Norfolk County Council

Norfolk Health Overview and Scrutiny Committee

Date: **Thursday 18 March 2021**

Time: **10.00am**

Venue: **Virtual meeting**

Pursuant to The Local Authorities and Police and Crime Panels (Coronavirus) (Flexibility of Local Authority Police and Crime Panel Meetings) (England and Wales) Regulations 2020, the 18 March 2021 meeting of Norfolk Health Overview and Scrutiny Committee (NHOSC) will be held using video conferencing.

Please click here to view the live meeting online: https://youtu.be/kSIlsrjNrHs

Committee Members and other participants: DO NOT follow this link, you will be sent a separate link to join the meeting.

Members of the public or interested parties may, at the discretion of the Chair, speak for up to five minutes on a matter relating to the following agenda. A speaker will need to give written notice of their wish to speak to Committee Officer, Hollie Adams (contact details below) by **no later than 5.00pm on Monday 15 March 2021**. Speaking will be for the purpose of providing the committee with additional information or a different perspective on an item on the agenda, not for the purposes of seeking information from NHS or other organisations that should more properly be pursued through other channels. Relevant NHS or other organisations represented at the meeting will be given an opportunity to respond but will be under no obligation to do so.

Membership

MAIN MEMBER	SUBSTITUTE MEMBER	REPRESENTING
Cllr Penny Carpenter	Cllr Ian Mackie / Cllr Graham Middleton / Cllr Haydn Thirtle / Cllr Alison Thomas	Norfolk County Council
Cllr Michael Chenery of Horsbrugh	Cllr Ian Mackie / Cllr Graham Middleton / Cllr Haydn Thirtle / Cllr Alison Thomas	Norfolk County Council
Cllr Fabian Eagle	Cllr Ian Mackie / Cllr Graham Middleton / Cllr Haydn Thirtle / Cllr Alison Thomas	Norfolk County Council

Cllr Emma Flaxman-Taylor	*Vacancy*	Great Yarmouth Borough Council
Cllr David Harrison	Cllr Tim Adams	Norfolk County Council
Cllr Brenda Jones	Cllr Julie Brociek-Coulton / Cllr Emma Corlett	Norfolk County Council
Cllr Chris Jones	Cllr Julie Brociek-Coulton / Cllr Emma Corlett	Norfolk County Council
Cllr Alexandra Kemp	Cllr Anthony Bubb	Borough Council of King's Lynn and West Norfolk
Cllr Robert Kybird Cllr	Cllr Helen Crane	Breckland District Council
Nigel Legg	Cllr David Bills	South Norfolk District Council
Cllr Laura McCartney-Gray	Cllr Cate Oliver	Norwich City Council
Cllr Richard Price	Cllr Ian Mackie / Cllr Graham Middleton / Cllr Haydn Thirtle / Cllr Alison Thomas	Norfolk County Council
Cllr Sue Prutton	Cllr Peter Bulman	Broadland District Council
Cllr Emma Spagnola	Cllr Wendy Fredericks	North Norfolk District Council
Cllr Sheila Young	Cllr Ian Mackie / Cllr Graham Middleton / Cllr Haydn Thirtle / Cllr Alison Thomas	Norfolk County Council
CO-OPTED MEMBER (non voting)	**CO-OPTED SUBSTITUTE MEMBER** (non voting)	**REPRESENTING**
Cllr Keith Robinson	Cllr Stephen Burroughes / Cllr Helen Armitage	Suffolk Health Scrutiny Committee
Cllr Judy Cloke	Cllr Stephen Burroughes / Cllr Helen Armitage	Suffolk Health Scrutiny Committee

For further details and general enquiries about this Agenda please contact the Committee Officer:
Hollie Adams on 01603 223029
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. Minutes

To confirm the minutes of the meeting of the Norfolk Health Overview and Scrutiny Committee held on 4 February 2021. (Page **5**)

3. Members to declare any Interests

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

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

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

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

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

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

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

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

5. Chair's announcements

6.	**10:05 – 11:05**	**The Queen Elizabeth Hospital NHS Foundation Trust** Progress report	(Page **11**)
	11:05 – 11:15	**Break**	
7.	**11:15 – 12:15**	**Local actions to address health and care workforce shortages** Progress report	(Page **34**)
8.	**12:15 – 12:20**	**Forward work programme**	(Page **50**)

Glossary of Terms and Abbreviations (Page **53**)

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Date Agenda Published: 10 March 2021

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Norfolk County Council

NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE
Minutes of the meeting held on Microsoft Teams (virtual meeting)
at 10am on 4 February 2021

Members Present:

Cllr Penny Carpenter (Chair)	Norfolk County Council
Cllr Nigel Legg (Vice-Chair)	South Norfolk District Council
Cllr Michael Chenery of Horsbrugh	Norfolk County Council
Cllr Fabian Eagle	Norfolk County Council
Cllr Emma Flaxman-Taylor	Great Yarmouth Borough Council
Cllr David Harrison	Norfolk County Council
Cllr Brenda Jones	Norfolk County Council
Cllr Chris Jones	Norfolk County Council
Cllr Alexandra Kemp	Borough Council of King's Lynn and West Norfolk
Cllr Robert Kybird	Breckland District Council
Cllr Laura McCartney-Gray	Norwich City Council
Cllr Richard Price	Norfolk County Council
Cllr Sue Prutton	Broadland District Council
Cllr Sheila Young	Norfolk County Council

Substitute Members Present:

Cllr Wendy Fredericks for Cllr Emma Spagnola	North Norfolk District Council

Also Present:

Hollie Adams	Committee Officer, Norfolk County Council
Jessamy Kinghorn	Head of Partnerships and Engagements, NHS England and NHS Improvement, East of England
Maureen Orr	Democratic Support and Scrutiny Team Manager, Norfolk County Council
Claire Weston	Head of Health and Justice (East of England), NHS England & Improvement, East of England

1. Apologies for Absence

1.1 Apologies were received from Cllr Keith Robinson and Cllr Emma Spagnola (Cllr Wendy Frederick substituting). Also absent was Cllr Judy Cloke.

2. Minutes

2.1 The minutes of the meeting on 26 November 2020 were agreed as an accurate record.

2.2 **Matters arising from the minutes:**

- Cllr Alexandra Kemp updated the Committee that the first meeting with local councillors regarding St James' Surgery had taken place; Southgates Surgery had no capacity for more patients at that time.

3. Declarations of Interest

3.1 The vice-chair declared a sensitive "other" interest.

4. Urgent Business

4.1 There were no items of urgent business.

5. Chair's Announcements

5.1 The Chair had no announcements.

6. Prison healthcare – access to physical and mental health services

6.1.1 The Chair noted that the meeting was taking place during the second nation-wide lockdown for Covid-19 and at a time of great pressure on the health service. She thanked the commissioners from NHS England & Improvement for attending the meeting and acknowledged the hard work of local health services for their work in dealing with the challenges of the pandemic.

6.1.2 The Committee received the report examining commissioning and delivery of physical and mental health services provided at the three mainstream prisons in Norfolk; HMP Norwich, HMP Bure and HMP Wayland

6.2.1 The following points were discussed and noted

- Members asked why no prison representatives had attended the meeting; the Democratic Support and Scrutiny Team Manager clarified that there was less capacity for healthcare services to attend meetings at that time, including those in prisons, because of the pressure of the Covid-19 pandemic. It may be possible to invite them to a future meeting if members wished to revisit the topic.
- Equity of healthcare was queried. A paper had been produced looking at equity and the principle of equivalence, setting out expectations for healthcare prison providers. In rare cases where prisoners died in custody, the Head of Health and Justice (East of England) reported that the prisons and probations ombudsman (PPO) would carry out a review to identify if care had been equivalent to care provided in the community.
- Areas of concern, such as breaches of access to healthcare or waiting times outside the required standards, would be reviewed by the Care Quality Commission, who would identify whether concerns were a systemic issue or a local breach of standards.
- Drug services and management of long-term conditions at Wayland were felt by a Member as not being equitable to those provided in the community, based on information in the report. The Head of Health and Justice (East of England) replied that support for long term conditions was monitored by the NHS QOF (Quality and Outcomes Framework), as it was in the community. The Improving Access to Psychological Therapies (IAPT) programme was commissioned for prisons in Norfolk; it was noted that not all areas commissioned this service for prisons.
- Concern was raised about commissioning of GP oversight; the Head of Health and Justice (East of England) replied that if there were any breaches in this service, they would have been identified during inspection.
- It was confirmed that commissioners made regular inspections to prisons and kept up to date on difficulties they were experiencing. Due to the Covid-19 pandemic, site visits had not been possible for the past year, but QOF points were reviewed to ensure commissioners were kept informed about compliance.
- When people first arrived at prison, they would receive a primary physical and mental health screening from a nurse; people may be unwilling to disclose information about their mental health at this time for various reasons, but nurses would flag any

concerns. A second health screen would be carried out shortly after arrival at prison to allow a nurse to explore health needs more fully.

- Learning disability in prison was underestimated; this could be because people did not want to disclose this information due to feeling vulnerable or anxious. The Head of Health and Justice (East of England) recognised that more needed to be done to understand learning disabilities in prisons, including following up on how recently prison staff had received training. There was a move towards de-medicalising learning disabilities, and toward providing support.
- The rate of suicide and self-harm in prisons and the higher rate in Norwich prison was queried. The Head of Health and Justice (East of England) replied that Norwich was a remand prison and these prisons tended to have a higher rate of suicides; prison officers and healthcare staff tried to identify people at risk of suicide and the prison service had introduced a key worker scheme to support prisoners with issues.
- Many routine actions had been stood down in order to allow staff to respond to the pandemic, protect prisoners' health and preserve life.
- The Chair queried how the health and wellbeing of prisoners was being supported if prisoners were in their cells for many hours a day due to a Covid-19 outbreak. The Head of Health and Justice (East of England) reported that since measures had been in place in prisons to preserve life, mental health teams had been visiting people in their cells who were at risk of crisis or poor mental health. In some prisons, teams were offering support services in cells or via phone therapy if telephony was available in cells. People were offered distraction packs to help them with their mental wellbeing. Some prison health teams delivered healthcare on wings during the time prisoners were out of cells.
- The Head of Health and Justice (East of England) **agreed** to find out how prison officers were trained to identify mental and physical health needs of prisoners.
- The Head of Health and Justice (East of England) was aware of the issue of undiagnosed autism in prisons and the need to develop strategies to identify and support people.
- It was clarified that commissioners would ensure prisons were responding to required health need rather than providing a specific number of GP sessions. Increasing responsibility for prescribing to appropriately trained nurses and other professionals had also reduced the requirements on GP time.
- The Head of Health and Justice (East of England) clarified that at the start of the pandemic, the need for some types of reporting were relaxed; this may have impacted on some of the performance indicators. The aortic aneurism screening outcome may be 0 as people were required to go to a hospital to receive this. Diabetic retinopathy screening was reviewed to ensure people received this as required in line with national requirements. A recent audit of seven prisons by Healthwatch Norfolk found that the diabetes service was good and, in some cases, better than in the community.
- It was suggested that there may be more complaints at Wayland Prison because this was a larger prison with more inmates.
- Concerns were raised about the quality of dentistry provision provided in prisons
- The fact that the Independent Monitoring Board (IMB) no longer attended contract meetings was queried. The Head of Health and Justice (East of England) agreed that the IMB performed a valuable role in ensuring the conditions in prisons were humane and standards were being driven. When the contract changed it was found that the IMB did not attend NHS meetings in other counties, and the arrangements were therefore changed to be in line with those in other areas. The IMB, Healthwatch and other organisations still worked together to drive forward standards in prisons.
- Members were concerned about the fact that prison healthcare services did not have access to community based clinical records and implications of this for prisoners' health. The Head of Health and Justice (East of England) replied that processes

were in place for prison healthcare professionals to contact community healthcare to gather information if an individual disclosed a healthcare need. Members **requested** information on why prisons were not able to access community healthcare records. Prison systems could access the records of patients moving between prisons.

- Work was underway to update SystemOne for prisons and bring about other changes related to registering people with a community GP before they leave prison. This was being centrally led to ensure changes were put in place nationally.
- Commissioning of interpretation services in prisons was queried. The Head of Health and Justice (East of England) confirmed that providers were responsible for engaging with interpreters and translation services where needed, including British Sign Language and other adaptations such as easy read documents. Commissioners would hear about any issues through PPO reports and deaths in custody, but there were no specific indicators to review breaches.
- Paragraph 2.81 on page 49 was queried: "The prison was in the process of implementing a new drug and alcohol strategy, but it did not have an action plan or needs analysis to inform future service developments" The Head of Health and Justice (East of England) thought this was probably an action for the Governor but **agreed** to find out more about this.
- The strategy for taking people off addictive drugs when they came into prison was queried; a formulary had been developed by the national pharmacists for health and justice and procedures were in place in compliance with this.
- The Head of Health and Justice (East of England) confirmed that prison 'hospitals' were cells set up to provide enhanced nursing; the prison environment was the responsibility of Her Majesty's Prison Service to maintain and therefore the commissioning team could not make changes to it. The Head of Health and Justice (East of England) did not consider the term 'hospital' a suitable description for this service. Cllr Kemp was keen that commissioners pursued improving the environment.
- The Head of Health and Justice (East of England) was asked whether the health and mental health of staff support was commissioned, and how the Covid-19 pandemic had impacted on staff. The Head of Health and Justice (East of England) replied that she would review the support given to staff with prison governors. During the pandemic, prison staff had given each other peer support.
- New prisoners were tested for Covid-19 on arrival at prison and then on day five; they were accommodated on a "reverse cohorting unit" for 14 days and would be tested twice in this time to identify whether they had the virus. Prisoners were also tested on release however could not be held if they were found to have Covid-19 so they would be released with advice on social distancing and isolating to reduce transmission.
- An update on how prisoners would be vaccinated was available on the Ministry of Justice website, and it was confirmed that vulnerable and elderly prisoners would be vaccinated first. It was however confirmed that prison officers were not included in the Joint Committee on Vaccination and Immunisation priority groups at that time.
- Staff vacancy rates were received from prison providers quarterly; it had been difficult to recruit staff in the Phoenix Substance misuse service, but progress was being made on this. Two of the Norfolk Prisons were in very rural locations which could create difficulties for staff recruitment and retention.
- it was noted as important for prison-based nurses to maintain contact with hospital-based healthcare professionals to ensure support was in place when people returned to prison.
- A Member asked when prisoners were given information on how to make complaints about the healthcare provided to them in prison and how they would be assisted to make a complaint if they had English as an additional language or communication

difficulties. The Head of Health and Justice (East of England) **agreed** to provide a written response to this question.

- It was confirmed that prison officer testing was part of community testing, and the Head of Health and Justice (East of England) was **asked** to confirm how prison officers would receive their test results.
- The wait time for mental health support and therapy in prison following referral during normal circumstances, i.e. before Covid-19, was queried; The Head of Health and Justice (East of England) **agreed** to find this out.

6.5 The Norfolk and Waveney Overview and Scrutiny Committee (NHOSC):

- **REQUESTED** additional information from NHSE&I on:
  - The number of prison officers who have received mental health awareness training, including both the the number and percentage of total number of prison officers trained.
  - Details of the training given to prison officers to spot prisoners' health needs, mental and physical.
  - Details of the work programme to update SystmOne so that people are registered with a GP prior to release from prison.
  - Details of the communication possible between SystmOne in prisons and SystmOne in the community.
  - Information on the point at which prisoners are told how to complain about healthcare services.
  - Information on the point at which prisoners are given details of the interpreting service that can assist them with making complaints.
  - Waiting times for Improving Access to Psychological Therapies (IAPT) one year ago, before the effects of the pandemic.
- **RECOMMENDED** that NHSE&I:
  1. Put in place a performance indicator for monitoring provision and use of interpreting services in prison healthcare.
  2. Check whether prison staff at Norwich prison are given the results of their regular Covid-19 tests and advise they should be as a matter of healthcare ethics
- **AGREED** that Prison healthcare would be included on NHOSC's forward work programme for 12 months' time

9. Forward work programme

9.1 The Norfolk Health Overview and Scrutiny Committee received and reviewed the forward work programme.

9.2 It was explained that the topics on the agenda for 18 March 2021 meeting may need to be adjusted depending on the pressures on the local and regional NHS due to the Covid-19 pandemic. Because of the wide ranging nature of the report on support for people with sensory impairments, the CCG felt they would be unlikely to be able to fully support this topic at the March meeting. It was thought the part affecting the Deaf community and NHSE&I's commissioning of British Sign Language and interpreting services could probably go ahead, but this would be dependent on NHSE&I staff being able to attend the meeting.

9.3 The Norfolk Health Overview and Scrutiny Committee **AGREED** the forward work programme with the addition of 'Prison healthcare – access to physical and mental health services' for February 2022.

Chairman

The meeting ended at 12:08

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Norfolk Health Overview and Scrutiny Committee
18 March 2021
Item no 6

The Queen Elizabeth Hospital NHS Foundation Trust – progress report

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

Examination of the Queen Elizabeth Hospital NHS Foundation Trust's (QEH) progress following the Care Quality Commission (CQC) full inspection in 2019 and the hospital's last report to NHOSC in February 2020.

1.0 Purpose of today's meeting

1.1 The purpose of today's meeting is to:-

(a) Examine the QEH's progress in addressing the issues raised by the 2019 CQC full inspection report alongside dealing with the demands of the Covid 19 pandemic.

(b) Examine the QEH's response to findings of the latest CQC visit in September 2020 (report published 16 December 2020)

1.2 The QEH was asked to provide the following information for today's meeting:-

- Action taken in line with CQC requirements since QEH representatives last attended NHOSC in February 2020
- Action still to be taken and the timeline for doing so
- The current position in respect of the hospital's key performance indicators (KPIs); service quality and financial, along with benchmarking against similar Trusts (if available and if meaningful benchmarking is possible in light of the variable effects of the Covid 19 pandemic across different hospitals at different times in the past year)
- Plans for catch-up during 2021 in elective surgery and other services where catch-up is necessary due to the impact of the pandemic
- Progress on reducing ambulance turnaround times at the hospital
- The current situation with regard to staffing and action to address shortfalls and relieve pressure (bearing in mind the impact of Covid 19)
- The current situation with building safety and bids for hospital re-build funding
- Details of the QEH's purchase of the Sandringham Hospital and the way in which the additional space is being used.
- Any other relevant information

The QEH's report is attached at **Appendix A**.

Members should note that the pandemic has had a negative impact across the NHS in terms of waiting times for services and ambulance turnaround times. The QEH's performance must be viewed in that context.

1.3 Representatives from the QEH will attend to answer the committee's questions.

2.0 Background

2.1 Representatives of the QEH attended NHOSC on 13 February 2020 along with the service commissioners, Norfolk and Waveney Clinical Commissioning Group (CCG). The committee examined the Trust's response to the CQC's inspection report published on 24 July 2019, which had continued to rate the hospital 'inadequate' overall. The hospital remained in 'special measures', where it had been since September 2018. The report to NHOSC and minutes of the meeting are available through the following link:- NHOSC 13 February 2020. It should be noted that the CQC inspection took place between 5 March and 24 April 2019, starting just seven weeks after the new Chief Executive joined the QEH.

In February 2020 the QEH judged that 75 out of 206 actions identified by the CQC had been completed and the Trust hoped to be out of special measures by summer 2020. This was before the onset of the Covid 19 pandemic and suspension of routine CQC inspections between March and September 2020.

2.2 The latest CQC report – December 2020

2.2.1 The CQC returned to the QEH between 14 and 23 September 2020 and published its report on 16 December 2020. The report is available on the CQC website:-
CQC inspection report Dec 2020

This was not a full inspection, which meant that the hospital's overall rating of 'inadequate' could not be changed. It focused on six services which had given concern in the 2019 inspection but did not cover the full range of the CQC's usual inspection questions (i.e. within the domains of Safe, Effective, Caring, Responsive, Well-led). The report specifies which domains were inspected within each of the six services.

The findings were encouraging, with an improved overall rating in four of the six services.

Urgent and Emergency Care and Medicine had been rated as 'Requires improvement' for 'Caring' in 2019, which was a strikingly low rating in this domain for an NHS establishment. In the September 2020 inspection both these services had improved to 'Good' for 'Caring'.

It should be noted that the inspection took place during the Covid 19 pandemic, which has been a period of great pressure on the NHS.

2.2.2 The following is a very brief summary of positive and negative findings in each of the six services inspected:-

Urgent and emergency care

Positives:-

- Across all key questions we saw that there had been a number of improvements which were focused on patient safety and improving the patient's journey
- There had been changes to local leadership and governance processes had been strengthened
- Staff ensured that patients were assessed and escalated if necessary
- There were processes in place to support a team approach to care
- The multidisciplinary team worked cohesively to a common goal
- Staff felt supported by the local, divisional and senior leadership teams
- Robust governance structures aligned to the Trust board
- Clear accountability across the division

Negatives:-

- Leaders had not been in post for sufficient time to demonstrate a sustained improvement in performance
- The service was not meeting national targets
- Recruitment to substantive posts had been challenging

Medicine

Positives:-

- There had been improvements across the service
- Patient records were complete and detailed
- Staffing levels were regularly reviewed and adjusted to manage peaks in activity on wards
- There were equipment checks in place
- There had been a number of changes in response to COVID -19, and staff had been trained to manage patients with different conditions to their usual speciality
- Risk assessments were completed, and staff acted on findings
- Patients and their families were considered when planning care and included where possible
- Staff demonstrated compassionate care and were supportive to patients, relatives and each other in perceived difficult circumstances
- There were robust processes underpinning the division's functioning with regular risk assessments and meetings to review performance and share learning across medicine specialities.

Negatives:-

- Leaders had not been in post for a sufficient time to demonstrate a continued and sustained improvement
- Patient records were not always stored securely

- Clinical areas were sometimes short staffed
- Equipment checks were not always completed (in one clinical area).
- Performance with national audits varied

Surgery

Positives:-

- Patients admitted to surgical area were assessed and monitored for risks, any deterioration was escalated quickly
- There were enough staff to manage patient care and treatment
- Incidents were recognised and shared locally and across the wider team
- Staff were aware of and had learnt from incidents that impacted on their services
- The World Health Organisation (WHO) five steps to safer surgery process had been embedded
- There were robust processes in place to monitor performance and risk
- Staff were largely positive about their jobs and the teams in which they worked
- The service had robust recovery plans and service development plans in place to ensure protected activity (in response to the Covid 19 outbreak's effect on referral to treatment times)

Negatives:-

- The service had been affected by the COVID- 19 outbreak and referral to treatment times had been impacted negatively
- Mandatory training compliance was lower than the Trust target

Maternity

Positives:-

- Maternity services had taken action to address concerns raised at the last inspection
- There had been changes to staff training and competence and agency staff were fully inducted
- Equipment was serviced regularly
- Medicines were stored securely
- Patient risks were identified and escalated appropriately
- staff shared learning from incidents
- There had been changes to the leadership team and governance processes had been reviewed and embedded

Negatives:-

- Staffing numbers were not within establishment which impacted on coordinators abilities to be supernumerary
- There was minimal representation from midwifery staff at meetings
- Although work had been completed on improving engagement, there were some pockets where the culture was not as positive

End of life care

Positives:-

- Since the outbreak of COVID- 19 there had been a Trust-wide focus on providing end of life care which resulted in significant improvements
- The end of life team worked collaboratively across the health economy to manage patients, ensure their comfort and support families
- There was an end of life care strategy which addressed concerns raised at the April 2019 inspection
- Staff were engaged with the processes of embedding practical elements to ensure good quality end of life care
- There was a governance process which included regular auditing which helped to identify areas of improvement and performance against targets
- Improvements were being driven by the team and Trust wide staff, despite the lack of palliative care consultants
- Records were generally to a good standard detailing action taken

Negatives:-

- Patients did not always receive timely care
- Records sometimes lacked details, such as printed staff names
- Mental capacity assessments were not always completed
- Performance against national and local standards were variable.

Diagnostic imaging

Positives:-

- There was recognition by leaders that further work was needed to embed new governance processes and risk management systems
- There had been a number of improvements within diagnostic imaging, particularly around the safe administration of contrast media
- Staff ensured there were processes in place to review the use of contrast media and ensure it was administered in line with guidance
- Staff were familiar with their roles and responsibilities on ensuring patients safety using appropriate risk assessments as necessary
- A new leadership team had developed systems for supporting staff to develop and staff were committed to improving
- There was a positive team culture amongst staff

Negatives:-

- There were some gaps in team leadership and staffing numbers which sometimes impacted on out of hours cover and morale
- Capacity issues also impacted on the Trust-wide performance in meeting referral to treatment times
- New governance processes and risk management systems were not fully embedded

2.2.3 The CQC found three breaches of legal requirements which resulted in three new improvement notices regarding the following (must dos):-

Maternity

- The Trust must ensure that anaesthetists complete PROMPT (Practical Obstetric Multi-Professional Training) training.

Diagnostic imaging

- The Trust must ensure that staffing levels are adequate to provide safe care and treatment to patients in a timely way.
- The Trust must be assured that the out of hours staffing arrangement is sustainable and robust to provide safe care and treatment to patients.

There were a further 33 areas where the CQC advised the Trust it should improve (should dos).

2.2.4 Several other conditions and warning notices that the hospital had been under were lifted during 2020 and January 2021. Details are set out in the QEH's report at Appendix A.

2.2.5 The QEH is expecting the CQC to return in spring 2021 for a full inspection of the Trust.

2.3 **Purchase of BMI Sandringham hospital**

2.3.1 On 24 September 2020 the Trust wrote to stakeholders that its Board of Directors and Governors' Council had approved the purchase of the BMI Sandringham Hospital, which is adjacent to the QEH.

This enabled an increase in elective surgical care capacity, which is particularly important as the Trust works to recover services to pre COVID-19 levels.

The purchase saw the trust increase its bed base by 30 and the number of theatres by two.

76 staff employed by the BMI Sandringham Hospital were to join the team at QEH.

3.0 Suggested approach

3.1 The committee may wish to discuss the following areas with the QEH representatives:-

(a) In view of the pressures of the Covid 19 pandemic during winter, has the QEH been able to address the 'must do' actions around improving staffing levels in diagnostic imaging and ensuring that staff receive mandatory training in the diagnostic imaging and maternity services?

(b) The QEH leadership team has focused on engaging with staff and building a positive culture to improve the service for patients. Given

the extreme and ongoing pressures on staff during the Covid 19 pandemic, how does the Trust plan to support this in the coming months?

(c) At the time of the last report to NHOSC the QEH was looking to develop a school of nursing in King's Lynn and it was hoped it could open in 2021. It is understood that the first students are expected to be recruited in the last quarter of 2021-22. What impact will this have on staffing at the hospital?

(d) In February 2020 NHOSC heard that the QEH had been identified as one of the least digitally mature healthcare organisations in England. What were the implications of this at the start of the Covid 19 pandemic and how has the situation changed since then?

(e) It is understood that the three acute hospitals in Norfolk have been looking to work more closely together. At the time of the last report to NHOSC this was happening particularly with the integration of urology and digital services. Have further developments been possible in the past year?

(f) In February 2020 NHOSC heard that the QEH has developed a proposal for a £250million capital investment that incorporated a mix of new build, refurbishment and redevelopment of existing accommodation. It is understood that no additional investment has been available. How does the Trust intend to manage its aging building in the absence of significant investment?

(g) Is an 18-week referral to treatment time still the standard that NHS hospitals are expected to achieve? If so, how long does the QEH expect it will take to reach that standard and are there interim targets during the period of performance recovery following the Covid 19 pandemic?

4.0 Action

4.1 The committee may wish to consider whether to make comments or recommendations as a result of today's discussion.

	0344 800 8020 (textphone) and we will do our best to help.

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

Updates from The Queen Elizabeth Hospital

- **Action taken in line with CQC requirements since QEH representatives last attended NHOSC in February 2020**
- **Action still to be taken and the timeline for doing so**

Following the Trust's unannounced CQC focused core service inspection in September 2020, the CQC published the inspection report on 17 December 2020.

The report highlighted the significant improvement and progress the Trust has made over the past 12-months and validated the accuracy of the Trust's own self-assessment (which returned the same results).

Whilst the 6 core services have been re-rated, the Trust's overall rating cannot be changed until the CQC carry out a full on-site inspection. It is anticipated this will be Spring 2021, when the CQC restart their inspection regime post COVID.

The publication of the report was accompanied by a message from Professor Ted Baker, Chief Inspector of Hospitals, who noted the improvements the Trust has made over the last year, highlighting a real change in culture with staff more positive and engaged and improvements in patient safety, experience and Infection Prevention and Control (IPC).

2020 CQC inspection highlights for QEH:

- None of the Trust's core services inspected are now rated 'inadequate' compared to 19 areas in the same services rated 'inadequate' in the Trust's 2019 inspection.
- All of the Trust's core services inspected (Medicine, Surgery, Urgent and Emergency Care, Maternity, Diagnostic Imaging and End of Life Care) are now rated as 'Good' for caring – marking a further significant improvement.
- The Trust has 3 'Must Do' and 33 'Should Do' actions from its 2020 inspection, the majority of which already feature in the Trust's Integrated Quality Improvement Plan, compared to 206 in total in 2019 and marking an 82% reduction in 'must' and 'should do' actions.
- Particular areas of improvement noted by the CQC included:
    - Patients were treated with respect and dignity
    - Staff were compassionate and include patients and their relatives in decision making
    - IPC is well managed
    - Local leadership teams are passionate about their services, visible and respected
    - Staff felt able to escalate concerns

"CQC's Chief Inspector of Hospitals, Prof Ted Baker, said: "We found real cultural change had taken place across the Trust and staff were demonstrably more positive and engaged. Our inspection team particularly noted how caring staff were and found examples of staff who exceeded expectations to help people."

"There was increased staff engagement processes in place to communicate with staff. However, leaders acknowledged that there was further work required to engage effectively with all staff groups".

CQC Report – December 2020

2019 CQC inspection ratings for QEH

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent & Emergency Care	Inadequate ↓↓ July 2019	Inadequate ↓ July 2019	Requires Improvement ↓ July 2019	Requires Improvement ↓↓ July 2019	Inadequate ↓↓ July 2019	Inadequate ↓↓ July 2019
Medical Care (including Older People's Care)	Inadequate ↓↓ July 2019	Inadequate ↓ July 2019	Requires Improvement ↓↓ July 2019	Requires Improvement ↓↓ July 2019	Inadequate ↓↓ July 2019	Inadequate ↓↓ July 2019
Surgery	Requires Improvement ↓↓ July 2019	Good ↑ July 2019	Good ↓↓ July 2019	Requires Improvement ↓↓ July 2019	Good ↑ July 2019	Requires Improvement ↓↓ July 2019
Critical Care	Good July 2015	Good July 2015	Good July 2015	Good July 2015	Good July 2015	Good July 2015
Maternity	Requires Improvement ↑ July 2019	Good ↑ July 2019	Good ↓↓ July 2019	Good ↑↑ July 2019	Requires Improvement ↑ July 2019	Requires Improvement ↑ July 2019
Gynaecology	Requires Improvement July 2019	Good July 2019	Good July 2019	Requires Improvement July 2019	Requires Improvement July 2019	Requires Improvement July 2019
Services for Children and Young People	Good ↓↓ July 2019	Good ↓↓ July 2019	Good ↓↓ July 2019	Good ↓↓ July 2019	Requires Improvement ↓ July 2019	Good ↓↓ July 2019
End of Life Care	Requires Improvement ↓↓ July 2019	Inadequate ↓↓ July 2019	Good ↓↓ July 2019	Inadequate ↓ July 2019	Inadequate ↓ July 2019	Inadequate ↓ July 2019
Outpatients	Good ↑ July 2019	Not Rated	Good ↓↓ July 2019	Requires Improvement ↓↓ July 2019	Requires Improvement ↓↓ July 2019	Requires Improvement ↓↓ July 2019
Diagnostic Imaging	Inadequate ↓ July 2019	Not Rated	Good ↓↓ July 2019	Requires Improvement ↓↓ July 2019	Inadequate ↓ July 2019	Inadequate ↓ July 2019
Overall Trust 2019	Inadequate ↓↓ July 2019	Inadequate ↓ July 2019	Requires Improvement ↓ July 2019	Requires Improvement ↓↓ July 2019	Inadequate ↓↓ July 2019	Inadequate ↓↓ July 2019

2020 CQC Inspection ratings for QEH

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent & Emergency Care	Requires Improvement ↑ December 2020	Requires Improvement ↑ December 2020	Good ↑ December 2020	Requires Improvement →← December 2020	Requires Improvement ↑ December 2020	Requires Improvement ↑ December 2020
Medical Care (including Older People's Care)	Good ↑↑ December 2020	Requires Improvement ↑ December 2020	Good ↑ December 2020	Requires Improvement July 2019	Requires Improvement ↑ December 2020	Requires Improvement ↑ December 2020
Surgery	Good ↑ December 2020	Good July 2019	Good July 2019	Requires Improvement July 2019	Requires Improvement ↓ December 2020	Requires Improvement →← December 2020
Critical Care	Good July 2015	Good July 2015	Good July 2015	Good July 2015	Good July 2015	Good July 2015
Maternity	Requires Improvement →← December 2020	Good July 2019	Good July 2019	Good July 2019	Requires Improvement →← December 2020	Requires Improvement →← December 2020
Gynaecology	Requires Improvement July 2019	Good July 2019	Good July 2019	Requires Improvement July 2019	Requires Improvement July 2019	Requires Improvement July 2019
Services for Children and Young People	Good July 2019	Good July 2019	Good July 2019	Good July 2019	Requires Improvement July 2019	Good July 2019
End of Life Care	Good ↑ December 2020	Requires Improvement ↑ December 2020	Good →← December 2020	Requires Improvement ↑ December 2020	Requires Improvement ↑ December 2020	Requires Improvement ↑ December 2020
Outpatients	Good July 2019	Not Rated	Good July 2019	Requires Improvement July 2019	Requires Improvement July 2019	Requires Improvement July 2019
Diagnostic Imaging	Requires Improvement ↑ December 2020	Not Rated	Good July 2019	Requires Improvement July 2019	Requires Improvement ↑ December 2020	Requires Improvement ↑ December 2020
Overall Trust 2020	Requires Improvement ↑ December 2020	Requires Improvement ↑ December 2020	Good ↑ December 2020	Requires Improvement →← December 2020	Requires Improvement ↑ December 2020	Requires Improvement ↑ December 2020

2019 versus 2020 Trust rating breakdown

	Inadequate	Requires Improvement	Good	Not Rated
2019 Report	19	22	23	2
2020 Report	Nil	36	28	2

Whilst the CQC has identified a combination of 36 actions in the 2020 report, these can be largely themed into 7 categories and highlight a degree of duplication across more than one core service.

Mandatory Training	**11**
Workforce	**7**
Audit	**3**
Appraisals	**3**
Record Keeping	**2**
Culture/Engagement	**2**
Emergency Department Performance	**1**
Other	**7**
Total	**36**

The Trust's Integrated Quality Improvement Programme (IQIP) is being refreshed to incorporate the latest CQC feedback, so that the Trust's continuous improvement journey retains focus.

Section and warning notices

The Trust received formal notification from the General Medical Council (GMC) on 30 April 2020 that conditions were removed. In addition, the GMC confirmed in December 2020 that it had removed the Trust from enhanced monitoring which is further evidence of improvement made.

The Trust received formal notification from the CQC on 6 January 2021 that its application to lift 5, Section 31 Conditions for Maternity Services had been approved. This is a significant decision by the CQC and extremely positive for the organisation. This letter sends a message of confidence in the organisation and its leadership regarding these improvements and provides a further level of assurance through external validation.

Following publication of the December 2020 report, the Trust received confirmation from the CQC in January 2021 that it was closing 5 of its 29A conditions. Whilst improvement was noted against the remaining 29A conditions, they were not reviewed in full during the September inspection, but will instead form part of the Trust's next on-site inspection later this year.

Following consideration at the Trust's January 2021 Quality Committee, QEH submitted a formal application to the CQC on 11 February 2021 to request the lifting of a further 11 of the remaining 17 Section 31 conditions. This application was accompanied by detailed evidence of improvement and compliance, with the Trust awaiting a decision from the CQC at the time of writing this report.

- **The current position in respect of the hospital's key performance indicators (KPIs); service quality and financial**

COVID-19

30 January 2020
Level 4 National Incident declared

17 March 2020
Postpone all non-elective operations by 15 April 2020 at the latest, for at least 3 months

29 April 2020
2nd phase response
Step up non-COVID-19 urgent services as soon as possible over the next 6 weeks

31 July 2020
3rd phase response
Stepped down to a Level 3 Incident
Return to 'near normal' levels of activity

5 November 2020
Return to Level 4 National Incident

The impact of COVID on the Trust and the wider NHS has been significant. At the height of the pandemic (January 2021) a significant proportion of the hospital's core bed base was occupied by patients with either confirmed or suspected COVID-19 (>200 COVID inpatients). This has necessitated significant changes in the ways in which care has been delivered to our patients, including a reconfiguration of the site and a move towards remote outpatient consultations.

As at 1 March 2021, the Trust has cared for a total of 1,644 COVID-19 positive patients, of which 480 have sadly died. A total of 59 COVID-19 positive inpatients are receiving care within the Trust of which none are receiving treatment on the Intensive Care Unit with a week on week reduction in cases, in line with the modelling and forecasts.

The impact of COVID-19 on all key performance metrics has been marked, specifically those relating to access for elective care, consistent with the impact seen across the wider NHS.

The Trust has maintained a clear focus on delivery of safe and compassionate care to patients and has taken proactive steps to ensure effective communication with patients and their families and carers. This includes the implementation of a dedicated 7-day patient COVID-19 helpline and recruiting a team of Family Liaison Officers to support improvements to communication with patients' relatives and loved ones, which has been a challenge for the Trust during the period in which visiting has been restricted.

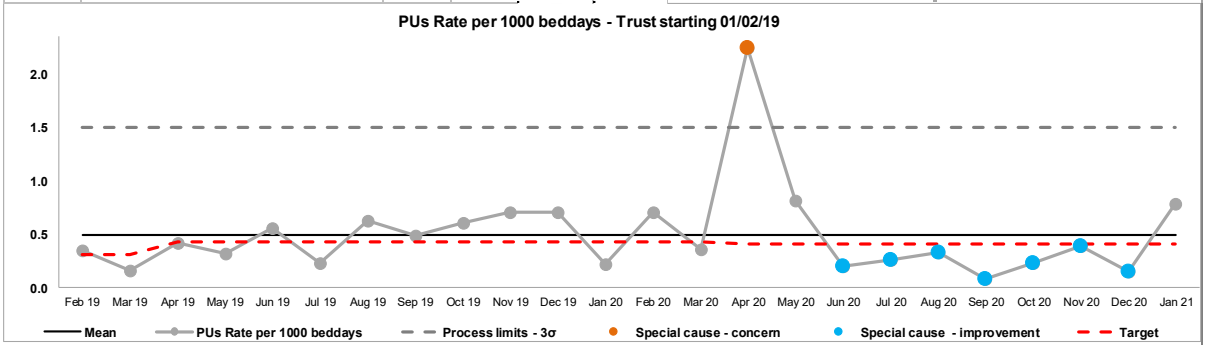
Quality
With regard to specific quality metrics, in line with the Trust's Strategic Objectives included in our 5-year Corporate Strategy (published June 2020), notwithstanding the challenge COVID has presented, we have made significant progress in a range of key areas (as at the end of Quarter 3 (end of December 2020).

- Individualised Plan of Care (IPOC) – During October and November 2020, 63.57% of patients with an expected death had an IPOC in place, which is above the quarterly target.

- The Trust has seen a reduction in pressure ulcers with lapses of care – the quarterly reduction target of 5 per quarter was achieved.
- Implementing SAFER - the number of discharges before midday increased by 13% in September 2020 to 27% in December 2020 across core ward areas.
- Screening Services – QEH has successfully restored its screening service in line with pre-COVID-19 standards and was one of the first Trusts to clear the backlog of patients awaiting appointments.
- Quality of care for pregnant women – following publication of the Ockenden Independent Review of Maternity Services at Shrewsbury and Telford NHS Trust on 14 December 2020, an immediate response was requested by NHS England and Improvement of all Trusts providing Maternity Services by 21 December 2020, including QEH. The Trust took immediate action to assess its progress against the recommendations, with compliance in 9 of the 12 Immediate and Essential actions and work underway (and partial compliance in the remaining 3 areas).This was presented to the Trust Board at its public meeting in February 2021.

With regard to our key quality performance metrics, as at the end of January 2021:
Pressure Ulcer rates.

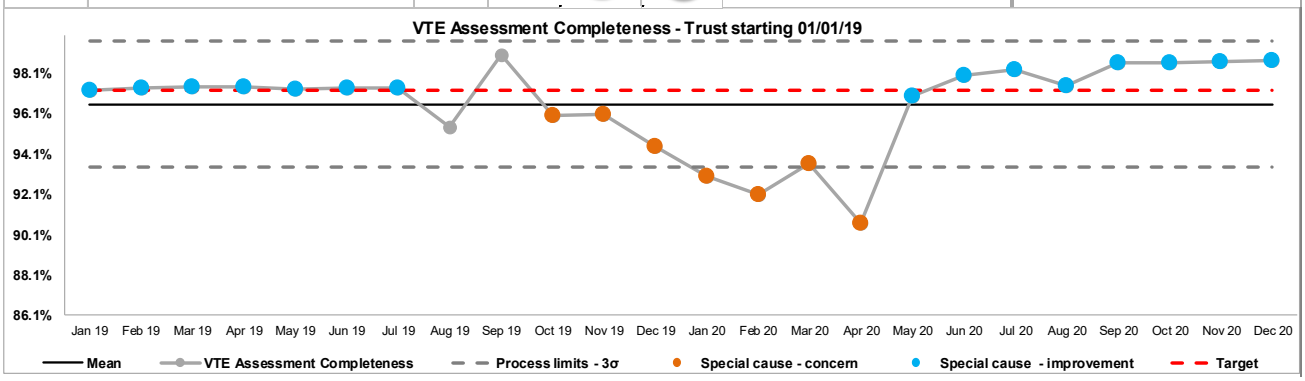
Data To	KPI Description	Target	Current Value	Variance	Assurance	*Variation Comment*	*Target Achievement*
Jan-21	PUs Rate per 1000 beddays	0.41	0.78			Common Cause (expected) variation	Variation indicates inconsistently passing and falling short of the target



A spike in pressure ulcers was seen at the height of the first wave of the pandemic within the Intensive Therapy Unit as a result of prone positioning. This was directly correlated to COVID-19 patients receiving care within the Trust and proactive actions were taken with regard to training for staff to ensure the rate reduced. This reduction has been maintained throughout the second wave of the pandemic.

VTE assessment completeness
Currently the VTE screening process is stable and with targets being met. This has now moved to business as usual as a result of this consistent delivery.

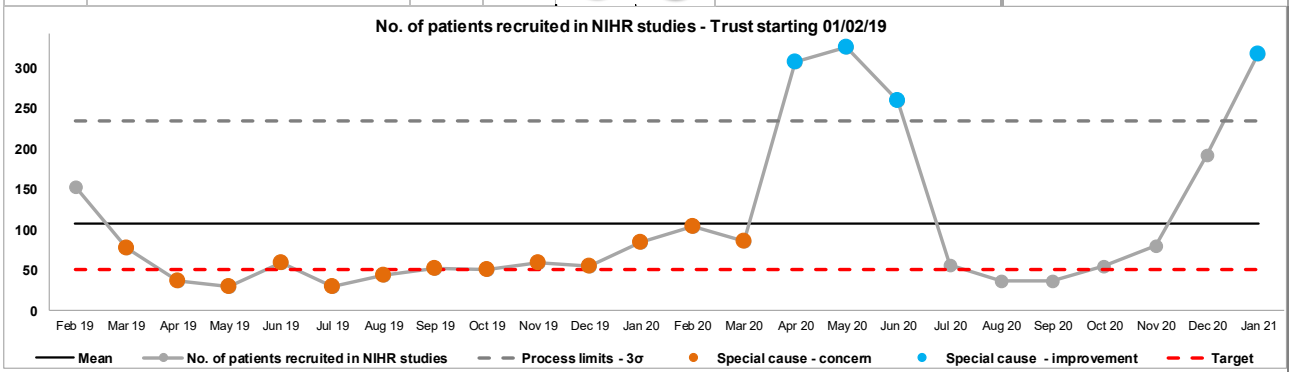
Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Dec-20	VTE Assessment Completeness	97.2%	98.8%	H	?	Special cause (unexpected) variation - Improvement (H)	Variation indicates inconsistently passing and falling short of the target



Research

The Trust has seen a significant boost in relation to research as a result of the COVID-19 pandemic.

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Jan-21	No. of patients recruited in NIHR studies	50	317	H	?	Special cause (unexpected) variation - Improvement (H)	Variation indicates inconsistently passing and falling short of the target



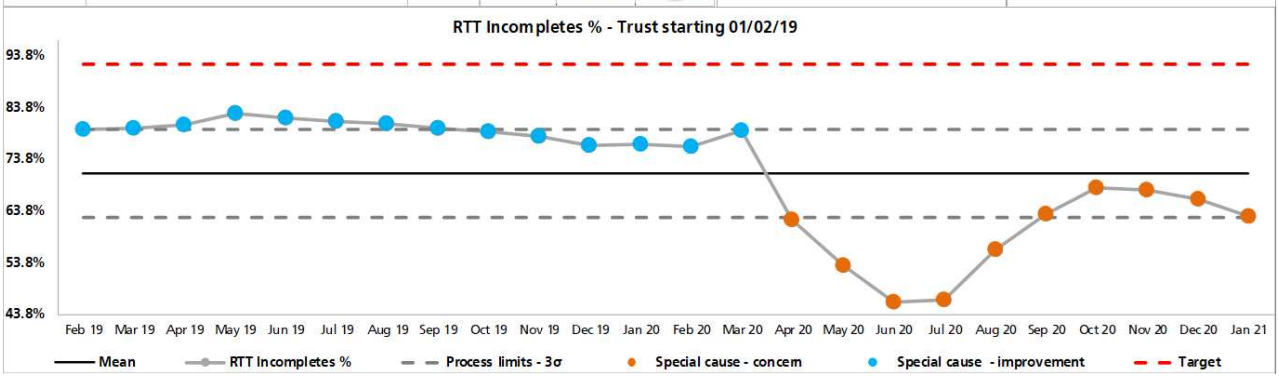
Performance

With regard to our main Performance KPIs, those aligned with access to elective care have been significantly affected as a result of the pandemic.

Elective Care

As at the end of January 2021, there were a total of 14,365 patients on the 18-week RTT waiting list. 5,343 of these patients had waited for over 18 weeks from referral.

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Jan-21	18 Weeks RTT - Incomplete Perf	92.0%	62.8%	L	F	Special cause (unexpected) variation - Concern (L)	Variation indicates consistently (F)alling short of the target



In line with national guidance, the Trust suspended all non-urgent elective admitted activity and reduced outpatient face-to-face activity. Patients referred on a suspected cancer or urgent pathways are still being seen either virtually or face-to-face.

Alongside this, Sandringham Ward, the Trust's ring-fenced surgical capacity, was converted to amber surgical capacity at the height of the pandemic.

Actions have been taken to mitigate this impact including sourcing of additional capacity for Orthopaedic and Gynaecology activity through Independent Sector Providers.

Due to the decrease in COVID-19 inpatients in recent weeks, the Sandringham Ward returned to a green surgical ward from 22 February 2021 with 26 inpatient beds.

52-week breaches

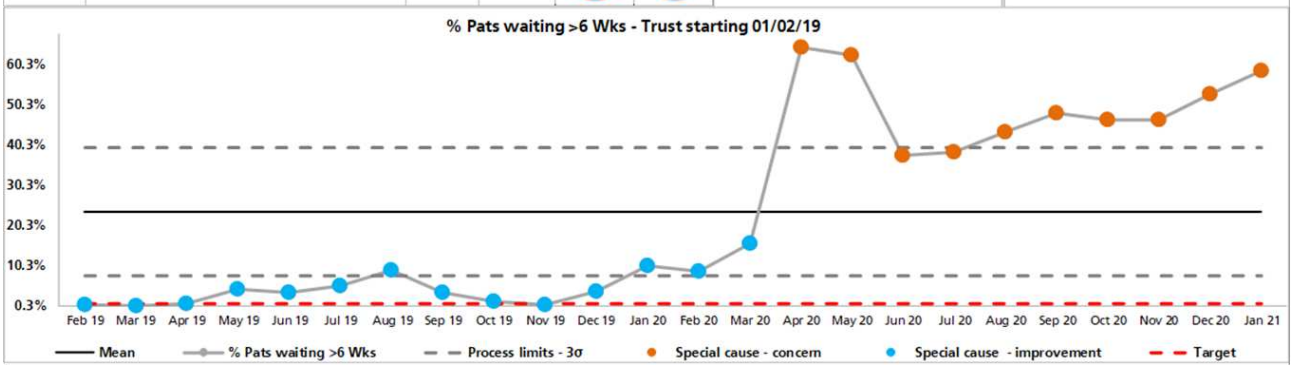
The Trust reported no 52-week breaches in 2019/20, however, waiting times significantly increased as a result of the cessation of routine elective activity in response to the COVID-19 pandemic.

At the end of January there were 1,032 patients who have been waiting longer than 52 weeks for treatment; the majority of these were in Orthopaedics (344), Gynaecology (187), Oral Surgery (144) and Ear, Nose and Throat (129).

Diagnostic waiting times

There were 3,651 breaches, 58.69% of patients waiting over 6 weeks in January 2021:

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Jan-21	Diagnostic Wait Times - % of over 6 Week Waiters	1.0%	58.7%	H	F	Special cause (unexpected) variation - Concern (H)	Variation indicates consistently (F)alling short of the target



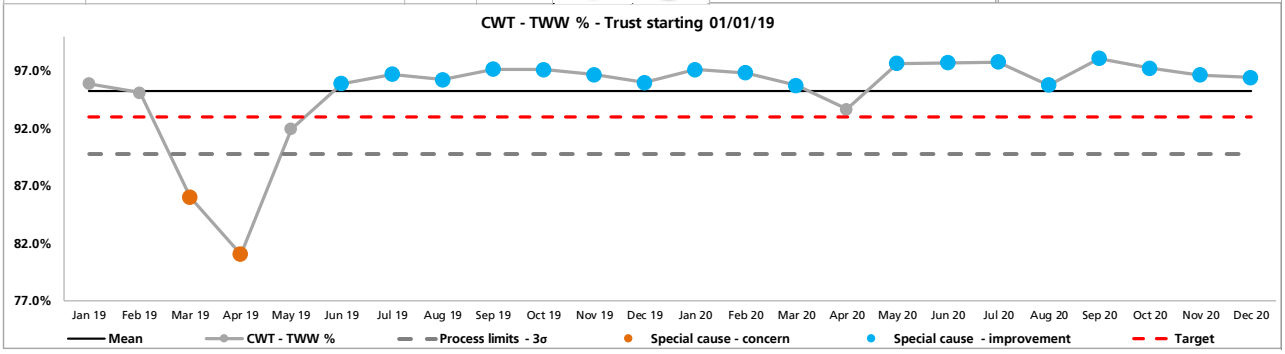
There has been a notable impact in relation to patients' reluctance to attend for appointments due to the COVID-19 situation; 115 more patient referrals were cancelled by patients in January 2021 compared to January 2020.

To address the increasing waits for CT extra resource has been procured. A mobile CT scanner arrived on 4 February 2021 for 28-days. 25 patients are being booked daily which releases capacity to undertake urgent, 2-week waits and cancer scans. Locum staff continue to undertake weekend CT lists.

Outsourcing of MRI is continuing, and weekly numbers have increased.

Cancer treatment
The Trust has maintained a clear focus on delivery of urgent care for cancer patients:

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Dec-20	Cancer Wait Times - Two Week Wait Performance	93.0%	96.4%	H	?	Special cause (unexpected) variation - Improvement (H)	Variation indicates inconsistently passing and falling short of the target



Finance
As at the end of January 2021, the Trust's in month financial position is showing a deficit of £410k, a positive variance in month of £5k against the plan, and a positive £66k for the year to date position.

The Trust is one of few Trusts nationally to have continued with a Cost Improvement Programme as it has responded to COVID and is on track to achieve its £4.4m savings target by year-end.

- **Plans for catch-up during 2021 in elective surgery and other services where catch-up is necessary due to the impact of the pandemic**

In line with guidance, the Trust continues to provide cancer surgery and clinically urgent outpatient and diagnostic services.

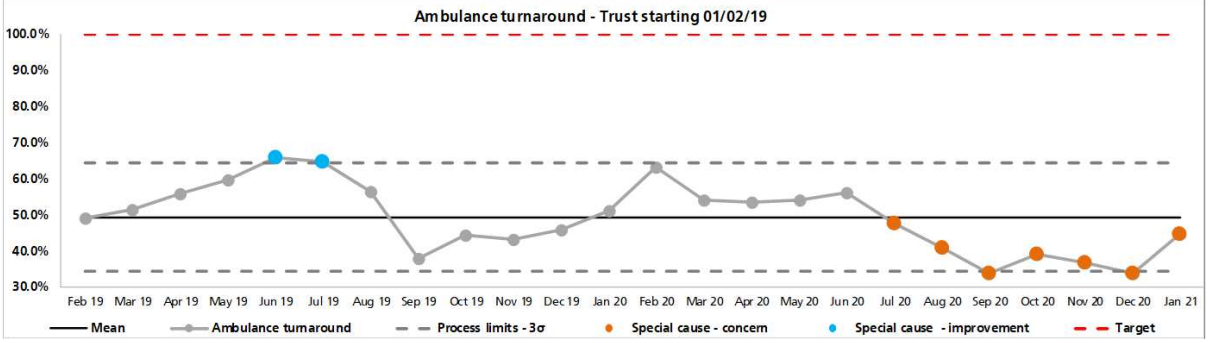
The Trust is developing plans for the full restoration of all elective activity and this will be dependent on the reconfiguration of the site and return of staff who have been redeployed to support COVID-19 essential services.

Further national and regional guidance on elective service restoration is expected over the coming weeks and it is anticipated that this will be based on clinical prioritisation of patient needs.

- **Progress on reducing ambulance turnaround times at the hospital**

In January 2021 there were 1,764 conveyances by the East of England Ambulance Service to the QEH Emergency Department. 47.5% of ambulance handovers took place in ≤ 15 minutes, which was the second highest performing in the region. Average ambulance handover time in January 2021 was 29 minutes, compared to 44 minutes in December 2020.

Data To	KPI Description	Target	Current Value	Variance	Assurance	Variation Comment	Target Achievement
Jan-21	Ambulance Handovers	100.0%	44.7%	L	F	Special cause (unexpected) variation - Concern (L)	Variation indicates consistently (F)alling short of the target



Latest ambulance handover performance by month from April 2020:

By Month	% within 15 Minutes	% within 30 Minutes	% greater than 60 Minutes	Total
2020 04	53.4%	93.2%	0.5%	1320
2020 05	54.1%	92.1%	1.5%	1548
2020 06	56.3%	93.7%	0.5%	1758
2020 07	47.7%	87.6%	3.9%	1926
2020 08	41.0%	80.2%	7.9%	1925
2020 09	33.7%	72.7%	11.0%	1872
2020 10	39.2%	75.1%	12.7%	1851
2020 11	36.8%	72.3%	13.8%	1795
2020 12	33.8%	66.7%	20.5%	1864
2021 01	44.7%	85.1%	8.2%	1699

Emergency Access performance

On 9 January 2021, the Trust's Red (COVID) Emergency Department re-located to the Day Surgery Unit as a result of meeting following the triggers previously approved by the Incident Control Team (ICT). A co-located Red Same Day Emergency Care Unit (SDEC) was set up to support rapid decision making and turnaround for patient's cohort that had previously been admitted to a Red ward.

The Trust's emergency access performance in January 2021 against the 95% national standard was 72.5%. February 2021 emergency access performance improved and was 83.5%. Emergency access performance and ambulance handover times have significantly improved since the separation of the Trust's Red and Amber Emergency – demonstrating that when the hospital has the space and capacity it needs in ED, it can deliver timely care for patients.

The current situation with regard to staffing and action to address shortfalls and relieve pressure (bearing in mind the impact of COVID-19)

As at the end of January 2021, the Trust employed 3,771 substantive staff and the Trust's vacancy rate was 7.50%. The Trust's Nursing and Midwifery vacancy rate is 7.19% and the Trust continues to recruit International nurses both working locally and across Norfolk and Waveney, with 80 further staff due to start in the next 6-months. In addition, fast-track recruitment processes have been put in place to increase the number of support staff available to support both our clinical and non-clinical teams. Medical and dental vacancy rate has decreased further from 10.26% to 7.40% with continued recruitment into key posts spanning all Divisions (this compares to a 16.53% vacancy rate for medical and dental staff in August 2020). The vacancy rate for Allied Healthcare Professionals has also been declining although remains challenging, however, our latest recruitment campaign on this staff group.

As part of the Trust's cultural transformation programme, QEH is reviewing pre-hire, on-boarding and post hire processes and two successful recruitment events were held in early January 2021 for Health Care Assistants (over 40 recruited) and Domestic staff (80 recruited). These recruitment events are held every quarter.

As the Trust has responded to COVID-19, staff have been redeployed as appropriate both internally and externally and additional support is in place via an agreed Memorandum of Understanding from the fire service and local authority staff to support COVID-19.

Trust-level sickness absence in January was 8.04% with the 12-month cumulative sickness at 6.28%. This continues to be challenging for the Trust and is monitored and escalated on a daily basis to ensure safe staffing levels are maintained. Reducing sickness absence remains a key area of focus going into 2021/22 as the Trust remains an outlier regionally in this area.

Stress and anxiety remains the highest cause of non-COVID related sickness absence, though the percentage of absence attributable to stress and anxiety has reduced from 21.7% to 18.3% of overall absence. The Trust has invested very considerably in staff wellness and listening to and responding to feedback and has received national recognition for this work. Improvements include:

- 20 new Mental Health First Aiders
- A new mental health lodge, manned by clinical psychology and mental health teams, providing support service for staff 6.30am-9pm
- Successful recruitment of a full-time specialist in Post-Traumatic Stress Disorder (PTSD) who will have a focus on emotional wellness and other issues related to trauma and stress and a dedicated Clinical Psychology
- In response to staff feedback, new staff rest areas in place and free refreshments 24/7
- Menopause awareness and manager training programme underway – including monthly menopause cafes
- Free breakfast bags for staff working in COVID areas and nights
- Free staff car parking extended until at least March 2022
- Improvements to the Trust's speak up culture – with more staff speaking up and raising concerns internally and in turn fewer concerns going straight to the CQC
- 19 new Freedom to Speak Up Champions supporting cultural change
- 3,772 staff have received their first COVID vaccination and 100% of front-line staff received their flu vaccination (QEH was the highest performing Trust regionally and nationally for flu jabs)

- Improved response rate (45% - which is the best rate since 2016) and results with 2020 National Staff Survey, indicating stronger engagement and improved morale across the Trust, consistent with the CQC's findings. The results are published on 11 March 2021
- The Trust repeated the Medical Engagement Survey in December 2020 and results show that engagement has improved significantly – which is another important marker of progress. The overall response rate for the survey rose from 20 to 37%, and the Consultant response rate rose from 24% to 54% 2019 to 2021. The results show that Consultants now very strongly engaged: highest (3) or high (6) relative engagement bands in 9/10 scales. Only *Good Interpersonal Relationships* (Sub-Scale 2) was rated within the medium range, and none were rated low or lowest. For those with managerial responsibilities (27), 9/10 were highest and 1/10 high. For all medical staff, 7/10 scales were in the high or highest relative engagement band compared to the external norms, the remaining three were medium. QEH's Medical Engagement Survey scores (culture and engagement) are the most improved in the East of England.
- Culture Transformation Programme underway following extensive engagement to shape this work, with a continued focus on creating a culture of kindness and putting our values into action a focus as we head into 2021/22

- **The current situation with building safety and bids for hospital re-build funding**

The Prime Minister announced 40 new hospitals across the NHS on Friday 2 October 2020, and regrettably, despite the considerable work the Trust has completed to develop a compelling case and extensive lobbying, QEH was not added to the Health Infrastructure Plan 2 list as hoped, based on the positive feedback we received on our bid from a broad range of stakeholders.

The QEH is a 'Best Buy' hospital and has been constructed using Reinforced Autoclaved Aerated Concrete (RAAC) planks which cover the vast majority of our estate. The 12 RAAC plank hospitals in the UK (including QEH, James Paget, West Suffolk and Hinchingbrooke in the East of England) are under heightened scrutiny following the collapse of a school roof in the south of England in 2018. If there is a failure in any of the 'best-buy' hospitals, then there will be significant consequences for all of these hospitals – involving the closure of hospitals. The other RAAC plank hospitals in the region, including James Paget and West Suffolk Hospitals, are on the HIP2 list and have had considerably more investment in recent years compared to QEH.

Our hospital is now 41-years-old and in desperate need of modernisation so that we can ensure it is fit for purpose for the patients and communities we serve. The current structural issues presented by the roof and wall construction present an inherent risk. The Trust has a critical backlog maintenance requirement and as requested we have demonstrated categorically with the recent work that we have completed, that the cost of refurbishing or completely replacing our estate and the need for a new Emergency Department which will meet today's demand on our services is almost equal in financial terms to that of a new hospital build.

The site has seen very limited redevelopment since construction, even though the demographic that the Trust serves has significantly changed and aged, and demand on our services is increasing considerably year-on-year, with further considerable population growth forecast in the decade to come as more people choose to move and live in West Norfolk either

for lifestyle choice or employment, as well as the older population we serve at our hospital which brings another unique factor to our future requirements. The site's clinical capacity requirements now go well beyond the intent of its original design and departments are not co-located in a way that is consistent with modern care pathways.

The Trust is considered an 'anchor' institution in West Norfolk as one of the largest employers in the area. Our ambition for the QEH, as recently published in our long-term strategy, is that the Trust will become the best rural District General Hospital in the NHS for patient and staff experience by 2025. This ambition simply cannot be delivered without significant capital investment so that we can develop a new hospital that is fit for purpose for the future which is nothing more than our patients and their families deserve.

We have developed a range of options as we have created a strong case for bringing a new hospital to QEH. The cost of living with the risks associated with the existing estate is £554million over the next ten years. In contrast, the cost of a total new build, which would provide opportunity for service transformation efficiencies to be integrated into the hospital to meet the demands and needs of modern healthcare requirements both now and in the future, is estimated to be £679million. The new build option will future-proof and right size the QEH for the decades to come, along with the added benefits of:

- Providing a sustainable service of the future, and meet the demand for future growth in line with the wider healthcare system
- Improving clinical outcomes delivered in 21st century facilities
- Wider social and economic benefits, due to the significant investment to the area
- Improving patient, staff and visitor experience
- Delivering service transformation using the estate as an enabler
- Reducing the health and safety risk, improving condition of the estate and eradicate the evidence based structural risks associated with RAAC plank construction
- Providing opportunity for enhanced use of digital technology and use of AI
- Improving environmental impacts in line with the net zero carbon agenda
- Efficiencies to revenue/operating costs
- Providing enhanced opportunity for Research and Development and educational provision
- Opportunity to use land for complementary healthcare/private commercial uses to provide wider benefits to local economy and community
- Supporting acute system/integrated care across Norfolk and Waveney

At the end of September 2020, the Trust submitted a compelling case for a new hospital as part of the NHS's response to the Comprehensive Spending Review. QEH remains hopeful that it will be a serious contender for one of the further 8 schemes that will compete to attract future funding to deliver new hospitals by 2030 with further details to be confirmed regarding selection process and criteria, as well as timescales.

In the meantime, the Trust continues to work proactively to lobby its case for a new hospital and significant capital monies, whilst mitigating the inherent risks with the current estate via a number of means, notably:

- Developing a Strategic Outline Case for a new hospital after receiving £500K from NHS Improvement/England to progress this work
- Submitting a case for significant national emergency capital to put in place failsafes to mitigate the structural integrity issues with the hospital
- RAAC radar survey to be completed for entire estate although delayed due to COVID

- We have recruited a dedicated team of surveyors and technicians to monitor and carry out emergency repairs on the estate – including leading on our tap and test' inspection – with completion forecast for end May 2021
- Trust RAAC Programme Board in place (commencing January 2021)
- The rescheduling of Secretary of State (Matt Hancock with James Wild MP) visit to QEH in the coming months remains a top priority

Position at 22 February 2021:

- 38 areas (71 planks) identified through 'tap and test' inspection regime with plank deflections and temporary propping installed

- 1 area identified with plank deflections (2 planks) with permanent steel supports installed.

- Main gymnasium remains closed due to plank deflections (100 planks) and inability to install temporary props.

- Steel supports in the process of being fabricated for installation in all ward areas.

- Risk remains 20 (Trust risk register).

- **Details of the QEH's purchase of the Sandringham Hospital and the way in which the additional space is being used.**

The Trust acquired the BMI Sandringham Hospital on 30 September 2020; at which time the 73 staff previously employed by BMI Healthcare Limited transferred to the Trust under TUPE regulations. This was a major strategic development for the Trust.

During October 2020, the Trust completed building work to improve the facility and increase capacity.

The ground floor, outpatient area opened on 27 October 2020 and is utilised for pre-operative assessment, including high risk anaesthetic clinics, and elective patient COVID-19 swabbing.

The Sandringham ward opened to 12 rooms on Tuesday 10 November 2020 and the remaining 14 rooms opened on Monday 16 November 2020, giving an additional bed capacity of 26 beds.

In response to the second wave of COVID-19, in late December 2020, the Trust converted the Sandringham ward from a green surgical ward to an amber surgical ward. On 22 February 2021, Sandringham ward reopened as a green surgical ward.

- **Strategic Projects**

Three important strategic developments are well-advanced – including:

<u>The School of Nursing</u>

The implementation of a School of Nursing in partnership with the College of West Anglia (CoWA) is a strategic priority for the Trust as outlined in the Corporate Strategy that will lead to a range of benefits for the organisation.

Following a successful bid co-ordinated by the Borough Council of King's Lynn and West Norfolk and the Town Deal Board, a grant of £597,000 has been secured to deliver the project that will result in high quality nursing training facilities being developed at the CoWA campus.

CoWA will deliver the Level 5 (foundation degree equivalent) Associate Nurse Apprenticeship to support the future workforce needs of QEH to enable talent to stay local and improve the quality and stability of the Trust's nursing workforce.

The intention is for recruitment to the Nursing Associate Programme to start in Quarter 4 of 2021/22.

Maternity Bereavement Suite

The Maternity Bereavement Suite (MBS) is a key strategic project for the Trust. The suite will provide a safe, homely environment for parents and their families to create precious memories with their baby, away from labour ward. The suite is expected to open by Autumn 2021. This development is being funded by £185,000 of Charitable Funds and donations.

Cancer Health and Wellbeing Centre

The main purpose of the Cancer Health and Wellbeing Centre is to support cancer patients - in 2015 in West Norfolk there were 7,459 people who were living up to 21 years after a cancer diagnosis.

Evidence reported by the National Cancer Survivorship Initiative (NCSI, 2013) shows that many cancer survivors have unmet needs particularly at the end of treatment, whilst others are struggling with consequences of treatment that could be either managed or avoided.

The Health and Wellbeing Centre will provide a dedicated Cancer Health and Wellbeing Centre to act as a hub and focus for the delivery of the Health and Wellbeing Agenda. The intention is that the Health and Wellbeing Centre will be complete and operational by the end of April 2021. This important development is being funded by £625,000 Charitable Funds.

Local action to address health and care workforce shortages

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

Examination of the Norfolk and Waveney Health and Care Partnership's[1] workforce workstream's local action to address and mitigate the effects of national workforce shortages affecting health and care services.

1.0 Purpose of today's meeting

1.1 Today's meeting is to examine local progress to address health and care workforce shortages since the Health and Care Partnership workforce workstream representatives last attended Norfolk Health Overview and Scrutiny Committee (NHOSC) in May and July 2019.

1.2 Norfolk and Waveney Health and Care Partnership (HCP) workforce workstream representatives have been asked to provide the following information:-

- Data to illustrate the current local workforce situation (demand and capacity) across primary, community and secondary care
- Details of the extent to which the health and care workforce increased at the start of the pandemic (including ex health and care staff volunteering to return to work and staff who were new to the workforce)
- Details of the extent to which the increase in staff has been maintained
- Information on the impact of the Covid 19 pandemic on the workforce in terms of redeployments within organisations and between organisations; the necessity for increased staffing in some services and the resulting reduction of staffing in others.
- Staff attrition rates, for trainees and established staff.
- The HCP's short-term plan for workforce during the pandemic and it's medium and long-term strategy
- Progress towards developing a new multi-agency workforce strategy for Norfolk and Waveney
- Any other relevant information

The Norfolk and Waveney HCP's report is attached at **Appendix A**. Representatives from the HCP will attend to answer Members' questions.

[1] Norfolk & Waveney Health and Care Partnership was formerly known as the Sustainability and Transformation Partnership (STP)

2.0 Background information

2.1 The workforce workstream representatives last attended NHOSC in May 2019, when the focus was on primary care workforce, and July 2019 when the committee looked at the wider workforce situation. The reports and minutes of the meetings are available via the following links:-
30 May 2019 NHOSC (item 8)
25 July 2019 NHOSC (item 9)

At the time of the last report there were over 50,000 people and 3,000 vacancies in the Norfolk and Waveney workforce. Nursing and midwifery was the area of greatest shortage, which was being focused on nationally and in Norfolk.

Nationally, training places had reduced and there was decreased interest in health and care as a career. A rise in stress related illness was being seen in staff.

A Norfolk and Waveney workforce strategy was under development, to be finalised by autumn 2019 through engaging with staff. A partnership was being set up to bring in apprenticeships across organisations.

The workforce strategy was published in August 2020 and is available on the Norfolk and Waveney HCP website via the following link:-
#WeCareTogether People Plan 2020-2025

2.2 In July 2019 the Health and Care Partnership representatives were asked to provide information from a national study on where healthcare professionals choose to work and why to NHOSC Members. Members hoped to understand the reasons why so few from the study were choosing East Anglia so that they could consider what more county and district councils could do to attract people to the area.

The HCP Director of Workforce has provided the following link to a national study which gives insight into the reasons people choose the areas where they study and work:-
https://www.health.org.uk/publications/reports/falling-short-the-nhs-workforce-challenge

The HCP workforce workstream met with UEA representatives in October 2020 to explore this subject and ran a webinar for all final year Occupational Therapists and Physiotherapists to try and offer jobs.

Three significant factors which the Norfolk and Waveney HCP is focused on in its work to improve student / staff retention are:-

1. A good placement experience – it is a critical indicator as to whether students go on to work in that locality.

2. Preceptorship – the transition into the workplace is a critical aspect to get right. Support is important early on in careers and building a community of employees may help with retention.
3. Fast tracked posts – formalised career trajectory for students who are high-fliers and may want to become advanced practitioners/leaders/researchers etc.

2.3 In July 2015 NHOSC received a detailed report on local workforce shortages from a task and finish group of its Members.

NHOSC made recommendations around:-

- Liaison between the NHS and local planning authorities to plan capacity for growing local needs
- Local provision of healthcare education and training
- Support for healthcare workers
- Promoting awareness of healthcare career opportunities
- Public engagement and information about the change to the primary care skill mix
- Realistic forecasting of workforce requirements based on predicted local needs rather than predicted funding levels

All the recommendations were accepted fully or in part except for one to the Norfolk and Cambridgeshire Local Enterprise Partnerships regarding work with higher education institutes to support recruitment of healthcare students and workers to Norfolk. The LEPs recognised the importance of the issue but explained that they did not have the capacity to support a specific campaign.

NHOSC received follow up reports and briefings and wrote to Government ministers and all Norfolk MPs on the issue of funding for Norwich Medical School. Links to all the relevant reports from 2015 and 2016 are included in section 5 below.

It was clear in 2015 that workforce shortages would be difficult to resolve and that concerted action was needed at national, regional and local level.

2.4 There has been action at all levels but NHOSC has continued to be aware of the impact of workforce shortage in many of the services it has examined in recent years. It has featured in Care Quality Commission reports on local NHS trusts that have been rated 'inadequate' and it has been an ongoing problem in primary care. In September 2020 the committee wrote to the Department of Health and Social Care asking for national level action to mitigate the shortage of NHS dentists.

3.0 Suggested approach

3.1 Members may wish to examine the following areas with the HCP :-

Effects of Covid 19 on the workforce

(a) How has the Covid 19 pandemic affected the requirements for different kinds of staff across the NHS?

(b) How long is it expected that the increased staffing rate due to Covid 19 can be maintained?

(c) This has been a period of extreme pressure on staff. What more can the local system do to support staff and encourage them to stay in service?

Workforce planning and supply

(d) Has it been possible to assess the impact of Brexit on staffing in Norfolk and Waveney? (This may not have been possible due to the over-riding impact of the Covid 19 pandemic).

(e) Is the HCP satisfied that there is thorough, systematic planning for future healthcare staffing needs in primary care (GP practices, dental practices, pharmacies and opticians) as well as in community and secondary care hospital settings?

(f) Is there potential to expand the nursing and medical schools at the University of East Anglia?

(g) NHOSC is aware that some local providers (e.g. the Queen Elizabeth Hospital NHS Foundation Trust) actively encourage and support young people leaving Local Authority care to join their workforce. Is there anything more that the Health and Care Partnership partners could do to promote and support healthcare careers for care leavers in Norfolk & Waveney?

(h) What more does the HCP think county and district councils could do to attract healthcare professionals to live and work in Norfolk?

(i) Does the Norfolk and Waveney People Board, established in September 2020, have all the powers and tools it needs to tackle workforce shortages?

4.0 Action

4.1 The committee may wish to consider whether to make comments or recommendations as a result of today's discussion.

5.0 Background documents

5.1 Reports to NHOSC in 2015-16:-

NHOSC 16 July 2015 (agenda item 8)
NHOSC 15 October 2015 (agenda item 7)

NHOSC 14 April 2016 (agenda item 8)
NHOSC 26 May 2016 (agenda item 7)

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Report by:- Anna Morgan, Director of Workforce
Norfolk and Waveney Health and Care Partnership

Workforce Update for Health Overview and Scrutiny Committee – March 2021

1. Introduction – This paper gives an overview of the progress on workforce matters since the report to HOSC in July 2019.

2. Background – *Recap from July 2019 report*

The last report drew attention to the lack of National leadership for workforce and the consequences seen in the National shortage of staff across the NHS (c100,000 at that time) and our local Norfolk and Waveney (N&W) position which was at that time c2000 vacancies in health and c1300 in social care. In July 2019 the NHS launched its interim People Plan with the aim to provide national leadership and direction for workforce, and the plan set out actions to change the culture to make the NHS a better place to work. The aspirations in the People Plan are explicitly extended to other partners such as Social Care. In N&W there are over 55,000 paid staff in health and social care, over 100,000 unpaid carers and an increasing number of volunteers. We highlighted the importance of retaining our staff, attracting new people to N&W and growing our workforce to address demand, due to an ageing population and an ageing workforce profile.

3. Current Workforce Data – March 21

3.1 NHS Workforce Profile – In the NHS we have 476 more staff than in 19/20 (181 are substantive, 295 bank/agency). Vacancies have decreased to 1524 at 6.9% (previously 8.9%). We have continued to recruit to apprenticeships and undertaken system wide recruitment initiatives for roles such as Therapists and Health Care Support Workers. Staff turnover is at 10.86% and continues to reduce, which is driven by people delaying retirement and role changes during COVID-19. This creates a risk that turnover may significantly increase later in the year. Sickness absence rates are at 4.79% and are reducing at four out of six providers, where sickness levels have returned to pre-COVID levels. QEHKL are the exception where sickness is 6.1% and continues to grow.

3.2 Social Care Workforce Profile – The vacancy rate for Social Workers has increased to 25% across the service as a whole, although individual service rates vary from 6% to 30% (as below). Turnover for social workers is around 10%, although we are starting to see an increase in leavers, and the intelligence from the exit surveys suggest that this is largely down to fatigue and the desire to move away from the intensity of social work. Sickness rates remain steady at around 5% for this staff group. Vacancy rates for Direct Care Workers are at 8% for Suffolk and 6% for Norfolk. For all job roles which would include Social Workers they are 7% Suffolk and 6% Norfolk. Turnover rate for Direct Care workers is 40% Suffolk and 35% Norfolk. Turnover rate for all job roles is 37% Suffolk and 31% Norfolk Historically N&W has used low numbers of agency staff, but are currently using 19, and have offered work to 14 more.

4. Impact of Covid 19 (February 2020 – February 2021) – The Pandemic hit the NHS and Social Care at a time when staffing was affected by sustained high vacancies, high turnover and sickness levels. From January 20 to September 20 N&W experienced increased staff absences as a result of shielding and Covid related illness. We began preparations to receive large numbers of patients requiring critical care and to build additional capacity in both the workforce and community services across health and social care to manage the impact. A system wide memorandum of understanding was developed to enable staff to be shared across NHS organisations. This was later expanded to social care and the wider system partners in the 2nd wave.

4.1 The N&W CCG re-deployed almost the entire workforce to roles within the system at the start of the first wave, including the strategic coordination of the response, roles within provider organisations including frontline clinical care. Other providers prepared and deployed groups of clinical and corporate staff to frontline health care as business as usual activities were paused. Several retired/external staff responded to a call to arms to help the NHS, however in the first 6 months of the pandemic there was no clear roles or requirement to employ all of the people that responded, and at that stage the additional capacity prepared was not needed.

4.2 By September 2020 we started to prepare again for a predicted challenging 2nd wave of Covid 19 and seasonal pressures. N&W CCG again developed a re-deployment register, prepared and deployed c40 staff to the vaccination campaign and 1 (ex-critical care specialist nurse) to the surge at the NNUH. By October, numbers of patients and staff affected by Covid started to rise rapidly. At the peak during November 20 to January 21, double the number of staff were absent from work at c1990 whole time equivalent staff, around 50% with Covid illness.

4.3 Wellbeing during Covid 19 – The health and wellbeing of our workforce has never been more important. We have seen the impact of the pandemic on our workforce, in particular the tragic loss of life of our health and social care colleagues. We have seen and continue to realise the immediate and longer-term impact on our workforce as a result of working and living through the pandemic. Our recently launched Mental Health Resilience Hub, led by NSFT, has identified support needs around anxiety, bereavement, and trauma. It is too early to identify cases of PTSD, but this is likely. With the launch of the vaccination programme we have also seen an increase in people seeking support for needle phobias and anxieties about vaccinations driven by the anti-vax movement.

4.4 In line with national guidance, Risk Assessments were offered to our NHS, Primary Care and CCG workforce early into the pandemic with a specific focus on our known ‘at risk’ and BAME workforce. Social Care followed similar advice provided through national guidance. c1,200 volunteers working in our NHS organisations were stood down to safeguard and minimise people on hospital sites. Risk assessments provided support and assurance to our people to ensure they received the correct PPE (national delays prevented PPE to organisations at the speed we would have liked) and where required, staff were redeployed to lower risk areas or moved to home working. Our #WeCareTogether photo documentary highlighted the importance of social and family support, as well as being part of a team. These stories from our staff highlighted the importance of people and ‘being kind’ to keep people motivated, and well during very challenging times.

4.5 Research – As part of evaluating the impact of COVID on our local workforce, UEA's ImpACT research group worked to identify four theoretical implications of the lessons learned from the rapid pace of change required from our teams. Outcomes of this work supports an approach for system change. We will sustain this through a holistic approach to facilitating learning, development and improvement, to influence the successful implementation of evidence into practice. It is therefore vital that the system supports strategies that enable the workplace to be the main resource for learning, development and improvement. This requires investment in system transformation and empowerment of our clinical leaders to enable staff to develop new insights into what works in real time and adapt to changing work patterns and roles, whilst living person centred values, holistic safety and ways of working. Facilitation expertise is an essential skill for addressing complexity, drawing on local knowledge, developing systems. [1]

4.6 Local Resilience for NHS organisations – The NHS turned to the Local Resilience Forum for help in building additional capacity from January to March 2021 at a time when staff sickness/absence and hospital admissions was at its peak, as well as supporting the vaccination programme. The Fire Service, the Armed forces, NCC and the District Councils provided additional staff to undertake a range of tasks such as; swabbing (staff and patients for Covid), Fit testing (measuring for PPE/masks), patient feeding, answering telephones, family liaison, cleaning, administration support, recruitment personnel and support to the vaccination sites in marshalling roles. Around 60-100 people have provided over 10K hours of their time, this was positively embraced at our 3 Acute Hospitals and vaccination sites and provided much needed practical support to our teams and patients.

4.7 Covid19 Vaccination Programme – In December 2020 N&W successfully commenced a programme of Covid Vaccinations as part of the National Campaign. This campaign created another significant impact on an already stretched workforce (as above). The vaccination programme is set to run until the summer, additional workforce capacity and leadership to support the programme to completion is our top priority.

5. Progress on Workforce Strategy – System Strategy – In April 2019 we launched a system wide conversation under the banner #WeCareTogether focusing discussions on how to achieve our goal to make N&W the best place to work in health and care. By this, we mean having the best staff, and supporting them to work well together, which will improve the working lives of our staff, and this will ensure that people get high quality, personalised and compassionate care.

5.1 By January 2020 we developed a final document entitled #WeCareTogether People Plan which set out how we will develop a more flexible resilient workforce that can adapt to the changing needs of health and care to respond to on-going demands. It was due to be launched in April 2020 and was paused as the emerging Covid 19 Pandemic started to take hold. During the following months of the pandemic we maintained a presence of our #WeCareTogether brand by capturing a photo

[1] *Jackson C, Manley K, Webster J, Hardy S. (2021). System wide learning from first wave Covid 19: A realist synthesis of what works? Research Square; 2020. DOI: 10.21203/rs.3.rs-115647/v1.*

documentary of the lived experiences of our staff across health, social care, voluntary sector on Instagram @wecaretogethernw. We continued to learn and inform our final workforce strategy throughout the next 6 months.

5.2 This celebration of staff appeared on BBC Look East, and the UEA (as mentioned above) worked with us to provide an analysis of the experiences which has since been published as part of the Centenary of Caring. In response to the appalling death of George Floyd, we also took the opportunity to focus our photo campaign on Black Lives Matters, providing a specific platform to celebrate our Black, Asian and Minority Ethnic staff. We embraced the learning in the final version of our People Plan and reflected our aspiration to take action and create an organisational culture where everyone feels they belong, making our culture universally understanding, kind and inclusive.

5.3 The final NHS People Plan was published at the end of July 2020 and our N&W response, our #WeCareTogether People Plan was published in August 2020, the first STP to respond to the National Plan. The N&W People Plan sets out how we will grow, retain and attract a workforce to our health and care system. A summary of our #WeCareTogether People Plan aims are as follows:

- **Create new opportunities**: Develop new roles and ways of working with evolving services and with greater effective use of technology as a system.
- **Promote good health and wellbeing:** Develop resources that support our people, so they thrive in their roles, improving retention, and achieve their career aspirations.
- **Maximise and value the skills:** Developing and implementing new roles across the whole system, empowering our people to work to the top of their license and registration, allowing for other functions to be delivered by supporting roles.
- **Creating a positive and inclusive culture:** Developing strong leadership at all levels that works collectively for the good of our workforce, our patients and service users across all of health and care.

5.4 Over the last financial year we have received over £1million to support the development of schemes aligned to our People Plan to learn more about how to keep our staff, to increase the number of nurses, accelerate recruitment to health care support workers and implement a range of other new roles.

5.5 Call to Arms – N&W was the most successful system in the EoE for the National Call to action to 'Bring Back Staff', attracting 1204 staff to work in N&W since the start of COVID Incident. 384 Registered staff, 298 unregistered staff and 514 students volunteered to be involved. Some of these staff have since been employed in permanent roles within trusts. We were interviewed by the Prime Ministers Implementation Unit (PMIU) to find out why we were successful in converting this interest into action. The top reasons were; speed of recruitment; tailored training; a buddy system to support staff in deployment and; an offer of work. As a result, we were supported to implement the 'Reservist' scheme.

5.6 Reservist Scheme – The Reservist scheme now has c70 registered general nurses providing support to the vaccination programme, in research and ward care. Recruitment into the scheme continues and now includes therapists. The Reservist Nurses have already contributed over 10K hours of support to our vaccination campaign. Two Reservist Nurses have also supported the Critical Care Team at NNUH during the peak of Covid admissions. In the first phase, this scheme is offered to retired staff. Future phases will include corporate staff and the general public as we

expand the number of roles available. We have mirrored some of the learning from the army reservists and enhanced the model with our own ideas. We offer speedy recruitment to the NNUH bank (staff are supplied to all organisations across health under this contract and the MOU), training, a minimum commitment to deployment days, a buddy system, social events and a relationship manager to ensure people continue to feel valued and connected.

5.7 Trainee Nursing Associates – N&W has been successful in attracting high numbers of applicants into the Trainee Nursing Associate Programmes. There are currently 6 cohorts of TNAs (30-40 in each), with the trailblazing cohort qualifying in September 2020 as Registered Nursing Associates (RNA). Trainees have been able to work across multiple systems, further increasing their knowledge base and exposure to different areas, enhancing patient care and service provision. We have a successful partnership with TNAs across all NHS providers, Primary Care, and Social Care. We are now planning to support these RNAs to convert into 1st level nurses.

5.8 Leadership – In 2019/2020 we ran our first N&W Systems leadership programme. We had 36 participants from health, social care and the voluntary sector. Participants were nominated by their CEO's or equivalents. Covid prevented the completion of the programme in its original format and as from April 2020 the content was delivered on-line. We are in the process of designing the 2021 programme for a further 36 participants. We are aiming to create a systems leadership community of practice, built on trust and collaboration, where leaders can use these skills to further the goals of the developing ICS.

5.9 Coaching Support – During the first wave of the COVID-19 pandemic of 2020, three coaching providers were commissioned by workforce team to provide team and individual coaching to leaders working across our system. The system coaching offer sought to support managerial and clinical leaders to cope with the pandemic and to adapt and transform their services and support their teams. We are now preparing a tender to secure external coaches to support our senior leaders for the foreseeable future. We have also developed a coaching in action programme for middle managers to ensure frontline staff are developed and supported in their teams.

5.10 Equality, Diversity & Inclusion – We held a system wide event on Inclusion chaired by Roger Kline (renowned inclusion expert and research fellow) and Harprit Hockley (Regional EDI lead). We are actively engaging our Equality, Diversity and Inclusion (EDI) leads across N&W and we are working together to better understand our staffs' lived experiences to implement the changes required. We will use these experiences and perspectives to support the development of initiatives with our ethnic minority groups and support our wider workforce to learn and become more aware of the micro-aggressions that exist in workplace cultures. Reviewing workforce processes to identify and remove any bias is also one of our immediate ambitions.

5.11 Health and Wellbeing – Our teams were proactive from the commencement of the pandemic ensuring our workforce had access to national and locally design resources and offers of support focusing on peoples physical, mental, social/family, and financial wellbeing. We established a N&W Health and Wellbeing Network which remains in place and is currently developing its plan for 21/22 which will be underpinned by the NHS Health and Wellbeing Framework, and Public Health England Workplace Health Needs Assessment so we can gather more information on the current wellbeing of our workforce.

5.12 Health and Care Academies – N&W is currently delivering four Senior Academy Programmes supported by H&SC organisations (commenced January). A total of 97 year 12 – 13 students, from a range of schools and colleges, are enrolled on a virtual 6-month programme to learn about career routes in the NHS and Social Care sectors. The aim is to expand the number of entrants into H&SC careers, particularly in nursing and midwifery and provide them with next steps of applying to Apprenticeships / job roles. The Junior Academy for Year 10 students will commence in May 2021.

5.13 Care Leavers / individuals from disadvantaged backgrounds – Working with NCC, a proposal has been written and submitted to offer a systemwide virtual programme to upskill and educate care leavers about H&SC career pathways. Currently, four bespoke online support groups have been held for care leavers (August 2020 – January 2021) and these engagements have allowed us to consider the readiness of these cohorts to access work opportunities. A reflection exercise is underway, and we will use this to feedback to our system partners shortly.

5.14 Supporting our learners, partnership working with our universities – we have worked with our Higher Education Institutions (HEIs) to minimise the impact of the pandemic of our pre-registration and medical learners. This includes virtual learning programmes, blended learning packages, and enhanced pastoral support to reduce attrition from programmes.

5.15 Two schemes to enable our system to find ways to retain our staff – i) Legacy Nurse Programme – This enables potential nurse retirees to return or remain in practice as part of a newly established legacy programme. Some clinical staff can retire at 55 years of age depending on their pension scheme. As 45% of our staff are over 45 years of age, we need to address the potential retirement flight risk that we carry. Legacy Nurses, (this will extend to other professions later) would be given the option of returning or remaining within the organisation on a Band 6 fixed term contract (up to 12 months maximum). The aim would be to support Legacy Nurses in the transition towards retirement, provide them with the opportunity to impart their invaluable knowledge and skills as clinical leaders to our workforce, thereby maximising the skills and abilities of others and to recognise and celebrate their contribution to the NHS throughout their careers. We have recruited 5 Legacy Nurses with a range of excellent experience to help us with this programme now.

ii) Retention Programme – N&W are an early adopter of the Wave 2 90-day Pathfinder programme to understand why people leave us either within the first two years in their career or towards the end of their career. Basic attrition metrics have been identified for Nursing, AHPs and HCSWs. This programme will enable us to reduce Nursing turnover from 11.7% (Nov 20) to 10.7% initially and to reduce 'Unknown' leaver reasons from 35.5% (Sept 20) to 14%. As part of this project we are looking at introducing flexible contract options to cater for the needs of staff at different stages in their lives. As part of this project we are opening a 'Virtual Careers Office' to provide career coaching, signposting and help our staff realise the many opportunities that health and care can offer.

5.16 Expansion of Students – At the end of 2020 recruitment cycle UEA was able to respond to the call from the Health Minister for a 25% increase in students being admitted to University. The Faculty of Medicine and Health Sciences has had restrictions in terms of placement capacity in a system that has undergone significant

redesign as a result of COVID 19. However, working closely within and across the region, expansion plans are being undertaken and predictions of the COVID 19 on people seeking 'harbour careers' means we anticipate increased applications to health-related professional training programmes. UEA remains keen to respond to workforce demands and is equally keen to work in partnership to further map and understand changing landscape of workforce, particularly in terms of providing the wide variety of routes into nursing, and clinical psychology expansion. UEA will focus on the career trajectory and potential for retaining and re-invigorating talent that already exists in the system offering rotation schemes, e.g. working in 'transfer roles' at UEA' and then being able to return to clinical practice refreshed (post COVID fatigue). As mentioned above UEA has introduced an ImpACT team of researchers with knowledge and experience of undertaking complex transformational research. The team are working with HEE and emergent ICS/CCGs to inform what a Workforce Transformation Hub/Academy can provide as system architecture to promote these initiatives and monitor our progress. A launch for this work is being planned for the Spring 2021.

5.17 Retention of Postgraduates – The landmass for recruitment to UEA is hindered by the geography consisting of the North Sea, whereas local competitors tend to reach out into their peripheries, extending into London and beyond. Therefore, when considering UEA's catchment area local recruitment is balanced with the international market potential. UEA is a research-intensive university and remains highly ranked in the League Tables, therefore sustaining this level of excellence has both positive and negative impact on local recruitment strategies. Travel links and close proximity to Cambridge is another mixed blessing, whereas more recently there has been a surge of movement out of cities into more rural locations, which brings potential for wider mix of new residents of working age to our locality.

5.18 UEA has invested media strategies to promote Norwich, and the UEA, which has proved popular, and students enjoy the campus experience on offer – which has been again drastically hindered due to the pandemic and enforced social restrictions. However, UEA are confident that students continue to appreciate campus life, and therefore UEA is planning for summer events and increased online marketing to continue to encourage students to confirm places on health-related courses. We are also working to consider what a new suite of health related programmes needs to offer, in terms of linking with UEA Climate research tackling global health challenges, and working with Humanities to produce a Health and Humanities suite of modules, that will further entice students to UEA and work to maximise expertise available from across the UEA's portfolio of excellence.

6. Adult Social Care Strategy – An Adult Social Care Workforce Strategy (*A Good Life: Excellence in Care*) was developed and launched in January 2021 and is all about ensuring we build on that excellence by having the right people in the right place at the right time with the right values, skills and experience to deliver the care needed both now and in the future. The strategy draws on other plans that include the Norfolk and Waveney social care workforce including:

- the Norfolk and Waveney *#WeCareTogether People Plan (2020),*
- the Eastern Region Adult Social Care Market *Workforce Development Plan* (2020) and
- the New Anglia Local Enterprise Partnership (LEP) Health and Social Care Sector Skills Plan (2016).

6.1 A Good Life: Excellence in Care focuses exclusively on those providing adult social care across Norfolk and Waveney. It gives an overview of the diverse nature

and needs of our dispersed workforce and places centre stage the 30,000 social care workers, the 114,000 unpaid carers and the thousands of volunteers that deliver social care across Norfolk and Waveney. This strategy covers individuals working for all types of social care service provider including day services/day opportunities, sheltered, supported and extra care housing, shared lives, residential and nursing homes, care at home including reablement and first response services, individual employers and personal assistants.

6.2 Social Care Workforce – The council received £2.089m workforce grant to address some of the immediate workforce pressures being faced by the care sector. The funding was received in February and must be spent by 31st March 2021. The Council has set up an emergency staffing bank to support providers directly; is expanding the wellbeing and bereavement support available to all care providers; providing a new recruitment campaign which launches this month and allocating over £1.5m to care providers to predominately support additional costs of overtime and childcare to maximise the availability of existing staff, but also to enable further financial support for those provider with exceptional circumstances.

6.3 Recruitment to Social Care – A recruitment campaign is launching in March and will include a full range of advertising including tv and radio, utilising Norfolk Care Careers portal, virtual job fayres and links with DWP and N&S Care Support. Similar work is being undertaken through the Care Careers Suffolk vacancy portal managed by Care Development East: http://carecareerssuffolk.co.uk/ Additionally New Anglia LEP are also supporting business, individuals, apprenticeships: Employment Opportunities - New Anglia. In addition, the council is organising virtual recruitment events targeting individual locations and matching of the national campaign messages and candidates via the DHSC Care for Others campaign.

6.4 In addition to individual recruitment cycles, we have a Countywide campaign involving the use of Search Marketing to reach Social Workers in Scotland, Ireland and North East England, and via NHS Jobs. NCC have recently recruited human resources business partner to specifically lead on the recruitment of social workers. They will be reviewing the effectiveness of this campaign, considering the merits of overseas recruitment, setting up a recruitment, reward and retention group, and putting on workshops for managers on recruitment practices.

6.5 Social Work Apprenticeships – Apprentices are employed by NCC in a new three-year fixed term contract apprenticeship post. The work is integrated with a bespoke 3-year degree programme at City College Norwich. Our current contract for 3 cohorts. We aim to recruit 10 social workers per cohort, so hope to have 30 social workers at the end of the current programme.

6.6 There is a project taking place to look at the induction process for remote working, and a review taking place of the social worker job/grade structure to further develop the career ladder.

7. Primary Care Network (PCN) Update – In the context of the pandemic, general practice has had to make significant changes to its operating model in order to maintain provision of urgent, same day, essential and routine care for the population of N&W. Increased patient need, reduced staff numbers and the need to separate face-to-face consultations for patients with symptoms of Covid-19 from other patients has required new ways of working in primary care and community settings. Practices have been flexible and dedicated in their response, while dealing with increased staff sickness, including staff vulnerable or shielding having to work at home.

7.1 2019/20 was the foundation year for PCN Development. NHSE&I flowed £43m nationally to ICSs and STPs for PCNs in June 2019. Their purpose was to enable delivery of the Long-Term Plan locally, ensuring multiagency approach to adopting new models of care. Three key pieces of guidance: PCN Development Guidance and Prospectus; refreshed maturity matrix; and diagnostic excel tool helped to give direction for the development of PCNs, their services and their workforce. In Year One, PCNs were expected to focus on developing their common purpose, building relationships both within their network and with the wider community, starting to work collaboratively on an agreed clinical priority/quality improvement project, and agreeing how the new roles will be developed.

7.2 Additional Role Reimbursement Scheme (ARRS) recruitment – This scheme provides additional funding for a new primary care workforce and grows each year for five years. As we co-produce our wrap around services with PCNs, working with clinical directors we will determine the number and type of community health and care roles needed as core staffing reflecting population health data and health inequalities. Our local providers are working closely with us and PCNs to develop hosted roles and to determine how recruitment can be supported (we already have a number of hosted roles in place). PCNs are reviewing their development plans and workforce trajectories however there has been an underspend on budget, largely due to delays from Covid and we have worked directly with PCNs to direct any underspend to practice/ PCN capacity, particularly with the vaccination programme.

7.3 Training and Development – Staff skills will be developed through our Training Hub which enables a consistent offer of high-quality training for primary care staff, supporting working in the new normal as well as at scale. The Training Hub initially paused its programme during the early phases of the pandemic; it is now developing a full programme of work delivered in a variety of ways. In light of the changing face of general practice, we are refreshing the training needs analysis carried out in autumn 2019 to ensure it meets the new needs of our PCNs. Working closely with local HEI to develop bespoke CPD packages for additional roles entering the system. This forms a blended approach to learning which has been successful during the pandemic. We developed and implemented training for new immunisers to support the flu vaccination programme this winter as well as continuing to support training of staff supporting the PCN Covid vaccination programme.

7.4 New roles being implemented across PCNs over the last 18 months: Trainee Nursing Associate – Will work with healthcare support workers and registered nurses to deliver care for patients and the public. **Advanced Clinical Practitioner (ACP)** – An ACP is a role that can be undertaken by General Practice Nurses or other highly experienced registered health and care practitioners such as Pharmacists, Paramedics or other allied health professionals. ACP roles involve a high degree of autonomy and clinical decision making and often include leadership, management and/or educational skills as well.

7.5 New roles introduced as part of the PCN contract in 2019/20 with capitated funding were: Clinical Pharmacist – Work at general practice and are in patient facing roles. They give advice on multiple medicines; provide health checks for patients; assist with medicine prescriptions working alongside GPs. 1 role was implemented per PCN. **Social Prescriber** – Social Prescribers give people time, focusing on ‘what matters to me’ and taking a holistic approach to people’s health and wellbeing. They connect people to community groups and statutory services for

practical and emotional support. 1 role was implemented per PCN with 100% funding. Both of these roles have continued to be recruited as ARRS budgets increased.

7.6 New roles introduced as part of the PCN contract with capitated funding in 2020/21 are: Physician Associate (PA) – PAs support doctors in the diagnosis and management of patients and will therefore have regular direct contact with patients. Often PAs are graduates who have undertaken post-graduate training and are working under the supervision of a GP. **Advance Practice Physiotherapists (First Contact Physiotherapists)** – APPs are advanced practitioners working within primary care with extensive expertise in the clinical assessment, diagnosis and management of musculoskeletal (MSK) conditions. There is the opportunity for rotational roles with other providers. **Pharmacy technicians** – able to manage prescription review and enquiries; **health and wellbeing coaches and care coordinators;** and **occupational health therapists, dieticians and podiatrists.**

7.7 New roles being introduced as part of the PCN contract with capitated funding in 2021/22 are: Community Paramedic and mental health practitioners – The paramedic role will work autonomously within the community, using their enhanced clinical assessment and treatment skills, to provide first point of contact for patients. This role will work as an alternative model to urgent and same day GP home visits for the primary care network and undertake clinical audits.

7.8 All roles are reimbursed at 100%, subject to maximum grade/ banding limits and the capitated sum due to the PCN, with the exception of the mental health practitioner role which is funded 50% by the PCN and 50% by the mental health provider trust. PCNs will determine what staff they need to deliver the PCN contract specification and best serve the health needs of their population.

8. Governance for Workforce – The NHS People Plan states that all systems should develop a local People Plan and a People Board to ensure that plans for recovery and stepping services back up through the remainder of 2020/21 have a strong focus on looking after our people, are aligned with service and financial plans, and are developed alongside partners – including in social care and public health. A N&W People Board was set up in September 2020 with the aim to take the lead in ensuring the National NHS People Plan and the local #WeCareTogether People Plan are delivered. It also ensures that our system goals are central to the work of the group and part of the delivery of the N&W ICS Plan. It is accountable for; building and developing workforce capacity and capability to enable the region to meet population health needs; and for developing innovative ways to ensure the supply of the right workforce, with the right skills and knowledge at the right time to deliver high quality patient care.

8.1 All system partners are represented at the People Board to support and monitor progress of our system workforce ambitions. The Chair (Josie Spencer, CEO of NCH&C) of our N&W People Board reports progress through to the regional People Board.

8.2 N&W are working with Health Education England to undertake a System Workforce Improvement Model (SWIM) assessment to understand current workforce capabilities and identify the capacity that will support delivery of the People Plan to achieve full subsidiarity of the workforce function. We are presenting the outcome of this to the People Board in March. The outcome of the assessment will help us to develop an action plan to continue to develop and mature our ability to operate as an integrated system on workforce.

9. Conclusion – N&W continues to make excellent progress on workforce particularly given the challenges our system has experienced over the last year. We have made good progress on reducing vacancies and retaining our staff; however, we are mindful of our potential retirement 'flight risk'. We have positive and thriving relationships in our system which has enabled us to move forwards with some exciting projects on workforce and this been recognised by colleagues in the Region. The pandemic has enabled us to shine a light on our workforce and the amazing job they do every day. We are enormously proud and thankful for the support from colleagues within CCG, NCC, UEA, our LRF partners and our Reservists in building capacity in our acute hospitals and supporting the vaccination campaign. N&W have a strong aligned workforce vision that is set out in our Adult Social Care Strategy and our #WeCareTogether People Plan.

Norfolk Health Overview and Scrutiny Committee

ACTION REQUIRED

Members are asked to consider the current forward work programme:-

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

Proposed Forward Work Programme 2021

Meeting dates	*Main agenda items*	*Administrative business*
10 June 2021	Ambulance Service (follow-up to NHOSC 8/10/20) To include i. An update on what has been done to address the CQC concerns about EEAST (i.e. in the September 2020 CQC report, including safeguarding of patients and staff). To include an explanation of the concerns in relation to Norfolk and Waveney, why the concerns persisted for so long, what EEAST has learned from the situation and its changes to policies and practices. ii. A progress report on the measures being put in place to improve the emergency response to patients with mental health requirements, including data on the effect of those measures and an explanation of why the past concerns about the service for patients with mental health emergencies have persisted for so long and what has been learned. Vulnerable adults primary care service Norwich (replacing City Reach) – progress report Children's neurodevelopmental disorders (i.e. autism and other conditions) – waiting times for diagnosis	
15 July 2021	Cancer Services (follow-up to NHOSC 8/10/20) i. The impact of Covid 19 on backlogs and waiting times within screening, diagnosis and treatment services ii. The impact on cancer patient outcomes in Norfolk and Waveney	

	iii. Measures to encourage people to come forward for screening, particularly those who are vulnerable and need support iv. Effectiveness of the measures to encourage people to come forward for screening. <u>Access to local NHS services for patients with sensory impairments</u> (follow-up to NHOSC 26/11/20)	

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

NOTE: Norfolk County Council election will be held on 6 May 2021

Provisional dates for NHOSC agenda items later in 2021-22

10 Mar 2022	<u>Prison healthcare</u> – access to physical and mental health services	

Provisional dates for items in the <u>NHOSC Briefing</u> 2021

June / July 2021 - Merger of Norfolk and Waveney CCGs and progression towards an Integrated Care System– progress briefing

- How the new CCG has maintained local focus one year on from merger
- Extent to which various healthcare statistics etc are still available on a district or locality basis to enable understanding of local issues.

June / July 2021 - ME / CFS service – steps taken by the CCG and service provider to comply with new NICE Guidance
Depending on publication of new NICE Guidance. Expected publication date 21 April 2021.

Also cover services commissioned to address long-Covid – subject to agreement by NHOSC on 18 March 2021.

June / July 2021 - Phlebotomy service in Lowestoft (issues raised at 26 November 2020 NHOSC)

Dec 2021 - Annual update on childhood immunisation take-up rates (follow-up from NHOSC 8/10/20 meeting)

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

Norfolk and Waveney CCG	-	Chairman of NHOSC – Penny Carpenter (substitute Vice Chairman of NHOSC – Dr Nigel Legg)
Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust	-	Sheila Young (substitute Michael Chenery of Horsbrugh)
Norfolk and Suffolk NHS Foundation Trust (mental health trust)	-	David Harrison (substitute Michael Chenery of Horsbrugh)
Norfolk and Norwich University Hospitals NHS Foundation Trust	-	Dr Nigel Legg (substitute David Harrison)
James Paget University Hospitals NHS Foundation Trust	-	Emma Flaxman-Taylor
Norfolk Community Health and Care NHS Trust	-	Emma Spagnola

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Norfolk Health Overview and Scrutiny Committee 18 March 2021

Glossary of Terms and Abbreviations

ACP	Advanced clinical practitioner
AHP	Allied Health Professional
APP	Advance practice physiotherapist
ARRS	Additional role reimbursement scheme
BAME	Black, Asian and minority ethnic
BMI	BMI Healthcare - established in 1970, BMI Healthcare is the UK's leading independent provider of private healthcare with more than 50 hospitals and healthcare facilities. On 10 July 2020 it was announced that the Competition and Markets Authority had fully approved the acquisition of BMI Healthcare by Circle Health.
CCG	Clinical Commissioning Group
CEO	Chief Executive Officer
CoWA	College of West Anglia
CPD	Continuous professional development
CQC	Care Quality Commission – the independent regulator of health and social care in England. Its purpose is to make sure health and social care services provide people with safe, effective, high quality care and encourage care services to improve.
CT	Computerised Tomography Scan – Uses X Rays And A Computer To Make Images Of The Inside Of The Body
ED	Emergency department
EDI	Equality Diversion and Inclusion
EoE	East of England
HCSW	Health care support worker
HEE	Health Education England
HEI	Higher education institute
HIP2	Health Infrastructure Plan 2 – published by the Department of Health & Social Care, September 2019
H&SC	Health and social care
ICT	Incident control team
ICS	Integrated Care System
IPC	Infection prevention and control
IPOC	Individualised programme of care
IQP	Integrated quality improvement programme
KPI	Key Performance Indicator
LEP	Local Enterprise Partnership
LRF	Local Resilience Forum
MBS	Maternity bereavement suite
MOU	Memorandum of understanding

MRI	Magnetic Resonance Imaging – a scan that produces multiple cross-sectional pictures of parts of the body
MSK	Musculoskeletal
NCC	Norfolk County Council
NCSI	National Cancer Survivorship Initiative
NHOSC	Norfolk Health Overview and Scrutiny Committee
NHSE&I	NHS England and NHS Improvement - supports the commissioning services by CCGs and directly commissions some primary care services and specialised services. Formerly two separate organisations, NHS E and NHS I merged in April 2019 with the NHS England Chief Executive taking the helm for both organisations. NHS Improvement, which itself was created in 2015 by the merger of two former organisations, Monitor and the Trust Development Authority, was formerly the regulator of NHS Foundation Trusts, other NHS Trusts and independent providers that provided NHS funded care.
NNUH	Norfolk and Norwich University Hospitals NHS Foundation Trust
NSFT	Norfolk and Suffolk NHS Foundation Trust (the mental health trust)
N&W	Norfolk and Waveney
PA	Physician Associate
PCN	Primary Care Network
PMIU	Prime Minister's Implementation Unit
PPE	Personal protective equipment
PROMPT	Practical obstetric multi-professional training
PTSD	Post traumatic stress disorder
PU	Pressure ulcer
QEH / QEHKL	Queen Elizabeth Hospital, King's Lynn
RAAC	Reinforced autoclaved aerated concrete
RNA	Registered Nursing Associate
RTT	Referral to treatment - the time from the date of referral to the start of treatment
SAFER patient flow bundle	A practical tool to reduce delays for patients in adult inpatient wards (excluding maternity):- S – Senior Review – all patients will have a senior review before midday by a clinician able to make management and discharge decisions A – All patients will have an expected discharge date and clinical criteria for discharge set by assuming ideal recovery and assuming no unnecessary waiting

	F – Flow of patients to commence at the earliest opportunity from assessment units to inpatient wards. Wards routinely receiving patients from assessment units will ensure the first patient arrives on the ward by 10am E – Early discharge – 33% of patients will be discharged from base inpatient wards before midday R – Review – a systematic multi-disciplinary team review of patients with extended lengths of stay (>7 days – also known as 'stranded patients') with a clear 'home first' mind set
SDEC	Same day emergency care
STP	Sustainability Transformation Partnership (now known as the Health Care Partnership)
SWIM	System Workforce Improvement Model
TNA	Trainee Nursing Associate
UEA	University of East Anglia
VTE	Venous thromboembolysim – the disease process relating to blood clots that form within veins
WHO	World Health Organisation