]

The Working Group heard that there is an awareness of a 'second pandemic' – that of mental health; that is, people have presented with increasingly poor mental health, anxiety and trauma, and Members were advised a rise in demand of mental health services was expected. Health providers' and the Council's response involving clinicians, front-line workers and people with lived experience, with focus on intervention, prevention, and protecting capacity, was flagged as an example of what could be achieved in collaboration with shared purpose.

> *"We need to prepare for the scenario that those communities who have been hardest hit by Covid will be hardest hit by second pandemic of mental health."*
>
> Rhian Loughlin, Regional Learning Coordinator for Social Prescribing (South West)

Concern was raised about the risk of losing local accountability within the context of the evolution of Integrated care systems, although Members heard that if utilised correctly a more collaborative approach was possible with community care organisations. Members were advised that there has been a positive recognition within the NHS that 'health is made in communities'; with a strong focus on personalised care and agency of individuals and communities. Members thought that there should be higher and targeted investment in

> *"We felt that involving community organisations and local groups was a really key part of helping to ensure those people who are isolated and those without internet access could be reached; and Volunteer NHS Responders who didn't play a huge part in the initial community involvement could be utilised more in the future".*
>
> Vicky Marriott, Area Manager, Healthwatch Bristol, North Somerset & South Gloucestershire

[7] Healthwatch (2020), 'Shielding stories – an insight into how vulnerable people coped in North Somerset'

community based resources; and they were advised that this was happening in Bristol with Covid financial assistance allocated to community development and health champions to reach those most in need.

The role of Social Prescriber Link Workers was highlighted as vital to help people navigate the health and social care system; they could not only free up capacity and remove barriers (such as arranging transport for ill and vulnerable people), but also help enable a relational approach[8] to services and welfare, avoiding communities being 'managed' by way of top down transactional arrangements. Members were advised that there had been a positive development of locality-based community health, care and wellbeing services.

Maintaining some capacity within the context of responding to Covid-19 was a huge challenge. The Working Group heard that promoting Covid safety placed wide-ranging restrictions on health providers and created a lack of capacity. Members heard that with challenges came opportunities, and acceleration and strengthening of partnership working across the system and with the voluntary sector was noted. Examples of how deepened partnership working created efficiency included, during this period, the mobilisation of 'whole system' 'out of hospital' service approaches ('Home-First'), which, Members were advised, could address a discharge system that has had profound challenges.

> *"One of the highlights is how quickly we have been able to adapt, pivot and work differently."*
>
> Cllr Asher Craig, Deputy Mayor, Communities, Equalities and Public Health

Members were advised that the Nightingale Hospital, converted from the Exhibition and Conference Centre at the University of the West of England to address the risk of lack of capacity for intensive care beds, would be re-purposed unless a second wave demanded use. Re-purposing options had yet to be agreed, but included use for diagnostics, 'step-down', and/or training facilities – all assisting with building capacity.

The expertise, dedication and flexibility of the workforce across social care and NHS settings was highlighted and commended. Members heard that whilst routine surgery was stood down, medical staff were trained to work differently, including anaesthetists being trained to support medically ill patients and trained to work in intensive care. Members were told that the contribution of private hospitals was limited due to the reliance on NHS surgeons and anaesthetists not adding any workforce capacity.

The workforce had received a positive profile during this period, and it was noted that the status of health and social care workers increased. Members agreed that this should be built upon to make recruitment more attractive, helping to build more capacity.

> *"There's a really important piece about making sure those health and care jobs look attractive to young people and to returners"*
>
> Cllr Helen Holland, Cabinet Member Adult Social Care; Co-Chair of Health & Wellbeing Board

[8] An approach to welfare and service provision which involves building relationships and enabling capabilities. Members were referred to Hilary Cottam's 'Radical Help'; see also Cottam's relational welfare approach.

The Working Group heard how the pandemic had shone a light on structural inequalities across society, which makes the task of enabling equitable and timely access to appropriate care, whilst ensuring people are supported, more difficult, and so a focus on community-led provision according the needs of local communities, cultural competency, economic disadvantage and health inequalities were called for.

Recommendations

Return to contents

The Health Scrutiny Working Group recommends that;

1. Health partners should work with the Council to consider how guidance about keeping safe and well and information about elective care appointments could be more easily understood, and more accessible to everyone. This should involve consulting with the Race Equality Covid-19 Steering Group, community groups, Healthwatch and social prescribers to better understand the needs of Bristol's diverse communities and increase the cultural competency of information provision.

2. The Council should work with city partners to place a greater focus on tackling the digital divide, and explore options that would enable every household to have equitable access to the internet.

3. BNSSG CCG and the Council should build on the recognition that 'health is made in communities', and so should further invest in community-led provision, including supporting local assets and expertise such as social prescribers and community pharmacies.

4. Preparations for the 'second pandemic' of mental health should be prioritised by health partners and the Council in terms of building capacity to meet increased demand as well as a focus on prevention. The systems approach being developed was commended as a good example of collaborative work between the Council and health partners and this should be built upon, taken forward, and an update of progress brought to by the Health Scrutiny Committee in 2021.

5. Healthier Together and its constituent parts should explore ways to make recruitment to health and care roles more attractive, helping to build more capacity. The expertise, dedication and flexibility of the workforce across social care and NHS settings was highlighted and commended, and arrangements should be made to ensure the work force is supported and able to manage increased demand in the future.

6. The feedback from patients was extremely useful, although better value could be gleaned by enabling more responses and a wider and more representative range of views across Bristol's diverse communities. Healthier Together should, therefore, explore ways to extend the patients' voice in future service developments of health care; and Healthwatch should be supported to build better representation of Bristol's communities within its valuable insights.

7. The positive role of volunteers and mutual aid groups during this period should be learnt from and the Council ought to explore further ways of supporting them.

8. Covid-19 has shone a light on structural inequalities, and so the Council's and health partners' response and recovery planning should build on the current focus on tackling underlying causes of health inequalities and ways to better enable equitable access to health care, no matter people's economic or ethnic backgrounds. This requires utilising the insight and expertise of the Health & Wellbeing Board, as well as local community groups, Healthwatch and national organisations including the Health Foundation. Also, this requires Healthier Together partners to investigate and agree a strategy to increase cultural competency across health care provision, and should ask the Race Equality Covid-19 Steering Group for advice.

9. Through robust data collection, Healthier Together should continue to reflect on known disparities in the risks and outcomes of COVID-19[9] to help gain an understanding of the disproportionate effects on BAME communities. The BNSSSG CCG report 'Impact of COVID-19 and lockdown on health inequalities and steps that need to be taken to address this in BNSSG'[10] should also be referred to and built on, and the Health and Wellbeing Board ought to be supported to identify how health inequalities effect Bristol's diverse communities, building knowledge, preventative strategies, and resilience for the future.

10a. This report should be considered at the Health & Wellbeing Board and be brought to the Healthier Together Executive and the Bristol, North Somerset & South Gloucestershire Clinical Commissioning Group Governing Body for response.

10b. The development of plans to manage waiting lists and support patients within the context of the impact of Covid-19 and to build resilience for the future should be considered by the Health Scrutiny Committee at the next meeting of the Health Scrutiny Committee in 2021, and there should be a review on the 2021-22 work programme.

10c. The scope of the Working Group did not allow time to explore the developments of testing and a Test and Trace system. Due to the importance of a robust Test and Trace system, and that there have been developments which may provide more local control (although this is not certain at the time of publication), an update should be brought to the Health Scrutiny Committee in 2021.

[9] Public Health England (2020), 'Disparities in the risk and outcomes of COVID-19'
[10] BNSSG CCG (2020) 'Impact of COVID-19 and lockdown on health inequalities and steps that need to be taken to address this in BNSSG'

Cllr Massey and all the Members of the Health Scrutiny Working Group (listed below) would like to thank all those who submitted evidence and participated in the Evidence Sessions, sharing their knowledge and experience, which has helped provide valuable scrutiny.

Health Scrutiny Working Group

Cllr Brenda Massey (Chair)

Cllr Celia Phipps

Cllr Eleanor Combley

Cllr Gill Kirk

Cllr Harriet Clough

Cllr Paul Goggin

Cllr Chris Windows

Health Scrutiny Working Group Report

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28th October 2020

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