NORTHUMBERLAND COUNTY COUNCIL

HEALTH AND WELLBEING OVERVIEW AND SCRUTINY COMMITTEE

At a meeting of the **Health and Wellbeing Overview and Scrutiny Committee** held in Committee Room 1, County Hall, Morpeth on Tuesday, 20 March 2018 at 9.30am.

PRESENT

Councillor Watson, J.
(Chair, in the Chair)

COUNCILLORS

Cessford, T.
Dungworth, S.E.
Foster, J.D.
Horncastle, C.W. (part)
Moore, R.
Nisbet, K. (part)
Rickerby, L.J.
Simpson, E. (part)
Seymour, C.

OFFICERS

M. Bird	Senior Democratic Services Officer
C. Malone	Communications Business Partner
E. Morgan	Director of Public Health

ALSO IN ATTENDANCE

S. Blackburn	Newcastle upon Tyne Hospitals NHS Foundation Trust
B. Dews	North East Ambulance Service NHS Foundation Trust
A. Foster	Northumberland, Tyne and Wear NHS Foundation Trust
J. Moon	Newcastle upon Tyne Hospitals NHS Foundation Trust
F. Neilson	NHS England / Public Health England
A. Pike	Newcastle upon Tyne Hospitals NHS Foundation Trust
C. Riley	Northumbria Healthcare NHS Foundation Trust
J. Rushmer	Northumbria Healthcare NHS Foundation Trust
D. Stephens	North East Ambulance Service NHS Foundation Trust
S. Stephenson	Northumbria Healthcare NHS Foundation Trust
S. Young	NHS Northumberland Clinical Commissioning Group

Eight members of the public were in attendance.

47. APOLOGIES FOR ABSENCE

Apologies were received from Councillor Jones.

The Chair also welcomed Councillor Cessford to his first meeting of the committee, since he had replaced Councillor Lawrie as a member of it.

48. MINUTES

RESOLVED that the meeting of the Health and Wellbeing OSC held on 16 January 2018, as circulated, be approved as a true record and signed by the Chair.

49. FORWARD PLAN OF KEY DECISIONS

Members received the latest Forward Plan of key decisions (enclosed with the official minutes as Appendix A). It was noted that there were currently no items included within this committee's remit.

RESOLVED that the information be noted.

50. HEALTH AND WELLBEING BOARD - MINUTES

The minutes of the Health and Wellbeing Board meetings held on 16 November 2017 and 11 January 2018 were presented for the scrutiny of any issues discussed at those meetings. (Copies enclosed with the official minutes as Appendix B.)

RESOLVED that the information be noted.

REPORTS FOR CONSIDERATION BY SCRUTINY

51. IMMUNISATION PROGRAMMES

A detailed presentation was provided by Fergus Neilson, representing both NHS England and Public Health England, about the various immunisation programmes and the latest information regarding their uptake levels in Northumberland. NHS England were the commissioners of these services. (Copy of presentation appended to the official minutes of the meeting.)

The presentation provided details of:

- Routine childhood vaccinations for 0-5s
- Catchup for 5-19 young people not vaccinated with MMR
- HPV for teenage girls
- Teenage Boosters
- Meningitis catchup for school leavers & students

- Shingles & Pneumococcal for older people
- Flu vaccinations for the range of target age & risk groups.

Detailed discussion followed, of which the key points from members and responses were:

Members expressed concern that the data provided on routine immunisations suggested that uptake had fallen sharply. It was clarified that this was attributable to an issue with the way the data was being reported and extracted rather than a low vaccination uptake rate, as GP practices had later been approached directly for checks on their vaccination rates. GPs recorded all the information, but there were complications with the flow of the information back to the central records system at Public Health England. This had been highlighted as an issue, and the Clinical Commissioning Group would follow up so the data flow was correct. The Chair acknowledged the issue needed attention and requested the up to date figures to be provided as soon as possible; it was suggested that there should be routine checks on the data provided by GPs and action taken if accurate information was not being received.

Reference was made to concerns at a previous meeting about students not being able to access and thus missing immunisations whilst away at university. Members were advised that vaccinations were provided in every school for children aged 12 - 16, and young people aged 17 - 18 were encouraged to see their GP to be immunised before going away to university. If they missed their opportunity, as in the case of the example given one young person missed the immunisation due to the timing of the roll out, they could register with a GP whilst at university to receive the jab. Members stressed that universities needed to do more to perhaps advise students about getting immunised using similar means to how they were reminded about registering to vote. It was added that the wider health system could perhaps do more to raise the profile of this issue; immunisations were important; many young people left the county to go to university and could catch flu if not immunised.

Mr Neil added that flu vaccination uptake in Northumberland was higher than in Cumbria and the North East as a whole, but more needed to be done to support young people and high risk groups such as pregnant women.

In response to a question, members were advised that the percentage of parents refusing the immunisation for their children was very low. It was acknowledged that some children might miss the treatment if absent on the date of treatment; it was important to receive the treatment when it was most easily available, but some catch up service provision was also arranged.

Replying to a question, members were advised that there was no alternative to the treatment being administered by injection, such as a spray. GPs could discuss with patients about overcoming phobias of needles.

A member asked how provision was ensured for children who received home education. Mr Neil would follow up this query.

A member stressed the importance of awareness of the expiration of protection against rubella as it could be a big concern for pregnant women. Members were

advised that the the measles, mumps and rubella (MMR) vaccine treated this and there was no screening for rubella in pregnancy now due to the low levels of it occurring in the population. There had been a brief dip in the take up of MMR at one point. MMR was currently offered to children at one year and at age 3 years 4 months. If one or both vaccinations were missed, a GP could provide this at any other point. There was less awareness raising about rubella as it was now rare. It was added that the national immunisation programmes regularly changed.

The Chair also took the opportunity to welcome the Rotarian organisation's support towards helping to eradicate Polio throughout the world.

Mr Neilson was thanked for his presentation and attendance. It was then:

RESOLVED that

(1) the information be noted;
(2) it be recommended that an improved mechanism to identify issues with data quality should be followed up;
(3) consideration be given to how to ensure a system wide means to ensure young people were vaccinated, perhaps in summer, before many left to go to university; and
(4) other queries be followed up, including immunisations for home educated children.

52. QUALITY ACCOUNTS

Quality Accounts were reports about the quality of services offered by an NHS healthcare provider. The reports were published annually by each provider, and were available to the public.

Northumberland's practice in recent years had been for the Health Overview and Scrutiny Committee to receive a presentation at its March meeting annually on the Quality Accounts/Future Priorities of local NHS Trusts. Representatives of Northumbria NHS Foundation Trust, North East Ambulance Service NHS Foundation Trust, Newcastle upon Tyne Hospitals NHS Foundation Trust and the Northumberland, Tyne and Wear NHS Foundation Trust all attended to give presentations. This was the first year that Newcastle Hospitals NHS Foundation Trust had been invited to attend, so all local Trusts were involved in this meeting.

Members were requested to receive and comment on the presentations from each Trust, and to consider agreeing to submit a formal response to each Trust following the meeting based on members' views.

(a) Northumbria NHS Foundation Trust Annual Plan and Quality Account 2017/18

A presentation was provided by Jeremy Rushmer, Executive Medical Director, Northumbria Healthcare NHS Foundation Trust. (Copy of presentation appended to the official minutes of the meeting.)

Key details included:

- the annual planning process
- safety and quality objectives 2017/18
- Quality Account 2017/18
- their performance on their priorities in 2017/18: on surviving sepsis, abdominal pain, breathlessness, flow, frailty and falls
- the Frailty Assessment Service (FAS)
- other inclusions - safety and quality projects, mortality indicators, examples of quality improvements initiatives, refreshed quality improvement journey
- safety and quality objectives 2018/19
- the draft Quality Account would be ready by mid April 2018, and circulated for comment to stakeholder for formal opinion in late April.

Detailed discussion followed, of which the key points from members and responses were:

- the category ‘as expected’, as compared to the green meaning ‘on or better than target and red ‘below target’, referred to how some but not all performance goals had been met
- regarding the two examples given of the performance in a single week in 17 November and one in 7 January, this information was provided to show the flow in improvement
- it was questioned why the figures shown for abdominal pain statistics were for a single week in August and the week commencing 8 January - members were advised that these had been chosen as representative weeks. It was questioned whether this approach could selectively pick good days; members were advised that the week of 8 January had been their most pressured time. Further information could be provided if wished further assurance. The Trust now managed to see 15 patients within the first hour and more patients were seen early in the process
- a member referred to the sepsis statistics; 67% looked like a low target, considering that the rate had been 31% in November and was now up to 99%? Members were advised that the employees in the service area had been asked to set their own targets
- a member questioned if additional staff had been on duty during the pressured time in January; members were informed that shift patterns had been altered but there had been staffing pressures throughout that period
- regarding concern that comparisons were not like for like, it was clarified that the labelling of the graph on the sepsis page was incorrect; both target headings should have been labelled ‘screening’
- clarification was was provided for the ‘breathlessness’ graph; 0 -8 category was referred to people treated per month
- the statistics only referred to the number of respiratory patients returned for home treatment. A small percentage were inpatients who had an average stay of 4 - 5 days. This was being progressed to see how more people could be treated at home
- it was questioned and confirmed that ambulance handover times only referred to Northumbria Specialist Emergency Care Hospital (NSECH) as there were no handovers at other sites
- it was questioned why ‘flow’ could not cover patients moving from NSECH to other hospitals, including community ones. Work took place on flow requirements to get patients home from NSECH

- regarding the reduction of beds due to staffing issues, members were advised that not all beds at Blyth had been able to be staffed, and remedial beds at North Tyneside had been removed
- work continued to take place on flow and getting patients home from NSECH
- replying to concerns about the clinical impact of changes, some but not other services were commissioned each year, and the decision had been taken to decommission some beds in North Tyneside. Members expressed concern about the impact on south east Northumberland, and reference was also made to the situation in Rothbury
- consideration would be given to why the pilot project for nursing homes having contact direct to paramedics, in order to reduce attendance at hospital, had not been successful
- concerns was expressed that some graphs provided were too detailed and unclear
- a member expressed concern that the graphs on the 'falls' page were difficult to understand, including how October 2017 was the highest month on the second one, and one of the lowest on the first one? Members were advised that the pale blue bars in the first graph referred to all falls, but it was not yet possible to confirm which had caused severe harm or not, as that took time to diagnose/record. The dark blue line in the second graph referred to nationally published data; Northumbria was only above the national average rate on two days. The Safety Thermometer methodology measured a sample
- praise was expressed for the high level of social services and healthcare service integration between the NHS and County Council in Northumberland
- a member stressed that it was difficult to compare with national statistics as Northumberland had different economic and social profiles. The county also had an older population, of which many had long term health problems
- in response to a question, breathlessness was not listed as one of the highest priorities as the Trust's focus was on the areas where limited resources would provide the most benefit
- in response to a question about to what extent the priorities reflected residents' concerns, members were advised that the Trust's listening campaign was undertaken regularly. A patients' experience programme had been established, and the 'Join our Journey' campaign had been launched in September 2017: to listen to residents' concerns. Fantastic feedback had been received from people who had accessed services. A Council of Governors also tested opinion. There were a number of established routes for people to have their say
- it was clarified that rehabilitation from surgery facilities were available at Wansbeck General Hospital, but the procedures were provided at North Tyneside General Hospital
- members were advised that the presentation did not cover all the Trust's services; details of some service areas not highlighted were included in monthly performance reports to the CCG; any missed targets were not forgotten. Patient flows was an ongoing concern being jointly addressed
- staff experience would be measured for the following year's report; staff happiness was considered very important in contributing to successful service outcomes.

Mr Rushmer advised that the updated account would be submitted for comment in late April, and was thanked for his presentation.

(The meeting then adjourned for a 10 minute break. Councillor Horncastle exited the meeting at this point.)

(b) North East Ambulance Service NHS Foundation Trust Annual Plan and Quality Account 2017/18

A presentation was provided by Barry Dews, Strategic Head of Operations and Debra Stephen, Deputy Director of Quality & Safety from the North East Ambulance Service. (Copy of presentation appended to the official minutes of the meeting.)

Key details included:

- ambulance response times standards up to 30 October 2017
- National benchmarking statistics, pre ARP
- ambulance call volumes
- new ambulance performance standards
- ambulance response programme
- Details of Ambulance Response Programme (ARP) categories 1 - 4
- Quality priorities 2017/18: (a) early identification of sepsis; (b) cardiac arrest; (c) long waits; (d) safeguarding referrals.
- the Quality Strategy 2017/20
- the Quality Priorities 2018/19 - continue work on sepsis, cardiac arrest and delays, plus other opportunities such as improving mental health pathways, - improving end of life care, the frailty agenda i.e. falls, dementia & emergency health care plans.

Detailed discussion followed, of which the key points from members and responses were:

In response to questions, it was confirmed that national performance data would not be reported on until April 2018. The latest data for Northumberland would be considered by the CCG's Board and be presented at a later date. Northumberland's performance within the wider North East area was affected by geographical distances and remoteness factors.

A member questioned the call volumes and why were they increasing, when there were other options other than calling 999? Members were advised that data was not available at the meeting, but it could be provided. The new standards had only been introduced in October 2017; the area received the lowest ambulance service funding per head of population. A range of relevant organisations were involved in issuing communications about other options to calling 999 including self care and pharmacies - this message would continue to be promoted.

A member asked if in future some comparisons on response times could be organised with other similar geographically big, sparsely populated counties.

Regarding the impact on First Responders on C1 and C2 calls, members were advised that ensuring they got to the scene as soon as possible was most appropriate, although only less than 1 - 2% of calls involved First Responders. The change in focus was on the clinical needs of the patient. C1 calls were very

successfully being conveyed to hospital, but if people had a fall without an injury, there could be a slower response if their condition was not life threatening.

Responding to a further question, members were informed that the 111 service had received investment and a broader range of clinicians were now being used to provide advice, including options such as self care. The CCG would continue to monitor whether the improvements to the 111 service were sustained.

Members were advised that NHS Pathways categorised calls; the whole call process was audited including how calls were reviewed and handled.

In response to a question, it was clarified that 'near miss' cases were those in which a patient was not harmed but potentially could have been. Statistics for Northumberland were not available however at the meeting.

A member requested an progress update on staffing recruitment and retention, and pathways for developing staff including becoming paramedics. Members were advised that a very good system was in place to nurture internal staff. Staff had been recruited from overseas. 24 apprentices were recruited to the Passenger Transport Service each year, of which many trained to become paramedics. A recruitment drive continued across the Trust.

Responding to a question, it was added that additional vehicles, including more double crewed ambulances, would be of benefit. It could however take six months to procure and get vehicles on the road.

Regarding emotive issues such as whether there could be targets for cardiac arrest cases, the Trust's focus was instead on how many more lives were saved through interventions. Skilled staff could also provide advice by telephone to people at the scene, and defibrillators were widely available for public use.

Replying to concerns about waiting times/delays in the handover process, many hospitals now had a Hospital Ambulance Liaison Officer (HALO), which eased the handover role. On 9 April 2018, a Clinical Operations Manager would be in post to manage handovers at NSECH and Durham. Handover delays had been a big focus over the past year, and the CCG was working with all relevant providers to take this forward.

Regarding cooperation with the Borders Ambulance Service, members were informed that a mutual aid approach was underpinned by policies and procedures. NEAS would only report on its own activity. Cases involving handovers across the border would only be recorded by the appropriate Trust.

Mr Dews and Ms Stephens were thanked for their presentation.

(c) Newcastle upon Tyne NHS Foundation Trust Annual Plan and Quality Account 2017/18

A presentation was provided by Frances Blackburn, Deputy Director of Nursing and Patient Services, Jackie Moon Head of Patient Safety and Risk, and Andy Pike,

Head of Quality Assurance and Clinical Effectiveness. (Copy of presentation appended to the official minutes of the meeting.)

Key details included:

- Quality Account 2017/18: Priority 1: To reduce all forms of healthcare associated infection (HCAI); Priority 2: sign up to safety; Priority 3: The delivery of harm free care; Priority 4: Safeguarding; Priority 5: To monitor mortality indicators with the aim of reducing avoidable deaths; Priority 6: Antimicrobial stewardship; Priority 7: Ill Health prevention; Priority 8: Palliative & end of life care; Priority 9: Safe & effective discharge; Priority 10: Enhancing the quality of care through participation in research; Priority 11: Patient participation in research; Priority 12: Improving the patient experience – key updates: meeting the accessible Information Standard; completing work with carers; Launch accessibility guides for disabled patients and visitors; and improving communication with deaf/hard of hearing patients; Priority 13: Dementia.
- 2018/19 proposed Quality Priorities:
    1) Patient Safety: reducing infection; pressure ulcer reduction; management of abnormal results; local safety standards for Invasive Procedures (LocSSIPs); human factors training
    2) Clinical Effectiveness: digital enhancements to care; alignment of Quality Assurance & clinical effectiveness processes
    3) Patient experience: deciding right; enhancing patient & public Involvement in qualities; improving experience of vulnerable patients.

Detailed discussion followed, of which the key points from members and responses were:

In response to a question members were advised that the hospital had smoke free status. The implementation of it could be challenging, but there were no smoking shelters on site. Consideration continued to be given to vaping, as some clinicians were uncomfortable with some products included in vapours.

It was confirmed that patients had the option of confirming their preferred place of death.

Research was shared through a regional network, including publications.

A member enquired why falls and antibiotics were not priorities for the next year when the targets had not been met; why weren't protocols already in place for how people were discharged to other areas? Members were informed that monitoring of discharges did take place, including standard definitions, but it needed to take account of possible different support arrangements in Newcastle, Northumberland or elsewhere.

No concerns existed about cross-charging across Trust areas, as it was tariff based upon where the patient lived; the money followed the patient. The Chair referred to good joint working between different Trusts, as for example some surgery would be delivered at Newcastle hospitals for Northumberland patients.

(Councillors Nisbet and Simpson then exited the meeting.)

The Chair referred to the good joint working Northumberland between the Council and NHS, and why was this not replicated more in other areas? Members were informed that Newcastle also had a lot of joint working; there was much cooperation at the clinician level, including the community rehabilitation team. There was joint funding for social care and health care staff.

Replying to a question it was confirmed that the levels of falls had stayed similar recently.

To conclude, the list of priorities represented key challenges. Some further key points included the public's wish for the use of more digital technologies, and a focus on patient involvement in all work.

Ms Henderson, Ms Moon and Mr Pike were thanked for their attendance.

At this point, as the meeting was approaching three hours in length it was RESOLVED to suspend standing orders to allow the meeting to continue beyond three hours in duration.

(d) Northumberland, Tyne and Wear (NTW) NHS Foundation Trust Annual Plan and Quality Account 2017/18

A presentation was provided by Anna Foster, Deputy Director of Commissioning & Quality Assurance, Northumberland from the Tyne and Wear NHS Foundation Trust (NTW). (Copy of presentation appended to the official minutes of the meeting.)

Key details included:

- the three overarching long term goals were refreshed in the 2017-22 NTW Strategy: patient safety; service user and carer experience; and effectiveness
- current Quality Priorities: embedding the Positive and Safe Strategy; co-production and personalisation of personal care plans; implement principles of the Triangle of Care; improving waiting times; and Mental Health Act - reading of patients' rights
- the process of identifying priorities for the next year: through when things have gone wrong (incidents); complaints received; feedback received from services users, their families & carers, and findings of regulators such as the Care Quality Commission. This analysis confirmed that their main challenges currently were: availability of inpatient beds; waiting times to access community services and starting treatment; involving families and carers; embedding Trust values. Therefore it was proposed that these should be their Quality Priorities for 2018/19.

Detailed discussion followed, of which the key points from members and responses were:

Regarding patient safety, benchmarking had taken place which included considering processes. There had been reductions in restraint requirements, violence and aggression, assisted by the use of other techniques. The Trust had an open reporting culture. Putting hands gently on a patient still counted as low level

restraint. Use of restraint mostly referred to people having psychosis episodes in secure mental health wards.

In response to the focus on the co-production and personalisation of care plans, feedback had been received that some plans included too much or too little detail.

In relation to the reading of patients' rights and whether patients were not being advised and/or nor aware of them, the focus was on the required periodical frequency of being reminded. This could be subject to interpretation as the guidelines were not clear. Big improvements had been witnessed, including with County Orders. If somebody was sectioned, their carers would be involved and informed.

A member referred to concerns about the availability of beds being an issue. Members were advised that consideration was being given to improving the inpatient experience and to avoid out of area admissions where possible; there was also a national incentive to reduce them. If people did have to be admitted elsewhere, work took place to bring them back as soon as possible. For example, somebody from Alnwick sent to Sunderland would still be within NTW's area, but not their locality.

There was a 'getting to know you' tool which involved carers when getting to know the service user, enabling the opportunity to arrange any beneficial actions. The Vice-chair applauded NTW for this work, as carers were essential; NTW's prioritisation of this was welcomed.

A member referred to national pressures and drew attention to whether this busy year was a trend or a blip. There was a rising acceptance of people with mental health issues, and stopping the deterioration in waiting times was important for the year ahead. NTW should be careful when using the term 'stability' as it should be about focusing on improving rather than continuing current levels.

The Royal College of Psychiatrists recommended the 85% bed occupancy figure, which acknowledged that staff also needed time for other development such as training. There were no concerns about levels of nursing staff.

A member stressed that if levels of demand continued, rather than having stability, things might need to be done differently. Members were advised of the 'creating capacity to care' work to release time for and assist front line staff's productivity..

A member asked about the level of collaboration across the North East when setting priorities; how often did people meet to discuss? Members were advised that a regional group met to discuss requirements. Trusts were however able to decide their own quality priorities as they were not imposed by regulators. Commissioning for Quality and Innovation (CQUIN) targets had also been set. It was added that the CCG had a System Transformation Board which ensured joined up working.

A member asked if discussions took place with other Trusts about addressing common concerns. Members were informed that there was frequent contact. Directors of nursing and finance also met up regularly.

To conclude, the Chair again thanked everybody for their presentations and answers, welcomed the very good questions asked of the officers, and also welcomed the public interest expressed in the meeting. Issues raised would be followed up and each of the Trusts would be written to about their Quality Accounts and future priorities. It was then:

RESOLVED that

(1) the information be noted;
(2) members' views/queries be followed up where identified; and
(3) a formal response be sent to each of the four Trusts based on members' views.

53. REPORT OF THE SENIOR DEMOCRATIC SERVICES OFFICER

Health and Wellbeing OSC Work Programme

Members considered the work programme for the Health and Wellbeing OSC. (Work programme enclosed with the official minutes as Appendix E).

Members received the dates of meetings during 2018/19 and noted the change of time to 2.00pm, to which one member expressed concern about being able to attend and the need to consult committee members on such changes.

Members were advised that the work programme consisted of everything discussed by the committee during 2017/18. A number of items were proposed for the next meeting on 15 May including an update from Healthwatch; the Annual Report of the Director of Public Health; scrutiny of methadone treatment following a referral from Council; and possibly also scrutiny of orthodontics provision and an update on dentistry provision in the Coquetdale area.

RESOLVED that the work programme be noted.

54. INFORMATION REPORTS

Policy Digest

Members were advised of the availability of the latest policy briefings, government announcements and ministerial speeches which might be of interest to members, which was available on the Council's website.

CHAIR _____

DATE _____