

Minutes of a meeting of the Health and Social Care Overview and Scrutiny Committee held remotely on Tuesday, 16 February 2021 at 4.30 pm

Commenced 4.30 pm
Concluded 6.45 pm

Present – Councillors

LABOUR	CONSERVATIVE	LIBERAL DEMOCRAT & INDEPENDENT GROUP
Greenwood Mir Godwin Lintern Humphreys	Goodall	Griffiths

NON VOTING CO-OPTED MEMBERS

Susan Crowe	Strategic Disability Partnership
Trevor Ramsay	Strategic Disability Partnership
G Sam Samociuk	Former Mental Health Nursing Lecturer

Observer: Sarah Ferriby (Portfolio Holder, Healthy People and Places)

Apologies: Councillor Hussain

Councillor Greenwood in the Chair

57. DISCLOSURES OF INTEREST

Susan Crowe disclosed that the organisation she was employed by (Bradford Talking Media) received public health funding (Minute 62)

Action: City Solicitor

58. INSPECTION OF REPORTS AND BACKGROUND PAPERS

There were no appeals submitted by the public to review decisions to restrict documents.

59. REFERRALS TO THE OVERVIEW AND SCRUTINY COMMITTEE

There were no referrals made to the Committee.

60. END OF LIFE CARE IN BRADFORD DISTRICT

Representatives from Bradford Teaching Hospitals Foundation Trust presented Document “U” providing a summary and overview of End of Life Care (EOLC) across Bradford District.

A PowerPoint presentation was provided which defined the nature of end of life care; support available in Bradford for people at the end of their life; statistics on the number of people at that stage in their life and where they were most likely to die; who would provide end of life care in the district and what characterised good end of life care.

The presentation also advised Members of the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) which was a specific type of advance care plan summarising the emergency care part of a wider advance of anticipatory care planning process creating a summary of recommendations for a person’s clinical care in a future emergency in which they would be unable to make choices and included a decision on resuscitation.

A background to resuscitation was provided and included an explanation of the phrase Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR). The presentation concluded with a summary of changes in care as a result of the pandemic including the establishment of a rapid review of resources to support clinicians; an Ethics Committee to guide complex decision making across hospitals in the District; allowing visiting for patients in their final days; chaplaincy and palliative care support seven days per week and a relatives contact line.

Following a very detailed presentation Members raised a number of points and questions to which the following responses were provided: -

- A reason to provide medical intervention when a patient had a DNACPR would be when intervention was required for an unrelated specific condition for example if a patient was choking and would be expected to recover without detriment.
- A person having learning disabilities would not be the rationale for a DNACPR although that did not mean that a person with learning disabilities would not decide to have a DNACPR.
- Supplementary information would be provided for Members to gauge the age range of people dying in the District.
- All family views or complaints were captured in patient records and, in Bradford, a bereaved carers survey was conducted. The majority of comments were positive but the survey identified if things could be done better, for all deaths in the Trust, and was shared on the Trust website. A national audit of End of Life Care was also conducted.
- Assurances were provided that checks were in place to ensure that sick patients who had a DNACPR would still wish for that to continue if they had recovered from their illness.
- General Practitioners (GPs) were asked to communicate with all patients with a Learning Disability and a DNACPR to review that decision and were sent tips and tools to enable them to have good conversations with those people.
- Since September 2020 with the rollout of the ReSPECT plan a copy of

those plans would be kept with the patient and a copy on GPs records.

- ‘Death Cafes’ to develop strategies to normalise death and address the fear of death tended to be supported by the voluntary sector. Discussions had been held at the Trust about that topic but progress had been halted by the current pandemic. The benefits of such services were acknowledged and there was a national push to get people thinking about issues which may include the care of pets after their loved ones had died; bucket lists and the development of compassionate communities.
- A healthy person had the capacity to make their views on resuscitation known and were within their rights to make a decision. That decision must be made in writing to enable it to be communicated between organisations. However, a person could make that request to a clinician who could convert it to a written request to allow that view to be communicated.
- Resuscitation had developed in recent years and was no longer limited to pumping a person’s chest to restart the heart. An example of a patient with severe sepsis being resuscitated with fluid resuscitation was provided. Those developments were the rationale for changing the terminology from Do Not Resuscitate to Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR).
- Language around end of life was very nuanced and was adapted towards the recipient. A patient’s outcome cannot be guaranteed and many conversations were undertaken about Cardio Pulmonary Resuscitation (CPR) to ascertain the predictable outcome. The DNACPR was a recommended decision which can be ignored.
- It was decided that the Gold Standards Framework, supporting multi-disciplinary care for patients in their last year of life, should be applied by taking account of many indicators, supported nationally, which say that in this circumstance and with these conditions it is likely that a person is approaching the last year of their life.

A Member, who was also a GP, referred to feeling uncomfortable at the beginning of the pandemic when there was a push towards ReSPECT plans and the Gold Standards Framework. He felt that he had not been through proper processes to support that process at that time.

In response Members were advised that prior to September 2020 there had only been ‘Do Not Resuscitate’ instructions. Conversations were still being held about end of life but there was no formal recognition. [A group of experts had produced guidance for GPs regarding how to have, and what constituted, good conversations with patients. Communications to support GPs, including from Safeguarding Leads, were issued. Since September there had been a move to the ReSPECT plans which included resuscitation and in addition recorded a conversation about peoples’ wishes and preferences, for example discussing if they wished to be admitted to hospital or Intensive Care Units. Further communications were issued and throughout a six-week period conversations were started and were ongoing about ReSPECT Plans and to learn how to start and conduct conversations with patients. It could be seen, from data in the report that this was done very quickly and from the beginning of pandemic it was known how many DNACPR were put in place. This was monitored weekly. That data showed that there was no sudden mass increase. It was hoped that ReSPECT conversations would increase so that people had the opportunity to state their wishes. It was stressed that a ReSPECT plan did not mean a patients had a

DNR instruction.

A Member who had also worked as a doctor expressed concerns that he had seen patients who were reluctant to acknowledge that they were approaching end of life. The stigma around palliative care prevented them from accessing beneficial support for pain relief, nausea etc. He was concerned that End of Life labels may attract that same stigma. That point and a hesitancy for both patients and clinicians to have those difficult and distressing conversations was acknowledged. A GP Specialising in Elderly Care in attendance at the meeting recognised that there were professions which may not accept people may be palliative. Support was provided to clinicians within the system to understand and support them to have those difficult conversations. It was reported that those conversations could also be rewarding and families were usually very grateful to have support although the process was distressing. Dying Matters, an event held every May, was used as an opportunity to hold events for both professionals and patients about dying and about getting that right. That event would happen again this year despite COVID and palliative colleagues would be involved. It was reported that funding had been received from the Clinical Commissioning Group (CCG) to support some parts of the population which struggled when referred for Goldline support. It was explained that the geographical areas to be targeted were known as they had less referrals for Goldline support.

Members were advised that attempts were being made to develop a system that was automatic rather than a personal decision. An example was provided that should a person suffer a stroke they would automatically be seen by a neurologist without additional conversations or discussions. It was confirmed that there had been a concerted effort to target the areas or clinicians that did not refer. Historically it was known that this was for non-malignant diagnoses. If you were young, white and had cancer almost categorically you would be referred for palliative care. Statistics showed that if you were elderly, of Asian ethnicity and had a non-cancer diagnoses such as heart disease you were much less likely to be referred or recognised as someone in the palliative phase of their life. That fact was a national issue and 'dying matters' was to try to get people understanding and asking for support. The last year of life was often focussed on and people were confused between end of life and palliative which would be defined as anyone with a terminal illness.

It was hoped that one positive of COVID would be that people would talk about dying more and consider what they may prefer. It was accepted that not all people wanted to talk about death but they needed to know that the opportunity was available to them.

A Member suggested End of Life was rebranded to 'support for people with skills of palliative care'. In response it was reported that there were debates within the speciality on that point and in Manchester they had a team called 'supportive care' as opposed to palliative care. Conversely there was some thought that this might defeat the ethos that discussions about death be encouraged.

The representatives of the Trust were thanked for the production of an informative report and presentation which had been produced during a very difficult and demanding period.

Resolved –

That the report be noted.

ACTION: Overview and Scrutiny Lead

61. PUBLIC HEALTH OUTCOMES FRAMEWORK (PHOF) PERFORMANCE REPORT

The report of the Director of Public Health, Document “V” provided an overview of the health and wellbeing of the population of the Bradford District based on the indicator and sub indicators within the Public Health Outcomes Framework (PHOF).

The report summarised how indicators and sub indicators compared against the England average and provided a summary of some of the key areas of Public Health relevant to the District. In addition, changes in trends in recent years were also provided.

Statistics portraying 54% of children in poverty were felt to be tragic and Members suggested that national input was required.

It was questioned what had been done to address areas where there was no significant improvement or situations worsening and, in response, and in light of the report containing 140 indicators it was felt that this was difficult to summarise. Members were assured that the Public Health Outcomes Framework (PHOF) was used to flag issues which were then raised with commissioning boards to develop work plans to tackle those issues. It was explained that improvements had been seen since 2010 but with less money a focus had been on young people where it was clear the most difference could be made. More specific data on the district could be provided to Members if needed.

A Member questioned the data suggesting there had been no significant change in fuel poverty despite his belief that the situation in Bradford was improving.

The indicators revealed that the healthy life expectancy in the district was worsening and it was questioned if people were becoming ill sooner or was earlier diagnosis or the way issues were recorded impacting on that figure. In answer it was agreed that screening levels had increased but to provide a more definitive answer it was agreed to consult analysts and get back to Members on that question.

Reference to ‘*unhealthy and life expectancy curtailed*’ detailed in the report was raised and further explanation was requested. It was explained that when compared with national figures more people living in poorer areas of Bradford were categorised as unhealthy. There was a nine-year difference between healthy life expectancy in areas across the district and despite any changes in definitions of unhealthy this was a key issue.

A Member expressed concern about being told he could only have a GP appointment if the situation was urgent and believed that making it difficult for

people to see a GP was leading to late diagnoses. He also suggested that the District had more green spaces than any other metropolitan district which could be utilised to tackle unhealthy lifestyles and childhood obesity. In response it was agreed to feedback those comments to be incorporated into the Healthy Living Strategy.

In response to questions about residents not getting outside and into the sunlight it was reported that a new vitamin supplement programme had started, however, dealing with COVID infection had been the focus of support.

The timeframe when the data in the report had been collected was questioned as it was believed that this had not captured the impact of COVID. It was confirmed that the data was captured in 2019-20 and some was even older. It was suspected that those statistics would have worsened during COVID. Reports were provided to Overview and Scrutiny Committees on specific topics and those reports would contain more detail of the impacts of COVID.

It was questioned if the information contained in Document "V" was shared with the Voluntary and Community Sector and it was confirmed that the information was shared and published on the website.

Resolved -

That the report be noted and the Director of Public Health be requested to provide a further report on Public Health Outcomes Framework indicators in 2021.

ACTION: Director of Public Health /Overview and Scrutiny Lead

62. HEALTH AND WELLBEING COMMISSIONING STRATEGY AND INTENTIONS - ADULT SOCIAL CARE 2021 UPDATE

The report of the Strategic Director, Health and Wellbeing (Document "W") provided an update, and advised Members, on the progress of the 2019-2021 Adult Social Care Commissioning Strategy and intentions of the Council's Department of Health and Wellbeing.

Members agreed that this was a valuable report and it was self-explanatory. Members were advised that additional information could be provided if requested.

Resolved –

That the report be noted and the Strategic Director, Health and Wellbeing be requested to provide a further report in 2021.

ACTION: Strategic Director, Health and Wellbeing /Overview and Scrutiny Lead

63. HEALTH AND SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

WORK PROGRAMME 2020/21

A work planning discussion took place on the Committee's work programme for the remainder of the 2020/21 municipal year.

Members were asked to provide details to the Overview and Scrutiny Lead of any additions they would like to be included in the work programme.

No resolution was passed on this item.

Chair

Note: These minutes are subject to approval as a correct record at the next meeting of the Health and Social Care Overview and Scrutiny Committee.

THIS AGENDA AND ACCOMPANYING DOCUMENTS HAVE BEEN PRODUCED, WHEREVER POSSIBLE, ON RECYCLED PAPER