Norfolk County Council

Norfolk Health Overview and Scrutiny Committee

Date: **Thursday 26 February 2015**

Time: **10.00am**

Venue: **Edwards Room, County Hall, Norwich**

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

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.

Membership

MAIN MEMBER	SUBSTITUTE MEMBER	REPRESENTING
Mr C Aldred	Mr P Gilmour	Norfolk County Council
Mr J Bracey	Mr P Balcombe	Broadland District Council
Mrs C Woollard	Ms S Bogelein	Norwich City Council
Mr M Carttiss	Mr N Dixon / Miss J Virgo	Norfolk County Council
Mrs J Chamberlin	Mr N Dixon / Miss J Virgo	Norfolk County Council
Michael Chenery of Horsbrugh	Mr N Dixon / Miss J Virgo	Norfolk County Council
Mrs A Claussen-Reynolds	Mr B Jarvis	North Norfolk District Council
Mr B Bremner	Mrs C Walker	Norfolk County Council
Mr D Harrison	Mr T East	Norfolk County Council
Mr R Bearman	Ms E Morgan	Norfolk County Council
Mr R Kybird	Mr R Richmond	Breckland District Council
Dr N Legg	Mr T Blowfield	South Norfolk District Council
Mrs M Somerville	Mr N Dixon / Miss J Virgo	Norfolk County Council
Mrs S Weymouth	*Vacancy*	Great Yarmouth Borough Council
Mr A Wright	Mrs S Young	King's Lynn and West Norfolk Borough Council

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

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

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

2. Minutes

To confirm the minutes of the meeting of the Norfolk Health Overview and Scrutiny Committee held on 15 January 2015. (Page 5)

3. Members to declare any Interests

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:

- your well being or financial position
- that of your family or close friends
- that of a club or society in which you have a management role
- that of another public body of which you are a member to a greater extent than others in your ward.

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

4. **To receive any items of business which the Chairman decides should be considered as a matter of urgency**

5. **Chairman's announcements**

6. **10.10 – 11.00** **Diabetes Care within Primary Care Services in Norfolk**

A report from NHS England on provision of services for patients with diabetes. (Page 11)

7. **11.00 – 11.50** **Ambulance response times and turnaround times at hospitals in Norfolk**

A progress report from the East of England Ambulance Service NHS Trust. (Page 22)

8. **11.50 – 12.00** **Forward work programme**

To consider and agree the forward work programme. (Page 46)

Glossary of Terms and Abbreviations (Page 51)

Chris Walton
Head of Democratic Services

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Date Agenda Published: 19 February 2015

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NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE
MINUTES OF THE MEETING HELD AT COUNTY HALL, NORWICH
On 15 January 2015

Present:

Mr C Aldred	Norfolk County Council
Mr R Bearman	Norfolk County Council
Mr J Bracey	Broadland District Council
Mr M Carttiss (Chairman)	Norfolk County Council
Mrs J Chamberlin	Norfolk County Council
Michael Chenery of Horsbrugh	Norfolk County Council
Mrs A Claussen-Reynolds	North Norfolk District Council
Mr D Harrison	Norfolk County Council
Mr R Kybird	Breckland District Council
Dr N Legg	South Norfolk District Council
Mrs M Somerville	Norfolk County Council
Mrs S Weymouth	Great Yarmouth Borough Council
Mr A Wright	King's Lynn and West Norfolk Borough Council

Substitute Member Present:
Ms S Bogelein for Mrs Wollard, Norwich City Council

Also Present:

Catherine Underwood	Director of Integrated Commissioning, Norfolk County Council
Debbie Olley	Director of Integrated Care (Interim), Norfolk Community Health and Care / Norfolk County Council
Laura Clear	Deputy Director Integrated Care and Systems Lead, Norfolk Community Health and Care / Norfolk County Council
Dr Anoop Dhesi	Chairman of North Norfolk Clinical Commissioning Group
John Everson	Head of Integrated Commissioning, North Norfolk Clinical Commissioning Group
Mark Burgis	Head of Clinical Pathway Design, North Norfolk Clinical Commissioning Group
James Joyce	Norfolk County Councillor
Sue Whitaker	Norfolk County Councillor
Chris MacDonald	Healthwatch Norfolk
Chris Walton	Head of Democratic Services
Maureen Orr	Democratic Support and Scrutiny Team Manager
Tim Shaw	Committee Officer

1 Apologies for Absence

Apologies for absence were received from Mr B Bremner and Mrs C Woollard.

2. Minutes

The minutes of the previous meeting held on 27 November 2014 were confirmed by the Committee and signed by the Chairman.

3. Declarations of Interest

There were no declarations of interest.

4. Urgent Business

There were no items of urgent business.

5. Chairman's Announcements

5.1 Mr Richard Bearman and Mrs Shirley Weymouth

The Chairman welcomed back onto the Committee Mr Richard Bearman. He also congratulated Mrs Shirley Weymouth on becoming Mayor-elect of Great Yarmouth Borough Council.

5.2 Congratulations to Norfolk Community Health and Care NHS Trust on a 'Good' rating by the Care Quality Commission

The Chairman said that the Member Briefing for January 2015 referred to the Care Quality Commission's latest inspection of Norfolk Community Health and Care NHS Trust for which they received a 'Good' rating. The CQC had said that it was quite an achievement for a community healthcare trust to receive a 'Good' rating in its new inspection regime. The Committee joined the Chairman in congratulating NCH&C on this result.

5.3 Members Visit to Norfolk Police Headquarters Control Centre at Wymondham December 9th 2014

5.4 The Chairman said that on 9 December 2014 a group of five Members of the Committee had visited the Police Control Centre at Wymondham to observe the service provided to people who needed support because of mental health issues rather than Police intervention.

5.5 At the request of the Chairman, Margaret Somerville updated the Committee on what the group of Members had learnt from the visit. She said that the group was impressed by the care and compassion shown by Police Officers and the Integrated Mental Health Team. She said that in April 2014, the first integrated Mental Health Team in the country was established in the Police Control Centre at Wymondham. Funding for this initiative had followed a bid to the Home Office Innovation Fund to establish an Integrated Mental Health Team. Norfolk County Council had provided bridge funding, pending the second innovation bid that was

agreed in July 2014 for the next two years.

5.6 Mrs Somerville went on to say that the group was informed that 15-25% of police time was engaged with people with mental health issues. This was both time consuming and inappropriate when what was really needed was a mental health intervention. There was a lack of understanding about how to access appropriate mental health services and they were often unavailable in crisis situations. There was difficulty in making referrals and inconsistent partnership working or data sharing with timely support, and the rural nature of Norfolk added to this difficulty. Mrs Somerville added that to have a dedicated team within the Police Control Centre who not only understood the mental health conditions, but also knew how to evaluate, refer or reassure those with mental health needs with their professional expertise, had proved invaluable. In one month before Christmas, calls included 106 people experiencing a psychotic episode, 27 potential suicide or self -harm, 89 with personality disorders and in 110 cases, there were concerns for safety. Several were repeat callers, with 77 previously known and 194 currently active. Repeat callers traditionally took at least 10-15 minutes but now these calls went directly to the mental health team and did not tie up the 999 service. Many of the callers were previously unknown to the service suggesting that they had problems as yet undiagnosed. In the month before Christmas the new arrangements had saved on the deployment of Police Officers on 22 occasions. Normally two Police Officers would have been deployed on a 999 response. Fifteen Section 136 calls were averted. A Section 136 effectively kept Police Officers away from frontline work but by averting the need for a S136, the team had reduced the pressure on the Mental Health Trust while at the same time giving those with mental health needs immediate support and a better quality of care. Those with serious mental health issues were not detained in padded police cells but were taken to Hellesdon, or a place of safety, to await assessment and a suitable bed wherever that might be.

5.7 The Chairman thanked Mrs Somerville for her detailed comments and said that a further opportunity for Committee Members to visit the Police Control Centre would be arranged for the end of January / February 2015. Those who would like to take part were asked to contact Maureen Orr.

6 Integration of Health and Social Care Services, Central and West Norfolk

6.1 The Committee received a suggested approach from the Democratic Support and Scrutiny Team Manager on progress with integration of health and social care services in central and west Norfolk in 2014-15 and plans for the future.

6.2 The Committee received evidence from Catherine Underwood, Director of Integrated Commissioning, Debbie Olley, Interim Director of Integrated Care and Laura Clear, Deputy Director Integrated Care and Systems Lead Norfolk County Council / Norfolk Community Health and Care who updated the Committee on integrated commissioning and operational plans across central and west Norfolk in 2015-16. The Committee also received a presentation from Dr Anoop Dhesi, Chairman of North Norfolk CCG, about the effectiveness of integrated services developed in North Norfolk in 2014-15.

6.3 In the course of discussion the following key points were made:

- The witnesses said that for the foreseeable future integration would continue to be a key theme for both health and social care services. Norfolk County Council and Norfolk Community Health and Care NHS Trust

(NCH&C) had entered into a formal agreement to create a single management arrangement for social care and community nursing and therapies across Norfolk, except for the Great Yarmouth and Waveney CCG area which would be looked at separately by the Great Yarmouth and Waveney Joint Health Scrutiny Committee in due course.

- Very strong progress had been made in ensuring that people had a joined up experience of health and social care but there were significant decisions still to be made, not least because of the requirements of the new Better Care Fund (BCF) for the pooling of health and social care resources.
- The establishment of the BCF for 2015 onwards would provide a national push towards much greater integration than had been achieved by the pilot schemes of the past.
- It was pointed out that there were now in effect five integration plans for Norfolk based on the five CCG areas, however, there was much in common between these plans.
- The Committee received a detailed presentation from Dr Anoop Dhesi, Chairman of North Norfolk CCG, about the effectiveness of integrated services developed in North Norfolk in 2014-15. This could be found on the Committee papers website.
- The revenue funding for 2015/16 for each of the CGCs was set out in the report from the Director of Integrated Commissioning and Interim Director of Integrated Services at paragraph 5.2.
- The biggest challenge for Social Care Services was the constant need to provide effective services to increasing numbers of older people and people with complex needs in the context of very significant pressure on County Council funding.
- Health and Social Care Services had appointed to a new senior management structure for integrated services across its organisations at no additional management cost.
- The witnesses said that health and social care commissioners and providers were concentrating on the integration of services for adults, however, the needs of young people and the needs of carers of young people, to access services in a way that would be of benefit to them in planning for the services that were needed in adulthood was very important.
- As well as integration with social care, new methods of integrated working between different parts of the NHS (e.g. primary and community care; community care and acute care; acute care and primary care) were being tried across the county.
- Mental Health Services were seen as an important aspect of an integrated health and social care services. A partnership board had been established to provide leadership and to provide joint work on mental health issues.

6.4 It was **agreed** that the Committee might wish to invite commissioners and providers to report back in 12 months on progress with health and social care integration.

7 NHS Workforce Planning for Norfolk

7.1 The Committee received a report from the Democratic Support and Scrutiny Team Manager that asked Members to make the appointments to a task and finish group to scrutinise NHS workforce planning for Norfolk and to agree on the terms of reference for that group.

7.2 The Committee **agreed** the terms of reference for the task and finish group to scrutinise NHS workforce planning for Norfolk that were set out in the report.

7.3 The Committee **agreed** to appoint the following Members to serve on that group:-

Michael Chenery of Horsbrugh
Alexandra Kemp
Robert Kybird
Nigel Legg
Margaret Somerville

7.4 It was also **agreed** that Alex Stewart of Healthwatch Norfolk should be invited to join the group on a co-opted, non-voting basis and that Chris MacDonald could substitute for him at the early meetings.

8 Forward work programme and appointment of substitute link members with local NHS Trusts and Clinical Commissioning Groups

8.1 The Committee considered the appointment of **substitute** link members with local NHS Trusts, where vacancies existed.

8.2 The Committee **agreed** to nominate the following Members as **substitute** link Members with NHS bodies:-

North Norfolk CCG – Michael Chenery of Horsbrugh
Great Yarmouth and Waveney CCG – Jenny Chamberlin
West Norfolk CCG – Tony Wright
James Paget University Hospital NHS Foundation Trust – Margaret Somerville

8.3 Maureen Orr was asked to email Members of the Committee for nominations to fill the vacancies that remained for substitute link members:-

Norwich CCG
Norfolk and Suffolk NHS Foundation Trust

8.4 The Chairman said that Emma Corlett, the County Council's Member Champion for Mental Health, had written to him to ask that the Committee consider looking at the situation regarding out of area placement of mental health patients and the overall effects of the radical redesign of services brought about by NSFT's 2012-16 Service Strategy.

8.5 The Committee **agreed** the current forward work programme that was set out in the officer report subject to the following changes:-

For the 16 April 2015 agenda – add an item concerning the Norfolk and Suffolk NHS Foundation Trust to cover:-

(a) An update on out of area placement of mental health patients
(b) The effect of changes to mental health services on support for homeless people
(c) The effect of the changes to mental health services on policing
(d) Disparity in the services available to mental health patients in different localities
(e) The numbers of adults in mental health residential care establishments in Norfolk compared to other parts of England.
(f) The levels of caseloads for NSFT staff
(g) Performance monitoring of the overall effects of the changes to mental

health services

For the 16 April 2015 agenda- add an item about 'Service given to patients with mental health issues in A&E following attempted suicide or self-harm episodes'.

8.6 The Committee also **agreed** that Dr Ian Mack, Chairman of Norfolk Stroke Network, should be asked to provide a report for the Member Briefing in April 2015 on the action taken to address the Care Quality Commission's (CQC) comments about access to the stroke care pathway for incomers to Norfolk. (It was noted that CQC's comments were made in its report about the latest inspection of Norfolk Community Health and Care NHS Trust, published in December 2015).

Chairman

The meeting concluded at 11.40 am

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Diabetes Care within Primary Care Services in Norfolk

Suggested approach from Maureen Orr, Scrutiny Support Manager

A report on primary care services including prevention, diagnosis, early intervention and long term care for people with diabetes in Norfolk.

1. Background

1.1 Norfolk Health Overview and Scrutiny Committee (NHOSC) previously received reports on diabetes services in Norfolk in 2008. At that time the committee was particularly concerned about:-

- Diabetes services for children
- Eye and foot screening services for people with diabetes

The committee established a scrutiny task & finish group, which reported in November 2009 with a series of recommendations to the former Primary Care Trusts and others. One of the recommendations was for the Great Yarmouth and Waveney Joint Health Scrutiny Committee (GY&W JHSC) to monitor progress with foot screening services in the area until certain issues had been resolved, which the joint committee did until mid 2010. Both NHOSC and GY&W JHSC were satisfied that progress was being made.

1.2 In November 2014 NHOSC agreed to put Diabetes on its agenda. This time the committee wished to look at the service people with diabetes are receiving in primary care (i.e. in GP's practices).

1.3 There were national press reports in November 2014 about patients with type 1 diabetes (i.e. requiring insulin) being refused prescriptions for blood-testing strips even though the Department of Health had previously written to GPs reminding them not to restrict access other than for clinical reasons. Diabetes UK argued that any short term savings from restricting access to blood testing strips would be tiny compared to the long term costs of treating complications arising from poorly managed blood glucose levels. NHS Clinical Commissioners said there had been over-testing and over-prescribing of strips for some patients in the past, which was not beneficial for them or the NHS.

2. Purpose of today's meeting

2.1 GPs and other practice staff play an important role in the prevention of diabetes as well as detection, diagnosis and early interventions for people

with diabetes. They also provide ongoing care for people with both type 1[1] and type 2[2] diabetes and refer them to other essential services such as eye screening.

2.2 NHS England is currently responsible for commissioning of primary care (i.e. GP practice) although Clinical Commissioning Group involvement is increasing. NHS Health Checks for people between the ages of 40 and 74 are an important route for early detection and diagnosis of diabetes and are commissioned by local authority Public Health. Services for people living with diabetes, e.g. eye screening, diabetic nurse clinics, podiatry (i.e. care of feet) are the responsibility of various different commissioners and providers.

2.3 Today's focus is on primary care in relation to diabetes and NHS England East Anglia Area Team (EAAT), with input from Norfolk County Council Public Health, has been asked to report on the performance of services commissioned for detection and diagnosis of diabetes and for the long term care of people with diabetes. NHS England EAAT's report is attached at Appendix A.

2.4 Diabetes UK is a charity that campaigns to improve services for people with diabetes across the UK. Sharon Roberts, Eastern Regional Manager of Diabetes UK, has been invited to today's meeting to give NHOSC the charity's views about diabetes services in the county.

2.5 The results of Diabetes UK's National Diabetes Audit 2012-13 (eastern region) are attached at Appendix B. The audit shows the number of people with diabetes registered in each of the 19 Clinical Commissioning Group (CCG) areas in the east of England (the numbers may not be complete if not all GP practices in the CCG area took part in the audit) and the percentage who are receiving the recommended care processes and treatment targets for diabetes.

Across the full range of care processes and treatments included in the Diabetes UK audit, North Norfolk and South Norfolk are the 1st and 2nd best performing areas out of 19 areas in the region. West Norfolk is 7th, Norwich is 11th and Great Yarmouth and Waveney is 19th.

The data also includes performance in relation to NHS Health Checks offered and received in 2013-14. Norfolk County Council is 8th out of 11 councils in the east of England, although it's performance is around the national average.

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[1] Type 1 diabetes - develops if the body is unable to produce any insulin. Usually appears before the age of 40. Is the least common of the two main types and accounts for between 5 – 15% of all people with diabetes. It is treated by insulin injections and diet and regular exercise is recommended.

[2] Type 2 diabetes - develops when the body can still make some insulin, but not enough, or when the insulin that is produced does not work properly. In most cases this is linked with being overweight. It is the most common of the two main types and accounts for between 85 – 95% of all people with diabetes. It is treated with lifestyle changes such as a healthier diet, weight loss and increased physical activity.

3. Suggested approach

3.1 After receiving the report from NHS England EAAT and a presentation from Diabetes UK, the committee may wish to discuss the following areas with the representatives:-

(a) Are the commissioners aware of restrictions on the equipment that is prescribed to patients with diabetes in Norfolk?

(b) What could be done to increase the uptake of NHS Health Checks?

(c) According to the Diabetes UK 2012-13 national audit, Great Yarmouth and Waveney has the poorest record in the east of England for provision of care processes and treatments. Is this a true reflection of the situation and what are commissioners doing to support better performance in that area?

(d) When is the new national system linking GP screening programmes with GP systems (GP2DRS) expected to be fully operational?

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NORFOLK HEALTH OVERVIEW & SCRUTINY COMMITTEE

FOR INFORMATION

1 Introduction

1.1 This report is to provide Norfolk Health Overview and Scrutiny Committee with an overview of diabetes care in primary care.

2 Background

2.1 NHS England commissions primary medical services using a variety of contracts: General Medical Services (GMS), Personal Medical Services and Alternate Primary Medical Services contracts. The GMS contract was introduced in 2003 and covers three main areas:

- the global sum – covering the costs of running a general practice, including some essential GP services. This ensures that practices provide services required for the management of registered patients who are ill with conditions from which recovery is generally expected, terminally ill or, suffering from chronic disease; and all appropriate ongoing treatment and care including the referral of patients for other services;
- the Quality and Outcomes Framework (QOF) – covering the two areas of clinical and public health. Practices can choose to provide these services; and
- Enhanced services (ES) – covering additional services that practices can choose to provide. ES can be commissioned nationally by NHS England or locally by the Clinical Commissioning Groups to meet the populations healthcare needs.

3 Diabetes care in Primary Care

3.1 Effective control and monitoring of diabetes mellitus can reduce mortality and morbidity. Much of the management and monitoring of diabetic patients, particularly those with Type 2, is undertaken by the GP and members of the primary care team.

Quality Outcomes Framework

3.2 The indicators are based on widely recognised approaches to the care of diabetes. Detailed guidelines for health professionals are published by NICE and SIGN.

3.3 There are a number of indicators within QOF which are generally those expected to be done or checked in an annual review. There is no requirement for the contractor to carry out all the items (e.g. retinal screening) however it is the contractor's responsibility to ensure they have been done. (Attached is an extract from QOF relating to the diabetes indicators for information)

3.4 In brief, the indicators are:

- Contractor establishes and maintains a register of all patients aged 17 or over with diabetes mellitus which specifies the type of diabetes where a diagnosis is confirmed;
- Maintain records of percentages of patients with diabetes, on the register:

- in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less;
- in whom the last blood pressure reading (measured in preceding 12 months) is 140/80 mmHg or less
- whose last measured cholesterol is 5 mmol/l or less
- with a diagnosis of nephropathy (clinical proteinuria) or micro-albuminiuria who are currently treated with an ACE-! (or ARBs)
- in whom the last IFCC HbA1c is 59 mmol/l or less in preceding 12 months
- in whom the last IFCC HbA1c is 64 mmol/l or less in preceding 12 months
- in whom the last IFCC HbA1c is 75 mmol/l or less in preceding 12 months
- with a record of foot examination and risk classification: low risk, increased risk, high risk or ulcerated foot, within preceding 12 months
- percentage of newly diagnosed patients in the preceding year who have a record of being referred to a structured education programme within 9 months after entry onto the register; and
- who have had an influenza immunisation in preceding August – March.

3.5 QOF data is extracted from practices systems on an annual basis and may be used by other organisations to measure standards of care and prevalence. It should be noted that in 2013/14, NHS England East Anglia Area Team made a local offer to practices regarding payment of QOF and therefore data extracted for that financial year may not be reliable.

3.6 The CCGs are responsible for commissioning support services such as podiatory and diabetic nurse clinics.

Diabetic eye screening commissioning and delivery across Norfolk

3.7 NHS England with the expertise of Public Health England (PHE) commission the annual diabetic eye screening programme (DESP). The aim of the programme is to identify changes at the back of the eye (Retinopathy) from Diabetes, which is a leading cause of blindness in the adult population.

3.8 People above the age of 12 years with Diabetes will be invited for an annual eye screen to check for Retinopathy. If any changes are identified they are referred either into Surveillance clinics for more frequent monitoring or hospital eye services for early treatment.

3.9 The programme is delivered by two providers:-

- Norfolk and Norwich DESP which is provided by the Norfolk and Norwich University Hospital Trust (NNUHT) ophthalmology team. This is a stable service which has been delivering screening since the inception of the screening programme in 2005. It serves the population of north and south Norfolk and Norwich, a total of around 500,000 population.

- The East Anglia DESP is provided by Health Intelligence Ltd, a provider of 4 years' experience, which after procurement, took on the staff from the Suffolk PCT community provider which previously delivered the programme. It serves the population of West Norfolk, Great Yarmouth and Waveney, Cambridgeshire fenlands, Suffolk, Mid and North Essex.

<u>Identifying the eligible population</u>

3.10 NNUHT rely on the GP practices referring people into the screening service. There are national standards for referral timescales – people must be screened within 3 months of diagnosis of diabetes. The programme monitors these referrals and advises the PHE team if there appears to have been a delayed referral. The PHE team will then investigate this directly with the GP practice to assure all parties that the referral pathway is robust. The team deliver to a number of community and GP practice sites within an on-going rota every year. Prior to the expected date of screening, the team send notice of those people within their register and ask each practice to review and inform them of any changes. (This is a similar approach undertaken by the cervical cancer screening programme). At least once a year, the practices are asked to carry out a QOF report which identifies all patients with diabetes aged 17 years and over. The numbers and names are then cross matched with the screening register. The programme screens those aged 12 years and above and as such the diabetes register should always be larger than the QOF report.

3.11 Nationally a system linking screening programmes with GP systems called GP2DRS is in the throes of being rolled out. This link will automatically identify all people with a diabetes code, enabling a more efficient and accurate identification process to ensure no person is missed. There continue to be some hold-ups nationally and so in the meantime, the usual method is employed.

3.12 EADESP IT service links to all GP practices and some acute trusts to the screening programme. The GP practice retains overall control of the data sharing with the full bespoke service allowing all people with a diabetes READ code, conditions associated with diabetes and medications used in the control of diabetes to be identified. This system is run on a monthly basis and ensures that the practice staff review the data and include or remove all relevant people. The efficiency of this service has found several patients with diabetes who were unknown to the screening programme. Commissioners therefore can be assured that the likelihood of any eligible person being missed from the screening register is remote. To satisfy a number of practices which had data sharing concerns, a lesser data sharing agreement was developed identifying people with a diabetes code but no other associated code. Although not as thorough as the full agreement, it nonetheless ensures that once the practice have diagnosed the person and coded them correctly they will be identified and offering a screen within weeks.

Table below shows the uptake of screening within the two DES programmes covering Norfolk for 2013/14

DES1-uptake	2012-13	2013-14	2013-14	2013-14	2013-14
	Q4 12/13	Q1 13/14	Q2 13/14	Q3 13/14	Q4 13/14
EADESP	87.40%	88.90%	89.26%	89.1%	88.91%
Norfolk and Norwich	93.30%	90.20%	87.50%	88.55%	89.10%

3.13 The performance and quality of programmes are monitored by NHS England Public Health and in addition there is a Quality assurance visit to the programmes every 3 years undertaken by the PHE screening QA service.

NHS Health Checks

3.14 Cardio vascular disease (CVD) is the biggest cause of preventable deaths and health inequalities in the UK. The NHS Health Check is a national risk assessment and prevention programme that identifies people at risk of developing heart disease, stroke, diabetes,

kidney disease and vascular dementia and helps them take action to avoid, reduce or manage their risk of developing these health problems. The health check is for people aged 40 – 74 without existing CVD, takes 20 – 30 minutes and people are assessed every five years.

3.15 Since April 2013 Norfolk County Council was mandated to provide the NHS Health Check programme for its residents. It is commissioned by Public Health and forms part of a wider strategy to reduce premature mortality and improve the health of the adult population.

3.16 In order to provide accessibility and patient choice in a large rural county, the service is delivered by a range of providers. Currently 95 GP's and 55 Pharmacies provide the service. Almost 80% of NHS Health Checks are delivered in GP practice and 20% delivered in the community by Pharmacy (both "on site" and "off site" at community events and in workplaces). The service is also delivered by the occupational health services of two large employers and in three Norfolk prisons.

Performance

3.17 In 2013 – 2014 a total of 24,625 people in Norfolk had an NHS Health Check, see table 1 (this is 65% of delivery target). There were 49,860 eligible people who were offered an NHS Health Check (this is 85% of the offer target).

Table 1: Location and Number of NHS Health Checks delivered across Norfolk 2013 - 2014

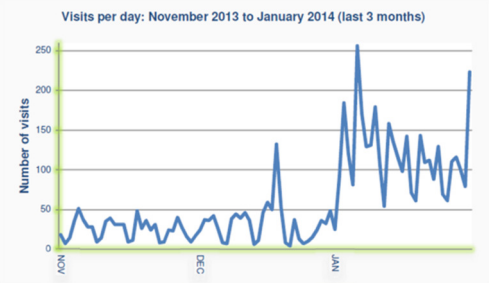
Location	Number	%
GP's	19,658	80%
Pharmacy	3,919	16%
Workplace & prison	1048	4%
Total	24,625	100%

In Norfolk since 2009 a total 114,540 people have had an NHS Health Check.

Precious Moments campaign

3.18 In order to increase uptake of NHS Health Checks and raise awareness in the community, the Precious moments" campaign was launched in January 2014. The key message was to look after your health, by having an NHS Health Check so you 'Don't miss out on life's precious moments', such as: a new baby, graduation, wedding, hobbies or holiday of a lifetime.

3.19 The campaign involved press, radio and promotional print material in health and community settings such as GP's pharmacy, libraries, petrol stations and on buses in rural and urban areas. The campaign saw a rise in enquires to the customer service centre and traffic to the Health Check page on the Norfolk's Living Well website. This translated to an increase in uptake of NHS Health Checks on the previous quarter.



Peaks and troughs reflect midweek (high) and weekend (lower) visitor numbers.

Plans for 2015 - 2016

3.20 In 2015 – 2016 the programme will:

- extend pharmacy provision to the Great Yarmouth area
- pilot an Outreach Service for people least likely to access mainstream services such as gypsies and travellers, homeless people and BME groups.
- establish an effective call / recall facility
- audit the service
- achieve 70% of delivery target (40,656) and deliver a total of 28,459 NHS Health Checks in Norfolk.

For more information about NHS Health Checks visit:
www.norfolkslivingwell.org.uk/nhshealthchecks

13 February 2015

Authors:

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Eastern National Diabetes Audit 2012-13 Data Summary

Percentage of all patients in Eastern receiving the care processes and treatment targets broken down by Clinical Commissioning Group area

CCG description	Registrations*	Eight care processes	Eight care processes Rank	Meet all six treatment targets	Meet all six treatment targets Rank
Basildon and Brentwood CCG	11,977	51.8%	15	41.9%	1
Bedfordshire CCG	17,368	45.9%	17	30.8%	17
Cambridgeshire and Peterborough CCG	28,696	54.9%	11	30.2%	18
Castle Point and Rochford CCG	9,369	59.7%	8	40.5%	2
East and North Hertfordshire CCG	12,201	42.4%	18	36.8%	6
Great Yarmouth and Waveney CCG	2,441	51.9%	14	33.8%	13
Herts Valleys CCG	10,496	63.2%	5	35.8%	9
Ipswich and East Suffolk CCG	15,110	47.3%	16	39.6%	4
Luton CCG	11,070	60.4%	7	33.4%	15
Mid Essex CCG	16,956	N/A	N/A	34.8%	10
North East Essex CCG	8,205	67.2%	1	34.1%	12
North Norfolk CCG	7,114	63.9%	4	35.9%	7
Norwich CCG	5,920	65.5%	2	31.6%	16

Eight care processes

HbA1c

Blood pressure

Cholesterol

Serum creatinine

Urine albumin

Foot surveillance

BMI

Smoking

Six treatment targets

HbA1C<48mmol/mol

HbA1C<58mmol/mol

HbA1C<86mmol/mol

Blood pressure<=140/80

Cholesterol<4mmol/L

Cholesterol<5mmol/L

Key:

Top 20%	Bottom 20%	* Registrations – figures may not include all registered patients in the CCG area if not all GP practices took part in the audit

CCG description	Registrations	Eight care processes	Eight care processes Rank	Meet all treatment targets	Meet all treatment targets Rank
South Norfolk CCG	7,924	64.6%	3	34.1%	11
Southend CCG	5,736	53.4%	13	39.7%	3
Thurrock CCG	5,976	55.2%	10	38.7%	5
West Essex CCG	10,006	54.0%	12	35.8%	8
West Norfolk CCG	5,942	55.6%	9	33.5%	14
West Suffolk CCG	7,013	60.7%	6	28.5%	19
England	**1,858,974**	**59.5%**		**36.0%**	

Overall ranking	CCG	Sum of rankings above	Overall ranking	CCG	Sum of rankings above
1	North Norfolk CCG	77	11	Norwich CCG	165
2	South Norfolk CCG	95	12	Thurrock CCG	169
3	Castle Point and Rochford CCG	105	13	Southend CCG	179
4	Ipswich and East Suffolk CCG	113	14	East and North Hertfordshire CCG	183
5	North East Essex CCG	113	15	Herts Valleys CCG	184
6	Basildon and Brentwood CCG	143	16	Cambridgeshire and Peterborough CCG	200
7	West Norfolk CCG	144	17	Bedfordshire CCG	201
8	Mid Essex CCG*	150	18	West Essex CCG	216
9	Luton CCG	157	19	Great Yarmouth and Waveney CCG	226
10	West Suffolk CCG	163			

Eastern Health Checks

Local Authority	Total eligible population 2013-2014	Appointments offered 2013-2014	Appointments offered 2013-2014 (percentage)	Appointments received* 2013-2014	Appointments received 2013-2014 (percentage)	Percentage of people that received an NHS Health Check of those offered 2013-2014
Bedford	45,492	8,403	18.5%	5,776	12.7%	68.7%
Hertfordshire	323,994	41,518	12.8%	27,096	8.4%	65.3%
Southend-on-Sea	50,583	9,180	18.1%	5,372	10.6%	58.5%
Thurrock	43,233	10,298	23.8%	5,938	13.7%	57.7%
Luton	45,536	13,059	28.7%	7,415	16.3%	56.8%
Suffolk	226,886	42,575	18.8%	22,857	10.1%	53.7%
Essex	431,699	92,696	21.5%	49,529	11.5%	53.4%
Norfolk	271,125	50,429	18.6%	24,693	9.1%	49.0%
Peterborough	48,250	13,216	27.4%	6,042	12.5%	45.7%
Central Bedfordshire	79,584	21,058	26.5%	9,608	12.1%	45.6%
Cambridgeshire	181,850	44,913	24.7%	18,256	10.0%	40.6%
National	**15,308,022**	**2,824,726**	**18.5%**	**1,382,864**	**9.0%**	**49.0%**

*Appointments received = the person attended for the Health Check

Ambulance response times and turnaround times in Norfolk

Suggested approach from Maureen Orr, Scrutiny Support Manager

A report on the trends in ambulance response and turnaround times in Norfolk and action underway to improve performance.

1. Background

1.1 Norfolk Health Overview and Scrutiny Committee (NHOSC) previously received reports on ambulance turnaround times at the Norfolk and Norwich (N&N) hospital on 12 July 2012, 7 March 2013, 28 November 2013 and 7 April 2014. The committee chose to focus on turnaround delays at the N&N during this time because they appeared to be a very significant contributor to the ambulance service's overall performance problems in Norfolk.

1.2 From 7 March 2013 onwards the committee also received updates on Project Domino, which aimed to address all aspects of the unplanned care pathway in central Norfolk that impacted on ambulance service performance and involved three CCGs (Norwich, North Norfolk and South Norfolk), the N&N, the East of England Ambulance Service NHS Trust (EEAST), Norfolk Community Health and Care, Norfolk and Suffolk NHS Foundation Trust and Norfolk County Council (adult social care).

1.3 In April 2014 the committee was reassured to see a sustained improvement in ambulance turnaround times at the N&N and welcomed the continuation of Project Domino phase 2.

1.4 In November 2014 NHOSC agreed to return to the subject of ambulance services in 2015 because it was aware that response times in Norfolk were still well below standard in some areas. NHOSC agreed to widen its focus to look at ambulance turnaround performance at the Queen Elizabeth (QEH) and James Paget (JP) hospitals as well as the N&N and to also look at ambulance response times across the county.

1.5 The ambulance turnaround standards are:-

(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.**

1.6 The response time standards are:-

Red calls (2 categories)

Reaching 75% of Red 1 and Red 2 calls within 8 minutes

Providing a transportable resource for 95% of Red 1 and Red 2 calls within 19 minutes of request.

Red 1 – patient suffered cardiac arrest or stopped breathing - two resources should be despatched to these incidents where possible.

Red 2 – all other life threatening emergencies.

Green calls (four categories)

Reaching 75% of Green 1 calls in 20 minutes and 75% of Green 2 calls in 30 minutes.

Reaching 75% of Green 3 calls in 50 minutes OR a phone assessment from the clinical support desk[1] within 20 minutes

Reaching 75% of Green 4 calls in 90 minutes OR a phone assessment from the clinical support desk within 60 minutes.

Green – non life threatening emergencies

Both the Red categories are national requirements but the four Green categories are recommended standards.

1.7 NHOSC scrutinised stroke services in 2013-14. In relation to stroke the ambulance service standards are:-

Stroke 60 - The percentage of Face Arm Speech Test (FAST) positive stroke patients (assessed face to face) potentially eligible for stroke thrombolysis, who arrive at a hyperacute stroke centre within 60 minutes of a call. The compliance standard is 56%; i.e. EEAST strives to get 56% of eligible stroke patients to a hyperacute centre within 60 minutes from the time of the 999 call.

Stroke Care Bundle - 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%.

[1] A clinician calling back for a secondary telephone triage to establish the best pathway of care

1.8 It is worth noting that there were reports in the media in December 2014 about discussions in the Department of Health and NHS on changing Red 2 response time standards in England from 8 minutes to 19 minutes.

At local level there have been agreements for 'recovery targets' in some areas (notably the North Norfolk area). These recognise that current local performance is well below national standards and set interim targets that are challenging but considered achievable for the locality.

One of the recommendations of a Healthwatch Norfolk report published in October 2014 following a survey of ambulance service users was:-

'If commissioners of the service review existing emergency response times (and tolerances within the service specification) and propose changes, they should do so following a *full public consultation* so that the public has the opportunity to influence any decisions taken.'

2. Purpose of today's meeting

2.1 Poor ambulance response times are deemed to be the highest clinical risk to patients in North Norfolk and are a significant risk in some other areas. Under performance on the Stroke 60 target is also a major concern in some area (notably North Norfolk).

2.2 CCGs across the region were asked to invest an additional £14.9m in EEAST in 2014-15 to recruit and train 420 paramedics, replace vehicles and equipment and to fund voluntary redundancies (£3m). In return EEAST promised to improve performance. Some of the non-recurrent funding was linked to achieving the improvements.

2.3 EEAST has been invited to update NHOSC on performance trends to date in respect of response times, stroke 60 transport times and turnaround times at the three acute hospitals in Norfolk. EEAST's report is attached at Appendix A.

2.4 Although ambulance turnaround figures for all three acute hospitals are included in EEAST's report, the N&N have been invited to report attend today's meeting as the largest hospital in Norfolk and consequently the one where the most hours are lost in ambulance delays. The N&N have been asked to update the committee on the measures that they have put in place to improve turnaround performance. Their report is attached at Appendix B.

2.5 North Norfolk CCG has also been invited to today's meeting as the lead commissioners of the N&N. The Chief Officer of North Norfolk CCG also has a leading role for Norfolk in commissioning the ambulance service in conjunction with other commissioners in the region. The CCG has been asked to update the committee on the success of the measures included in Project Domino (in the central Norfolk area) together with other commissioning actions to encourage better ambulance response times and turnaround performance. The CCG's report is attached at Appendix C.

3. Suggested approach

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

3.2 **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 hospitals are actively and adequately addressing their part of the problem?

(b) Has EEAST been successful in recruiting and retaining the numbers of paramedics that it needs?

(c) The Red call standards are reported on a simple pass / fail basis that does not reflect the length of time that a 'failed' response actually took. EEAST has agreed with some of the local commissioners to eliminate the longest waits for responses to Red calls. While this would not necessarily improve the performance statistics it would improve responses for patients. Has there been progress in reducing the overall length of time that people have waited for response to Red call?

3.3 **Norfolk and Norwich University Hospitals NHS Foundation Trust**

(d) Are you satisfied that all the health and social care agencies whose co-operation is required to manage demand for acute care are actively and adequately addressing their part of the problem?

(e) Has the hospital been successful in attracting applicants for the 5 additional A&E consultants and the 6 A&E paramedics that it is seeking to recruit?

(f) Given all of the measures you have already taken, are there any other steps you can take to manage the flow of patients through the hospital?

3.4 **North Norfolk CCG (commissioner of the N&N and with a role in regional commissioning of EEAST)**

(g) Has the CCG continued to fund the Hospital Ambulance Liaison Officers at the N&N to reduce ambulance turnaround delays?

(h) Given the efforts that have already gone into Domino phase 1 and 2 in central Norfolk and other measures to manage demand for acute care across the rest of the county, were the commissioners surprised by the pressure on hospitals over the Christmas and New Year period? (The N&N declared an internal major incident and the QEH was on black alert).

(i) Are the commissioners enforcing financial penalties against EEAST in relation to ambulance response times and against EEAST and the acute hospitals in relation to turnaround delays at the hospitals?

(j) Demand for ambulances has been significantly above the activity levels commissioned by the CCGs in 2014-15. Will the CCGs take this into account when commissioning for 2015-16?

(k) Can the CCG update the committee on the findings of the recent Emergency Care Intensive Support Team (ECIST) review of the Norfolk system?

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East of England Ambulance Service NHS
NHS Trust

Since the 1st April 2013, ambulance turnaround standards were introduced to all Ambulance Trusts and Acute Trusts with an Emergency Department (ED) for Ambulance handover standards at the ED.

(a) 15 minutes - The time from ambulance arrival on the hospital site to the clinical handover of the patient (also known as 'trolley clear')

(b) 15 minutes - The time from clinical handover of the patient to the ambulance leaving the site (also known as 'ambulance clear')

The Norfolk and Norwich Hospital is the busiest ED in the region, and one of the busiest in the country. Ambulance arrivals at the hospital are circa 900 per week.

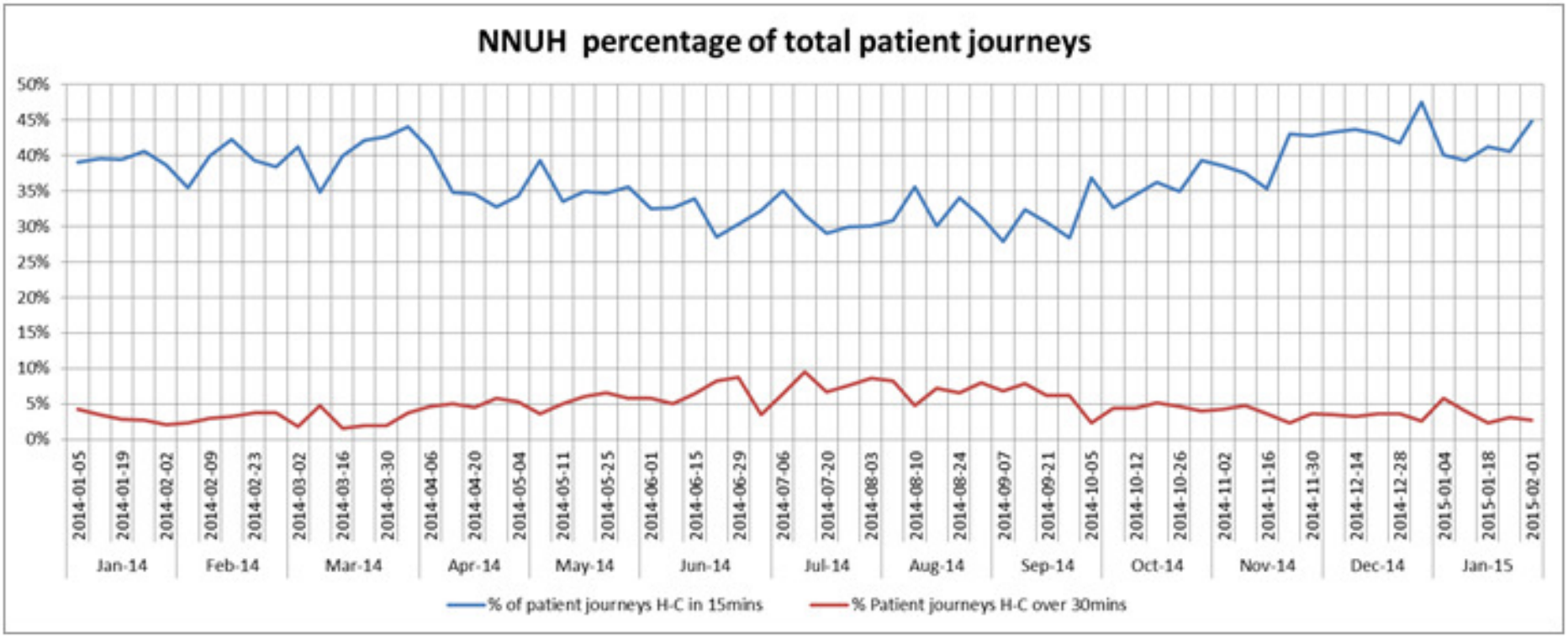
Breach times of 30 minutes and 60 minutes were also introduced alongside the standard in which trigger fines payable back to ambulance commissioners were included. Following the introduction of these standards, the previous process that was used regarding vehicles booking clear and or out of service was changed as it was felt the process at that time did not meet the requirement of the new contractual arrangements. In September 2013 new out of service codes were agreed with commissioners that could be applied to validate a reason why the ambulance was not available for the next emergency call. It is recognised by the Trust and our commissioners that there are certain exceptional circumstances and occasions where the 15 minute target (for being available for the next emergency call) is not possible. The agreed codes include:

- Vehicles off Road (VOR) – Breakdowns etc
- Replacement of essential equipment still in use by patient (Spinal Board etc)
- Extended vehicle cleaning/de-contamination
- Safeguarding/Vulnerable adult and child referrals
- Restocking essential equipment and drugs (Drugs are held in the ED)

- Cohorting of patients due to crews unable to handover and EEAST staff cohorting multiple patients to allow the return of some crews to be available
- Crews that will be off duty or into a meal break window.

Handover to Clear Performance (EEAST)

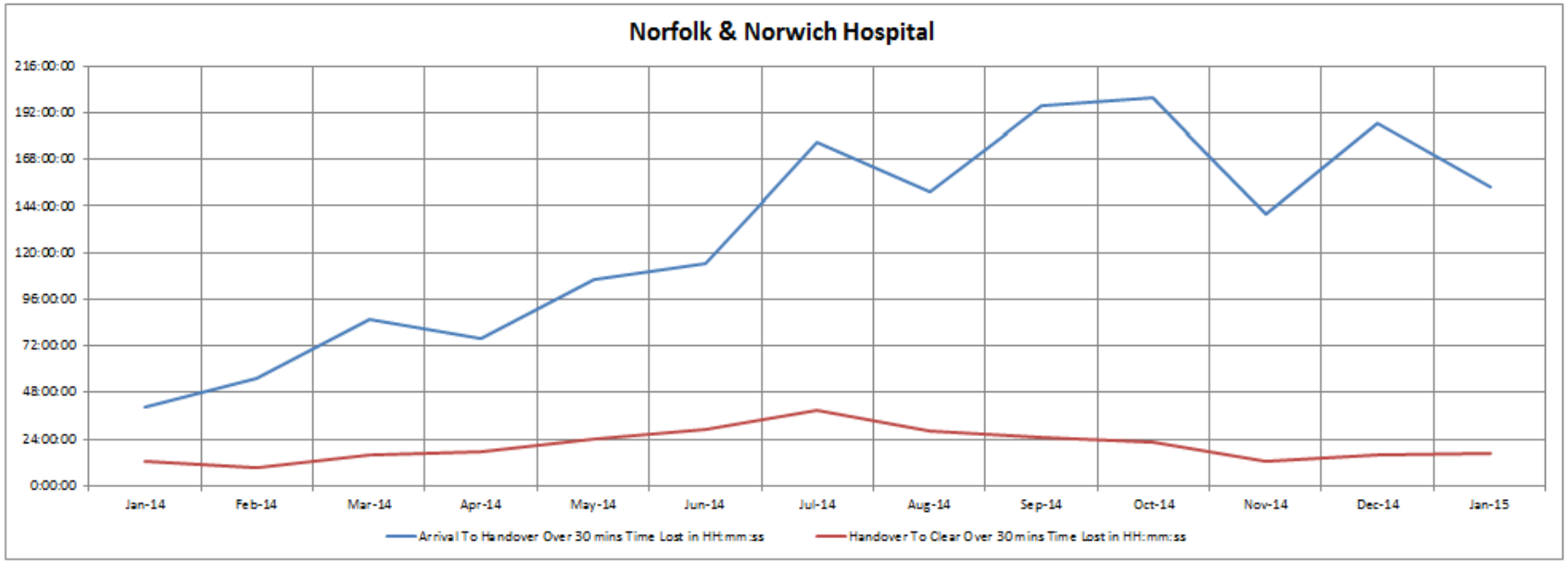
The handover to clear performance by EEAST crews at the Norfolk & Norwich University Hospital (NNUH) and the Queen Elizabeth Hospital (QE) continue to demonstrate stability. Improvements have been seen in the "Green in 15" time standard. The average performance for the green in 15 times is now consistently around 40%. This is when a crew have completed the handover of a patient and are available for the next emergency call or standby. On average less than 5% of crews are delayed over 30 mins from completing their patient handover. There are a number of options being considered where greater accuracy of the trolley clear submit button press (that ends the arrival to handover time and starts the handover to clear time) can be achieved. Any early button press to start the handover to clear time impacts negatively upon EEAST's handover to clear performance. We do have to reset the handover times when crews report the trolley clear button being pressed by ED staff. Handover has occurred when both a verbal and physical transfer of the patient has occurred only. The graph below represents the percentage of crews available in 15 minutes, and delays over 30 minutes at NNUH.

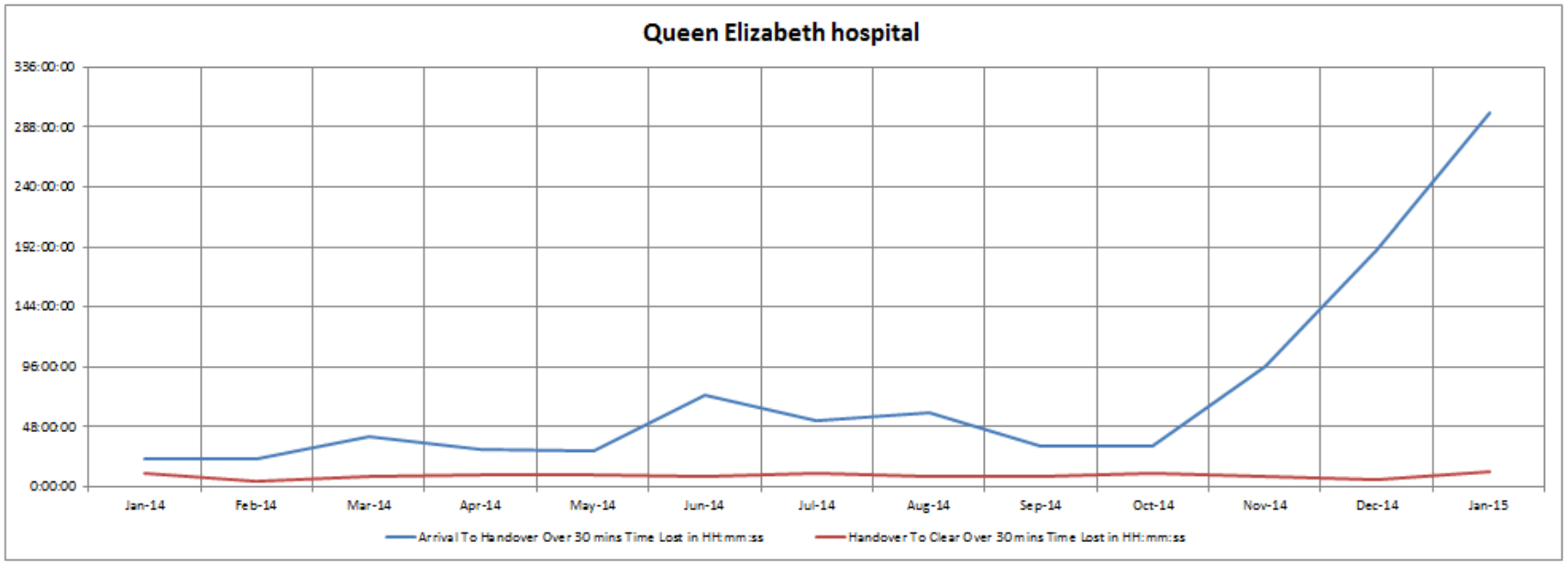


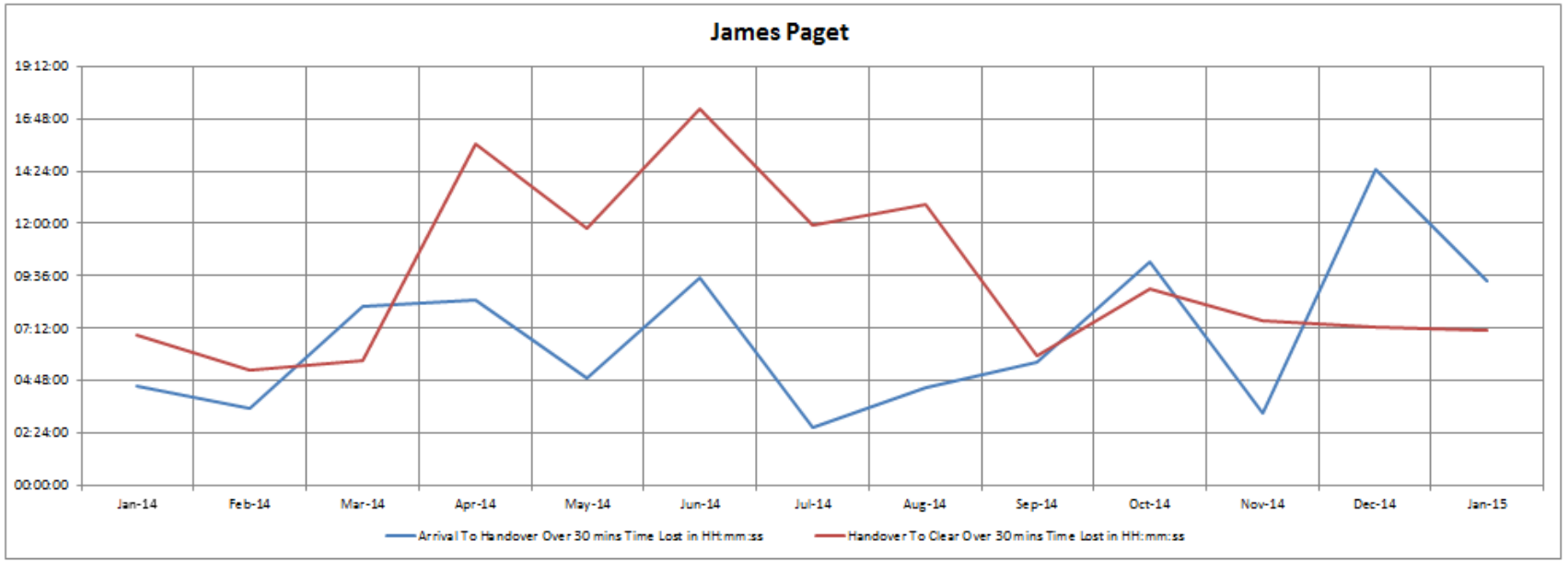
There are a number of reasons that still exist to which an Ambulance crew maybe delayed over 30 mins and are simply unavoidable. We do not have any codes to apply for welfare issues for example that arise for our crews. Instances such as highly emotive and traumatic calls are instances when a crew may be delayed receiving staff support or a debrief that an out of service code cannot be applied to.

Handover to Clear Performance V Arrival to Handover Performance

The charts below highlight both handover to clear and arrival to handover at the 3 main hospitals, in the last year. The recent increase in arrival to handover delays is evident.



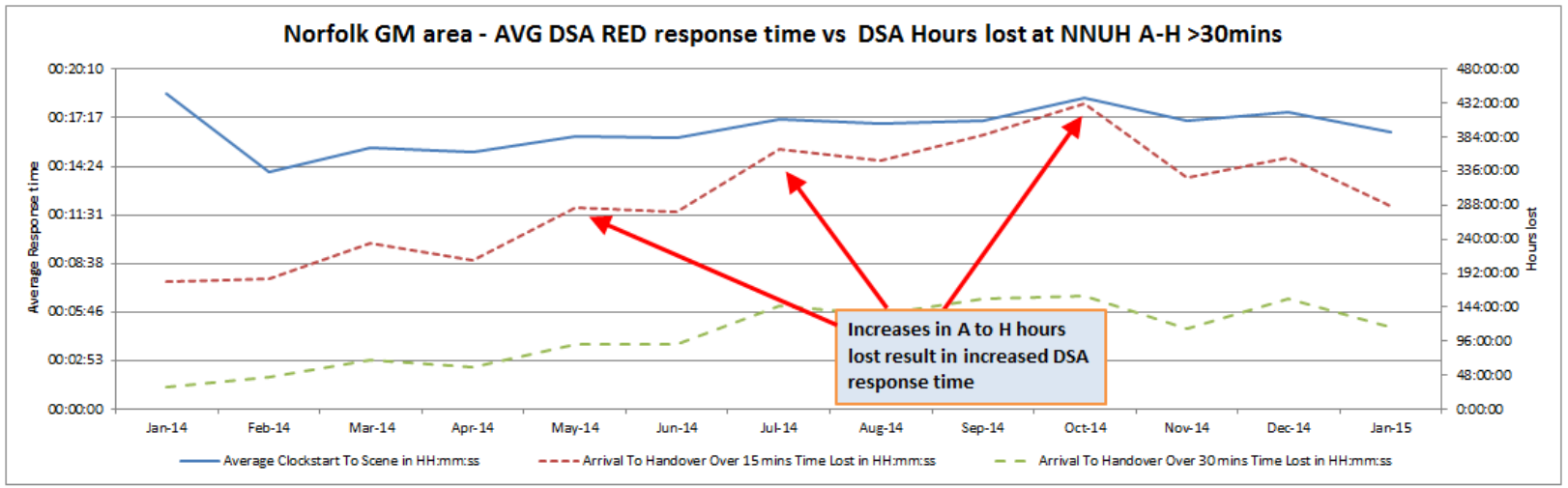

Queen Elizabeth hospital
336:00:00
288:00:00
240:00:00
192:00:00
144:00:00
96:00:00
48:00:00
0:00:00
Jan-14
Feb-14
Mar-14
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Jan-15
Arrival To Handover Over 30 mins Time Lost in HH:mm:ss
Handover To Clear Over 30 mins Time Lost in HH:mm:ss


James Paget
19:12:00
16:48:00
14:24:00
12:00:00
09:36:00
07:12:00
04:48:00
02:24:00
00:00:00
Jan-14
Feb-14
Mar-14
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Jan-15
Arrival To Handover Over 30 mins Time Lost in HH:mm:ss
Handover To Clear Over 30 mins Time Lost in HH:mm:ss

Hospital Ambulance liaison Officer (HALO)

EEAST introduced a team of staff known as Hospital Ambulance Liaison Officers (HALO) to support both EEAST and the NNUH in the turnaround of crews as quickly, efficiently and as safely as possible. Starting on the 1st October, 2013 the HALO's have been instrumental in supporting both crews and the NNUH with ambulance turnaround, in particular handover to clear times. EEAST were successful in securing winter funding to extend the HALOs presence at all our acutes, and in particular increase the availability at NNUH, such that they are now 24/7 for the remainder of the winter period. The NNUH are entirely supportive of the HALO role, and we both recognise that they are funded by winter funding monies only. We have worked in close conjunction with the NNUH ED team and senior trust management to ensure the role develops and becomes an integrated role for both organisations. The HALO has worked with the ED staff to highlight peaks in demand and aids capacity planning and awareness. The HALO has been a success and has supported both EEAST and NNUH.

The impact of hours lost at the N&N on EEAST's wider performance



There is a direct correlation between lost hours and handover performance at the ED. During peaks, the level of delays seen in Ambulance handover had an effect of losing valuable Ambulance resources and a negative impact on Ambulance response times in Norfolk. This chart demonstrates how handover delays at the NNUH from January 2014 to the end of January 2015 have had an effect on the average response times in Norfolk and that the peaks in delays that result in an increase in lost hours, can be mapped against the increase in average response times.

It is therefore vital that delays are kept to the absolute minimum. The dramatic improvements in the NNUH handover performance has been sustained since April 2013 and all providers work very closely in managing ambulance delays. EEAST participate at the weekly Capacity Planning Group meeting in central Norfolk and all delays are discussed and accounted for.

Norfolk Ambulance Response Times

Set out below are the performance figures for Norfolk set against the agreed trajectories by each CCG. The key theme is a generally improving performance picture against the agreed trajectories, this set against higher demand, worsening weather of the winter period and deteriorating handover times at the ED's .

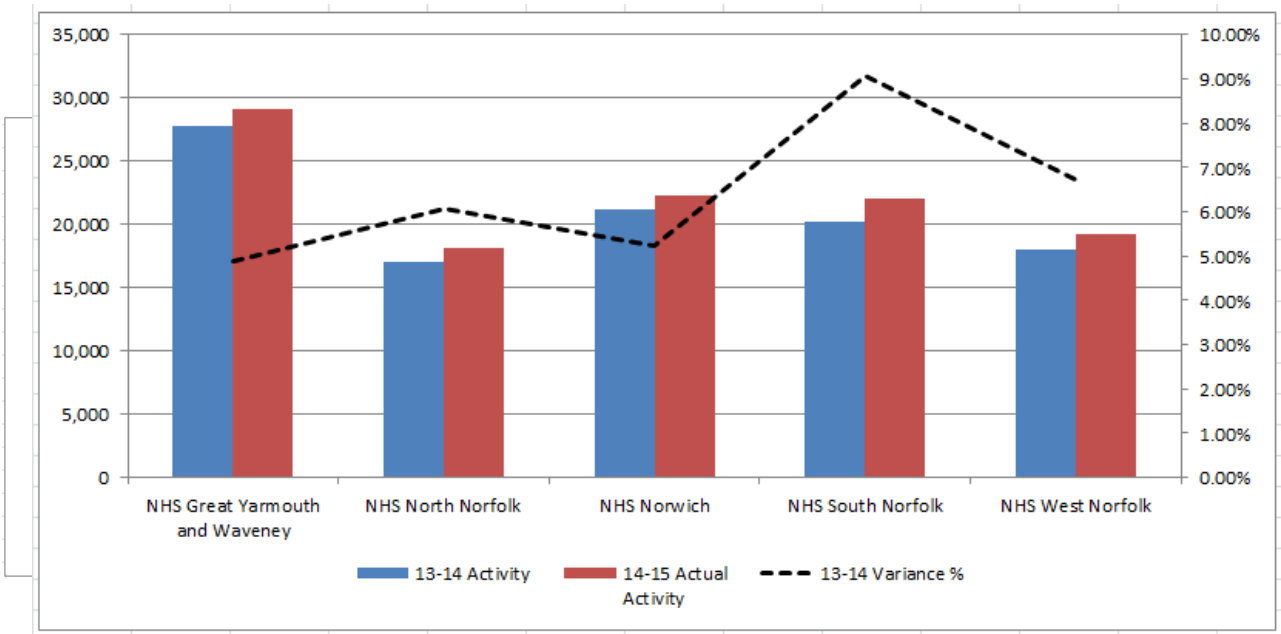
Category					Red 1 A8											
Target		Oct-13	Dec-13	Mar-14	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Norfolk	Trajecton	69.6%	72.8%	71.8%	69.4%	68.8%	66.5%	66.4%	67.1%	71.3%	71.3%	70.3%	65.4%	69.2%	70.5%	79.6%
	Actual				69.4%	67.0%	65.5%	62.2%	61.6%	63.2%	65.0%	68.9%	72.2%	72.9%		
	RAG				0.0%	-1.8%	-1.1%	-4.2%	-5.4%	-8.2%	-6.3%	-1.3%	6.8%	3.7%		
	Variance	/ Number						-9	-10	-17	-13	-3	17	9		
Category					Red 2 A8											
Target		Oct-13	Dec-13	Mar-14	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Norfolk	Trajecton	65.1%	65.7%	60.8%	58.2%	58.0%	55.6%	55.9%	56.0%	59.5%	70.4%	69.6%	65.2%	68.5%	70.1%	79.4%
	Actual				58.2%	57.0%	58.1%	55.3%	53.5%	56.9%	55.4%	60.3%	57.6%	62.2%		
	RAG				0.0%	-1.0%	2.5%	-0.6%	-2.5%	-2.6%	-15.0%	-9.3%	-7.6%	-6.3%		
	Variance	/ Number						-23	-98	-96	-599	-375	-332	-269		
Category					Red 19											
Target		Oct-13	Dec-13	Mar-14	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Norfolk	Trajecton	90.4%	89.7%	88.5%	88.3%	88.1%	86.5%	86.9%	87.0%	89.1%	87.6%	87.0%	84.7%	87.0%	88.0%	96.2%
	Actual				88.3%	86.9%	88.5%	84.9%	84.9%	87.1%	85.8%	89.0%	88.0%	90.9%		
	RAG				0.0%	-1.2%	2.0%	-2.0%	-2.1%	-1.9%	-1.8%	2.0%	3.2%	3.9%		
	Variance	/ Number						-85	-85	-75	-75	82	150	175		

Category					Green1 20											
Target		Oct-13	Dec-13	Mar-14	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Norfolk	Trajectory	80.3%	80.3%	84.1%	80.6%	79.5%	75.5%	76.6%	76.1%	80.9%	93.0%	92.6%	80.9%	88.0%	92.7%	99.0%
	Actual					72.1%	72.5%	69.4%	75.9%	81.9%	78.6%	85.9%	81.5%	84.4%		
	RAG					-7.4%	-3.0%	-7.3%	-0.2%	0.9%	-14.5%	-6.7%	0.6%	-3.5%		
	Variance / Number							-47	-1	4	-65	-25	2	-15		
Category					Green2 30											
Target		Oct-13	Dec-13	Mar-14	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Norfolk	Trajectory	87.6%	86.5%	88.4%	85.6%	84.9%	81.0%	82.5%	81.9%	85.9%	95.9%	95.2%	83.7%	90.6%	95.3%	99.9%
	Actual					83.5%	82.4%	79.2%	77.3%	80.3%	76.1%	84.6%	82.7%	85.1%		
	RAG					-1.5%	1.4%	-3.2%	-4.6%	-5.6%	-19.8%	-10.6%	-1.0%	-5.5%		
	Variance / Number							-102	-149	-170	-634	-332	-35	-178		
Category					Green3 50											
Target		Oct-13	Dec-13	Mar-14	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Norfolk	Trajectory	97.6%	98.6%	96.0%	96.9%	94.9%	90.7%	92.0%	91.3%	96.9%	94.9%	94.0%	79.9%	88.9%	94.8%	99.9%
	Actual					97.8%	95.3%	92.5%	91.5%	93.4%	93.3%	94.3%	89.7%	95.3%		
	RAG					2.8%	4.6%	0.5%	0.2%	-3.5%	-1.6%	0.2%	9.8%	6.4%		
	Variance / Number							1	1	-8	-4	0	21	14		
Category					Green 4 90											
Target		Oct-13	Dec-13	Mar-14	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Norfolk	Trajectory	94.2%	94.5%	97.4%	97.3%	96.0%	91.7%	92.6%	91.4%	97.6%	93.0%	91.3%	72.7%	82.4%	90.7%	99.9%
	Actual					92.3%	92.8%	89.9%	89.2%	88.1%	89.6%	90.2%	88.3%	90.0%		
	RAG					-3.8%	1.1%	-2.7%	-2.3%	-9.5%	-3.4%	-1.1%	15.6%	7.6%		
	Variance / Number							-17	-15	-58	-22	-8	113	54		

Norfolk Ambulance Activity

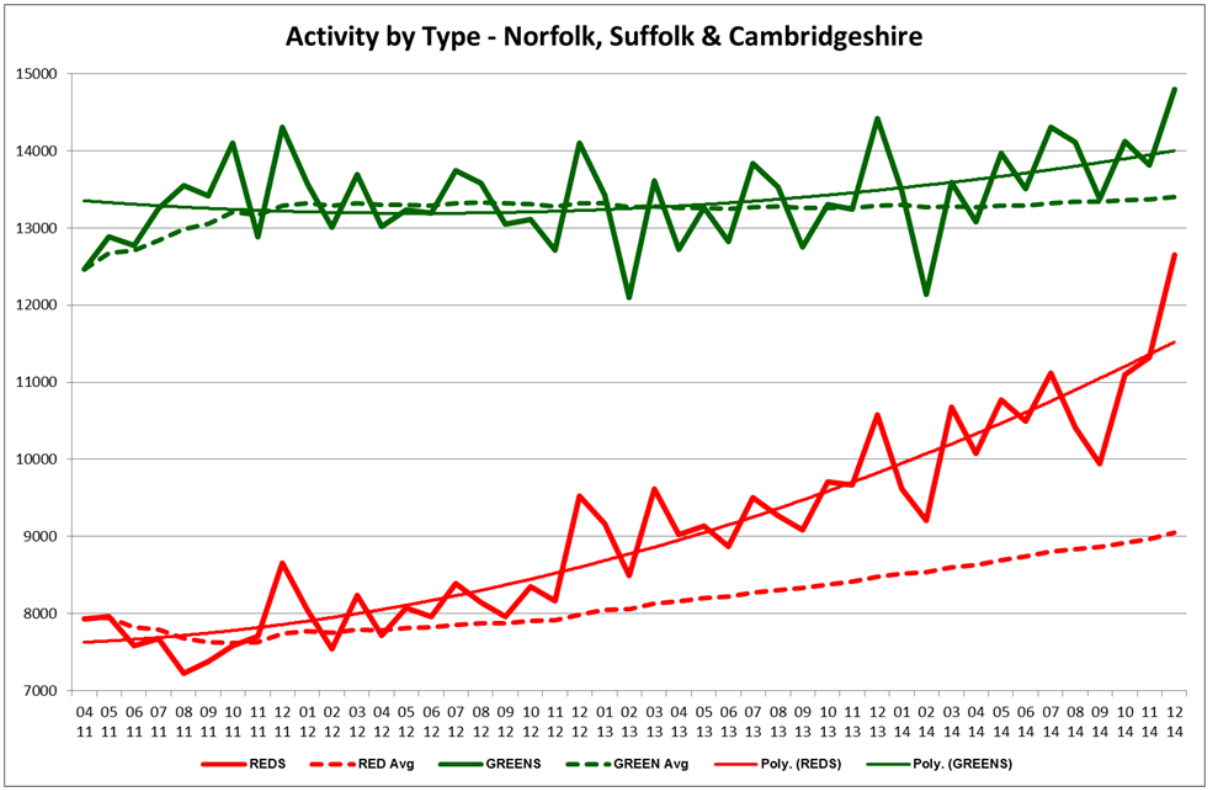
Ambulance activity is commissioned by each individual CCG. The current arrangement is that a consortium of CCG's collectively commission Ambulance activity in the East of England. Each CCG can purchase more or less activity. Discussions take place with commissioners to set activity levels in Q4 which in turn forms the commissioned levels of activity for the new financial year. This also allows for planning of the year ahead with activity levels forming the basis for planning resourcing levels.

	A&E ACTIVITY			
CCG	13-14 Activity	14-15 Actual Activity	13-14 Variance	13-14 Variance %
NHS Great Yarmouth and Waveney	27,823	29,178	1,355	4.87%
NHS North Norfolk	17,082	18,117	1,035	6.06%
NHS Norwich	21,171	22,279	1,108	5.23%
NHS South Norfolk	20,248	22,085	1,837	9.07%
NHS West Norfolk	18,067	19,286	1,219	6.75%
Norfolk Cluster Total	**104,391**	**110,945**	**6,554**	**6.28%**



The activity commissioned for this year was underestimated significantly. The increases by CCG are shown below.

Suffice to say that the increase of demand on EEAST has been significant, and these totals of actual incident increase are highlighted at the top. Cambridgeshire suffers from the highest over-activity from last year and has a pull on some Norfolk resources in an effort to cope. Equally, the graph below demonstrates how in this locality we are seeing generalised increases in acuity of the call, not just volume, such that green calls have remained largely static and that red call volume (8 min response time target) has significantly increased, which is where the bulk of the extra activity sits.



Norfolk's Resourcing

In Norfolk, resourcing focus remains on ambulances, as part of EEASTs key priorities, focusing especially on weekends and then nights before weekdays. Response Car cover continues to be challenged but with the emphasis on the core delivery of Ambulances there is a continued focus on their coverage, protecting the rural community, and key response cars supporting the urban areas. Current recruitment and training activity is on track and more of the students are now working on our ambulances (see below). This does add pressure to response car coverage, in that we require paramedics to mentor the large number of students.

Ambulance resourcing did increase across Norfolk in December and was consistently above budgeted hours, something we intend to hold throughout winter, directly as a result of SAP and direct entry recruitment. Response car hours are generally improved but continue to remain below budgeted levels whilst recruitment continues.

Health Care Referral Tier is now fully operational and is assisting us in using less Private Ambulances, and providing more resilience around our urgent workload delivery. Norfolk sees up to 8 vehicles per day.

Norfolk's Recruitment

Since April of last year we expect to place on courses 65 student paramedics in Central Norfolk, 30 in West Norfolk and 23 in the Great Yarmouth and Waveney area. In addition we have had 10 direct entry paramedics into Norfolk. Recruitment continues to be strong and we have reopened the Norwich Training Centre to support.

Norfolk's Stroke Care

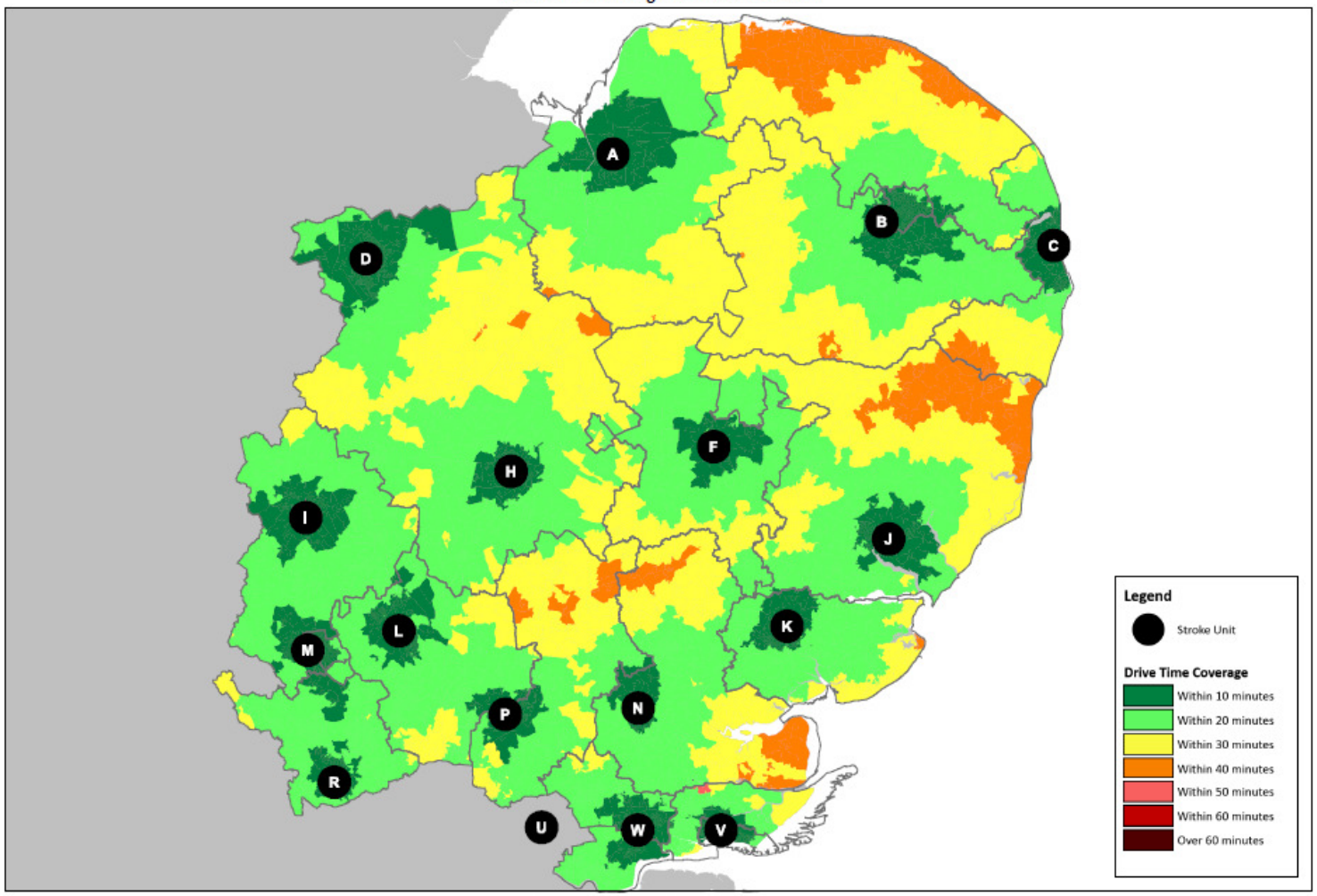
As can be seen from the table below, Norfolk averages approximately 50% stroke 60 (against a 56% target), but a much higher compliance in the care bundle itself, mostly in the 90's.

East of England Ambulance Service NHS Trust Operating Framework Indicators 2014/15 - Norfolk

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14
The percentage of Face Arm Speech Test (FAST) positive stroke patients (assessed face to face) potentially eligible for stroke thrombolysis, who arrive at a hyperacute stroke centre within 60 minutes of call.								
Performance (%)	49.4%	44.6%	57.9%	53.3%	46.9%	42.3%	67.4%	51.6%
# of successes (Numerator)	41	29	33	32	23	11	31	16
# of incidents (Denominator)	83	65	57	60	49	26	46	31
b) The percentage of suspected stroke patients (assessed face to face) who receive an appropriate care bundle. (As per National Ambulance CPI Care Bundle)								
Performance (%)	96.4%	96.3%	97.0%	99.4%	96.3%	95.8%	89.9%	96.3%
# of successes (Numerator)	133	104	161	167	130	92	98	104
# of incidents (Denominator)	138	108	166	168	135	96	109	108
Number of exceptions	0	4	20	8	10	4	5	11

The difference in our ability to deliver the care well, but not so on the transport time is well represented in the map below highlighting the travel times to the nearest stroke units. Vast areas of Norfolk have emergency drive times of in excess of 20 mins. The 60 minute target starts from the time the 999 call is received to arrival at a hyper-acute stroke unit. Given these drive times and the current stroke configuration the 60 minute target proves extremely challenging in a rural county.

East of England Ambulance Service NHS Trust
Drive Time Coverage to Stroke Facilities



Norfolk's Tail Breaches

The charts below refer to the longest waits patients experience for the 2 red call categories from latest data for December and cumulative from April of last year. Again, given the demand in December and the weather , actual numbers compare well to the cumulative, and reflect the reduction we have witnessed in our tail breaches. As an example of festive demand, activity across Norfolk, Suffolk and Cambridgeshire was around 14% over contract for the week ending 4th January. Every red call tail breach is reported on verbally at each of our locality meetings on a monthly basis.

Latest Month - December

CCG	Performance					
	Red 1 (8 Mins)			Red 2 (8 Mins)		
	Activity	Performance	Over 30 min	Activity	Performance	Over 40 min
NHS Great Yarmouth and Waveney	80	80.00%	-	1,235	67.21%	1
NHS North Norfolk	44	50.00%	-	771	42.80%	4
NHS Norwich	59	86.44%	-	1,077	75.86%	1
NHS South Norfolk	55	63.64%	1	1,029	43.25%	2
NHS West Norfolk	46	73.91%	1	924	55.30%	4

Cumulative - April 14 to December 14

CCG	Performance					
	Red 1 (8 Mins)			Red 2 (8 Mins)		
	Activity	Performance	Over 30 min	Activity	Performance	Over 40 min
NHS Great Yarmouth and Waveney	631	72.74%	-	10,410	65.37%	28
NHS North Norfolk	286	44.06%	1	6,589	40.23%	54
NHS Norwich	501	82.63%	-	8,578	74.41%	11
NHS South Norfolk	393	51.92%	5	8,107	43.78%	24
NHS West Norfolk	397	64.99%	1	6,980	54.13%	19

Ambulance response times and turnaround times in Norfolk - Update to NHOSC 26th February 2015

From: Chris Cobb – Director of Medicine & Emergency Care
The Norfolk and Norwich University Hospitals NHS Foundation Trust

For: Norfolk Health Overview and Scrutiny Committee 26th February 2015.

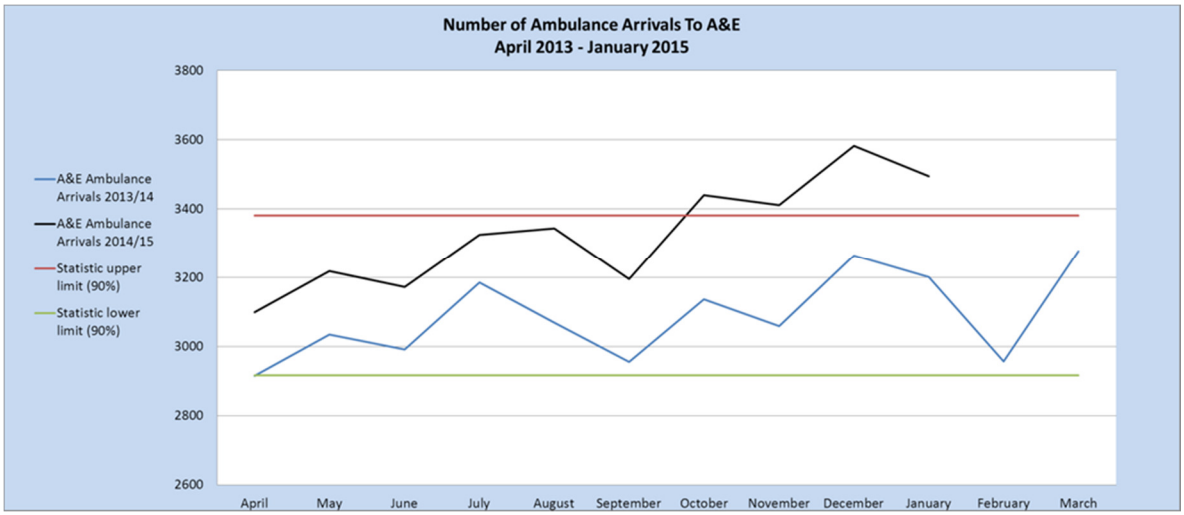
The NNUH have been asked to update the committee on the measures that have been put in place to improve turnaround performance

Background

When ambulance handover delays occur at the NNUH it is usually as a consequence of reduced flow throughout the Hospital and/or a significantly higher than expected demand on the emergency admission areas.

Throughout 2014/2015 there has been an unprecedented rise in the demand for A&E services. Ambulance arrivals at A&E have increased by 8% on the same period in 2013/14. The statistically predictable upper control level for ambulance arrivals at the NNUH has been exceeded each month since October 2014 which indicates that the activity has grown at an extraordinary rate.

Table 1. Ambulance arrivals at A&E April – December 2014



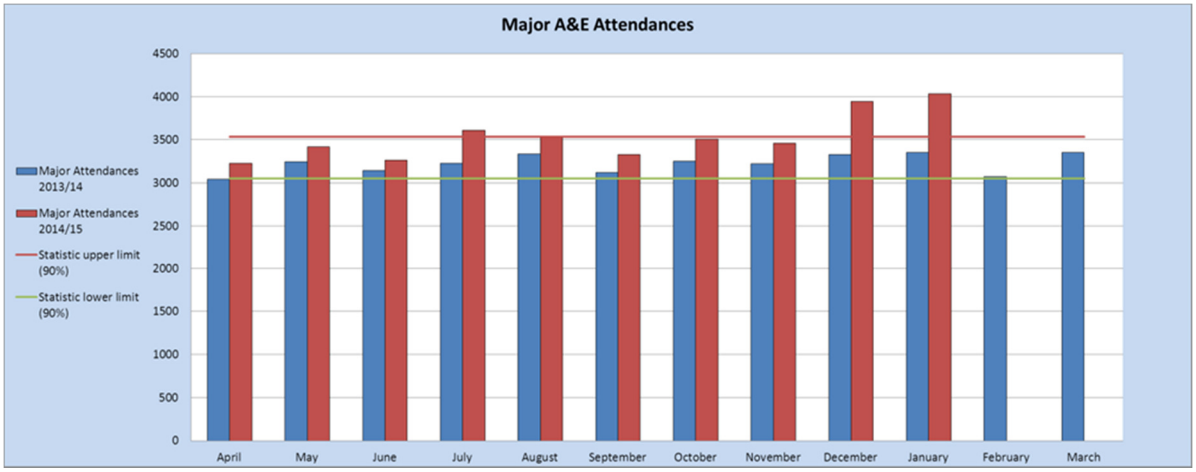
	Apr	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March	YTD
A&E Ambulance Arrivals 2013/14	2915	3035	2991	3185	3069	2955	3137	3059	3264	3201	2957	3278	30811
A&E Ambulance Arrivals 2014/15	3099	3218	3173	3325	3343	3195	3440	3411	3582	3494			33280
% Change	6.3%	6.0%	6.1%	4.4%	8.9%	8.1%	9.7%	11.5%	9.7%	9.2%			8.0%

The significant growth in ambulance arrivals has contributed to an increase in "Resuscitation" or "Majors" patient attendances at A&E. These patients are the most complex and as an average require the following amount of clinical time per patient in A&E:

Resus patients: 155 Minutes
Majors patients: 98 Minutes

The rise in Majors patient attendances since April 2014 has placed the A&E department and its staff under considerable and sustained pressure. In January 2015 the additional clinical time required to manage the increased number of majors patients was 36 hours per day. As a consequence of the time required to manage the volume of this cohort of patients appropriately there are periods where ambulance delays occur.

Table 2. Major A&E attendances April – December 2014



	Apr	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March	YTD
A&E Major attendees 2013/1	3045	3248	3142	3229	3334	3122	3250	3225	3328	3354	3071	3353	32277
A&E Major attendees 2014/1	3226	3422	3265	3608	3537	3331	3506	3462	3946	4036			35339
% Change	5.9%	5.4%	3.9%	11.7%	6.1%	6.7%	7.9%	7.3%	18.6%	20.3%			9.5%

Major Actions Implemented

To help improve ambulance handover times and to allow the Hospital to maintain flow a number of initiatives have been agreed including but not limited to the following:

1. **Urgent Care Centre** **Re-opened November 2014**
   Allows Minor patients to be filtered away from A&E

2. **Henderson Ward** **Opened December 2014**
   Creates 25 additional beds to facilitate flow out of A&E

3. **Mattishall Ward** **Opened December 2014**
   Creates 19 additional escalation beds to facilitate flow out of A&E

4. **14.25 additional Specialty doctors** **Agreed January 2015**
   Additional specialty consultant to support emergency activity and to promote earlier ward/board rounds

5. **ECIST plan** **Issued January 2015**
   Recommends a number of actions to improve flow and create capacity

6. **A&E 10 steps protocol** **Agreed December 2015**
   Internal protocol to generate appropriate actions within A&E and faster specialty response

7. **Uplift to band 7 of x ENP's** **December 2014**
   Promotion of Emergency Nurse Practitioners to enhance skill mix/decision making

8. **Recruit 5 Additional A&E consultants** **Advertised January 2015**

Additional decision makers to promote flow and manage volume

9. **Recruit 6 Paramedics for A&E** **Advertised January 2015**
   Assist with handover process and build on positive relationship with EEAST

10. **Joint Handover plan** **Implemented November 2015**
    a. Additional cubicles 16-19
    b. Increase nurses on shift to 23
    c. Additional paediatric cubicle
    d. Recruitment of additional decision makers

    Jointly agreed plan with EEAST and CCG to provide additional capacity within A&E

January 2015 was one of the most challenging in terms of volume and complexity of attendance at the NNUH. Despite this, using EEAST's unvalidated data, the NNUH performance against the <15 minute handover requirement compared favourably with other hospitals in our region. The NNUH completed more successful <15 minute handovers in January than those Trusts highlighted in yellow handled in total.

Table 3. East of England Region – Ambulance Handover <15 minutes

Hospital	Total Handovers	<15 Minutes	% <15
Bedford Hospital South Wing	1269	948	74.70%
James Paget Hospital	1670	1031	61.74%
Hinchingbrooke Hospital	788	460	58.38%
Norfolk & Norwich University Hospital	3478	1846	53.08%
Ipswich Hospital	2121	1112	52.43%
Southend University Hospital	2316	1141	49.27%
Peterborough City Hospital	1683	817	48.54%
Barnet General Hospital	346	165	47.69%
Luton And Dunstable Hospital	1912	889	46.50%
Addenbrookes Hospital	2146	996	46.41%
Queen Elizabeth Hospital	1441	641	44.48%
Basildon & Thurrock Hospital	1936	805	41.58%
Lister Hospital	2208	763	34.56%
West Suffolk Hospital	1327	419	31.57%
Broomfield Hospital	1609	485	30.14%
Watford General Hospital	1851	463	25.01%
Princess Alexandra Hospital	1628	347	21.31%
Colchester General Hospital	1838	283	15.40%
Total	**31567**	**13611**	**43.12%**

The Central Norfolk Health and Social Care system meet regularly to ensure a structured joined up approach to urgent & emergency care provision via project Domino. Additionally, the System Resilience Group (SRG) recently invited the Emergency Care Intensive Support Team (ECIST) to evaluate the whole system and provide recommendations for improvement.

The longer term plan for the NNUH is the relocation of the minors department into an ambulatory care centre and the expansion of the majors area to provide additional capacity. The work to relocate minors in underway and the majors expansion project will commence in 2015/16.

NHS
North Norfolk
Clinical Commissioning Group

SUBJECT	Project Domino Update - 26 February 2015
PRESENTED BY	Mark Burgis, Head of Clinical Pathway Design, North Norfolk CCG.
SUBMITTED TO	Norfolk Health Overview and Scrutiny Committee (NHOSC).
PURPOSE OF PAPER	To update NHOSC on the current position of Project Domino.

1. Background

Project Domino was initiated in October 2012 with the aim of improving all aspects of the urgent and emergency care system to try to meet current and future health and social care requirements covering the population areas of Norwich, South Norfolk and North Norfolk CCGs. The project has brought together all providers across the system including the Norfolk and Norwich University Hospital (NNUH), the East of England Ambulance Service (EEAST), Norfolk Community Health and Care (NCH&C), Norfolk and Suffolk NHS Foundation Trust (NSFT), Norfolk County Council (Adult Social Care) and the Voluntary/Independent Sector. Project Domino has sought to identify and solve the causes of delay in all aspects of the urgent and emergency care system from the moment a patient calls for help to when they are discharged from care.

It is clear that at a time of unparalleled pressure on our urgent and emergency care system, successful delivery of the ongoing initiatives which make up Project Domino is key to ensuring that the system is able to maintain a safe and effective service for patients.

2. Current position

Project Domino has highlighted that it is imperative that all parts of the system are working effectively together to be able to deliver the best care for patients. One of the key successes has been the way that all providers have come together to tackle the challenges faced, and to co-develop the projects and initiatives implemented.

Since the last report of progress to NHOSC in April 2014 there have been a number of changes that have impacted the work of Project Domino:

- *The former 'Urgent Care Network' (UCN) has been changed to the 'System Resilience Group' (SRG):*
  This group now has an additional responsibility to consider Referral to Treatment (RTT) performance, seeking a balanced health and social care system of planned and unplanned care. Given the pressures on the system at present the membership of this group was revised to Chief Officer / Chief Executive level and the group now meets weekly rather than monthly (as of the beginning of February 2015)
- *Additional 'System Resilience' Funding was made available:* During June 2014, NHS England made additional funding available to help support Urgent Care Systems, particularly over the winter period. The total operational resilience funding allocated to the three CCG's was as follows:

NHS Norwich CCG	£1,175K
NHS North Norfolk CCG	£1,152K
NHS South Norfolk CCG	£1,311K
Total for Central Norfolk	**£3,638K**

The SRG was responsible for agreeing the projects that utilised this additional funding and progress against plan is monitored and evaluated by Project Domino as the 'operational arm' of the SRG.

- *Emergency Care Intensive Support Team (ECIST) review:* During December 2014 a team of Clinicians and Managers from the national ECIST team spent one week reviewing the Central Norfolk system and have made a number of recommendations for improvement. While informal feedback has been received we await the full and final report which is due imminently. System wide recommendations made will be implemented using the Domino Project architecture and the ECIST team will continue to work with the local team during the phased implementation.
- *Capacity Planning Group (CPG) meeting weekly:* A multidisciplinary team of operational managers and clinicians from all organisations now meets weekly at the NNUH to review and address any operational issues that require action. ECIST feedback was that this group was one of the most functional groups of its kind that they had witnessed and is seen as key to help deliver improved performance across the Central Norfolk System.
- A new governance structure to provide a holistic view of all urgent care projects within the Central Norfolk System has been agreed by the SRG. System Resilience Funding and Marginal Rate Credit projects now report to Domino.
- There are now three work streams, Demand, Flow and Discharge which are all attended by all providers. This has helped prevent 'silo' working and ensures each project has been agreed and bought into by all providers. Each project looks at the pathway from start to finish to help fully understand the consequences of any proposed change.
- Domino Programme will be underpinned by dashboards and data:-
    - Operational Dashboard – developing real time data to support our system to operate effectively.
    - Assurance Dashboard – developing appropriate outcome, patient satisfaction and trend data to help us evaluate our performance and plan.

Some of the initiatives delivered through Domino include:

Urgent Care Centre (UCC) at the NNUH

- SRG funding enabled the re-opening of the UCC in November 2014. The SRG has now made a longer term commitment to the UCC which has helped to manage minor illness and prevent emergency admissions into the acute hospital.

Expanding paramedic skills (CQUIN) that sat under Domino 1

- 40 paramedics trained in wound closure March 2014, this is now part of business as usual

Troponin

- Patients receiving a 90 minute Troponin test instead of a 12 hour troponin test reducing length of stay for negative patients and reducing time to referral to specialty in positive patients

Community IV Services (2 year CQUIN)

- To continue provision of a safe and effective community IV service for 2 clinical pathways (Cellulitis and Osteomylitis) and to develop 2 further pathways

Hospital Ambulance Liaison Officers (HALO)

- Paramedic to support the health system to improve the arrival to clear process
- HALO role allows a direct link back to EEAST's HEOC to establish and resolve demand related issues
- Role operational 08.00 – 01.00 initially, this was increased to 24 hours in early February 2015

Some of the new / projects in scoping and coming on stream include:

GP Enhanced Clinical Triage Pilot

- The process involves ambulance staff (at scene) calling a GP to discuss the most appropriate point of care for patients who have called for an ambulance
- There will be follow up of every patient involved in the trial

Direction of Choice Protocol

- At point of admission the patient / family receives a letter outlining the transfer of care discharge process
- These have been in use for a period of time and therefore needed to be reviewed
- New letters and pathway designed to help provide patients with more clear information around transfer of care arrangements

GP Urgent booking system

- Currently scoping the process through demand work stream on how we can stagger GP urgent into AMU throughout the day plus potential to book GP arrivals into clinics

Virtual Ward

- Project is being rolled out in Norwich
- Supporting patients to be discharged to their own home from hospital

Enhanced Falls Service

- Pilot currently being run in North Norfolk
- NCH&C will provide a clinical triage service accessible to Ambulance Crews, GP's and all other clinical and care service
- Looking to obtain learnings to share across Central Norfolk

Discharge to Assess

- Front door planning for discharge

3. Next steps

Given the intense pressure that the Urgent Care System is currently under, Project Domino will continue to focus on rapid implementation of schemes to help tackle the problems the system is experiencing. In particular, Commissioners will continue to work with Providers to ensure that all ECIST recommendations are implemented swiftly. We will continue to evaluate the impact of Project Domino schemes to both assess their impact (positive or negative) and highlight areas where further work is required.

It should also be noted that the recruitment of the requisite workforce has been a significant issue in the roll out and implementation of nearly all Domino / SRG initiatives. In some cases this has limited the impact of schemes but the system continues to work with partners to help tackle this problem, including supporting the NHOSC Workforce Planning Group.

Forward work programme and appointment of substitute link members with local NHS Trusts and Clinical Commissioning Groups

Report by Maureen Orr, Democratic Support and Scrutiny Team Manager

The Committee is asked to:-

(a) Appoint a substitute link member with NHS Norwich Clinical Commissioning Group.
(b) Consider the current forward work programme and suggest issues for future scrutiny.

1. Substitute link members with local NHS Trusts

1.1 Norfolk Health Overview and Scrutiny Committee appoints link members to attend local NHS provider Trust Board and Governors meetings and Clinical Commissioning Group (CCG) Governing Body meetings. The nominated member or a nominated substitute member may attend in the capacity of NHOSC link member.

1.2 The role of the link member, or nominated substitute, is to attend the NHS body's meetings in public to observe and keep abreast of developments in the Trust or CCG's area and alert NHOSC to any issues that may require the committee's attention.

1.3 The link member holds no formal position with the NHS body whose meetings they attend but is present at the formal request of NHOSC. Any other member of NHOSC may attend NHS meetings in public in a personal capacity if they wish.

1.4 Nominated NHOSC formal link members are listed on the Forward Work Programme paper presented at each meeting (Appendix A).

1.5 On 15 January 2015 NHOSC nominated Members to serve as substitute link members with four NHS organisations where substitutes had not previously been nominated. There were other two organisations where substitute link members were not nominated:-

- NHS Norwich Clinical Commissioning Group
- Norfolk and Suffolk NHS Foundation Trust.

NHOSC agreed that the Democratic Support and Scrutiny Team Manager would email Members after the meeting to invite expressions of interest in serving as a substitute link member for either of these two organisations. Cllr Margaret Somerville expressed an interest in serving as substitute link member for NHS Norwich CCG.

2. Forward work programme

The current forward work programme is attached at Appendix A.

3. Action

3.1 NHOSC is asked to:-

(a) Confirm Cllr Margaret Somerville as substitute NHOSC link member for Norwich Clinical Commissioning Group.

(b) Consider the current forward work programme (Appendix A):-

- Whether there are topics to be added, deleted, postponed or brought forward
- To agree the briefings, scrutiny topic and dates.

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Appendix A

Norfolk Health Overview and Scrutiny Committee

Proposed Forward Work Programme 2015

Meeting dates	*Briefings/Main scrutiny topic/initial review of topics/follow-ups*	*Administrative business*
16 Apr 2015	Service given to patients with Mental Health issues in A&E following attempted suicide or self harm episodes Mental health services provided by Norfolk and Suffolk NHS Foundation Trust – an update report from the Trust to cover:- (a) An update on out of area placement and internal displacement of mental health patients (b) The effect of changes to mental health services on support for homeless people (c) The effect of the changes to mental health services on policing (d) Disparity in the services available to mental health patients in different localities (e) The numbers of adults in mental health residential care establishments in Norfolk compared to other parts of England. (f) The levels of caseloads for NSFT staff (g) Performance monitoring of the overall effects of the changes to mental health services Report also to include an update on actions to address the requirements of the Care Quality Commission inspection report published on 3 February 2015.	
28 May 2015	Changes to services arising from system wide review in West Norfolk – consultation with the committee. Changes to mental health services in west Norfolk – consultation with the committee regarding permanent changes following the trial period ending in March 2015. Consultation on long term plans to maintain and improve access to primary care services in Norwich and surrounding areas – potential consultation by NHS England EAAT in May or July 2015, depending on the outcome of a strategic review by Enable East (starting March 2015).	*Potential consultation in May or July 2015 depending on decisions by NHS England*
16 July 2015	NHS workforce planning in Norfolk - report of the scrutiny task & finish group.	

	Ambulance response times and turnaround times in hospitals in Norfolk	*Subject to agreement by NHOSC 26 Feb 2015*

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

Provisional dates for reports to the Committee / items in the Briefing 2015

April 2015 – in the Briefing – a report by Norfolk Stroke Network on action taken to address the CQC's comments about access to the stroke care pathway for incomers to Norfolk. (The comments were made in the CQC's report of the latest inspection of Norfolk Community Health and Care NHS Trust, published in December 2015).

Oct 2015 - Policing and Mental Health Services - an update from the Police & Crime Commissioner for Norfolk, Norfolk and Suffolk NHS Foundation Trust and Norfolk Constabulary (further to the presentation given to NHOSC in October 2014).

Nov 2015 – Stroke Services in Norfolk – update (12 months after the responses to stroke recommendations, presented to NHOSC 27 November 2014).

Jan 2016 – Integration of health and social care services, central and west Norfolk – a progress update (follow up on the report received 15 Jan 2015).

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

Clinical Commissioning Groups

North Norfolk	-	Mr J Bracey (substitute M Chenery of Horsbrugh)
South Norfolk	-	Dr N Legg (substitute Mr R Kybird)
Gt Yarmouth and Waveney	-	Mrs S Weymouth (substitute Mrs J Chamberlin)
West Norfolk	-	M Chenery of Horsbrugh (substitute Mr A Wright)
Norwich	-	Mr J Bracey

NHS Provider Trusts

Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust	-	Mr A Wright (substitute M Chenery of Horsbrugh)
Norfolk and Suffolk NHS Foundation Trust (mental health trust)	-	M Chenery of Horsbrugh
Norfolk and Norwich University Hospitals NHS Foundation Trust	-	Dr N Legg (substitute Mrs M Somerville)
James Paget University Hospitals NHS Foundation Trust	-	Mr C Aldred (substitute Mrs M Somerville)
Norfolk Community Health and Care NHS Trust	-	Mrs J Chamberlin (substitute Mrs M Somerville)

Norfolk Health Overview and Scrutiny Committee and
Great Yarmouth & Waveney Health Overview and Scrutiny Committee

Glossary of Terms and Abbreviations

ACE	Angiotensin-converting enzyme inhibitors – a group of medicines uses in the treatment of high blood pressure (hypertension) and heart failure. They are also used in some people with diabetes.
A&E	Accident and emergency
AMU	Acute medical unit
ARB	Angiotensin receptor blockers – a group of medicines used for some people with diabetes
BME	Black, minority ethnic
BMI	Body mass index
CCG	Clinical Commissioning Group
CPC	Capacity Planning Group
CQC	Care Quality Commission
CQUIN	Care Quality and Innovation (performance targets for which providers can receive additional funding)
CVD	Cardio vascular disease
DESP	Diabetic eye screening programme
DES	Diabetic eye screening
EAAT	East Anglia Area Team
EADESP	East Anglia Diabetic Eye Screening Programme
ED	Emergency Department
ECIST	Emergency Care Intensive Support Team
EEAST	East of England Ambulance Service NHS Trust
ENP	Emergency Nurse Practitioner
ES	Enhanced services
FAST	Face Arm Speech Time (to call 999) – test for diagnosis of stroke
GMS	General Medical Services
GP	General practitioner
GP2DRS	General Practice to Diabetic Retinopathy Screening (IT system)
GY&W JHSC	Great Yarmouth and Waveney Joint Health Scrutiny Committee
HALO	Hospital ambulance liaison officer
HbA1c	'Glycosylated haemoglobin' molecule. By measuring gylcated haemoglobin clinicians are able to get an overall picture of average blood sugar levels over a period of weeks / months. For people without diabetes the range is:- 20-41 mmol/mol (4 – 5.9%) For people with diabetes an HbA1c level of 48 mmol/mol (6.5%) is considered good control

	For people at greater risk of hypoglcemia (lower than normal blood sugar) a target of HbA1c of 59 mmol/mol (7.5%) reduces the risk of hypos
HEOC	Health Emergency Operations Centre
IFCC	International Federation of Clinical Chemistry
JPUH / JPH / JP	James Paget University Hospital
MMOL	Millimole (one thousandth of a mole)
MOL	Symbol for 'Mole'
MOLE	The amount of substance in a system which contains as many elementary entities as there are atoms in 0.012 kilogram of carbon 12
NCH&C	Norfolk Community Health and Care NHS Trust
NHOSC	Norfolk Health Overview and Scrutiny Committee
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NNUH (N&N, NNUHFT)	Norfolk and Norwich University Hospitals NHS Foundation Trust
NSFT	Norfolk and Suffolk NHS Foundation Trust (the mental health trust)
OSC	Overview and Scrutiny Committee
PHE	Public Health England
Q	Quarter
QA	Quality assurance
QEH / QE	Queen Elizabeth Hospital, King's Lynn
QOF	Quality and Outcomes Framework
RAG	Red, amber, green
READ code	Read codes are the standard clinical system used in General Practice in the United Kingdom. They support detailed clinical encoding of multiple patient phenomena including: occupation; social circumstances; ethnicity and religion; clinical signs, symptoms and observations; laboratory tests and results; diagnoses; diagnostic, therapeutic or surgical procedures performed; and a variety of administrative items (e.g. whether a screening recall has been sent and by what communication method, or whether an item of service fee has been claimed). The first version was developed in the early 1980s by Dr James Read, a Loughborough general medical practitioner.
Resus	Resuscitation
RTT	Referral to treatment
SAP	Student Ambulance Paramedic
SIGN	Scottish Intercollegiate Guidelines Network
SRG	System Resilience Group
Tail breach	A breach of the standard for providing a transportable resource (i.e. a vehicle capable of transporting a patient to

	hospital) to Red 1 and Red 2 calls within the standard response time (i.e. within 19 minutes of request)
UCC	Urgent Care Centre
UCN	Urgent care network
VOR	Vehicle off road