Norfolk County Council

Norfolk Health Overview and Scrutiny Committee

Date: **Thursday, 28 February 2019**

Time: **10:00**

Venue: **Edwards Room, County Hall, Martineau Lane, Norwich, Norfolk, NR1 2DH**

Persons attending the meeting are requested to turn off mobile phones.

Those members of the public or interested parties who have indicated to the Committee Administrator, Timothy Shaw (contact details below), before the meeting that they wish to speak will, at the discretion of the Chairman, be given a maximum of five minutes at the microphone. Others may ask to speak and this again is at the discretion of the Chairman. Speaking will be for the purpose of providing the committee with additional information or a different perspective on an item on the agenda, not for the purposes of seeking information from NHS or other organisations that should more properly be pursued through other channels. Relevant NHS or other organisations represented at the meeting will be given an opportunity to respond but will be under no obligation to do so.

Main Member	Substitute Member	Representing
Mr D Fullman	Mr M Fulton-McAlister	Norwich City Council
Michael Chenery of Horsbrugh	Mr S Eyre/Ms C Bowes	Norfolk County Council
Ms E Corlett	Miss K Clipsham/Mr M Smith-Clare	Norfolk County Council
Mr F Eagle	Mr S Eyre/Ms C Bowes	Norfolk County Council
Ms E Flaxman-Taylor	Mr G Carpenter	Great Yarmouth Borough Council
Mrs S Fraser	Mr T Smith	Borough Council of King's Lynn and West Norfolk
Mr G Middleton	Mr S Eyre/Ms C Bowes	Norfolk County Council
Mr D Harrison	Mr T Adams	Norfolk County Council
Mr F O'Neill	Mr R Foulger	Broadland District Council
Mrs B Jones	Miss K Clipsham/Mr M Smith-Clare	Norfolk County Council
Dr N Legg	Mr C Foulger	South Norfolk District Council
Mr R Price	Mr S Eyre/Ms C Bowes	Norfolk County Council
Mr P Wilkinson	Mr R Richmond	Breckland District Council

Mrs A Claussen-Reynolds	Mr M Knowles	North Norfolk District Council
Mrs S Young	Mr S Eyre/Mrs C Bowes	Norfolk County Council

Membership

For further details and general enquiries about this Agenda please contact the Committee Officer:

Tim Shaw on 01603 222948 or email committees@norfolk.gov.uk

Under the Council's protocol on the use of media equipment at meetings held in public, this meeting may be filmed, recorded or photographed. Anyone who wishes to do so must inform the Chairman and ensure that it is done in a manner clearly visible to anyone present. The wishes of any individual not to be recorded or filmed must be appropriately respected.

A g e n d a

1. **To receive apologies and details of any substitute members attending**

2 **NHOSC minutes of 17 January 2019** **Page 5**

3. **Declarations of Interest**

If you have a **Disclosable Pecuniary Interest** in a matter to be considered at the meeting and that interest is on your Register of Interests you must not speak or vote on the matter.

If you have a **Disclosable Pecuniary Interest** in a matter to be considered at the meeting and that interest is not on your Register of Interests you must declare that interest at the meeting and not speak or vote on the matter

In either case you may remain in the room where the meeting is taking place. If you consider that it would be inappropriate in the circumstances to remain in the room, you may leave the room while the matter is dealt with.

If you do not have a Disclosable Pecuniary Interest you may nevertheless have an **Other Interest** in a matter to be discussed if it affects, to a greater extent than others in your division

- Your wellbeing or financial position, or
- that of your family or close friends
- Any body -
    - Exercising functions of a public nature.
    - Directed to charitable purposes; or
    - One of whose principal purposes includes the influence of public opinion or policy (including any political party or trade union);

Of which you are in a position of general control or management.

If that is the case then you must declare such an interest but can speak and vote on the matter.

4. **Any items of business the Chairman decides should be considered as a matter of urgency**

5. **Chairman's Announcements**

6	**10.10 - 11.10**	**Ambulance response and turnaround times**	**Page 12**
		Appendix A (page 18) - East of England Ambulance Service NHS Trust report	
		Appendix B (page 38) - Norfolk and Norwich University Hospitals NHS Foundation Trust report	
		Appendix C (page 43) - Queen Elizabeth Hospital NHS Foundation Trust report	
		Appendix D (page 50) - Hospital handover hours lost Jan 2019	
	11.10 - 11.20	**Break at Chairman's discretion**	**Page**
7	**11.20 - 12.20**	**Children's speech and language therapy**	**Page 52**
		Appendix A (page 56) - commissioners' report	
		Appendix B (page 66) - SENsational Families paper	
8	**12.20 - 12.30**	**Forward work programme**	**Page 88**
		Glossary of terms and abbreviations	**Page 91**

Chris Walton
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Date Agenda Published: 20 February 2019

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Norfolk County Council

NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE
MINUTES OF THE MEETING HELD AT COUNTY HALL, NORWICH
on 17 January 2019

Present:

Michael Chenery of Horsbrugh (Chairman)	Norfolk County Council
Ms C Bowes (substitute for Mr F Eagle)	Norfolk County Council
Mrs A Claussen-Reynolds	North Norfolk District Council
Ms E Corlett	Norfolk County Council
Mr D Fullman	Norwich City Council
Mrs S Fraser	Borough Council of King's Lynn and West Norfolk
Mr D Harrison	Norfolk County Council
Dr N Legg	South Norfolk District Council
Mrs B Jones	Norfolk County Council
Mr R Price	Norfolk County Council
Mr P Wilkinson	Breckland District Council
Mrs S Young	Norfolk County Council

Also Present:

Prof S Barnett	Trust Chair, The Queen Elizabeth Hospital NHS Foundation Trust
Caroline Shaw	Chief Executive, The Queen Elizabeth Hospital NHS Foundation Trust
John Webster	Accountable Officer, West Norfolk CCG
Jon Wade	Chief Operating Officer, The Queen Elizabeth Hospital NHS Foundation Trust
Alexandra Kemp	Local Member for Clenchwarton and King's Lynn South
Antek Lejk	Chief Executive, Norfolk and Suffolk NHS Foundation Trust
Marcus Hayward	Norfolk and Suffolk NHS Foundation Trust Senior Operational Team
Frank Sims	Chief Executive, South Norfolk CCG (lead commissioner for mental health services in Norfolk and Waveney)
Dr Tony Palframan	GP Lead for Mental Health, South Norfolk CCG
Rebecca Driver	Norfolk and Suffolk NHS Foundation Trust
Jane Murray	Member of Suffolk Health Scrutiny Committee
Keith Robinson	Member of Suffolk Health Scrutiny Committee
Maureen Orr	Democratic Support and Scrutiny Team Manager
Chris Walton	Head of Democratic Services
Tim Shaw	Committee Officer

1 Apologies for Absence

1.1 Apologies for absence were received from Mr F Eagle, Ms E Flaxman-Taylor, Mr G Middleton and Mr F O'Neill.

2. Minutes

2.1 The minutes of the previous meeting held on 6 December 2018 were confirmed by the Committee and signed by the Chairman.

3. Declarations of Interest

3.1 There were no declarations of interest.

4. Urgent Business

4.1 There were no items of urgent business.

5. Chairman's Announcements

5.1 There were no Chairman's announcements.

6 The Queen Elizabeth Hospital NHS Foundation Trust – response to the Care Quality Commission report

6.1 The Committee received a suggested approach by Maureen Orr, Democratic Support and Scrutiny Team Manager, to a report from the Queen Elizabeth Hospital NHS Foundation Trust about the QEH response to the Care Quality Commission (CQC) inspection of the QEH between 4 April and 21 June 2018, published on 13 September 2018.

6.2 The Committee received evidence from Professor Steve Barnett, Trust Chair, The Queen Elizabeth Hospital NHS Foundation Trust, Caroline Shaw, Chief Executive, The Queen Elizabeth Hospital NHS Foundation Trust, Jon Wade, Chief Operating Officer, The Queen Elizabeth Hospital NHS Foundation Trust and John Webster**,** Accountable Officer, West Norfolk CCG.

6.3 The Committee received a PowerPoint presentation from Professor Steve Barnett, Trust Chair, The Queen Elizabeth Hospital NHS Foundation Trust which can be found on the Committee pages website.

6.4 The Committee heard from Alexandra Kemp, local Member for Clenchwarton and King's Lynn South, who said that many of her constituents were concerned about the potential loss of hospital services from the QEH as part of the STP Plan Agenda and would struggle to afford the cost of travel to Norwich if services transferred to the Norfolk and Norwich Hospital. She asked for an assurance from the speakers that they were committed to recruiting and retaining a full complement of suitably-qualified staff at the QEH; and that the QEH Board was still acting on the findings of the HOSC NHS Workforce Planning Task Group in 2015, of which she was a member, which recommended stepping up recruitment through training medical staff in the new Higher Education Department at COWA and making arrangements for UEA nursing students to take up placements at the QEH. She also asked how the QEH Board would ensure the hospital workplace was more attractive to nurses coming to King's Lynn.

6.5 In reply, the speakers said that there were no plans to transfer cancer surgery (or any other form of surgery) to the N&N or to any other hospital because of a shortage of qualified nursing staff at the QEH. This proposal had not originated from within the QEH and the hospital was confident of being able to maintain patient clinical safety. The QEH planned to take all necessary steps to attract and retain qualified nurses so that it remained in control of its own surgical programme and continued to serve the needs of its emergency patients. The speakers added that the means by which the QEH planned to achieve a recruitment drive for nurses was set out on pages 20 and 30 of the agenda. The QEH realised the importance of working with a wide range of partner organisations both in Norfolk and the surrounding counties and planned to continue to do so through the work of the STP.

6.6 During discussion the following key points were made

- The speakers said that since the time of the CQC inspection, the QEH had taken additional measures to fill vacancies and cope with staff sickness.
- At the start of January 2019, the "fill rate" on shifts at the QEH was said to be at between 90% to 95% of the expected number of nursing staff on any given shift. This was an increase from 70% and 80% of the expected number of nursing staff on any given shift at the start of 2018. Approximately 15% of the "fill rate" was currently made up of agency staff. At 90% to 95%, the "fill rate" (which included the full range of nursing skills required to meet the needs of the shift) was now at the national average for an acute hospital.
- Preparations were being made for the impact that Brexit would have on the work of the hospital. Risk assessment and mitigation work was underway. The priority was to ensure that the 115 members of the nursing and support staff at the hospital who might be affected by Brexit understood the steps that they would have to take to remain in the country and felt that they were fully supported by the hospital.
- The speakers said that the QEH would work with local schools and colleges to encourage students to seek rewarding careers within the medical profession and apply to work at the QEH. The QEH would also work with local recruitment agencies to build new and improved links with the local labour market.
- Prof S Barnett said that he had a wide range of experience of working as a non-executive Director at a NHS Trust and would look to remain at the QEH for a minimum of at least 3 years.
- In reply to questions, Caroline Shaw said that as the newly appointed Chief Executive of The Queen Elizabeth Hospital NHS Foundation Trust she would be looking to:
    - Focus on strengthening leadership and staff engagement.
    - Maintain safe staffing levels.
    - Address urgent care and patient flow challenges (including winter pressures).
    - Ensure nursing staff became familiar with the care needs of all the patients on their ward and a more effective patient discharge process was put in place.
    - Resolve quality and governance issues.
    - Develop a plan for financial stability.
    - Ensure that Stroke Services remained rated joint top in the Eastern region and 6th in the country.
- The Committee discussed the commissioners' and wider health and care system's role in supporting the QEH to improve and the capacity of the QEH to address the CQC's requirements for improvement.
- Cllr Sue Fraser, Disabilities Champion for the Borough Council of King's Lynn and West Norfolk, asked that the speakers from the QEH speak to her after the

meeting about ideas for staff training in relation to patients with Learning Disabilities.

- Cllr Annie Claussen-Reynolds said that she also wanted to talk to the speakers outside of the meeting.
- In reply, the speakers from the QEH said that they were willing to speak to those Members of the Committee who approached them.
- It was necessary to increase bed numbers because of overall population growth and rising demand.
- The QEH was working on future demand and capacity modelling.
- Given the rise in demand for hospital services, Members questioned whether "Block Contracts" (whereby the hospital received a fixed amount of funding regardless of how many patients they served) provided the hospital with a sustainable level of funding. The speakers said that the QEH did not have a Block Contract with the CCG at this time. Whether the hospital would be willing to enter into a Block Contract with the CCG in the future would partly depend on the size of the contract that was offered to the hospital.
- The speakers said that the reason why the QEH was showing less progress against the CQC's 'must do' and 'should do' actions than might be expected was because of a rigorous self-assessment process which had led to a recalibration of the hospital's Quality Improvement Programme. The QEH was in the process of recruiting three Quality Improvement Managers for this work.
- The divisions in leadership within the maternity service were being fully addressed.
- There were plans to expand the size of the A&E Department so that it could cope with increased numbers of patients.
- In reply to questions, the speakers said that there were four resuscitation cubicles at the hospital and that this number had not changed. There had been difficulties fitting new equipment into other cubicles because of room size constraints but this was now rectified.
- In addition to the service improvements required by CQC there were some high-rated risks in the QEH's risk register relating to the poor state of repair of the hospital building that had to be addressed. A refurbishment programme was planned for the hospital.

6.7 The Committee **recommended**:

1. That QEH representatives be asked to speak with Cllr Sue Fraser, Disabilities Champion for the Borough Council of King's Lynn and West Norfolk, regarding ideas for staff training in relation to patients with Learning Disabilities.

2. That the QEH representatives come back to the Committee with a progress report in 6 months' time; July 2019.

6.8 The Committee **noted** the QEH's good progress towards completing the 'must do' and 'should do' actions in the CQC's report and that the CQC was expected to reinspect the QEH around March or April 2019.

7 Norfolk and Suffolk NHS Foundation Trust – response to the Care Quality Commission report

7.1 The Committee received a suggested approach by Maureen Orr, Democratic Support and Scrutiny Team Manager, to a follow up report from the Norfolk and Suffolk NHS Foundation Trust (NSFT) and NHS commissioners about their response

to the Care Quality Commission's (CQC) inspection report of the NSFT between 3 and 27 September 2018, published on 28 November 2018.

7.2 The Committee received evidence from Antek Lejk, Chief Executive, Norfolk and Suffolk NHS Foundation Trust, Marcus Hayward, Norfolk and Suffolk NHS Foundation Trust Senior Operational Team, Frank Sims, Chief Executive, South Norfolk CCG (lead commissioner for mental health services in Norfolk and Waveney) and Dr Tony Palframan, GP Lead for Mental Health, South Norfolk CCG.

7.3 Cllr Jane Murray and Cllr Keith Robinson, Members of Suffolk Health Scrutiny Committee, were in attendance for this meeting and asked questions of the speakers.

7.4 The Committee received a PowerPoint presentation from Antek Lejk, Chief Executive, Norfolk and Suffolk NHS Foundation Trust which can be found on the Committee pages website.

7.5 During discussion the following key points were made:

- The speakers said that the NSFT had taken immediate enforcement action in relation to the most significant concerns raised in the Care Quality Commission's (CQC) inspection report.
- The NSFT recognised the failings identified by the CQC and the potential harm that this had caused for service users.
- The NSFT had already made significant progress.
- The NSFT aimed to deliver critical 'Must Do' issues by end of March 2019.
- The NSFT had reduced layers of management and increased clinical leadership in its operational teams. The NSFT had a new Executive Team in place with the overriding priorities of ensuring service users were safe and of creating a safety culture amongst all staff.
- Each of the Directors was assigned a geographical area of responsibility and encouraged to take a more "hands on approach" to the everyday work of the NSFT.
- A new overall staffing structure was being planned and local teams would have control of resources and be able to make decisions themselves. Service users would be included in local teams for decision-making. The new staffing structure would be shared with Members of the Committee.
- The NSFT was reporting to NHS Improvement on a weekly basis.
- The NSFT was acting on the downgrading of emergency and urgent referrals, ensuring they were only authorised after a sound evidence-based clinical review.
- The NSFT recognised the importance of putting in place the staffing and procedural processes to deliver a reliable 24/7 service.
- There was a high turnover of NSFT staff in the first few months of their employment and national shortages in key areas of specialist staffing.
- In reply to questions, the GP Lead for Mental Health, South Norfolk CCG said that recruiting and retaining of Admiral Nurses was a challenge although in the central area there number had increased from two to six nurses.
- The speakers explained the different routes into the services provided by the NSFT and the work that was being done to centralise specialist services. They also spoke about the difficulties in "prioritising" patients who were waiting for mental health services and how this did not compare favourably with patients waiting for acute hospital services.

- The speakers said that the NSFT aimed for all crisis referrals to be seen face-to-face within four hours. This standard was not being met in only a small number of cases.
- Crisis referrals, which had been given a different priority or not seen within four hours, were now reported to the Executive Board daily and were audited to make sure any re- prioritization was valid clinically and that people were safe.
- Attention was being placed on seeing those service users with the longest waits, with steady progress being made.
- Teams were supported by a dedicated experienced clinician and via weekly service user tracker meetings.
- In reply to questions from Members of Suffolk Health Scrutiny Committee, the speakers said that the commissioning of beds for children suffering from eating disorders was the responsibility of NHS England.
- The number of downgrades from emergency care had reduced significantly in the last few months.
- Members expressed concern that some 25% of girls were said to be self-harming in some way. The speakers said that there were different degrees of self-harming and that the primary level of support for many of these girls came from the voluntary sector although there were issues round joined up support with the NSFT that needed to be addressed.

7.6 The Committee **agreed**:

1. NSFT should provide details regarding the numbers of patients receiving urgent mental health assessment in their own homes and the numbers brought in to NSFT team bases for urgent assessment in the weeks since the CQC report was published.

2. NSFT should provide a copy of its staff structure chart in about 4 weeks' time (after consultations are complete).

3. The Commissioners and NSFT should provide details of the number of occasions where families of patients placed in out-of-area beds due to unavailability of local beds have received help with travelling expenses and the number that have had a carer assessment.

4. The Commissioners and NSFT should come back to the Committee with a progress report in 6 months' time; July 2019. Senior clinicians from NSFT (e.g. Medical Director; Chief Nurse) to attend on that occasion.

8 Forward Work Programme

8.1 The Committee received a report from Maureen Orr, Democratic Support and Scrutiny Team Manager, that set out the current forward work programme.

8.2 The Committee **agreed** the forward work programme as set out in the report.

8.3 Members requested information on the following items to be included in the NHOSC Briefing so that the Committee could decide whether to add the subjects to future meeting agendas:

- Children's autism services – assessment and diagnosis – progress update since 11 Jan 2018 NHOSC.

- Eating disorder services – information about the community service in central and west Norfolk (information about the Great Yarmouth and Waveney service was included in the January 2019 NHOSC Briefing); information about the tier 4 specialist service available to Norfolk residents.

Chairman

The meeting concluded at 12.50 pm

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Ambulance response times and turnaround times in Norfolk

Suggested approach from Maureen Orr, Democratic Support and Scrutiny Team Manager

Examination of the trends in ambulance response and turnaround times in 2018-19 and action to improve performance.

1. Purpose of today's meeting

1.1 The focus areas for today's meeting are:-

(a) To examine the action taken at the Norfolk and Norwich Hospital and the Queen Elizabeth Hospital to improve the flow of patients and reduce ambulance arrival to hand-over times.

(b) To examine the East of England Ambulance Service NHS Trust's capacity and response times for the whole population in Norfolk and for specific patient groups (strokes, heart attacks and people in mental health crisis).

1.2 The East of England Ambulance Service NHS Trust (EEAST) has provided the report at **Appendix A** covering ambulance response times in the five Norfolk and Waveney CCG areas, the responses for particular patient groups, turnaround times at the three acute hospitals, trends in demand, the capacity of the service and assessment of the success of initiatives taken to help cope with demand during winter 2018-19 for far.

Representatives from EEAST will attend the meeting to answer Members' questions.

1.3 Although ambulance turnaround figures for all three of Norfolk's acute hospitals are included in EEAST's report just two have been asked to report to and attend today's meeting; the Norfolk and Norwich Hospital NHS Foundation Trust (NNUH) and the Queen Elizabeth Hospital NHS Foundation Trust (QEH).

The NNUH is the busiest hospital in the region in terms of arrivals by ambulance and delays at the NNUH therefore have the greatest potential to affect ambulance response times. The NNUH's report is attached at **Appendix B**.

The QEH has been asked to attend because compared to other similar sized hospitals in the region it has had relatively high levels of ambulance

delays in 2018-19. The QEH's is at **Appendix C**. These cover the initiatives that the hospitals have taken to improve patient flow and ambulance turnaround.

Appendix D is a report on Hospital Handover Hours Lost in January 2019. The figures are published monthly on EEAST's website and show relative performance at hospitals across the east of England. The position in January 2019, with the greatest number of hours lost in delays at the NNUH and a high number lost at the QEH is reflective of the trend in 2018-19. Previous months reports are available on EEAST's website:- https://www.eastamb.nhs.uk/search/?sitekit=true&search=Hospital+Hours+lost&task=search&indexname=full-index.

1.4 A representative from North Norfolk CCG, who is also the Norfolk and Waveney Winter Room Director for 2018-19, will attend the meeting on behalf of the commissioners.

The ambulance service is jointly commissioned by all 19 CCGs in the east of England, including NN & WN CCGs (the co-ordinating commissioner is Ipswich and East Suffolk CCG).

NHOSC has long recognised that, to an extent, ambulance delays at hospitals and their knock-on effects on the service's capacity to respond to new calls are symptomatic of pressures across the local health and care system. They are not necessarily within the power of hospitals or the ambulance service to resolve by themselves. The CCG representative can answer the committee's questions on the success of the measures to tackle the causes of delay in all aspects of the urgent and emergency care system across central and west Norfolk.

2. Previous report to NHOSC

2.1 Norfolk Health Overview and Scrutiny Committee (NHOSC) has had concerns about ambulance response times and turnaround times in Norfolk for a considerable period of time and has frequently returned to the subject. The last report was on 24 May 2018 when the committee heard that EEAST was recruiting more frontline staff, increasing its ambulance cover and expected to see its performance against national targets improve over time.

The need for transport pathways for the conveyance of mental health patients to hospital and other facilities remained an issue to be resolved by EEAST in partnership with Norfolk County Council, Norfolk Constabulary and Norfolk and Suffolk NHS Foundation Trust. The committee heard that EEAST was looking to pilot liaison with the mental health service within Commissioning for Quality and Innovation (CQuIN) funding.

The reports and minutes of 24 May 2018 NHOSC are available on the County Council website via the following link:- https://norfolkcc.cmis.uk.com/norfolkcc/Meetings/tabid/128/ctl/ViewMeetingPublic/mid/496/Meeting/1410/Committee/22/Default.aspx

The committee asked for information on good practice from the Department of Health and Social Care's Emergency Care Intensive Support Team (ECIST) and for details of how far good practice measures had been implemented at Norfolk's three acute hospitals. This information was provided to NHOSC Members in the July and September 2018 NHOSC Briefings and is available from the Democratic Support and Scrutiny Team Manager maureen.orr@norfolk.gov.uk on request. It reflected the situation as it stood in September 2018, but more recent developments at the NNUH and QEH are included in the reports to today's meeting.

The NHS representatives at NHOSC on 24 May 2018 were also asked to provide written responses to matters raised by Cromer Town Council, which they did in June 2018.

3. National ambulance standards

3.1 New **response time** standards for England were introduced in winter 2017, as follows:-

Call category	**National Standard**	**How long does the ambulance service have to make a decision?**	**How is this measured?**
C1 Calls about people with life-threatening injuries & illnesses	7 minutes mean response time 15 minutes 90th centile response time (i.e. these type of calls will be responded to at least 9 out of 10 times before 15 minutes)	The earliest of:- • The problem is identified • An ambulance response is dispatched • 30 seconds from the call being connected	The first ambulance service-dispatched emergency responder arrives at the scene of the incident There is an additional Category 1 transport standard to ensure that these patients also receive early ambulance transportation
C2 Emergency calls	18 minutes mean response time 40 minutes 90th centile response time (i.e. these type of calls will be responded to at least 9 out of 10 times before 40 minutes)	The earliest of:- • The problem being identified • An ambulance response is dispatched • 240 seconds from the call being connected	If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle counts. If the patient does not need transport the first ambulance service-dispatched responder at the scene of the incident counts
C3 Urgent calls	120 minutes 90th centile response time (i.e. these type of calls will be responded to at least 9 out of 10 times before 120 minutes		

C4 Less urgent calls	180 minutes 90th centile response time (i.e. these calls will be responded to at least 9 out of 10 times before 180 minutes)		

3.2 Condition specific measures were also being introduced in 2017 to track the time from 999 call to hospital treatment for heart attacks and strokes, where a prompt response is particularly critical. By 2022 the aim was for 90% of eligible heart attack patients to receive definitive treatment (balloon inflation during angioplasty at a specialist heart attack centre) within 150 minutes. 90% of stroke patients were also receive appropriate management (thrombolysis for those who require it, and first CT scan for all other stroke patients) within 180 minutes of making a 999 call. From April 2019 EEAST will be measured against the new outcome-based target for stroke.

The **Stroke Care Bundle** target still applies - the percentage of suspected stroke patients (assessed face to face) who receive an appropriate care bundle. (As per National Ambulance Clinical Performance Indicator Care Bundle). The compliance performance standard is 95%. Previous reports to NHOSC have shown this has been consistently met and exceeded in Norfolk and Waveney.

3.3 The **ambulance turnaround at hospitals** standards are as follows:-

(a) 15 minutes - The time from ambulance arrival on the hospital site to the clinical handover of the patient (also known as 'trolley clear'). **The hospital is responsible for this part.**

(b) 15 minutes - The time from clinical handover of the patient to the ambulance leaving the site (also known as 'ambulance clear'). **The ambulance service is responsible for this part.**

4. Suggested approach

4.1 Members may wish to explore the following areas with the representatives at today's meeting:-

4.2 **East of England Ambulance Service NHS Trust**

(a) Are you satisfied that all the health and social care agencies whose co-operation is necessary to resolve the issue of ambulance delays at Norfolk's hospitals are actively and adequately addressing their part of the problem?

(b) The figures show wide variation between hospitals in respect of ambulance arrival to patient handover times. In EEAST's opinion,

what are the main reasons for such variable performance by the hospitals?

(c) What are the local arrangements for implementing the outcome based targets for heart attacks and strokes in terms of the patient's pathway from 999 call to definitive treatment in the acute hospital? (See paragraph 3.2 above)

(d) What specific changes have been made to the pathways for conveyance of mental health patients to hospital and other facilities?

(e) How does EEAST manage the hand-off of callers to other agencies when they think the caller does not require an ambulance?

4.3 **Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH) and Queen Elizabeth Hospital NHS Foundation Trust (QEH)**

(a) The NNUH has made significant changes in recent years to improve the flow of patients through its emergency department, including the establishment of an Older People's Emergency Department, a Children's Emergency Department and expansion of Rapid Assessment and Treatment and the area for receiving the most seriously ill or injured patients. Nevertheless, the figures show that a high level of ambulance hours are lost in handover delays at the hospital. What more can be done to improve flow?

(b) The figures show that a high proportion of ambulance hours are lost at the QEH in comparison to the numbers of ambulance arrivals. Why has the QEH been performing worse than other hospitals in the region in this respect?

(c) What additional steps has the QEH taken to improve flow of patients through the Emergency Department?

(d) Do the hospitals consider that more could be done to improve patient flow through the Emergency Departments by moving patients to another area while awaiting the results of investigations and diagnostic tests?

(e) To what extent do the Emergency Departments have access to patients' clinical records? Could better access to patient records speed up patient flow by reducing the time spent on investigations?

4.4 **The CCGs (North Norfolk and West Norfolk)**

(f) In May 2018 NHOSC heard that EEAST's funding was rising from £213.5m in 2017-18 to £225m in 2018-19 and would rise again to £240m in 2019-20 subject to activity profiles remaining as predicted. This was intended to fund increased staffing and more double staffed ambulances to improve the service. It was understood that

the improvement would take time to achieve. Do the commissioners consider that performance is moving in the right direction quickly enough?

5. Action

5.1 The committee may wish to consider whether to:-

(a) Make comments and / or recommendations to EEAST, the NNUH, QEH or the commissioners based on the information received at today's meeting.

(b) Ask for further information for the NHOSC Briefing or to examine specific aspects of ambulance response and turnaround times in Norfolk at a future committee meeting.

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Report by the East of England Ambulance Service NHS Trust February 2019

Introduction

This is an update for members to provide information on ambulance demand and response times, along with updates on stroke performance, staff and recruitment and the trends for the three hospitals.

EEAST is commissioned at a regional level, not on an individual CCG level. The ambulance response programme (ARP) standards, introduced in October 2017, cannot be compared to previous standards. These national standards, which will take two years to implement completely, aim to get the right vehicle in the right place at the right time. The Trust has a contract with its commissioners based on a performance trajectory, at a regional level delivered via the independent service review undertaken.

Ambulance Demand for Norfolk (October 2018 to January 2019)

2017 to 2018

Norfolk & Waveney STP	Calls	Incidents Response
Oct-17	17633	12536
Nov-17	18561	12427
Dec-17	21603	13333
Jan-18	19147	12795

Trust	Calls	Incidents Response
Oct-17	101791	65271
Nov-17	103866	64806
Dec-17	119494	69937
Jan-18	106875	67719

Norfolk % of all Trust count	Calls	Incidents Response
Oct-17	17.32%	19.21%
Nov-17	17.87%	19.18%
Dec-17	18.08%	19.06%
Jan-18	17.92%	18.89%

Norfolk & Waveney STP	111 Calls	111 Responses
Oct-17	3656	2946
Nov-17	3756	2878

2018 to 2019

Norfolk & Waveney STP	Calls	Incidents Response
Oct-18	19231	13095
Nov-18	18666	12750
Dec-18	19953	14203
Jan-19	19962	14139

Trust	Calls	Incidents Response
Oct-18	104285	66316
Nov-18	105721	67165
Dec-18	108961	73009
Jan-19	110196	72830

Norfolk % of all Trust count	Calls	Incidents Response
Oct-18	18.44%	19.75%
Nov-18	17.66%	18.98%
Dec-18	18.31%	19.45%
Jan-19	18.11%	19.41%

Norfolk & Waveney STP	111 Calls	111 Responses
Oct-18	4262	3212
Nov-18	4550	3467

Dec-17	4389	3012
Jan-18	4144	3127

Dec-18	5084	3954
Jan-19	4978	3719

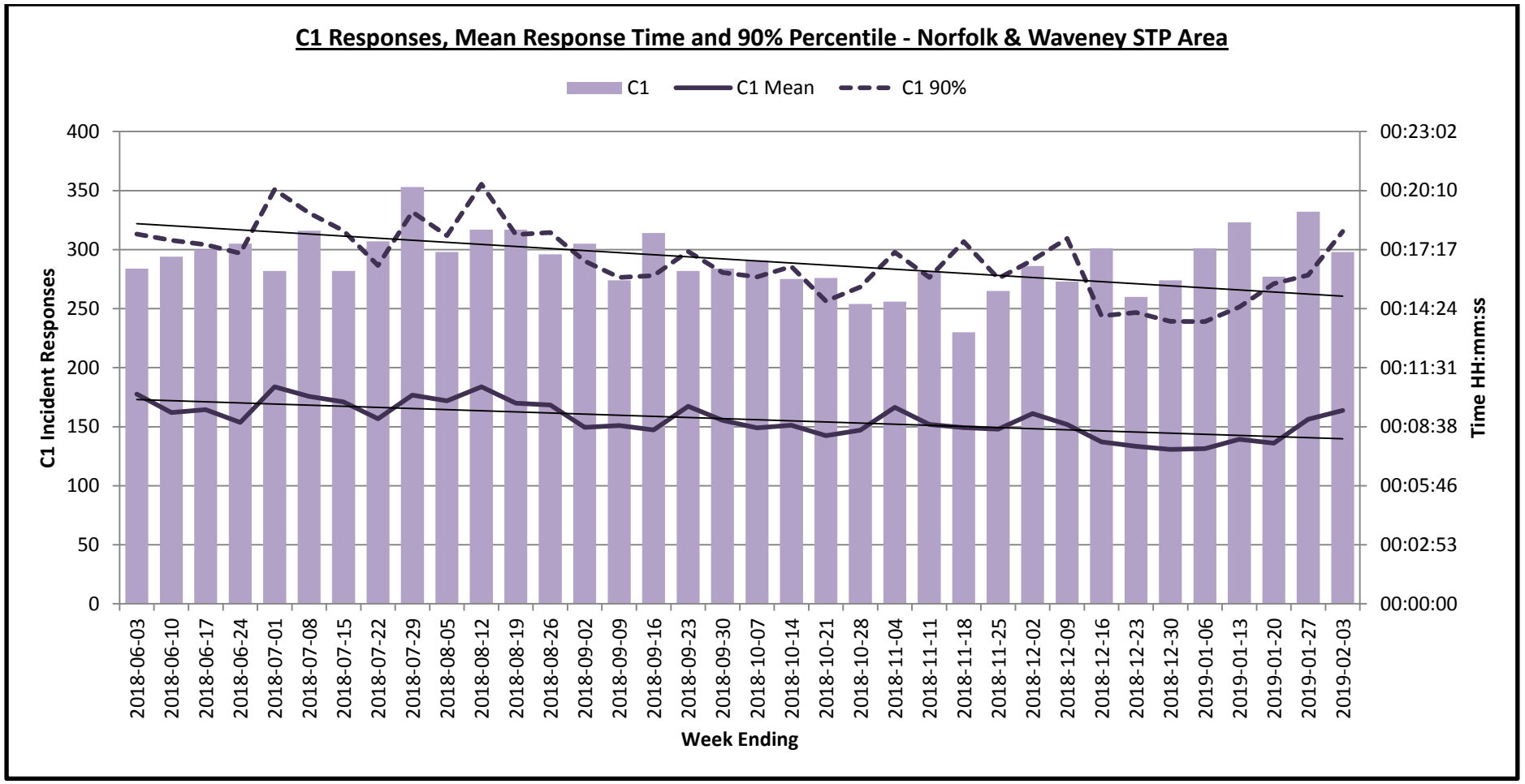
Trust	111 Calls	111 Responses
Oct-17	16248	12775
Nov-17	16893	12750
Dec-17	21048	14844
Jan-18	19807	14788

Trust	111 Calls	111 Responses
Oct-18	18995	14418
Nov-18	21194	16030
Dec-18	23703	18417
Jan-19	22785	17129

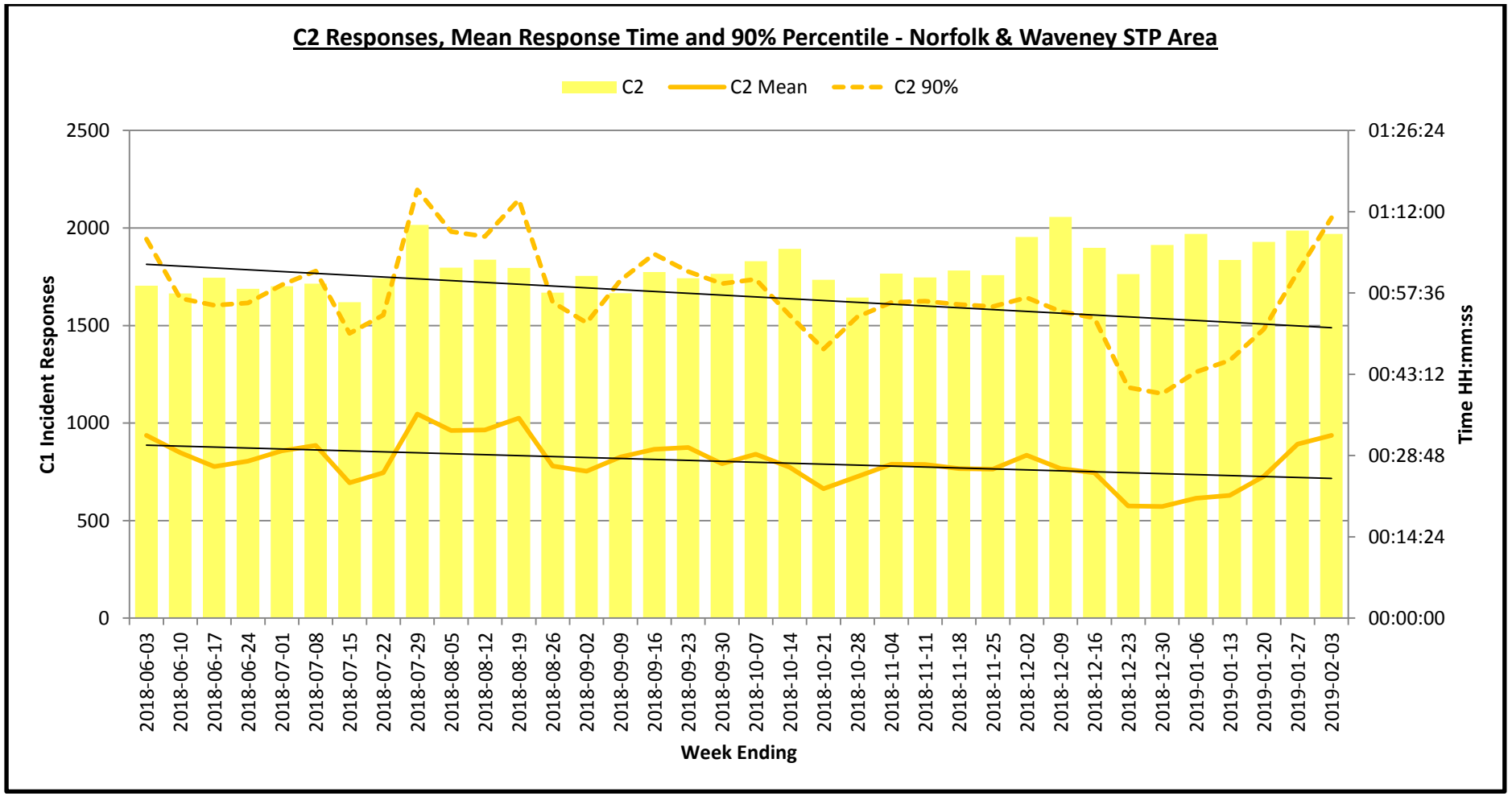
Norfolk % of all Trust count	111 Calls	111 Responses
Oct-17	22.50%	23.06%
Nov-17	22.23%	22.57%
Dec-17	20.85%	20.29%
Jan-18	20.92%	21.15%

Norfolk % of all Trust count	111 Calls	111 Responses
Oct-18	22.44%	22.28%
Nov-18	21.47%	21.63%
Dec-18	21.45%	21.47%
Jan-19	21.85%	21.71%

The graph below shows the number of Category 1 (C1) responses by week from 28th May 2018 to 03rd February 2019 and the C1 mean response time and C1 90% Percentile for Norfolk & Waveney STP area. On average, there are 291 C1 responses per week in the Norfolk & Waveney STP area. There has been a steady improvement in both C1 mean and C1 90th percentile since June 2018 (the lower the better).



The graph below shows the number of C2 responses by week from 28th May 2018 to 3rd February 2019 and the C2 mean response time and C2 90% Percentile for Norfolk & Waveney STP. On average, there are 1801 C2 responses per week in Norfolk & Waveney STP. There has been a improving trend in both C2 mean and C2 90th percentile in March (the lower the better).



Great Yarmouth and Waveney CCG Response Times – December 2018 and January 2019 by Week

Weekending	C1 Mean Average Response Time	C1 90th Percentile	C2 Mean Average Response Time	C2 90th Percentile	C3 Mean Average Response Time	C3 90th Percentile	C4 Mean Average Response Time	C4 90th Percentile
2018-12-02	0:07:35	0:14:12	0:23:18	0:47:32	1:11:25	2:35:28	1:24:40	4:20:16
2018-12-09	0:07:02	0:13:25	0:21:02	0:43:37	1:08:10	2:40:11	1:05:22	2:19:18
2018-12-16	0:06:43	0:12:19	0:21:47	0:48:58	1:07:01	2:34:31	0:48:52	2:35:57
2018-12-23	0:06:08	0:11:19	0:18:25	0:39:41	0:42:53	1:59:26	0:45:49	1:49:44
2018-12-30	0:05:53	0:09:05	0:16:15	0:32:44	0:44:25	2:00:16	0:55:43	2:07:31
2019-01-06	0:06:37	0:11:26	0:18:15	0:38:44	0:40:30	1:36:33	0:47:53	2:37:39
2019-01-13	0:06:20	0:11:01	0:19:07	0:42:13	0:55:43	2:23:04	0:55:17	2:12:42
2019-01-20	0:06:36	0:11:13	0:24:01	0:54:36	1:31:04	4:21:30	1:33:42	6:16:52
2019-01-27	0:06:59	0:12:35	0:26:13	0:56:34	1:23:45	3:49:08	1:42:18	5:21:46

North Norfolk CCG Response Times – December 2018 and January 2019 by Week

Weekending	C1 Mean Average Response Time	C1 90th Percentile	C2 Mean Average Response Time	C2 90th Percentile	C3 Mean Average Response Time	C3 90th Percentile	C4 Mean Average Response Time	C4 90th Percentile
2018-12-02	0:11:06	0:19:23	0:37:01	1:03:59	2:12:30	5:25:29	2:00:43	4:35:01
2018-12-09	0:11:41	0:21:40	0:33:28	1:02:55	1:43:58	3:37:58	1:10:26	2:26:33
2018-12-16	0:10:02	0:19:34	0:32:04	1:02:37	1:30:29	3:31:14	1:35:12	3:15:45
2018-12-23	0:08:54	0:20:36	0:24:29	0:46:06	0:56:20	2:00:04	1:00:00	2:15:50
2018-12-30	0:09:56	0:15:31	0:25:02	0:47:17	0:54:43	1:58:58	0:56:40	2:57:36
2019-01-06	0:10:14	0:16:58	0:27:57	0:54:18	1:05:25	2:30:12	1:27:34	3:44:33
2019-01-13	0:10:44	0:17:29	0:27:31	0:52:55	1:07:05	2:51:17	1:03:45	2:47:10
2019-01-20	0:12:03	0:23:38	0:31:47	0:59:22	1:11:28	2:20:21	0:23:16	0:53:28
2019-01-27	0:11:48	0:16:54	0:38:46	1:06:27	2:14:04	5:12:34	1:41:12	5:57:57

Norwich CCG Response Times – December 2018 and January 2019 by Week

Weekending	C1 Mean Average Response Time	C1 90th Percentile	C2 Mean Average Response Time	C2 90th Percentile	C3 Mean Average Response Time	C3 90th Percentile	C4 Mean Average Response Time	C4 90th Percentile
2018-12-02	0:06:34	0:10:19	0:24:18	0:54:09	1:45:55	4:49:52	2:25:19	5:21:24
2018-12-09	0:06:13	0:11:54	0:22:51	0:51:19	1:39:09	4:09:31	1:58:24	6:26:35
2018-12-16	0:06:11	0:09:49	0:22:08	0:50:43	1:16:36	3:36:01	1:27:04	5:06:58
2018-12-23	0:05:29	0:08:12	0:15:45	0:34:16	0:42:25	1:42:47	0:31:05	1:23:31
2018-12-30	0:05:00	0:08:27	0:17:56	0:40:29	0:48:16	2:07:26	0:56:26	2:19:46
2019-01-06	0:05:02	0:08:00	0:18:22	0:40:36	1:09:04	3:20:15	2:07:17	6:31:41
2019-01-13	0:05:31	0:08:07	0:17:13	0:37:35	0:57:15	2:24:06	1:13:45	3:34:15
2019-01-20	0:05:43	0:09:06	0:20:14	0:41:45	1:23:08	3:23:48	1:23:28	2:57:15
2019-01-27	0:05:49	0:08:45	0:23:10	0:50:54	1:57:43	4:34:00	1:47:24	5:59:47

South Norfolk CCG Response Times – December 2018 and January 2019 by Week

Weekending	C1 Mean Average Response Time	C1 90th Percentile	C2 Mean Average Response Time	C2 90th Percentile	C3 Mean Average Response Time	C3 90th Percentile	C4 Mean Average Response Time	C4 90th Percentile
2018-12-02	0:11:50	0:18:52	0:32:14	1:00:29	1:53:49	4:46:17	1:56:54	3:38:00
2018-12-09	0:11:24	0:20:50	0:28:13	0:53:11	1:26:54	3:12:10	1:54:07	5:03:31
2018-12-16	0:09:20	0:16:18	0:28:31	0:55:21	1:27:31	2:55:06	1:02:18	2:21:43
2018-12-23	0:09:46	0:16:31	0:20:18	0:37:31	0:45:11	1:43:36	0:41:43	1:43:54
2018-12-30	0:10:05	0:17:14	0:20:06	0:35:20	0:48:53	1:45:17	1:22:25	3:40:01
2019-01-06	0:09:08	0:14:59	0:23:09	0:42:12	1:01:40	2:25:41	1:04:53	3:05:07
2019-01-13	0:09:18	0:16:29	0:23:12	0:40:15	1:07:46	2:40:15	1:09:47	2:46:12
2019-01-20	0:08:29	0:16:22	0:27:26	0:51:19	1:07:12	2:39:51	0:48:14	1:50:45
2019-01-27	0:12:24	0:19:16	0:32:38	1:00:15	1:54:27	4:35:16	2:02:23	3:21:24

West Norfolk CCG Response Times – December 2018 and January 2019 by Week

Weekending	C1 Mean Average Response Time	C1 90th Percentile	C2 Mean Average Response Time	C2 90th Percentile	C3 Mean Average Response Time	C3 90th Percentile	C4 Mean Average Response Time	C4 90th Percentile
2018-12-02	0:10:56	0:18:51	0:30:10	0:58:20	2:09:21	6:15:46	1:59:12	5:57:20
2018-12-09	0:09:47	0:20:05	0:30:04	1:02:45	1:51:22	4:32:50	2:23:47	8:22:54
2018-12-16	0:08:48	0:15:43	0:26:43	0:52:19	1:13:35	2:36:28	1:52:44	4:36:10
2018-12-23	0:08:59	0:19:09	0:22:21	0:46:13	0:43:05	1:37:52	0:33:33	1:14:17
2018-12-30	0:09:22	0:16:13	0:21:37	0:45:32	0:55:47	2:05:49	1:03:12	3:02:00
2019-01-06	0:08:13	0:14:41	0:21:25	0:43:34	0:52:55	1:57:05	1:10:53	2:13:18
2019-01-13	0:09:13	0:16:54	0:24:10	0:49:29	1:11:57	2:49:06	1:03:51	2:13:33
2019-01-20	0:09:41	0:17:15	0:24:11	0:48:21	0:52:06	1:49:15	0:54:38	1:33:39
2019-01-27	0:09:53	0:18:02	0:36:38	1:16:07	1:58:04	4:24:27	1:05:59	2:48:01

Stroke Performance

EEAST is measured against two stroke targets. One is around the level of care given by ambulance clinicians (called the stroke bundle). From April this year EEAST will be measured against the proportion of patients that receive appropriate treatment, according to the latest guidance. These outcomes are thrombolysis or first CT scan within 180 minutes of making a 999 call, with an expectation that 90% of patients will have these standards met by 2022.

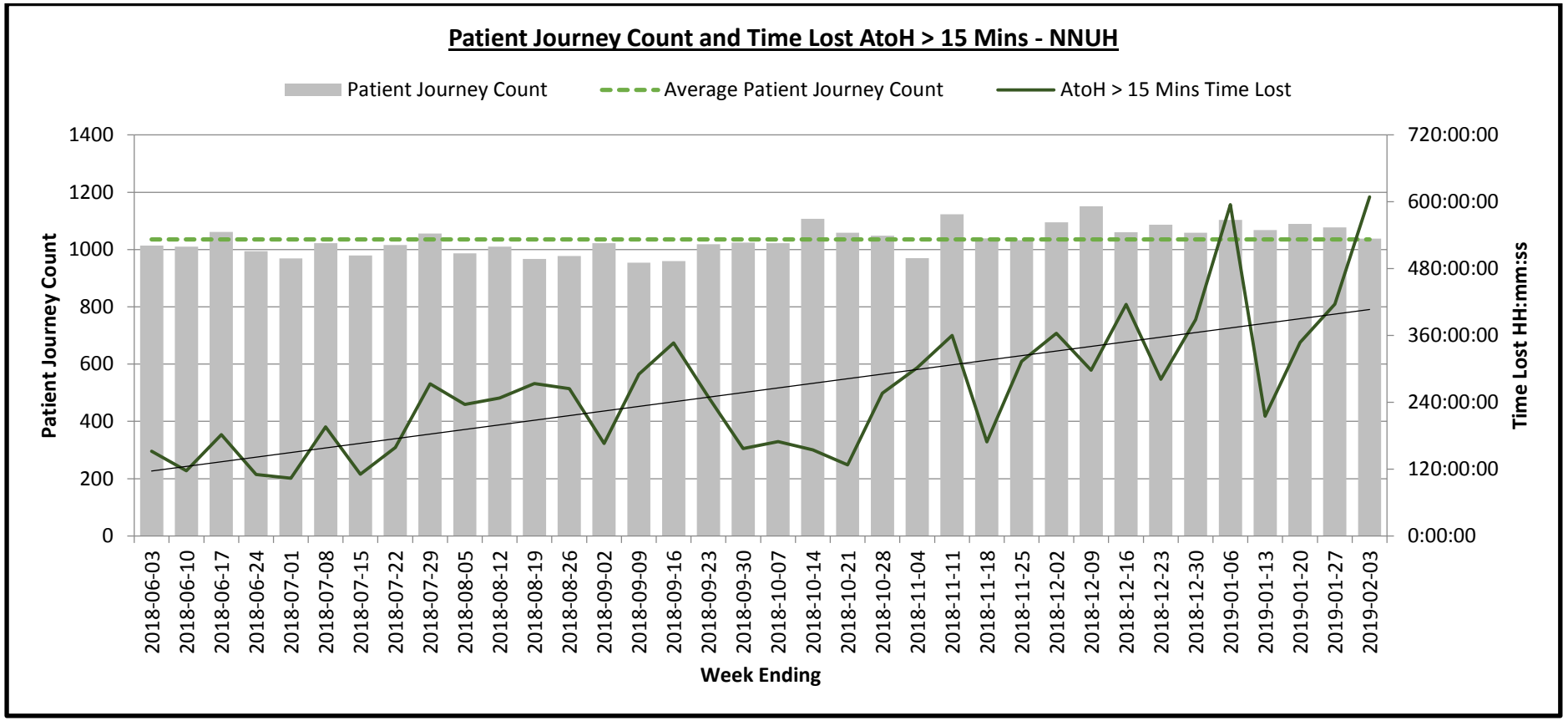
The stroke care bundle target measures if EEAST delivered the right clinical care to each patient. As can be seen from table below, EEAST across Norfolk and Waveney has excellent care bundle results. The target is 95% achievement of the stroke care bundle.

Stroke care bundle results in Norfolk and Waveney STP Area

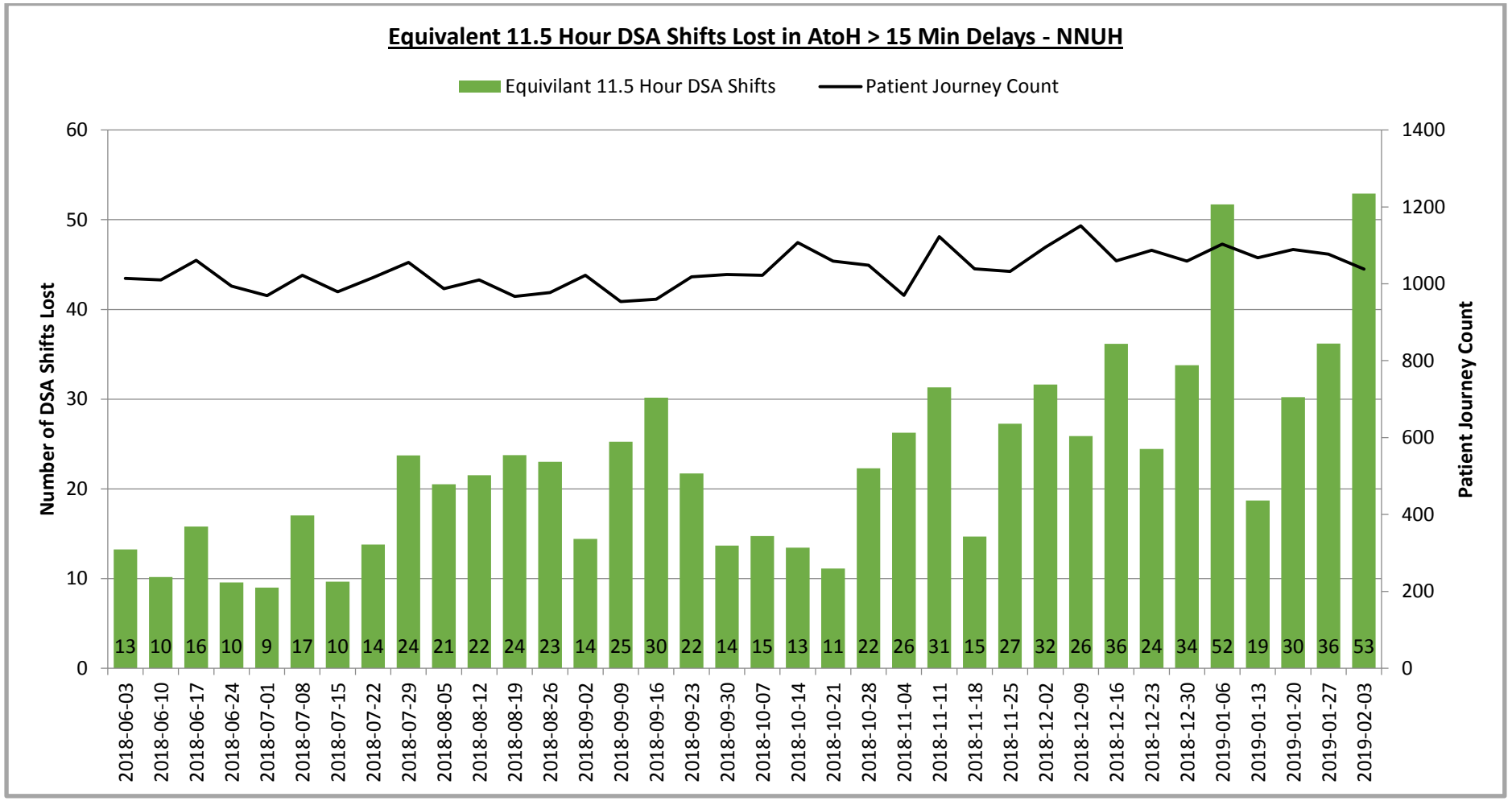
CCG	November 2018
West Norfolk & Waveney	100%
East Norfolk	100%
Norfolk & Waveney STP	100%

As you can see, the standard of care provided by paramedic and technician crews across Norfolk & Waveney remains excellent, as it has done for the past year.

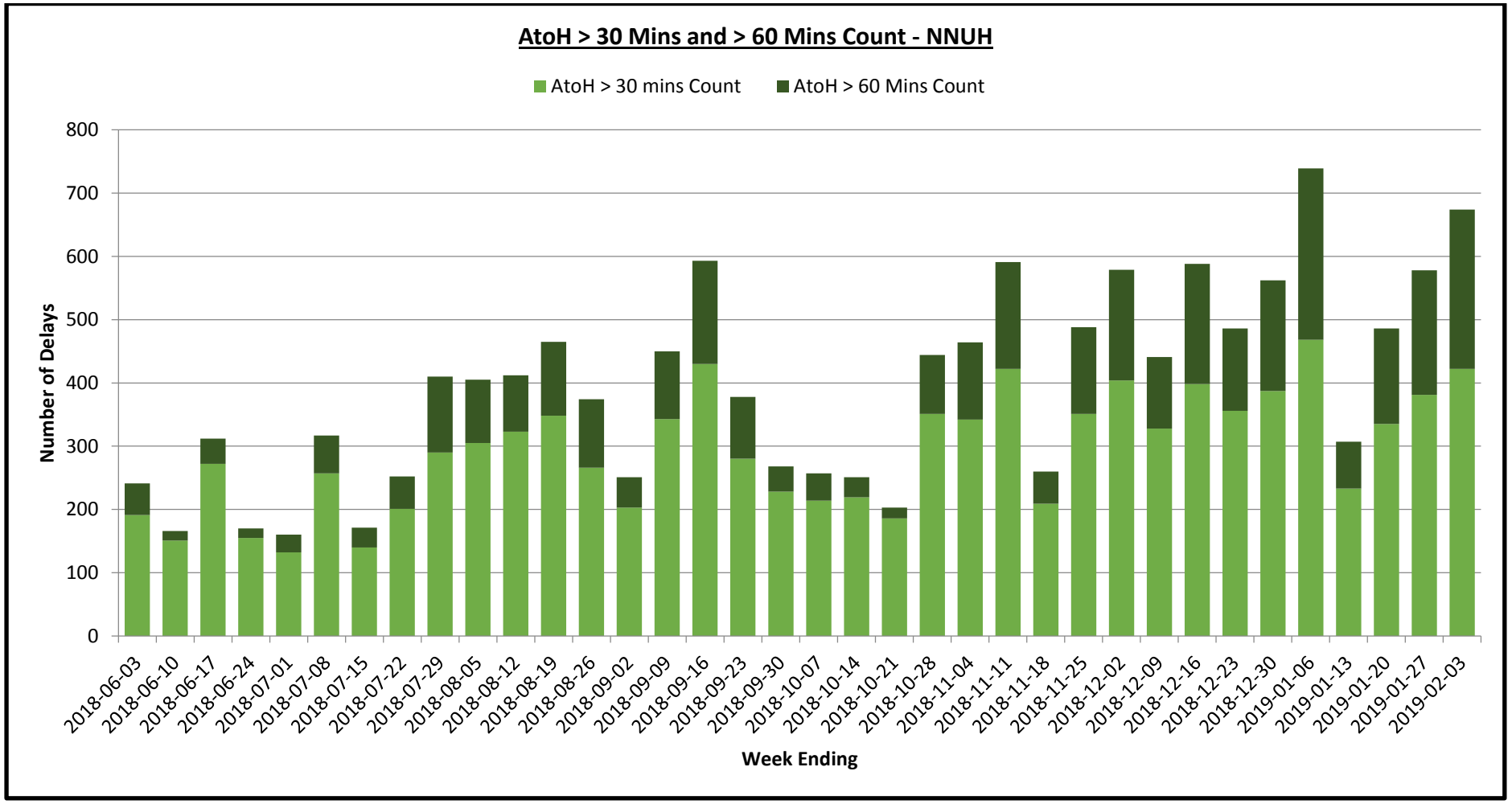
This graph shows the patient journey count into NNUH by week from 28.05.2018 to 03.02.2019. The average patient journey count was 1035 per week and this was exceeded in 17 weeks. Arrival to Handover (AtoH) > 15 mins time lost peaked at 608 hours WE 03.02.2019 and on average, 261 hours were lost a week over the 36 week review period.



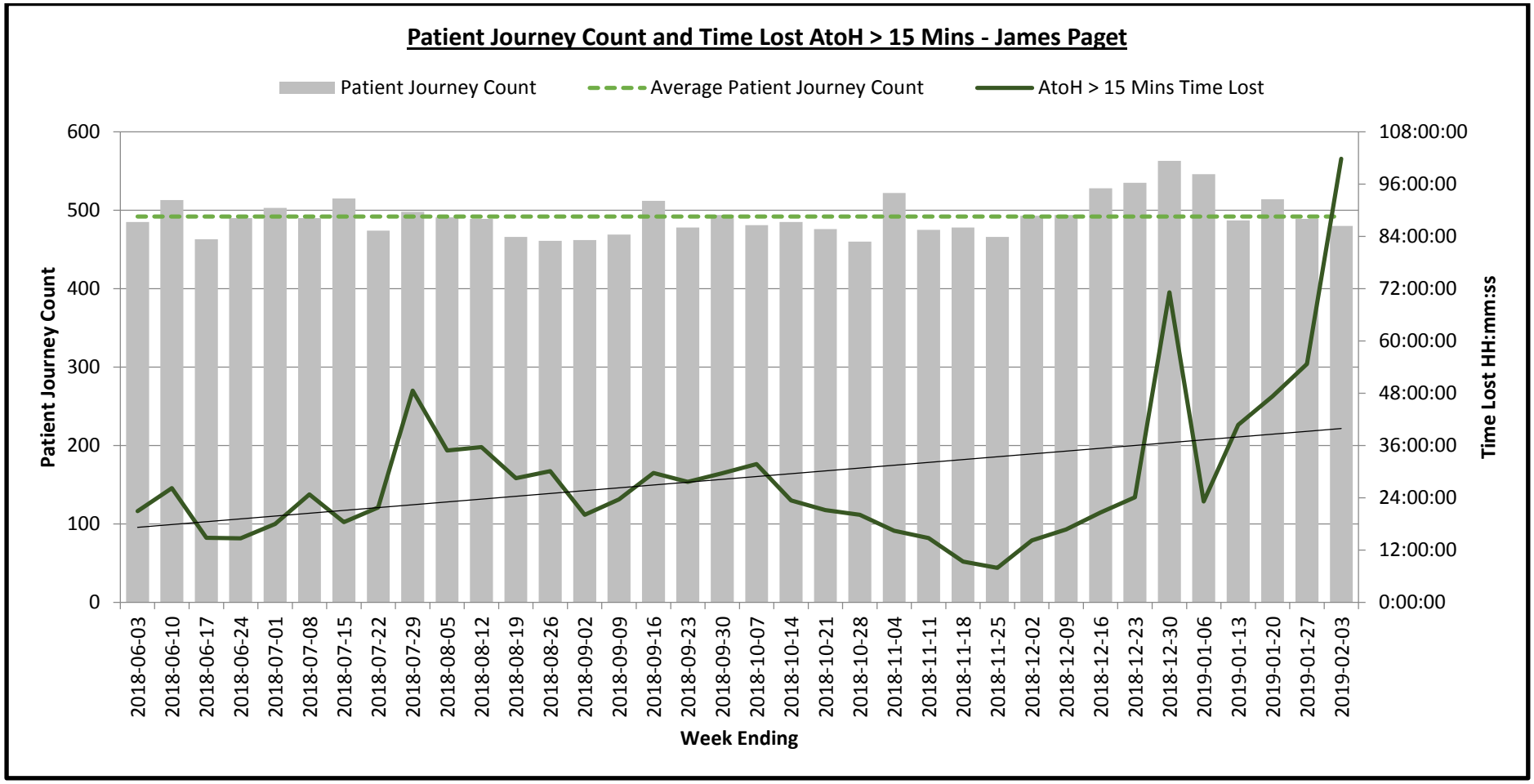
This graph shows equivalent number of 11.5 hour DSA shifts lost in AtoH > 15 min delays at the NNUH from 28.05.18 to 03.02.19. On average, 23 shifts were lost per week due to AtoH delays however; as many as 53 shifts were lost in one week (WE 03.02.2019).



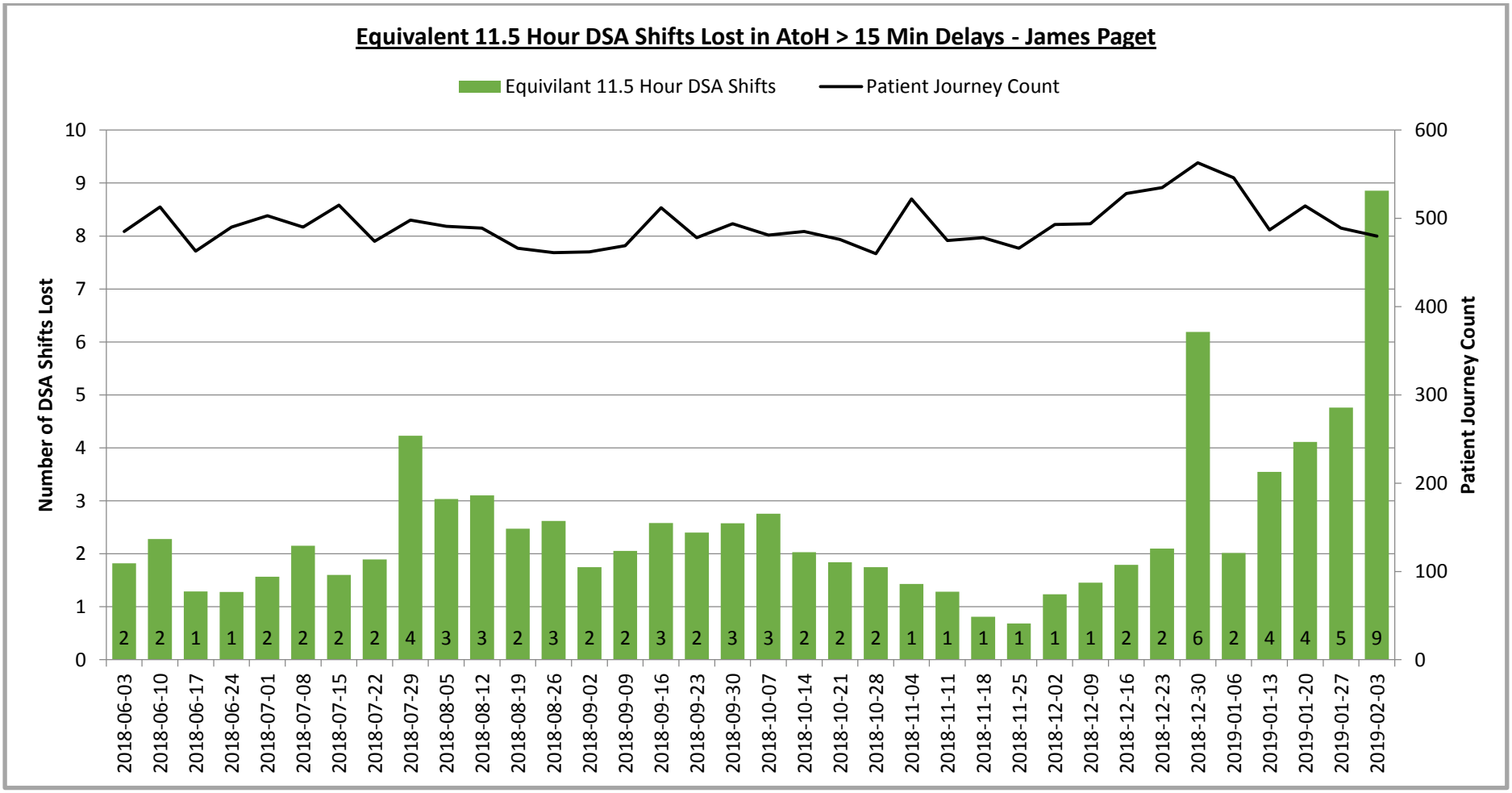
This graph shows the number of occasions where AtoH was > 30 mins and AtoH was greater than 60 mins. There were 10521 AtoH delays > 30 mins from 28.05.2018 to 03.02.2019 (28% of all patient journeys) and 3672 AtoH delays > 60 mins in the same time frame (10% of all patient journeys).



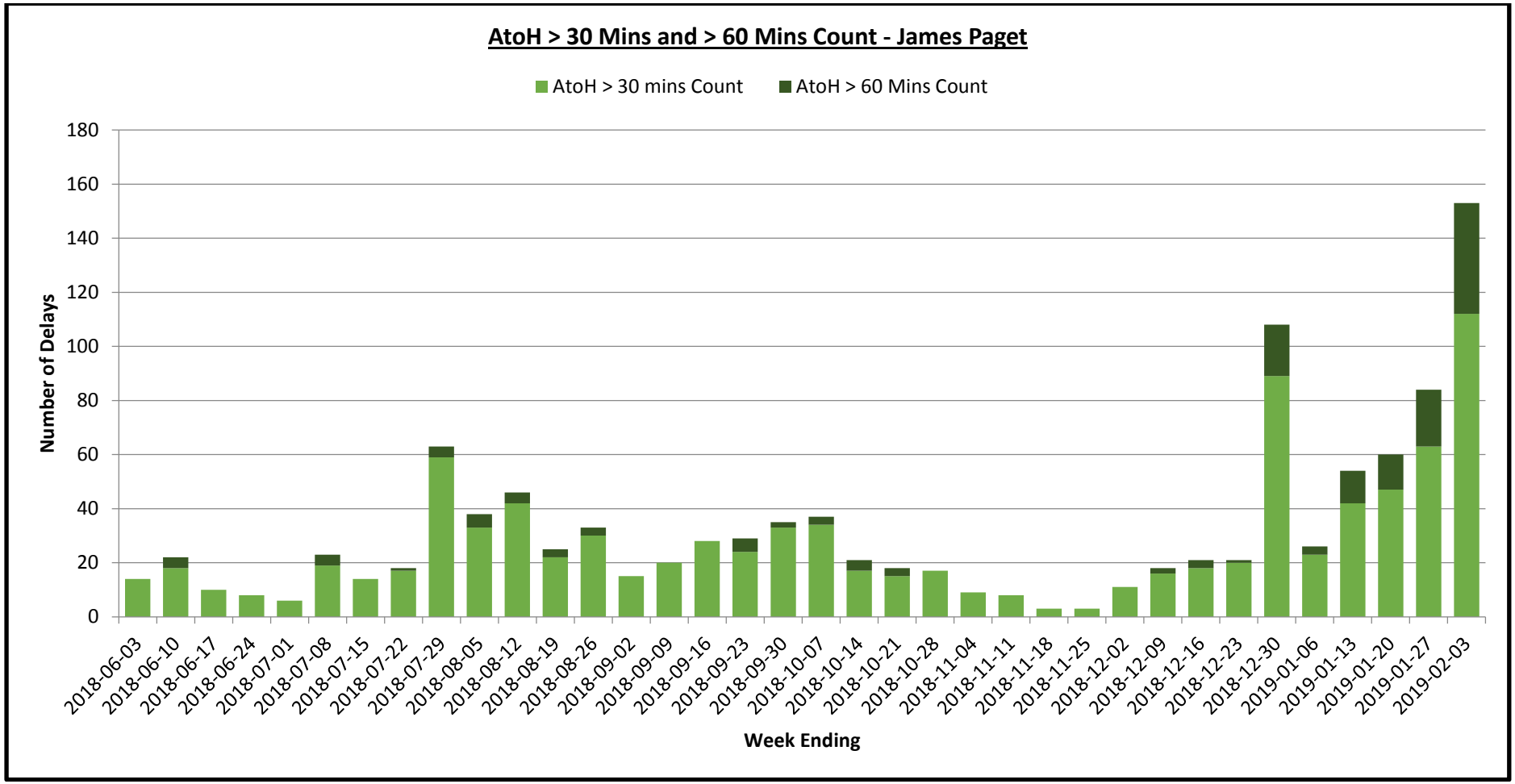
This graph shows the patient journey count into James Paget by week from 28.05.2018 to 03.02.2019. The average patient journey count was 492 and this was exceeded in 14 weeks. AtoH > 15 mins time lost peaked at 101 hours WE 03.02.2018 and on average, 28 hours were lost a week over the 36-week review period.



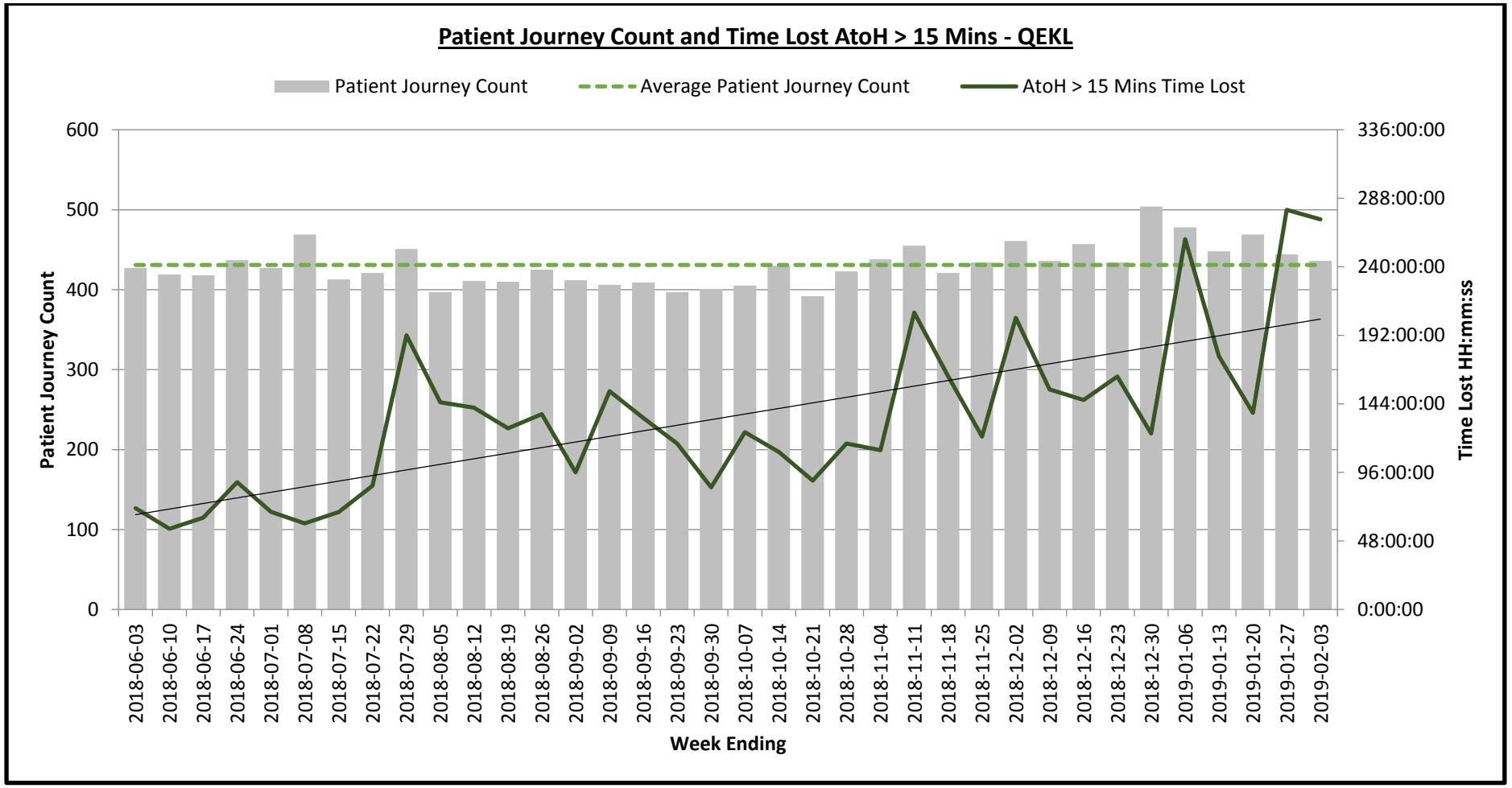
This graph shows equivalent number of 11.5 hour DSA shifts lost in AtoH > 15 min delays at James Paget from 28.05.18 to 03.02.19. On average, 2 shifts were lost per week due to AtoH delays however; as many as 9 shifts were lost in one week (WE 03.02.2019).



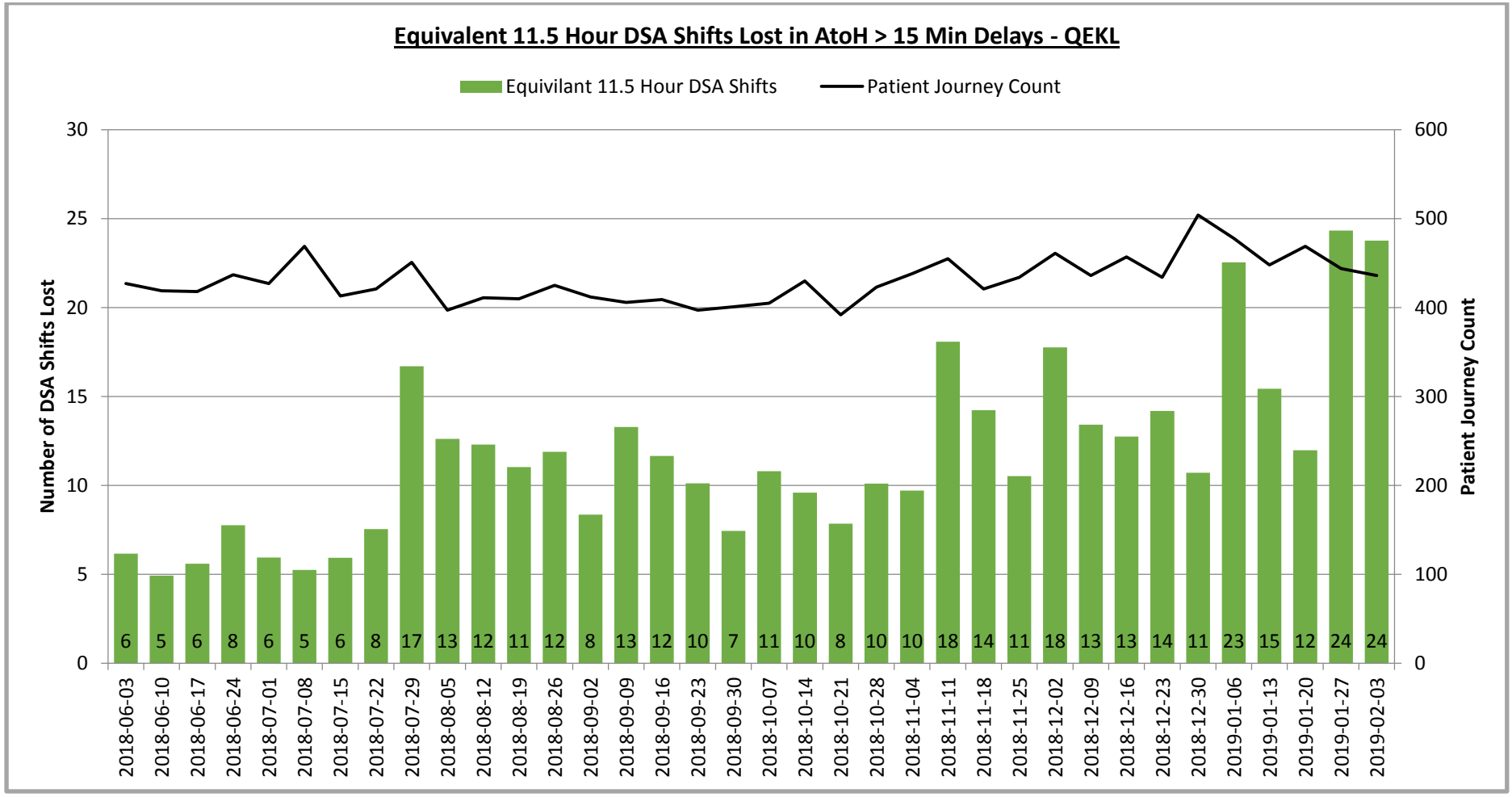
This graph shows the number of occasions where AtoH was > 30 mins and AtoH was greater than 60 mins. There were 959 AtoH delays > 30 mins from 28.05.2018 to 03.02.2019 (5.4% of all patient journeys) and 160 AtoH delays > 60 mins in the same time frame (0.9% of all patient journeys).



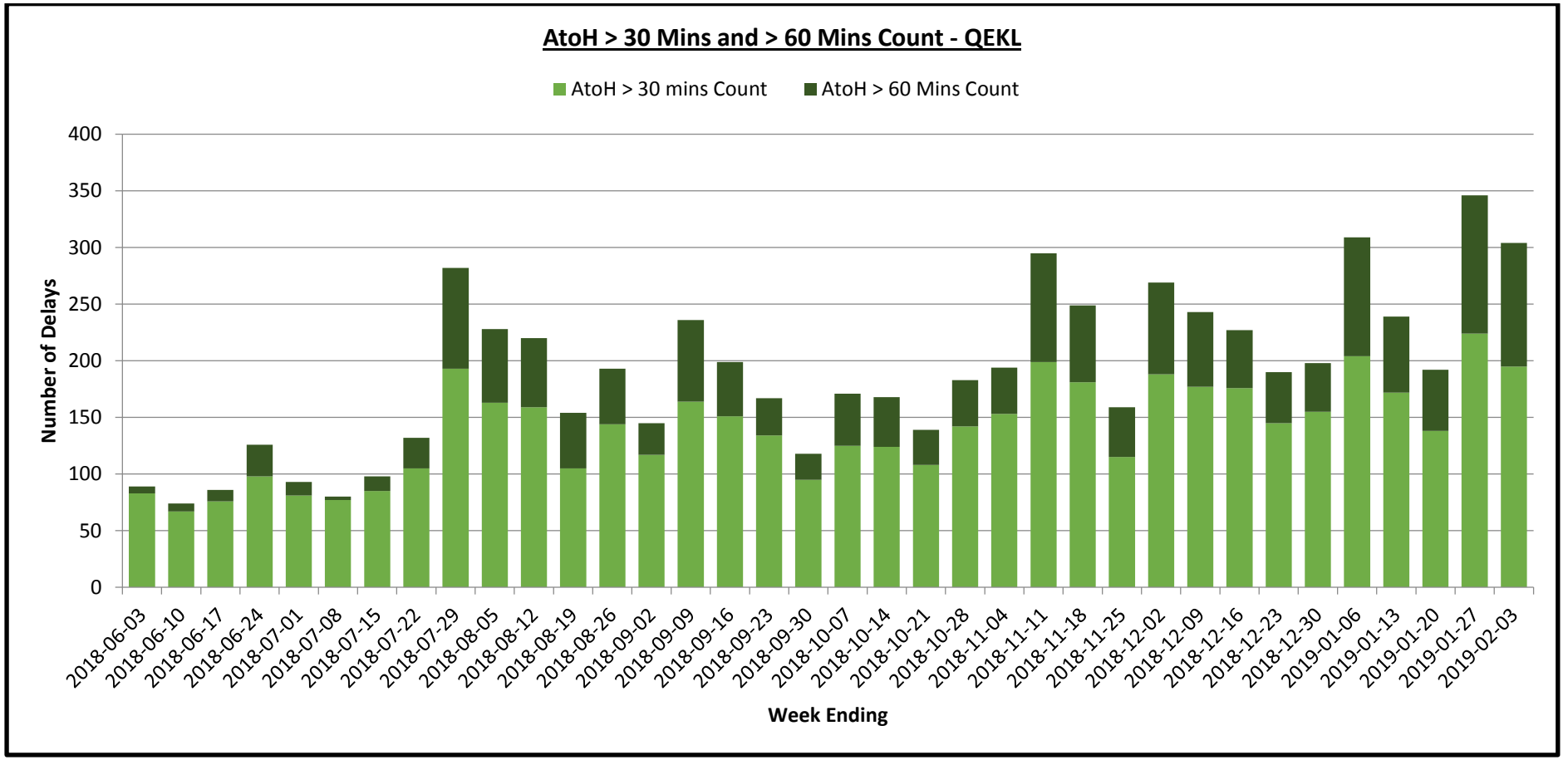
This graph shows the patient journey count into Queen Elizabeth King's Lynn (QEKL) by week from 28.05.2018 to 03.02.2019. The average patient journey count was 431 and this was exceeded in 16 weeks. AtoH > 15 mins time lost peaked at 279 hours WE 27.01.2019 and on average, 135 hours were lost a week over the 36 week review period.



This graph shows equivalent number of 11.5 hour DSA shifts lost in AtoH > 15 min delays at QEKL from 28.05.18 to 03.02.19. On average, 12 shifts were lost per week due to AtoH delays however, as many as 24 shifts were lost in one week (WE 27.01.2019).



This graph shows the number of occasions where AtoH was > 30 mins and AtoH was greater than 60 mins. There were 5018 AtoH delays > 30 mins from 28.05.2018 to 03.02.2019 (32% of all patient journeys) and 1777 AtoH delays > 60 mins in the same time frame (11.5% of all patient journeys)



Staff Recruitment Plan

At the beginning of this financial year (2018/19) the Ambulance Commissioning Consortium of 19 CCGs across the eastern region agreed to an uplift in funding to recruit a further 330 staff over three years. This will see the Trust recruit and train a further 1300 plus people to cover turnaover and this growth along with addressing current vacancies.

Specifically for Norfolk & Waveney, this will increase our number to 700 wte staff from the previous establishment figure of 618 wte. The current establishment is 634 wte, leaving 66 vacancies.

The Trust is pleased to update that a total of 49 new starters will join EEAST in Norfolk & Waveney between now and June 2019. The majority of these new staff will be student Paramedics or Emergency Medical Technicians.

This is tempered however by the number of staff that has left the locality during 2018-19. To date a total of 49.7 wte have left the trust from Norfolk & Waveney. This is a combination of staff retiring (9) or leaving for other roles across the local health system.

The Trust recognises that this remains challenging and is delivering a range of activities to address this including:

- Setting up of a dedicated local recruitment team that is able to target local colleges, educational establishments and programmes, and recruitment events.
- Focussed graduate recruitment campaigns
- Continuing to engage with armed forces service leavers (this is through the NHS Step-into-Health programme) to look at EEAST as an alternative career option
- New marketing materials and recruitment campaigns to raise awareness of careers in the Trust and benefits of working for EEAST
- Targeted recruitment campaigns utilising, Bus stops, Bus backs and radio advertising
- Social media recruitment strategy
- Taster days and engagement sessions
- Use of on-line job boards in addition to NHS jobs
- Building capacity in recruitment team
- Recruitment improvement project and safer and resilient recruitment initiatives
- Outsourcing of some volume recruitment
- Purchase of private training provision to frontload 3-year workforce plan
- Working with HEE to agree funding to support 3-year workforce plan including liaison with Higher Education Institutes
- Investment in the Trusts training and education infrastructure
- Developing and promoting apprenticeships for transition to new clinical career pathway
- Developing advanced and specialist routes to improve recruitment and retention

Sickness absence remains a challenge across the Trust, as it does within the wider NHS, but has robust policies and procedures to support staff in returning to work where possible.

Current sickness ranges between 6-8% across the area.

Mental Health Pathways

EEAST continues to work with commissioners and provider partners to seek the safest and most appropriate and efficient transport option for mental health patients. EEAST also continues to engage with senior partners within Norfolk County Council, Norfolk Constabulary, NSFT to review and identify gaps in the transport pathway for mental health patients.

Transport for Mental health patients is often a cause for concern, but does not always fit within the EEAST contract. This is dependent upon the type of transport required and the presenting condition of the patient. Commissioners, NSFT & EEAST have been working to identify the most appropriate escalation process to prevent delays in transport for higher acuity patients.

EEAST has few primary pathways available that prevent some patients from being conveyed to the emergency departments. Whilst some progress has been made in recent weeks with Norwich-based services, this is not available throughout the rest of the county. As a result, patients are often conveyed to ED for mental health assessments. This is not necessarily the most appropriate location, but sometimes, especially out of normal working hours, support services are not available for their presenting need. Patients with a medical need will usually be conveyed in order to address their need first before any mental health assessment.

Developments during winter 2018-19

Following the very difficult winter period of 2017-18 where Trust and our patients' experienced significant delays in the community EEAST changed a number of internal processes and resource planning. This included a revised annual leave policy covering the festive period and an increased planning period i.e. long range planning with a 12 week 'look-ahead'. This was an action from the risk summit of January 2017.

The Trust also incentivised overtime across key dates within the festive period to maximise patient facing staff hours.

As a result of the actions above, the 2018-19 festive period both performance and patient outcomes was significantly better than 2017-18.

EEAST has also continued additional schemes throughout the current financial year, and supported the wider health economy. These schemes and support are as follows;

- Early Intervention Vehicle in Great Yarmouth & Waveney

- Early Intervention Vehicle across the Central Norfolk system
- Specialist paramedic schemes across Norfolk
- Urgent Care Desk (aimed at dispatching Specialist Paramedics and ECP's to appropriate calls for their skillset)
- Released a Senior Operational manager to work within the Norfolk & Waveney STP Winter Room (based at the NNUH)
- Released an Operational Manager to support process improvements at QEH(KL)
- Facilitated system-wide workshops to identify and support ambulance handover challenges at our hospitals.

Our Vision
To provide every patient with the care we want for those we love the most

Norfolk and Norwich University Hospitals NHS
NHS Foundation Trust

AMBULANCE HANDOVER AT NNUH - REPORT TO NHOSC - 28 FEBRUARY 2019

From: Chris Cobb – Chief Operating Officer
Norfolk and Norwich University Hospitals NHS Foundation Trust

For: Norfolk Health Overview and Scrutiny Committee - 28 Feb 2019

The NNUH have been asked to update the committee on ambulance handover delays at the Hospital during the winter period and be prepared to answer four specific questions. The questions and response are shown at end of this paper.

Background

Winter 2018/19 is proving exceptionally challenging for the Central Norfolk system and the NNUH. Pre winter a significant amount of planning was undertaken to identify key schemes to provide additional capacity as shown below:

Table 1: Winter Plan 2018/19

		Winter Plan Additional Capacity			
		Non-Elective		Elective	Treatmen
1	Modular Ward		December	20	
2	Open Closed Beds	17	October - December		
3	NNUH @Home Virtual Ward	30	December		
4	8 Cubicle RATS development		December		6
5	Disharge Lounge	23	December		
6	Super Stranded initiative	23	December		
	Winter Plan Total	93		20	6
		QEH Mitigation/ Growth			
		Non-Elective		Elective	Treatmen
1	New CDU	12	January		
2	Relocation of GMDU	28	January	-28	
3	Gastro Unit		January	28	
	Mitigation Total	40		0	6
	Enhance Winter Plan Total	133		20	6

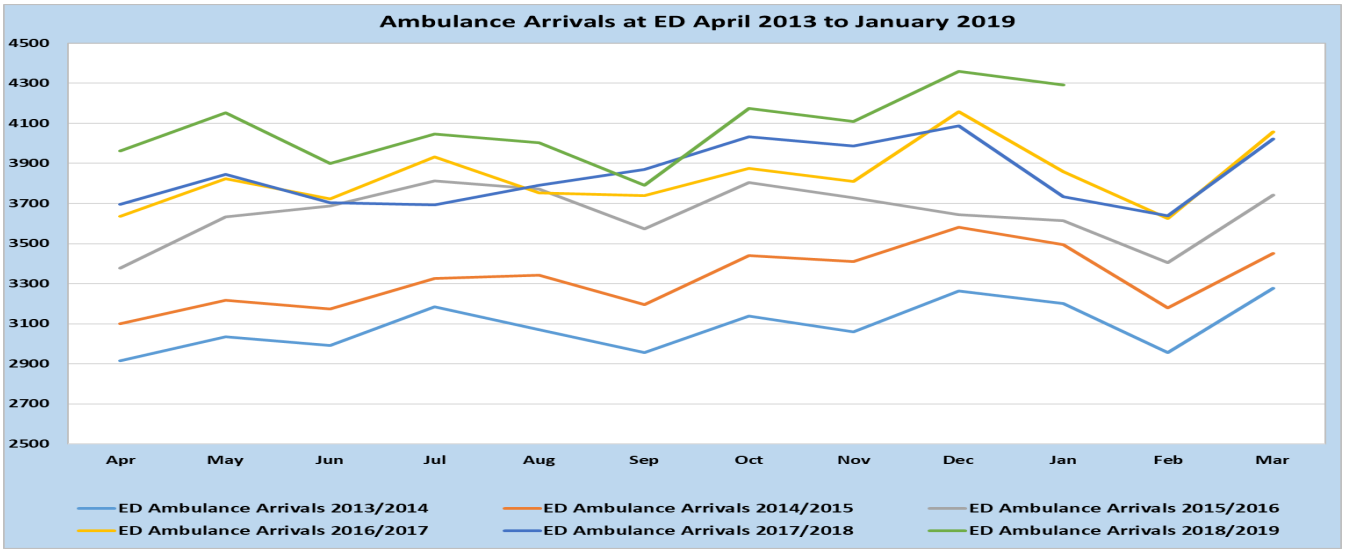
Not all of this additional capacity has been delivered in accordance with the original timelines.

Ambulance Activity

There has been significant growth in the total numbers of attendances at ED in the last 12 months. In the period April to January, ambulance arrivals at the NNUH represented 42.9% of the total attendances at the ED department.

The rate of conveyance by ambulance to the NNUH is higher than our near neighbours predominantly due to the specialist nature, size and catchment area of the NNUH.

Table 2. Ambulance arrivals at ED Apr 2013 – Jan 2019

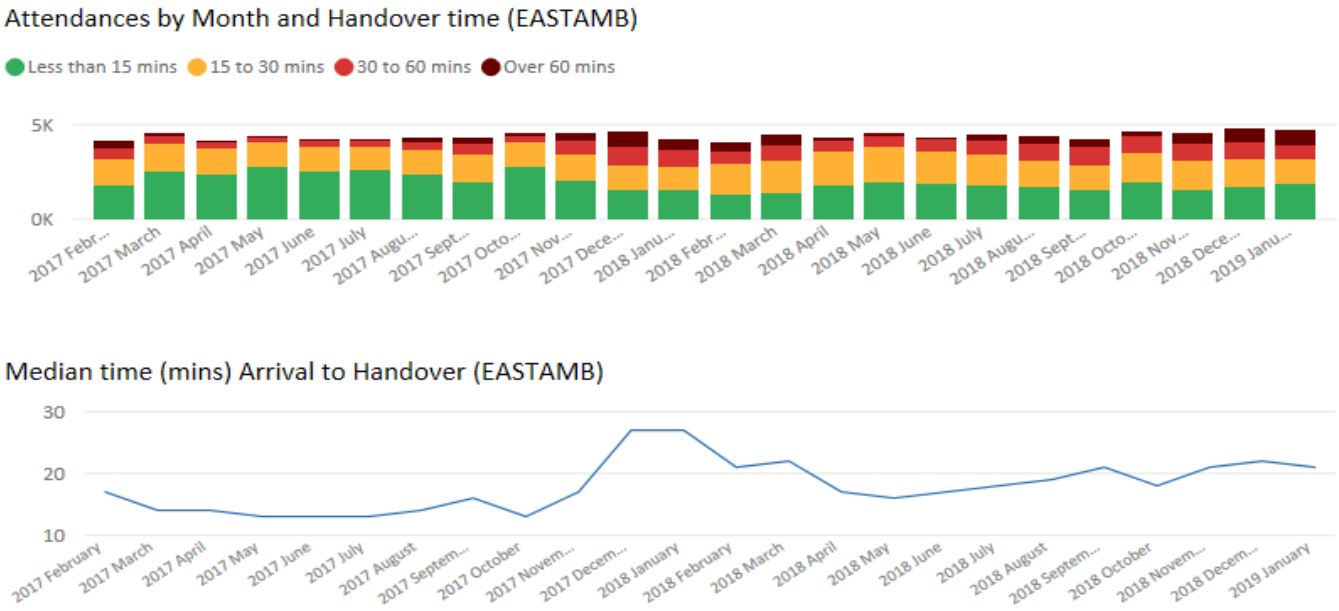


In December and January 2019 there have been significant increases in ambulance arrivals at the NNUH. This has placed additional pressure on the ED and has resulted in increased handover delays despite the addition of 8 further assessment spaces.

Table 3. Ambulance % variance in arrivals at ED Apr 2017 – Jan 2019

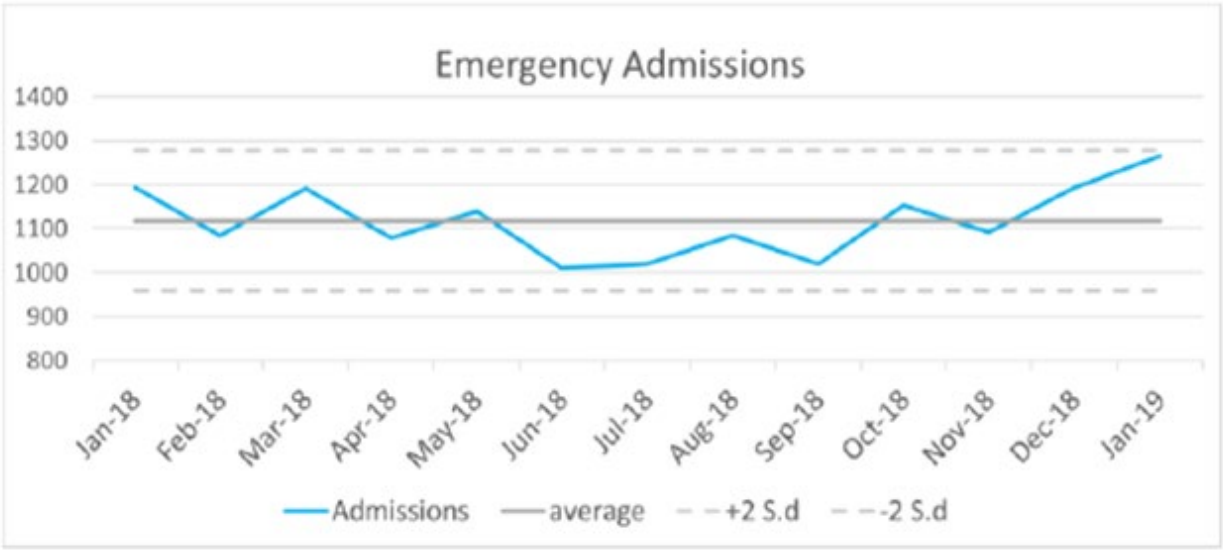
Month	Arrivals 2017/18	Arrivals 2018/19	Variance on 2017/18	% increase
April	3700	3954	254	6.9%
May	3848	4150	302	7.8%
Jun	3701	3900	199	5.4%
July	3689	4053	364	9.9%
August	3803	4005	202	5.3%
September	3861	3777	-84	-2.2%
October	4021	4186	165	4.1%
November	4004	4107	103	2.6%
December	4054	4346	292	7.2%
January	3749	4288	539	14.4%
February	3645			
March	4030			

Table 4. Ambulance Handovert ED Feb 17 2013 – Jan 2019



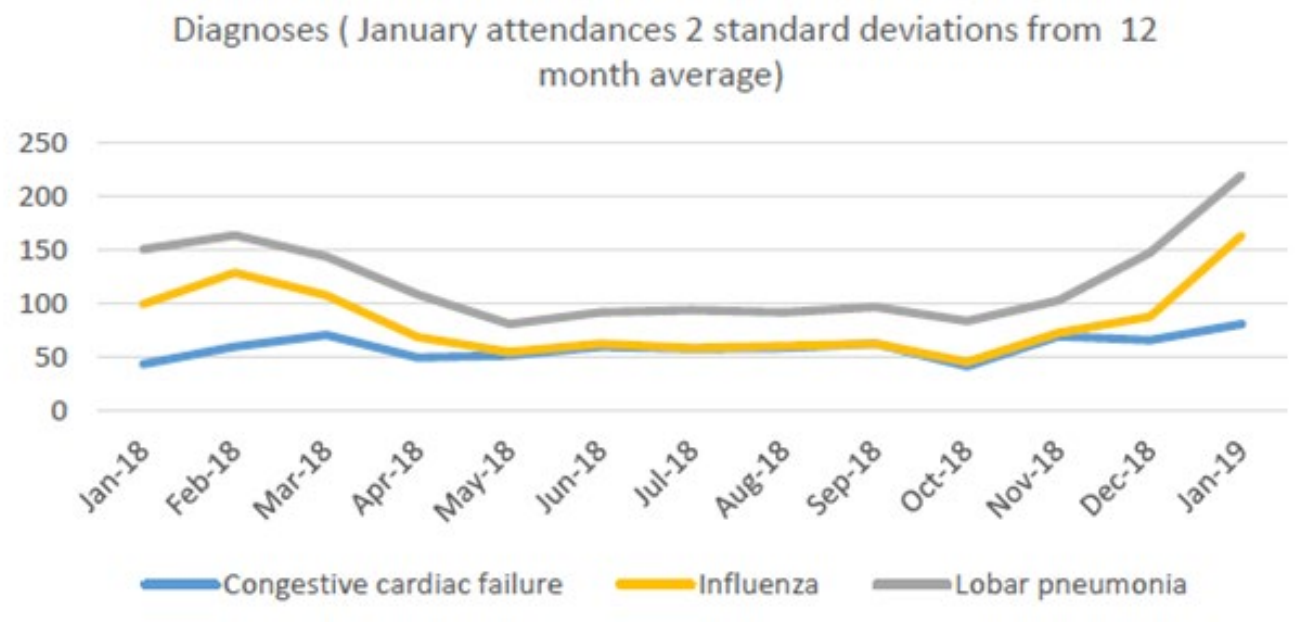
Demand & Acuity of presentation

The number of emergency admissions in Winter 18/19 has increased by 8% and January saw the highest number of emergency admissions in a single month. There was an increase in ambulance arrivals of 30% compared with January 2018 and 65% of those arrivals were ultimately admitted to hospital.



A significant increase in respiratory and cardiac conditions with high levels of acuity is a primary reason for the increase in admissions.

Table 5: Main areas of growth in high acuity admissions



The acute nature of emergency admissions has resulted in the longer length of stay patient numbers not reducing in accordance with the winter plan.

The combination of increased attendances, admissions, ambulance arrivals and acuity of presentation has resulted in the NNUH becoming very congested and in need of further expansion of inpatient capacity and/or alternative pathways outside of the NNUH.

The current pressures on inpatient beds have resulted in a requirement to open “escalation beds” (Beds usually available for day procedures and specialist interventions) on a daily basis in order to accommodate the demand on our services. The escalation areas do not have allocated staff and the process required to identify suitable patients and staff to open the areas can be a time consuming process. Flow from the A&E into the hospital is often slowed down and can result in a position recognised as “Exit Block” from the ED into the hospital admission areas due to a lack of bed availability.

Plans to improve the ambulance handover delays have been formulated with NHS England and NHS Improvement and aim to ensure 0 delays > 1 hour by 1 April 2019.

Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH)

(a) The NNUH has made significant changes in recent years to improve the flow of patients through its emergency department, including the establishment of an Older People’s Emergency Department, a Children’s Emergency Department and expansion of Rapid Assessment and Treatment and the area for receiving the most seriously ill or injured patients. Nevertheless, the figures show that a high level of ambulance hours are lost in handover delays at the hospital. What more can be done to improve flow?

The NNUH invested in 8 additional RATS cubicles in a purpose built facility in December 2018. The increased volume of attendances and admissions has prevented the unit from functioning as planned. Further work to develop RATS and improve ambulance handover delays is underway.

Our acute inpatient bed capacity cannot currently meet demand. In the short term, the NNUH is committed to a pathway redesign project that aims to move any over-capacity issues into the main body of the Hospital.

A review of system capacity across the Norfolk STP has identified a significant shortfall in bed capacity that will result in a 500 bed shortfall across Norfolk by 2023 in a "do nothing" environment.

The NNUH is working with system partners to redesign pathways and/or provide additional capacity to improve flow into and out of the Hospital.

EEAST are leading a system wide pathways project to identify and optimise use of alternatives to ED. A workshop in January has identified a number of opportunities both within and external to the NNUH that will assist with flow.

(b) Do the hospitals consider that more could be done to improve patient flow through the Emergency Departments by moving patients to another area while awaiting the results of investigations and diagnostic tests?

The NNUH has established a Clinical Decisions Unit specifically for this purpose. The demand on the Hospital has often resulted in the CDU being full with no alternative space available within the Hospital. In the summer of 2019 the NNUH will modify some of the existing ED footprint to create a new CDU and create 12 additional inpatient beds.

(c) To what extent do the Emergency Departments have access to patients' clinical records? Could better access to patient records speed up patient flow by reducing the time spent on investigations?

The Emergency Department have limited access at the moment and can access some of the historic NNUH discharge letters on our internal patient record systems but better access to community records/care plans and mental health, police alerts and patients with special requirements records would improve patient flow and reduce investigations in the ED. A significant amount of funding is required to enhance Norfolk's digital capability in order to allow all health providers access to all of the relevant patient data to improve care.

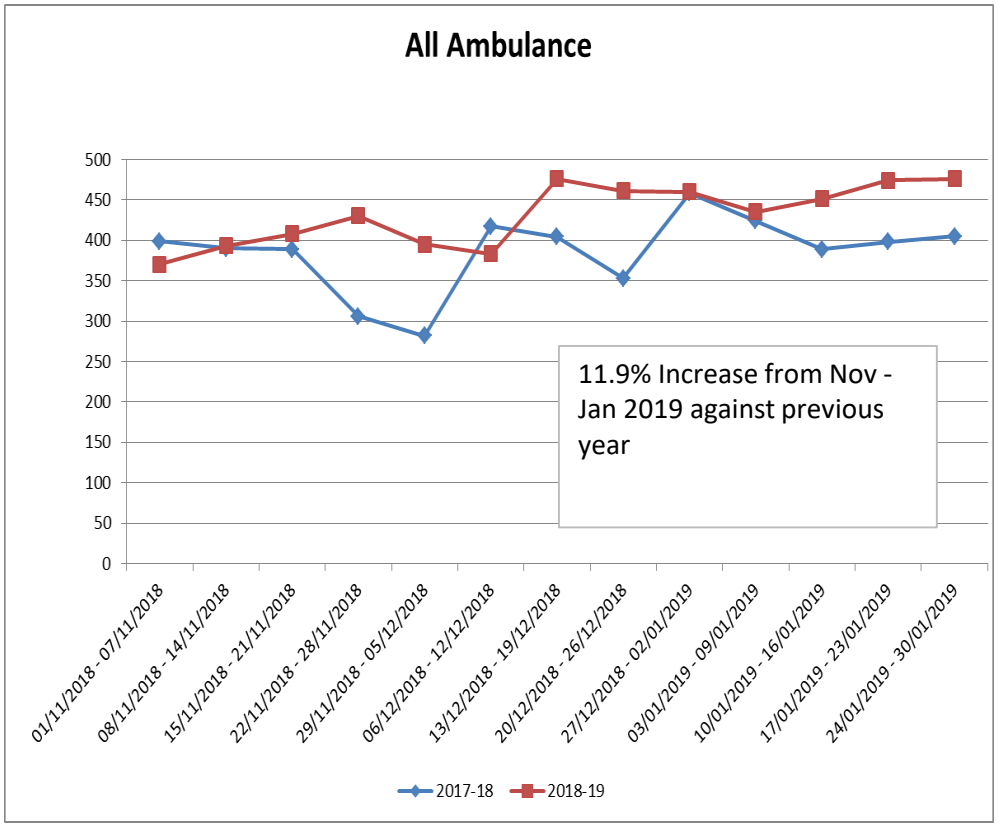
The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

Emergency Department Ambulance Handover

28TH February 2019

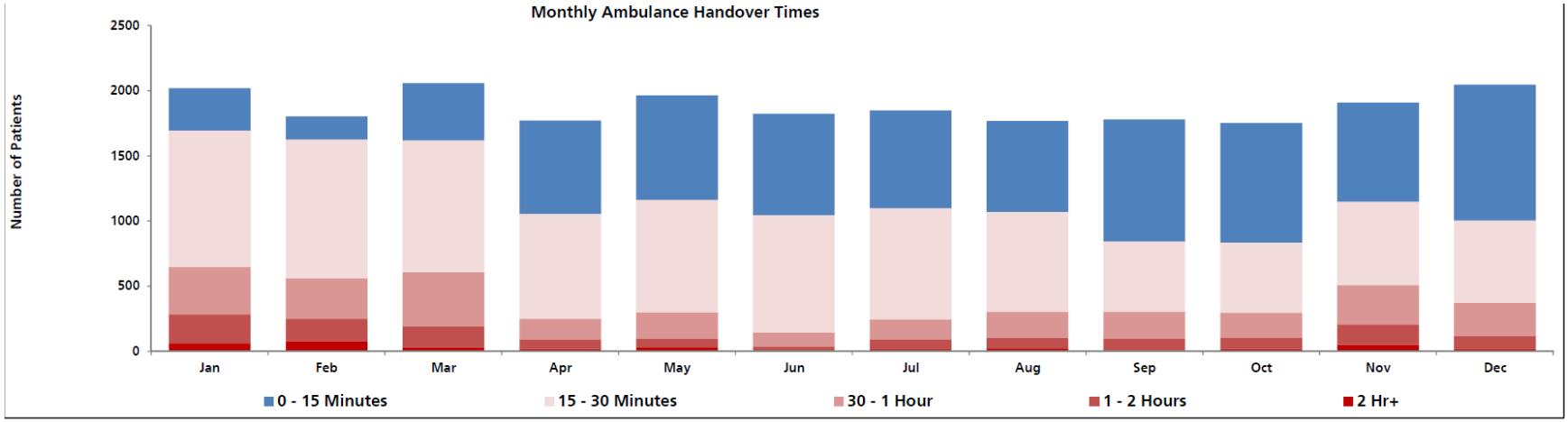
Jon Wade
Chief Operating Officer

Activity



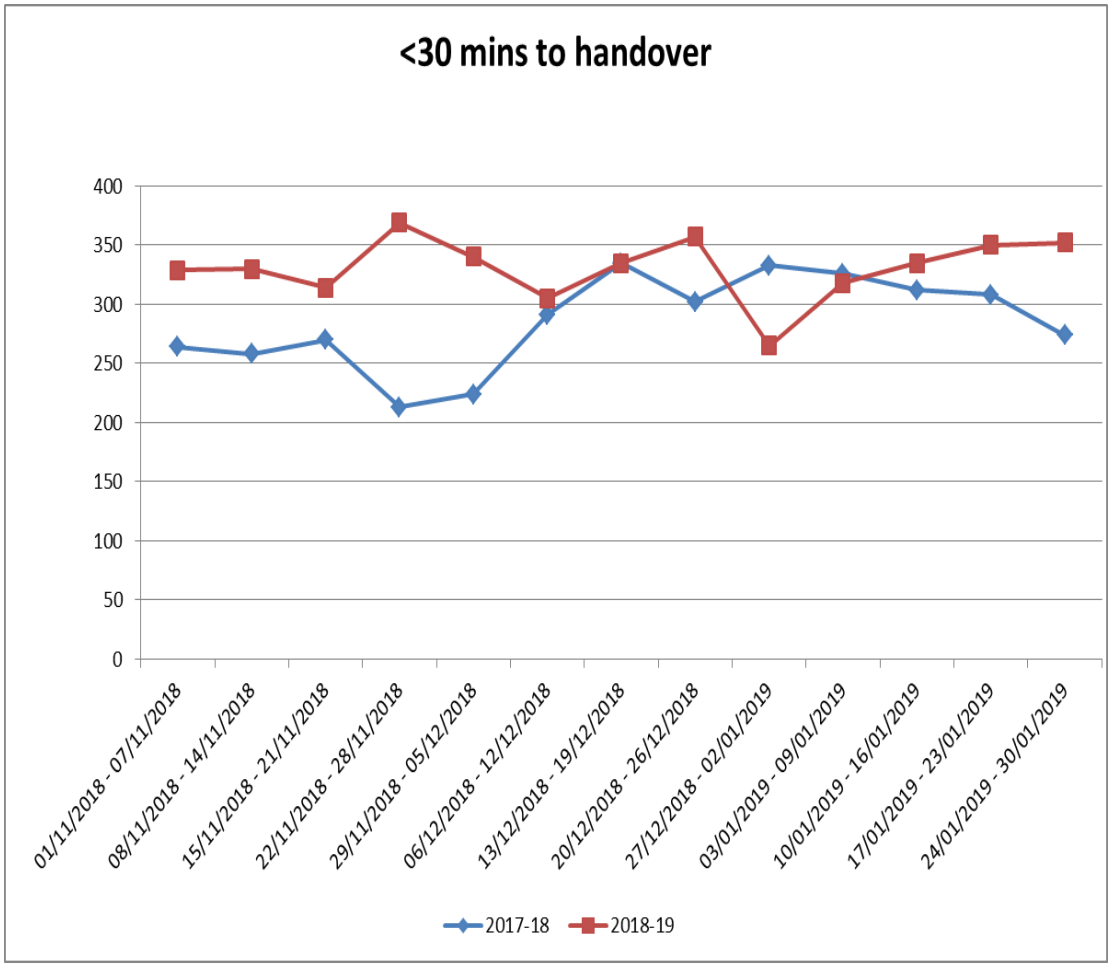
The average number of arrivals in 17/18 was 55 in 18/19 we have increased to 61 per day

Performance



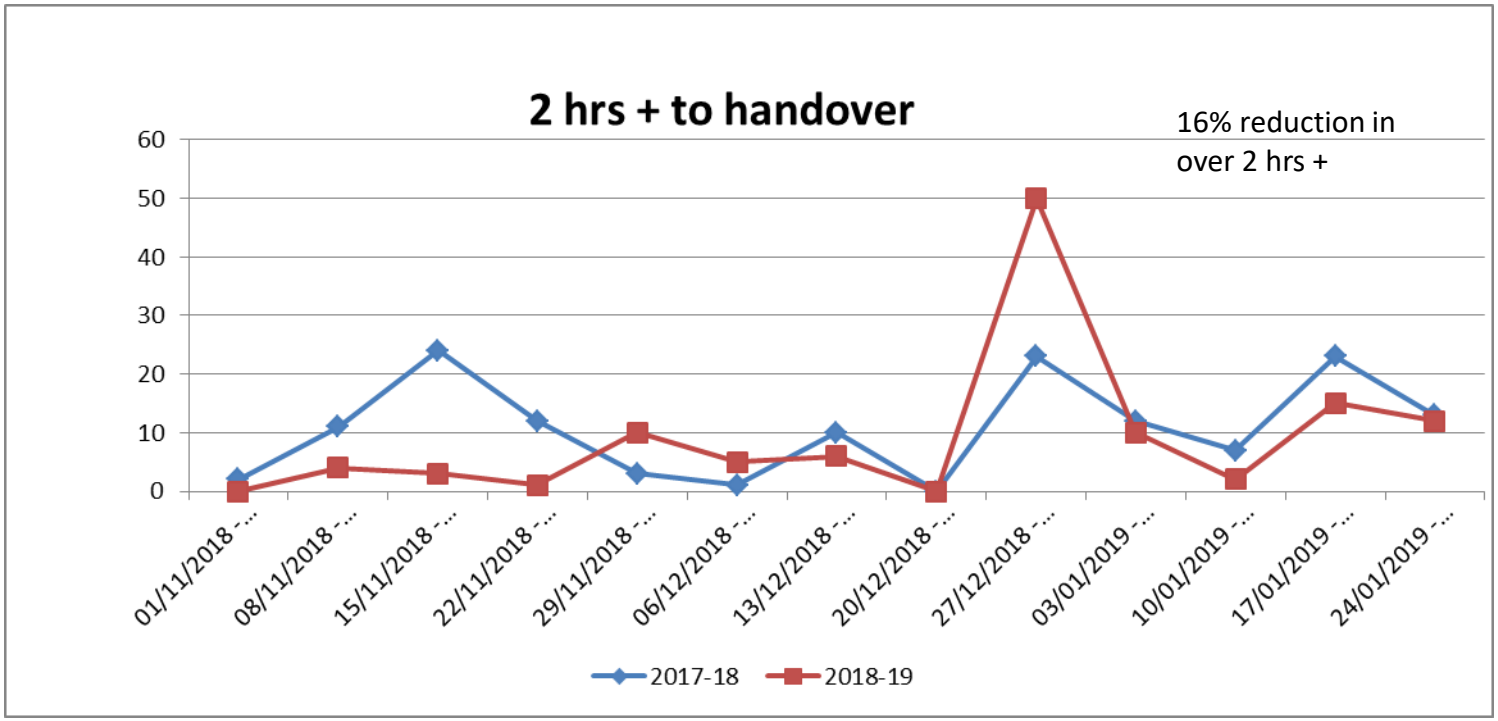
Improving picture through the year with 15% of ambulances handover in 15 minutes in January up to 50% of handovers in 15 minutes in December.
Position remains unacceptable and more work must be completed.

Performance



We have seen a 15.8% improvement in the <30 mins in 2018/19 although we have had a higher overall number of conveyances through the emergency department.

Performance



Drivers for delays

- 15-30min
  - A&E issues
  - EEAST issues
  - Team working issues
- 30-90min
  - Organisational flow
  - Co-horting not available
  - Large number of arrivals in short time
- 90min+
  - Estate specific requirements
  - D&V sideroom, Flu sideroom

Next actions

- HALO and EEAST manager embedded in Trust
- Work ongoing to address increasing conveyance rates with commissioners and EEAST
- Continue improvements in front door (streaming, Assessment Zone)
- Continue improvement in discharge of patients (Discharge to Assess)
- ED estate currently being redesigned
- Norfolk wide procurement of an Electronic Patient Record ongoing

Hospital handover hours lost – January 2019

	arrival to hand over hours lost over 15 minutes (hh:mm:ss)	hand over to clear hours lost over 15 minutes (hh:mm:ss)
Addenbrookes Hospital	174:37:29	127:22:29
Barnet General Hospital	85:44:32	16:13:00
Basildon & Thurrock Hospital	408:52:44	98:56:49
Bedford Hospital South Wing	89:04:18	59:31:30
Broomfield Hospital	618:23:48	120:55:35
Colchester General Hospital	203:33:40	104:41:18
Hinchingbrooke Hospital	121:20:59	51:48:00
Ipswich Hospital	295:38:39	41:38:19
James Paget Hospital	191:26:30	104:27:16
Lister Hospital	462:17:28	87:13:56
Luton And Dunstable Hospital	265:14:55	65:09:07
Norfolk & Norwich University Hospital	1799:23:37	203:29:54
Peterborough City Hospital	616:13:22	66:55:33
Princess Alexandra Hospital	343:26:08	86:31:58
Queen Elizabeth Hospital	961:33:14	68:02:00
Southend University Hospital	460:13:36	115:35:18
Watford General Hospital	624:32:43	98:45:37
West Suffolk Hospital	318:24:19	64:44:00
TOTAL	**8040:02:01**	**1582:01:39**

What this information means:

Handing over a patient from an ambulance to a hospital emergency department is expected to take no more than 15 minutes. Ambulance crews then have a further 15 minutes in which to complete any outstanding paperwork, make sure their vehicles are clean and meet infection prevention standards and to restock with essentials such as clean linen. Delays beyond these times mean a poor experience for the patient waiting to be admitted into the hospital but also delays ambulance vehicles returning to the front line and being available for another emergency call in the local community.

In this table, column 1 – arrival to handover – shows the number of hours lost where the patient handover has been delayed (i.e. the patient has waited with the ambulance crew for more than 15 minutes before being accepted by the hospital staff) and column 2 – handover to clear - shows that once handover has been achieved, how many hours are lost (over 15 minutes) in completing the task of making the vehicle ready to go to another patient.

The impact on EEAST resources means that at any one time EEAST loses at least 60 ambulance hours per day waiting to handover patient care to hospital staff. With the average crew shifts being 12 hours, that means 5 twelve hour shifts are lost every day of the year where crews are unable to take the next call or back up a colleague who is in the community with a patient who needs conveying to hospital.

Children's speech and language therapy

Suggested approach by Maureen Orr, Democratic Support and Scrutiny Team Manager

An update report from commissioners on access to and waiting times for children's integrated speech and language therapy (SLT) in central and west Norfolk.

1. Purpose of today's meeting

1.1 The focus areas for today's meeting are:-

(a) To follow up on progress with the action plan from the 2018 independent review of the integrated service in central and west Norfolk.

(b) To follow up on issues raised by parents regarding access to speech and language therapy, particularly for children with learning disabilities, Downs Syndrome or autism.

1.2 The Clinical Commissioning Groups (CCGs) and Norfolk County Council Children's Services have provided the progress report at **Appendix A** and representatives from the commissioners and the service provider, East Coast Community Healthcare, will attend to answer Members' questions.

1.3 A member of SENsational Families Group spoke to NHOSC when Children's SLT was on the agenda in July 2018. SENsational Families is a small Norfolk based charity offering advice and support to local families who have a child with a disability or special education need (SEN). The Group has provided an information paper for today's meeting, which is attached at **Appendix B** and representatives will attend.

Following a meeting between Members of NHOSC and the SENsational Families Group in Norwich on 20 September 2018 questions regarding provision of SLT for children with certain conditions and the situation regarding tribunals for access to SLT were directed to the commissioners for both SLT and autism in the local NHS and the County Council. The questions and answers are were included in the NHOSC Briefing in December 2018 and are attached as Appendix 1 to Appendix B.

One additional question posed to the commissioners in September 2018 about provision of a single point of contact that parents could go to for all the services required by their child with special needs has been addressed in their paper for today's meeting (Appendix A).

1.4 Family Voice, a local voluntary organisation which aims to improve the lives of disabled and SEN children and their families, was involved with the commissioning of the central and west Norfolk integrated SLT service and in the 2018 independent review. Family Voice has provided information on families' experience of children's SLT to NHOSC on previous occasions and has been invited to attend today's meeting.

2. Background

2.1 The last report to NHOSC on 'Children's Speech and Language Therapy' was on 12 July 2018. The report and minutes of the meeting are available on the County Council website via the following link, NHOSC 12 July 2018

The committee originally added Children's SLT to its forward work programme in February 2017 following concerns about waiting times. The figures received by NHOSC in July 2018 showed that the service was improving in this respect, with 93% of children and young people receiving their first intervention within 18 weeks of referral in the year to March 2018. However, the commissioners acknowledged that the service was struggling to keep pace with demand and that they needed to very carefully consider the outcome of the independent review of the service, the level of resources that could be provided for SLT against other priorities and find new ways of working.

Family Voice and SENsational Families group representatives told the committee of their concerns about a lack of SLT resources and their lack of assurance that the service was fit for purpose.

2.2 During its research for the 'Access to health and social care services for Norfolk families with Autism', published in October 2018, Healthwatch Norfolk gathered information about families' experience of accessing SLT. For the NHOSC Briefing The Healthwatch Norfolk Project Manager summarised their observations as follows (as reported in the NHOSC Briefing, December 2018):-
'

> *Speech and language therapy (SALT) services were often alluded to as vital support that was lacking across Norfolk and possibly overstretched. Some parents highlighted that too frequently children were quickly discharged without the understanding of how to work with children with possible social communication difficulties. This often resulted in children being re-referred causing further delays in accessing help and support. Some families emphasised the lack of contact and involvement they had from SALT services, which was further complicated by the long waiting lists in the service.*
>
> *Parents believed that these services needed to have a more timely impact on the child which just wasn't currently happening with the present provision across Norfolk. They felt more services were needed for SALT and some families highlighted having to pay for services privately. They also recalled the lack of ongoing consistency of staff working in SALT services which proved problematic for some families with autistic children.*

Some felt there were too many people involved, which led to poor communication between professionals resulting in a lack of awareness of what each other had done.'

The Healthwatch report is available on its website:- https://www.healthwatchnorfolk.co.uk/wp-content/uploads/2019/01/HWN-Final-Full-report-Autism.pdf

2.2 In the October and December 2018 NHOSC Briefings, Members received updates on the outcome of the Better Communication CIC independent review of the integrated service and the action plan around the 10 recommendations arising from it. Copies of the Briefings are available from the Democratic Support and Scrutiny Team Manager maureen.orr@norfolk.gov.uk on request but the latest progress update is at Appendix A attached. The full report of the independent review report is available on the County Council website:- https://www.norfolk.gov.uk/children-and-families/send-local-offer/about-the-local-offer/norfolks-local-offer-in-development (click on Speech and Language Service Review).

2.3 Speech and Language Therapy (SLT) services in Norfolk are commissioned under two separate contracts:-

- An integrated speech and language therapy service commissioned jointly by 4 of the 5 CCGs in Norfolk (all except for Great Yarmouth and Waveney Clinical Commissioning Group (CCG)) and Norfolk County Council Children's Services. The commissioners have a Section 75 agreement pooled fund which covers the contract from 4 April 2016 to 31 May 2020. The service area for the Norfolk County Council educational element of the contract is Norfolk-wide, including Great Yarmouth, but the health element is for central and west Norfolk only.
  (This service is the subject of today's meeting)

- A speech and language therapy service commissioned by Great Yarmouth and Waveney CCG for its own area under a contract running from 2011 to 2019 and providing the health element of the service for Great Yarmouth and Waveney.
  (Not the subject of today's meeting)

The contract holder in both cases is East Coast Community Healthcare (ECCH).

3. Suggested approach

3.1 After the commissioning representatives have presented their report, Members may wish to discuss the following areas:-

(a) The independent review made recommendations about improving communication and engagement with children, young people and their families. The update at Appendix A shows actions in relation to communication to be 'complete' or 'on track'. To what extent has this action reassured service user families?

(b) The service will receive a 30% (£510,093) uplift in funding effective from April 2019. Some of the extra funding will be invested in additional SLT workforce capacity. Based on recent recruitment experience, does ECCH expect to be able to source additional Speech and Language Therapists or are there other plans for increasing the overall capacity workforce?

(c) Waiting times for SLT were reducing at the time of the last report to NHOSC in July 2018 but are gradually increasing again. The report at Appendix A describes the action taken to reverse this trend. When do ECCH and the commissioners expect the service will meet its agreed waiting time standard (i.e. 95% of children and young people receiving their first SLT intervention within 18 weeks of referral)?

(d) The action plan at Appendix A confirms that the remodelling of the SLT complex and special school offer (within existing resources) is progressing as expected. How has the service changed so far?

(e) How much extra resource is being made available for the service provided for schools and what difference will it make?

(f) Appendix A says that the SLT drop-in sessions have had enough capacity to meet demand since April 2018 and that this has been achieved by restructuring the sessions. Are the families who use the sessions content with the new structure?

4. Action

4.1 Following the discussions with representatives at today's meeting, Members may wish to consider whether:-

(a) There is further information or progress updates that the committee wishes to receive at a future meeting.

(b) There are comments or recommendations that the committee wishes to make as a result of today's discussions.

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Health Overview and Scrutiny Panel - Update Report for 28th February 2019

In December 2018, Norfolk HOSC received a briefing paper which included the action plan that was developed following the Independent Review of the Integrated Children's Speech and Language Therapy (SLT) service in Norfolk. The committee asked to be updated on progress of the action plan and to respond directly to a concern raised by parents of children with special educational needs and/or disability (SEND).

The commissioners have provided the following information:-

Norfolk's Integrated Children and Young People Speech and Language Therapy (SLT) Service contract (excluding Great Yarmouth and Waveney)

Presented by:
Michael Bateman - Head of Education High Needs SEND Service, Norfolk County Council (NCC)

Rebecca Hulme - Chief Nurse Great Yarmouth and Waveney CCG, Director of Children, Young People and Maternity Norfolk and Waveney

Jonathan Williams – Chief Executive East Coast Community Healthcare

Louise Barrett - Deputy Director Health Improvement & Children's Services, East Coast Community Healthcare (ECCH)

The purpose of this paper is to;

1. Provide key messages, against the action plan to address the recommendations made by the independent review of current need and provision for children and young people with speech, language and communication needs in Norfolk.

2. Provide a response to the HOSC question why children with SEND do not have a single point of contact in place

Authors:
Debra Oldman, SEND Projects Manager, Education High Needs SEND Service, NCC
Clare Angell, Senior Commissioning Manager for Children, Young People & Maternity Norfolk and Waveney

1 Key Messages

1.1 Additional Resource for the SLT Service

All commissioners accepted the unmet needs of Norfolk children with speech, language and communication needs (SLCN) that were identified in the Independent Review. In recognising this and pressures in the SLT service, a 30% uplift in funding has been agreed, effective from April 2019, subject to contract standing order exemption. The uplift will provide additional funding of £510,093 to support the service to meet needs of Norfolk children with SLCN.

Table 1. New funding for Integrated SLT contract in Norfolk (excluding Great Yarmouth and Waveney)

Commissioner	Baseline	30% uplift	Total
Norfolk County Council	946,377	£283,913	£1,230,290
Norwich, North Norfolk, South Norfolk and West Norfolk Clinical Commissioning Groups	753,937	£226,181	£980,118
Total	1,700,314	£510,094	£2,210,408

1.2 How will this funding be prioritised?

Discussions are continuing between commissioners and ECCH following proposals developed and submitted by the provider in January 2019. Areas identified for investment include; support for families of pre-school children with complex needs, an improved service offer for schools, additional speech and language therapy (SLT) workforce capacity and adoption of a county wide menu of screening tools.

2. Current Position

There has been a gradual reduction in the number of children and young people who receive their first appointment within 18 weeks of referral (88% in quarter one, 86% quarter two, 84% quarter three). This performance is consistent with the demands described in the Independent Review and the impact of the contract performance measures which require ECCH to prioritise the requests for education, health and care plans (EHCP) assessment and provision. The level of EHCP requests for assessment have remained higher than projected at the time of the original procurement process. ECCH and the Education High Needs SEND Service have identified that and implemented measures to ensure that all requests for assessments are appropriate. This approach has started to see a reduction of requests; and the impact of the additional investment in staff and training for schools and settings across Norfolk should result in reduced demand for specialist input by ECCH and in turn, reduce waiting times.

The drop-in service for families of pre-school children with possible SLCN remains popular. The difficulties associated with families being turned away from a small number of sessions has been carefully considered. Performance has improved (Appendix 1) as a result of modifications to the structure of the sessions and the current arrangements provide sufficient drop in capacity to meet the numbers of families attending.

The Independent Review was clear that the drop-in sessions were important for families in accessing support. The recorded outcomes of sessions indicate that not all children who attend these sessions will require SLT intervention but may require support from other services. ECCH, Cambridgeshire Community Services (providers of the Healthy Child Programme), health and local authority commissioners, the new Early Childhood and Family Service and other referrers are working to further simplify the referral process for speech and language therapy in addition to providing appropriate support to families from the wider children's workforce. The collective work to date and that planned for the next twelve months

offers assurance that service improvement will be realised during 2019/20 and children and young people will be able to access a better system of support for SLCN.

3. Norfolk SLCN Stakeholder Group

To improve outcomes for children and young people across Norfolk, we recognise that all services delivering support for SLCN must be aligned and underpinned by effective partnerships. The Norfolk SLCN stakeholder group brings together system-wide stakeholders including SENCO networks, School Associations, ECCH, Education High Needs SEND Service, Virtual School SEND, Virtual School Sensory Support, Family Voice Norfolk, Special Educational Needs and Disabilities Information Advice and Support Service (SENDIASS), Cambridgeshire Community Services NHS Trust and Public Health. The aim of the group is to establish mechanisms for stakeholders to engage; this includes parent carer networks. A draft Norfolk wide strategy (Appendix 2) has since been developed; and engagement with wider stakeholders such as schools and families will be invited during the spring.

3.1 Strengthening partnership working

The review highlighted the importance of improving communication and engagement with children, young people and their families. The SLT project working group, established in September 2018, began by sharing outcomes of the review via the Local Offer website and SEND e-newsletters and organised an initial meeting with SENsational families. Family Voice are represented on this and the stakeholder group to help us engage with those with lived experiences and a communications strategy has been developed. The working group has published further guidance for schools to outline what support can and should be offered to children and young people before they are referred for specialist services and we will be engaging with multiple parent carer networks in the spring. An important piece of work that is underway is a mapping exercise of all partners and services who offer support with Speech, Language and Communication Needs (SLCN). This will enable better partnership working and raise the profile of the importance of speech and language communication in Norfolk.

The stakeholder group is also aware of SLCN developments that are being led by partners. This includes the Norfolk Health Visitor SLCN pilot for health visitor training with a target cohort for those who don't access formal educational settings and the innovative work of the Community Champions; an early support service with an emphasis on SLCN, working with a contained target cohort within the catchment of the Norwich Opportunity Area (NOA). The working group was able to work together to support a bid to the Education Endowment Fund for a targeted programme of Elklan Training across Norfolk schools.

Due to the size of the action plan, it has been split into sections across multiple pages. The plan was last updated on the 15th February 2019.

Recommendation	Actions	Timeframe / Deadline	Status as of Dec18	Status at Feb19	Narrative
R1.1	Develop a SLCN strategy	Sep-19	Draft plan Dec 18	Complete	Arrangements are being made to share and receive feedback on the draft strategy with a focussed group of stakeholders, including groups representing families.
R2	Develop Stakeholder Communication and Engagement Plan with current / proposed contract to reboot / bring system back on board and include meaningful involvement in redesign.	Nov-18	On track	On track	Decision approved for a 30% uplift in funding of £510,093. Progressing as expected.
R2	Issue communication outlining the outcome of review / next steps to stakeholders involved in independent review	Dec-18	On track	Complete	The outcomes of the review have been published on the Local Offer with a targeted communications issued via direct emails and e-Newsletters. Further work will continue in the spring through stakeholder engagement.
R2	Establish a SLCN stakeholder group with system-wide representation	Sep-18	Complete	Complete	A key piece of work is re-engaging with schools to review the system offer for SLCN. Representatives for schools have been identified who will attend stakeholder meetings and we expect to attend school forums and networks throughout 2019 to further build confidence and partnership working.
R2	Remodelling of complex and special school offer within existing resources	Jan-19 (start of Spring Term)	On track	On track	Progressing as expected, with additional outreach resource utilised by ECCH to bolster support at complex needs schools . Wider review of whole range of services as part of review / redesign and VSSS is part of the review. This work has not started yet but will be considered as part of the Transformation work agreed by Members.
R2	Map demand and capacity with ECCH to review resource and identify gaps	Oct-18	Complete	Complete	A stakeholder workshop was held in January 2019 to review proposals to address the gaps across the system. These proposals included specific tools and resources for schools and additional and specialist support for families. An implementation plan for April 2019 has been agreed.
R2	Develop single point of contact for groups of schools and settings	Mar-19	On track	On track	The mechanism for a single point of contact is in place for the core speech and language therapy service provided by ECCH. The East Coast Community Access Team (ECCA) are available Monday to Friday 7am-8pm with additional information on the Norfolk Local Offer website. A single point of contact (SPOC) for SEND would encompass multiple services for children and young people across health, education and social care and any work to review this request formally sits outside of the speech and language service. The Norfolk SLCN stakeholder group have commenced a system-wide piece of work to understand whether a single point of contact for SEND is feasible within existing resources. This work will look at how better access to information and advice might resolve challneges for parents seeking progress with support for their child.
R2	Review how services are provided to schools	Sep-18	On track	On track	Progressing as expected. A key outcome of the review included extra resource within our additional and targeted provision, e.g. schools. This work continues and will be part of the wider review of whole range of services as part of the Transformation work

V4

Recommendation	Actions	Timeframe / Deadline	Status as of Dec18	Status at Feb19	Narrative
R2	Issue advice to schools on how to support children with SLCN in a graduated approach, with process for support and including clarification on the EHCP SLT assessment referral process.	Sep-18	Complete	Complete	No additional narrative required
R3	Brief Chief Officers re Review Findings and options appraisal paper for decision over resource envelope	Dec-18	Complete	Complete	No additional narrative required
R3	Options paper to CHIG, Joint Strategic Commissioning Committee (JSCC) Suffolk County Council (SCC), NCC to determine scope for additional resource and confirmation on whether redesign either within existing resource envelope or with additional funds	From Nov-18	Complete	Complete	No additional narrative required
R4	Mapping of other funding streams to explore opportunities to pool resources or align outcomes for service delivery to support a balanced system model	Jun-19	On track	On track	The original timeframe was not realistic for this piece of work due to the complexity of funding within the SLCN system. With potential contractual implications, further work and time is needed to understand the commissioning landscape and any impact of aligning or pooling resources. Some elements are within the SLT contract area and some outside and part of the wider system.
R4	Clarification / engagement work with schools on expectations for children at SEN Support / use of delegated funding	Dec-18	On track	Complete	This action is now considered out of scope as this work is taken forward by SEN colleages through the published SEN Support Guidance for schools (October 2018)
R4	Clarification of enhanced offer as part of core contract for schools	Sep-18	Complete	Complete	No additional narrative required
R4	Mapping of SLCN services across the system to identify the total resource available to the system	Apr-19	Expected Dec 18	On track	The timeline has been revised. A mapping exercise is active and likely to continue throughout spring 2019 to ensure we capture all services providing support in speech, language and communication across Norfolk.
R5	NCC decision over re-use of delegated and 'top-up' funding to support targeted SLT interventions in schools and settings and upskill of workforce programme	Dec-18	On track	On track	Additional advice will be provided to schools on how targeted SLT interventions is schools can be delivered. Will be part of the wider review of whole range of services as part of the Transformation work
R5	Review existing KPIs for current contract delivery to include outcome measures, qualitative data and current output focus	Nov-18	Complete	Complete	Work is planned over spring 2019 to implement these changes for the next financial year

Recommendation	Actions	Timeframe / Deadline	Status as of Dec18	Status at Feb19	Narrative
R6	Develop system KPIs as part of the strategy e.g. joint outcomes framework for SLCN population and success measures	Jan-19	On track	On track	Progressing as expected and being led by the Norfolk SLCN stakeholder group. The aim of this work is to embed shared outcomes for multiple commissioned services to ensure that across Norfolk, we are using the same measurements to monitor the quality of services for children and young people. This work is ambitious and will require collaboration over an extensive period of time. The first step is to identify a targeted number of commissioned services that provide SLC support and work with commissioners to implement consistent qualitative and quantitive outcomes. This work has commenced. Further to this, a joint SEN commissioned framework between education, health and social care is being designed and led by Norfolk County Council strategic commissioning team.
R7	Commissioners will communicate with stakeholders to embed learning and understanding of the service	Oct-18	On track	On track	Progressing as expected. This work commenced in October 2018 with the formation of the Norfork SLCN stakeholder group and continues.
R8	Review referral routes/process to maximise efficiency and improve routes into service	Oct-18	Complete	Complete	No additional narrative required
R8	Review drop-in model to determine any service changes	Oct-18	Expected Jan 19	On track	This work is linked to the outcomes of the new early childhood and family service. ECCH are committed to working with Norfolk County Council to determine how the drop-in model will evolve in the future in light of new service model for early years.
R8	Review of telephone triage and the flow from triage into service / signposting to determine continuation, amendment or redirection of resource elsewhere	Oct-18	Expected Dec 18	Complete	ECCH have reviewed telephone triage and will to continue to monitor how this resource will be managed in the future. It is expected that the wider-system work will have a postive impact on demand for ECCH's services.
R8	Implement Link Therapist model across Norfolk in line with recommendations (links A9)	Mar-19	On track	On track	Link Therapists progressing as expected and forms part of the ECCH's proposals of the funding uplift
R9	SLT School interventions guidance on expectations for school implementation prior to EHCP needs assessment confirmed as part of School SEN Support Guidance and expectations around use of notional SEN funding.	Nov-18	Complete	Complete	No additional narrative required
R10	Review of ring-fenced provision for Virtual School Sensory Support and consideration of tapering down / upskilling of VSSS workforce for some activity	Dec-18	On track	In Progress	This work will be part of the wider review of whole range of services. This work has not started yet but will be considered as part of the Transformation work agreed by Members to continue.
R10	Explore targeted use of key stage 1/2 SLCN outreach teacher to support training of universal school workforce in delivery specialist / targeted interventions in school.	Dec-18	On track	On track	Progressing with developing working model and identifying caseload

2. Provide a response to the HOSC question why children with SEND do not have a single point of contact in place

Currently, a single point of contact for services for children with SEND sits outside of the remit of the integrated speech and language therapy (SLT) service provided by East Coast Community Healthcare (ECCH). Within ECCH SLT service, parents and professionals can contact the East Coast Community Access (ECCA) team, for queries, advice and information on referrals and further information is available on the Norfolk Local Offer website.

It is understood that families feel there isn't a named contact or professional who can navigate the system on their behalf to check they are getting the right support and answer any queries or concerns that may arise.

For some children in Norfolk with very complex needs, families are offered a key worker service, provided by Norfolk Community Health & Care (NCHC) and this individual may provide a range of support from domiciliary care to coordinating packages of care across health and social care. This is a bespoke service provided for our most vulnerable children and young people.

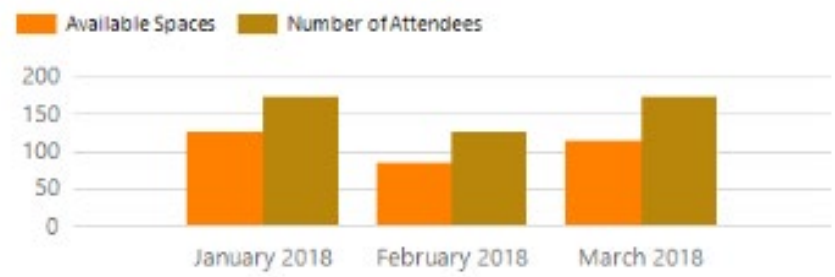
The Norfolk Stakeholder group for SLCN is keen to revisit the need for such a service/function in Norfolk and will be working with partners to ensure that simplified access to services is prioritised.

An initial meeting, with a focussed group of agencies supporting families, is planned for the spring. It is proposed that following this scoping exercise, a wider series of engagement exercises with families take place.

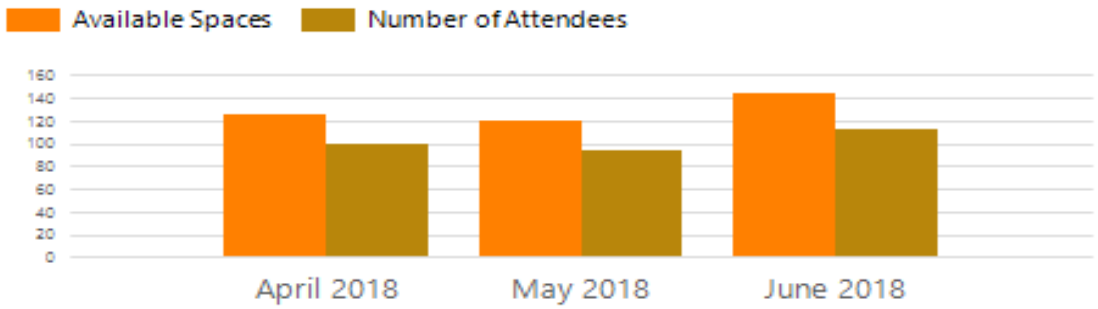
Appendix 1

Provision and take-up of spaces at Drop-in sessions (over 12 months)

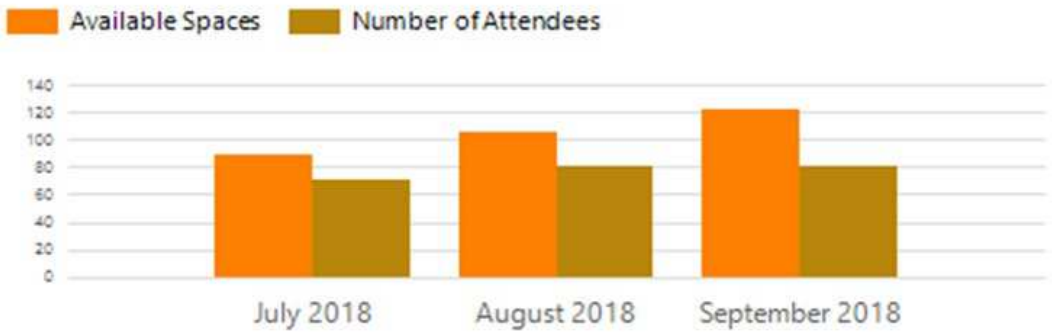
Quarter 4 2017/18



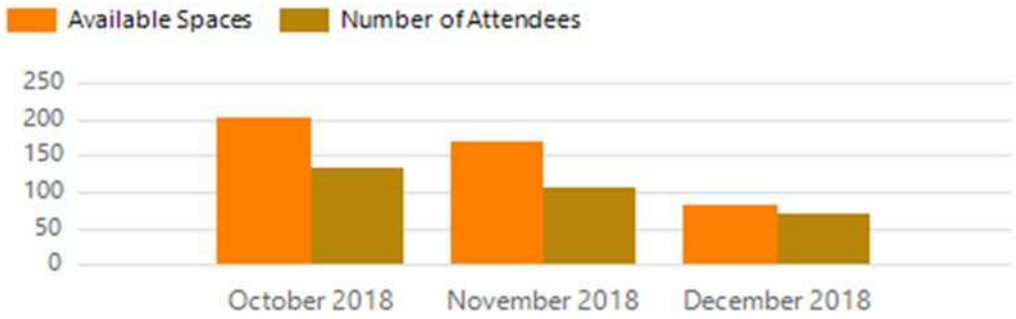
Quarter 1 2018/19



Quarter 2 2018/19



Quarter 3 2018-19



Appendix 2

Norfolk plan on a page for SLCN 2018/19

<table>
<tr><th colspan="6">Scope and Purpose</th></tr>
<tr><td colspan="6">The ability to communicate is an essential life skill for all children and young people and underpins a child's social, emotional and educational development.
Working together, we will; ensure that all children and young people receive good, effective and equitable support, promote the role of parents and carers and communicative partners and achieve better outcomes for children and young people.</td></tr>
<tr><th colspan="6">Expected Outcomes</th></tr>
<tr><td colspan="6">• Children and young people will spend time in communication friendly environments supported by an infrastructure that makes it easier for those with a targeted level of need to understand and express themselves
• Setting and school staff will be supported to be confident and competent to deliver targeted interventions and educational support for their pupils
• Parents of children with an identified SLCN receive additional support to ensure confidence in their role as key communication partners
• Children and young people will understand the importance of communications in everyday life
• Timely, impactful interventions at every stage</td></tr>
<tr><th colspan="6">Goals</th></tr>
<tr><td colspan="6">To enable stakeholders across Norfolk to plan and deliver a fair and sustainable system of services to identify and support those with speech, language and communication needs.</td></tr>
<tr><th colspan="6">Priorities for action</th></tr>
<tr><td>Workforce Training and development</td><td>Enabling parents to be communicative partners for their child</td><td>Working in partnership with schools and educational settings</td><td>More children with Specialist SLCN have their needs met as part of multi-agency professional packages of support</td><td>Reduce the gap in services commissioned for children with SLCN</td><td>Work to ensure CYP, parents and stakeholders understand the importance of communication as an essential life skill</td></tr>
<tr><th colspan="6">Targets</th></tr>
<tr><td>Increase in drop in Session / targeted training for parents</td><td>Increase in impactful training sessions For schools And settings</td><td colspan="2">SLCN services will be measured by shared outcomes</td><td>Reduction in waiting times</td><td>Evidence of increased parental confidence</td><td>Greater equality of sustainable provision in universal, targeted and specialist provision of SLCN services</td></tr>
<tr><th colspan="6">Guiding Principles</th></tr>
<tr><td>By working together towards the same aims with shared accountability and responsibility; we are more likely to achieve better outcomes for CYP</td><td>System wide change can only be achieved through co-production and delivery of needs led and impactful services</td><td colspan="2">We are all champions of communication and will promote the importance of developing core speech, language and communication skills</td><td colspan="2">With access to information, advice and support, those who interact with a child most are best placed to facilitate learning and support to enable that child to thrive.</td></tr>
<tr><th colspan="6">References</th></tr>
<tr><td colspan="6">Balanced System®
Bercow (Ten years on)
Independent Review of Speech, Language and Communication Provision in Norfolk 2018</td></tr>
</table>

SENsational Families

Paediatric Speech and Language Services in Norfolk: an update to the HOSC

February 14th, 2019

Introduction

Over the last year the joint commissioning group, East Coast Community Healthcare (ECCH) and groups representing SEND children and their families such as ourselves, have been asked to submit evidence regarding ECCH's ability to deliver a fit for purpose speech and language therapy service to children and young people with speech, language and communication needs (SCLN) in Norfolk.

The purpose of this report is to directly reply to ECCH's claim to our organisation, that their speech and language therapy service is not obliged to provide intervention to children with as autism spectrum disorder (ASD) diagnosis, or to provide specialist long term interventions to other children with complex SCLN such as those with Down's syndrome (Appendix 1).

Additionally, we would like to once again address the findings of the Independent Review of Speech, Language and Communication Provision in Norfolk produced by Better Communications CIC in August 2018. Unfortunately, SENsational families were not made aware of any subsequent actions taken by the joint commissioning group and ECCH until this month. We welcome the opportunity to contribute to the discussion on behalf of the 1250-member families we represent across Norfolk who have been negatively affected by the issues raised.

As a result of ECCH's reply to our questions and the findings of the independent review, we have raised further questions to ECCH and the joint commissioning group regarding the future delivery of speech and language therapy in Norfolk. These can be found at the end if this report and we hope the HOSC will again forward them on our behalf.

Response to ECCH regarding non-delivery of service to children with complex SCLN

When we met with members of the HOSC in September 2018, our members identified multiple areas of concern regarding the speech and language service. One of the more egregious findings from our members (their comments can be found in Appendix 2 and 3) is that children with an Autism Spectrum Diagnosis (ASD) were being discharged by ECCH immediately after assessment with no further therapy, intervention, advice or signposting offered. This is despite the identification of complex needs and deficits as part of either ECCH or other SLT assessments.

Further, children with other complex SCLN such as those that occur as a result of Down's syndrome, were either being discharged immediately or only offered a basic six-week course of therapy. After this, regardless of progress made, children were again discharged, and families were forced to either seek re-referral and its associated waiting time or attempt to access speech and language through other means such as fighting for personal budgets through the local authority or via expensive private services. As of today, these conditions are still be experienced by our families. This is leaving the children with the most complex SCLN without any kind of speech and language therapy.

Our questions regarding these issues were put forward by HOSC to ECCH and the commissioners of the service. In response to the question **"What evidence is there that SLT is not beneficial for children with autism and Down's syndrome?"**

ECCH replied in detail regarding their approach to both conditions (Appendix 1).

For SLT interventions for autism spectrum disorders (ASD) the response states that ECCH are not responsible for providing "direct support to schools and families" to implement social communication and therapeutic strategies they have "identified as part of a broader assessment." In terms of ASD they are only "commissioned to contribute to the Autism Spectrum diagnostic assessment and provide intervention for a speech and language disorder ***alongside*** *there Autism." (Appendix 2, emphasis mine).*

Firstly, pervasive impairments of social communication and interaction are one of two core diagnostic features of ASD (APA, 2013). The universal speech, language and communication impairments of those with ASD cover a large spectrum including pragmatic language (Parsons et al., 2017), receptive and expressive language (Mody and Belliveau, 2013), figurative language (Kalandadze et al, 2016), language and auditory processing (Bavinet et al, 2014; Arnett et al, 2018) and social communication (Kasari and Patterson, 2013).

In terms of complex and pervasive language disorders such as ASD and Downs syndrome, there is evidence that individualised direct and indirect specialist intervention from a well-qualified speech and language therapist leads to improvement in the child's speech, language and communication (Ebbels et al, 2018). The Royal College of Speech and Language Therapist's (RCSLT, 2009) publication regarding the delivery of service to individuals with ASD, referenced to in the answer to SENsational families, directly contradicts ECCH's position that they are not obligated to treat children with an ASD diagnosis. The RCSLT are clear there is

> *"evidence of the effectiveness of different targeted approaches to the treatment and management of social communication impairments and functioning of children with ASD." (RSSLT, 2009 pp. 2).*

Further, the SEND code of practice, which details the statutory obligations of the CCG's and local authority in jointly commissioning services as part of the SEND reforms 2014, state that speech language and communication needs are a "feature" of autism spectrum disorders. Specifically, the code of practice says,

> *"Children and young people with ASD, including Asperger's Syndrome and Autism, are likely to have particular difficulties with social interaction. They may also experience difficulties with language, communication and imagination, which can impact on how they relate to others." (Department for Education and Department of Health, 2015 pp.97)*

As it is well established that speech, language and communication needs are part of autism spectrum disorder, we question the basis on which ECCH claim they can discharge and refuse intervention to children with an ASD. Additionally, we feel it is important to know whether the joint commissioning group were aware that ECCH were not going to deliver interventions to children with speech, language and communication needs as a feature of their ASD diagnosis before they accepted their bid to run the service. To entirely exclude a group from receiving intervention from an SLT service, whose condition is characterised by SLCN, is discriminatory and short sighted. To leave children with an ASD diagnosis without speech and language intervention contradicts both the current literature, the SEND code of practice and the recommendations of Bercow: 10 Years On (iCAN and RCSLT, 2018).

Response to Independent review of Speech, Language and Communication provision in Norfolk (Better Communication CIC, 2018)

The independent review of speech and language produced by Better Communications CIC in August 2018 has identified many of the issues our members have personally experienced in their dealing with the paediatric SLT service delivered by ECCH. Some troubling issues were highlighted.

Children are not receiving interventions or therapy after assessment by ECCH

This is a topic raised in the report and is an ongoing area of concern for our families. The experiences of the families we represent are reflected in the findings. Combined, we have identified several failings in the delivery of the SLT service that have contributed to the lack of access to speech and language therapy.

- **ECCH's SLT service model does not follow a whole system approach**

  The independent review suggested that ECCH's service model does not adhere to the one endorsed by Better Communication CIC. The Balanced system, created and offered by Better Communications, provides a 'whole system' framework in which all services that commission speech and language therapy, including education, the local authority and Norfolk CCG's, offer a fully integrated service (please see https://www.thebalancedsystem.org/ for more information). This reflects the statutory guidance in the SEND code of practice (DofE and DofH, 2015) and the recommendations of Bercow: Ten Years On (iCAN and RCSLT, 2018).

  The review concluded that ECCH's basic SLT model is a 'pick and mix approach' of different models that 'lacks clarity' (Better Communications CIC, 2018). Further, the model delivered by ECCH does not follow a 'whole system' approach as schools have not been included as joint commissioners. This has led to gaps in service especially at the targeted level, which provides interventions such as training school staff to deliver a programme of therapy where progress is regularly tracked and monitored by an experienced SLT (Gascoigne, 2013). There is also a lack of direct therapy by experienced SLT's at the specialist level. These gaps are reflected in the experiences of our members who have been left with no ongoing intervention or therapy despite obtaining assessments that clearly state their children have major deficits in their speech, language and communication skills.

  We believe this piecemeal approach to delivering the service is leading to confusion for families about whether health, schools or the local authority are responsible for delivering SLT to children with special educational needs that include complex SCLN. Considering the service is supposed to be integrated and jointly commissioned, this is a major failing the in the SLT delivery model.

- **Underfunding**

  Better communications suggested the ECCH's current model was heavily underfunded. Further it will not meet the future predicted needs of Norfolk's population. The report could not find any way the service could be run more efferently as it stands and requires more top-level funding from the commissioners to include schools. As the ECCH group made over

£600,000 in profit in the 2016/2017 financial year (ECCH, 2017) and runs private speech and language training (https://www.ecch.org/our-services/services/cf-children-and-young-peoples-speech-and-language-therapy/training/) we are interested to know what percentage of this money is reinvested back into to the SLT

- **No performance tracking required for outcomes of assessment, type of intervention offered, and long-term impact of therapy on children with complex SCLN**
  The report criticised the Key Performance Indicators (KPIs) as being heavily biased toward referral numbers and wait times, with no real tracking of the impact of assessment or therapy. Considering the KPI's assess whether ECCH is delivering the service it is required to, it seems absurd they do not assess the nature or success of the speech and language therapy offered. We propose the KPI's include numbers of children discharged directly after assessment, the number of children offered ongoing therapy, the nature of that therapy, and the outcome of that therapy. Given the number of children with ASD and other SCLN related disorders being discharged we would also like to know the percentage of children with these diagnoses being directly discharged after assessment versus those offered therapy.

- **One size fits all approach to therapy**
  For children who are deemed to have sufficiently severe SCLN, am 'enhanced offer' of a six-session block of intervention is given followed by discharge, regardless of the complexity or long-term nature of the SCLN. If further intervention is required, families are forced to re-enter the referral system and wait for a further assessment where intervention may or may not be granted.

ECCH sought advice from Better Communication CIC in 2015 before the bid was submitted to the joint commission and were warned not to submit it as it was only funded to provide 55% of Balanced system model. They submitted anyway and won the bid.

ECCH sought advice from Better Communication CIC, the authors of the independent review about their bid for paediatric SLT in 2015 prior to submission and were told, "the modelling concluded that the tender was only funded to 55% of what would be need to fund the balanced model." (Better Communication CIC Independent Review of Speech and Language, August 2018, p.17). They state further that the authors, "counselled [ECCH] against attempting to deliver the model without a strategy for schools making specific enhanced contributions to the commission in their roles as commissioners of services for population they serve under the 2014 SEND reforms."

We find it extremely troubling that ECCH went forward with their bid, and won, despite being warned by the creators of the programme they were emulating that they could not deliver the whole system model set out in their contract bid. It is clear from the independent report and from the experiences of our members there are now massive gaps in service especially at the targeted and specialist intervention level due to this failure to deliver the whole system service that was needed to meet the SCLN of children in Norfolk.

Conclusions

- ECCH have made it clear to SENSational families that they are not obligated to deliver targeted or specialist therapy and interventions to children with complex SCLN that arise out of diagnosis such as autism spectrum disorder and Down's syndrome.

- ECCH knew their bid was only funded to 55% of the full Balanced system model. This implies they knew they could not deliver a whole system approach to SLT that included education, before they submitted their bid to the joint commissioning group in 2015.

- We agree with the findings of the Better Communication CIC independent review into SLT in Norfolk. ECCH have failed to deliver speech and language therapy to children who need targeted and specialist ongoing intervention provided either directly by an SLT or indirectly via specialist training with frequent monitoring and oversight by trained SLT's

- We find that ECCH is not delivering a fit for purpose speech and language therapy service. Children with speech, language and social communication disorders are still being discharged with no intervention in place despite assessments stating they have complex SCLN

- SENsational families will continue to fight for an easy to access, fully integrated SaLT service in Norfolk that delivers therapy to **ALL** children with complex SCLN, so they can progress and reach their full potential

Questions for ECCH and the joint commissioning group

1. Were the joint commissioning group aware that ECCH had sought advice regarding their SLT model prior to bidding, and were warned not to submit their bid as it could not deliver a whole system service due to be severely underfunded?

2. Considering the independent review, our reply and the continued complaints from the families we represent, are ECCH going to start delivering ongoing targeted and specialist interventions to children with ASD, Downs Syndrome and other complex speech, language and communication needs that arise out of their diagnosis? If not, who is supposed to be delivering this much needed service?

3. Will future key performance indicators for ECCH's paediatric SLT service include percentages of children immediately discharged, their diagnosis, types of therapy offered and the impact that therapy?

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Appendix 1

Responses provided by the commissioners and provider of the integrated Children's Speech & Language service, central & west Norfolk – in response to issues raised following Norfolk Health Overview and Scrutiny Committee Members' visit with SENsational Families Group on 20 September 2018

East Coast Community Healthcare provided a comprehensive response to question 1. Therefore, the text below includes extracts from Appendix one, which describes the approach for children with particular needs in more detail.

1. What evidence is there that SLT is not beneficial for children with Autism & Downs Syndrome?

As a profession Speech and Language Therapists are required to take an evidence based approach to their work, whatever their specialism. Evidence based practice can be defined as;

"Evidence-based medicine is the integration of best research evidence with clinical expertise and patient values." (Sackett, 2000)

Whilst all healthcare professions are required to work within an evidence based framework it is acknowledged within the profession that:

"In many instances there will be little or no evidence to support a particular approach." (Reilly, 2004)

Children's speech and language therapists typically take a developmental approach to assessment and intervention. There will be points in an individual child's development where there is greater or lesser need for "therapy" from a speech and language therapist. This will depend on the child's attention and listening skills, their cognitive development, the ability to cope with the demands of therapy, and the support available from their home, nursery or school setting.

East Coast Community Healthcare Children's Speech and Language Therapy are commissioned to contribute to the Autistic Spectrum Diagnostic Assessment and provide intervention for children who have a speech or language disorder alongside their Autism. The service will recommend social communication strategies and therapeutic approaches if identified as part of a broader assessment; however they do not then provide direct support schools/families to implement these.

There is no one size fits all approach or intervention and whatever intervention is implemented it should be based on the individual's needs (NICE, 2013).

'The number of studies that have evaluated the effectiveness of [Speech and Language Therapy] intervention in relation to Down Syndrome are few'. (Buckley S. J., 2000).

There is some evidence that proposes children with Down syndrome should be seen at least monthly in school, targets reviewed and activities set for parents, teachers and assistants to include in their daily routines (Buckley S. J., 2002). Some children with Down's syndrome of school age may benefit from weekly individual or groups sessions of speech and language therapy (Buckley S. J., 2002). At all times, intervention should be provided by, or overseen by an appropriately qualified Speech and Language Therapist (The Royal College of Speech and Language Therapists, 2010)

Sue Buckley presents evidence that addresses issues such as the benefits of naturalistic, language interaction intervention compared to direct teaching approaches, and the benefits of direct work on phonology. (Buckley S. J., 2000). As with all clients, speech and language therapists must adapt interventions to suit individual interests, learning styles and needs. Because speech and language therapy should take into account individual needs and circumstances, it's not possible to specify a format or amount of speech and language therapy that will be right for everyone who has Down's syndrome at a particular age or in a certain situation (Baksi, 2006).

2. How much is spent fighting tribunals for access to SLT and on settling appeals in parents' favour before the case goes to tribunal (for all children, not just ones with autism)?

It is not possible to easily extract the cost of tribunals in relation to Speech and Language Therapy alone. Usually, tribunals relate to concerns about a whole range of provision; and most often the placement Norfolk County Council are stating (special or mainstream). It should be noted therefore that costs for SLT will sit within the total cost envelopes detailed in table 1.

Table 1. Breakdown of costs for tribunals over last three financial years

Academic year	Cost (£)
2015-16	85,570
2016-17	106,923
2017-18	219,498

3. What is the success / failure rate of cases that go to tribunals?

Equally, it is a complex task to extract information on the outcome of cases that go to tribunals specifically relating to Speech and Language Therapy however, Table 2 shows the number in broader terms for the last 12 months:

Table 2. Breakdown of outcomes relating to tribunals

Outcome	Number
Cases heard at full hearing and resolved in NCC's favour	9

Cases heard at full hearing and resolved in parents' favour	6
Cases withdrawn / LA determined prior to full hearing	55
Cases yet to be determined/in process	30
Total number of cases since November 2017	100

Appendix one: Approaches to Speech and Language Therapy for children with particular needs

Context

As a profession Speech and Language Therapists are required to take an evidence based approach to their work, whatever their specialism. Evidence based practice can be defined as;

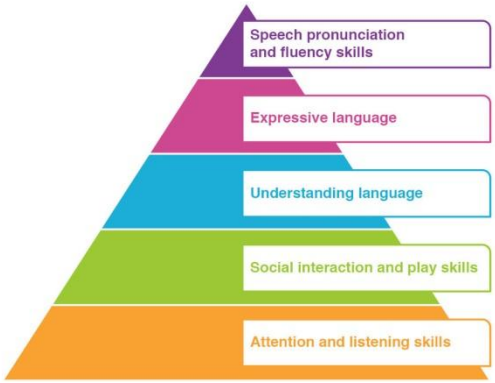
"Evidence-based medicine is the integration of best research evidence with clinical expertise and patient values."

(Sackett, 2000)

Whilst all healthcare professions are required to work within an evidence based framework it is acknowledged within the profession that:

"In many instances there will be little or no evidence to support a particular approach." (Reilly, 2004)

Children's speech and language therapists typically take a developmental approach to assessment and intervention. There will be points in an individual child's development where there is greater or less need for "therapy" from a speech and language therapist. This will depend on the child's attention and listening skills, their cognitive development, the ability to cope with the demands of therapy, and the support available from their home and nursery or school setting.



Speech and Language Development Pyramid.

Children develop language skills from the bottom of this pyramid upwards, so in the early days the focus will always be on developing a child's attention, listening and understanding.

What evidence is there that SLT is not beneficial for children with autism?

The Royal College of Speech and Language Therapists provide detailed guidance regarding clinical evidence base for approaches which aim to support children with Autistic Spectrum Disorder to develop their speech, language and communication skills, (The Royal College of Speech and Language Therapists, 2009)
Specialist programmes may be devised which target areas of identified need including social communication skills. Social Stories ™have for example, been shown to be an effective approach for improving social skills and understanding appropriate behaviour (Quirmbach LM, 2009), however the evidence base for this is limited and would benefit from further investigation (Francis, 2005).

A number of different Alternative and Augmentative Communication (AAC) approaches are used to support communication development and opportunities. One system with a stronger evidence base is the Picture Exchange Communication Card System® (PECS®), which has been used in facilitating communication with a specific cohort of children. Sign language, interactive communication boards, general visual support, communication cue cards, conversation books, and voice output communication aids have all been used with people with ASD.

There is some evidence to indicate that particular approaches will support skills acquisition but there is limited evidence that these skills will be maintained and/or transferred into other situations. For example, specific social skills training (SST) programmes have been shown to result in low levels skill maintenance and generalisation in part due to 'contrived, restricted and decontextualized settings' e.g. pull-out sessions and resource rooms rather day to day settings (Gresham, 2001). There are social communication interventions which are demonstrated to have some benefit for children with ASD. The evidence from (Bellini S, 2007) suggest the best outcomes are achieved when programmes are implemented within the child's normal day to day environment and this what ECCH would advocate.

East Coast Community Healthcare Children's Speech and Language Therapy are commissioned to contribute to the Autistic Spectrum Diagnostic Assessment and provide intervention for children who have a speech or language disorder alongside their Autism. They are not commissioned to provide social communication intervention for this group of children, when no additional needs are identified. The service will recommend social communication strategies and therapeutic approaches if identified as part of a broader assessment; however they do not then support schools/families to implement these.

There is no one size fits all approach or intervention and whatever intervention is implemented it should be based on the individual's needs (NICE, 2013).

What evidence is there that SLT is not beneficial for children with Downs Syndrome?

Children with Down Syndrome have a number of features of their appearance and their skills and abilities which are similar. For example they generally have low muscle tone, leading to delays in their development of the fine tuning of their movements; there is an increased incidence of glue ear leading to impacting upon hearing as well as variability in their visual acuity, often requiring glasses. They have smaller lower jaws leading to the impression of a large tongue and all will have some degree of

learning disability which impacts on the development of all of their skills. It is important when determining the best therapeutic input to remember that children with Downs Syndrome develop at different rates and ways, having individual strengths, needs, talents and interest at different points in childhood.
“The number of studies that have evaluated the effectiveness of [Speech and Language Therapy] intervention in relation to Down Syndrome are few”. (Buckley S. J., 2000).

There is some evidence that proposes children with Down Syndrome should be seen at least monthly in school, targets reviewed and activities set for parents, teachers and assistants to include in their daily routines (Buckley S. J., 2002). Some children with Down’s syndrome of school age may benefit from weekly individual or groups sessions of speech and language therapy (Buckley S. J., 2002). At all times intervention should be provided by or overseen by an appropriately qualified Speech and Language Therapist (The Royal College of Speech and Language Therapists, 2010)

Sue Buckley presents evidence that addresses issues such as the benefits of naturalistic, language interaction intervention compared to direct teaching approaches, and the benefits of direct work on phonology. (Buckley S. J., 2000). As with all clients, speech and language therapists must adapt interventions to suit individual interests, learning styles and needs. Because speech and language therapy should take into account individual needs and circumstances, it’s not possible to specify a format or amount of speech and language therapy that will be right for everyone who has Down’s syndrome at a particular age or in a certain situation (Baksi, 2006).

There is a strong body of evidence to suggest that using signing supports the development of understanding of spoken language for young people with Down Syndrome and it will be important for parents to sign for their child. All experts identify that language is learned all day, every day, as children are involved in communication with their families and friends, therefore the focus of effective therapy must be to share skills with parents because they will be their child's best therapist. (Buckley and Provost 2002).

It will usually be the role of the speech and language therapist in the pre-school and primary years to set the goals and next steps in a child’s language development journey and sometimes this will involve direct therapy sessions but more often it will involve coaching those people who work with the young person on a daily basis. These people are best placed to offer these opportunities in real life contexts to support using these skills in a meaningful way. There is little value to a child being able to use a word out of context such in a picture book and not being able to use it in real life situations.

East Coast Community Healthcare Children’s Speech and Language Therapy provide support to a number of children from weekly intervention to monthly dependant on current need and circumstance. When speech and language therapists do weekly speech and language therapy sessions with children, we expect the child to master a new skill week on week. Children with Down Syndrome typically need more time to practise and consolidate new skills and therefore it would be rare for weekly therapy to be indicated on an indefinite ongoing basis. On occasions we will advise that

intervention is not advised because the individual child is not receptive to a specific approach/therapy at that point in time.

Children with Learning Disabilities

Children with a learning disability have equal access to the ECCH service. When assessing an individual child's needs it is important that the therapist considers the child's overall cognitive ability alongside their speech language and communication skills. If a child's speech language and communication skills are in line with their general development it may be consider that direct speech and language therapy may add little or no benefit to their progress. In these cases specific advice and strategies would be provided for the team around the child to implement. If a child with a learning disability has an additional identified need e.g. cleft palate or eating and drinking difficulties is for all children with this need and they will be seen by a therapist with expertise in that specific clinical area.

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Appendix 2

Comments given to the HOSC meeting from SENsational families regarding SLT, July 2018

We welcome the findings of the independent review as it largely reflects what families have been telling us and we have been feeding back ever since ECCH took over in 2016. That waiting times for therapy are too long and that for many children the current approach of assess, discharge and re - referral isn't working.

There are a few things we would like to highlight:

The independent review hasn't mentioned the amount of families paying for private therapy for their children. In our survey many families stated that they were funding private therapy as they felt they had no other option. The answers ranged from a couple of hundred pounds so far to one person having paid over £5500.

Its a shame that the Independent Review hasn't shared the results with families' comments from the surveys as has happened with previous surveys such the SEND sufficiency consultation as this gives a more personal view. Had we known this was the case we would have submitted a paper with all of our data and comments from our survey.

I will share a couple of those comments now as it shows the level of feeling about this subject.

"As I understand it, there are not enough therapists to cope with the amount of children. I am also a SENCO and have stopped advising other parents to refer to ECCH due to the constraints of the service. I feel many children are being failed. This is not the fault of individual therapists. Relatives cannot believe that my son who is 5 and non verbal, does not receive regular therapy. It feels like ECCH are thinking he is beyond hope!"

"I have twins, they need to be seen and treated as individuals, not squeezed into one appointment. They are totally different. Please do not copy and paste a report and then leave the wrong name in, or get the child's details wrong, it is very upsetting. There is no hands on speech support, it's handouts and generic . When every child needs are different and learns in a different way. The wait for some appointments is too long and then they're signed off after 9 months, regardless of the child's needs. Then another 6 months before you can refer again. It's a nightmare and disgraceful how we have been treated"

One of our questions in the survey was about ECCH having held a number of 'Community as Teachers' events around the County as this was something ECCH were asked to do at the last HOSC. Feedback we received was that most parents weren't told about them and they weren't promoted widely. We only found out because someone spotted it online and shared in our group.

Because of this, very few parents attended.

The survey wasn't promoted widely enough. We were told that there had been a similar number of responses to this survey as the SEND sufficiency one. But SALT isn't just a SEND issue. This was shared via the Local offer, Healthwatch, Family Voice and ECCH.

Initially the survey wasn't on the home page of the Local Offer, we asked for it to be moved as it was hard to access - several clicks away from the home page. Families do not browse the Local Offer, it's an information resource base and people tend to look for something specific. Healthwatch is great but again, not something families are aware of. We hadn't head of it until Stuart Brunton-Douglas mentioned it.

ECCH did not share the survey initially on their website but did later on when the survey had been running for a while and we highlighted this with Stuart BD. And again, this is not a website people go to browse. A far more effective way of getting the survey into the public domain would have been to email families who had been referred to ECCH (almost 10000 over the 2 years according to the report). This would have meant that those families whose children didn't have SEND would have been given the opportunity also. When we raised this we didn't receive a reply for ages and then were told that due to GDPR this was not possible. So instead of 140 families who responded we could have a much more representative sample. Families shared that Speech Therapists did not mention the survey to families either when they were having their SALT sessions.

Family Voice did not share the survey initially. We had to email and ask them to share which they did on their FB page but they didn't share via email until we asked them to- even tho they had shared the dental survey. It felt as if the council didn't want to know what people had to say.

The report states that drop in centres received the most positive feedback. This has not been our experience. We wonder if it was mostly professionals who rated it positively rater than families as most kids with SEND won't access drop ins.

This is an account from a mum who was recommended to attend a drop-in clinic after concerns were raised about one of her children. She has 3 children under 4, 1 diagnosed ASD and twins one suspected ASD.

'When a drop-in was recommended I explained I would find it incredibly difficult however she then went on to say there are lots of them and hopefully we could find one that could suit as the waiting list for a home visit was extremely long and would be the 18 weeks just to get him seen to be referred. She told me a couple of drop ins in this area and even told me ones as far as Thetford however agreed that would be too much. They found a closer one at Bowthorpe sure start centre. It was at 9.30 so I had time to drop eldest child at school and get over to Bowthorpe for the drop in. I was told that as the drop in was 9.30-11.30 I was best to get there early as they see you in the order of arrivals but no mention of numbers being capped etc.

I decided I would do it.. I could go with just the two and juggle it...

I dropped eldest off as quickly as possible and drove to Bowthorpe.. by the time I got the boys out of the car into the buggy etc it was 9.15am when I arrived however was greeted by 2 ladies from ECCH and was told they already have their 6 families and wouldn't be able to see us and was turned away.

When I got slightly upset at that point as just how hard it was to get there to be turned away she then went on to tell me that it's a drop in and they have no control on how many will turn up so could never guarantee anyone to be seen it's a case of first come first served.

Also they were supposed to have a second therapist but that therapist was ill so wouldn't be seeing the 12 families they originally had planned and unfortunately I would need to try again at another drop in..

Obviously I got upset as I couldn't possibly keep chasing them at drop ins on the chance I might be seen.. I also explained how I was feeling let down, I told them I have a child that has ASD and was non verbal at 3 and didn't get speech therapy and how I had to fundraise to get the support.. and now I have another child and he needs to be seen.

I went outside and just burst into tears in frustration... a lady from the sure start centre come out after me, she tried to help get them to see me but obviously couldn't.'

Families have been told that NCC will not accept reports form private Speech therapists as they are not the commissioned service. The line that has been taken by both ECCH and some EHCP co - ordinators is that as they are private therapists, they could be overstating a child's needs in terms of therapy as they have to 'pay the bills'. This is something we have heard time and time again and not only is it an insult to the therapist, many of whom used to work for the NHS before ECCH took over, they are also governed by the same professional body and to do this would be highly unprofessional and unethical.

However, the report also hasn't highlighted that ECCH themselves have been offering private therapy to some families whilst they wait for the child to reach the top of the waiting list. Marie from Better Communication told us that this has been resolved and won't happen again but we felt it should be noted that this has happened and given what has been said about private therapists, it seems a bit rich that ECCH have been charging £50 per 30 mins for therapy when the going private rate is £30-35.

We know of several parents who have had to fight for up to 2 years and attend mediation / start tribunal proceedings before their child has received an appropriate level of SALT or a Personal Budget for private therapy. Families haven't got the time, energy and shouldn't have to go to these lengths. Those families will always ask themselves: How much more progress would my child have made and how much further could they have come, if the right provision had been in place to begin with?

The Independent Review has highlighted several areas of concern and recommendations of how to improve Speech and Language Services, however in the future we feel surveys could be shared in a more effective way as this approach felt a bit half hearted and many of the responses have come from us promoting it. To gain a truly meaningful picture every method of contact should be used. Email and text are commonly employed as ways of sharing satisfaction surveys, particularly within the NHS and we feel that this should have happened here.

It is an established fact that early intervention in children with any kind of additional need is crucial to their development and future outcomes. Denying or reducing levels of support to young children is a false economy as their problems do not simply 'go away' they actually become obstacles in accessing education and ultimately employment. These young people are likely to need further intervention later on, incurring more cost and potentially increased reliance on public services throughout their lives.

One of the 'emerging themes' from the Independent Review states:

'The service specification was ambitious in attempting to provide a whole system approach for SLT in Norfolk. Challenges in terms of service funding, resources and the allocation of resources outside of this contract have led to a series of unintended consequences.'

At the Children's Services Committee on Tuesday NCC admitted they had under estimated and therefore under resourced their EHCP department which last year resulted in only 9% of EHCP's being delivered within their target time and leaving more than 90% of children with SEND potentially unsupported in their educational setting.

As parents, we pose the question:

Is NCC's continued efforts in trying to reduce costs and make savings from all of their budgets, putting vulnerable children and young people in Norfolk with SEND at risk?

Appendix 3

Responses to the 2018 SENsational families survey regarding ECCH paediatric speech and language therapy in Norfolk

1. I am so disappointed by NCCG and NCC that I am looking into legal aid for judicial review of SALT provision and my son EHCP.

2. The current SALT provision provided by ECCH is not meeting the needs of the children it has been commissioned to help. In particular the children with complex SALT needs.

3. I haven't heard of any events.i feel very much on my own this time. We have work sheets and we are waiting for a 6 week block which I have been told will be quite a wait. The 6 weeks M has been offered apparently won't scratch the surface of his issues.

4. The waiting lists are far too long. I'm not sure if the policy has changed as we have not had a recent appointment, but the automatic discharge policy, placing the onus back on the school/parent to request a child is seen again, is disgraceful. All the individual therapists who have assessed my son have been helpful and professional, but the waits are far too long and more input is required. Scrimping on this is so short-sighted as improvements in communication and interaction will have huge benefits in terms of ability to access the curriculum and make progress in other subjects, as well as enabling the child to verbalise problems rather than having to show distress through behaviour.

5. ECCH are not providing 'actual therapy sessions' for our children. The service is not appropriate any more and is failing out children's needs. I as a parent am left with no advice, no help and heafty private SALT bills! It's totally unacceptable that such an important thing as being able to communicate.

6. As I understand it, there are not enough therapists to cope with the amount of children. I am also a SENCO and have stopped advising other parents to refer to ECCH due to the constraints of the service. I feel many children are being failed. This is not the fault of individual therapists. Relatives cannot believe that my son who is 5 and non verbal does not receive regular therapy. It feels like ECCH are thinking he is beyond hope!

7. I have twins, they need to be seen and treated as individuals, not squeezed into one appointment. They are totally different. Please do not copy and paste report and then leave the wrong name in, or get the child's details wrong, its very upsetting. There is no hands on speech support, its handouts and generic . When every child needs are different and learns in a different way. The wait for some appointments is too long and then signed off after 9 months, regardless of the child's needs. Then another 6 months before you can refer again. Its a nightmare and disgraceful how we have been treated.

8. No specific support considering my son has ASD. The last SLT came to see him without contacting me and then couldn't answer my questions about the ASD traits of his speech difficulties. He has seen an SLT twice in two years.

9. Too Long waiting between report identifying that the child needs speech therapy waiting time so far not seen is 5 months- child will start at school in July 2018.

10. Your provision is utterly disorganised and without consistency. Your staff are immature and pointless

11. Since moving to ECCH the service has gone downhill. I have a non verbal child who has progressed to phase 5 PECS using a private therapist. I am a single parent not working. In January an advanced offer was agreed to support her in school. Not heard anything since. It's disgusting and I am going to the papers about this. You shouldn't get away with leaving children like they are just another number. Should be ashamed of yourselves.

12. We were told that my son aged 3.5 who has significant SALT needs due to Down syndrome does not require SALT !!! as he is too young . This is obviously inaccurate and all evidence indicates that children with DS benefit hugely from early intervention . He has benefitted a lot since starting regular private SALT . He now understands many signs , can sign back and is making different Soeech sounds . He is also attempting done words now . Discharging a child with obvious need shows the service is not fit for purpose . A friend with a child of same age and similar communication issues has been seen regularly for one to one sessions 4-6 weekly . There is a complete inequity in service . Is it because my son has Down syndrome ?

13. Our grandson has a speech problem - he sometimes whistles as he speaks. EECH did an assessment over the telephone and stated he did not need intervention. More than words did a face to face assessment - he has a speak problem that can be corrected with therapy. How can EECH therapist correctly diagnose a child over the phone - it was not a skype call just a normal telephone call - I have serious concerns over their assessment process.

14. Our son had really been let down by ECCH, he is in clear need and has been recognised as having a need however we receive no support. Lots of nothing. When someone does come to see him to review he always has the wait and see with Home sheets and signed off. Not good enough! His progress isn't due to ECCH it's due to us having to find funds to help our son privately. Shocking service

15. Waiting lists are too long- we need more SALT's to help our children

16. When we see a therapist , she is very helpful and very professional . However the wait between the sessions are so long . When you can see how your child's life is being effected due to not being able to communicate fully , and you don't have as much support as you feel you need , it can make you feel very helpless as a mother . The difficulties in communication have effected almost every part in her life , from making friends to asking if for food. Speech and language is vital for children if it is needed. There seems to be such a demand for this service and not enough staff,

17. Some members of staff were amazing but actually getting seen was very frustrating following transfer to your service. I was constantly chasing as my daughter was rapidly heading towards school and was not being seen routinely.

18. Provision is inadequate and failing children who are most vulnerable. Communication is the key to so many other developmental aspects - failing children when they need it most and when a positive input could make such a wide reaching difference. We are setting our children up for a school career (and potentially a lifetime) of disillusionment, emotional well-being difficulties, poor social interaction, poor prospects. My child is no less deserving of the richest and broadest of opportunities just because he was born with this difficulty.

19. The service is appalling. Our children are being let down. Assessment and discharge is not good enough.

20. We do total communication as part of everyday life & at nursery. My child learns & thrives on concentrated regular 1:1 speech therapy. This doesn't exist. The East coast model is a cop out & is setting my child up to fail in mainstream.

21. I feel that intervention at an early age would help more than waiting until a child is 3, as by then they have already adjusted to life without speech and dealt with the frustrations it causes.

22. Since discharging in May/June speech is has got worse, school have now made a referral back, what a waste of a year!

23. No service other than assessment provided

24. When my son received his autism diagnosis at age 15 he was not seen by a SALT. He was diagnosed via CAMHS. No pathway for young people it appears. Ignore them and they will go away?

25. Simple question, for WHAT you are paid???? Doing nothing???!!@

26. The service offered for our son was disjointed from the outset, no clear messages about the process for us as parents. Emphasis was very much on sign and no encouragement to use speech. Once using private services our sons speech developed massively. I am worried about this service and the way it works to support children to communicate. Staff were trying hard to get things right but they talked about the system being wrong, no time to work with children and frustration about funding.

27. Service seems to be underfunded especially since being split from NHS. Our visits reduced drastically after that and we have had to chase to get these reinstated even with my child's severe and complex needs.

28. I think the money spent on SaLT at ECCH would be better spent at 'More Than Words'

29. ECCH appear to want to discharge the children ASAP ! In 2013 our daughter was having weekly sessions then cut down to 1 every few months and then bizarrely discharged to have to be referred again and be put on a waiting list ??? Seen again and discharged only to have to be referred again as we are trying to obtain a personal budget and co-ordination said we could not use a private report as we had to have confirmation that the NHS do not provide

the therapy she requires. We duly did this and now LA have changed the goal posts and said school can do this. Teachers are not qualified SALT therapists so ECCH should provide this therapy or we should be able to have a personal budget to pay privately !!!

30. Feel my son's speech and language needs are not being met and that he has been left to it because he is almost non verbal.

31. Under staffed Too many cases miss/ undiagnosed. Once diagnosed no treatment provided just a plan for schools and families to follow. Thank goodness we have used a private therapist to assist in the mean time! We would have a son with serious behaviour issues otherwise. He is damaged as a result of not getting enough support earlier. With glue ear not diagnosed despite school hearing screening .... and with other difficulties (possible ASD/ SPD) he will need a lot of input. More earlier on may have been more cost effective in the long run. Just need more therapists to be able to provide the sessions with child straight after assessment. Waiting times horrific still. Just not good enough. Norfolk has a huge S&L problem. It's not about to disappear. More funding, support, professionals, sessions desperately needed. Schools are at breaking point over this and other underfunding issues. Our children are losing out and putting a greater strain on resources.

32. ECH are failing most if not all the children in Norfolk, this will be detrimental to our children's future. The long term effects of this lack of service will cost Society in the future, making a very high proportion of these children unemployable, benefit claimants costing society thousands. When this next generation need not be unemployable because there SALT needs were not addressed (early intervention) but ignored and discharged.

33. The service provided by therapists is hugely variable, we are 'lucky' to now have a very knowledgable therapist who has been really helpful. However prior to this was a different experience and meant my children did not receive an acceptable service. The delay between referrals and therapy commencing is unacceptable. The provision of private therapy by ECCH to the same children they see on the NHS is ethically questionable and needs investigating.

Norfolk Health Overview and Scrutiny Committee

ACTION REQUIRED
Members are asked to suggest issues for the forward work programme that they would like to bring to the committee's attention. Members are also asked to consider the current forward work programme:-

- whether there are topics to be added or deleted, postponed or brought forward;
- to agree the briefings, scrutiny topics and dates below.

Proposed Forward Work Programme 2019

Meeting dates	*Briefings/Main scrutiny topic/initial review of topics/follow-ups*	*Administrative business*
11 Apr 2019	Access to NHS dentistry in Norfolk – follow up to the report to NHOSC on 24 May 2018 on access in West Norfolk, and examination of the situation in the rest of Norfolk. Local action to address health and care workforce shortages – a short report by Norfolk & Waveney STP Workforce Workstream Lead.	*STP Workforce Lead has asked to move this item to May 2019*
30 May 2019	Access to palliative and end of life care – follow-up from NHOSC's meeting on 18 October 2018.	
25 July 2019	The Queen Elizabeth Hospital NHS Foundation Trust - response to the Care Quality Commission report – progress report Norfolk and Suffolk NHS Foundation Trust - response to the Care Quality Commission report – progress update	

NOTE: These items are provisional only. The OSC reserves the right to reschedule this draft timetable.

Provisional dates for report to the Committee / items in the Briefing 2019

Sept 2019 (on the agenda) - **Physical health checks for adults with learning disabilities** – update since Sept 2018

July 2019 (in the Briefing)	-	**Continuing healthcare** – update on trends in referrals and assessment of eligibility for CHC and explanation of those trends.

Other activities

Visit to be arranged	-	Follow-up visit to the Older People's Emergency Department (OPED), Norfolk and Norwich hospital to be arranged after expansion works are completed in 2019-20.

Main Committee Members have a formal link with the following local healthcare commissioners and providers:-

Clinical Commissioning Groups

North Norfolk	-	M Chenery of Horsbrugh (substitute Mr D Harrison)
South Norfolk	-	Dr N Legg (substitute Mr P Wilkinson)
Gt Yarmouth and Waveney	-	Ms E Flaxman-Taylor
West Norfolk	-	M Chenery of Horsbrugh (substitute Mrs S Young)
Norwich	-	Ms E Corlett (substitute Ms B Jones)

Norfolk and Waveney Joint Strategic Commissioning Committee

For meetings held in west and north Norfolk	-	M Chenery of Horsbrugh
For meetings held in east and south Norfolk	-	Dr N Legg

NHS Provider Trusts

Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust	-	Mrs S Young (substitute M Chenery of Horsbrugh)
Norfolk and Suffolk NHS Foundation Trust (mental health trust)	-	M Chenery of Horsbrugh (substitute Ms B Jones)

Norfolk and Norwich University Hospitals NHS Foundation Trust	-	Dr N Legg (substitute Mr D Harrison)
James Paget University Hospitals NHS Foundation Trust	-	Ms E Flaxman-Taylor (substitute Mr M Smith-Clare)
Norfolk Community Health and Care NHS Trust	-	Mr G Middleton (substitute Mr D Fullman)

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Glossary of Terms and Abbreviations

AAC	Alternative and Augmentative Communication
A&E	Accident and emergency
AtoH	Arrival to handover (i.e. time from arrival of ambulance at hospital to handover of patient to care of the hospital staff)
ARP	Ambulance response standards
ASD	Autistic Spectrum Disorders
C1 & C2	Categories of calls under the Ambulance Response Programme:- C1 – life threatening C2 – other emergencies
CAMHS	Child and adolescent mental health service
CCG	Clinical Commissioning Group
CDU	Clinical Decision Unit
CHC	Continuing Healthcare
CQuIN	Commissioning For Quality And Innovation
CT	Computerised tomography – a CT scan uses X-rays and a computer to create detailed images of the inside of the body. CT scans are sometimes referred to as CAT scans
DS	Downs Syndrome
DSA	Double staffed ambulance
D&V	Diarrhoea and vomiting
EBM	Evidence based medicine
ECCA	East Coast Community Access Team
ECCH	East Coast Community Healthcare
ECIST	Emergency Care Intensive Support Team (Department Of Health)
ECP	Emergency Care Practitioner
ED	Emergency Department
EEAST	East Of England Ambulance Service NHS Trust
EHCP	Education Health and Care Plan
Elklan training	A speech and language therapy training provider, established in 1999
FYTD	For year to date
GDPR	General Data Protection Regulation 2018
GMDU	General Medical Day Unit
HALO	Hospital Ambulance Liaison Officer
HEE	Health Education England
JSCC	Joint Strategic Commissioning Committee
KPI	Key performance indicator
LA	Local Authority

NCC	Norfolk County Council
NCH&C	Norfolk Community Health and Care NHS Trust
NHOSC	Norfolk Health Overview and Scrutiny Committee
NICE	National Institute for Health and Care Excellence
NNCCG	North Norfolk Clinical Commissioning Group
NNUH (N&N, NNUHFT)	Norfolk and Norwich University Hospitals NHS Foundation Trust
NOA	Norwich Opportunity Area
OPED	Older People's Emergency Department
OSC	Overview and Scrutiny Committee
PECS	Picture Exchange Communication System – an alternative/ augmentative communication system.
QEH	Queen Elizabeth Hospital, King's Lynn
RATS	Rapid assessment and treatment service
RCSLT	Royal College of Speech and Language Therapists
SCC	Suffolk County Council
SEN	Special Educational Needs
SENCO	Special Educational Needs Coordinatior
SEND	Special Educational Needs & Disabilities
SENDIASS	Special Educational Needs and Disabilitites Information Advice and Support Service
SLCN	Speech, language and communication needs
SLT / SALT / S&LT	Speech and language therapy
SPOC	Single point of contact
SST	Social skills training
STP	Sustainability and Transformation Partnership (or Plan)
TBC	To be confirmed
VSSS	Virtual school sensory support
WE	Week ending
WNCCG	West Norfolk Clinical Commissioning Group