At a meeting of the HEALTH AND WELLBEING SCRUTINY COMMITTEE held in the CIVIC CENTRE, SUNDERLAND on WEDNESDAY 5th FEBRUARY, 2020 at 5.30p.m.

Present:-

Councillor D. Dixon in the Chair

Councillors Cunningham, Davison, Heron, Leadbitter, N. MacKnight, Mann, McClennan and McDonough

Also in attendance:-

Mr. Mark Cotton – Assistant Director of Communications and Engagement, North East Ambulance Services
Ms. Deborah Cornell – Head of Corporate Affairs, Sunderland CCG
Mr. Nigel Cummings – Scrutiny Officer, Sunderland City Council
Ms. Ruth Frostwick – Locality Commissioning Manager, Sunderland CCG
Mr. David Gallagher – Chief Operating Officer, Sunderland CCG
Dr. Fadi Khalil – Medical Director, All Together Better
Ms. Helen Ray – Chief Executive, North East Ambulance Services
Ms. Joanne Stewart – Principal Governance Services Officer, Sunderland City Council

The Chairman opened the meeting and introductions were made.

Apologies for Absence

Apologies for absence were submitted to the meeting on behalf of Councillors Butler and O'Brien

Minutes of the last meeting of the Committee held on 8th January, 2020

Councillor McClennan referred to paragraph three of the minute for Managing the Market and stated that it did not fully reflect the comments she had made and that it should be duly amended to read:-

'Councillor McClennan referred to recent, well publicised figures for male on male rape and sexual assault, which highlighted that 1 in 6 men would suffer in this way. She asked if the Council provided help for these victims under the domestic violence services or other services.'

And it was:-

1. RESOLVED that the minutes of the last meeting of the Health and Wellbeing Scrutiny Committee held on 8th January, 2020 (copy circulated) be confirmed and signed as a correct record subject to the amendment as set out.

Declarations of Interest (including Whipping Declarations)

Item 4 – Ambulance Performance Update

Councillor MacKnight made an open declaration in the above item as he was employed by one of the CCG organisations which commissioned services for the North East Ambulance Services.

Ambulance Performance Update

The Assistant Director of Communications and Engagement for North East Ambulance Service submitted a report which attached a presentation for Members information.

(for copy report – see original minutes)

The Chairman welcomed and introduced Mr Mark Cotton, Assistant Director of Communications, North East Ambulance Service (NEAS) who provided the Committee with a detailed presentation covering a wide range of issues including:

- Ambulance resources across the South Tyne area;
- How the service was performing;
- The key drivers on performance; and
- The national picture.

Mr Cotton also drew members attention to the updated figures in the presentation to that which was included in their agenda packs which gave a more up to date view of the current position.

(for copy presentation – see original minutes)

Councillor McDonough referred to the changes in vehicle numbers and asked if it was not counterproductive to reduce the number of rapid response vehicles which may be a more responsive, low resource vehicle than the two crew ambulances which were increasing in number. Ms. Ray advised that the operational thinking behind it was that when a rapid response vehicle was used it had been found that should the patient require moving then the ambulance would also need to be called out to transport them, which then saw double the resource being used. The service needs to ensure that they had the right level of vehicle suitable for the most patients. In the instance of low acuity, C3 and C4 patients could continue to use the rapid response vehicles. Ms. Ray advised that this was an area which was consistently refreshed and reviewed to ensure that the service met the need.

In response to a further question from Councillor McDonough as to why figures were not improving if there were more paramedics being recruited, Ms. Ray drew Members attention to the slide entitled ‘improving overall response’; and explained that coming into the winter months the commissioners had supported the service with further investment; these funds had been invested into frontline staff support, mainly through third party providers, and the figures showed that when the services were resourced to the right level, they were able to respond to all patients in a timely

and efficient manner. There remained a staffing gap and they were aware that they needed to pitch to the commissioning teams that the extra resource was required but other areas of the health economy would also be making the same requests for extra funding in their area.

The Chairman commented that residents of the city saw that there had been an increase in resources for the service, more ambulances on the road and a brand new accident and emergency department but waiting times and turnaround times were not improving. He referred to NEAS having become the cheapest ambulance service in the country and asked why this was and stated that he was sure residents would much rather see the service spending more and being ranked the best. Ms. Ray advised that there was a gap of some £12million between NEAS and the next nearest ambulance trust so there was still a level of investment required. Commissioners advise that they have to work to get a real balance, for example, if turnaround times for ambulances were better it could see five more vehicles on the road regionally, but it was difficult as the hospital continues to face an ever increasing problem with an ageing and sicker population with lower life expectancy.

Councillor McDonough commented that the turnaround times for the ambulances was a key issue to address but not a new problem and asked what they were looking to do differently to see improvements. Ms. Ray advised that one of her roles was also Chairman of the Urgent and Emergency Care Network Group and that over the last three months they had refreshed all of their plans into a matrix framework. Members were advised that the problem arose once the patient arrived at the accident and emergency department and that the only hospitals in the area who did not suffer the same issues were Newcastle and North Tees. They were looking at best practice from other areas, whilst also looking at community models and initially expanding the provision of an emergency operation centre, getting clinicians to work in other ways, which in turn could free up ambulance crews; although there was some work to be undertaken to configure these services. Ms. Ray advised that hospitals were now also being challenged to raise the number of bed spaces available as it was recognised that they required more capacity in hospitals. These changes and more investment into adult social care services would help towards alleviating current pressures on services.

Councillor McClennan shared her concern that the presentation given to them had been based around spreadsheets, graphs and figures and commented that it should not be forgotten that they were referring to patients and people who were not just numbers.

Councillor Davison sought an explanation around the significant increase in vehicles and was advised by Mr. Cotton that the slides show that there will now be 112 two crew vehicles on the road where there had previously only been 74. In relation to Sunderland specifically, he advised that of the new two crew vehicles five would be in the Sunderland area, with one not working between the hours of 00:00 and 08:00am as there was not the demand for it. Ms. Ray explained that none of the vehicles were going out of commission but that they were looking to work different hours to better suit the needs of the area.

In response to a further question from Councillor Davison around the maintenance of vehicles and how often they were off road, Ms. Ray advised that there was a rolling stock of vehicles so that vehicles could be taken off road regularly for maintenance, repair and upgrade where necessary. Ms. Ray also advised that they had reserve

vehicles available so if a vehicle went out of commission whilst on shift the maintenance team could take a replacement vehicle to the crew so that they could carry on providing the service whilst the team dealt with the issues with the original vehicle.

When asked for an explanation of the conveyance rate, Ms. Ray advised that it was those times when a patient was transported by ambulance but not to hospital, so possibly to a GP, an urgent treatment centre or care home, etc.

Councillor Heron referred to turnaround times of ambulances and felt that it was ambitious for an ambulance crew to deliver a patient to accident and emergency and then restock and clean the vehicle in the thirty minute target. Ms. Ray advised that it was felt that this was more than enough time if the patient was able to be admitted to the emergency department but that this was where the hold up could be due to the pressures the department may already be under at that time. She told the Committee that the service were quite unique in that they never left a patient on the ambulance and that this was down to good relationships with the hospitals. Patients were kept within the emergency departments until they could be admitted so that they were always visible to staff and the hospitals were brilliant in supporting them with this.

When asked where the community paramedics would be located, Ms. Ray explained that they would rotate in a particular area. Berwick currently had a similar service and it was felt that it worked well in rural areas where staff could work between GP surgeries, the ambulance service, the patient's home, etc. It offered the staff better career opportunities and progressions and team work and they were keen to look at how to run a similar scheme in the urban environment.

In response to a question from Councillor Mann as to how categories were assigned to patients and what the key drivers for classification were, Ms. Ray explained that the majority of patients were assigned a category when they dialled into either 999 or the 111 service. NEAS had a co-located team so that all calls came into the same service and were given the same treatment through the same national triage system. The Committee were advised that the call handlers were not clinicians, although they were very highly trained, but they had access to clinical teams so that if they were unsure as to how to categorise a patient they could pass the call on to them for re-screening. If the response time was not going to be met by the ambulance and crew, call handlers were open and honest with the patient and they were provided with thirty minute call-backs to ensure that the patient did not deteriorate whilst waiting. If, for any reason the call-back was not answered then a patient would be automatically upgraded in category so that a team were dispatched to them sooner.

The Chairman referred to the demanding and high pressured work environment for staff and asked if there were high levels of absence rates, and if these had any impact on performance. Ms. Ray commented that they were aware of the high pressure environment that staff worked in, both ambulance personnel and call handlers and advised Members that they had good occupational health support for staff. They were currently running at 7% sickness rate with a target of 5% so it was higher than they were aiming for. The Committee were informed that they had worked on the sickness policy over the last few months and how better to manage sickness absence. It was felt that staff absences did not have a knock on effect on issues such as turnaround times as they looked to backfill posts to maintain staff

levels so that there were enough people available to cover some sickness, training / development days and/or annual leave.

There being no further questions or comments, the Chairman thanked Mr. Cotton and Ms Ray for their presentation, and it was:-

2. RESOLVED that the content of the presentation be received and noted.

End of life Care – Update

The Sunderland Clinical Commissioning Group (SCCG) submitted a report to provide the Committee with an update on the SCCG End of Life Care Strategy.

(for copy report – see original minutes)

Dr. Khalil, Medical Director, All Together Better and Ms. Frostwick, Locality Commissioning Manager, Sunderland CCG, gave a presentation to the Committee which provided an update on the developments with regards to the end of life strategy which had been developed by the CCG in consultation with stakeholders.

The presentation provided an overview of end of life care in Sunderland and set out targets and outcomes, alongside what had been achieved to date and expectations for future work areas.

(for copy presentation – see original minutes)

In response to a query from Councillor MacKnight as to the work with care homes, following on from the vanguard areas which were introduced, Dr. Khalil advised that each care home was now aligned to their own GP service, who carried out regular visits within the care homes. Advance care plan practices had been introduced in the care homes and they were seeing evidence of improvements being made. There was an issue due to the turnover of staff within care homes but this would always be a challenge that had to be addressed due to the nature of the job.

With regards to training, the Committee were informed that trainers now went into the care homes to give staff presentations and homework and there were files kept for audit which held staff accreditations and details of any training members of staff had undertaken.

Councillor Heron referred to the links with GP's and care homes and stated that residents could also continue to access the work and support provided by Marie Curie and MacMillan nurses as they did in the Coalfields area. Ms. Frostwick agreed that they played a massive part in the support provided to residents in care homes and advised that they would be included in workstreams going forward.

Councillor McClennan referred to the palliative care register and asked how old a patient had to be to be added to the register and was informed that the register did not have age restrictions and that any patient who has a potentially terminal disease would be added to the register. In a follow up question, Councillor McClennan asked if a patient could request to be added to the register and was advised that they could not but that should their care plan indicate that they were receiving palliative care,

i.e. nearing the end of life, then they would be added to the register and rag rated in line with their diagnosis.

Councillor McClennan commented on the numbers of deaths which took place away from care homes, Sunderland being the lowest in the North East and lower than the national average, and asked if they had looked at the possible reasons for this, i.e. could it be due to the paperwork that care homes would have to complete in those instances or if it could be the potential damaging impact on a care home's reputation? She also referred to the Gold Standard Framework for care homes and asked if they had looked at offering a financial incentive to business owners to be accredited at gold standard and Dr. Khalil advised that there was one in place and that there were also incentives attached to some training standards. He advised the Committee that they had provided additional extra resources into care homes and now provided a more experienced nurse to carry out a weekly visit to oversee and support training as well as providing a nurse adjudicator role and it was about all parties working together. He explained that a lot of improvements had been made and they were continuing to see improvement in the sector.

Councillor Davison raised concerns over the choice that patients were given as to their place of death, and as to how patients die, especially when admitted to hospital where they could be deprived of some basic rights. She did not feel that how a patient died should be standardised and asked what choice a patient with a terminal illness had in how their end of life care was provided. Dr. Khalil explained that a standard would mean that every patient had an end of life care plan, not that one plan would be suitable for all patients, and that the weekly visit from the GP would help in establishing that plan. The patient's individual choices would all be included within their plan and would not be dictated to them by any clinician but they would need to know that the patient would have the relevant people around them at the time to support them.

Dr. Khalil went on to agree that hospital was not the place for patients to go to die but advised that it did happen and that at times patients and families may feel that they did not get the level of support that they needed at that time. He felt that this was not due to hospital staff not trying their best but that it was simply not the best place for their end of life care. Councillor Davison reiterated her grave concerns over the treatment she was aware some patients had received, whereby it had not been in line with the choices of the family or patient and commented that she had seen better practices in other neighbouring authorities.

In response to a query from Councillor Mann around the figures in relation to whether families had received different end of life experiences than what was the patients preferred options, Ms. Frostwick explained that this information had not previously been collected, although they were gathering the data now and advised that this could be analysed and further information provided once it was available.

Councillor Mann referred to patients that needed adaptations to be made to care homes before they could be transferred there from hospital and possible delays this may cause and was informed by Dr. Khalil that they did not find that this was as much of an issue as it may have been previously. He explained that there were separate assessment processes now, and that the trust assessment would ensure that any alterations that would need to be made to accommodate the patient were done without delay. He assured the Committee that if they did encounter delays nowadays that they were not of a magnitude to cause concern.

Councillor Dixon asked if the end of life strategy arose from the assessment of population need; which would include the ageing population, those with multiple conditions and those with dementia and queried how population need was measured. Dr. Khalil advised that they knew the demographics of the population and were aware of how palliative care was provided to patients, with most of the care being aged related, and advised that it was very much provided in a multitude of ways that best fit the specific patient. Advance care planning was working towards providing a more integrated service for the patient but there was still a lot of work to be done to continue seeing improvements. He commented that difficult discussions had to be had with patients and family members that they were not always happy with but these discussions needed to be open and frank so that the population begin to understand what the real issues were.

Councillor Cunningham referred to service users and carers and asked how they were involved in the planning, developing, monitoring and evaluation of end of life care services and was informed by Dr. Kahlil that there had been a tendency to focus on quantitative information in the past and they had not been as good as documenting the quality received but advised that there was some university research now being undertaken on the quality of end of life care. He advised Members that they did receive a lot of anecdotal information after a patient had passed away which was an almost informal, soft level of feedback but agreed that this was an area of information gathering which was missing at the moment.

In response to a query from Councillor Cunningham as to whether any consideration had been given to local public awareness plans or campaigns around the issues of death, dying and bereavement, Ms. Frostwick advised that there were national campaigns which the services promoted such as the Dying Matters awareness week whereby the issue of care plans and making wills were discussed but there was a need to provide more. Councillor MacKnight advised of a death café which he was aware was ran by palliative care nurses which helped patients think in a different way about end of life care and helped to share relevant information with them in a relaxed environment.

Councillor Leadbitter commented that she was pleased to hear that more help was going into helping residents stay in care homes and stated that a lot of residents saw the care home as their own home and would wish to stay there; but could understand how families and relatives may think otherwise in the patient's final days. Ms. Frostwick agreed and advised that they looked to provide care homes with as much support as they could and they could see that the attitude and approach in care homes and with staff was changing in light of this.

Councillor McDonough went on to comment that often families may feel that their relative would only get the care they needed in hospital and not in their care home or that patients had a sense of safety when admitted to hospital and it was about how to address those attitudes towards thinking differently. Ms. Frostwick commented that part of the discussions that were being had with patients when preparing their end of life care packages was around what could be offered to support them in feeling less scared and vulnerable and what care they could receive in the best environment for themselves.

The Chairman thanked Dr. Khalil and Ms. Frostwick for their report and informative presentation and asked if an example of an end of care plan could be shared with the Committee for their information and, it was:-

3. RESOLVED that the information provided in the presentation be received and noted.

Annual Work Programme 2019/20

The Strategic Director of People, Communications and Partnerships submitted a report (copy circulated) which set out for Members information the current work programme for the Committee's work during the 2019-20 municipal year.

(for copy report – see original minutes)

Councillor MacKnight referred to the Urgent Care item expected at the next meeting of the Committee and requested that some information be provided in relation to a couple of incidents he was aware of. Firstly, a family member had been offered to attend the centres at either Pallion or South Tyneside, when they lived 400 metres from the Hetton centre as there had been no minor illness or GP access slots available. He asked if information could be provided on the number of appointments that were available at centres and the percentage of service utilisation within his report. Mr. Gallagher advised that this information could be provided but commented that should there be specific incidents the Councillor wished to raise with him outside of the meeting he could look into those directly.

There being no further comments, it was:-

4. RESOLVED that the work programme for 2019/20 be received and noted.

Notice of Key Decisions

The Strategic Director of People, Communications and Partnerships submitted a report (copy circulated) providing Members with an opportunity to consider those items on the Executive's Notice of Key Decisions for the 28 day period from 13 January, 2020.

(for copy report – see original minutes)

5. RESOLVED that the Notice of Key Decisions be received and noted.

The Chairman then closed the meeting having thanked Members and Officers for their attendance and contribution to the meeting.

(Signed) D. DIXON,
Chairman.