Appendix 1

OVERVIEW AND SCRUTINY COMMITTEE
REPORT ON HEALTH SCRUTINY MEETING
25 JANUARY 2023

The primary item for Scrutiny at this meeting was East of England Ambulance Service (EEAST). The Committee had been given prior sight of their Urgent and Emergency Care Clinical Strategy 2022-2025 allowing headline questions to be put to the EEAST prior to the meeting. **Pages 17-31** of the Health Scrutiny Meeting are appended (**Agenda Item 5a** and **5b**) which indicates the scope of Scrutiny; the Questions posed prior to the meeting and the responses.

Kate Vaughton – Director of Integration and Deputy CEO was the main witness responding the Scrutiny Panel – Kate transferred over from Clinical Commissioning and has a reputation for effective change.

The complete list of witnesses contributing to the discussion:

- Kate Vaughton, Deputy Chief Executive, East of England Ambulance Service NHS Trust
- Andrew Kelso, Medical Director, NHS Suffolk and North East Essex ICB
- Nick Hulme, Chief Executive Officer, East Suffolk and North Essex NHS Foundation Trust
- Craig Black, Interim Chief Executive Officer, West Suffolk NHS Foundation Trust
- Clement Mawoyo, Director of Integrated Adult Health and Social Care, West Suffolk

When considering the failure of EEAST and its poor CQC Reports (currently Requires Improvement) over the past few years, it seems appropriate first to note the challenges and put into context some of the criticisms they have received:

- Over the past 10 years calls to the 999 Service has increased exponentially (and is continuing to increase) and is not matched by the increase in their service provision
- An example given: On Monday 19 December EEAST took 2,000 more calls than the same day in 2021
- The 'other' Community-based services do not have sufficient capacity to manage their own clients with the consequence that many of these escalate to EEAST.
- The acuity of patients being treated has risen considerably – and managing these on site and at handover to the next clinical resource takes greater time
- A high number of patients have been waiting up to 2 years for access to diagnosis on their elective care pathways and have deteriorated as a consequence
- The stress on clinical staff has resulted in greater staff turnover
- The recruitment of a new clinical staff member does not equal the loss of one experienced member
- The inability of Ambulance Crews to discharge their patients at hospitals as they too are operating beyond capacity
- Patients are stuck in hospital as there is insufficient community care to support them in their community – this bed-blocking in turn prevents patients being transferred out of Accident Department and the consequential knock-on effect to waiting ambulance crews
- Annual Requalification and upskill training has suffered as staff do not have sufficient down-time to undertake these
- Investigations of internal complaints was taking an exceptionally long time, placing yet further stress on staff waiting outcomes
- Prioritising Categories 1 and 2 (the highest level of risk to life/limb/organ) resulted in patients in Categories 3 and 4 waiting excessively long times for help – these patients may then deteriorate and increase the demand on services. (see note later regarding actions taken by Nick Hulme).

- However much we may wish it to be otherwise, it is a fact that patients in rural areas are subjected to a delay their transfer of care. Many of our rural communities are at least 30 minutes from a hospital. Ambulances which serve rural areas will inevitably be challenged to meet the arbitrary 8 minute/19-minute arrival at scene times.

How does EEAST seek to improve the current performance:

- Increase clinical staffing levels
- Move away from transporting and transfer the care to the best/most appropriate clinical/communityl resource
- Allowing appropriate community team to have access to Cat 3-5 of the Stack (Patients waiting for an ambulance) and for them to commission Urgent Community Response Services. *I remain uncertain how this will work until Community Services is strengthened.*
- Strengthening the relationship/deployment of Community First Responders and other voluntary response services eg. SARS in Suffolk, NARS in Norfolk and BASICS in Essex
- The introduction of three Advanced Paramedic Urgent Care vehicles (APUC) across Norfolk, Waveney and Suffolk and Northeast Essex – treating on scene and currently preventing 80% of those patients from needing transfer to hospital. Additional recruitment of Advanced Paramedics took place, and these were due to start early 2023.
- Develop a new model of "hear and treat" via triaging and "see and treat" – this will require the support of other services to be involved in transfers of care eg. Community Mental Health Services/GPs
- Improved career development pathways for workforce
- EEAST is working with the Integrated Care Boards to develop a Joint Resource Mental Health Vehicle in collaboration with community mental health teams
- A Frailty Services is being developed in Ipswich
- EEAST already has an Urgent Care Early Intervention Service
- Improve retention and recruitment of clinical staff (**see page 27**)
- Recruit more Community First Responders (CRFs) currently 49 Groups in Suffolk.

During this discussion, I sought reassurance, from Kate Vaughton, that CFRs would be better integrated with permanent paid staff (currently this is not the case, and they are not always well received by crews). Also, that they are permitted to use the skills they are taught to allow them to monitor patients effectively during the wait for transfer of care and report any significant deterioration.

At a recent Integrated Care Board Meeting, Nick Hulme, CEO of Ipswich and Colchester Hospital, (an inspiring leader who takes a problem and applies a solution!), noted that he had been supporting EEAST by putting together a REACT team of clinicians and therapists from his own resources and sending them out to treat patients from Categories 3 and 4 of the Stack- which helped prevent deterioration and reduced the number of admissions to his Hospital. I asked West Suffolk Hospital if they are going to do similar and Clement Mawoyo, (West Suffolk's Director of Integrated Adult Services), responded that they are taking the 'best learning' from other health providers. I am hoping this translates or has translated into actions.

Whilst recognising that there is much work required to improve their own services, it is apparent that the failings are not confined to EEAST but are "system wide" and all elements need increased capacity and finances. In addition, more Community Services are needed to educate the public in self-care and prevention; to prevent deterioration of existing conditions and to care for patients holistically - meeting all the needs that inform their well-being, and also to ensure safe discharge to prevent re-admission through lack of appropriate support.

It is a great disappointment to me, that despite Suffolk County Council employing a Co-ordinator to introduce Community Catalysts to West Suffolk – through the many meetings I attend and the vast number of people I encounter – not one person has heard of Community Catalysts. Through this Report I challenge my SCC Colleagues to take this back to SCC and robustly challenge the need for such services here in the West. A dramatic increase in Community Support Workers would impact positively on Health and Social Care, and particularly on the ambulance service. I would also ask – how many people has this scheme currently recruited with the three co-ordinators across Suffolk and Waveney?

Since writing this report I note that a poster is being circulated from the VASP – it may be co-incidental that I complained to the Leader of Suffolk County Council prior to this.

I have copied below the **DRAFT RECOMMENDATIONS** discussed at this meeting for your information but note these are yet to be approved at the next HOSC Meeting in April

Phlebotomy

The Committee has requested an Information Bulletin on Phlebotomy, This is a subject that concerns me greatly. The words "integrated care" do not seem to correlate with the Phlebotomy Services across much of Suffolk. This service is inadequate and fragmented with different pots of money paid to differing groups to achieve what is a vital assessment test.

Whilst GPs Contracts with the NHS include an element of Phlebotomy, it seems that many of these are not achieving their agreed level or that the number of tests required is significantly greater than that in their Contract. Consequently – there may be an alternative provider set up or patients have to travel some distance, often in poor weather on more than one bus, for long periods for this simple 5-minute test. This does not meet with the "Putting Patients at the Heart of Care" or the Environment Agenda. It is costly, time consuming and far from easy for a sick patient. Additionally, marrying up the appointment with the bus – which may or may not arrive given the recent cutbacks – causes undue stress. This service needs a comprehensive overhaul and streamlining of the service, with patients at the heart of the discussion and the provision being delivered locally. Historically, patients could sit and wait at West Suffolk Hospital for a blood test. Due to the high turnover of staff, there is now a wait of over two weeks.

The HOSC was also made aware of the high number of "failure to arrive for appointments" occurring at GP practices. With figures looking to be around 10%. GP Practices are independent businesses and thus work in different ways. Some have a cancellation line programmed into their telephone system and other do not have the ability to do this – but this was a significant factor as getting through to the surgery can involve a long wait and this was a clear deterrent. The figure was more confusing given that most Surgeries now only give "on the day" appointments other than for nurse-led appointments. A more in-depth examination of this is required to enable any substantive conclusions.

The HOSC remains acutely aware of the continuing shortcomings in Dentistry, and this will be bought back the Committee at the next meeting on 19 April 2023, along with Maternity Services.

Margaret Marks

Pages 17-31 of the HOSC Meeting Papers is appended. (**Agenda Item 5a and 5b**)

DRAFT recommendations Agenda Item 5 - East of England Ambulance Service NHS Trust (EEAST) – Urgent and Emergency Care Clinical Strategy 2022-2025

The Committee:-

1. Thanked all panel members for their clear and concise responses to members' questions;
2. Noted that the key challenges facing the ambulance and emergency care services were increasing demand, acuity (degree of illness), and handover delays;
3. Noted the changes in approach to providing urgent clinical care that the Strategy was intended to achieve to address these challenges, and the vital role of partner organisations including the voluntary sector in increasing capacity for local and in-home treatment;
4. Noted the key role played by call centres in initial assessment, triage and managing patients in the 'stack', also noted that centres are sometimes under-staffed;
5. Noted the key role of hospital / ambulance liaison officers (HALO) in managing incoming patients and enabling ambulances to discharge patients in a more timely manner;
6. Noted that acuity of illness in the population was increasing, due to an accumulation of factors, including delays in provision of elective care, and that this was having an impact across the health and care system; it was noted that "years of healthy life", as an indicator of population health was decreasing and the importance of investment in prevention and early intervention was highlighted as being key to addressing pressures in the system in the medium to long term.
7. Noted that members could keep abreast of EEAST's performance, via the published reports provided at EEAST public Board meetings;
8. Noted that Integrated Care Boards (ICBs) were finalising their Joint Forward Plans for 2023-2028 and that information about how to contribute views on the Suffolk and Northeast Essex ICB Plan had been circulated to the Committee. Councillors, members of the public and stakeholders were encouraged to give their views via the website at: https://www.letstalksnee.co.uk/.
9. Noted that Integrated Care Boards had a critical role in supporting EEAST to implement their Urgent and Emergency Care Clinical Strategy across the wider system and that the SNEE ICB Urgent and Emergency Care Committee would oversee this work;
10. Recommended to the Deputy Chief Executive of EEAST and the SNEE ICB (as apply), that:-
    a. EEAST management focus on support for call centre staff through improving retention (turnover is high), career progression and training (staff are often too busy to take time for training)
    b. EEAST management continue to develop opportunities and initiatives to improve communications between EEAST staff and volunteers;
    c. EEAST and the SNEE ICB place additional focus on supporting and using local responders including the Urgent Care Responder Service and community first responders, linking local up with defibrillator training programmes, and working with Integrated Neighbourhood Teams to reduce trips to hospital
    d. The SNEE ICB through the Emergency Care Committee continue to engage with Primary Care Networks to increase capacity in local services through general practices and pharmacies, as well as involving adult social care where appropriate such as through the Community Catalyst scheme
    e. EEAST and its partners develop a public facing communications plan about how to access the range of urgent care services available and about changes taking place within the health and care system. The communication should be clear and free of 'jargon', and seek to manage public expectations about NHS response *(eg a 999 call will not automatically translate to an ambulance dispatch)*. A simple leaflet was suggested, which councillors could use to raise awareness through their local networks.

f. EEAST and its partners engage with councillors in Suffolk to support outreach to local communities (for example through parish council meetings and area committees); this would raise awareness of opportunities to volunteer for the Trust as a Community First Responder and support deployment and registration of defibrillators as well as convey other key messages such as the communications plan.

11. Requested a further report from the ICB and EEAST, in 6 to 12 months' time, to set out progress made in addressing key challenges; the report should include information about community response, local treatment centres, community cars, and the role of CFRs, SARS, GoodSam, PCNs and INTs, REACT and Early Intervention. How are the arrangements working? What difference had been made to response targets in categories 1 and 2 (urgent), and categories 3 – 5 (less urgent) through implementation of changes? What is working well and what barriers need to be overcome?

12. Requested further information about the additional funding announced nationally including £500m available to local authority social care to improve discharges through the Better Care Fund; £200m to ICBs to improve discharges and a further £200 made available to ambulance services, for which further guidance was awaited from NHS England. The Committee requested information including how much would come to Suffolk, how much of the £500m would be recurrent funding and how the funds had or would be used to provide greatest impact;

13. Members of the Committee would be pleased to accept an invitation from EEAST to visit staff and see a call centre in action, including meeting with members of the Urgent Community Response Team;

14. Given the role of population health as a factor in urgent care response, the Chairman agreed to discuss this topic with the Chairman of the Health and Wellbeing Board as a matter of concern and possible interest to the Board.