Appendix 1

HEALTH SCRUTINY REPORT FOR WEST SUFFOLK OVERVIEW AND SCRUTINY FROM THE HOSC MEETING OF 12 OCTOBER 2022

Improving Palliative and End of Life Care in Suffolk

Scrutiny Focus:

a) What is the National Direction for palliative and end of life care?
b) What are the priorities for the Integrated Care Board(s) in relation to palliative and end of life care and how are these priorities currently being delivered?
c) What role can the Integrated Care Partnerships and local communities play?
d) To what extent are the identified outcome measures being achieved?
e) What is working well and what needs improvement?
a) How are the Integrated Care Systems ensuring work is co-produced?

There are currently six national ambitions for palliative and end of life care

a) Each person is seen an individual
b) Each person gets fair access to care
c) Maximising comfort and wellbeing
d) Care is co-ordinated
e) All staff are prepared to care
f) Each community is prepared to help

The Committee expressed concern that many people currently who wish to die at home are denied that opportunity, and they sought reassurance that there would be greater emphasis on achieving this outcome. The Panel explained that there are many reasons why this is not always possible.

- The wishes of the patient are not known or documented – it is intended that all patients will be encouraged to complete a RESPECT form (Recommended Summary Plan for Emergency Care and Treatment). This will give clear guidance to care givers in the event that the patient loses capacity to articulate their wishes later on. The Committee was informed that 85% of people who have completed a RESPECT form die in their chosen place. In West Suffolk the ROSI App (Record Once Share Insight) was introduced in July 2022. The allows patients to record their wishes and share the app with their chosen care givers.
- The patient may have medical needs that cannot be met in a community setting and they may have to remain in hospital, although this may not be their choice
- They have no relatives who could support their care needs in a home environment
- Their family cannot cope with having them at home – which may be due to limited space for equipment
- It was noted that if the patient cannot die in their chosen place, where possible, they are asked specifically where they would not want to die.

We discussed pain management for patients being cared for in the home environment and the challenges of having trained staff being available "at the time of need".

- The Community Nurses, GP's and MacMillan are involved in the discharge planning for End of Life and Palliative Care patients
- A 24/7 clinical support line has been introduced for patients/relatives
- Patients/Relatives/lay carers, who feel able, are being trained to deliver some of the anticipatory medications

What additional support is given through the introduction of the Integrated Care Boards/Partnerships and what role can the ICP and local communities play?

- There is a statutory requirement for all ICBs to consider the needs of its community in relation to End of Life Care
- Communities will be equipped to assist in supporting each other through the increased use of voluntary groups
- Greater emphasis will be given to bereavement support
- More work is being undertaken to reduce the admission/re-admission rate of patients living with a terminal illness
- The development of "compassionate communities" that understands end of life and can provide support
- The introduction of workshops for End-of-Life Care

To what extent are the identified outcomes measures being achieved?

- A dashboard to record and measure outcomes is being developed

What is working well and what needs to be improved

- The increased introduction of RESPECT forms and the ROSI APP
- Additional community support reducing the need for emergency admission
- Increased support for pain relief
- The introduction of the 24/7 clinical support line

How is the ICSs ensuring work is co-produced given the sensitivity of the subject

- Introduction of End-of-Life workshops
- Information sharing on patient preferences for end-of-life care

We were advised that the success of this higher ambition seeks to achieve the following outcomes:

a) An improved quality of care in accordance with the Gold Standards Framework for best practice in end-of-life care.
b) An increase in percentage of deaths that occur in the places of choice, at home, in care homes, in hospital, in hospices and other places, across all ages.
c) Improved reported pain management in end-of-life care.
d) A high proportion of people with a Care Plan and Advanced Care Wishes recorded.
e) More people at the end of life with self-directed support, personal budgets, personal health budget and direct payments.

Healthwatch Suffolk undertook a review of End of Life and Palliative care in Suffolk and NE Essex in July 2021. Their findings are documented on pages 16 -19 of the HOSC report. The summary headline of these are:

a) Communicate clearly – make sure people have understood what they have been told.
b) Compassion and understanding are important to people – think about communication style.
c) Offer the choice to be supported at key moments.
d) The system must continue to encourage community conversations about death and dying.
e) Give people access to the tools they need to prepare for death, or the death of someone close to them.
f) Make it easier to share and access end of life preferences.
g) Co-produce information for patients and families about what to expect when a person is dying.
h) Make sure people know what to expect when supporting someone who is dying at home, including what services are available and when to access them.
i) Consider the opportunities new digital technologies bring for information sharing with patients and families
j) Make sure all professionals can access the information that they need about patients with specific long-term conditions.
k) Consider how information sharing and communication between professionals can be improved at all levels.
l) Be clear about who, or which service, is responsible for the delivery of care and decision making
m) Ensure information about support is available to all, even if they may not benefit from formal therapeutic intervention at the time of death.
n) Help people to talk about grief within families and communities.
o) Encourage continuous reflective learning for all professionals delivering end of life care through formal and informal support systems.
p) Ensure a continued review of people's experiences using this report as a baseline of experiences.
q) Undertake further work with Black Asian and other Ethnic Minority groups.

Through the comprehensive HOSC report and the detailed responses from the Panel, it was noted that there is an urgent need to

- Increase the availability of respite care beds for palliative care across the County
- There is a shortage of palliative care specialists
- There is an inconsistency in the availability and type of care
- There is a need to increase the workforce across health and social care
- There is a need to increase the use of and support the Voluntary sector

The Committee was encouraged by the evident desire by all the Panel members to improve end of life and palliative care for patients, relatives and care givers and has requested that this item be reviewed in the new year with a report on progress.

Norfolk and Suffolk NHS Foundation Trust (NSFT) Response to the CQC Report April 2022 following an Inspection in November/December 2021

In summary, the CQC's overall findings included the following areas of concern:

a) Inconsistent levels of staff in general and of suitably qualified staff.
b) Ineffective medicines management
c) Staff were unaware of ligature risk assessments and the removal of ligature points to ensure patient safety (for clarity – this refers to items that may be used for hanging)
d) A lack of patient risk assessment and risk management
e) Ineffective management of long waiting lists
f) Staff did not carry out adequate patient observations
g) Poor management of patient outcomes and progress
h) Inadequate staff maintenance of, and access to, patient records
i) Not all staff had undertaken mandatory training
j) Lack of staff supervision and appraisals
k) Inadequate reporting, management and learning from patient incidents
l) Unsupportive work cultures
m) Fragile relationships with stakeholders, especially in relation to children and young people
n) Lack of openness and transparency in information provided to the boards and media

The CQC provided the Trust with a list of 109 actions which the Trust MUST improve, in order to comply with its legal obligations. These are listed on the CQC Report pages 8 – 14 (available online).

During Autumn 2022 the Chair of the Trust received notification from 140 doctors expressing a lack of confidence in the organisational leadership. The letter cited concerns including unmanageable workloads, staff turnover, demoralisation and patient safety.

The CQC revisited the Trust w/c 13 September 2022 to review progress against the Section 29A Notice.

PROGRESS AND IMPROVEMENTS TO DATE:

The committee was informed that 87% of the essential "must dos" are complete.

The Trust has employed an Internal Audit Service to scrutinise and review the improvements

It was noted that this Trust had been subjected to many issues over the past few years and the CEO was asked "what are you doing this time that is different and leads you to believe the changes are sufficient and sustainable"

The committee was informed that they believe many of the previous failures were due to trying to do too much in one go, placing an impossible burden on already overstretched services. Their current approach is in three phases.

- **Phase 1** (to August 2022) focused on compliance of the 14 immediate areas identified by CQC

- **Phase 2** (to October 2023) focus on sustaining improvements and delivery of longer-term priorities to address some of the underlying challenges faced by the Trust. To include: safety, culture and engagement,

governance and leadership, demand and capacity and changing services with system partners.

- **Phase 3** (October 2023) focus on ensuring they imbed, sustain and evidence lasting improvement and deliver innovation in mental health care provision with partners

The Trust Board Members present shared with the Committee some of the challenges faced by them which contributes to these failings – many of which are common to other NHS providers.

Demand and Capacity – the unprecedented demand for services and the challenges of timely intervention combined with shortages of qualified mental health staff and consultants. This places an increased burden on existing staff, who not only face the additional workload but also the criticism of system failure.

Recruitment and Retention – constant challenges exist – from January 2022 through to September 871 recruited but 609 resigned and there is a high level of sickness.

This is a greater challenge than simply numbers as it represents a loss of valuable knowledge and increased need for training.

It was noted that 40,000 nurses across the NHS resigned in the last year.

The Trust recognised that addressing staff retention is of prime importance for improved service delivery. They have commenced a significant programme which encourages greater support of existing staff and seeks to overcome some of the reasons for resignation.

A survey of their nurses revealed a level of dissatisfaction in the following areas:

- they felt undervalued
- they wanted improved training and opportunity for upskilling/progression
- they wanted to feel safe
- they were concerned for their wellbeing
- they had financial concerns

Improvement plans are in place to address these issues in consultation with staff.

All staff are invited to have a face-to-face discussion if they indicate they wish to resign, and management will work with them to address any resolvable issues.

Unresolved Datixing complaints. Most of the outstanding complaints were "low level" and are now resolved. Management is working with staff on a desensitising programme to reduce the impact of unintentional actions/comments and also to educate how the impact of actions/words can adversely affect colleagues.

Stuart Richardson, CEO commented that the Trust aims to deliver only what an Acute Trust should be delivering. They will analyse the delivery of care pathways and ensure that where patients do not need that level of service they are signposted to a more appropriate resource.

He also commented that the triaging of patients at the point of referral needs improving and patients then signposted to the most appropriate resource. Increased use of Mental Health navigators helping to support people back to normal life – encouraging their participation in volunteering services.

James Reeder, SCC Cabinet Member and member of the NSFT Board advised that from mid-November the Trust will engage the services of "external guardianship" which will allow the staff to report concerns anonymously. The Board will review these concerns. It is believed that this will give greater confidence to staff in bringing concerns in the open.

The committee welcomed the planned and implemented improvements and has requested that a report back on:

-Recruitment and Retention
-Reductions/levels of staff sickness
-Documented plan of action and evidence of success
-Initiatives and outcomes in improvement in concerns from Nursing staff

Update on Dentistry
This remains an area of concern. The new Dental Contract has been provided to Dentists for consideration and the HOSC has requested sight of this. It is anticipated it will be in the Programme again in 2023.

Future Systems Programme (West Suffolk Hospital Build Programme)
The programme is at a critical point having submitted outline planning to West Suffolk Council Planning Officers. The public consultation is now complete with the primary concern being expressed around traffic management. It is anticipated that these plans will come before Development Control at the end of November for a decision.

I have attached the short update from Gary Norgate, Programme Director which he presented at the HOSC (**Appendix A**).

Councillor Margaret Marks