Norfolk County Council

Norfolk Health Overview and Scrutiny Committee

Date: **Thursday, 13 October 2016**

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.

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 R Bearman	Mr A Dearnley	Norfolk County Council
Mr M Carttiss	Mr N Dixon/ Mrs S Gurney/Mrs A Thomas/ Miss J Virgo	Norfolk County Council
Mrs J Chamberlin	Mr N Dixon/Mrs S Gurney/Mrs A Thomas/Miss J Virgo	Norfolk County Council
Michael Chenery of Horsbrugh	Mr N Dixon/ Mrs S Gurney/ Mrs A Thomas/Miss J Virgo	Norfolk County Council
Ms E Corlett	Ms S Whitaker	Norfolk County Council
Mr D Harrison	Mr B Hannah	Norfolk County Council
Mrs L Hempsall	Mrs E Emsell	Broadland District Council
Dr N Legg	Mr C Foulger	South Norfolk District Council
Dr K Maguire	Ms L Grahame	Norwich City Council
Mrs M Stone	Mr N Dixon/ Mrs S Gurney/ Mrs A Thomas/Miss J Virgo	Norfolk County Council
Mrs S Weymouth	Mrs M Fairhead	Great Yarmouth Borough Council
Mr P Wilkinson	Mr R Richmond	Norfolk County Council
Mr G Williams	*Vacancy*	North Norfolk District Council
Mrs S Young	Mr T Smith	King's Lynn and West Norfolk Borough Council

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

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A g e n d a

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

2. **NHOSC Minutes of 8 September 2016** **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

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

5. **Chairman's Announcements**

6. **10.10 - 10.55** **Stroke services in Norfolk** **Page 14**

Appendix A **(Page 16)** - Update from Norfolk and Waveney Stroke Network

10.55 - 11.05 Break at the Chairman's discretion

7.	**11.05 - 11.50**	**Ambulance response times and turnaround times in Norfolk** Appendix A **(Page 52)** - Report from the East of England Ambulance Service NHS Trust Appendix B **(Page 70)** - Report from Norfolk and Norwich University Hospitals NHS Foundation Trust	**Page 46**
8.	**11.50 - 12.00**	**Forward work programme** To consider and agree the forward work programme	**Page 75**
9.	**12.00-12.05**	**Letter to Norfolk and Suffolk NHS Foundation Trust regarding unexpected deaths**	**Page 78**
		Glossary of Terms and Abbreviations	**Page 83**

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Norfolk County Council

NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE
MINUTES OF THE MEETING HELD AT COUNTY HALL, NORWICH
On 8 September 2016

Present:

Mr R Bearman	Norfolk County Council
Mr M Carttiss (Chairman)	Norfolk County Council
Mrs J Chamberlin	Norfolk County Council
Michael Chenery of Horsbrugh	Norfolk County Council
Ms E Corlett	Norfolk County Council
Mr D Harrison	Norfolk County Council
Mrs L Hempsall	Broadland District Council
Dr N Legg	South Norfolk District Council
Dr K Maguire	Norwich City Council
Mrs M Stone	Norfolk County Council
Mrs S Weymouth	Great Yarmouth Borough Council
Mr P Wilkinson	Breckland District Council
Mrs S Young	King's Lynn and West Norfolk Borough Council

Substitute Member Present:

Mr P Gilmour for Mr C Aldred

Also Present:

Michael Scott	Chief Executive, Norfolk and Suffolk NHS Foundation Trust
Michael Lozano	Head of Patient Safety and Risk
Penny Jewkes	Representing the Campaign to Save Mental Health Services in Norfolk and Suffolk
Terry O'Shea	Representing the Campaign to Save Mental Health Services in Norfolk and Suffolk
Jonathan Stanley	Child and Adolescent Mental Health Services (CAMHS) Strategic Commissioner, Norfolk County Council and Clinical Commissioning Groups
Clive Rennie	Assistant Director of Commissioning Mental Health and Learning Disabilities,
Ricky Cooper	Head of Social Work, Children's Services Norfolk County Council
Trish Hagan	Head of Children, Young People and Maternity Services, Great Yarmouth & Waveney CCG
Sue Spooner	Healthwatch Norfolk

Jane Shuttler	Member of the public; a 'Patient Voice' at NCH&C's Board meeting in April 2016
Jenny Beesley	Member of the public
Dorothy Hosein	Chief Executive, Queen Elizabeth Hospital NHS Foundation Trust
Julia Hunt	Acting Director of Nursing, James Paget University Hospitals NHS Foundation Trust
Louise Sokalsky	Divisional Nursing Director for Medicine, NNUH
Julie Noble	Lead Nurse Specialist Palliative Care, NNUH
Sarah Downey	Clinical Lead for End of Life Care, James Paget University Hospitals NHS Foundation Trust
Emma McKay	Norfolk and Norwich University Hospitals NHS Foundation Trust
Susie Capon	Deputy Director of Adult Services (Planned Care), East Coast Community Healthcare
Katie Soden	Lead Consultant, Priscilla Bacon Lodge for Specialist Palliative Care Services, Norfolk Community Health and Care NHS Trust
Lorrayne Barrett	Director of Norfolk Adult Operations and Integration, Norfolk County Council Adult Social Care & Norfolk Community Health and Care NHS Trust
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 C Aldred and Mr G Williams.

2. Minutes

The minutes of the previous meeting held on 26 May 2016 were confirmed by the Committee and signed by the Chairman.

3. **Declarations of Interest**

3.1 Ms E Corlett declared an "other interest" as a Member of the Campaign to Save Mental Health Services in Norfolk and Suffolk.

3.2 Mrs S Young declared an "other interest" in that she was a member of the West Norfolk Older Persons Forum and the West Norfolk Patient Partnership.

4. **Urgent Business**

There were no items of urgent business.

5. Chairman's Announcements

5.1 **Tribute to the late Mr John Bracey**

Members of the Committee stood in silent tribute to the memory of the late Mr John Bracey who had died on 26 August 2016 at the age of 93. Mr Bracey had served as the Broadland District Council representative on the Committee from November 2005 to April 2015 during which time he had made a significant contribution to health scrutiny. The Chairman said that Mr Bracey's vast experience and wisdom were invaluable to him and other Members, particularly during the years when Mr Bracey was Vice Chairman of the Committee from 2009 to 2014. Mr Bracey was a much-liked and well-respected Councillor and would be sadly missed.

5.2 **Welcome to new Member of the Committee – Dr Kevin Maguire, replacing Ms Sandra Bogelein**

The Chairman welcomed Dr Kevin Maguire to his first meeting of the Committee as the representative from Norwich City Council. It was noted that Dr Maguire had replaced Ms Sandra Bogelein who had made a significant contribution to the work of the Committee. Ms Bogelein was the substitute link member with Norfolk and Suffolk NHS Foundation Trust. The Chairman said that the Committee would have an opportunity to nominate a new substitute link member during consideration of the Forward Work Programme item at the end of the meeting.

5.3 **Informal meeting with Mr Ian Newton, Department of Health, 2.00pm, Thursday 29 September 2016, County Hall**

The Chairman reminded the Committee that Mr Ian Newton from the Department of Health would be attending County Hall on Thursday 29 September 2016 to meet informally with Members on the issue of the development of a primary care education and training tariff. The new tariff had implications for the future medical workforce in the county and the meeting followed on from the Committee's work on NHS Workforce Planning in Norfolk. The Managing Director of Norfolk County Council would be in attendance and the Chairman of the Local Medical Committee hoped to attend, surgery pressures permitting. A representative from Norwich Medical School had also been invited. Those Members of the Committee who had not already confirmed their attendance and would like to attend were asked to contact Mrs M Orr.

6 **Norfolk and Suffolk NHS Foundation Trust – unexpected deaths**

6.1 The Committee received a suggested approach by Maureen Orr, Democratic Support and Scrutiny Team Manager, to a report from the Norfolk and Suffolk NHS Foundation Trust that provided an update on the outcome of the independent review of unexpected deaths (between April 2012 and December 2015) that the Norfolk and Suffolk NHS Foundation Trust had commissioned of Verita in February 2015. The report provided a response to the recommendations of the Verita review and to NHS England's governance audit in April 2016.

6.2 The Committee received evidence from Michael Scott, Chief Executive, Norfolk and Suffolk NHS Foundation Trust and Michael Lozano, Head of Patient Safety and Risk, Norfolk and Suffolk NHS Foundation Trust. The Committee also heard from Penny Jewkes and Terry O' Shea who represented the Campaign to Save Mental Health Services in Norfolk and Suffolk.

6.3 The following key points were noted:

- The Committee's attention was drawn to Appendix C to the Committee report (that contained an action plan for the implementation of the recommendations that arose from the independent Verita investigation) and to NHS England's governance audit that aimed to provide an assurance to trusts and commissioners that unexpected deaths of people with mental health problems, including older people and those with learning disabilities, would be appropriately investigated.
- The Committee was informed that the classification of incidents at the NSFT was a local decision, made in accordance with NHS England's Serious Incident (SI) Framework. However, no standardised process was used throughout England for the determination of unexpected deaths requiring serious investigation. This made for a lack of consistency between trusts in the investigation and reporting thresholds for unexpected deaths.
- The NSFT reported incidents at a rate that was substantially higher than the national average for health trusts and included drug and alcohol services in its reported figures whereas the majority of mental health trusts did not provide these services. Deaths due to drugs and alcohol misuse made up for approximately 30% of the suicidal and unexpected deaths that were reported by the NSFT. Also, the NSFT could be expected to record more deaths because it was one of the largest mental health trusts in the country.
- There had been no change in the way in which the NSFT reported on deaths since before 2012.
- The NSFT had four members of staff who were tasked with investigating cases of suicide and unexpected death.
- In comparing the numbers of suicides at the local authority level with the national average the Verita report had found that most Norfolk and Suffolk local authority areas remained at or below the national average.
- The NSFT crisis and wellbeing service kept contact with some 30,000 people, many of whom were self-referred.
- The underfunding of mental health services, when compared to other health services, was of serious concern to the NSFT and was an issue that had been taken up with the Government.
- In reply to questions, Mr Scott reaffirmed to the Committee that the NSFT had accepted all the recommendations that arose from the Verita investigation. Verita had kept in regular contact with the NSFT throughout the investigation. The NSFT had not, however, consulted with its front line staff/ staff representatives about the terms of reference for the review.
- Action had already been taken in respect of many of the recommendations, particularly where they related to the training requirements of front-line staff.
- The actions that were required of the NSFT were monitored by the NSFT Board of Directors.
- The NSFT Board was working with the County Council's Public Health department on a comprehensive suicide prevention strategy for Norfolk. The NSFT Board was due to be presented with its own new draft suicide preventive strategy at a NSFT Board meeting by the end of the year.
- The witnesses said that the reason why unexpected deaths (while reported to the NSFT Board) were not discussed in any detail at Board meetings was

because a “quality and safety committee” of the Board held regular meetings to review unexpected deaths in the county.

- Information about issues of public concern could be found on the NSFT website.
- The witnesses said that the Patient Safety Team at the NSFT was reviewing its process of involving bereaved families and carers with a view to developing a more engaged, communicative and face to face approach. The NSFT was also examining the innovative approaches that were being taken elsewhere in the country to see what lessons could be learnt for Norfolk.
- The NSFT was looking to put in place new and innovative patient discharge arrangements and to work more closely with voluntary organisations like the Samaritans.
- The NSFT was also looking to develop its working relationship with the Police, partly through its presence at the Wymondham Police Control Centre, and to build on its countywide “Time for Talk” campaign and on the outcomes of a recent event held at the Forum in Norwich aimed at vulnerable men (who made up for 80% of the recorded cases of suicide in the country).
- Penny Jewkes and Terry O’ Shea (representatives of the Campaign to Save Mental Health Services in Norfolk and Suffolk) spoke about the withdrawal of the homeless and outreach service, the continuing year on year rise in the number of unexpected deaths in Norfolk (this being the sixth year of a year on year rise in the number of Coroner Reports that have raised issues of concern), an apparent lack of public information about the number of cases of suicide and unexpected deaths in the county and the limitations of the Verita review.

6.4 **RESOLVED**

That the Committee write to the NSFT to request detailed information that was either not included or was not fully explored in Verita’s review of unexpected deaths and in the discussion at today’s meeting.

7 Children’s Mental Health Services in Norfolk

7.1 The Committee received a suggested approach by Maureen Orr, Democratic Support and Scrutiny Team Manager, to reports that addressed the areas of children’s mental health services that were identified for further scrutiny at the meeting on 26 February 2016, following reports that were presented to the Committee on 3 December 2015.

7.2 The Committee received evidence from Jonathan Stanley, Child and Adolescent Mental Health Services (CAMHS) Strategic Commissioner, Norfolk County Council and Clinical Commissioning Groups, Clive Rennie, Assistant Director of Commissioning Mental Health and Learning Disabilities, Ricky Cooper, Head of Social Work, Children’s Services Norfolk County Council and Trish Hagan, Head of Children, Young People and Maternity Services, Great Yarmouth & Waveney CCG.

7.3 The following key points were noted:

- The NHS England assured LTP contained 12 agreed recurrent developments for children’s mental health services in Norfolk that were set out in Appendix B to the report.

- At this very early stage of what was a 5 year Development Plan some service developments had begun to be implemented and others remained at varying stages of planning and implementation.
- The 5 Norfolk CCGs remained committed to the allocation of the £1.9m for children's mental health services in Norfolk that was identified in the LTP process for 2016/17 onwards. The Norfolk CCGs were, however, unable to commit to provide a notional £0.25m of additional "uplift" that they were expected to meet from core baseline funding. This had implications for the agreed service developments in the published LTP. This matter was due to be examined by the Health and Wellbeing Board.
- The £1.9m would be partly spent on providing for the needs of children with serious eating disorders. It would also help fund new crisis pathways for meeting the out-of-hours needs of children's mental health.
- In addition, the £1.9m would go some way to addressing the effects of earlier reductions in spending and allow for improvements in the staffing situation and in waiting times.
- With reference to paragraph 2.3 of the report (at page 66 of the agenda) Members noted the recent improvements that had taken place in the arrangements for health assessments, and in particular the health assessments for Looked After Children. The health assessments were being carried out by a wider range of medical professionals than was the case in the past. They were also being carried out closer to the home of the child. The improvement in health assessments had been recognised by the Corporate Parenting Board.
- Under the Sustainability Transformation Plan process health and social care were working jointly to identify how to best deliver the services for Looked After Children.

7.4 **RESOLVED**

That in April 2017 the Committee receive an update on Children's Mental Health Services in Norfolk, covering:-

- Development of the service and early outcomes achieved by the Local Transformation Plan (LTP);
- Waiting times;
- Performance against LTP Key Performance Indicators;
- Staffing situation;
- Situation regarding two areas of special interest:-
    - Self Harm
    - Looked After Children.

8 End of Life Care

8.1 The Committee received a suggested approach by Maureen Orr, Democratic Support and Scrutiny Team Manager, to reports from NHS acute and community care providers on their responses to National Institute for Health and Care Excellence (NICE) guidance on the care of dying adults published in December 2015 and to the Care Quality Commission's (CQC) 'A different ending' report published in May 2016.

8.2 The Committee also received a presentation from Sue Spooner of Healthwatch on the findings of its 'Thinking Ahead' research report into the barriers to advanced care planning for end of life that could be found at Appendix G to the report. The presentation and the questions and answers session that followed highlighted the importance of people planning for end of life and being able to talk about the issues and concerns that they might have.

8.3 At the end of the presentation, Jennifer Beesley and Jane Shuttler (Members of the public with an interest in end of life issues), spoke about the concerns that they had with the services that were available for end of life care.

8.4 Jennifer Beesley spoke about the importance of timely advice to patients on end of life issues and of patients being able to obtain access to the right services and care within the community. She said that the contribution that was made on end of life issues by the voluntary sector should not be undervalued. The lack of in-patient beds in the Great Yarmouth area (and in the west of the county) was a matter of public concern. Jennifer Beesley also stressed the importance of good communication with both the patient and those important to the patient.

8.5 Jane Shuttler spoke about the importance of having in place staff who were adequately prepared to meet patient preferences about end of life issues. This included having in place suitable arrangements for the fast track discharge of patients to their own homes in the last days of life. Jane Shuttler said that the NHS was often slow to respond as patients had to wait indefinite times for care packages and even for an acceptance to their fast track application. The Committee noted that the personal experiences of Jane Shutter were being used for staff training purposes on end of life issues.

8.6 The Committee then received evidence from Dorothy Hosein**,** Chief Executive, Queen Elizabeth Hospital NHS Foundation Trust, Sarah Downey, Clinical Lead for End of Life Care, James Paget University Hospitals NHS Foundation Trust, Emma McKay**,** Norfolk and Norwich University Hospitals NHS Foundation Trust, Susie Capon, Deputy Director of Adult Services (Planned Care), East Coast Community Healthcare, Katie Soden, Lead Consultant, Priscilla Bacon Lodge for Specialist Palliative Care Services, Norfolk Community Health and Care NHS Trust and Lorrayne Barrett, Director of Norfolk Adult Operations and Integration, Norfolk County Council Adult Social Care & Norfolk Community Health and Care NHS Trust

8.6 The following key points were noted:

- Members spoke about the requirement for the family to receive clear and timely information about the care of the patient.
- Members also spoke about the high quality of the work that was being done by specialist end of life nurses and by those working in the voluntary sector.
- The witnesses spoke about how the voluntary sector took a leading role in service delivery and in patient feedback.
- The witnesses also spoke about how they encouraged decision making in the person's last days of life and how they explained the dying persons' prognosis to the patient and family.
- Following up with family, in a sensitive way at an appropriate stage after a person's death, was acknowledged as an important way of helping families and helping to improve services.
- In addition the witnesses spoke about the importance of providing fully integrated services, adopting a person-centred approach to end of life issues,

of raising public awareness of planning for end of life issues and of assuring people that their wishes would be properly recorded and shared appropriately.

- It was pointed out that information had to be securely stored and shared in a way in which it could be clearly understood by a wide range of medical and care staff.
- Greater investment in training and education for all staff involved in end of life care was seen as crucial if the failings of how the Liverpool Care Pathway was implemented were to be avoided.

8.7 **RESOLVED**

1. That the Committee consider at a later date whether it wishes to return to the subject of end of life services.

2. That any further questions from Members about the subject of end of life issues should be sent to Maureen Orr for forwarding on to the appropriate NHS organisations to answer (and be reported back to Members in the Members Briefing Note).

9. Forward Work Programme

9.1 The Committee received a suggested approach by the report from Maureen Orr, Democratic Support and Scrutiny Team Manager, that set out a proposed forward work programme for the remainder of 2016.

9.2 **RESOLVED**

That the Committee:

1. Agree its forward work programme as set out in the report, subject to the subject of 'Community Pharmacy' being moved from 13 October 2016 to 12 January 2017 provisionally. It was noted that the proposals for community pharmacy were under review and NHS England Midlands and East (East) was unlikely to be in a position to discuss them with the Committee until after Christmas.

2. Note Members who had any other items which they wished to have considered for inclusion in the forward work programme should contact Maureen Orr, Democratic Support and Scrutiny Team Manager, in the first instance.

9.3 It was further **RESOLVED:**

That Margaret Stone be appointed as NHOSC's substitute link member with Norfolk and Suffolk NHS Foundation Trust.

Chairman

The meeting concluded at 13:30 pm

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Stroke Services in Norfolk

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

The Norfolk and Waveney Stroke Network will update the committee on progress with recommendations made by the committee in 2014 and following the Review of Stroke Rehabilitation in the Community, November 2015.

1. Background

1.1 On 17 July 2014 Norfolk Health Overview and Scrutiny Committee (NHOSC) approved a report by its Stroke Services in Norfolk Task and Finish group with 21 recommendations for organisations involved in local stroke care.

1.2 The Norfolk and Waveney Stroke Network (the Network) undertook to co-ordinate responses to NHOSC from each of the organisations concerned and presented a report in November 2014. The committee's recommendations were all accepted or partially accepted and the Network explained the action that had already been taken in respect of each of them.

1.3 Representatives from the Network from the Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH), the Strategic Clinical Network (East of England) and James Paget University Hospitals NHS Foundation Trust (JPUH), attended NHOSC on 5 December 2015 and updated the committee on further developments in relation to the committee's original recommendations and on a subsequent 'Review of Stroke Rehabilitation in the Community' by the Network and Public Health, which was undertaken at NHOSC's request.

2. Purpose of today's meeting

2.1 The Network has been invited to today's meeting to update the committee on:-

(a) Progress on NHOSC's original recommendations for which further action was required at the time of the last meeting.
(b) Progress with implementation of the recommendations of the 'Review of Stroke Rehabilitation in the Community'

The Network's report is attached at Appendix A.

2.2 Representatives from the Network will attend today's meeting and members will have the opportunity to discuss progress with stroke services.

3. Suggested approach

3.1 After the Network representatives have presented the update report NHOSC may wish to discuss developments in stroke services, particularly in the following areas:-

(a) NHOSC is aware that workforce shortages continue to be a challenge across NHS services. What is the trend in terms of availability of stroke specialist staff for local services in Norfolk?

(b) Is the Network functioning as expected in terms of engagement with the regional Strategic Network and in its ability to drive the development of local services?

(c) NHOSC's 2014 review noted the variability of stroke services / pathways across Norfolk and it is clear from the Network's latest report (Appendix A) that the variation is still there. Are the five CCGs moving towards collaborative agreement on commissioning equitable, comprehensive stroke services across Norfolk, from acute to longer term rehabilitation?

Stroke Services in Norfolk

TABLE 1 Updates on recommendations made by NHOSC in July 2014, where implementation is still in progress

Recommendation		**To**	**Response up to December 2015**	***Progress at 26th September 2016 as reported by the Norfolk & Waveney Stroke Network Group***
Pre hospital				
7.	That the Norfolk and Waveney Stroke Network seeks assurance from the three acute hospitals in Norfolk that they report back to EEAST on failures to provide pre-alerts of the arrival of stroke patients so the problem can be quantified and appropriately addressed and that EEAST identifies a lead for stroke with whom the hospitals can liaise consistently. (Paragraph 4.12)	Norfolk and Waveney Stroke Network EEAST	**Accepted**: By Nov EEAST had established a new Stroke lead for Norfolk who would attend the Network meetings. In Oct 2015 there were regular dialogues ongoing between NNUH and EEAST and JPUH was undertaking monthly breach interrogation. Information about ongoing liaison with EEAST was still awaited from the QEH in Nov 2015.	There is an **East of England Ambulance Service Trust (EEAST)** area clinical lead in place and issues regarding pre-alerts at each of the acute hospitals are discussed regularly. EEAST are not aware of any concerns or issues but have reported on the increase of stroke assessments being completed more frequently in the ambulance due to patient flow and capacity issues. Assurance has been received from NNUH and JPUH. QEHKL Stroke matron has met with EEAST and they have formulated a pre-alert form to aid communications with direct phone calls from the ambulance crew to ensure that they are met at the front door in Accident & Emergency. This has shown early signs of improving the times. Band 6 staff have been trained up which has shown significant improvements with door to scan timings. Monthly meetings are planned with EEAST to look at any issues arising.

Recommendation		To	Response up to December 2015	*Progress at 26th September 2016 as reported by the Norfolk & Waveney Stroke Network Group*
8.	That the NNUH, JPUH, QEH and EEAST consider what more could be done to enable the ambulance service and the acute hospitals to work together to shorten the diagnosis time for stroke. (Paragraph 4.13)	NNUH JPUH QEH EEAST	**Accepted**: At the Norfolk and Waveney Stroke Network Meeting on 21st October 2014 Network members agreed to hold meetings based around each hospital system and to then collectively share their work at the Network meetings. This was on the agenda for Network meetings in 2015. In October 2015 the Network reported ongoing liaison between EEAST and the NNUH and JPUH. Information about ongoing liaison with EEAST was still awaited from the QEH in Nov 2015.	The outcome from local hospital systems pathway work is discussed regularly at the Norfolk & Waveney Stroke Network where it is a bi-monthly standing agenda item. **QEHKL:** EEAST's East Locality Sector Head has met with the QEHKL Stroke Consultant and some of his team periodically to discuss pathway redesign and any issues. There is a clear line of dialogue for any issues that arise.
Hyper acute and acute				
11.	That the James Paget University Hospitals NHS Trust **urgently** increases the number of stroke specialist consultants in its service. (Paragraph 5.6)	JPUH	**Accepted**: In December 2015 the JPUH reported that despite repeated efforts it not yet been able to fill the third full time stroke specialist post. There remains a severe shortage of appropriate specialist trainees in stroke both locally and nationally. The post has been advertised twice nationally in the last 12 months, including a substantial recruitment bonus. JPUH had also made use of a headhunting agency and a European	NOTE:- NHOSC scrutinised 'NHS Workforce Planning in Norfolk', in July 2015 covering national workforce shortages and the national and local initiatives underway to address them. Norfolk and Suffolk Workforce Partnership / Health Education East of England updated NHOSC on 26 May 2016.

Recommendation		To	Response up to December 2015	*Progress at 26th September 2016 as reported by the Norfolk & Waveney Stroke Network Group*
			recruitment agency, as well as advertising JPUH and the Norfolk area at the British Geriatrics Society conference last year. There had been tentative interest from a couple of local trainees finishing in 2016, but they were not yet eligible to apply. JPUH intended to continue to work with the European agency but suitable candidates were still rare. The hospital had however recruited a locum stroke consultant with extensive stroke specialist experience to work until at least February 2016. This had given increased its consultant staffing from 2.1 WTE to 3.1 WTE. A neurology consultant with an interest in stroke had also been recruited (in 2014) and was an integral part of the team helping to push forward JPUH's involvement in stroke research and education. With regard to improving weekend stroke specialist review, JPUH was waiting for equipment to start on a pilot of telemedicine consultant ward rounds, which if successful could make it possible for the hospital to link more closely with another specialist unit in the long term. It was also continuing to use the	In spite of the national workforce difficulties in stroke, JPUH is pleased to report that JPUH has recruited a new consultant with stroke specialist accreditation to work in stroke and acute medicine from 3rd October 2016. This brings the total number of stroke consultants up to 4. Taking account of their other work this represents 2.6 whole time equivalents devoted to stroke. There remains funding for another 0.5 whole time equivalent consultant in stroke and JPUH will look to advertise this again in 2017, possibly as a shared stroke and geriatrics post. JPUH is currently piloting weekend stroke ward rounds to improve the specialist cover on the stroke unit and continue to participate in the regional telemedicine service for out of hours thrombolysis. Some Telemedicine ward rounds have taken place at JPUH but were

Recommendation		To	Response up to December 2015	*Progress at 26th September 2016 as reported by the Norfolk & Waveney Stroke Network Group*
			successful regional telemedicine service for stroke thrombolysis.	not as beneficial as having an in-person ward round.
14.	That the Norfolk and Waveney Stroke Network undertakes an assessment of how many patients are delayed at acute and community hospitals due to waiting for NHS Continuing Care assessment or funding and establish what the cost is. (Paragraph 5.7)	Norfolk and Waveney Stroke Network	**Accepted**: The acute hospitals and CCGs supported this recommendation but in December 2015 the Network reported that there was difficulty in obtaining data and it was investigating if central Norfolk holds data through its Capacity Planning Group and if NNUH have data. There was no update in the December report regarding the position at the QEH and JPUH.	**NNUH:** North Norfolk CCG has advised that the central CCGs are scoping a Continuing Health Care (CHC) Discharge to Assess model which will be implemented in the NNUH in early January 2017. There is currently a daily call with NNUH, CCGs, Commissioning Support Unity (CSU) CHC service and community to support discharge and flow from the hospital to secure timely discharge to the most suitable setting for patients. For both Norwich CCG and North Norfolk CCG there is a daily call in place which focuses on delays in the NNUHT, covering CHC delays with the CHC team in the community. There is a discharge hub in place as well as discharge co-coordinators on every ward, pushing those ready for discharge through the system, but beds outside of the NNUH are limited due to accessing suitable nursing home beds.

Recommendation		To	Response up to December 2015	*Progress at 26th September 2016 as reported by the Norfolk & Waveney Stroke Network Group*
				Central Norfolk Capacity Planning Group (CPG) is reviewing the stroke pathway. **QEHKL:** West Norfolk now assess patients in the community setting once the patient has stabilised, therefore there are no delays with NHS CHC assessing on discharge. This is following the Discharge to Assess model. **JPUH:** There is a daily conference call with their CCG and Social Care on all delays within the Trust. In relation to CHC there is a 'plan for every patient' with daily board rounds and 2-hourly updates for every patient with the CHC team based within the hospital with case managers supporting the more complex patient. Going forward, the wards will look at completing their own checklist to speed up the process.

Recommendation		To	Response up to December 2015	*Progress at 26th September 2016 as reported by the Norfolk & Waveney Stroke Network Group*
				On 22nd September 2016 on the stroke unit, there were 3 patients awaiting continuing health care assessment, and 3 more who have had their decision but are still awaiting placement. 2 of those were social care and 1 was awarded continuing health care. **NCH&C:** A recent development has involved one of the ward sisters, with suitable experience, completing the Decision Support Tool (DST) on the ward on behalf of CHC in order to create a smoother process and reduce delays. This intervention was agreed with the Commissioning Support Unit.

TABLE 2 – **Progress on recommendations from the 'Review of Stroke Rehabilitation in the Community' report produced by NCC Public Health in November 2015**

Recommendation		**Progress**
1.	Commission outcomes which encourage integrated care and support with long term goal planning and direct routes back into specialised rehabilitation for all stroke survivors	**NNUH:** Central Norfolk has an integrated stroke pathway. This consists of acute care at NNUH and specialist stroke rehabilitation at Beech ward in NCH&C Trust. Early Supported Discharge (ESD) and 6 month follow up are provided by specialist staff at NCH&C, with support from medical staff at NNUH. There is no commissioning in place for re-entry into the stroke service once discharged. Any new event is through the normal channel with patients signposted to the appropriate service i.e. rehabilitation / therapy / gym membership. All agreed that Commissioners need to work with Providers on what is required within the two year commissioning intentions round. **QEHKL:** West Norfolk commissions an integrated pathway for stroke services, with the QEH providing the specialist stroke community rehabilitation for Stroke survivors. The rehabilitation is provided for as long as required to meet the patient's needs, ensuring that the patients are involved with setting their care goals both short and long term. There is a Spasticity clinic in place at QEHKL with all stroke patients allocated a Case Manager.

		JPUH: All patients suitable for early intensive rehabilitation are supported by the ESD team on discharge, and then if they have ongoing needs passed on to the integrated community neuro rehabilitation team. There are strong links between these teams and the stroke unit therapy team. All patients are offered Stroke Association follow up, and we are working on closer links between the ESD team and the Stroke Association support worker. Patients are provided with professionals contact details. Discussions are also ongoing regarding 6 month follow up. Patients may be re-referred to outpatient clinics or to the integrated community neuro team but there is no commissioned pathway back into the stroke unit or to ESD.
2.	Adopt consistent quality and performance indicators across Norfolk, taking the lead from the new NICE quality standards.	All the CCGs and acute trusts will have the same requirements to meet the NICE standards. It is therefore important that all the Norfolk CCGs agree collaboratively what quality standards to use and commission the same stroke services. All agreed that the main top 5 items from the 2013 NICE guidelines to be shared. Sentinel Stroke National Audit Programme (SSNAP) Data is scrutinised by the Norfolk & Waveney Stroke Network meetings. This should be addressed in the forthcoming two year commissioning round. **NNUH:** There is a monthly board report for stroke that consists of key clinical targets. Information is

		also provided to CCGs as per agreement. The clinical team review performance at departmental meetings and conduct a Root Cause Analysis (RCA) to improve patient care. **QEHKL:** The QEHKL report within their Board Report on a monthly basis against all National Stroke indicators. They also provide a quarterly SSNAP audit report. All data against national Stroke indicators are provided to West Norfolk CCG Clinical Quality Team with any issues addressed at the monthly Clinical Quality Review Meetings. **JPUH:** All services are monitored through the contract and quality meetings. The quarterly SSNAP data is provided to the CCG and the JPUH quality meeting and the stroke team attend to give regular updates. There are monthly reports to the Board on key quality indicators and we are aiming to harmonise these as far as possible with the SSNAP dataset.
3.	Increase the number of people reviewed at six weeks, six months and one year.	**NNUH:** Offer a 6 month follow up either in the community or in the acute setting to all stroke patients. All are nurse led and if required, referred to a Consultant when appropriate. Follow up clinic slots have been increased from 1st April 2016. For the community, reviews using the Long Term Stroke Care (LoTS) assessment tool are in place; all patients are being offered a review at 6 months, however take up is low.

		QEHKL: Is restructuring clinics to ensure that all the 6 monthly criteria is covered, and then discharged to primary care. Therapy is also offered. Clinical reviews are taken between 6 – 8 weeks. There is very little take up of 12 monthly reviews, with all stroke patients offered a follow up. **JPUH:** The last audit of stroke follow up showed that 88% of surviving patients attended an appointment at 6 weeks. Virtually all were offered an appointment but some cancelled, particularly nursing home residents who were often too frail to attend. 7% were offered an appointment at 6 months. Under the new proposed model, patients with no residual disability at discharge or who are discharged to a nursing home will receive a telephone follow up at 6 weeks. This model has proved popular with TIA patients. Patients with outstanding medical needs (including young stroke patients requiring specific investigations) will still see a Consultant, but around 50% should be suitable for nurse led follow up. The nurses will have easy access to consultant appointments for any patients who need one. This change should free up enough capacity to allow JPUH to additionally offer a 6 month follow up to all patients, either as a structured telephone call, nurse-led clinic or a consultant clinic appointment according to the patient's needs.

4.	Provide equitable access to screening and assessment for psychological problems.	**NNUH:** Has access to clinical psychologists across the pathways, working in ESD. **QEHKL:** Has clinical psychology in place through the entire stroke pathway; however the treatment programme is limited. Mood and cognitive screening is available. Additional funding has been made available for two extra days of psychology intervention for stroke patients, although no one has been recruited to this vacancy yet. **JPUH:** Has no direct access to a clinical psychologist for stroke patients; however, teams have had some training to offer Level 2 psychology support as part of therapy time. Mood assessments are offered to all patients. There is access to the Colman Hospital and also Livability Icanho in Suffolk who can offer clinical psychology input, but strict referral criteria are applied.
5.	Increase the number of carers receiving regular assessments.	This falls under the remit of the **local authority** with carers' assessments part of the discharge process from the acute trusts. Confirmation has been given that patients are not sent home if the required support is beyond what the carer can provide. NCC Social care has a performance indicator which measures how well carers are supported. It is acknowledged that there is a delay in taking these assessments forward by NCC.

		For Norfolk, the number of carers assessments and reviews in July 2016 (most recent data) was 210, which is up on 200 in June 2016 but down on June 2015 when there were 353 carers assessments and reviews. However, NCC commissions the Carers Agency Partnership to provide a range of services to carers (e.g. short breaks, telephone support, carers groups) and 1260 carers accessed the Partnership's services in June 2016, which is up on June 2015 when there were 1080 carers accessing Partnership services. The amount of people supported by NCC has consistently increased month on month due to a wider range of carers being identified. NCC has agreed to extend funding for 6 whole time equivalent dedicated carers assessors for 1 year from April 2016, but to note that this does not specifically relate to stroke care. There are also carers assessors in Social Care Centre of Expertise (SCCE) who carry out telephone assessments, and also within the mental health team. Clinics are also being set up in surgeries on agreement. The Stroke Association has funding to bring in a more formal assessment (based on the

		Collaborations for Leadership in Applied Health Research and Care - CLARHC), and will be offered in West Norfolk as a pilot in Autumn 2016 and will be focused on carers of stroke. There will be performance indicators on the outcomes.
6.	Provide improved, consistent information for stroke survivors and their families across Norfolk.	**NNUH:** All patients are given the purple plastic wallet containing the Stroke Association Starter pack together with various booklets depending on the individual and the severity of the stroke. The driving leaflet from DVLA is also handed out. **QEHKL:** There is access to all the Stroke Association booklets, with a purple plastic wallet handed out to the patient. There are also team specific leaflets handed out which relate to local services available e.g. post-stroke spasticity, sensory work, splint work. The driving leaflet from DVLA is also handed out. **JPUH:** All patients are currently given the Stroke Association pack at home by the Stroke Association Information and Support worker. At discharge from hospital, a joint care plan (stroke information leaflet) is provided to the patient on discharge which gives details of the therapy teams and contact numbers, as well as the hospital discharge letter. A selection of the Stroke Association leaflets are also handed out according to the patient's type of stroke and these are also freely available for patients and

		families from a display on the ward. There are plans to move to giving out the Stroke Association pack to all patients in hospital. **NCH&C:** On transfer home the patients will share this purple wallet information with the ESD team and any other relevant information is added to the wallet. The inpatient rehabilitation unit has noticed that some relatives may take the wallet home rather than ensure it travels across with the patient. The clinical staff will ask for it to be returned so that information can be added as necessary. Stroke Association leaflets are also handed out, but this varies depending on impairment. Where the Stroke Association is commissioned to provide a service, it can provide information face to face with clients and carers on a wide range of subjects and refer to support groups where appropriate. The Stroke Association also has a website and helpline which anyone can access for support and information. The **Stroke Association** has reported that for: **West Norfolk CCG** area there is: Information Advice and Support 1 full-time equivalent (FTE), Communication Support 0.7 FTE, Long term support 0.3 FTE and Stroke prevention 0.8 FTE.

		Gt Yarmouth and Waveney CCG area there is: Information Advice and support 0.8 FTE It is to be noted that there is no variability of commissioning the Stroke Association Services across the Norfolk CCGs. The Stroke Association is discussing proposals with North Norfolk CCG for a stroke recovery service and six month reviews, and a similar proposal to Norwich CCG.
7.	Embed feedback, satisfaction surveys, friends and family tests (FFT) in quality improvement.	**NNUH:** Feedback is received through acute care and the pathway meetings via the FFT and relatives' clinics. Acute ward: June 2016 – 100%, July 2016 – 100%, August 2016 – 90.91%. Hyper Acute – June 2016 – 100%, July 2016 – 100%, August 2016 – 75%. The above is discussed at departmental clinical governance meetings and actioned as appropriate. There is a monthly relatives' clinic at NNUH where clinical staff are available for any queries and support. There is a monthly cross pathway meeting where staff from NNUH and NCH&C discuss clinical outcomes and areas for improvement. NNUH hold an annual stroke study day with free access to all staff working in stroke in the region. There is also a Stroke Forum at NNUH.

		QEHKL: The results of the monthly FFT test and patient satisfaction surveys are discussed at the monthly QEHKL Stroke meeting with feedback discussed with the health professionals. FFT response rate and likelihood to recommend for the last 3 months are as follows: Response rate for June 2016 - 69.88%; July 2016 - 75.64%; August 2016 - 77.11%. Likelihood to recommend June 2016 - 96.55%; July 2016 - 91.53%; and August 2016- 93.75 %. There is also a Service User group for stroke victims. **JPUH:** FFT responses and comments from the stroke unit are shared weekly and reviewed at the Stroke Clinical Governance meeting. Actions taken are shared with all stroke staff in a monthly newsletter. Feedback of the last 12 months, 93% of patients had a positive experience within JPUH stroke unit. Comments are taken on board - for example following some anonymous feedback from a relative about difficulty obtaining information at the weekend we have created a poster and a new leaflet for relatives explaining the various ways in which families can obtain updates even if they cannot visit during working hours. Annual patient satisfaction surveys in ESD have been revised with a response rate around 50% which is shared with the stroke management team and all stroke staff.

		NCH&C: Patient and Carer questionnaires are sent out. There is a FFT but the response rate for this could be improved, with the format being reviewed. There is a Stroke Forum. Improved engagement through the Patient and Carer group is being developed as the response rate is low. There is local representative in the Norfolk area. On Beech Ward at Norwich Community Hospital, engagement with carers is being looked at more effectively. There is a local organisation which focuses on carers, providing carer support in the Norfolk area. When there are issues flagged by carers, these are discussed in the unit with the carer and / or patient present with lessons learnt and addressed. Work continues with Norfolk Carers. A representative from the Norwich carer group will be attending the Patient and Carers Stroke group in October. A flow chart is being developed to show the process of supporting carers for our stroke patients across the stroke pathway. **EEAST:** There is engagement with all patient groups, including the FFT. There is also a Trust User Group which encompasses stroke patients. **STROKE ASSOCIATION:** The team is based at QEHKL. A national survey is independently circulated; a recent survey reflected a 65% return with good support of the services. Any issues are highlighted and passed back to the co-ordinators.

		The Network also holds events at QEHKL for stroke patients. **HEALTHWATCH:** The Engagement Team attends various events across Norfolk, gathering general information on topical issues in relation to health and social care. There is targeted engagement, looking at specific areas. There is a website where feedback is left; linking into Friends and Family Tests associated NHS informatics. Volunteers link in with specific work. Healthwatch is also commissioned to provide independent reports by the CCGs and NHSE.
8.	Encourage a wide range of Voluntary, Community and Social Enterprise activities, for example peer-led groups, carer and peer-support and community asset mapping.	**NNUH:** There are a number of patient support groups across Norfolk. They provide a variety of services. The details of which along with contact details are given to all patients in the patient pack. We also conduct patient forums within our pathway. NCH&C is organising the next forum on 25th October 2016 where staff from across acute and rehabilitation teams will be attending. **QEHKL:** The Stroke Association run a comprehensive programme of groups / activities in West Norfolk including Long Term Support Groups (for those affected by stroke and their carers), Communication Support Groups, a Healthy Lifestyle Programme, Tai Chi classes, Hydrotherapy sessions, and an Art & Craft Group. The Friends of the Stroke Unit fundraise for, and raise awareness

		of, QEH Stroke Services and have financed equipment, courses and the refurbishment of the TIA Clinic. **JPUH:** The Stroke Therapy Team Leader has been working on improving our links with local stroke groups. Links are already established between the Speech and Language service and several local support groups. There will now be consideration to use group leaders to disseminate developments in the stroke service and to gain feedback from their members. The Stroke Association Information, Advice and Support worker currently makes contact with all patients after discharge and informs them about local stroke groups and other community activities and support organisations. The ESD team will also signpost patients as appropriate. The Stroke Association hold a weekly drop in session on the JPUH site for stroke survivors and their carers which is highlighted to patients on the acute ward and in ESD. The Stroke Specialist Nurses recently ran an information stall hosted by the Heartcare Cardiac Support Group, with similar events hosted by the local stroke support groups. **NCC:** There will be a project supported by Public Health who will scope this exercise with involvement from QEHKL, NNUHT and the CCGs. This has been delayed by restructuring within the Public Health Team. The NHS HERON website provides a

		comprehensive and searchable source of NHS services.
9.	Use standardised communication and assessment tools for transfer between services.	This is an IT issue. IT will be one of the key issues in the Sustainability Transformation Plan, recognising that this will be a challenge for transfer across different services. However, due to the very small numbers of transfers between services this has not yet caused any significant problems. Electronic discharge letters now hold more detail, with ongoing work on the electronic transfer of care letters. **NNUH** refer to the electronic discharge and clinical information as soon as a call is made from **EEAST**, this gives the clinical team an advantage of assessing the patient on arrival. It is not possible to transfer SSNAP records between services. There is no common guideline, however there is increasing commonality regarding radiology and pharmacy.
10.	Improve the SSNAP data compliance.	SSNAP data is being received and reviewed at the Norfolk & Waveney Stroke Network meetings. **NNUH:** Is in the top 5 of the country for annual numbers treated by one stroke unit, with a large volume of stroke patient (1200 / 1250 per year), therefore the data as collected effectively is very meaningful in terms of the numbers.

		QEHKL: CAPTURE STROKE software is now in place, with inputting up to date. Data collection has improved Compliance is improving on stroke care with patients. **JPUH:** consistently in the top band for audit compliance and above average performance on clinical indicators. **NCH&C:** The 6 month follow up figures for NCH&C on SSNAP are consistently low. This needs to be addressed and is considered to be a coding issue.
	Care Homes – training of staff	**NNUH**: NNUH lead the Central Norfolk Stroke pathway and commission services from NCH&C. The current work (see in NCH&C below) NCH&C is conducting is supported by NNUH. **QEHKL:** The QEHKL Community Stroke Team has gained funding from Ipsen to provide a training day (October 19th 2016) for carers in residential and nursing homes, and professional carers who visit patients at home. The training is free, and the course title is 'Caring for Stroke Patients with Spasticity'. The course aims to educate attendees on what is a stroke/spasticity, posture, positioning, equipment, upper limb, splints, stretches. The course is only available to those in the West Norfolk area. Speech Therapy training (a one day's course) is in place in the residential homes, especially around

		dysphagia. The training package will now be shared with NNUH. **JPUH:** Currently not aware of any local work with care home staff but would be interested in using the new NCH&C leaflet to send out with patients discharged from the stroke unit to a care home. **NCH&C:** Feedback from the 6-month follow up around the care home environment resulted in a leaflet being developed 'Ten Top Tips in Stroke Care' to support stroke care. This was a multi-agency venture including the Independent Care Sector and Stroke Association. This has also been included in the monthly newsletter circulated to all care homes within central Norfolk and Suffolk for use by all care home managers and staff. Feedback has been very positive. There is no capacity within the NCH&C teams to free up clinicians to provide training, but the profile of stroke care has been raised. Stroke Care Team Lead is liaising with the Chief Operating Officer Norfolk and Suffolk Care Support, to sustain the benefits of this piece of work and source funding for further training in order to develop the knowledge base of carers of clients who have had a stroke. A Senior Stroke Nurse is supporting this development too, as are other members of the clinical rehabilitation team.

		This leaflet will be made available to other stroke services. This piece of work will be promoted through the Stroke Forum (2017). The Norfolk & Waveney Stroke Network would like this to be promoted through the Norfolk Care Awards in February 2017 together with submission to the Life after Stroke Awards.

No updates are required to the items in the following table.

TABLE 3 - Other recommendations made by NHOSC in July 2014, where completion, implementation or rejection after full consideration was reported to NHOSC on 3 December 2015
(recommendation and paragraph numbers refer to the 'Report of the Stroke Services in Norfolk Task & Finish Group' presented to NHOSC on 17 July 2014)

Recommendation		**Outcome** (as reported to NHOSC on 3 December 2015)
Strategic Overview		
1.	The members of the Norfolk and Waveney Stroke Network commit to regular meetings and to working with the Cardiovascular Strategic Clinical Network and the Clinical Senate to drive co-ordinated improvement of stroke services in the county. (Paragraph 2.7)	**Done** Meetings are ongoing on a two monthly cycle. The local network receives reports from the Strategic Network meetings.
2.	That the NHS England East Anglia Area Team should be involved in the Norfolk and Waveney Stroke Network and that a clinical lead for the Network should be identified. (Paragraph 2.7)	**Done** The Manager has been attending Network meetings. The clinical lead role is shared between the three consultants from the three acute hospitals – this has worked well.
Preventative		
3.	That the Norfolk and Waveney Stroke Network takes up the recommendations of the Health Needs Assessment and oversees collective work between CCGs and Public Health to identify additional data sources and further analyse data in relation to stroke. (Paragraph 3.2)	**Done** Public Health has provided data at CCG level (May 2015). Network meeting in December 2015 considered responses from CCG Accountable Officers.

Recommendation		Outcome (as reported to NHOSC on 3 December 2015)
4.	That NHS England East Anglia Area Team considers the scope for introducing blood pressure checks at dental surgeries and pharmacies. (Paragraph 3.4)	**Done** NHS England passed this on to NCC Public Health for consideration. They advised that those pharmacies that wish to already provide blood pressure checks under the Health Checks contract. Dentists are also able to provide Health Checks if they wish, but none do in Norfolk. The commissioners think that opportunities to reduce risk in vulnerable groups could be better addressed by targeting the following: • Annual health check for people with learning disability • GP physical health check of MH patients • Supported housing residents
5.	That Norfolk County Council Public Health, who are responsible for commissioning the NHS Health Checks in the county, assess the numbers of people who are eligible for a NHS Health Check and the numbers who actually take up a Health Check and make the information available to the NHS England commissioners and GPs on a practice by practice basis to encourage action in the areas of low take-up (Paragraph 3.4)	**Done** The data was presented at the August 2015 Network meeting and then shared with CCGs. The Network has continued to monitor Public Health's future plans for Health Checks.
Pre hospital		
6.	That EEAST reviews the number and location of ambulance bases in Norfolk in relation to travelling times	**Done** EEAST has carried out a review and intended to open a new base at Hoveton but was unable to do so due to staffing issues

Recommendation		Outcome (as reported to NHOSC on 3 December 2015)
	to the hyper acute stroke units with a view to achieving the Stroke 60 standard in all parts of the county. (Paragraph 4.10)	(as at Oct 2015). EEAST pointed out that there are some parts of Norfolk & Waveney where even if an ambulance was close to a patient, they would not reach a hyper-acute stroke unit in 60 minutes. Demand for the ambulance service was above contracted levels and significantly impacting on performance, including Stroke 60 performance in some geographic areas (as at Oct 2015). Ambulance waiting times and turnaround times at hospitals was on NHOSC's agenda in October 2015. Robert Morton, Chief Executive Officer of EEAST pointed out that for thrombolysis what really matters is the overall time from call out to needle, not just time taken for transportation to hospital. NHOSC will examine progress with EEAST again on 13 Oct 2016.
9.	That EEAST focuses on improving its performance by ensuring that double staffed ambulances are first on scene to a higher proportion of suspected stroke patients and that patients are transported to hospital without delay. (Paragraph 4.15)	**Done** (but the desired improvement in performance was not fully achieved) EEAST remodelled its delivery of service in Norfolk by converting 3 rapid response vehicles (RRVs) to double-staffed ambulances (DSAs). Further DSA ambulance hours were also added. The EEAST stroke lead also carried out some work to reinforce the need to reduce time spent 'on scene' by the crew. Performance is still an issue. NOTE:- NHOSC has ambulance response times and turnaround times on its agenda in October 2016 and can raise the issues directly with EEAST.

Recommendation		Outcome (as reported to NHOSC on 3 December 2015)
10.	That the stroke team at the NNUH should be a standalone team, as is recommended in the National Stroke Strategy 2007 and that it should be staffed to the appropriate levels in all the relative disciplines. (Paragraph 5.3.2)	**Done** There is now a standalone team at the NNUH.
12.	That the Norfolk and Waveney Stroke Network reviews that number of stroke specialist staff in post (i.e. people actually in post, not the number of posts in the establishment), and the availability of staff in post in supporting disciplines, to assess the clinical safety of the services. (Paragraph 5.6)	**Done** A spreadsheet compiled by NNUH regarding staffing in the 3 services in Norfolk was seen by NHOSC on 3 December 2015 (also updated with additional QEH information after the meeting and circulated with the minutes).
13.	That the Local Education and Training Board explains what is being done to resolve the shortage of stroke specialist consultants, other stroke specialist staff and staff in other disciplines whose expertise is needed in the stroke care pathway. (Paragraph 5.6)	**Done** HEEoE acknowledged the challenges and explained that stroke as a sub specialty has had difficulty recruiting country wide from Aug 2014 and this, it is in part believed, is linked to changes in the way that at a national level the Specialty Advisory Committee for Medicine for the Elderly no longer credits this as an out of programme experience towards a trainee's CCT. Prior to Aug 2014 HEEoE has always recruited to between 6-8 posts each year; from Aug 2014 intake only 4 of 8 posts have been filled. This issue is being picked up by HEEoE at a national level and HEEoE continues to create training opportunities for stroke as a sub specialty and pursues several rounds of recruitment in order to fill these posts each year. HEEoE can only offer the opportunity it cannot mandate

Recommendation		Outcome (as reported to NHOSC on 3 December 2015)
		trainees to take up these opportunities in what is a competitive process but continues to work with service colleagues to make these opportunities as attractive as possible. NOTE:- NHOSC scrutinised 'NHS Workforce Planning in Norfolk', in July 2015 covering national workforce shortages and the national and local initiatives underway to address them. Norfolk and Suffolk Workforce Partnership / Health Education East of England updated Members on progress on 26 May 2016.
Rehabilitative		
15.	That the Norfolk and Waveney Stroke Network reviews the staffing of stroke rehabilitative services across Norfolk, including the availability of staff in the necessary supporting disciplines (including psychology) to ensure the appropriate level of support. (Paragraph 6.2.4)	**Done** The Network received the final version in November 2015
16.	That the Norfolk and Waveney Stroke Network assesses the relative merits of the three rehabilitative stroke services in Norfolk with a view to commissioning services in future that bring the maximum benefit to the greatest number of patients, within the available overall funding limits. (Paragraph 6.2.6)	**Done** The Network asked Norfolk County Council Public Health to lead on a clinical outcomes based assessment, the report of which was received in November 2015 ('Review of Stroke Rehabilitation in the Community') NOTE:- The report made 10 recommendations, which are considered to supersede and follow on from the NHOSC recommendation. The Network has been asked to update

Recommendation		Outcome (as reported to NHOSC on 3 December 2015)
		NHOSC on progress with these 10 recommendations on 13 October 2016.
17.	That the Local Education and Training Board explains what is being done to improve the availability of trained Psychologists. (Paragraph 7.4)	**Done** HEEoE explained the cycle of commissioning regional programmes as part of the annual investment plan. NOTE:- NHOSC scrutinised 'NHS Workforce Planning in Norfolk', in July 2015 covering national workforce shortages and the national and local initiatives underway to address them. Norfolk and Suffolk Workforce Partnership / Health Education East of England updated Members on progress on 26 May 2016.
Long term		
18.	That Norfolk County Council adult social care, Norfolk Independent Care, Norfolk Community Health and Care and East Coast Community Healthcare meet to consider how more training in the long term care of stroke survivors can be delivered to care home staff in private and public sector care homes across Norfolk, how progress with such training can be tracked and how good practice can be shared across the care home spectrum. (Paragraph 7.7)	**Done** Norfolk Independent Care met with Norfolk County Council, NCH&C and ECCH and developed an action plan to drive forward consistency of training. A task & finish group was convened to support the development of a consistent approach to the training of care workers in relation to the long term care of stroke survivors, to review how training is tracked and to agree a system for sharing good practice.
19.	That the five Norfolk CCGs should work together to commission an integrated prevention, information,	**Done** The Network started by asking Norfolk County Council Public Health to review current commissioning. The 'Review of Stroke

Recommendation		Outcome (as reported to NHOSC on 3 December 2015)
	communication and six month stroke review service across Norfolk. (Paragraph 7.8)	Rehabilitation in the Community' report was received in November 2015. NOTE:- The report made 10 recommendations, which are considered to supersede and follow on from the NHOSC recommendation. The Network has been asked to update NHOSC on progress with these 10 recommendations on 13 October 2016.
The cost of stroke and stroke services		
20.	That Norfolk and Waveney Stroke Network collectively considers whether CCGs and Norfolk County Council could usefully commission research on the overall cost of stroke to the health and social care authorities in the county and robust evaluation of the overall cost effectiveness of the three existing stroke service systems in the county. (Paragraph 8.2)	**Done** This recommendation was partially accepted. The Network acknowledged that such a project would be of considerable interest but was concerned about the cost. It explored the possibility with UEA and Public Health. The conclusion reached in August 2015 was that the costs were prohibitive.
Next steps		
21.	That representatives of Norfolk and Waveney Stroke Network meet with the Stroke Services Task & Finish Group to discuss the recommendations of this report before responding to Norfolk Health Overview and Scrutiny Committee. (Paragraph 10.1)	**Done** The Network met with the NHOSC task & finish group on 19 August 2014.

Ambulance response times and turnaround times in Norfolk

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

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

1. Background

1.1 During 2012 – 14 Norfolk Health Overview and Scrutiny Committee (NHOSC) focused its attention on the subject of ambulance turnaround delays at the Norfolk and Norwich Hospital (NNUH), which appeared to be a very significant contributor to the ambulance service's overall performance problems in Norfolk. In April 2014 the committee was reassured to see a sustained improvement in ambulance turnaround times at the NNUH.

1.2 NHOSC returned to the subject of ambulance services in February 2015 because it was aware that response times in Norfolk were still below locally agreed standards in some areas. At this stage NHOSC widened its focus to look at county-wide ambulance response times and the turnaround performance at the Queen Elizabeth (QEH) and James Paget (JPUH) hospitals as well as the NNUH.

1.3 EEAST, the NNUH and North Norfolk CCG were asked to return to NHOSC again in October 2015 following a dip in response time performance in the preceding months (up to July 2015) and the fact that average hospital turnaround times (both arrival to patient handover, and handover to ambulance clear) had not achieved the 15 minute standards in any of the 12 months to July 2015.

1.4 For ambulance turnaround at hospitals, the 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.**

1.5 For ambulance response to patients, the national standards, to be met at a region-wide level 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.

1.6 NHOSC scrutinised stroke services in 2013-14. In relation to stroke EEAST's 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%.

1.7 It should be noted that EEAST is expected to meet the national response time standards on a regional level and not on a county or locality level. There have, however, been local agreements in recent years between

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

EEAST and Clinical Commissioning Groups (CCGs) for 'recovery targets' in some areas (notably the North Norfolk area). These recognised that current local performance is well below national standards and set interim targets that were challenging but considered achievable in the locality, taking into account rurality and local geography.

1.8 At NHOSC on 15 October 2015 the Chief Executive of EEAST pointed out some of the drawbacks of the performance standard measurement system, for instance:-

(a) Performance targets for Red 1 and Red 2 calls were set at a simple pass / fail standard that did not reflect the length of time that a 'failed' response actually took, or the outcome for the patient.
(b) The Stroke 60 standard measured only the ambulance services' part in a patient's journey but the outcome for the patient also depends on the length of time the hospital takes to assess their condition and provide the appropriate treatment.

1.9 On 8 August 2016 the Care Quality Commission (CQC) published an inspection report for EEAST. The overall rating for the Trust, which covers Bedfordshire, Cambridgeshire, Essex, Hertfordshire, Norfolk and Suffolk and a population of around 6 million people, was 'Requires Improvement'. The ratings for 'safe', 'effective', 'responsive' and 'well-led' were all 'Requires Improvement' but for 'caring' the Trust was rated 'Outstanding'. The CQC said that the Trust must:-

- Improve performance and response times for emergency calls
- Ensure there are adequate numbers of suitable skilled staff and qualified staff to provide safe care and treatment
- Ensure staff appropriately mentored and supported to carry out their role including appraisals.
- Ensure staff complete mandatory training (professional updates)
- Ensure that incidents are reported consistently and learning fed back to staff.
- Ensure that all staff are aware of safeguarding procedures and there is a consistent approach to reporting safeguarding.
- Ensure that medicines management is consistent across the trust that controlled medicines are stored and managed according to regulation and legislation.
- Ensure that all vehicles and equipment are appropriately cleaned and maintained.
- Ensure all staff are aware of their responsibilities under the Mental Capacity Act 2005.
- Ensure all staff are aware of their responsibility under Duty of Candour requirements
- Ensure records are stored securely on vehicles.

The full report is available on the CQC website:-
http://www.cqc.org.uk/provider/RYC

2. Purpose of today's meeting

2.2 EEAST has been asked to report today with information on the past year in terms of:-

- Activity levels
- Handover performance at the three acute hospitals
- Developments in the Hospital Ambulance Liaison Officer role
- The impact of hours lost at the three hospitals on EEAST's wider performance in Norfolk
- Ambulance response times across the five CCG areas
- Performance against stroke standards
- Current numbers of vacancies and numbers of students compared to total staffing numbers
- Recruitment strategy.

EEAST's report is attached at Appendix A

2.3 Although ambulance turnaround figures for all three acute hospitals are included in EEAST's report, the NNUH has been invited to report and to attend today's meeting as the largest hospital in Norfolk and consequently the one where potentially the most hours can be lost in ambulance delays. The NNUH has been asked to update the committee on the success of measures put in place to improve turnaround performance.

The NNUH's report is attached at Appendix B.

2.4 North Norfolk CCG has also been invited to today's meeting as the lead commissioner of the NNUH. 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 can also 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 in central Norfolk.

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 qualified and experienced paramedics that it needs?

(c) Is EEAST satisfied that the balance between experienced paramedics and trainees in the workforce is manageable in terms of

providing satisfactory training and of delivering the service to meet rising demand?

(d) 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 previously reported progress in eliminating the longest waits for responses to Red calls. Has there been further progress in this respect?

(e) The NNUH's report (at Appendix B) mentions that the system of recording the time from ambulance arrival to handover of the patient has changed. The 'arrival' reading is triggered by an automatic response from a "geofield" located in a streetlight on the approach to the hospital. Previously 5 minutes was added to allow time for the ambulance to get from there to A&E and for staff and patient to disembark but that is no longer done. Why has the time recording method changed?

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

(f) Ambulance turnaround at hospitals depends in part on the flow of patients through the acute hospital and through NHS community care and social care services. Given that NNUH is in financial special measures, the 24 bed Henderson re-ablement unit is due to close in October due to lack of funds and the project for an Ambulatory Care and Diagnostic Centre has been put on hold, is there anything that the NNUH can realistically do to improve patient flow through the hospital this winter?

(g) 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?

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

(h) In the past EEAST and local CCGs have agreed local trajectory targets to improve response time performance in parts of Norfolk. Are local trajectory targets still used and if so, how is EEAST currently performing against them?

(i) Demand for ambulances for life threatening emergencies in Norfolk has increased by 15.31% over the past 12 months. Are the CCGs funding EEAST to the appropriate level to meet the increase in demand?

(j) NHOSC has heard on several occasions about the positive impact that Hospital Ambulance Liaison Officers (HALO) have on ambulance turnaround times but it appears that appears that the funding for the role is uncertain from year to year. Can the CCGs and /or the providers come to an arrangement that guarantees funding for HALOs at the NNUH in future?

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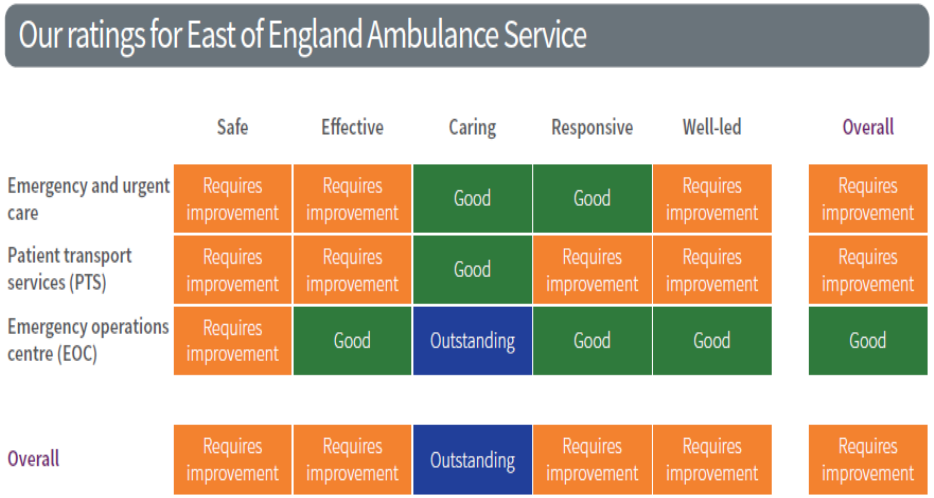
East of England Ambulance Service NHS Trust

Care Quality Commission (CQC)

Earlier in the year the CQC carried out an inspection of the East of England Ambulance Service NHS Trust (EEAST). The CQC published their report last month and rated EEAST overall as 'Requires Improvement'.

The CQC were clear that EEAST was at the upper end of this rating and expect EEAST to move into 'Good' when the next inspection occurs. EEAST is particularly pleased that the CQC recognised the 'Outstanding' care staff deliver to patients. Indeed EEAST is the only ambulance service so far to have received an 'Outstanding' rating in its overall results. An action plan has been developed to address the findings of the report.



Hospital handovers

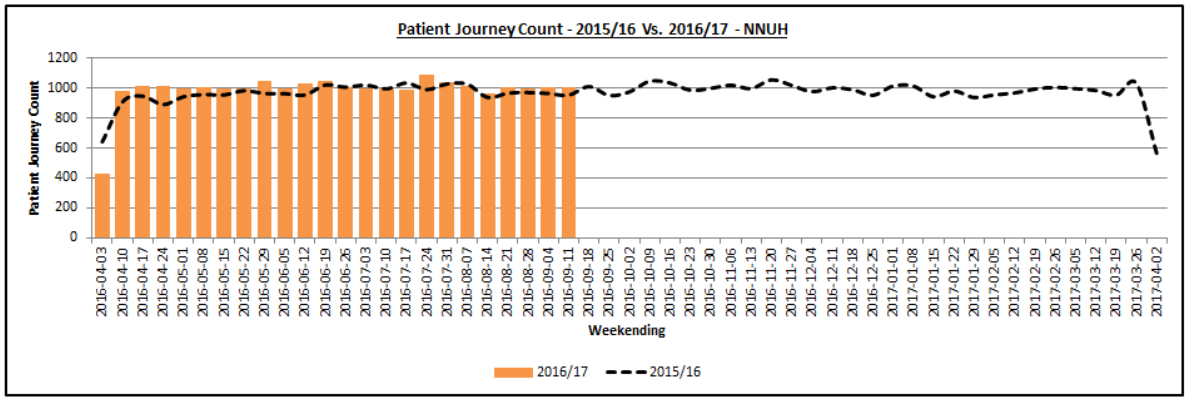
Since the 1st April 2013, ambulance turnaround standards were introduced to all Ambulance Trusts and Acute Trusts with an Emergency Department (ED) for ambulance handovers at the ED.

(a) 15 minutes - **Arrival to handover**; the time from ambulance arrival on the hospital site to the clinical handover of the patient to the hospital staff.

(b) 15 minutes - **Handover to clear**; the time from when the clinical handover of the patient has been completed to the ambulance being ready and available to take the next 999 call.

Any delays in arrival to handover or handover to clear have a direct impact on ambulance resourcing, in effect reducing the number of ambulances available to respond to patients in the community. 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 1000 per week (Fig 1) up by 2.35% on last year.

Figure 1: patient journey count



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 continue to demonstrate relative stability. The average performance for the green in 15 times is now around 40% between the two sites. This is when a crew have completed the handover of a patient and are available for the next emergency call. On average 8% of crews are delayed over 30 mins from completing their patient handover.

There are a number of occasions when a crew maybe delayed over 30 mins, for instance staff welfare issues, referral to safeguarding of vulnerable patients and cleaning and restocking of the ambulance. Instances such as highly emotive and traumatic calls may result in a crew being delayed so they can receive support or attend a debrief. However, the principle is an 'on average' one and EEAST are currently just 3 minutes away from the 15 minute target in Norfolk.

Handover to Clear Performance V Arrival to Handover Performance

Figures 2, 3 and 4 below represent the overall hours lost in both stages of the handover process, those being arrival to handover and handover to clear over 15 mins at the three EDs since May 2016.

Figure 2: hours lost at the Norfolk and Norwich University Hospitals NHS Foundation Trust

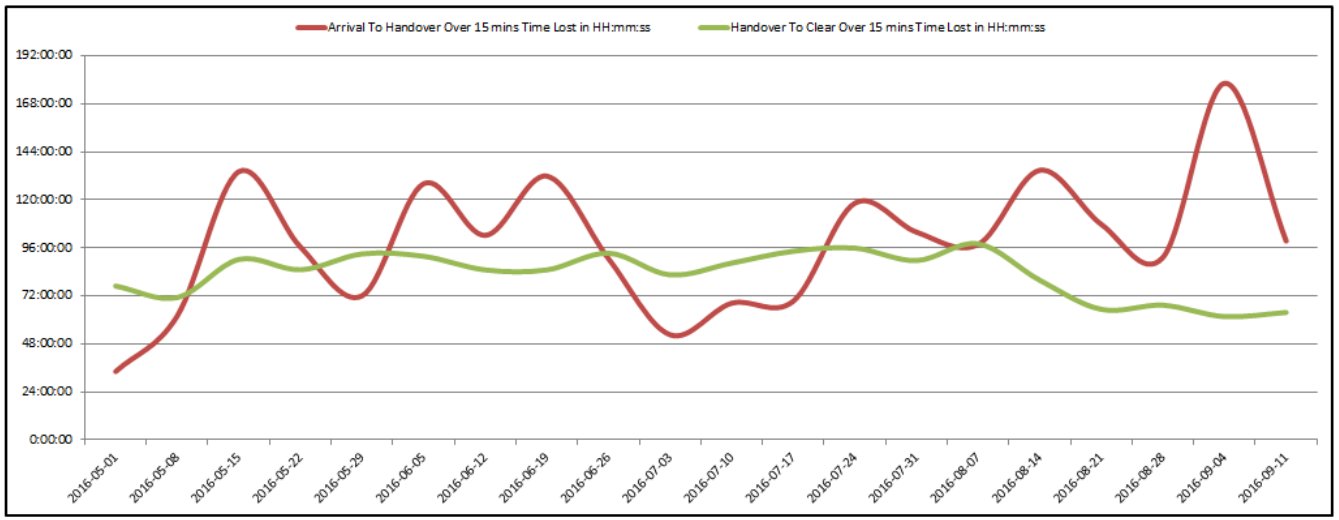


Figure 3: hours lost at the Queen Elizabeth Hospital King's Lynn NHS Trust

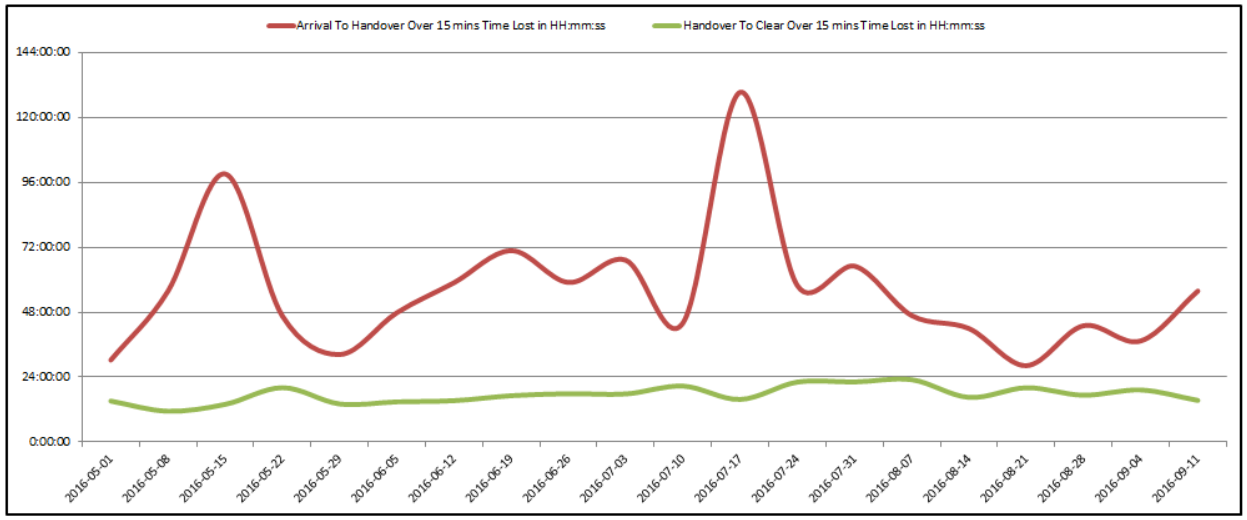
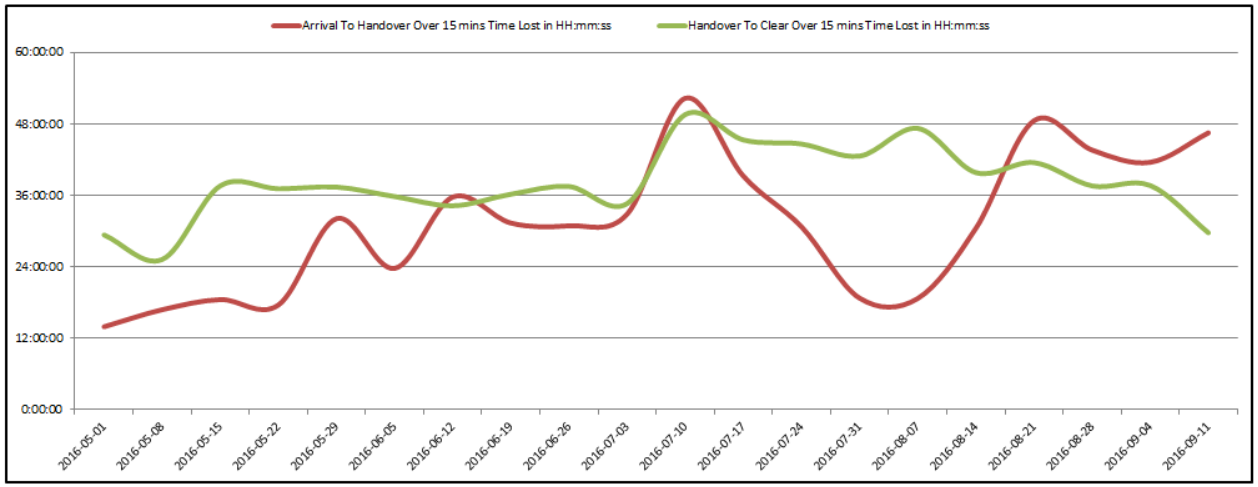


Figure 4: hours lost at the James Paget University Hospitals NHS Foundation Trust



The charts highlight that more hours are lost in the arrival to handover element than the handover to clear. EEAST work closely with the acute staff at each site to ensure that ambulance handovers are achieved in a timely manner but they continue to remain high. The comparison to last year's data is displayed below for all three hospitals.

Figure 5: handover to clear for 2015/16 and 2016/17 at the Norfolk and Norwich University Hospitals NHS Foundation Trust

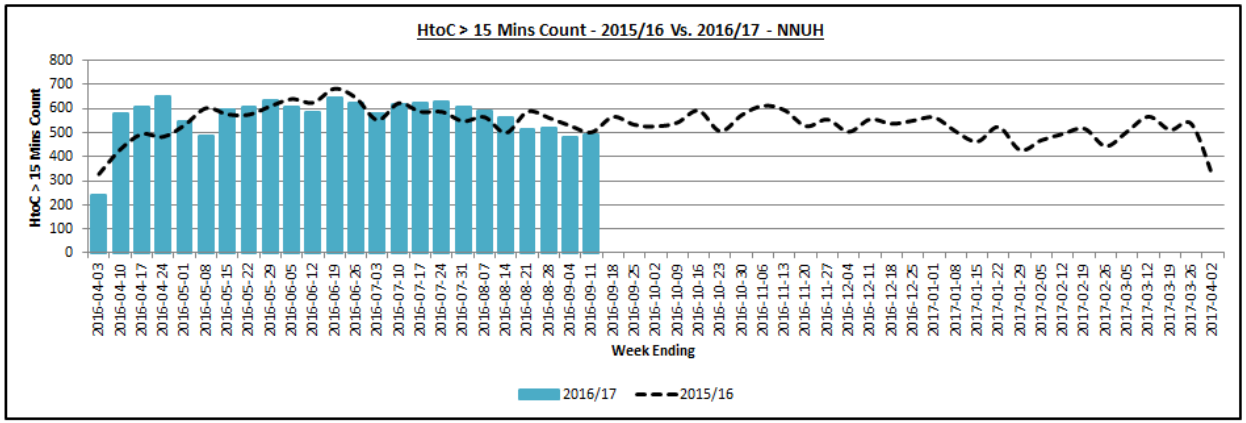


Figure 6: arrival to handover for 2015/16 and 2016/17 at the Norfolk and Norwich University Hospitals NHS Foundation Trust

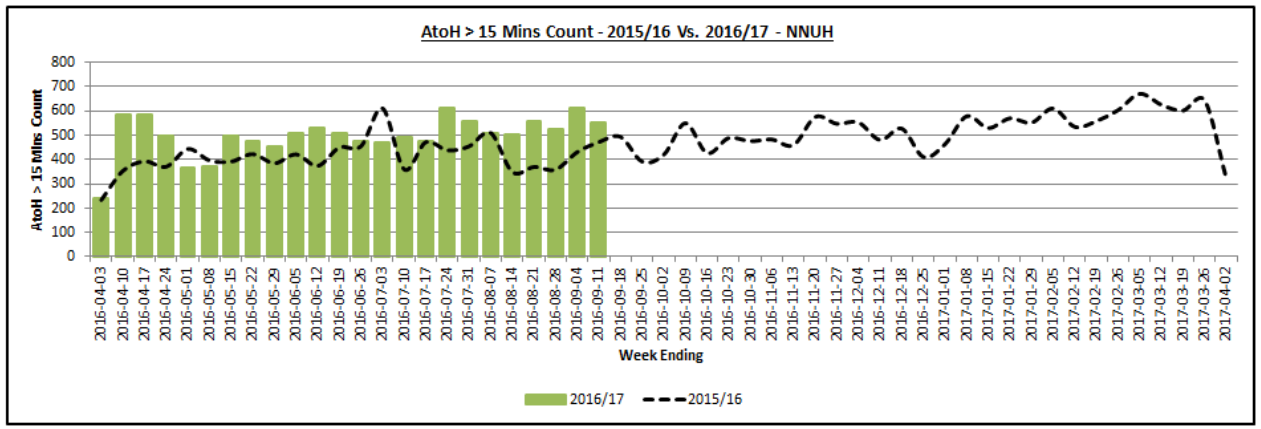


Figure 7: handover to clear for 2015/16 and 2016/17 at the Queen Elizabeth Hospital King's Lynn NHS Trust

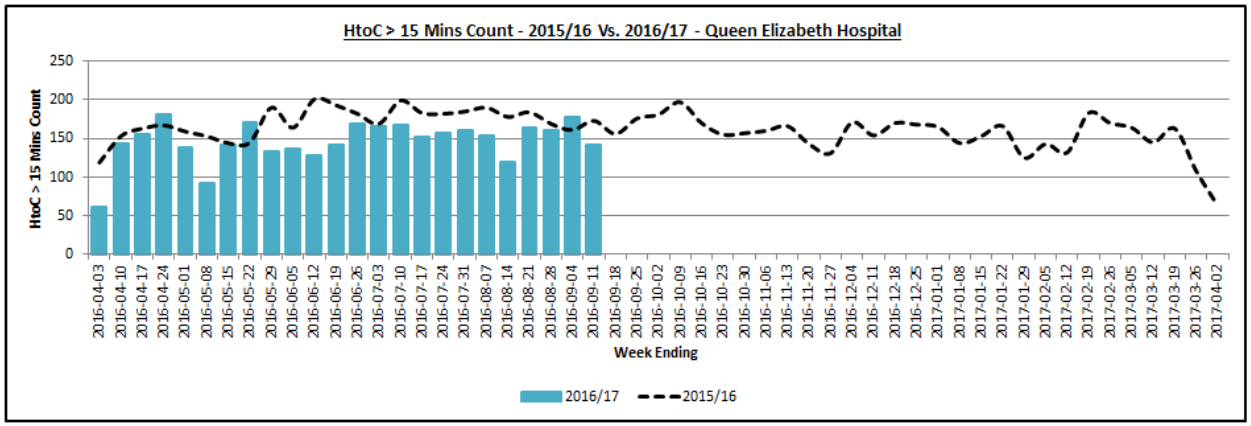


Figure 8: arrival to handover for 2015/16 and 2016/17 at the Queen Elizabeth Hospital King's Lynn NHS Trust

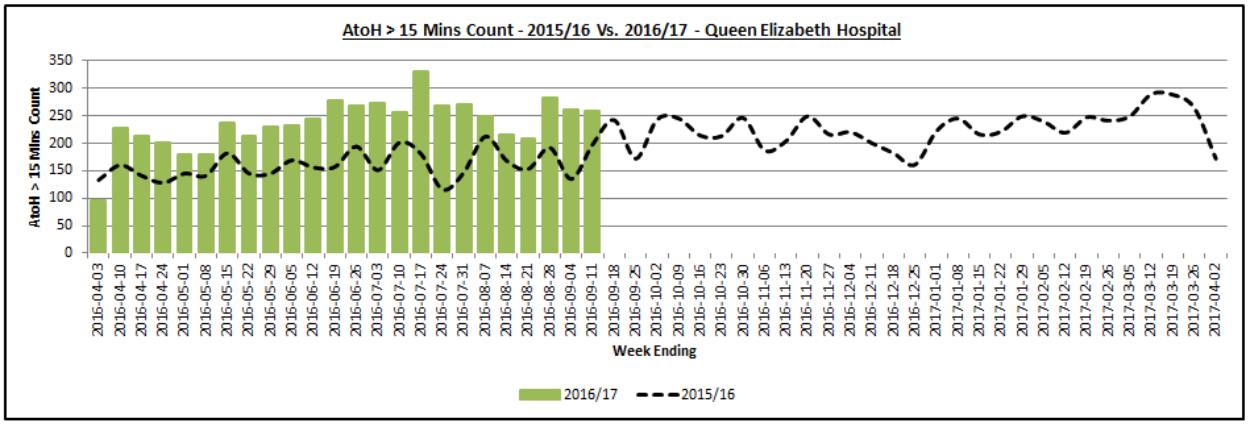


Figure 9: handover to clear for 2015/16 and 2016/17 at the James Paget University Hospitals NHS Foundation Trust

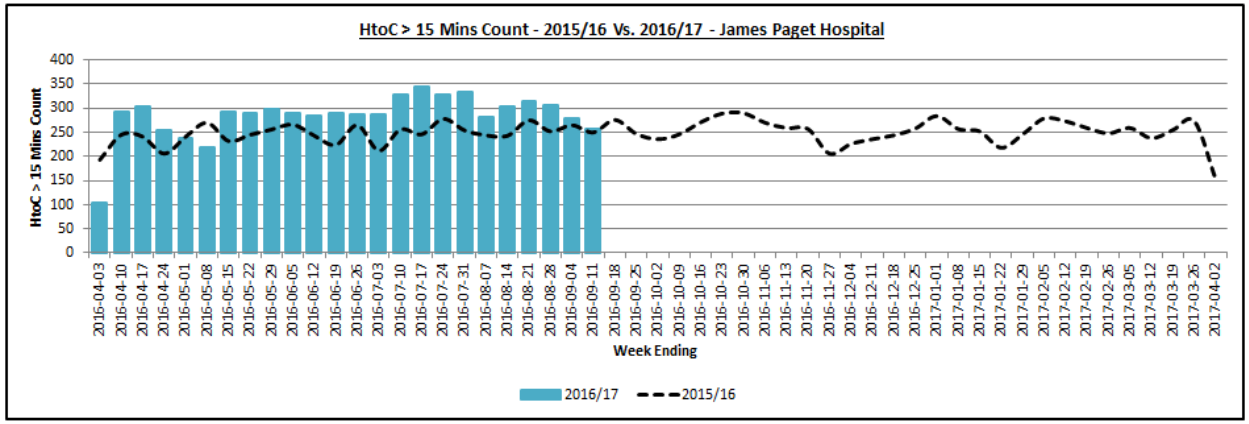
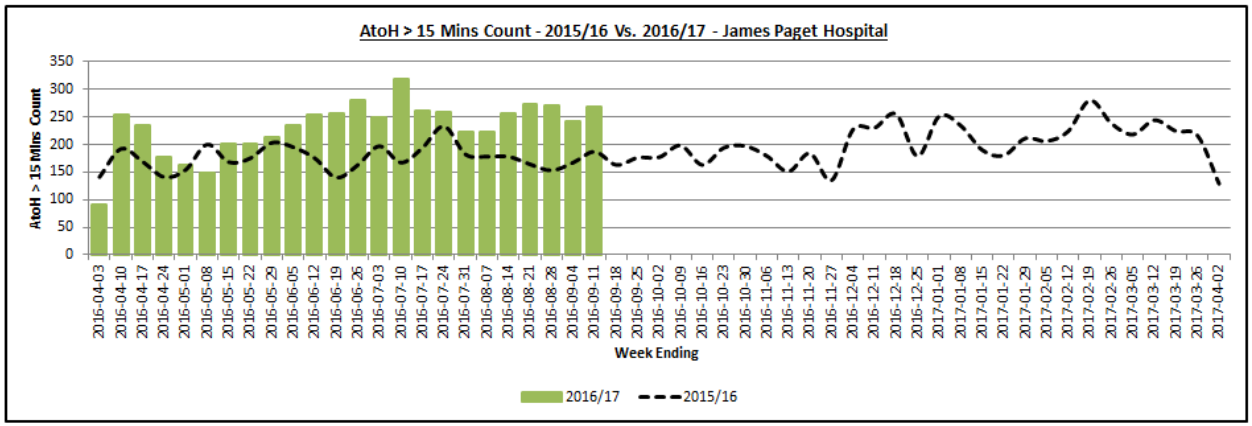


Figure 10: arrival to handover for 2015/16 and 2016/17 at the James Paget University Hospitals NHS Foundation Trust



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 in 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 at most Acutes for

winter 2015, and in particular to increase the availability at NNUH. Whilst that role didn't continue into the 16/17 financial year for the majority, the NNUH did continue to maintain the HALO function, primarily as it is the region's busiest acute. The HALO works with the ED staff to highlight peaks in demand and aids capacity planning and awareness and is now looking to assist in triaging ambulatory patients toward the urgent care centre. The NNUH HALO has been a success and has supported both EEAST and NNUH in addressing some of the continued challenges.

The impact of hours lost on EEAST's performance

Hospital handover delays have a direct impact on ambulance resourcing, performance and patient experience. When a crew is delayed at a hospital it means that it is not available to respond to a patient in the community. This becomes a significant issue at times of increased demand or if multiple ambulance crews are delayed at hospitals. There is also a vortex effect when the only available dispatch at times is from ambulances becoming available at a hospital and this impacts on the travel time to many locations across the area with the obvious elongation of drive times on narrow and challenging roads.

To put this into context, in August EEAST regionally lost 4,589 hours in arrival to handover delays over 15 minutes. This equates to more than 380 double staffed ambulance 12 hour shifts. This represents almost 12 full front line ambulance shifts lost every day of the week. However, ambulance delays at hospitals tend to reflect the wider demand and pressures on the urgent and emergency care system, and not just the ED department.

EEAST works closely with every hospital to ensure delays are minimised, and has good relationships with all three hospitals in Norfolk. EEAST also participates in the A&E recovery board and pre-hospital improvement boards working alongside colleagues from the acute, community and 111 providers. Handover delays are not isolated to Norfolk, but are replicated across our region and nationally.

Norfolk Ambulance Response Times

EEAST has seen a sustained recovery in its performance since March. However, there are further improvements required in Norfolk. In Norfolk the five main challenges to performance are:-

1. Continuing student ambulance paramedic training (training requires EEAST to take them off front line duties so they can attend University)
2. Demand on the 999 service, including significantly increased demand for the sickest patients who require a more complex ambulance response
3. Hospital delays regionally
4. Overall ambulance capacity Vs increased activity
5. Rurality and Road infrastructure

Resourcing

Over the last two years EEAST has sustained a recruitment drive to increase frontline staffing. There is an ongoing challenge to balance the training and development programme (which is absolutely essential to increasing frontline staffing numbers and skill sets) against maintaining operational cover. This will be a challenge for a number of months as we continue with the re-training programme, upskilling our staff and before our first student paramedics register as paramedics.

The table below shows the number of front line staff in post in Norfolk for August. This shows the vast numbers of student paramedics currently employed who are in training. As these students complete their training and qualify as paramedics, it will improve EEAST resourcing both in terms of skill set and capacity. EEAST will continue to proactively recruit staff to minimise vacancies. It is worth noting that Norfolk has been very successful in recruiting to our full establishment, however this presents a further challenge in the number of student ambulance paramedics. This is a two and a half year programme and the first cohort of students are due to qualify in January.

Figure 11: Norfolk staffing

EEAST area	Emergency care assistants	Emergency medical technicians	Student paramedics	Paramedics	Paramedic supervisors	Emergency care practitioners	HCRT	Total
Central Norfolk	17	55	68	84	5	5	15	**249**
West Norfolk	20	29	55	55	4	7	6	**176**
Waveney	19	24	54	59	2	2	7	**167**
Total	**56**	**108**	**177**	**198**	**11**	**14**	**28**	**592**

EEAST is funded to provide a regional trajectory against the national standard. Over the past few years, EEAST has worked closely with commissioners to understand what level of resourcing is needed at individual CCG levels to meet mandated national targets. Given the rural nature of Norfolk, the gap between current resources and what would be needed to deliver the national standards is significant. EEAST actively engages with co-responding schemes in rural communities to ensure that where a life is threatened, a rapid response from within the community can occur and this is an ongoing focus for the service.

Demand

Demand on the 999 service has continued to increase, a trend experienced across the country. Over the last year EEAST has seen significant increases in demand. EEAST in Norfolk has seen green call volume (non life threatening calls) remain largely static, but red calls (potentially life threatening calls and

requiring an eight minute response) increase significantly (+15.31%) over the last 12 months as shown in Figure 12. The optimal way to operate is to proactively move resource to stand by points to await calls and therefore reduce the time taken to travel. With the significant increase in 8 minute response activity coupled with the resource challenges, the capacity to proactively move resource is minimal.

Figure 12: Activity by type in Norfolk

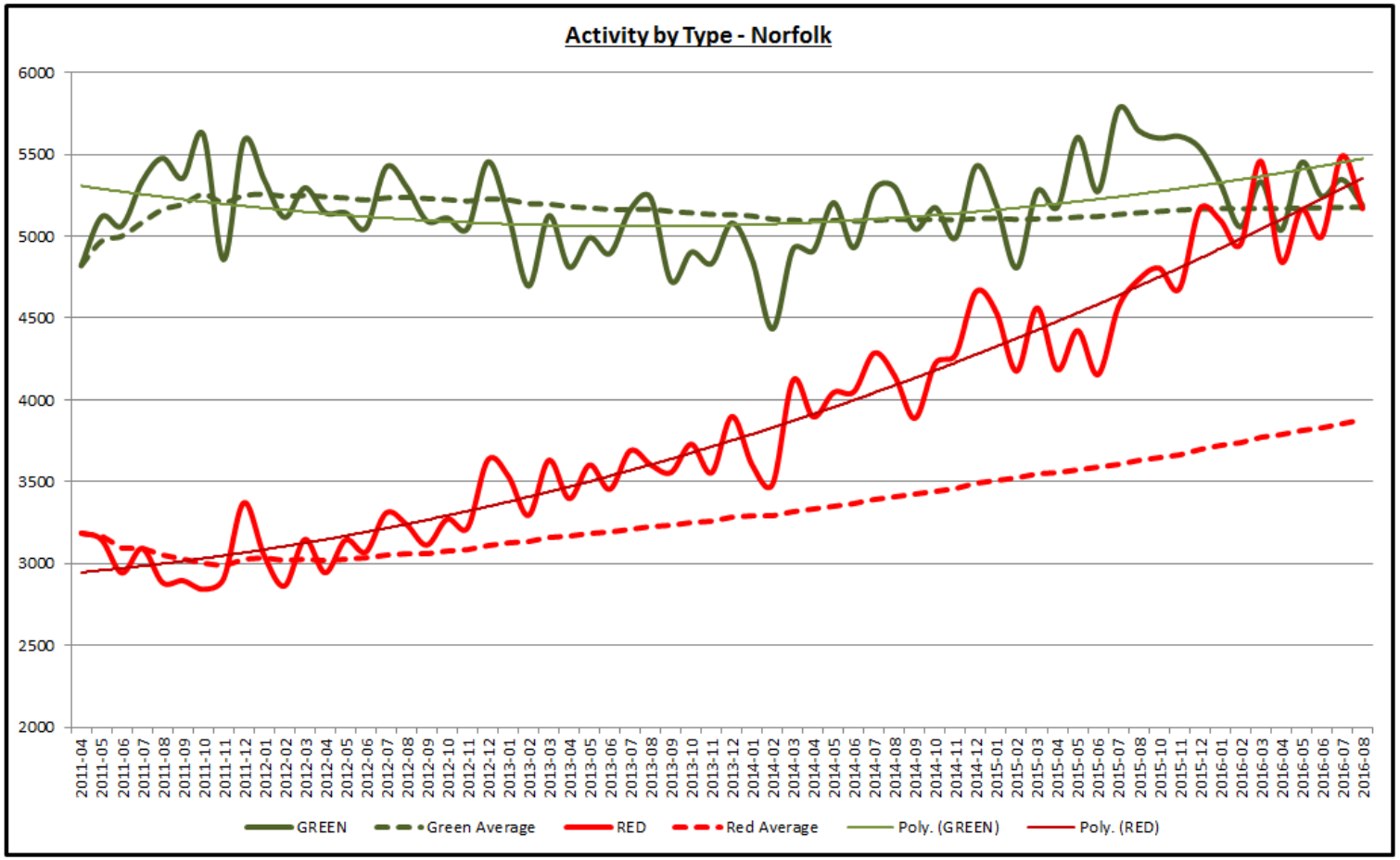


Figure 13: Norfolk Red activity

Red Incident Responses - 2014/15 vs. 2015/15 - Norfolk CCG's

Great Yarmouth and Waveney CCG, North Norfolk CCG, Norwich CCG, South Norfolk CCG, West Norfolk CCG

Month	2014-15	2015-16	Variance	%
September	4457	5015	558	12.52%
October	4903	5481	578	11.79%
November	4904	5334	430	8.77%
December	5338	5955	617	11.56%
January	5229	5863	634	12.12%
February	4797	5657	860	17.93%
March	5171	6296	1125	**21.76%**
April	4784	5572	788	16.47%
May	5036	5924	888	17.63%
June	4785	5748	963	**20.13%**
July	5159	6316	1157	**22.43%**
August	5358	5935	577	10.77%
12 Month Total	**59921**	**69096**	**9175**	**15.31%**

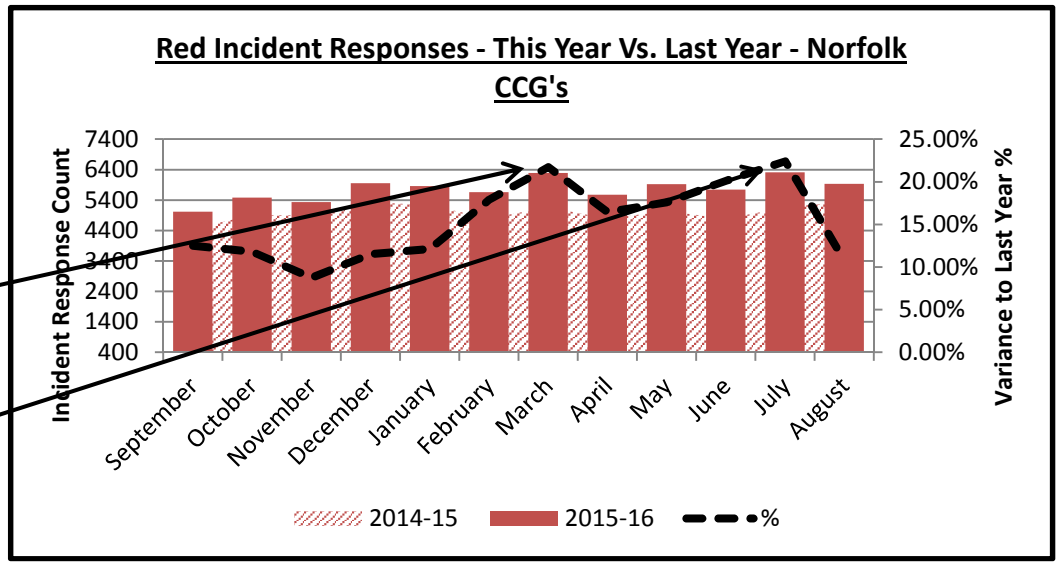
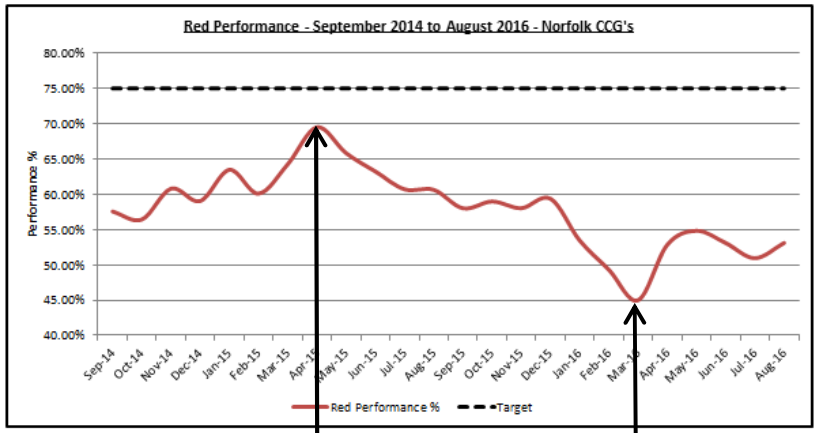


Figure 14: Norfolk Red performance

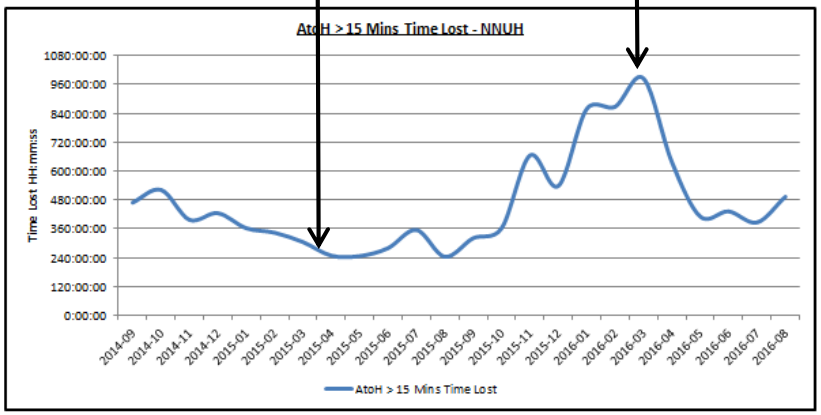
Month	ed Performance
Sep-14	57.57%
Oct-14	56.43%
Nov-14	60.81%
Dec-14	59.05%
Jan-15	63.47%
Feb-15	60.10%
Mar-15	64.26%
Apr-15	69.50%
May-15	65.83%
Jun-15	63.24%
Jul-15	60.71%
Aug-15	60.64%
Sep-15	58.03%
Oct-15	58.99%
Nov-15	58.04%
Dec-15	59.38%
Jan-16	53.45%
Feb-16	49.30%
Mar-16	45.00%
Apr-16	52.85%
May-16	54.84%
Jun-16	53.10%
Jul-16	50.95%
Aug-16	53.11%

Red Performance - Sept 2014 to August 2016 - Norfolk CCG's



AtoH Delays Over 15 Mins at the Norfolk & Norwich University Hospital

Month	AtoH > 15 Mins Time Lost
2014-09	469:20:18
2014-10	522:13:19
2014-11	397:45:45
2014-12	425:21:17
2015-01	362:54:06
2015-02	344:01:20
2015-03	305:12:10
2015-04	248:34:20
2015-05	247:00:34
2015-06	279:52:15
2015-07	355:25:44
2015-08	244:10:08
2015-09	321:15:51
2015-10	362:34:49
2015-11	665:18:32
2015-12	538:17:28
2016-01	858:21:00
2016-02	867:41:06
2016-03	985:30:56
2016-04	637:42:37
2016-05	411:25:19
2016-06	432:33:44
2016-07	386:49:40
2016-08	493:40:54



Please note from the previous figure that a year on year comparison from 2014/15 to 2015/16 shows a total of 15.31% rise in activity within the Red1 and Red2 response categories, with the highest months being March 2016.

This is a clear correlation with the increased hours lost over 15 minutes and the challenge in resource availability to achieve the National Response Time standards.

We continue to work in partnership with the NNUH to ensure that ambulances are able to handover within a timely manner so that the crews are in a position to be available to respond at the point of need.

Despite these challenges, we are still getting to more patients within 8 minutes, with the exception of March and April where the volume of hours lost at hospital and 999 Red activity spiked. This is shown in the graph below.

No of Patients Reached within 8 Mins - This Year vs. Last Year - Norfolk CCG's

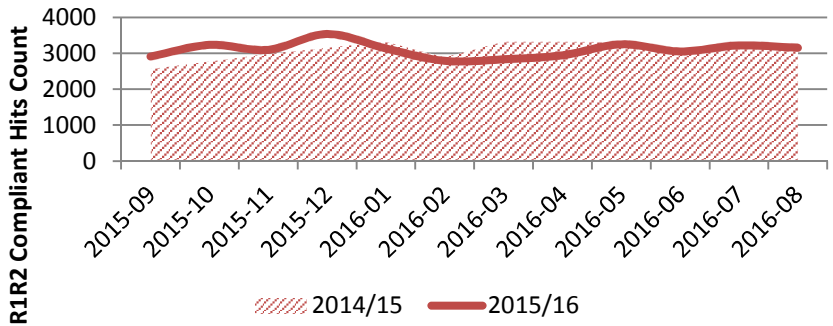


Figure 15: Red 1 performance and average response times by month

Row Labels	Great Yarmouth and Waveney	North Norfolk	Norwich	South Norfolk	West Norfolk	Grand Total
2015-09	77.01%	57.89%	80.30%	56.60%	68.75%	70.21%
2015-10	76.19%	51.52%	77.33%	59.65%	56.25%	67.34%
2015-11	79.12%	44.74%	82.14%	40.48%	76.09%	69.77%
2015-12	78.95%	48.08%	77.50%	64.06%	61.29%	68.27%
2016-01	72.22%	47.54%	83.56%	43.64%	66.67%	64.60%
2016-02	79.49%	35.85%	76.81%	57.89%	69.64%	65.81%
2016-03	60.26%	38.46%	58.11%	30.51%	57.89%	49.83%
2016-04	63.64%	43.86%	63.41%	36.73%	50.00%	53.50%
2016-05	72.73%	47.62%	74.42%	46.00%	51.79%	62.11%
2016-06	63.41%	47.73%	80.82%	56.52%	64.06%	64.40%
2016-07	65.00%	45.00%	68.06%	28.81%	58.18%	55.52%
2016-08	72.94%	48.15%	79.49%	37.88%	62.22%	61.89%
Grand Total	**71.88%**	**45.92%**	**75.11%**	**46.58%**	**61.68%**	**62.73%**

Row Labels	Great Yarmouth and Waveney	North Norfolk	Norwich	South Norfolk	West Norfolk	Grand Total
2015-09	00:05:58	00:07:59	00:05:39	00:08:17	00:07:35	00:06:50
2015-10	00:06:11	00:08:58	00:05:46	00:07:30	00:07:53	00:06:54
2015-11	00:05:45	00:09:06	00:05:04	00:09:30	00:06:42	00:06:39
2015-12	00:06:31	00:08:55	00:05:51	00:07:42	00:07:39	00:07:08
2016-01	00:07:16	00:09:48	00:05:47	00:09:49	00:07:51	00:07:55
2016-02	00:06:17	00:12:06	00:06:14	00:09:09	00:07:25	00:07:59
2016-03	00:08:47	00:11:11	00:07:54	00:11:39	00:09:44	00:09:39
2016-04	00:07:41	00:10:56	00:07:04	00:11:37	00:10:03	00:09:08
2016-05	00:06:59	00:09:48	00:06:44	00:09:27	00:09:06	00:08:02
2016-06	00:07:48	00:10:09	00:07:05	00:09:34	00:08:06	00:08:18
2016-07	00:07:17	00:11:29	00:07:47	00:12:08	00:08:14	00:08:57
2016-08	00:06:51	00:09:50	00:06:33	00:11:28	00:08:49	00:08:27
Grand Total	**00:06:56**	**00:10:07**	**00:06:27**	**00:09:50**	**00:08:16**	**00:08:00**

The light blue table shows Red 1 performance by month by CCG where it can clearly be seen that from an 8 minute performance perspective the most challenged geographical areas are North and South Norfolk.

However it is important to note the average response times in comparison provided in the Amber table. Whilst EEAST are not directly achieving the 8 minute response time to the 75% National Standard in Norfolk as a County the overall average response time is total is 8 minutes.

With the increased rurality of these two areas we are focusing on trying to reduce these averages as close to the 8 minute standard as possible. Actions being taken include:-

- ✓ Working in partnership with the CCG's to explore new alternative care pathway opportunities to allow EEAST clinicians to refer patients and avoid conveyance to hospital
- ✓ Emergency Care Practitioners working alongside other Health Care Professionals within local minor injuries units to improve ambulance conveyance to these local centres for treatment
- ✓ Exploring better use of technology to gain advice and guidance from higher clinical physicians to discuss patient assessment and treatment
- ✓ Trialling a staff responder scheme in geographically challenged areas where additional responding hours can be provided
- ✓ Increasing Community First Responder schemes and hours of availability
- ✓ Utilising paramedic managers to respond to patients to improve ambulance responses and better support staff

Figure 16: Red 2 performance and average response times by month

Row Labels	Great Yarmouth and Waveney	North Norfolk	Norwich	South Norfolk	West Norfolk	Grand Total
2015-09	66.15%	42.19%	72.17%	44.49%	53.52%	57.27%
2015-10	66.94%	40.36%	75.97%	44.02%	56.22%	58.51%
2015-11	68.47%	38.23%	72.44%	43.70%	56.91%	57.34%
2015-12	65.39%	41.08%	73.67%	46.04%	62.58%	58.82%
2016-01	60.61%	35.63%	64.94%	41.16%	56.26%	52.77%
2016-02	59.12%	33.02%	60.02%	36.40%	45.57%	48.33%
2016-03	53.46%	32.50%	53.31%	34.58%	45.25%	44.75%
2016-04	63.22%	32.51%	66.79%	41.45%	52.93%	52.81%
2016-05	64.97%	40.74%	66.55%	39.95%	53.71%	54.43%
2016-06	62.04%	31.60%	68.69%	41.45%	52.73%	52.45%
2016-07	60.27%	32.88%	65.17%	37.70%	50.47%	50.70%
2016-08	61.40%	34.72%	69.11%	39.44%	52.58%	52.59%
Grand Total	**62.41%**	**36.13%**	**67.30%**	**40.73%**	**53.11%**	**53.24%**

Row Labels	Great Yarmouth and Waveney	North Norfolk	Norwich	South Norfolk	West Norfolk	Grand Total
2015-09	00:07:50	00:11:39	00:06:26	00:10:30	00:09:07	00:08:52
2015-10	00:07:38	00:11:40	00:06:09	00:10:36	00:08:59	00:08:44
2015-11	00:07:22	00:12:03	00:06:31	00:10:53	00:08:44	00:08:53
2015-12	00:07:37	00:11:16	00:06:34	00:10:24	00:07:59	00:08:37
2016-01	00:08:28	00:12:52	00:07:19	00:11:27	00:09:06	00:09:39
2016-02	00:08:46	00:13:29	00:08:09	00:12:17	00:10:27	00:10:22
2016-03	00:09:45	00:14:40	00:09:04	00:13:20	00:11:25	00:11:25
2016-04	00:07:46	00:13:07	00:07:17	00:11:17	00:09:42	00:09:35
2016-05	00:07:42	00:11:48	00:07:18	00:11:36	00:09:02	00:09:17
2016-06	00:08:17	00:13:08	00:07:13	00:11:35	00:09:51	00:09:50
2016-07	00:08:37	00:13:46	00:07:41	00:12:09	00:10:15	00:10:14
2016-08	00:08:21	00:12:38	00:07:01	00:11:39	00:09:51	00:09:43
Grand Total	**00:08:13**	**00:12:43**	**00:07:14**	**00:11:31**	**00:09:34**	**00:09:38**

Patient experience

EEAST regularly carries out surveys with patients to understand their experience of contacting and using the ambulance service. The latest results were published in July and the headlines for the Norfolk, Suffolk and Cambridgeshire area were as follows:

Question	Very acceptable	Acceptable	Fairly acceptable	Unacceptable	Very unacceptable
How would you rate the handling of your call?	85.4%	14.6%	0%	0%	0%
How would you rate the length of time you waited for the ambulance service to arrive?	62.7%	29.4%	3.9%	3.9%	0%

- 98% described the ambulance service staff as being very professional, with 2% saying a little improvement was needed
- 100% said that the ambulance staff treated them with dignity and respect
- 76.5% said they were involved in the decisions made regarding their care, with 5.9% saying they were not involved.
- 94.3% were very satisfied with the care they received, with the remaining being satisfied or fairly satisfied

The full results can be found at www.eastamb.nhs.uk/performance/patient-surveys/Patient-experience-report-emergency-services-July-2016.pdf

Stroke Care and Performance

There are two ambulance clinical quality indicators around stroke:

1. 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 hyper acute stroke centre (HASU) within 60 minutes of call.

2. Stroke care bundle. The percentage of suspected stroke patients (assessed face to face) who receive an appropriate care bundle

Figure 17 shows EEAST's performance against the stroke 60 indicator in Norfolk, by CCG area. It can be seen from this that the greatest difficulties achieving the stroke 60 target will be faced in North Norfolk. Figure 18 highlights the drive time challenges faced in Norfolk to the HASU, showing the challenges of this indictor for North Norfolk. Each month EEAST meets with commissioners and stroke 60 misses are discussed in detail, specifically looking at why the miss occurred, if there was any patient harm and if any patterns emerge resulting in actions to improve.

Figure 17: Stroke 60 performance by CCG in Norfolk

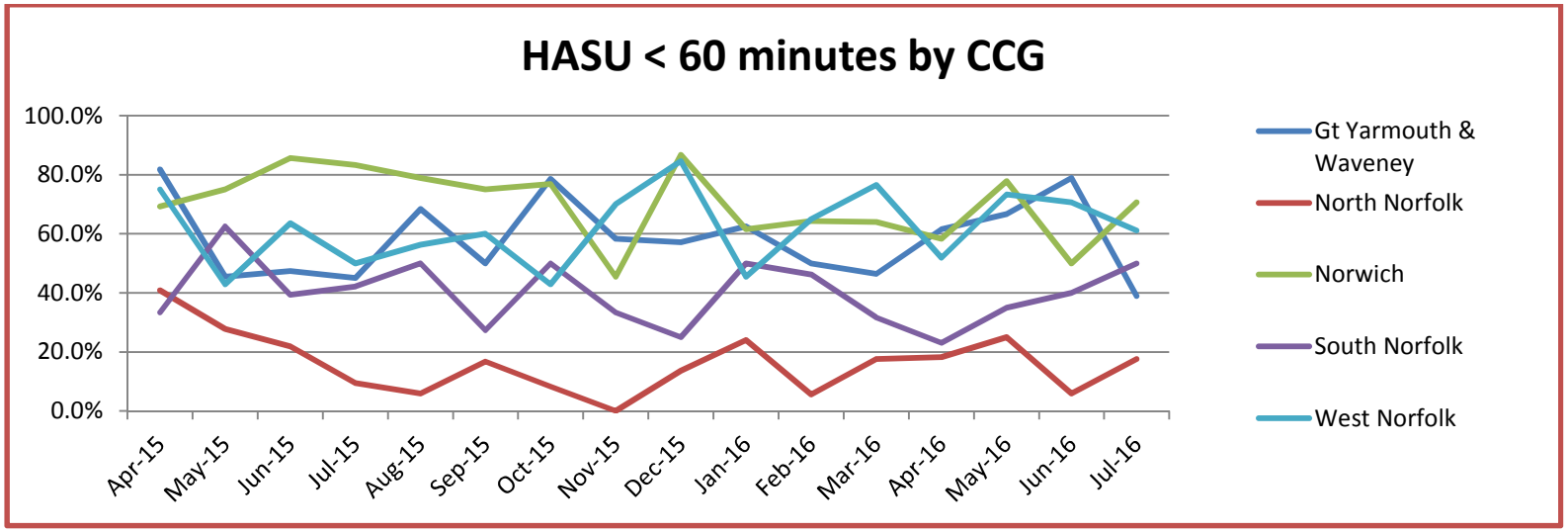


Figure 18: Drive time to stroke facilities

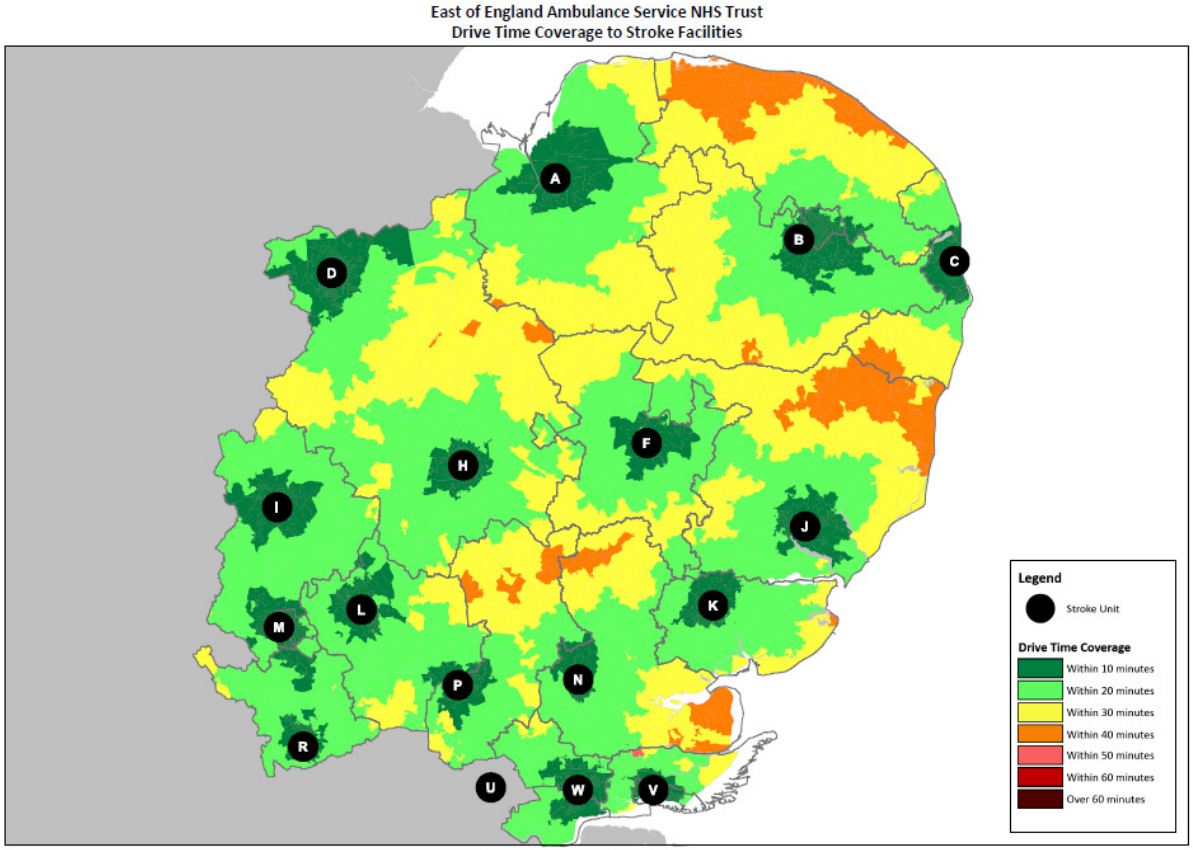
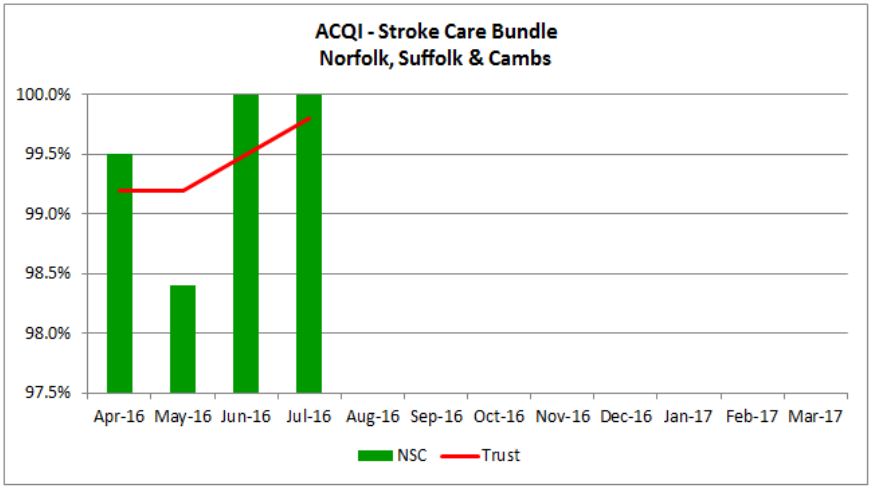


Figure 19 shows EEAST's excellent performance against the stroke care bundle indicator in Norfolk, Suffolk and Cambridgeshire.

Figure 19: stroke care bundle performance

Stroke Care Bundle

July 2016



Stroke Care Bundle - Indicators	E Norfolk	Waveney	W Norfolk
BP recorded (systolic & diastolic)	100%	100%	100%
FAS (Test) result	100%	100%	100%
Blood Glucose recorded	100%	100%	100%
Care Bundle complete	100%	100%	100%

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 13 October 2016

From: Richard Parker - Chief Operating Officer
Norfolk and Norwich University Hospitals NHS Foundation Trust

For: Norfolk Health Overview and Scrutiny Committee 13 October 2016

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

Background

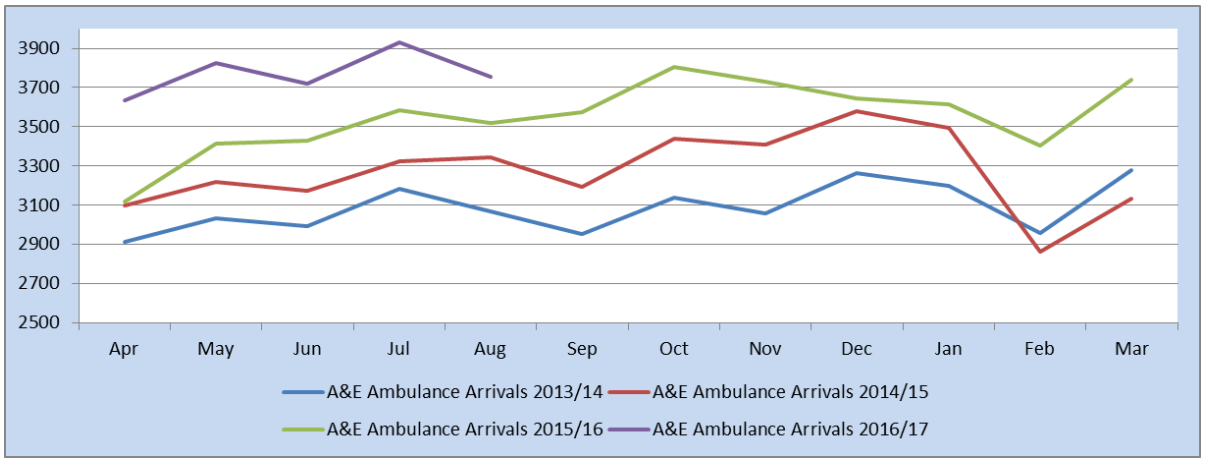
When ambulance handover delays occur at the NNUH it is usually as a consequence of reduced flow throughout the Hospital and/or a significantly higher than expected demand on the emergency admission areas. The attendances at the A&E department were predicted to rise by no more than 2.5% in 2016/17. As at 31st August, attendances in 2016 have risen by 6.5%. The increase in demand has resulted in handover delays.

Ambulance Activity

Ambulance arrivals at the NNUH represent 35% of the total attendances at the A&E department.

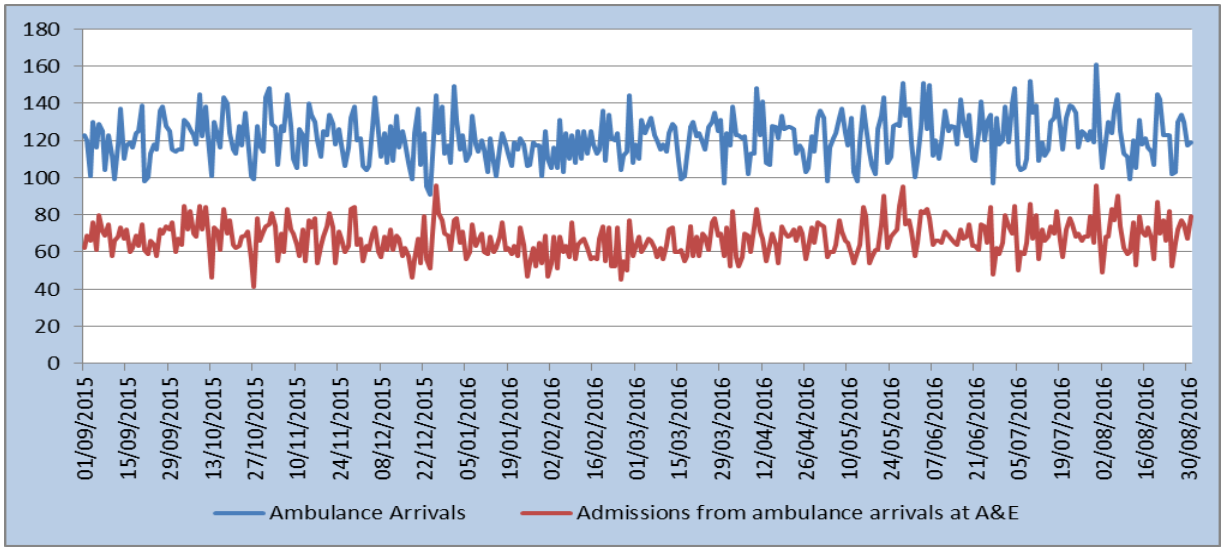
In 2016/17 there has been an overall increase of 8.6% in all ambulance arrivals to the Trust on the same period of 2015/16. The increase in number of patients arriving at A&E via ambulance is a little higher at 10.6%. This represents on average 12 additional ambulances per day at the A&E department.

Table 1. Ambulance arrivals at A&E April 2013 – August 2016.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	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	2861	3134	39275
A&E Ambulance Arrivals 2015/16	3118	3413	3429	3584	3520	3573	3804	3728	3645	3615	3405	3741	42575
A&E Ambulance Arrivals 2016/17	3635	3824	3722	3932	3754								18867

Ambulance arrival at A&E to admission



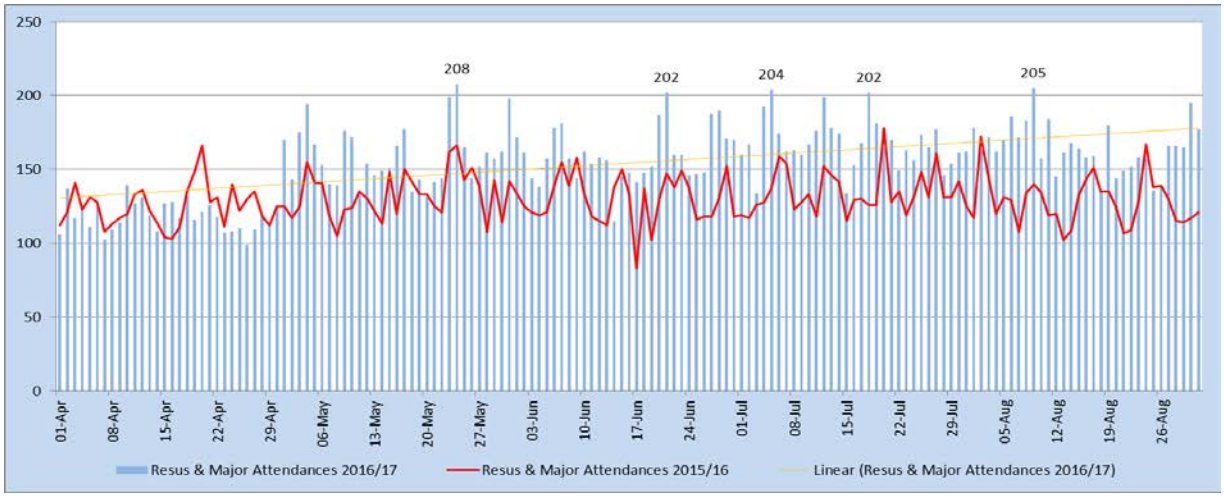
During the period 1 September - 31 August 2016, the rate of admission of ambulance arrivals at A&E has decreased from an average of 57% in 2014 to 55% in 2016. The vast majority of those patients admitted have been seen in either the Majors or Resus areas of the A&E department.

Acuity

Patients requiring Resus or Majors are the patient group with the highest acuity and immediate/urgent care requirements. There has been an 18.5**%** increase in combined majors/resus attendances 1 April – 31 August 2016 versus the same period of 2015.

This represents an additional 3681 resus/majors patient attendances compared with the same period in 2015. That is an average of 24 additional resus/majors patients per day. Assuming that, on average, 180 minutes are required for resus and majors patients, 24 additional patients per day represents 72 additional hours of clinical time in A&E every day. If there is not a consistent uninterrupted outlet to the emergency admission areas it is likely that this level of demand will result in a congested A&E and 4 hour standard breaches and ambulance handover delays.

Table 2. Resus & Major A&E attendances April – August 2016.



Ambulance Handover Performance

The period January – April 2016 was one of the most challenging in terms of volume and complexity of attendance at the NNUH. Since January the performance against the 15 minute handover standard has not yet been re-established at the 2015 levels of achievement. However, there has been a change in the measurement of handover times that shows a slightly misleading downturn in performance.

Ambulance arrivals at the NNUH are triggered by an automatic response from a "geofield" located in a streetlight on the approach to the hospital. Prior to April 2016 a 5 minute allowance was added to the handover time to allow the ambulance time to arrive, disembark the patient safely and enter the A&E department. Since April 2015 the arrival time has been counted at the point that the ambulance triggers the geofield not the arrival time at the hospital.

Table 3. Validated A&E only ambulance handover performance April 2015 – September 2016

NNUH Validated ambulance Handover - A&E only		
Month	<15 Min Handover	> 60 min handover
Apr-15	82.17%	8
May-15	81.91%	17
Jun-15	80.99%	30
Jul-15	79.70%	47
Aug-15	82.91%	4
Sep-15	79.46%	8
Oct-15	81.33%	6
Nov-15	72.33%	33
Dec-15	76.21%	12
Jan-16	65.59%	33
Feb-16	59.30%	19
Mar-16	59.26%	36
Apr-16	43.50%	27
May-16	48.66%	7
Jun-16	48.00%	7
Jul-16	44.99%	11
Aug-16	45.07%	13

Adjusted performance excludes geofield allowance from 1 April 2016

As a snapshot indicator: despite the failure to achieve the national standard, using EEAST's unvalidated data, the NNUH completed more successful <15 minute handovers in August than any other trust in the region and is not currently an outlier in terms of performance against this standard.

Table 3. East of England Region – un-validated ambulance arrival to handover (all entrances) <15 minutes – August 2016. (Source of data: EEAST Daily regional arrival –handover report).

Hospital	Recorded Handovers	<15 mins Total	<15 mins %
Bedford Hospital South Wing	1560	955	61.22%
Stoke Mandeville Hospital	87	50	57.47%
Addenbrookes Hospital	2778	1447	52.09%
Broomfield Hospital	2536	1274	50.24%
Luton And Dunstable Hospital	2043	986	48.26%
Peterborough City Hospital	1751	840	47.97%
Norfolk & Norwich University Hospital	4209	1855	45.07%
James Paget Hospital	2055	924	44.96%
Southend University Hospital	2355	1050	44.59%
Basildon & Thurrock Hospital	1997	825	41.31%
Princess Alexandra Hospital	1746	673	38.55%
Barnet General Hospital	351	132	37.61%
Queen Elizabeth Hospital	1713	636	37.13%
Ipswich Hospital	2389	868	36.33%
West Suffolk Hospital	1630	490	30.06%
Colchester General Hospital	2720	798	29.34%
Hinchingbrooke Hospital	775	226	29.16%
Watford General Hospital	2216	532	24.01%
Lister Hospital	2623	435	16.58%

Table 4. East of England Region – un-validated ambulance arrival to clear (all entrances) <15 minutes - August 2016.

Performance against the arrival to clear standard that applies to EEAST has also failed to meet the requisite 15 minute standard. August is shown below as an indicator of current performance.

Arrival to Clear	Recorded Journeys	% <15
Bedford Hospital South Wing	1673	13.81%
Luton And Dunstable Hospital	2654	12.74%
Stoke Mandeville Hospital	97	9.28%
Basildon & Thurrock Hospital	2739	9.09%
Addenbrookes Hospital	2938	8.37%
Hinchingbrooke Hospital	1111	8.28%
Queen Elizabeth Hospital	1976	8.20%
Lister Hospital	2933	8.11%
Barnet General Hospital	609	8.05%
Princess Alexandra Hospital	1909	7.96%
West Suffolk Hospital	1836	7.79%
Norfolk & Norwich University Hospital	4489	7.66%
Broomfield Hospital	2669	6.97%
Colchester General Hospital	2859	6.96%
Southend University Hospital	2789	6.38%
Watford General Hospital	2582	5.96%
Ipswich Hospital	2456	5.62%
James Paget Hospital	2060	5.39%
Peterborough City Hospital	1985	5.04%

Major Actions Implemented to improve ambulance handover

The NNUH, like many other acute hospitals in the UK, has experienced significant challenges and activity growth at an unpredictable rate across a number of points of access to the Hospital.

Local plans to improve urgent and emergency care are embedded within a system wide recovery plan that is led by CCGs and has agreed contractual performance trajectories. A summary of the most recent actions that will assist with ambulance handover is shown below:

1. A revised Urgent Care Centre model of care was introduced on 1st July 2016 to improve access to the A&E department.

2. A new streaming protocol for walk in patients was introduced in A&E Triage on 15th August 2016.

3. Expanded Ambulatory Emergency Care accommodation was completed in July 2016. Phase 2 works (to create additional care spaces) commenced in September and are due to be completed by the end of October 2016.

4. A new Clinical Decisions Unit for A&E opened on 18th July 2016.

5. Three additional A&E consultants have joined the Department since June 2016 and an advert is out for four more.

6. The Lead A&E consultant has been asked to produce a new rota to increase overnight consultant cover for A&E during weekends from December 2016.

7. Recruitment to Acute Physician vacancies has started to deliver results with additional staff joining the team in September and October 2016.

8. A pre hospital bloods project has been successful and evaluation data from the ambulance service will be requested via the new A&E Delivery Board.

9. An Electronic booking pilot for Medical Ambulatory Emergency Care is now at demonstration stage and is expected to “go live” with 6 practices from the end of September 2016.

10. The system wide Urgent Care Recovery Plan is currently being revised to ensure focus on the 5 new national “mandated actions”.

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 2016 - 17

Meeting dates	*Briefings/Main scrutiny topic/initial review of topics/follow-ups*	*Administrative business*
8 Dec 2016	Supported Care, North Norfolk and Rural Broadland – consultation by North Norfolk CCG	
12 Jan 2017	Community pharmacy – reports from NHS England Midlands and East (East) and Norfolk Local Pharmaceutical Committee on forthcoming changes to local pharmacy services.	*Provisional depending on when NHS E is ready to report*
23 Feb 2017	Continuing healthcare in Norfolk – an update on the implementation and evaluation of the new policy introduced by North Norfolk, South Norfolk, Norwich and West Norfolk CCGs	

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 in 2017

6 April 2017 – Children's mental health services in Norfolk – scrutiny of the service after a full year of operation following the Local Transformation Plan changes.

6 April 2017 – IC24's NHS 111 and GP Out of Hours Service in Central and West Norfolk – an update from IC24 and Norwich CCG (further to the meeting on 14 April 2016)

Members serving on Task & Finish Groups

Task & finish group	Membership	Progress
Children's Services Committee Task & Finish Group Review Review of access to support and interventions for children's emotional wellbeing and mental health	**From NHOSC** Mrs M Stone (appointed 14 April 2016) Ms E Corlett (Chairs the T&F Group and joined NHOSC subsequent to its establishment)	The group expects to report to CS committee in January 2017.

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 David Harrison)
South Norfolk	-	Dr N Legg (substitute Mrs M Stone)
Gt Yarmouth and Waveney	-	Mrs M Stone (substitute Mrs M Fairhead)
West Norfolk	-	M Chenery of Horsbrugh (substitute Mrs S Young)
Norwich	-	Mrs M Stone (substitute Ms E Corlett)

NHS Provider Trusts

Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust	-	M Chenery of Horsbrugh (substitute Mrs S Young)
Norfolk and Suffolk NHS Foundation Trust (mental health trust)	-	M Chenery of Horsbrugh (substitute Mrs M Stone)
Norfolk and Norwich University Hospitals NHS Foundation Trust	-	Dr N Legg (substitute Mrs M Stone)
James Paget University Hospitals NHS Foundation Trust	-	Mr C Aldred (substitute Mrs M Stone)

Norfolk Community Health and Care NHS Trust	-	Mrs J Chamberlin (substitute Mrs M Stone)

Norfolk Health Overview and Scrutiny Committee
13 October 2016
Item no 9

Letter to Norfolk and Suffolk NHS Foundation Trust regarding unexpected deaths

Report by Maureen Orr, Democratic Support and Scrutiny Team Manager

1. Background

1.1 On 8 September 2016 Norfolk Health Overview and Scrutiny Committee (NHOSC) received a report on 'Norfolk and Suffolk NHS Foundation Trust (NSFT) – unexpected deaths – outcome of the Verita review and resulting actions'. The Chief Executive and Head of Patient Safety and Risk attended the meeting to present NSFT's action plans and answer Members' questions.

1.2 During the meeting some issues were raised that were not covered by the Verita review and, due to time constraints on the day, there were some questions that Members did not have the opportunity to ask or explore as fully as they would have liked.

1.3 NHOSC agreed to write to NSFT on these matters. Copies of the letter sent on 9 December 2016 and NSFT's acknowledgement received on 14 September are attached at **Appendix A**. NSFT has undertaken to provide a full response by 28 October 2016.

1.4 NSFT's response will be included with the NHOSC agenda papers for 8 December 2016 meeting. At that stage Members will be able to consider whether to invite NSFT to a future meeting.

2. Action

2.1 NHOSC is asked to note this report.

IN TRAN communication for all	If you need this report in large print, audio, Braille, alternative format or in a different language please contact Customer Services on 0344 800 8020 or 0344 800 8011 (Textphone) and we will do our best to help.

Item 9 Appendix A

Norfolk County Council

County Hall
Martineau Lane
Norwich
Norfolk
NR1 2DH

Mr M Scott
Chief Executive
Norfolk and Suffolk NHS Foundation Trust

Letter sent by email

9 September 2016

Dear Mr Scott

Norfolk and Suffolk NHS Foundation Trust (NSFT) – unexpected deaths

Thank you for attending Norfolk Health Overview and Scrutiny Committee (NHOSC) yesterday and presenting NSFT's response to the Verita review of unexpected deaths carried out earlier this year.

There were some issues raised during the meeting that were not covered by the Verita review and, due to time constraints on the day, some questions that Members did not have the opportunity to ask or to explore as fully as they would have liked. The Chairman has asked me to write to you about these matters on the Committee's behalf.

Could you please respond on the following points by 30 September 2016:-

1. Please provide data comparing NSFT's current level of unexpected deaths with levels in Norfolk and Suffolk in previous years.

2. What affect did the radical redesign of NSFT's services under the Service Strategy 2012-2016 have on levels of unexpected deaths?

3. Are there trends in unexpected deaths that indicate concerns in specific localities or services?

4. Other than general mitigations (e.g. comparison with national average; unreliability of national data; the size of the trust in comparison with others) does NSFT have specific explanations for and analysis of the causes of the increase in unexpected deaths within the trust's area? e.g. to do with
    - specific localities;
    - service lines;
    - service changes;
    - withdrawal of the homeless and outreach service;
    - availability of staff and resources.

5. What is the trend in Coroner Reports to Prevent Future Deaths made in respect of NSFT in recent years and how does this compare with other mental health trusts in England?

6. Please provide assurance of public access to NSFT's information in respect of unexpected deaths in respect of:-
    (a) Statistics published on NSFT's website
    (b) Recording of the Board's analysis and action in response to unexpected deaths

7. We understand that concerns were first raised about the increase in deaths in the summer of 2013. What actions did the Board take during the two and a half years before they commissioned the Verita report?

8. The Verita report notes a comment that Lorenzo (the trust's new electronic patient record management system) would help with Root Cause Analysis (RCA) processes and risk assessments. Is there any data or evidence that this has been the case? Has Lorenzo been raised as an issue in any RCA since its implementation?

9. Please provide year-on-year data, pre and post radical redesign, of the numbers of people under the care of drug and alcohol services (not just the numbers referred but the numbers taken on by the service).

10. Please provide year-on-year data on the number of redundancies and the number of vacancies at NSFT by locality for the period of the 2012-2016 Service Strategy.

11. Regarding the Verita review:-
    (a) Who was involved in setting the terms of reference for the Verita review?
        i. Were staff with experience of unexpected deaths on their caseloads, staff representative bodies and bereaved family members involved?
        ii. Was the Campaign to Save Mental Health Services in Norfolk and Suffolk involved? (this was disputed at yesterday's meeting)
    (b) Did Verita raise concerns with NSFT about the limitations of the terms of reference?
    (c) Did families of service users raise concerns about the limitations of the terms of reference?
    (d) Were bereaved families whose family member died within the period being investigated notified that the review was taking place?
    (e) Were bereaved families whose family member died within the period being investigated explicitly invited to take part in the review?
    (f) How many NSFT staff in addition to the 11 listed in Appendix A to the Verita report were interviewed during the review?
        i. Please provide a breakdown of locality / professional background and band; and
        ii. How many of these staff had direct experience of an unexpected death of someone in their care?

(g) How many of the cases of unexpected death reviewed were:-

i. Of people under the care of the well-being service?
ii. Of people who had been formally discharged from services?
iii. For those who had been formally discharged, what were the lengths of time between discharge and death?

It is the NHOSC Chairman's intention that your response will be included within the Committee's published agenda papers for 13 October 2016. If it is not possible to respond by 30 September, could you please let me know the date by which you would be able to send the information.

Yours sincerely

Maureen Orr

Democratic Support and Scrutiny Team Manager

Ref: JS.cwc
14 September 2016

Trust Management
1st Floor Admin Block
Hellesdon Hospital
Drayton High Road
Hellesdon
Norwich NR6 5BE

Ms M Orr
Scrutiny Support Manager
Norfolk County Council
County Hall
Martineau Lane
Norwich NR1 2DH

Dear Ms Orr

Re: NSFT Unexpected Deaths

Thank you for your letter of 9th September 2016 following the Health Overview and Scrutiny Committee. We are committed to openness and transparency in our reporting, and want to make sure we provide accurate and detailed information.

We are due to receive our draft report from CQC this week, and will need to allocate resources to checking the accuracy and developing a plan in response. We also need to respond to NHS Improvement with an amended Quality Improvement Plan based on the outcomes of the draft report, in readiness for our Quality Summit in October.

To do justice to the information you have requested, I would suggest that we agree that we will provide a response by the 28th October rather than the 30th September. I hope you can appreciate that this delay is to ensure a full and thorough response, given the other commitments we have this month.

Kind regards

Yours sincerely,

Jane Sayer
Director of Nursing Quality and Patient Safety

Cc Michael Scott

Norfolk Health Overview and Scrutiny Committee 13 October 2016

Glossary of Terms and Abbreviations

A&E	Accident and emergency
AtoH	Arrival to handover – the time taken from the arrival of an ambulance at hospital to the transfer of the patient to hospital care
CCG	Clinical Commissioning Group
CCT	Certificate Of Competition Of Training
CHC	Continuing health care
CLARHC	Collaborations for Leadership in Applied Health Research and Care
CPG	Capacity planning group
CQC	Care Quality Commission
CS	Children's Services (Norfolk County Council)
CSU	Commissioning Support Unit
DSA	Double Staffed Ambulance
DST	Decision support tool
DVLA	Driver and vehicle licensing agency
ECCH	East Coast Community Healthcare
ED	Emergency department
EEAST	East Of England Ambulance Service NHS Trust
ESD	Early Supported Discharge
FAST	Face Arm Speech Time (to call 999) – test for diagnosis of stroke
FFT	Friends and Family Test
FTE	Full time equivalent
HALO	Hospital Ambulance Liaison Officer
HASU	Hyper acute stroke unit
HEEoE	Health Education East of England
IC24	Integrated Care 24 (a not for profit social enterprise organisation providing GP out of hours and NHS 111 services in Norfolk)
IT	Information technology
JPUH	James Paget University Hospital
LoTS	Long term stroke care assessment tool
NCC	Norfolk County Council
NCH&C (NCHC)	Norfolk Community Health and Care NHS Trust
NHOSC	Norfolk Health Overview and Scrutiny Committee
NHS E	NHS England
NICE	National Institute for Health and Care Excellence
NNUH	Norfolk and Norwich University Hospitals NHS Foundation Trust
OSC	Overview and Scrutiny Committee

PTS	Patient transport service
QEH / QEHKL	Queen Elizabeth Hospital, King's Lynn
RCA	Root cause analysis
RRV	Rapid response vehicle
SCCE	Social Care Centre of Expertise
SSNAP	Sentinel Stroke National Audit Programme
T&F	Task and finish
TIA	Transient ischaemic attack – a temporary inadequacy in blood circulation in part of the brain, usually caused by a tiny clot. Causes symptoms similar to a stroke.
UEA	University of East Anglia
WTE	Whole time equivalent