Norfolk County Council
at your service

Norfolk Health Overview and Scrutiny Committee

Date: **Thursday 17 July 2014**

Time: **10.00am**

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

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

Members of the public or interested parties who have indicated to the Committee Administrator, Timothy Shaw (contact details below), before the meeting that they wish to speak will, at the discretion of the Chairman, be given a maximum of five minutes at the microphone. Others may ask to speak and this again is at the discretion of the Chairman.

Membership

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

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

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

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 29 May 2014. (Page 5)

3. **Members to declare any Interests**

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

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

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

If you do not have a Disclosable Pecuniary Interest you may nevertheless have an **Other Interest** in a matter to be discussed if it affects:

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

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

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

5. **Chairman's announcements**

6. **10:10 – 11:00** **Access to NHS dentistry in Norfolk** (Page 10)

Appendix A - Update from the commissioner of dental services on action following the new oral health needs assessment. (Page 13)

Appendix B – Update from Norfolk Local Dental Committee (Page 16)

7.	**11:00 – 11:15**	**Stroke services in Norfolk**	(Page 18)
		Appendix A - report of the Norfolk Health Overview and Scrutiny Committee task and finish group.	(Page 20)
8.	**11:15 – 11:30**	**Delayed Discharge from Hospital in Norfolk**	(Page 81)
		Appendix A - report of the joint Norfolk Health Overview and Scrutiny Committee and former Community Services Overview and Scrutiny Panel task & finish group.	(Page 83)
9.	**11:30 – 11:35**	**Norfolk Health Overview and Scrutiny Committee Appointments**	
		Committee appointments to joint committees and other roles.	(Page 134)
10.	**11:35 - 11:45**	**Forward Work Programme**	
		To consider and agree the forward work programme	(Page 137)
Glossary of Terms and Abbreviations			(Page 140)

Chris Walton
Head of Democratic Services

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Date Agenda Published: 9 July 2014

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NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE
MINUTES OF THE MEETING HELD AT COUNTY HALL, NORWICH
ON 29 May 2014

Present:

Mr C Aldred	Norfolk County Council
Mr J Bracey	Broadland District Council
Mr D Bradford	Norwich City Council
Mr M Carttiss (elected Chairman)	Norfolk County Council
Michael Chenery of Horsbrugh	Norfolk County Council
Mr D Harrison	Norfolk County Council
Ms A Kemp	Norfolk County Council
Dr N Legg	South Norfolk District Council
Mrs M Somerville	Norfolk County Council
Mr A Wright	Borough Council of King's Lynn and West Norfolk

Substitute Members Present:

Mrs J Virgo for Mrs J Chamberlin

Also Present:

John Paul Garside	Board Secretary and Head of Legal Services, Norfolk and Norwich University Hospitals NHS Foundation Trust
Liz Libiszewski	Director of Nursing, Quality & Patient Experience, James Paget University Hospitals NHS Foundation Trust
Valerie Newton	Deputy Director of Nursing, Queen Elizabeth Hospital NHS Foundation Trust
Jo Segasby	Director of Women, Children and Cancer Services, Norfolk and Norwich University Hospitals NHS Foundation Trust
Dr Lisa Cook	Queen Elizabeth Hospital NHS Foundation Trust
Dr Katie Soden	Lead Consultant at Priscilla Bacon Centre, Norfolk Community Health and Care NHS Trust
Alex Stewart	Health-watch Norfolk
Chris Walton	Head of Democratic Services, Norfolk County Council
Maureen Orr	Scrutiny Support Manager (Health)
Tim Shaw	Committee Officer

1(a) Election of Chairman

Resolved (unanimously)
That Mr M R H Carttiss be elected Chairman of the Committee for the ensuing year.

(Mr M R H Carttiss in the Chair)

1(b) Election of Vice-Chairman

Resolved (unanimously)
That Mr A Wright be elected Vice-Chairman of the Committee for the ensuing year.

2. Apologies for Absence

Apologies for absence were received from Mrs J Chamberlin, Mrs A Claussen-Reynolds and Mrs M Fairhead .

3. Minutes

The minutes of the previous meeting held on 17 April 2014 were confirmed by the Committee and signed by the Chairman.

4. Declarations of Interest

There were no declarations of interest.

5. Urgent Business

There were no items of urgent business.

6. Chairman's Announcements

6.1 The Chairman paid tribute to the work of Mr Bracey, the former Vice-Chairman of the Committee, who had been appointed Vice-Chairman of Broadland District Council and remained a member of the Committee. The Chairman also congratulated Mr Wright from the Borough Council of King's Lynn and West Norfolk, the longest serving member of the Committee, on his election as the Committee's new Vice-Chairman and welcomed to the Committee the newly appointed Members of the County Council.

6.2 The Chairman said that he had received a proposal from the Commissioning Manager, Integrated Mental Health and Learning, who would like to run a 'Dementia Friends' session for 50 minutes at the end of the next meeting of the Committee on 17 July 2014. The Chairman pointed out that 'Dementia Friends' was an initiative to encourage 1 million people nationwide to use their knowledge about dementia in the community and at work. The session would be open to Members and to staff. Members of the Committee were asked to let Maureen Orr know if they were interested in attending the event.

7. Hospital Complaints Processing and Reporting

7.1 The Committee received a suggested approach from the Scrutiny Support Manager (Health) to reports from the Norfolk acute hospitals on how their Boards and their Governors received information about complaints and how they learnt from and acted upon trends in complaints.

7.2 The Committee received evidence from John Paul Garside, Board Secretary and Head of Legal Services, Norfolk and Norwich University Hospitals NHS Foundation Trust, Liz Libiszewski**,** Director of Nursing, Quality & Patient Experience, James Paget University Hospitals NHS Foundation Trust and Valerie Newton, Deputy Director of Nursing, Queen Elizabeth Hospital NHS Foundation Trust.

7.3 In the course of discussion, the following key points were made:

- The witnesses said that anyone who was receiving, or had received, NHS treatment or services could complain. They could complain in person or get someone else, usually a relative or close friend, to complain on their behalf. They could complain by writing to the Chief Executive of the Trust, via the Trust's website and/or with the assistance of the Trust's Patient Advice and Liaison Service (PALS).
- The witnesses pointed out that the Patient Advice and Liaison Service (PALS) was an informal service and did not replace the NHS complaints procedure. The PALS and hospital complaints team were distinct and separate and there was no obligation on patients to go through PALS first.
- PALS staff ensured that up to date PALS posters and leaflets were displayed and available in hospital wards.
- The witnesses said that the three Acute Trusts aimed to acknowledge complaints in writing within 3 days of receipt.
- Mr Garside said that a complainant could expect to receive a first response within 10 working days and a full substantive response within 25 working days.
- The witnesses said that local efforts to resolve complaints were usually successful and that very few complaints were referred to the Parliamentary and Health Service Ombudsman.
- The witnesses explained the procedures that the Trusts had put in place to make sure they acted on complaints. The witnesses said that Information was provided on a monthly basis to the Boards of all three Trusts about the nature of the complaints that related to their hospitals, with a particular emphasis on the outcomes of the complaints process, and whether patients thought that their concerns had been 'properly heard and addressed'.
- In order to ensure that complaints were used to learn lessons that lead to service improvements for patients, information about complaints was also provided to the relevant ward/departmental manager and clinical director and elsewhere within management structures of the hospitals.
- In reply to questions, it was pointed out that complaints about car parking at the NNUH had led to significant improvements at that hospital, including an enlarged car-park.
- The QEH had provided benchmarking data for all three acute hospitals which was included in the appendix to the Scrutiny Officer's report.
- Where complaints involved agency staff the agency was informed at the earliest opportunity.
- The hospitals used social website media to keep in contact with the views of young people.
- In reply to questions the witnesses said that where complaints spanned organisational boundaries, there were arrangements in place for a 'joined up' approach to sharing them with the CCGs, Adult Social Services and other organisations so that they were dealt with effectively and as quickly as possible.
- The complaints were broken down into different categories of complaint and complaints about individual members of staff were dealt with sensitively in

accordance with established HR practice.

- An established “Speak up Policy” at the NNUH gave staff a series of options whereby they could raise any issues of concern through local line management, with the Chief Executive, and with the hospital’s HR department.
- The JPH had designated a senior member of staff within the hospital’s HR team with specific responsibility for whistleblowing, so as to ensure that the hospital acted on intelligence received from whistle-blowers.
- Val Newton agreed to supply information for Members of the Committee on how many people had brought up the 17 cases of whistle-blowing at the QEH (that were mentioned on page 58 of the agenda papers) and how many of these individuals had brought forward more than one of these whistle-blowing cases.
- In response to a member question, John Garside explained that the Care Quality Commission's Intelligence Monitoring Report published on 21 October 2013 had shown the Norfolk and Norwich University Hospitals NHS Foundation Trust with an elevated risk due to four cases of whistle-blowing. The hospital no longer had such an elevated risk. Mr Garside also explained that there were no occasions in the last two years where staff had used the hospital's internal whistle-blowing process (i.e. the 'safety valve' in the Speak-Up Policy whereby staff could approach a Senior Independent Director).
- It was pointed out that none of the three acute hospitals had “gagging clauses” in contracts that prevented former members of staff raising issues of concern.
- Alex Stewart of Health-watch Norfolk explained the information that was included at Appendix D to the report which set out Health-watch Norfolk‘s involvement in the NHS complaints process.

7.4 The Committee agreed to receive Health- watch Norfolk’s report on complaints handling in Norfolk when it was published (the report was expected to be published on 23 July 2014). It was noted that the Committee would then be able to decide whether to look further at the subject of hospital complaint handling.

8 End of Life Care in Norfolk’s Acute Hospitals

8.1 The Committee received a suggested approach from the Scrutiny Support Manager (Health) to an update on new end of life care practices in hospitals to replace use of the Liverpool Care Pathway.

8.2 The Committee received evidence from Jo Segasby, Director of Women, Children and Cancer Services, Norfolk and Norwich University Hospitals NHS Foundation Trust, Dr Lisa Cook, Queen Elizabeth Hospital NHS Foundation Trust, Liz Libiszewski, Director of Nursing, Quality & Patient Experience, James Paget University Hospitals NHS Foundation Trust and Dr Katie Soden, Lead Consultant at Priscilla Bacon Centre, Norfolk Community Health and Care NHS Trust.

8.3 In the course of discussion, the following key points were made:

- The witnesses pointed out that the Liverpool Care Pathway (LCP) was being phased out in Norfolk and replaced with more personalised plans for end of life care following the publication of an independent national report from the Leadership Alliance for the Care of Dying People.
- The witnesses added that Government guidance as to what policy would replace the LCP was awaited and this was causing some degree of

uncertainty within the NHS.

- There was, however, no need for consultation about what made for good care of patients since this was the same for all patients and family needs always needed to be respected.
- The spiritual needs of patients requiring end of life care were also not neglected.
- It was pointed out that the Priscilla Bacon Centre, Norfolk Community Health and Care NHS Trust, would officially no longer follow the LCP from 1st June 2014 but in practice the Centre had not been using the LCP for a number of months.
- The witnesses added that they were working together to integrate care and develop a single "yellow folder " for patients with end of life needs and that they were piloting new electronic palliative care records.
- The acute hospitals in Norfolk had raised standards by ensuring that a named senior consultant was responsible for a patient's care needs.

8.4 The Committee noted the information provided by the acute hospitals and Norfolk Community Health and Care.

9 Terms of Reference for Great Yarmouth and Waveney Joint Health Scrutiny Committee

9.1 The Committee agreed the revised terms of reference for the Great Yarmouth and Waveney Joint Health Scrutiny Committee and that Suffolk County Council should be informed of this decision.

9.2 The Committee also agreed that Mr Carttiss, Mr Aldred and the NHOSC Member for Great Yarmouth Borough Council would serve on the joint committee.

9.3 It was noted that the next meeting of the Great Yarmouth and Waveney Joint Health Scrutiny Committee had been arranged for 23 July 2014 at the Orbis Centre, Lowestoft and that all Members of the NHOSC were eligible to be substitute members of the Joint Committee.

10 Forward Work Programme

10.1 The proposed forward work programme was agreed.

Officers were asked to look at putting the page numbers for appendices to reports on the NHOSC agenda sheets.

10.2 The meeting concluded at 11.45 am

Chairman

Access to NHS Dentistry

Suggested approach from Maureen Orr, Scrutiny Support Manager

NHS England (East Anglia Area Team) will update Members on the current position with access to NHS dentistry in Norfolk.

1. Background

1.1 Norfolk Health Overview and Scrutiny Committee (NHOSC) last received reports on access to NHS dentistry in September 2013. At that stage the committee spoke to representatives from NHS England, Public Health England and Norfolk Local Dental Committee.

1.2 NHS England reported that access to NHS dentistry had increased by 2% since March 2011 with approximately 8500 new patients accessing NHS dental services locally with 97% of patients in Great Yarmouth & Waveney and 95% in Norfolk able to get an appointment easily. It also highlighted that there was to be a new East Anglia oral health needs assessment. The Local Dental Committee pointed out that there were no guarantees that funding for NHS dentistry in Norfolk would not be lost to dental health services elsewhere in the East Anglia area if needs in other areas were found to be greater.

1.3 NHS England East Anglia Area Team was also undertaking a review of dental urgent activity, including the dental pathways within the 111 service in partnership with East Anglia Commissioning Support Unit to ensure the appropriate services were provided.

1.4 In relation to orthodontic services, NHOSC heard in September 2013 that the waiting list in Norfolk was on average approximately 10 weeks from referral to assessment but that there were local variations, with an 18 month waiting list in King's Lynn. An orthodontic needs assessment was to be completed by December 2013 to inform commissioning plans for the future.

1.5 The committee also discussed dental services for vulnerable people and children, including Looked After Children and was assured by NHS England that it would continue to work to promote good dental health for all groups.

1.6 Norfolk Local Dental Committee reported that there had been a slow

start to the relationship between the new commissioners (NHS England East Anglia Area Team), who were formally established in April 2013, and local dentists. However, and East Anglia Local Professional Dental Network had recently been established and it was hoped that there would be progress in this respect.

1.7 NHOSC had previously been interested in the new dental contract that the Department of Health has been piloting since July 2011 and its potential effects on the availability of NHS as opposed to private dentistry. Stage 2 pilots are still ongoing. The government is committed to introducing a new dental contract based on registration, capitation and quality at some stage in the future and says that the aim is to improve oral health and increase access to NHS dentists.

2.0 Purpose of today's meeting

2.1 NHS England, East Anglia Area Team (EAAT), has been invited to update NHOSC on the current position on access to NHS dentists in the county. The EAAT report is attached at Appendix A.

2.2 Norfolk Local Dental Committee has provided a report for NHOSC on its views about dentistry in the county (Appendix B).

3.0 Suggested approach

3.1 After hearing from the representatives of the NHS England EAAT, the Committee may wish to explore the following areas:-

(a) The last time that NHOSC looked at this subject a new oral health needs assessment was expected to be complete by the end of 2013. In fact, it has not yet been completed. Can the NHS England EAAT confirm when they expect the assessment to be ready and give assurance that NHOSC will receive a copy of the assessment?

(b) It is understood that NHS England EAAT will start procurement of new dental services in 2015-16. Can the EAAT assure the Committee that it will consult NHOSC about any proposed substantial changes or developments to local dental services (including orthodontic services) before the new contracts are awarded.

(c) NHS England EAAT's report mentions that:-

(a) there has been work with NHS111 to improve access to urgent out of hours dental provision
(b) data on orthodontic waiting times is being collected
(c) an impact evaluation of the pack sent to care homes regarding domiciliary dental services will be undertaken

Can NHS England EAAT give the Committee an update on these items?

(d) NHS England EAAT's report mentions that there is significant variation across Norfolk in access to sedation services for dentistry. Can the EEAT explain what the variations are and when they will be resolved?

(e) Can NHS England EAAT comment on the issues mentioned in the Norfolk Local Dental Committee paper:-

(a) The vacancy for a consultant in restorative dentistry at the Norfolk and Norwich Hospital – is it possible for the Area Team to fund 2 more sessions to make this a more attractive position for prospective candidates?

(b) Difficulty in referring patients with complex periodontal or root filling problems to periodontal / endodontic specialists - can the Area Team make more rapid progress with a new pathway to resolve this problem?

(c) Domiciliary care – how does NHS England plan to meet the increasing need for home visits for patients in need of increasingly complex dental treatment?

(d) General anaesthetic services for special needs patients – is the Area Team able to provide further funding to reduce the waiting list at the Norfolk and Norwich Hospital for vulnerable patients who require for general anaesthetic for dental procedures?

Appendix A

ACCESS TO PRIMARY DENTAL SERVICES

1 Introduction

This paper provides HOSC with a progress report on activity undertaken since the last report in 2013 to improve access to primary care dental services.

2 Commissioning Arrangements

Following the NHS reorganisation in April 2013, NHS England has assumed responsibility for the commissioning of dental services (excluding public health services which are the responsibility of the Local Authority). This responsibility is discharged through the NHS England East Anglia Area Team (the Area Team)

The Area Team has established a Local Professional Dental Network (LPN) which has the following key functions :

- To support the Area Team in commissioning services
- To provide clinical leadership and facilitate wider clinical engagement
- To provide a mechanism for engaging patients, carers and the public
- To establish solid and productive local commissioning relationships
- To advise and work in partnership with the health and wellbeing boards
- To feed into other clinical networks
- To engage with local representative committees

The Norfolk Locality Group (previously known as the Oral Health Advisory Group) comprising clinicians from across all dental sectors in Norfolk also continues to meet on a regular basis, with patient representation. The Chair of the local group sits on the East Anglia LPN to ensure that local commissioning needs are identified and can be addressed

The constructive working relationship with the Local Dental Committees (LDC) continues with joint meetings with the 3 local LDCs being held on a regular basis.

The working relationship with Norfolk Healthwatch continues.

2 Understanding Local Need & Commissioning Intentions

Work is continuing to complete an Oral Health Needs Assessment to inform the priorities for commissioners and national guidance to support a consistent approach to the assessment of need is expected to support this.
There are also a number of national working groups which are developing evidence based pathways to improve outcomes for patients, with a focus on

improving access and outcomes for vulnerable adults and children, oral surgery and orthodontics. It is expected that these groups will report in April 2015.

In view of the ongoing work to complete the needs assessment and finalise the evidence based pathways, the Area Team has extended current contracts for dental services that were due to come to an end prior to March 2016 until that date. This will enable the development of clear commissioning intentions early in 2015, commencing procurements where appropriate in 2015/16.

3. Access to Primary Care Dental Services

The area team remains committed to maintaining stability and access to dental services. Access figures are now produced by Area Team and are set out below. Work will be progressed to enable a breakdown by Health and Wellbeing Board area.

Number of patients seen in the previous 24 months in Q56 East Anglia in the time period March 2009 to March 2014

Month	Adult Patients	Child Patients	All Patients	Population	All patients as a percentage of resident population
March 2009	958,258	335,136	1,293,394	2,310,800	55.97 %
March 2010	995,110	337,177	1,332,287	2,335,500	57.05 %
March 2011	1,027,275	337,260	1,364,535	2,345,500	58.18 %
March 2012	1,044,995	336,991	1,381,986	2,371,600	58.27 %
March 2013	1,050,815	334,647	1,385,462	2,396,400	57.81 %
March 2014	1,058,750	337,038	1,395,788	2,446,591	57.05 %

Access data relating to Norfolk March 2009 to March 2013

Month	Adult Patients	Child Patients	All Patients	Population	All patients as a percentage of resident population
31/3/2010	337,010	96,237	433,247	756,400	57.3%
31/3/2011	346,536	96,288	442,824	757,100	58.5%
31/3/2012	353,583	96,117	449,700	765,200	58.77%
31/3/2013	355,131	96,118	451,249	762,000	59.22%

The latest GP Practice Survey Results (July to September 2013 data) show that 94% of patients were successful in getting an NHS dental appointment in East Anglia in the previous two years. This is 1% above the England rate of 93%.

Overall experience of dental services for those who tried to get a NHS dental appointment in the last two years was 85% good or very good, 9% neither good nor poor, 6% fairly or very poor. This is 1% above the England rate for good or very good and 1% below the England rate for fairly or very poor.

The most recent Vital Signs data (March 2014) reports that 93.7% of patients reported satisfaction with the dentistry received against a national position of 93.8%. Satisfaction with the time to wait for an appointment was 91.0% against 90.9% nationally.

3.1 Access to Urgent Care

The Area Team has been working to ensure that there are clear pathways to ensure patients can access urgent, out of hours dental care based on need. . Effective triage pathways are being implemented with the NHS111 provider to improve access to Urgent Out of Hours dental provision.

3.2 Orthodontics

The orthodontic Personal Dental Services (PDS) contracts have been extended until 31 March 2016 in line with NHS England national guidance. This will allow the area team to consider its options and future commissioning decisions once the final version of the Orthodontic Needs Assessment is completed. Currently a working group led by the LPN and the Consultant in Dental Public Health is working to finalise the Orthodontic Needs Assessment.

A review of the current orthodontic contracts including quality indicators is underway. As part of this process data on waiting times will be collected and shared with local GDPs to inform referral choices.

3.3 Domiciliary Services

A review of existing arrangements for domiciliary care across the county will look at criteria for a domiciliary visit, activity and location and availability of services. It is anticipated that a procurement process for domiciliary services will be undertaken across East Anglia in 2015/16.

The pack for care homes which was funded by Norfolk County Council Public Health Directorate has now been sent out and evaluation of the pack and its impact is due to be undertaken.

3.4 Sedation services

The Area Team is currently reviewing the contracts that it holds for sedation services including community services. There is significant variation in access across East Anglia

4. Quality Assurance framework

The Area Team has commenced development of a quality assurance framework for primary care dental providers. This will ensure proactive performance management processes, triangulating both soft and hard information and intelligence from various sources to help inform knowledge of individual practices.

NHS England East Anglia Area Team
July 2014

Appendix B

Report to Norfolk County Council Health Overview and Scrutiny Committee

Following the last meeting of the Health Overview and Scrutiny Committee when the issue of NHS dentistry in Norfolk was discussed, I am pleased to report that the Area Team commissioning NHS dentistry in Norfolk have developed their pathways of communication with the profession in the county. Regular meetings between representatives of the profession and the commissioners take place when problems can be addressed and, if possible dealt with. Progress of NHS dental contract reform is extremely slow and there are unlikely to be any marked changes over the next 12-18 months. As such this should allow the patients to be cared for in much the same way as over the past 5 years using the same contracting arrangements and there should be little or no change to their ability to access dental care in Norfolk. Capacity to commission additional services is limited due to efficiency savings the NHS is facing at present, and this includes the dental budget, however the Area Team have commissioned an Oral Health Needs Assessment which, when published, may help identify areas within the county requiring additional funding. It must be borne in mind that the Area Team's dental budget covers Norfolk together with Suffolk and Cambridgeshire and it will be spent where ever there is a need across that area, not necessarily in Norfolk. They have also commissioned an Orthodontic Needs Assessment which is likely to be published soon and again will help to indicate how NHS Orthodontics is commissioned across the three counties in the future. I would expect the Area Team to share these documents with the Norfolk Health and Wellbeing board to assist their plans for the population of Norfolk.
There are however some issues which will affect patient care in the county that are still to be resolved.

1. **Secondary Care restorative services**. There has been a vacancy at the Norfolk and Norwich hospital for a part time consultant in restorative dentistry since the retirement of the previous consultant. This post offers advice to general dental practitioners who refer patients from the county with more complex restorative needs and either provide a treatment plan for that practitioner or suggest referral to a centre with the capability to undertake this treatment. In the past this has been to the Eastman postgraduate dental hospital in London. This was discussed at the last HOSC meeting. The consultant will also take tertiary referrals (consultant to consultant) from their maxillo facial colleagues following cancer surgery to place implants to retain dentures amongst other things. They will also take referrals from orthodontic consultants who have treated children with many congenitally missing teeth, again for implants. Both of these services are not available due to the vacancy of the post and so patients are having to travel long distances to receive this treatment - not a satisfactory arrangement for those patients who have just undergone extensive cancer treatment. The hospital trust have advertised extensively for a new consultant but with no luck so far. It seems the problem is lack of sessions for any prospective candidate. If 2 more sessions could be funded by the Area Team then it might make the post more attractive. At present patients are being seriously inconvenienced by this vacancy.
2. **Periodontal/Endodontic specialists**. At our last meeting a discussion took place over the difficulty dentists were experiencing in referring those patients with complex periodontal or root filling problems. Unfortunately this situation hasn't improved at all and patients still have to travel to the Eastman dental hospital for treatment as before. The Area Team have started to try and develop a pathway for these patients but it is still fledgling and needs to progressed more rapidly.
3. **Domiciliary care**. The ability of patients who are housebound either in their own home or care/nursing home to receive a home visit in Norfolk is very variable. There are parts of the county where it is almost impossible to get a dental home visit. This has been the status for some years but over the next few years the need for home visits for patients

with increasingly complex treatment will greatly increase. At present the salaried service (originally known as the school service) try and assist in the more remote areas of Norfolk but they are finding the demand is now exceeding supply - more so, since they circulated all care homes in Norfolk with an educational oral health pack to try and help those care homes to improve the oral health of their residents. This problem is not restricted to Norfolk but has the capacity to be quite a significant drain on the Area Team dental budget.

4. **General Anaesthetic services for special needs patients**. These GA sessions have to take place at the Norfolk and Norwich hospital since regulations introduced several years prevented general anaesthesia for being undertaken in high street practices or the salaried service departments. The salaries service have reported a considerable increase in these patients for whom a GA is the only way to provide dental treatment. Further funding from the Area Team may be needed to ameliorate these burgeoning waiting lists at the hospital for the most vulnerable of patients.

Nick Stolls (Norfolk Local Dental Committee secretary) June 16th 2014

Stroke Services in Norfolk

Report by the scrutiny task & finish group

The report of the scrutiny task & finish group on Stroke Services in Norfolk is presented to Norfolk Health Overview and Scrutiny Committee (NHOSC) for approval and endorsement of the recommendations.

1. Introduction

1.1 NHOSC received an initial report about stroke services in Norfolk on 5 September 2013. The committee decided to establish a scrutiny task and finish group to examine stroke services in detail.

1.2 The group's report is attached at Appendix A. The report includes details of the membership of the group and its terms of reference as well as its conclusions and recommendations.

2. Action

2.1 NHOSC is asked to:-

(a) Approve the task and finish group's report and endorse its recommendations.

(b) Direct the recommendations to the appropriate organisations, as set out in the report, asking them to respond in writing by 30 September 2014 setting out:-
   a. Whether or not each recommendation is accepted;
   b. A detailed explanation for any that are not accepted;
   c. A deliverable plan for implementing those that are accepted;
   d. Details of how successful implementation will be measured.

(c) Ask the Norfolk and Waveney Stroke Network to meet with members of the task and finish group before submitting a written response to the recommendations.

(d) Send the report to the Stroke Association, which has offered to distribute it to local service users for comments.

(e) Send the report to the Care Quality Commission for information.

(f) Send the report to Norfolk MPs for information.

(g) Receive a report on the responses to the recommendations at a

future meeting after 30 September 2014.

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Norfolk Health Overview and Scrutiny Committee

Report of the Stroke Services in Norfolk Task & Finish Group

July 2014

Chairman's Foreword

Stroke is one of those conditions where medical understanding and treatment has come a long way in recent years. Not long ago there was no point in rushing to hospital with stroke because little could be done and the expected outcome was death or disability. Now suspected stroke patients are blue-lighted to hyper-acute care and, for some, the longer term prospects are good thanks to thrombolysis and intensive rehabilitation. Overall, better care has led to lower mortality rates and better preventative medicine has caused the incidence of stroke to fall.

In spite of this excellent progress, stroke remains the leading cause of severe adult disability in the UK. Paralysis and loss of speech are clearly devastating but stroke survivors often experience other after effects which are less obvious to the world but equally hard for them and those closest to them. Cognitive and psychological problems can put enormous emotional strain on patients, their families and carers.

London has forged ahead with improvements in stroke care over the last few years and clinical experts have set new standards which they think could improve outcomes for patients across England. We wanted to see if our local services are up there with the best. Stroke can happen at any age but three quarters of cases are in people over the age of 65. Given the demographics of Norfolk, we think it is particularly important that this county should be near the top of the league for prevention and treatment of stroke.

There is certainly great dedication and professionalism in all of our acute and rehabilitative stroke teams. We met patients who were very appreciative of the care they had received. However, it was equally clear to us that the 'gold standard' in stroke care is not being achieved across Norfolk. People need to get to hospital quicker, more should get thrombolysis, and there is a great need for longer term support for people living with the after effects of stroke.

The real difficulties in recruiting stroke specialist and other staff left our stroke teams running below par for too long. It is an all too familiar story and yet another NHS workforce issue that needs to be urgently addressed. We know that managers, clinicians and others have been working very, very hard to do that and there has been progress over the months since our scrutiny began.

I would like to thank everyone that we met for their openness and co-operation with us. We were treated with courtesy and helpfulness everywhere we went. I hope that the recommendations in our report will in turn be helpful to everyone who wants to see even better stroke services in Norfolk.

Councillor Margaret Somerville
Chairman of Stroke Services in Norfolk Scrutiny Task & Finish Group

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Report of the Stroke Services in Norfolk Scrutiny Task & Finish Group

1. Introduction

1.1 Norfolk Health Overview and Scrutiny Committee (NHOSC) received a report on stroke services across the county in September 2013. NHOSC asked for the report primarily because it was aware that the Norfolk and Norwich (NNUH) hospital had not met a range of expected stroke care standards throughout 2012-13. The Committee also knew that NHS Midlands and East, the former Strategic Health Authority, had been in the process of reviewing stroke services prior to the reorganisation of NHS commissioning in April 2013. Its aim had been to improve both acute and community stroke services, potentially centralising the hyper acute services. With the demise of the Strategic Health Authority in April 2013, NHOSC was unclear about who would drive the necessary improvements across the stroke care pathways in Norfolk.

1.2 In September 2012 NHS Midlands and East published a specification for stroke care from pre hospital through to rehabilitative care. It was seen as a gold standard for delivering better stroke services to patients. The report to NHOSC in September 2013 showed the gap between the gold standard specification and the services actually commissioned and provided in Norfolk. The report is available on the Norfolk County Council website 05/09/2013 - Agenda

1.3 The Committee agreed to establish a scrutiny task and finish group to:-

1. Understand the stroke care pathway, the connections between the new commissioners and providers involved in the pathway and the current level of performance in terms of outcomes for patients.
2. Examine the commissioners' and providers' intentions for improving stroke care services in Norfolk.
3. Make recommendations for improvement of the local services, if necessary, particularly in relation to prevention of strokes, acute care and rehabilitative care.

The group's full terms of reference are attached at Appendix 1.

1.4 Our task and finish group included five members of NHOSC and one co-opted member of Healthwatch Norfolk:-

Cllr J Bracey
Cllr M Chenery of Horsbrugh
Cllr N Legg (Vice Chairman)
Cllr M Somerville (Chairman)
Mr A Stewart (Chief Executive, Healthwatch Norfolk)
Cllr T Wright

1.5 We started our work by visiting the acute and rehabilitative stroke services at:-

- Norfolk and Norwich Hospital
- The Queen Elizabeth Hospital
- James Paget Hospital
- Norwich Community Hospital

We also visited NHS 111 at Hellesdon to see how suspected stroke calls are handled between the 111 and the 999 service.

Notes of all our visits are available from the Scrutiny Support Manager (Health).

1.6 Having met the teams at the hospitals, we invited a range of clinicians, managers and other interested groups and individuals to a series of five meetings at County Hall. During these sessions we received further information about the services and discussed views on how they could be improved. The groups and individuals that we met are listed below:-

<u>Clinical Commissioning Groups</u>
- James Elliott, Deputy Chief Executive, NHS Norwich CCG
- Kate Gill, Director of Operations and Deputy Chief Executive, NHS Great Yarmouth and Waveney
- Rachel Leeds, Programme Manager, NHS Great Yarmouth and Waveney
- Dr Ian Mack, Chairman, NHS West Norfolk CCG

<u>Strategic Clinical Network</u>
- Dr Tony O'Brien, Clinical Lead
- Candy Jeffries, Cardiovascular Strategic Clinical Network Manager

<u>East of England Ambulance Service NHS Trust</u>
- Matt Broad – General Manager
- Brett Norton – Duty Manager, Health Emergency Operations Centre (HEOC)

<u>NHS 111</u>
- Susanna Winter, Manager

<u>Norfolk and Norwich University Hospital NHS Foundation Trust</u>
- Dr Kneale Metcalf – Consultant Stroke Medicine
- Chris Cobb – Director of Medicine and Emergency Services
- Manjari Mull – Stroke Services Manager

<u>Norfolk Community Health and Care NHS Trust</u>
- Anna Morgan – Director of Nursing, Quality and Operations
- Jane Webster – Assistant Director of Specialist Services
- Nicky Wyatt – Stroke Nurse

<u>East Coast Community Health and Care</u>

- Jonathan Williams, Executive Director of Quality and Assurance (Joint Acting Chief Executive Officer)
- Geraldine Rose, Professional Head of Speech and Language Therapy

Norfolk County Council
Community Services (social care):
- Tim O'Mullane, Head of Social Care Norwich

Public Health:
- Dr Kadhim Alabady, Principal Epidemiologist

Norfolk & Waveney Local Medical Committee
- Dr Ian Hume, Medical Secretary

Norfolk Independent Care
- Dennis Bacon, Chairman

East of England Stroke Forum
- Elizabeth Bennett, Chairman

Third Sector Stakeholders
- Neil Chapman, Assistant Regional Manager, The Stroke Association
- Sarah Betsworth, Regional Head of Operations, The Stroke Association
- Angela Page, Occupational Therapist, Headway
- Michelle Jennings, Norwich Locality Lead, Norfolk Carers Support

Housing
- Tony Cooke, Housing Standards Manager, South Norfolk Council

Psychological care
- Dr Andrew Bateman – NeuroRehabilitation Manager, Oliver Zangwill Centre for Neuropsychological Rehabilitation, Princess of Wales Hospital, Ely

Service Users and Carers
- Colin and Joyce Bell

Minutes of all our meetings are available from the Scrutiny Support Manager (Health). All of the information we received is referenced in Appendix 2 and is available on request.

1.7 Over the past six months we have gained insight into the challenges facing stroke services in Norfolk along with an appreciation and respect for the dedicated people who work in the services.

1.8 This report will focus specifically on the areas that our terms of reference asked us to address (see paragraph 1.3) and will follow the phases of the stroke care pathway, which are:-

- Primary prevention
- Pre-hospital
- Acute phase
    - Hyper acute stroke care
    - Acute stroke care
    - TIA services
    - Tertiary care services (e.g. neuro and vascular surgery referrals)
- Community rehabilitation
    - Early supported discharge (ESD)
    - Stroke specialist community rehabilitation
- Long term care
- Secondary prevention
- End of life

We looked at the phases from primary prevention through to long term care and considered the question of strategic overview of the stroke pathway across the county.

2. Strategic overview

2.1 With regard to the strategic overview of stroke care services in Norfolk we met with representatives from the Clinical Commissioning Groups, the Cardiovascular Strategic Network and the East of England Stroke Forum who were able to give us some background to the impetus for improvement in stroke care.

2.2 In 2007 the National Stroke Strategy was published with the aim of improving outcomes for patients. It quoted evidence that outcomes in the UK compared poorly with other countries, with high levels of avoidable disability and mortality and this despite our services being amongst the most expensive. The NHS responded to the challenge most notably in London where stroke services were reorganised and appeared to achieve dramatic improvements in outcomes for patients. The transformation in London was achieved by whole system reorganisation funded by an additional investment of £20million per annum from all the London Primary Care Trusts. The final model included 8 hyper acute stroke units all of which also had an acute stroke unit on site, an additional 16 acute stroke units and 24 Transient Ischaemic Attack (TIA) services. The new system required 400 additional nurses and about 100 therapists.

2.3 In our part of England, the NHS Midlands and East the Strategic Health Authority carried out a review of stroke services in the 12 months to March 2013, which was the transitional year before changes to NHS commissioning introduced by the Health and Social Care Act 2012 took full effect. The NHS Midlands and East review was intended to help the new commissioners bring forward proposals to make a ‘step-change’ (i.e. very significant) improvement in the quality of the services in our region. It produced the gold standard specification referred to in paragraph 1.2 above.

2.4 The review highlighted that none of the 45 providers of acute stroke care in the Midlands and East area, which stretched from Norfolk to Shropshire, delivered hyper acute stroke care that met best practice. An Expert External Advisory Group (EEAG) working as part of the review suggested that this situation could be addressed by reducing the number of hyper acute providers from 45 to 24 – 26 across the region. The model of centralisation had already been introduced for certain cancer and heart services in the region and was considered to be effective.

The EEAG also encouraged the local NHS to be clear about the governance arrangements for driving improvements to stroke services and suggested it should carry on with improvements to other parts of the stroke care pathway even though the future of hyper acute services was still under discussion.

2.5 Whilst the review was able to provide guidance about how to achieve improvements through reorganisation of stroke services, the final decisions were down to the new commissioners, the CCGs, working in conjunction with the local hospitals and other service providers. The local NHS in the Anglia area, which includes Norfolk, Suffolk and Cambridgeshire, did not agree that centralising hyper acute stroke services would be a practical way of achieving better outcomes for patients here. They proposed to retain all seven existing hyper acute stroke services at the following hospitals:-

1. Addenbrookes
2. Ipswich
3. James Paget
4. Norfolk and Norwich
5. Peterborough
6. Queen Elizabeth Kings Lynn
7. West Suffolk

This was partly because of the greater distances that stroke emergency patients would have to travel and the significant under performance of the East of England Ambulance Service NHS Trust in terms of response times in rural areas. Stroke can be hard to diagnose and centralisation could lead to significant numbers of patients who are not actually suffering a stroke being taken by ambulance to a hospital far away from home, which would not be good for the patients and their families or for the ambulance service in terms of its response times to other patients.

2.6 In our discussions with representatives from Norwich, Great Yarmouth and Waveney and West Norfolk CCGs in December 2013 it was clear that they still did not think that centralisation of stroke services was a good option for Norfolk at that time. However, they all acknowledged the chronic shortage of stroke consultants, nurses and staff in many of the therapeutic disciplines needed for stroke care, and it was clear that staffing three full stroke services in county would be an ongoing

challenge. At the time, the JPUH and NNUH hospitals were looking to get around the problem by recruiting additional staff to share across their two services.

2.7 NHS Midlands and East was clear that stroke services in our county need to improve. The challenge they left for the new commissioners and service providers was to agree on how it should be done. One of NHOSC's concerns in September 2013 was the lack of clarity about who would take the strategic lead to drive improvements not just in hyper acute / acute care but right across the stroke care pathway.

We were therefore delighted to hear in December 2013 that a local stroke network, the Norfolk and Waveney Stroke Network, chaired by Dr Ian Mack of West Norfolk CCG, had recently been established and regular meetings were planned for 2014. The local Network includes the five CCGs, the three acute hospitals, the ambulance trust and Healthwatch Norfolk. At the time of our task and finish group meeting in April 2014 we heard that the local Network had only met once and had cancelled its second meeting. We also heard that that it planned to meet twice before the end of May 2014.

Given the challenges facing stroke care, the need for urgent improvement and the necessity for co-ordination and strategic overview of the process, we **recommend** that members of the Norfolk and Waveney Stroke Network commit to regular meetings and to working with the Cardiovascular Strategic Clinical Network and the Clinical Senate to drive co-ordinated improvement of stroke services in the county.

We note that NHS England East Anglia Area Team is not currently represented on the Norfolk and Waveney Stroke Network and we have heard that there is no identified clinical lead. The Area Team commissions GP services, sets the Quality Outcomes Framework (QOF) targets and commissions Local Enhanced Services. Given the extent of their influence over primary care, and the importance of primary care in prevention of stroke, we **recommend** that the NHS England East Anglia Area Team should be involved in the Norfolk and Waveney Stroke Network and that a clinical lead for the Network should be identified.

In our view an effective local stroke network is vital if the challenge of improving stroke services in Norfolk is to be met. As will be seen in the remainder of this report, many of our recommendations are directed toward this local network.

2.8 Throughout our scrutiny of each stage of the stroke care pathway we focused on the work already underway to improve the services and ideas for what more could be done.

3. Primary prevention

3.1 GPs and Public Health staff are the main players in preventative services.

All GPs in Norfolk are commissioned by NHS England East Anglia Area Team and Public Health services are commissioned and provided by Norfolk County Council. We met with representatives from Norfolk and Waveney Local Medical Committee, for the GPs, and Norfolk Public Health specifically to discuss prevention of stroke.

3.2 In January 2014 Norfolk Public Health published a 'Health Needs Assessment, Stroke or Transient Ischaemic Attacks (TIA)' (the Needs Assessment). The assessment gathers together information to help local commissioners plan for the future provision and improvement of stroke services. It includes all the relevant data on stroke in Norfolk including best estimates where actual data is not available. The Health Needs Assessment also recommends that further work is required between CCGs and Public Health to identify additional data sources and further analyse data in relation to stroke.

We **recommend** that the Norfolk and Waveney Stroke Network takes up the recommendations of the Health Needs Assessment and oversees collective work between CCGs and Public Health to identify additional data sources and further analyse data in relation to stroke.

3.3 We were particularly struck by the fact that the rate of diagnosed stroke on GP Quality Outcomes Framework (QOF) registers across Norfolk was 2.1% in 2012-13, which was higher than the England average rate of 1.7%. One clear reason for the higher prevalence of stroke is that Norfolk has a much older age profile than England as a whole and the prevalence of stroke increases with age. Having said this, another of the striking facts that we learnt during our scrutiny was that stroke can affect people of all ages. For example, a child with sickle cell anaemia can have a first stroke by the age of two and a major stroke by the age of 18. Nationally, 25% of strokes occur in people under the age of 65.

There were an average of 873 deaths per year from stroke in Norfolk in the years 2010-12, and an estimated 6,149 people (in 2012) living with a longstanding health condition caused by stroke. This was expected to increase to 7,099 people by 2020.

3.4 Stroke prevention starts with public health education to encourage people to make healthy lifestyle choices. Primary care also plays an important role. The NHS Health Check commissioned by Public Health at GP practices and pharmacies, aims to help prevent stroke, heart disease, diabetes, kidney disease and certain types of dementia. Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions or has certain risk factors, will be invited once every five years to have a check to assess their risk of disease. GPs use the QRISK2 tool to assess the patient's level of risk and can then intervene with drug treatments or lifestyle advice and continue to review and monitor patients. There is a financial incentive for them to do this through the QOF.

One of the younger stroke survivors who we met told us that his blood pressure had not been checked before his stroke in 2005. GPs could play an important preventative role simply by asking people if they know their blood pressure and cholesterol levels and making these checks if they have not already been done. In fact, we think the opportunities for checking blood pressure could be greatly increased if dentists and pharmacists were also encouraged to undertake these checks. We **recommend** that NHS England East Anglia Area Team considers the scope for introducing blood pressure checks at dental surgeries and pharmacies.

We further **recommend** that Norfolk County Council Public Health, who are responsible for commissioning the NHS Health Checks in the county, assess the numbers of people who are eligible for a NHS Health Check and the numbers who actually take up a Health Check and make the information available to the NHS England commissioners and GPs on a practice by practice basis to encourage action in the areas of low take-up.

3.5 Common sense tells us that it would better to prevent strokes than to deal with the consequences, both for the sake of individuals and families involved and for the NHS budget. Data on the total cost of stroke in Norfolk is not currently available as the social care CareFirst system does not records costs against specific medical conditions. This will change from April 2014 when the cost of social care related to stroke will be separately accounted for.

In the meantime, National Institute for Health and Clinical Excellence's (NICE) Cost Impact and Commissioning Assessment: quality standard for stroke gives an indication of the kind of savings that could be made by preventing stroke. In England, NICE estimates that stoke costs the economy around £7 billion per year:-

Direct costs to the NHS	-	£2.8 billion per annum (around £5.5million per 100,000 population)
Costs of informal care	-	£2.4 billion per annum
Costs because of lost productivity and disability	-	£1.8 billion per annum

Stroke patients occupy around 20% of all acute hospital beds and 25% of long term beds.

NICE has analysed the cost of investment in stroke services of the quality envisaged in the National Stroke Strategy 2007 against the savings that could be realised by reducing the costly effects of stroke.

3.6 Although the core activities of Primary Care and Public Health clearly act

to prevent of stroke, we came across only one other NHS commissioned service specifically aimed at stroke prevention during the course of our scrutiny. This was a 28 hours per week Stroke Prevention service provided by the Stroke Association as part of a wider package of services commissioned from them by the Queen Elizabeth Hospital, King's Lynn.

The service is offered to clients and their families in West Norfolk who wish to address lifestyle issues, particularly concerning alcohol, smoking, exercise, diet and weight management. The aim is to enable clients to live more healthily and prevent either a first or repeat stroke. It provides stroke prevention information and support on a one to one basis and including to family members as this helps to ensure the success of lifestyle changes. The support is also offered in group sessions through such schemes as a Healthy Lifestyle Programme, which looks at issues relating to the whole person, including reducing stress and anxiety management.

3.7 We appreciate the difficulty of cost : benefit analysis in relation to preventative services but given the high cost of stroke to both health and social care, we are surprised that there are not more examples of stroke specific preventative services across the county, especially for people who are at high risk.

We have made a recommendation which includes an element of preventative service at paragraph 7.7.

4. Pre hospital

4.1 The pre hospital phase of the stroke care pathway encompasses the recognition of suspected stroke and transportation of the patient to hospital. Speed is of the essence in the pre hospital phase because, as the ambulance service puts it, 'time is brain'.

Where a stroke has been caused by a blood clot rather than by a bleed, thrombolysis (i.e. injection of a clot-busting drug) can lead to a good recovery in about 10 per cent of cases. People with suspected stroke need to get to hospital fast because:-

(a) A brain scan is required to determine that their stroke has been caused by a clot. Thrombolysis would harm a patient whose stroke has been caused by a bleed in the brain.
(b) Thrombolysis can only be given within four and a half hours of the onset of symptoms.
(c) In suitable cases, the sooner thrombolysis is given the better the outcome for the patient.

The time window of four and a half hours for thrombolysis applies in where standard brain scanning techniques are used. We understand that a new technique, perfusion scanning, can allow thrombolysis to be administered as much as 12 hours after the patient was last known to be

well.

4.2 The national Act FAST campaign successfully raised public awareness of the symptoms of stroke and the imperative to call 999:-

F – face (drooping on one side)
A – arm (unable to raise)
S – speech (slurred)
T – time to call 999

We understand that nationally collected data shows that hospital admissions rise when the campaign is run and people's awareness of stroke is raised. We were pleased to note that the campaign was re-run towards the end of the 2013-14 financial year.

4.3 When people play their part and are fast to spot a potential stroke, the NHS services that come into play are NHS 111, 999 and the East of England Ambulance Service NHS Trust (EEAST), all of which are commissioned by the Clinical Commissioning Groups. In January 2014 we met with managers from NHS 111 and EEAST to discuss their role and visited the Health Emergency Operations Centre in Hellesdon to see their co-ordination.

4.4 We were impressed by the NHS 111 service which, after a shaky start in 2013, appeared to be working well. We saw the system pathway used to identify stroke cases and pass them through for direct ambulance dispatch.

4.5 Given that every suspected stroke patient is an emergency case, EEAST's well known under-performance in terms of response times, especially in rural areas, is a serious concern. Representatives from EEAST gave us the details of the challenges they face and the action underway to address them.

4.6 The ambulance service will code a FAST-positive suspected stroke case as a Red 2 call, with a target to get to such patients within 8 minutes 75% of the time. The ambulance service also has two specific targets to meet in relation to stroke:-

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

Stroke Care Bundle - The percentage of suspected stroke patients (assessed face to face) who receive an appropriate care bundle. (As per National Ambulance Clinical Performance

Indicator Care Bundle). The compliance performance standard is 95%.

EEAST's performance against these standards is shown overleaf.

EEAST performance against stroke standards in Norfolk CCG areas April 2013 – March 2014

East of England Ambulance Service NHS Trust Operating Framework Indicators 2013/14

NHS Great Yarmouth and Waveney

a) The percentage of Face Arm Speech Test (FAST) positive stroke patients (assessed face to face) potentially eligible for stroke thrombolysis, who arrive at a hyperacute stroke centre within 60 minutes of call.

	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Performance (%)	44.4%	56.4%	74.1%	57.8%	57.1%	48.4%	56.3%	63.3%	67.9%	94.1%	80.0%	57.1%
Number of incidents (Denominator)	36	39	27	45	35	31	32	30	28	17	10	7
Number of successes (Numerator)	16	22	20	26	20	15	18	19	19	16	8	4

b) The percentage of suspected stroke patients (assessed face to face) who receive an appropriate care bundle. (As per National Ambulance CPI Care Bundle)

Performance (%)	96.7%	91.7%	100.0%	92.9%	100.0%	93.5%	100.0%	100.0%	100.0%	97.4%	100.0%	77.8%
Number of incidents (Denominator)	30	36	24	42	35	31	31	30	28	39	22	9
Number of successes (Numerator)	29	33	24	39	35	29	31	30	28	38	22	7

NHS North Norfolk

a) The percentage of Face Arm Speech Test (FAST) positive stroke patients (assessed face to face) potentially eligible for stroke thrombolysis, who arrive at a hyperacute stroke centre within 60 minutes of call.

Performance (%)	40.0%	15.4%	0.0%	0.0%	25.0%	25.0%	27.3%	10.0%	5.9%	27.3%	6.3%	38.1%
Number of incidents (Denominator)	10	13	21	27	8	12	11	20	17	11	16	21
Number of successes (Numerator)	4	2	0	0	2	3	3	2	1	3	1	8

b) The percentage of suspected stroke patients (assessed face to face) who receive an appropriate care bundle. (As per National Ambulance CPI Care Bundle)

Performance (%)	100.0%	95.7%	100.0%	96.4%	100.0%	100.0%	97.6%	86.8%	94.3%	80.0%	100.0%	90.9%
Number of incidents (Denominator)	24	23	33	55	26	18	41	38	35	30	47	22
Number of successes (Numerator)	24	22	33	53	26	18	40	33	33	24	47	20

NHS Norwich

a) The percentage of Face Arm Speech Test (FAST) positive stroke patients (assessed face to face) potentially eligible for stroke thrombolysis, who arrive at a hyperacute stroke centre within 60 minutes of call.

Performance (%)	75.0%	60.0%	62.5%	73.7%	100.0%	77.8%	57.1%	80.0%	85.0%	69.2%	50.0%	81.8%
Number of incidents (Denominator)	8	5	8	19	8	9	14	10	20	13	18	11
Number of successes (Numerator)	6	3	5	14	8	7	8	8	17	9	9	9

b) The percentage of suspected stroke patients (assessed face to face) who receive an appropriate care bundle. (As per National Ambulance CPI Care Bundle)

Performance (%)	100.0%	92.3%	86.7%	97.4%	100.0%	89.5%	100.0%	89.7%	100.0%	100.0%	94.9%	73.3%
Number of incidents (Denominator)	16	13	15	39	25	19	32	29	39	25	39	15
Number of successes (Numerator)	16	12	13	38	25	17	32	26	39	25	37	11

NHS South Norfolk

a) The percentage of Face Arm Speech Test (FAST) positive stroke patients (assessed face to face) potentially eligible for stroke thrombolysis, who arrive at a hyperacute stroke centre within 60 minutes of call.

Performance (%)	23.1%	30.8%	38.5%	50.0%	46.2%	25.0%	27.3%	26.7%	27.8%	50.0%	40.0%	75.0%
Number of incidents (Denominator)	13	13	13	18	13	20	11	15	18	20	10	12
Number of successes (Numerator)	3	4	5	9	6	5	3	4	5	10	4	9

b) The percentage of suspected stroke patients (assessed face to face) who receive an appropriate care bundle. (As per National Ambulance CPI Care Bundle)

Performance (%)	88.0%	95.7%	96.2%	97.7%	100.0%	97.2%	92.6%	97.6%	100.0%	97.6%	100.0%	100.0%
Number of incidents (Denominator)	25	23	26	44	41	36	27	41	36	41	28	12
Number of successes (Numerator)	22	22	25	43	41	35	25	40	36	40	28	12

NHS West Norfolk

a) The percentage of Face Arm Speech Test (FAST) positive stroke patients (assessed face to face) potentially eligible for stroke thrombolysis, who arrive at a hyperacute stroke centre within 60 minutes of call.

Performance (%)	37.5%	69.2%	56.3%	63.0%	57.1%	30.0%	50.0%	57.1%	57.7%	57.1%	41.7%	47.1%
Number of incidents (Denominator)	8	13	16	27	7	10	14	21	26	14	12	17

Number of successes (Numerator)	3	9	9	17	4	3	7	12	15	8	5	8

b) The percentage of suspected stroke patients (assessed face to face) who receive an appropriate care bundle. (As per National Ambulance CPI Care Bundle)

Performance (%)	82.6%	100.0%	94.1%	92.0%	94.3%	100.0%	95.0%	100.0%	97.8%	97.6%	97.6%	94.1%
Number of incidents (Denominator)	23	32	34	50	35	27	40	39	45	41	41	17
Number of successes (Numerator)	19	32	32	46	33	27	38	39	44	40	40	16

4.7 As can be seen from the figures above, EEAST is not meeting the Stroke 60 standard for Norfolk and in some areas the performance is far below standard. For instance, in North Norfolk Stroke 60 was met in just 15.51% of cases.

Delivery against the Stroke Care Bundle standard is better, although it too is not consistently delivered across the county. For instance, in the Norwich CCG area the standard was met in only 6 months out of 12 in 2013-14.

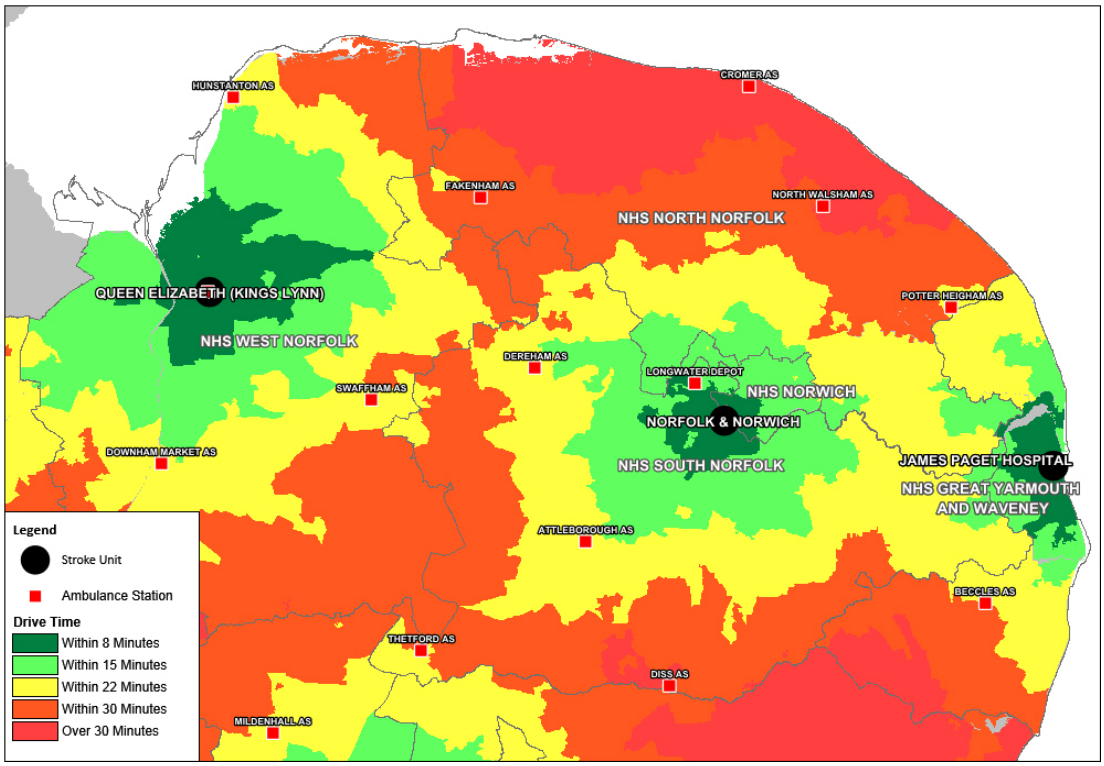
EEAST explained that the Stroke 60 standard in a rural county like Norfolk is hugely challenging for the following reasons:-

- The assessment of stroke can often prove challenging as a number of other conditions "mimic" stroke.
- Establishing the time of onset and completing the care bundle may also be difficult.
- A patient who has suffered a dense stroke that has caused a hemiplegia (paralysis of the arm, leg, and trunk on the same side of the body) can be very difficult to manually handle and move from a house.
- Stroke patients are often found in bed which means moving the patient down flights of stairs.
- Stroke patients often present with hemiplegia and vomiting, which makes it very challenging to provide care in a fast moving ambulance and the speed has to be tempered for the safety of the patient and ambulance clinician who may be standing up to provide care.

The complications often result in time being spent on scene assessing and then moving the patient in circumstances that are difficult and result in extended on scene times. The optimum time spent on scene should be as short as absolutely necessary. However inevitably with the challenge stroke patients present, this can be extended and impact on Stroke 60 being achieved.

4.8 The distance to be travelled by ambulance and the nature of the roads also plays a part. The map of Norfolk and Suffolk below, which was commissioned by EEAST, shows the drive times to current stroke centres under emergency blue light driving conditions. The North Norfolk CCG area has approx ¾ of its geographical area 30 minutes from a stroke centre. A further approx ¼ is over 30 minutes from a stroke centre. North Norfolk also has the highest prevalence of stroke or TIA cases in Norfolk.

Drive Time to Nearest Stroke Unit



4.9 We were interested in the role of Rapid Response Vehicles (cars) in response to stroke. Clearly a stroke patient needs a double staffed ambulance (DSA) to get them to hospital but a Rapid Response Vehicle (RRV) is sometimes dispatched as well as an ambulance to get a paramedic to the patient as quickly as possible. We asked for details of the number of stroke cases where an RRV arrived first and how long it took for the ambulance to arrive after that. We received the following information for 2014:-

STROKE 60 DSA/RRV RESPONSE ANALYSIS January – April 2014

Month	DSA/RRV incidents	RRV First	DSA first	Average back up time
Jan-14	33	11	22	00:12:16
Feb-14	18	4	14	00:08:01
Mar-14	47	10	37	00:08:50
Apr-14	35	6	29	00:12:49

The 2014 figures show a significant improvement on earlier data we received for October and November 2013, which was as follows:-

Month	DSA/RRV Incidents	RRV First	DSA First	Avg Backup Time
October 2013	51	23	28	00:14:57
November 2013	64	33	31	00:20:21

4.10 In January 2014 EEAST acknowledged that its performance in Norfolk is below the standard required and promised that resources for Norfolk would be increased, with a 24 hour ambulance stationed at Cromer, more staff coverage, and Rapid Response Vehicles (cars) being replaced by ambulances.

On 1st March 2014 EEAST remodelled its delivery of service in Norfolk by converting 3 rapid response vehicles (RRVs) to double staffed ambulances (DSAs). Additional DSA hours and a new working pattern were introduced in Cromer as well:-

Ambulance station	**Previous level of cover**	**From 1st March 2014**
Cromer	2 x 24/7 hours/days DSAs 1 x 16/7 hours/days RRV	3 x 24/7 hours/days DSAs 1 x 12 hour DSA (Fri/Sat) 1 x 16/7 hours RRV
Diss	2 x 24/7 hours/days DSA 70 hour RRV	3 x 24/7 hours/days DSA 70 hour RRV
Fakenham	1 x 24/7 hours/days DSA 84 hour RRV	1 x 24/7 hours/days ambulance 1 x 10/7 hours/days ambulance 84 hour RRV

The representatives from EEAST also told us that even with these changes achieving the Stroke 60 standard would remain a significant challenge. They were very clear that reducing the number of locations providing hyper acute stroke services in Norfolk would not be a good idea in the current circumstances.

We would very much like to see the ambulance service meeting the Stroke 60 standard to give patients the best possible chance of a good outcome after stroke. It is of great concern to us that EEAST seemed to hold little hope of doing that in the foreseeable future. We therefore **recommend** that EEAST reviews the number and location of ambulance bases in Norfolk in relation to travelling times to the hyper acute stroke units with a view to achieving the Stroke 60 standard in all parts of the county.

4.11 The acute hospitals stroke teams with whom we spoke emphasised the importance of active liaison between the hospital and ambulance teams to ensure good communication and a thorough understanding of the stroke pathway outside and inside hospital. We got the impression that liaison

has been patchy at times because of staff turnover and that there has not been a consistently identified lead for stroke at EEAST with whom the hospitals can liaise.

4.12 The hospital stroke teams are supposed to receive a pre-alert from the ambulance service when a stroke patient is on the way. From what we heard this certainly does not happen in all cases. For example, the NNUH said that pre alerts are received for about 70% of patients.

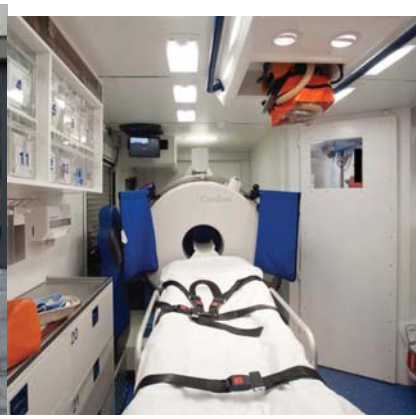
If it is the case that a hospital receives pre alerts in only 70% of cases rather than 100% then it is the responsibility of both the hospital and the ambulance service to rectify the situation.

We **recommend** that the Norfolk and Waveney Stroke Network seeks assurance from the three acute hospitals in Norfolk that they report back to EEAST on failures to provide pre-alerts of the arrival of stroke patients so the problem can be quantified and appropriately addressed and that EEAST identifies a lead for stroke with whom the hospitals can liaise consistently.

4.13 Unfortunately, stroke can be difficult to diagnose accurately. The consultant from the NNUH commented that it should be possible for the hospital and ambulance service to work together to shorten the diagnosis time for stroke and for the hospital to use test results carried out on the ambulance. For example, the NNUH has in the past provided training sessions for ambulance teams in identification of stroke and commented that having an identified lead for stroke at EEAST could help to get these sessions restarted. We have recommended that EEAST identifies such a lead (see paragraph 4.12).

We **recommend** that the NNUH, JPUH, QEH and EEAST consider what more could be done to enable the ambulance service and the acute hospitals to work together to shorten the diagnosis time for stroke.

4.14 EEAST gave us interesting information about practice in Germany where there are mobile CT scanners and thrombolysis is administered in an ambulance setting (photographs below).



The representatives from EEAST pointed out that pre hospital thrombolysis for heart attack was successfully introduced in England 10 years ago but the treatment had ceased as PPCI (primary percutaneous coronary intervention) at a heart attack centre is now the favoured treatment.

The possibility of pre hospital thrombolysis for stroke was mentioned in the context of potential centralisation of hyper acute services in a rural area with long travel times to hospital. It was recognised that it would be an expensive solution aside from the practicalities of operating the large mobile CT vehicle on Norfolk roads.

4.15 Working on the assumption that pre-hospital thrombolysis is an aspiration that would not be a viable in Norfolk in the foreseeable future, we **recommend** that EEAST focuses on improving its performance by ensuring that double staffed ambulances are first on scene to a higher proportion of suspected stroke patients and that patients are transported to hospital without delay.

We note that EEAST has already improved in this respect during 2014.

5. Acute stroke care

5.1 We have three acute hospitals in Norfolk providing hyper acute and acute stroke care. Details of the services provided by each of the hospitals were included in the report to NHOSC on 5 September 2013 (see the link at paragraph 1.2 above). The services are commissioned as follows:-

- Norfolk and Norwich University Hospital NHS Foundation Trust (NNUH) – commissioned by Norwich CCG (co-ordinating for the central Norfolk CCGs, i.e. North Norfolk, South Norfolk and Norwich)
- The Queen Elizabeth Hospital NHS Foundation Trust (QEH) – commissioned by West Norfolk CCG
- James Paget University Hospitals NHS Foundation Trust (JPUH) – commissioned by Great Yarmouth and Waveney CCG.

We met with the clinical and management teams at each hospital to discuss current performance and plans for improvements.

5.2 Although we were grateful to receive extensive performance data from each of the hospitals, we found considerable difficulty in making meaningful comparisons between them as the data was presented in different styles and offered different levels of detail. The Royal College of Physicians' (RCP) Sentinel Stroke National Audit Programme (SSNAP) will eventually provide consistent benchmarking data and trend information. The SSNAP which started in July 2013 replaced the former pilot audits and the Stroke Improvement National Audit Programme (SINAP). All the Norfolk services are now uploading data to SSNAP, with the QEH the last to start in September 2013.

We were advised by the Cardiovascular Strategic Clinical Network Manager in December 2013 that the SSNAP data was currently unreliable for comparative purposes because of lack of clarity over some of the data definitions and that it would be six months to a year before SSNAP data could be considered robust and reliable. Nevertheless, we have included overleaf an extract from the SSNAP Clinical Audit October to December 2013 public report for information. We must emphasise that the SSNAP data shown in this report is at summary level only and there is a wealth of detail on each element of the stroke care pathway available on the Royal College of Physicians website:-
SSNAP data

We would also point out that the RCP acknowledges that the collection of therapy data in SSNAP is not sensitive enough to determine what should have been required for each patient. However, in the RCP's view it provides an overview of therapy intensity across whole pathways.

The extract overleaf shows the difference in overall performance between hospitals in our region and hospitals in London in October – December 2013. On a scale from A (best) to E (worst) the latest overall performance scores for our local acute hospitals are:-

JPUH - D (down from C in July – Sept 2013)
NNUH – D (was also D in July – Sept 2013)
QEH – D (no data available for July – Sept 2013)

We were very much struck that the teams at each of the acute hospitals recognised the room for improvement in their services and we were impressed by their hard work and passion for reaching the high standards which have been set.

Extract from Sentinal Stroke National Audit Programme Clinical Audit October - December 2013

Routinely Admitting Teams		Overall Performance				Patient Centred Data											Team Centred Data										
Trust	Team Name	SSNAP Level	CA	AC	Combined KI Level	D1 Scan	D2 SU	D3 Throm	D4 Spec Asst	D5 OT	D6 PT	D7 SALT	D8 MDT	D9 Std Disch	D10 Disch Proc	PC KI Level	D1 Scan	D2 SU	D3 Throm	D4 Spec Asst	D5 OT	D6 PT	D7 SALT	D8 MDT	D9 Std Disch	D10 Disch Proc	TC KI Level
London - London SCN																												
Barking, Havering and Redbridge University Hospitals NHS Trust	Queens Hospital Romford HASU	D	C↑	B	C↓	B	C	C↓	C↓	A	A↑	C	C	B	D	B	B	C↑	C↓	C↓	A	A↑	C↓	B	C↓	E	C↓
Barts Health NHS Trust	Royal London Hospital HASU	B↑↑	B↑↑	C↑	A	B	C	A	A↑	A	A↑	C↓↓	B	B	A	A	B	C	A	A↑	A	A↑	B	B	B	A	A
Imperial College Healthcare NHS Trust	Charing Cross Hospital HASU	C	A	A	C	A	B	A	B↑	C	C	D↑	D↑	C↑↑	B↑	B↑↑	A	B	A	B↑	C	B↑	E	D↓	C↑↑	C	C
King's College Hospital NHS Foundation Trust	King's College Hospital HASU	C↓	B↓	B	B	A↑	C	A	B	B↑	D↓↓	C	C↓	B	B	B	A	C	A	B	B↑	C↓	B↑	B	B	B↑	B
King's College Hospital NHS Foundation Trust	Princess Royal University Hospital HASU	D	C↓	B	C	A	D	B	B	E↓↓	C	B	D	B↑↑	D	C	A	D	B	B	E↓	C↓	B	D	A↑↑↑	E	C
North West London Hospitals NHS Trust	Northwick Park Hospital HASU	C	C	B	B↓	B	B↓	A	B↓	A	A↑	A↑	D	B	D	B	B	B↓	A	B↓	A	B	B	C↓	C↓↓	E↓	B↓
St George's Healthcare NHS Trust	St George's Hospital HASU	D	B↓	B↑	D↓	A	D↓	B	D	C	C↓	C	D↓	B	B↑	C	A	D↓	B	D	D↓	D↓	D↓	D↓	B	D	D↓
University College London Hospitals NHS Foundation Trust	University College Hospital HASU	D↓	B	D	B↓	A	D↓	B↓	C	A	A	D↓	C	C↓	B↓	B↓	A	D↓	B↓	C	C↓↓	B	D	B	C↓	B↓	C↓
Midlands & East - East of England SCN																												
Basildon and Thurrock University Hospitals NHS Foundation Trust	Basildon University Hospital	D	A↑	C↑	D↓	A↑	C↑	C	C	C	C	E↓↓	D	C	C↓	D↓	A↑	C↑	C	C	C	C	E↓↓	D	D↓	C↓	D↓
Bedford Hospital NHS Trust	Bedford Hospital	D↑	A↑↑	B↑	D	E	B↑	D↑	D↑	A	A↑	E	D↑	B	C	D	E	B↑	D↑	D↑	A	A↑	E	D↑	B	D↓	D
Cambridge University Hospitals NHS Foundation Trust	Addenbrooke's Hospital	E	A↑↑↑	E	E	D	D	D	E	E↓↓	E	E	E	E	E	E	D	D	D	E	E	E	D	E	E	E	E
Colchester Hospital University NHS Foundation Trust	Colchester General Hospital	B	A	C	A↑	A	C	B↑	B	A↑	A	D↑	B	B↓	A	A↑	A	C	B↑	B	A	A	D	B	B↓	A	A
East and North Hertfordshire NHS Trust	Lister Hospital	D	A↑	D	C↑	C↓	C↑	C	D	A	A↑	E	B↑	C↑	D	C↑	C↓	C	C	D	A	A↑	E	A↑	C↑	D	C
Ipswich Hospital NHS Trust	Ipswich Hospital	D	A↑	B	D↓	C	C↓	D↓↓	C	C	C↓	D	D	B	C↑	D↓	C	C↓	D↓↓	C	C	C↓	E↓	C↑	B	C↑	D↓
James Paget University Hospitals NHS Foundation Trust	James Paget Hospital	D	B	C	D↓	C↓	B	E↓↓	D↓	A	B	E	D	C↓	D	D↓	C↓	B	E↓↓	D↓	A	B	E	C↑	C↓	D	D↓
Luton and Dunstable University Hospital NHS Foundation Trust	Luton and Dunstable Hospital	E	A	E	E	C↓	D↓	D	E↓	E	E	E	E	D	C	E↓	C↓	D↓	D	E↓	E	E	E	D↑	D	D	E
Mid Essex Hospital Services NHS Trust	Broomfield Hospital	D	A↑	C	C↑	B↑	C↑	C	C↑	B↑	B↑↑	D	D	B	D↑	C↑	B↑	C↑	C	C↑	C	B↑↑	D	D↓	B	E	D
Norfolk and Norwich University Hospitals NHS Foundation Trust	Norfolk and Norwich University Hospital	D	A↑	D	D	C	C↑	C	B	C↓	D	C	D	E	D	D	C	C↑	C	B	C	D	C	C↓	E	E	D
Peterborough and Stamford Hospitals NHS Foundation Trust	Peterborough City Hospital	E↓	A	E	E↓	C↓↓	C	E	D↓↓↓	E↓↓	E↓↓	E	D	E	E	E↓	C↓↓	C	E	D↓↓↓	E↓↓	E↓	E	C	E	E	E↓
Princess Alexandra Hospital NHS Trust	Princess Alexandra Hospital	D	D↑	C	C	B	C	D	C	C	B	B	D	C	B	C	B	C	D	C	C	B	B	D	C	B	C
Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	Queen Elizabeth Hospital Kings Lynn	D	A↑↑↑↑	E	D	D	B	B	D	B	E	E	B	E	D	D	D	B	B	D	B	E	E	B	E	D	D
Southend University Hospital NHS Foundation Trust	Southend Hospital	D	A	D↓	C	B↑	C↓	A↑	B↑	C	B↑	D	C↑	B	D	C	B↑	C↓	A↑	B↑	C	B↑	D	B	B	D	B↑
West Hertfordshire Hospitals NHS Trust	Watford General Hospital	D	A	C↑	D	B	C	B	B	C	D	E	E	B	D	D	B	C	B	B	C	D	E	D	B	D	D
West Suffolk NHS Foundation Trust	West Suffolk Hospital	D	A↑	C	C↑	A	B	D↓	B	B↑↑	B↑↑	E	C↑↑	B↑	D	C↑	A	B	D↓	B	B↑↑	B↑↑	E	C↑	B↑	D	C↑
Midlands & East - East Midlands SCN																												
Derby Hospitals NHS Foundation Trust	Royal Derby Hospital	D	A↑↑↑↑	C	D	D	D	D	B	A	A	E	D	C	D	D	D	D	D	B	A	A	E	C	C	D	D
Kettering General Hospital NHS Foundation Trust	Kettering General Hospital	E	B↑↑	D↑	E	D↑	E	E	D↑	E	E	E	D	E	E	E	E	E	E	E	E	E	E	E	D	D↓↓	E
Northampton General Hospital NHS Trust	Northampton General Hospital	D	A	B	D	C	D	D↓	A	C	C	E	C	E	E	D	C↓	D	D↓↓	A	C	C	E	B	E	E	D
Nottingham University Hospitals NHS Trust	Nottingham City Hospital	D	B↑↑↑	D	D	D	B	B	C	B	C	E	C	D	D	D	D	B	B	C	B	C	E	C	D	D	D
Sherwood Forest Hospitals NHS Foundation Trust	Kings Mill Hospital	D	A	C	D	D	D↓	D↓	D	C↓	C	E	C	B	B	D	D	D↓	D↓	D	C↓	C	E	C↑	B	B	D
United Lincolnshire Hospitals NHS Trust	Lincoln County Hospital	D↓	C↓	D	B	A	C	A	B	A	A	B↑	B	D↓	E	B	A	C	A	B	A	A	B↑	B	D↓	E	B
United Lincolnshire Hospitals NHS Trust	Pilgrim Hospital	C↑	B↑	D	B↑	A↑	C	D	B↑	A	A↑	A	B↑	C↑	D	B↑	A↑	C	D↑	B↑	A	A↑	A	B↑	C↑	D	B↑
University Hospitals of Leicester NHS Trust	Leicester Royal Infirmary	E	B↑	C	D	D↓	D↓	D	C	D	D↓	E	E↓	B↑	D	D	D↓	D↓	D	C	D	D	E	D	B↑	D	D

Key to the table included overleaf

Key to SSNAP data

Abbreviated heading	Full Description
SSNAP Level	SSNAP Level
CA	Case ascertainment
AC	Audit compliance
Combined Total KI level	Combined Total Key Indicator Level
D1 Scan	Domain 1: Scanning
D2 SU	Domain 2: Stroke unit
D3 Throm	Domain 3: Thrombolysis
D4 Spec asst	Domain 4: Specialist assessments
D5 OT	Domain 5: Occupational therapy
D6 PT	Domain 6: Physiotherapy
D7 SALT	Domain 7: Speech and language therapy
D8 MDT	Domain 8: Multi-disciplinary team working
D9 Std disch	Domain 9: Standards by discharge
D10 Disch proc	Domain 10: Discharge processes
PC KI level	Patient-centred Total Key Indicator Level
TC KI level	Team-centred Total Key Indicator Level

SSNAP includes 44 key indicators to represent high quality stroke care. The RCP emphasises that these set an extremely high standard to which services are encourage to aspire, and the results should be read in that context. The results are organised to show:-

Patient centred domain scores – whereby scores are attributed to every team which treated the patient at any point in their care.

Team centred domain scores – whereby scores are attributed to the team considered most appropriate to take responsibility for the measure.

Combined total key indicator scores – calculated by averaging the patient-centred and team-centred total key indicator scores.

The table overleaf shows a detailed comparison of SSNAP data for the three acute hospitals in Norfolk in October to December 2013 against national results.

SSNAP October – December 2013

	National	NNUH		JPUH		QEH	
1.1 Proportion of patients scanned within 1 hour of clock start	41.7	47.3	↑	44.2	↑	33.1	↓
1.2 Proportion of patients scanned within 12 hours of clock start	84.8	81.7	↑	88.4	↑	73.7	↓
1.3 Median time between clock start and scan (hours:mins)	1:23	1:04	↑	1:08	↑	2:06	↓
2.1 Proportion of patients directly admitted to a stroke unit within 4 hours of clock start	58.1	76.7	↑	86	↑	79.7	↑
2.2 Median time between clock start and arrival on stroke unit (hours:mins)	3:36	3:10	↑	3:16	↑	2:29	↑
2.3 Proportion of patients who spent at least 90% of their stay on stroke unit	84.2	88.6	↑	96.9	↑	94.3	↑
3.1 Proportion of <u>all</u> stroke patients given thrombolysis (all stroke types)	11.3	11.2	↓	3.5	↓	21.2	↑
3.2 Proportion of <u>eligible</u> patients (according to the RCP guideline minimum threshold) given thrombolysis	74.7	81.3	↑	37.5	↓	82.6	↑
3.3 Proportion of patients who were thrombolysed within 1 hour of clock start	52.8	63	↑	0	↓	48	↓
3.4 Proportion of applicable patients directly admitted to a stroke unit within 4 hours of clock start AND who either receive thrombolysis or have a pre-specified justifiable reason ('no but') for why it could not be given	56.8	76.7	↑	86	↑	79.7	↑
3.5 Median time between clock start and thrombolysis (hours:mins)	0:58	0:56	↑	1:12	↓	1:02	↓
4.1 Proportion of patients assessed by a stroke specialist consultant physician within 24h of clock start	74.8	72.6	↓	77.9	↑	81.4	↑
4.2 Median time between clock start and being assessed by stroke consultant (hours:mins)	13:52	14:24	↓	13:13	↑	14:03	↓

	National	NNUH		JPUH		QEH	
4.3 Proportion of patients who were assessed by a nurse trained in stroke management within 24h of clock start	86.9	93.8	↑	93	↑	88.1	↑
4.4 Median time between clock start and being assessed by stroke nurse (hours:mins)	2:11	0:19	↑	0:08	↑	1:12	↑
4.5 Proportion of applicable patients who were given a swallow screen within 4h of clock start	64.2	86.4	↑	64.2	↑	67.6	↑
4.6 Proportion of applicable patients who were given a formal swallow assessment within 72h of clock start	79.3	91.1	↑	52	↓	71.2	↓
5.1 Proportion of patients reported as requiring occupational therapy	81.2	85.5	↑	91.8	↑	81.1	↓
5.2 Median number of minutes per day on which occupational therapy is received	40	50	↑	54.7	↑	33.3	↓
5.3 Median % of days as an inpatient on which occupational therapy is received	44.3	39.2	↓	60.2	↑	70.2	↑
5.4 Compliance (%) against the therapy target of an average of 25.7 minutes of occupational therapy across all patients (Target = 45 minutes x (5/7) x 0.8 which is 45 minutes of occupational therapy x 5 out of 7 days per week x 80% of patients)	55.9	65.3	↑	117.7	↑	73.8	↑
6.1 Proportion of patients reported as requiring physiotherapy	86.4	94.4	↑	91.8	↑	81.1	↓
6.2 Median number of minutes per day on which physiotherapy is received	32.7	32.5	↓	36.5	↑	25	↓
6.3 Median % of days as an inpatient on which physiotherapy is received	54.6	38.4	↓	58.4	↑	46	↓
6.4 Compliance (%) against the therapy target of an average of 27.1 minutes of physiotherapy across all patients (Target = 45 minutes x (5/7) x 0.85 which is 45 minutes of physiotherapy x 5 out of 7 days per week x 85% of patients)	56.3	43.1	↓	71.8	↑	34.2	↓
7.1 Proportion of patients reported as requiring speech and language therapy	49	55.8	↑	42.9	↓	32.8	↓

	National	NNUH		JPUH		QEH	
7.2 Median number of minutes per day on which speech and language therapy is received	30	46.7	↑	35	↑	29.2	↓
7.3 Median % of days as an inpatient on which speech and language therapy is received	28.1	29.2	↑	28.4	↑	40	↑
7.4 Compliance (%) against the therapy target of an average of 16.1 minutes of speech and language therapy across all patients (Target = 45 minutes x (5/7) x 0.5 which is 45 minutes of speech and language therapy x 5 out of 7 days per week x 50% of patients)	25.7	47.3	↑	26.5	↑	23.8	↓
8.1 Proportion of applicable patients who were assessed by an occupational therapist within 72h of clock start	86.3	80.7	↓	89.5	↑	99.1	↑
8.2 Median time between clock start and being assessed by occupational therapist (hours:mins)	24:00	28:47	↓	21:18	↑	22:59	↑
8.3 Proportion of applicable patients who were assessed by a physiotherapist within 72h of clock start	93.5	95.3	↑	93.6	↑	98.2	↑
8.4 Median time between clock start and being assessed by physiotherapist (hours:mins)	22:25	23:41	↓	22:53	↑	22:55	↑
8.5 Proportion of applicable patients who were assessed by a speech and language therapist within 72h of clock start	78.6	92.5	↑	77.8	↓	95.7	↑
8.6 Median time between clock start and being assessed by speech and language therapist (hours:mins)	25:29	23:45	↑	28:36	↑	23:08	↓
8.7 Proportion of applicable patients who have rehabilitation goals agreed within 5 days of clock start	81	56.9	↓	81	↑	96.5	↑
8.8 Proportion of applicable patients who are assessed by a nurse within 24h AND at least one therapist within 24h AND all relevant therapists within 72h AND have rehab goals agreed within 5 days	44.5	30.8	↓	34.6	↓	56.8	↑

	National	NNUH		JPUH		QEH	
9.1 Proportion of applicable patients screened for nutrition and seen by a dietitian by discharge	60.8	33.8	↓	73.3	↑	45	↑
9.2 Proportion of applicable patients who have a continence plan drawn up within 3 weeks of clock start	75.3	36.8	↓	67.6	↓	0	↓
9.3 Proportion of applicable patients who have mood and cognition screening by discharge	79.2	40.9	↓	95.7	↑	86.4	↑
10.1 Proportion of applicable patients receiving a joint health and social care plan on discharge	68.3	8.6	↓	76.9	↑	61	↓
10.2 Proportion of patients treated by a stroke skilled Early Supported Discharge team	24.8	32.3	↑	45.2	↑	0.9	↓
10.3 Proportion of applicable patients in atrial fibrillation on discharge who are discharged on anticoagulants or with a plan to start anticoagulation	91.9	100	↑	88.2	↓	100	↑
10.4 Proportion of those patients who are discharged alive who are given a named person to contact after discharge	75.9	45.2	↓	0	↓	80.9	↑

5.3 Norfolk and Norwich University Hospital NHS Foundation Trust

5.3.1 The NNUH is a high volume stroke service; the tenth biggest in England. It treats more than 1000 stroke cases per year compared to around 500 treated at the Queen Elizabeth Hospital and around 500 treated at the James Paget Hospital.

As NHOSC's attention was drawn to the subject of stroke by the fact that the NNUH had failed to meet its contractual targets in relation to stroke throughout 2012, we looked in detail at the improvements the service has been making. At the request of Norwich CCG the NNUH put in place a formal improvement plan in July 2013:-

1. Recruitment of an additional stroke physician (shared with JPUH)
2. Two specialist registrars in Stroke
3. Joint NNUH/CCG visits to Sheffield and Newcastle to understand and bring back transferable best practice from other parts of the country
4. Additional ring-fenced beds for hyper-acute and acute stroke care
5. Additional nursing posts
6. Dedicated diagnostic slots for the Stroke service
7. Better clinical liaison between the stroke service and A&E.

5.3.2 We heard from the N&N that:-

1. It had not proved possible to recruit a joint consultant with the JPUH. The NNUH had since appointed two consultants in stroke medicine. It had also advertised for a one year fixed term locum consultant post and expects to appoint to this post by the end of June 2014.
2. There were two specialist registrars and a speciality grade doctor in stroke in post until 31 July 2014. Replacements are needed from 1 August 2014 and the NNUH is looking to recruit three specialist registrars and one speciality grade doctor in stroke by 1 August.
3. The visits to Newcastle and Sheffield had taken place and had provoked a review of the thrombolysis pathway and documentation. Further consideration was being given to the role of specialist nurses. The visit to Newcastle had highlighted the advantages of "vertical integration" of services – with various levels of stroke service across multiple organisations and sites. In June 2014 the NNUH told us that the thrombolysis pathway is working well and will further benefit when 6 stroke consultants are in post from October 2014. As a first step towards nurse role development the hospital had approved additional vacancies and were actively recruiting nurses in June 2014. It had also started a programme with the therapy team to look at developing therapy competencies for unqualified Band 4 staff.
4. There have been 12 additional beds in the NNUH stroke unit since 1 October 2013. One bed was kept vacant on hyper acute stroke unit (HASU) to ensure a bed for a potential thrombolysis patient at all times. The rest of the beds are dedicated for stroke but in times of bed pressures all priorities are re-assessed. Since the additional beds in the stroke unit were opened no patients whose primary care need was stroke had been placed on other wards. At times of bed pressure, when the patients could not be directly admitted to the stroke ward they stayed in the Acute Medical Unit and were moved to the stroke ward as soon as there was a bed.
5. 8 qualified stroke nurses had been recruited and the NNUH was looking to recruit 8 more. The plan was to recruit experienced nurses, alongside newly qualified nurses from the University of East Anglia and possible overseas recruitment.
6. There was a 'next on table' arrangement for CT head scans for all urgent suspected strokes and 4 dedicated Doppler slots were available on Monday and Friday and 2 dedicated slots on Tuesday Wednesday and Thursday. Dedicated MRI slots were available to the stroke service from 20 November 2013. In June 2014 the NNUH told us that further work was underway regarding weekend capacity for CT head scans.
7. The stroke unit was working closely with A&E with regular communication on issues and organised teaching sessions on stroke for A&E doctors and nurses. The NNUH was reviewing the role of the Immediate Assessment Unit in relation to stroke.

We also heard that the NNUH was planning to separate its stroke team from the Older People's Medicine Team, and there was discussion about whether stroke should be a stand alone team or whether it should join with the cardiology team.

The stroke service at the NNUH is a large and busy one which is likely to serve more patients as Norfolk's population ages. As mentioned in paragraph 3.3, a quarter of strokes occur in people under the age of 65. This fact suggests to us that stroke services should stand alone and move away from the Older People's Medicine team. We **recommend** that the stroke team at the NNUH should be a stand alone team, as is recommended in the National Stroke Strategy 2007 and that it should be staffed to the appropriate levels in all the relative disciplines.

We understand that the NNUH is already working towards this goal and plans for stroke to be stand alone by 1 October 2014.

5.3.3 We know that there is a shortage of staff in many disciplines across the NHS at the moment and stroke consultants are a case in point. At the time we started our scrutiny there were just 3 full time equivalent stroke consultants at the NNUH when British Association of Stroke Physicians (BASP) standards suggested that they should have 6. We were told that the NNUH is one of the 10 most busy stroke units in the country.

The situation regarding nurse staffing was also of particular concern to us, especially the staffing levels at night. There were just two nurses on the 12 bed hyper acute stroke unit at night, which was the minimum level, and we heard there had at times been just 2 nurses and 2 auxiliaries on duty at night for the 36 beds in the acute unit. The NNUH was looking to address this by recruiting more nurses.

There was always a co-ordinator on duty in the hyper acute stroke unit but not always in the acute unit. Again, the NNUH was looking to address this issue when it recruited more nurses. The TIA service was located with the acute stroke unit, which was helping to integrate stroke and TIA nursing staff.

We welcomed the NNUH's efforts to recruit more consultants and nurses and this CCG's support in this respect.

5.3.4 Performance at the NNUH has been improving but we note that the latest data presented to Norwich CCG (March 2014) shows that the hospital continues to be below its contractual targets for stroke:-

Extract from Norwich CCG 3 June 2014 Board papers

Norfolk and Norwich University Hospital Foundation Trust HARVEST REPORT – May 2014 - Stroke

Performance increased in March.

Performance has been below contractual targets, that being:	Current Position
• 90% of patients with a primary diagnosis of Stroke admitted to a designated Hyper Acute Stroke Unit (HASU) within 4 hours of hospital arrival	82.8% of patients with a primary diagnosis of stroke were admitted to a designated hyper acute stroke unit (HASU) within 4 hours of hospital arrival. 11 out of 64 patients breached this target, the predominant reason being a lack of bed capacity.
• 90% of urgent scans performed on eligible patients within 60 minutes of arrival at hospital	86.5% of eligible patients received an urgent scan within 60 minutes of arrival at hospital. 5 out of 37 patients breached this target, the majority of which were requested as routine rather than urgent scans.
• 75% door to needle time of 60 minutes for all eligible thrombolysis	71.4% of eligible thrombolysis patients had a door to needle time of less than or equal to 60 minutes. 2 out of 7 patients breached this target both of whom who were out of hours patients.

5.3.5 We asked the team from the NNUH to tell us what more they thought could be done to improve the services. Apart from the need for additional consultants, doctors, nursing and therapy staff, their thoughts were as follows (work towards some of this was already underway):-

- A 7 day service – working seamlessly with 7 day Early Supported Discharge
- The clinical network to look at effective service change across Norfolk
- Good access to imaging
- More / better patient symptom monitoring systems
- Better access to GP notes (electronic)

5.4 **The Queen Elizabeth Hospital**

5.4.1 We heard very positive reports about the QEH service and how it had improved in recent years and that the previous SINAP data showed the service in the top 5% in the country. Data for the QEH was not available in the first quarter of the new SSNAP audit (July – September 2013)

5.4.2 The standard measures for stroke performance in west Norfolk are:-

- The proportion of stroke patients spending at least 90% of their time on a dedicated Stroke Unit (target 80%)
- The proportion of higher risk TIAs treated within 24 hours (target 60%)

The latest performance report to West Norfolk CCG on 29 May 2014 showed that the QEH service exceeded these standards across the year from April 2013 to March 2014 but that there was deterioration in performance in Quarter 4, which was being discussed at the Norfolk Stroke Network.

These positive reports about the QEH service need to be read in the context that no stroke services in England, including this one, is currently operating at a 'gold standard' level.

5.4.3 There are 3 stroke consultants at the QEH, where ideally there should be 4. With the current staffing level they cannot provide a 24/7 consultant led service but they have introduced 7 day working for stroke consultants, and 6 day working for therapists (physiotherapists & speech and language therapists). Stroke nurse specialists meet and assess incoming stroke patients 24/7 and consultant expertise is always available via telemedicine.

5.4.4 The QEH faces the same difficulties as all other hospitals in recruiting staff and we heard how they have been working to address shortages in nursing and therapy staff.

5.4.5 The fact that the QEH is currently in special measures because of financial problems is clearly a cause for concern for the stroke service as well as all other services delivered at the hospital. Norfolk Health Overview and Scrutiny Committee is expecting to receive a report from West Norfolk CCG on the system-wide review of health services in west Norfolk, including the QEH, at its 4 September 2014 meeting.

5.5 **James Paget University Hospital**

5.5.1 Of the three acute stroke services in Norfolk it is the future of the JPUH service that gives us most immediate concern. The issue that worries us is about staffing. Like other hospitals JPUH is below the BASP recommended staffing level for consultants and therapists but it is unique in having two stroke trained consultants but no fully qualified stroke specialist consultants. We met the team and would like to stress that we have the highest respect for them and the service they provide. In fact SSNAP data from July to September 2013 showed the JPUH performing better overall than the NNUH. The hospital's stroke performance statistics for 2013-14 were also encouraging with all standards being met, when measured across the full year, except for the percentage of patients directly admitted to a stroke ward within 4 hours, which was below

standard:-

James Paget University Hospital NHS Foundation Trust – stroke performance 2013-14

Stroke standard	Target	Actual 2013-14
% with AF anti coagulated on discharge	60%	80%
Direct admission to stroke ward within 4 hours	**90%**	**75%**
% spending 90% of their stay on a stroke ward	80%	85.71%
Access to brain imaging within 1 hour of arrival	50%	51.2%
Access to brain imaging within 24 hours of arrival	100%	100%
Management of high risk TIA – clinic appointment	60%	81.82%
Patients supported by a skilled ESD team	40%	46.88%

Despite these positive results, the staffing situation for stroke at the JPUH remains a serious ongoing concern.

5.5.2 JPUH and NNUH proposed a networking solution with joint working of staff between the two hospitals, including joint recruitment of two consultants. The plan involved block rotation between the NNUH's hyper acute stroke units, acute stroke unit, rehabilitation (NCH&C's Beech Ward) and JPUH. The NNUH also talked about stratification of services across the two hospitals but it was not clear to us what this would mean in practice. Integration of computer systems across the NNUH, JPUH and QEH to allow sharing of blood tests and patient information was already underway as part of the implementation of the Eastern Pathology Alliance (EPA) , a partnership created to deliver community pathology services to Norfolk. The JPUH was also looking towards a joint rota with the NNUH for radiographers to provide more cover for CT scans at night.

5.5.3 In January 2014 we were told that the hospitals had not been able to recruit any joint consultants and that each hospital would now try to recruit two consultants for their own service only (which the NNUH has successfully done). After that they would try to recruit an additional two consultants to serve both hospitals. The NNUH was interviewing two candidates for its posts on 27 February but the JPUH had yet to advertise its two consultant posts. Given the national shortage of stroke consultants we have doubts about whether the JPUH will be able to recruit. On the positive side the NNUH team stressed that they would continue to offer support for the JPUH stroke service and were committed to a continuing service at both hospitals. Nevertheless, the consultant complement at both hospitals remains below par. We also understand that after August 2014 recruitment of junior doctors to the hospitals will become more difficult because of a national training policy decision to deploy more junior doctors in primary care, where there is also a severe shortage.

5.6 **Understaffing at the acute hospitals**

We are aware that the discussions about networking between the NNUH

and the JPUH have gone on for some years but the situation is still unresolved. We question the NNUH's ability to provide adequate and safe support to the JPUH given the current degree of understaffing in both services. We **recommend** that the James Paget University Hospitals NHS Trust **urgently** increases the number of stroke specialist consultants in its service.

We further **recommend** that the Norfolk and Waveney Stroke Network reviews that number of stroke specialist staff in post (i.e. people actually in post, not the number of posts in the establishment) and the availability of staff in post in supporting disciplines to assess the clinical safety of the services.

We recognise that there is a national shortage of qualified stroke specialist staff and we are aware of the staff shortages in other disciplines. We **recommend** that Health Education East of England explains what is being done to resolve the shortage of stroke specialist consultants, other stroke specialist staff and staff in other disciplines whose expertise is needed in the stroke care pathway.

5.7 Continuing Health Care Assessment

The issue of delay caused by the NHS Continuing Health Care assessment process came up when we were looking at this part of the pathway. NHS Continuing Health Care is a complex subject, which could usefully bear separate scrutiny, but it is clear from what we heard that stroke patients who are not considered suitable for intensive rehabilitative therapy are sometimes waiting in the acute hospitals for NHS Continuing Health Care assessment and funding long after they are medically stable. This means that the most severely disabled stroke patients can sometimes be delayed in the least suitable care setting for the longest time.

We are aware that Continuing Health Care is a complex area but it appears to us that if patients could be assessed and moved through the system more quickly then money would be available to reinvest in other improvements along an integrated stroke care pathway. We **recommend** that the Norfolk and Waveney Stroke Network undertakes an assessment of how many stroke patients are delayed at acute and community hospitals due to waiting for NHS Continuing Health Care assessment or funding and establish what the cost is.

6. Rehabilitation

6.1 We learnt a great deal about the effects of stroke and the need for excellent rehabilitative services to help people make the best possible recovery for their own sake and for that of their family and friends. The physical and psychological effects of stroke can be numerous. Some people make a good recovery with only minor longer term effects, other people may be left very disabled. As explained in paragraph 4.1, the

treatment of a patient in the early stage of stroke can have a dramatic effect of their long term prospects. The mortality rate for stroke is about 18.6%. For those who survive, the long term effects can include any or all of the following, to varying degrees:-

Paralysis
Fatigue
Cognitive impairment
Aphasia (difficulty with speech and language)
Depression and anxiety
Emotionalism
Attention and concentration difficulties
Memory problems
Spatial awareness difficulties
Problems with perception
Apraxia (inability to perform purposeful actions such as using everyday tools)
Problems with executive functioning (planning and executing a series of tasks)
Lack of mental capacity (decision making)
Anger management problems
Psycho sexual problems

6.2 **Intensive rehabilitation**

6.2.1 Although they are organised in different ways, we found there were well structured early rehabilitative services in every part of the county for at least the first six weeks after stroke. The staff we met were dedicated and the patients and families we spoke to were very appreciative of the help they received. During our visits to the acute hospitals and Norwich Community Hospital, we discussed the services with the following providers:-

- Norfolk Community Health and Care NHS Trust (NCH&C) – provides in-patient rehabilitation for stroke patients at Beech Ward and an Early Supported Discharge (ESD) service for patients with mild to moderate disability following stroke. Patients' average length of stay with the ESD team is 6 weeks but the service is commissioned for up to 16 weeks. The ESD nurses also provide a six month follow-up for stroke patients. The central Norfolk CCGs commission the NNUH to provide the whole stroke pathway and the NNUH sub-contracts this part to NCH&C. ESD was originally commissioned in a pilot area and has been extended to the whole central Norfolk area, along with 6 month follow-up, within similar staffing numbers. NCH&C also provides generalist community rehabilitative services to stroke patients at community hospitals across the county (except the Great Yarmouth area) and in patients' homes.
- QEH - provides a six week period of rehabilitative support as part of its stroke care pathway, commissioned by West Norfolk CCG. (The QEH also commissions Stroke Association services, which start at this stage

of the pathway but are discussed in detail in section 7, Long Term Care)

- JPUH - provides rehabilitative services and Early Supported Discharge, commissioned by Great Yarmouth and Waveney CCG.
- East Coast Community Healthcare – provides community neurology / occupational therapy and a speech and language service specifically for stroke patients.

Although the QEH service does not nominally include Early Supported Discharge, its rehabilitative service offers similar benefits to a potentially a wider range of stroke patients (in terms of their level of disability).

6.2.3 The NHS Midlands and East gold standard service specification says that an Early Supported Discharge (ESD) service should include the following disciplines (the numbers in brackets are the number of whole time equivalent staff recommended per 100 cases per year):-

- Occupational Therapy (1)
- Physiotherapy (1)
- Speech and Language Therapy (0.4)

The ESD should also be able to access support from:-

- Stroke physician (0.1)
- Nurse (0- 1.2)
- Social worker (0- 0.5)
- Rehabilitation assistants (0.25)
- Clinical Psychology
- Dieticians
- Orthotics
- Orthoptics

Some of the representatives we met who work in ESD would challenge the NHS Midlands and East recommended level of nurse staffing, which they believe is potentially too low. They point out that nurses can work to prevent readmissions by sorting out medications, blood pressure issues, symptom control and general health problems experienced by stroke survivors.

6.2.4 As with the acute part of the pathway we found that the rehabilitative and supporting therapies were understaffed in some instances. For instance at the time of our visits in November 2013 the JPUH was 1.5 fte therapists below the level it wanted and all the hospitals were affected by difficulties in recruiting nursing staff. We were assured that all the necessary support disciplines were available to patients at the hospitals but it was unclear to us exactly to what extent they were available. For instance, there was a 0.4 fte Psychologist vacancy at the QEH to which the hospital had not been able to recruit.

We **recommend** that that the Norfolk and Waveney Stroke Network reviews the staffing of stroke rehabilitative services across Norfolk, including the availability of staff in the necessary supporting disciplines (including psychology) to ensure the appropriate level of support.

6.2.5 As with the acute services, it was not easy for us to compare the merits of the three different early rehabilitative service models across the county from the visits we carried out and the information we received. We heard anecdotal evidence from patients and carers, who appreciated the services they had received, but we are not aware of reliable quantitative evidence to compare the medical outcomes of the three models. SSNAP covers the rehabilitative disciplines and we know that Beech Ward was submitting data. However, there was a difficulty in submitting meaningful data from a community service setting because the SSNAP system is more focused more towards the acute settings. As mentioned in paragraph 5.2, the Royal College of Physicians acknowledges the limitations of SSNAP in relation to therapies and we have therefore not focused on SSNAP when considering rehabilitative services.

6.2.6 The stroke service in central Norfolk is the only one of the three where acute care and early stage rehabilitation is provided on separate sites, with acute care at the N&N and intensive rehabilitation in Beech Ward at the Norwich Community Hospital site. Transfers from the NNUH to Beech Ward appear to be fairly rapid (2-3 days) and the service at the unit is impressive but only a relatively small proportion of stroke patients benefit from it. Others go to community hospitals, where they receive less intensive generalist rehabilitation not specific to stroke, or are discharged to a residential setting.

Beech Ward has 24 beds, with an average length of stay of 33 days, but the N&N is dealing with just over 1,000 stroke cases per annum. Clearly, not all of these 1,000 need to go to Beech Ward because some are disabled to such an extent that intensive rehabilitative therapy would yield only minimal improvement, or they have pre-existing problems that prevent them from participating in intensive therapy for stroke. Beech Ward focuses instead on patients who are most likely to benefit from its services.

We know that the Beech Ward and the ESD service in central Norfolk is very much appreciated by the people who receive it. Patients sometimes come into Beech Ward from out of the area and stroke survivors sometimes move to stay with relatives in Norfolk so that they can benefit from ESD. However, we have some concerns about the limits to the range of patients who receive the services. We heard that there are occasional disagreements between the NNUH and NCH&C teams about which individual patients should go to Beech Ward and this makes us question whether there are, in fact, more patients in central Norfolk who could benefit from a more intensive level of rehabilitative service than they currently get. NCH&C has told us that they do not think there are many and we appreciate that they have the best operational knowledge.

However, we would like to see some research in this area to show whether or not the services are bringing maximum benefit to the widest range of stroke survivors.

We **recommend** that the Norfolk and Waveney Stroke Network assesses the relative merits of the three rehabilitative stroke services in Norfolk with a view to commissioning services in future that bring the maximum benefit to the greatest number of patients, within the available overall funding limits.

6.2.7 **Community rehabilitation**

The handover of patients from intensive stroke rehabilitation services to the generalist NHS community services is another area about which we have concerns. We heard conflicting views about this stage of the pathway. Some of the staff working in the stroke specialist rehabilitative therapy services described it as patients 'falling off a cliff' because the therapies provided in the community in some areas were sparse, non stroke specific and slow to start. This was not, they stressed, through any fault of the staff working in the community services but simply to do with the level of community resources that have been commissioned. NCH&C stroke staff told us that they think there should be a community stroke team, which would act as an extended version of the current ESD service and could provide support for some stroke patients in the longer term. At very least they would like to see a link person with stroke specialism in each NCH&C community team who would visit patients after they are discharged from ESD or Beech Ward

6.2.8 A significant number of stroke patients who are leaving the 6 week intensive stroke rehabilitation services still need therapies such as speech and language, physiotherapy and occupational therapy provided by NHS community services. In central and west Norfolk these therapies are provided by NCH&C, for which South Norfolk CCG is currently the lead commissioner. In the Great Yarmouth area they are provided by East Coast Community Healthcare community interest company, for which Great Yarmouth and Waveney CCG is the commissioner.

6.2.9 NCH&C told us that they do not collect data on how long ESD patients wait to receive onward care from other nursing and therapy services within the community. They assured us that in terms of onward nursing care there are no waits and patients would be seen within a week of discharge from ESD if nursing needs such as wounds or catheter care were present, and in most cases community nurses would already be involved. They also assured us that waits for physiotherapy and occupational therapy would be minimal. It depended on what the individual patient's needs are in terms of long term intervention from community services and how urgent the need is. The wait for speech and language therapy was around 6-7 weeks.

6.2.10 For central Norfolk, we were assured that the Early Supported Discharge

service will always keep the occasional patient for a longer period of time if the community team is unable to pick up the on-going care for more than 4-6 weeks. This is to prevent patients from losing the benefit of intensive therapy and potentially regressing. We were also encouraged to hear that the therapy leads on Beech Ward and ESD had set up a 'transference of care meeting' which is a quarterly meeting attended by community and stroke therapists to discuss issues, changes to service delivery and to provide support to each other. We hope that this will help patients move smoothly from one service to the other and will improve outcomes for both patients and carers.

6.2.11 We were concerned that at the time of our visit in November 2013 there seemed to be lack of clarity between the West Norfolk CCG and the providers over when the QEH's period of intensive support for a stroke patient should end and NCH&C's less intensive support for west Norfolk patients should begin.

6.2.12 East Coast Community Healthcare was able to give us average waiting times for patients entering its stroke specific community services:-

Neurology / OT service – 12.1 days
Speech and language – 19.6 days

6.2.13 The Stroke Association told us about the need for very careful communication when rehabilitative services come to an end. There is a need for realism, balancing the patient's natural hope to make a full recovery with clinical judgement, but the way in which that judgement is communicated is very important. The patient should not be left feeling hopeless.

In our view, it would be easier to give positive messages to patients at this stage if more longer term support was available across the county.

7. Long Term Care

7.1. The Stroke Association estimates that after stroke the outcomes for patients are as follows:-

42% will be independent
22% have mild disability
14% have moderate disability
10% have severe disability
12% have very severe disability

This means that 58% of stroke survivors are likely to have some level of need for on-going rehabilitative care and longer term NHS and /or social care.

7.2 Although investment in preventative services could help to reduce the incidence of stroke and investment in pre hospital, hyper acute, acute and

early rehabilitative services could reduce the degree of disability caused, we must recognise that there are already a substantial cohort of patients who require longer term rehabilitation and support and there will be more in future.

The Stroke Association told us;

'Almost without fail patients report that they would like the input to be for longer as they feel that they would benefit physically and emotionally from sustained input.'

7.3 During our scrutiny we met patients on our visits to the stroke units and Beech Ward and spoke in depth with a stroke survivor and carer at one of our meetings in County Hall. We also met with other agencies who often work with stroke survivors and their families:-

- The Stroke Association
- Headway
- Norfolk County Council adult social services
- Norfolk Independent Care (for care home providers)
- Norfolk Carers Support
- District Council housing

We also took advice on psychological services from the NeuroRehabilitation Manager, Oliver Zangwill Centre for Neuropsychological Rehabilitation, Princess of Wales Hospital, Ely

We are immensely grateful to all the people who met with us and helped to broaden our understanding of stroke, its implications for patients and their families, and their experience of the services in Norfolk. Details of all our discussions are available in the minutes of our meetings but for this report we are focusing only on the areas where we think we can usefully make comments or recommend change.

7.4 **Psychological support**

We include psychological support in the Long Term Care section of our report because the post stroke psychological problems can sometimes occur up to five years after the stroke. The NHS Midlands and East gold standard stroke service specification says that psychological support should be available from the very earliest stages and everyone we spoke to about this subject confirmed that psychological support in the early stages of stroke could be extremely important in some cases, especially where there is evidence of profound cognitive impairment. Patients often have problems with social interaction, which psychological treatment would help. People also impressed on us that psychological support can be very useful for carers and families. The Stroke Association's research shows that caring gets harder over time. For those who had been caring for up to three years 48% said they were stressed by caring. This figure goes up to 69% for those who have been caring for 7 years or more.

The Clinical Lead from the Cardiovascular Strategic Clinical Network spoke to us about cognitive impairment and vascular dementia. About 40% of stroke patients suffer from cognitive impairment. This combined with physical disability after stroke makes for a greater burden for the carer. From the patients' point of view cognitive impairment is a major source of frustration and distress. It is high impact, high prevalence and there is a lack of effective treatment options. The stress caused to friends and family should also not be overlooked. The results can be divorce, suicide and criminal justice problems.

The Royal College of Physicians National Clinical Guidelines for Stroke 4th edition published in September 2012 says that stroke services should adopt a 'stepped care' approach to delivering psychological care:-

Step 1 - the routine assessments conducted within the multi disciplinary team (MDT) of all admitted patients, and the more detailed assessment of patients exhibiting symptoms of psychological disorder at any time after stroke.
Step 2 - the management of mild or moderate problems by MDT members who have been appropriately trained and where possible working under specialist supervision.
Step 3 - the management of more severe or persistent disorder, usually by a specialist.

Although we were assured that stroke teams can call on the support of psychologists throughout the acute and rehabilitative process it was difficult for us to ascertain how readily such specialist support is actually available to patients and their families and whether it is called upon as much as it should be. The Stroke Association says that help with psychological problems is high on the list of things that stroke patients say they *wish* they had been offered.

We were aware that the Queen Elizabeth Hospital had not been able to fill a Psychologist vacancy and we were told that there is a national shortage of community based trained Psychologists.

We **recommend** that Health Education East of England explains what is being done to improve the availability of trained Psychologists.

We have also made a recommendation about reviewing the availability of psychological support in the local stroke services in paragraph 6.2.4.

7.5 **Patient reviews**

The National Institute for Health and Clinical Excellence (NICE) recommends that people with stroke are reviewed six months after leaving hospital. We found very patchy compliance with this in Norfolk. The JPUH does not do 6 month follow-ups and the QEH team estimated that they do them for about 65% of patients. Central Norfolk is better, with

NCH&C's ESD service providing the 6 month follow up for all the patients who use the Beech Ward and ESD, and for others who have come through the NNUH stroke unit.

We are aware of debate about the value of six month post stroke reviews and whether they should be carried out by the NHS team that originally treated the patient or whether 3rd sector providers could carry them out as part of a package of long term support. In our opinion six month follow-ups are as important for the family / carers as they are for the patient and they should be done. We are aware that the Stroke Association currently provides six month post stroke reviews as part of its Information Advice and Support services in 15 areas across the country. They use the Greater Manchester Stroke Assessment Tool which was successfully piloted in partnership with Collaboration for Leadership in Applied Health Research and Care (CLAHRC) for Greater Manchester. They find an average of three unmet needs per person, which are then resolved, helping to reduce the sense of abandonment many stroke survivors report in the months and years after their stroke.

We understand that this model delivers six month post stroke reviews at considerably lower cost. It seems to us that there is an opportunity to extend post stroke six month reviews to more patients in Norfolk by commissioning them as part of a longer term support model, which could be provided by the third sector.

We have included patient review in the recommendation at paragraph 7.8.

7.6 **Communication support**

One stroke survivor and carer who we met emphasised the need for raising awareness of the consequences of stroke particularly with regard to the problems and challenges that patients, carers and families affected by aphasia have to face on a daily basis, often for very many years. They said that people need to recognise that it may not just be speech that is affected but also writing skills, comprehension and problem solving. They impressed on us that ongoing support in the community is vital to the health and wellbeing of all concerned in this situation.

One in three stroke survivors suffer from aphasia, which causes people to say one thing when they mean another. All of the rehabilitative services across the county include speech and language therapy but only the Queen Elizabeth Hospital has commissioned longer term communication support for patients and their families.

We have included communication support in the recommendation at paragraph 7.8.

7.7 **Training for care home staff**

During our discussions with Norfolk County Council adult social care,

Norfolk Independent Care, Norfolk Community Health and Care and East Coast Community Healthcare we were very encourage by their enthusiasm to achieve more consistent training for care home staff in the care of stroke survivors. We would like to see them consider how the delivery of such training could be organised and how they would track progress.

We **recommend** that Norfolk County Council adult social care, Norfolk Independent Care, Norfolk Community Health and Care and East Coast Community Healthcare meet to consider how more training in the long term care of stroke survivors can be delivered to care home staff in private and pubic sector care homes across Norfolk, how progress with such training can be tracked and how good practice can be shared across the care home spectrum.

7.8 **Equity of services**

It was clear to us that longer term support services for stroke patients vary greatly across the county and, in our opinion, some parts of Norfolk are under served. We must stress that this particular concern is not about the early rehabilitative, acute or hyper acute services, which although they differ from each other appear to us to be fairly equitable in what they aim to achieve. The situation with NHS commissioned longer term support services across the county is as follows:-

West Norfolk - the Queen Elizabeth Hospital commissions the Stroke Association to provide a package of services:-

- Information Advice and Support – 35 hours per week
  This service provides information, emotional support and practical advice to patients and carers in hospital, at home and in the community. The service aims to address the complex needs of a stroke survivor and their carer, from benefits advice to healthy living to social reintegration. It helps stroke survivors and their families to navigate the health and social care system, seeking to ensure they are able to access appropriate care, support and therapies. People can remain in the service for up to a year or until agreed goals are achieved.

- Communication Support – 21 hours per week
  This service is offers specialist, person-centred communication support, which extends the support given by speech and language therapy services. It is orientated towards supporting the stroke survivor to regaining communication with their family, their peers and the wider society in such a way so to increase their confidence and inclusion and reduce social isolation. This helps the individual to remain independent and reduce anxiety. The service is either provided in a group setting or in the person's home. The scope of service delivery is enhanced by the use of volunteers, many of whom work one to one with clients. The service also includes activities such as a communication café, where clients meet in a local coffee shop, a setting which enhances social

integration and normality and is an opportunity for people to put into practice the techniques and strategies they have learnt in the group / home setting.

- Long Term Support – 14 hours per week
  This service provides a number of opportunities for stroke survivors to meet together for social support, advice, interaction and fun. There are two LTS groups in West Norfolk; Hunstanton and Downham Market. The groups meet regularly with a programme of exercise, speakers and outings to enable stroke survivors to reintegrate with the wider community. Both groups have considerable support from volunteers acting as drivers, committee members and organisers and many of these volunteers are stroke survivors themselves. The service has also introduced a swimming group, where clients swim at a local leisure centre and Hydrotherapy sessions, which are provided by an appropriately trained physiotherapist.

Great Yarmouth - the CCG commissions the Stroke Association to provide
- Information and Advice

Central Norfolk – no equivalent NHS commissioned services.

We understand that a Communication Support service formerly commissioned in central Norfolk came to an end in March 2012.

Whilst we acknowledge that the CCGs were established to make their own decisions and to commission services according to the specific needs of their own community, there can be no doubt that the public dislikes a 'post code lottery' in health.

We **recommend** that the five Norfolk CCGs should work together to commission an integrated prevention, information, communication and six month stroke review service across Norfolk.

There are examples of excellent voluntary schemes for stroke survivors currently running without NHS or County Council backing (e.g. the Aphasia Café at the Forum in Norwich). However, we think it is vital to have formally commissioned, stable longer term support services for stroke survivors and their carers. Otherwise there is a higher risk of crisis, which costs more in financial terms as well as in suffering.

The introduction of the Better Care Fund (see paragraph 8.3) would be an opportunity for different, more equitable services to be commissioned in the future.

8. The cost of stroke and stroke services

8.1 There is growing concern about the affordability of health and social care services in the future. An Institute for Public Policy Research Paper published on 24 April 2014 estimated that by 2017 the number

of older people in England needing care will outstrip the number of family members who are able to provide it. The drive towards integration of health and social care, with more health needs met in the community and not in hospital is intended keep services within the limits of affordability as well as to improve the patients' experience.

8.2 During our scrutiny we found that there is no data on the overall cost of stroke to health and social care services in Norfolk. We feel that this must surely be an obstacle to commissioners as they look to put in place cost effective integrated services. We think that research into the overall cost of stroke and the comparative overall cost of the three systems of care currently in place in Norfolk would be helpful. The PRISMA model used in Quebec, Canada is an interesting template for robust, ongoing evaluation of integrated care pilots. We note that PRISMA did not show positive effects from health and social care integration until the third year of evaluation.

We **recommend** that the Norfolk and Waveney Stroke Network collectively considers whether CCGs and Norfolk County Council could usefully commission research on the overall cost of stroke to the health and social care authorities in the county and robust evaluation of the overall cost effectiveness of the three existing stroke service systems in the county.

It seems to us that the information is very much needed to inform effective commissioning decisions in the future.

8.3 At the start of our scrutiny we were aware that the Department of Health and the Department for Communities and Local Government had set out their expectations for health and social care services to deliver integrated services through a pooled budget agreement, the Better Care Fund (BCF). Nationally the figure for the BCF was set at £3.8 billion in 2015-16. It was to include limited new money, with the funding mainly being drawn from existing health and social care budgets:-

£1.1 billion existing transfer from health to social care
£130 million Carers' Breaks funding
£300 million Clinical Commissioning Group (CCG) re-ablement funding
£350 million capital grant funding (including £220 million Disabled Facilities Grant)
£1.9 billion from NHS allocations

The BCF was intended by Government as major push to encourage local health and social care commissioners to change local services so that more people are treated in the community and demand for acute services is reduced as much as possible. NHS England announced that it expected a 15% reduction in acute hospital spending. Unsurprisingly, there have been reservations about this in

the acute hospital sector where finances are already under pressure.

In Norfolk the health and social care authorities agreed a BCF of £62,461,000 in 2015-16. They also agreed to use £5,644,000 in 2014-15 in transition to the BCF, which was more than they were actually required to commit for this year. The Norfolk Health and Wellbeing Board signed off the plan on 1 April 2014.

There has been speculation in the national press that the launch of the BCF could be delayed because of concerns that across the country there is not enough detail in the plans to demonstrate how savings will be made. However, integrated care commissioners in Norfolk have informed us that at the time of writing (5 June 2014) there is nothing to indicate a delay to starting the BCF from April 2015. They have also assured us that they will start to put their plans for further integration into action during 2014-15 and that progress in this year is not dependent on the formal pooling of funds envisaged in the BCF.

Whatever the national situation regarding the BCF, it appears to us that there could be opportunities to save money and improve care for stroke patients by further integration of health and social care services and by commissioning services differently to close the current gaps in preventative and longer term stroke care. Fully integrated budgets for stroke health and social care commissioning would be a step forward.

9. Conclusions

9.1 During our scrutiny we heard the story of a stroke survivor whose stroke happened nearly a decade ago when stroke was not treated as an emergency, CT scans were not done at the weekend, thrombolysis was not available and intensive rehabilitation was not given. That person, like so many others, is living with the consequences. We fully recognise the huge improvements in stroke services since that time and cannot praise the dedication of clinicians and managers highly enough.

9.2 We are equally conscious that more can be done and higher standards have been set. Some parts of the country, notably London, have achieved better results by centralising hyper acute services so that more people benefit from thrombolysis. We would like see better outcomes for patients in Norfolk but we are not convinced that centralisation of our hyper acute services would achieve that. The distances to travel would be much greater and we have too many concerns about the ambulance service's performance to recommend it. As we see it, the current focus needs to be on bringing all three existing services systems up to acceptable staffing levels across the full range of stroke specialist and supporting disciplines.

9.3 The clinical networks and stroke commissioners have been looking at stroke services for the past two to three years without making any significant changes in how the services in Norfolk are structured. It looks

to us as though the major upheaval of the Health and Social Care Act 2012 probably delayed progress in this respect by at least a year. However, now that the CCGs have been in place for more than a year and the local stroke network has been running for more than 6 months, we think it is time for action.

9.4 We would very much like to see a more equitable service across Norfolk in terms of preventative and longer term support services and we hope that the Norfolk and Waveney Stroke Network and all of the CCGs will consider commissioning services differently in future to make this happen within the available funding.

All of our recommendations are listed at the end of the report.

10. Next steps

10.1 We began our scrutiny some months before the Norfolk and Waveney Stroke Network was established. We think it would be useful for our group to discuss the recommendations of this report with representatives of the Norfolk and Waveney Stroke Network before they respond to Norfolk Health Overview and Scrutiny Committee. Our final recommendations are therefore:-

We **recommend** that representatives of Norfolk and Waveney Stroke Network meet with the Stroke Services Task & Finish Group to discuss the recommendations of this report before responding to Norfolk Health Overview and Scrutiny Committee.

We **recommend** that NHOSC asks all the organisations to whom recommendations are addressed to respond in writing by 30 September 2014 setting out:-

- Whether or not each recommendation is accepted;
- A detailed explanation for any that are not accepted;
- A deliverable plan for implementing those that are accepted;
- Details of how successful implementation will be measured.

Recommendations		**To**
Strategic Overview		
1.	That members of the Norfolk and Waveney Stroke Network commit to regular meetings and to working with the Cardiovascular Strategic Clinical Network and the Clinical Senate to drive co-ordinated improvement of stroke services in the county. (Paragraph 2.7)	Norfolk and Waveney Stroke Network
2.	That the NHS England East Anglia Area Team should be involved in the Norfolk and Waveney Stroke Network and that a clinical lead for the Network should be identified. (Paragraph 2.7)	Norfolk and Waveney Stroke Network NHS England East Anglia Area Team
Preventative		
3.	That the Norfolk and Waveney Stroke Network takes up the recommendations of the Health Needs Assessment and oversees collective work between CCGs and Public Health to identify additional data sources and further analyse data in relation to stroke. (Paragraph 3.2)	Norfolk and Waveney Stroke Network
4.	That NHS England East Anglia Area Team considers the scope for introducing blood pressure checks at dental surgeries and pharmacies. (Paragraph 3.4)	NHS England East Anglia Area Team
5.	That Norfolk County Council Public Health, who are responsible for commissioning the NHS Health Checks in the county, assess the numbers of people who are eligible for a NHS Health Check and the numbers who actually take up a Health Check and make the	Norfolk County Council Public Health

Recommendations		To
	information available to the NHS England commissioners and GPs on a practice by practice basis to encourage action in the areas of low take-up (Paragraph 3.4)	
Pre hospital		
6.	That EEAST reviews the number and location of ambulance bases in Norfolk in relation to travelling times to the hyper acute stroke units with a view to achieving the Stroke 60 standard in all parts of the county. (Paragraph 4.10)	EEAST
7.	That the Norfolk and Waveney Stroke Network seeks assurance from the three acute hospitals in Norfolk that they report back to EEAST on failures to provide pre-alerts of the arrival of stroke patients so the problem can be quantified and appropriately addressed and that EEAST identifies a lead for stroke with whom the hospitals can liaise consistently. (Paragraph 4.12)	Norfolk and Waveney Stroke Network EEAST
8.	That the NNUH, JPUH, QEH and EEAST consider what more could be done to enable the ambulance service and the acute hospitals to work together to shorten the diagnosis time for stroke. (Paragraph 4.13)	NNUH JPUH QEH EEAST
9.	That EEAST focuses on improving its performance by ensuring that double staffed ambulances are first on scene to a higher proportion of suspected stroke patients and that patients are transported to hospital without delay. (Paragraph 4.15)	EEAST

Recommendations		To
Hyper acute and acute		
10.	That the stroke team at the NNUH should be a stand alone team, as is recommended in the National Stroke Strategy 2007 and that it should be staffed to the appropriate levels in all the relative disciplines. (Paragraph 5.3.2)	NNUH
11.	That the James Paget University Hospitals NHS Trust **urgently** increases the number of stroke specialist consultants in its service. (Paragraph 5.6)	JPUH
12.	That the Norfolk and Waveney Stroke Network reviews that number of stroke specialist staff in post (i.e. people actually in post, not the number of posts in the establishment), and the availability of staff in post in supporting disciplines, to assess the clinical safety of the services. (Paragraph 5.6)	Norfolk & Waveney Stroke Network
13.	That the Local Education and Training Board explains what is being done to resolve the shortage of stroke specialist consultants, other stroke specialist staff and staff in other disciplines whose expertise is needed in the stroke care pathway. (Paragraph 5.6)	Health Education East of England
14.	That the Norfolk and Waveney Stroke Network undertakes an assessment of how many patients are delayed at acute and community hospitals due to waiting for NHS Continuing Care assessment or funding and establish what the cost is. (Paragraph 5.7)	Norfolk and Waveney Stroke Network

Recommendations		To
Rehabilitative		
15.	That the Norfolk and Waveney Stroke Network reviews the staffing of stroke rehabilitative services across Norfolk, including the availability of staff in the necessary supporting disciplines (including psychology) to ensure the appropriate level of support. (Paragraph 6.2.4)	Norfolk and Waveney Stroke Network
16.	That the Norfolk and Waveney Stroke Network assesses the relative merits of the three rehabilitative stroke services in Norfolk with a view to commissioning services in future that bring the maximum benefit to the greatest number of patients, within the available overall funding limits. (Paragraph 6.2.6)	Norfolk and Waveney Stroke Network
Long term		
17.	That the Local Education and Training Board explains what is being done to improve the availability of trained Psychologists. (Paragraph 7.4)	Health Education East of England
18.	That Norfolk County Council adult social care, Norfolk Independent Care, Norfolk Community Health and Care and East Coast Community Healthcare meet to consider how more training in the long term care of stroke survivors can be delivered to care home staff in private and pubic sector care homes across Norfolk, how progress with such training can be tracked and how good practice can be shared across the care home spectrum. (Paragraph 7.7)	Norfolk County Council Adult Social Care Norfolk Independent Care NCH&C ECCH
19.	That the five Norfolk CCGs should work together to commission an integrated prevention,	CCGs (x 5)

Recommendations		To
	information, communication and six month stroke review service across Norfolk. (Paragraph 7.8)	
The cost of stroke and stroke services		
20.	That Norfolk and Waveney Stroke Network collectively considers whether CCGs and Norfolk County Council could usefully commission research on the overall cost of stroke to the health and social care authorities in the county and robust evaluation of the overall cost effectiveness of the three existing stroke service systems in the county. (Paragraph 8.2)	Norfolk and Waveney Stroke Network
Next steps		
21.	That representatives of Norfolk and Waveney Stroke Network meet with the Stroke Services Task & Finish Group to discuss the recommendations of this report before responding to Norfolk Health Overview and Scrutiny Committee. (Paragraph 10.1)	Norfolk and Waveney Stroke Network
22.	That NHOSC asks all the organisations to whom recommendations are addressed to respond in writing by 30 September 2014 setting out:- • Whether or not each recommendation is accepted; • A detailed explanation for any that are not accepted; • A deliverable plan for implementing those that are accepted; • Details of how successful implementation will be measured. (Paragraph 10.1)	NHOSC All the above

Glossary of Terms and Abbreviations

A&E	Accident and Emergency
AC	Audit compliance
AF	Atrial fibrillation
BASP	British Association of Stroke Physicians
BCF	Better Care Fund
CA	Case ascertainment
CCG	Clinical Commissioning Group
CLAHRC	Collaboration for Leadership in Applied Health Research and Care
CT	Computerised tomography scan – uses x rays and a computer to make images of the inside of the body
DSA	Double staffed ambulance
EPA	
EEAG	External Expert Advisory Group
EEAST	East of England Ambulance Service NHS Trust
ESD	Early Supported Discharge
FAST	Face Arm Speech Time (to call 999) – test for diagnosis of stroke
FTE	Full time equivalent
GP	General practitioner
HASU	Hyper acute stroke unit
HEOC	Health and Emergency Operations Centre (ambulance service)
JPUH	James Paget University Hospital
MDT	Multi Disciplinary Team (acute hospitals)
NCH&C	Norfolk Community Health and Care NHS Trust
NHOSC	Norfolk Health Overview and Scrutiny Committee
NHS	National Health Service
NIC	Norfolk Independent Care
NICE	National Institute for Health and Care Excellence
NNUH	Norfolk and Norwich University Hospitals NHS Foundation Trust
OT	Occupational Therapist / Therapy
PPCI	Primary percutaneous coronary intervention
PRISMA	Preferred reporting items for systematic reviews and meta-analysis approach
PT	Physiotherapy
QEH	Queen Elizabeth Hospital, King's Lynn
QOF	Quality outcomes framework
RCP	Royal College of Physicians

RRV	Rapid response vehicle
SINAP	Stroke improvement national audit programme
SLT / SALT	Speech and language therapy
SSNAP	Sentinel Stroke National Audit Programme
SU	Stroke unit
TC	Team centred
Thrombolysis	Breakdown of blood clots by pharmacological means
TIA	Transient ischaemic attack – a temporary inadequacy in blood circulation in part of the brain, usually caused by a tiny clot. Causes symptoms similar to a stroke.

Terms of Reference

Norfolk County Council
Norfolk Health Overview and Scrutiny Committee (NHOSC)
Terms of reference for scrutiny of Stroke services in Norfolk
Scrutiny by Task and finish group
Membership of task and finish group 5 Members of NHOSC:- Mr J Bracey Mr M Chenery of Horsbrugh Dr N Legg (Vice Chairman) Mrs M Somerville (Chairman) Mr T Wright (substitute Member of NHOSC) 1 co-opted Member of Healthwatch Norfolk (non voting):- Mr A Stewart
Reasons for scrutiny 1. The National Stroke Strategy 2007 highlighted the fact that stroke services in this country compared poorly with other countries. NHS Midlands and East was working on a review to improve stroke services and produced a new service specification shortly before it was abolished in April 2013. Responsibility for improving the outcomes for patients in Norfolk now rests with the five Clinical Commissioning Group (CCGs) and NHS England East Anglia Area Team. It is not clear how the new commissioners plan to achieve this across the stroke care pathway. 2. The Norfolk and Norwich hospital did not meet a range of expected stroke care standards throughout 2012-13. The other acute hospitals in Norfolk also fell below their expected standards at times when they were under pressure. The East of England Ambulance Service NHS Trust has not been meeting its response time standards in Norfolk, which also impacts on stroke patients.
Purpose and objectives of study 1. To understand the stroke care pathway, the connections between the new commissioners and providers involved in the pathway and the

current level of performance in terms of outcomes for patients.
2. To examine the commissioners' and providers' intentions for improving stroke care services in Norfolk.
3. To make recommendations for improvement of the local services, if necessary, particularly in relation to prevention of strokes, acute care and rehabilitative care.

Issues and questions to be addressed

i) What more can be done to address stroke prevention? (Stroke is known to be the greatest cost to adult social care budgets for people who are living with long term conditions).
ii) What more can be done to improve the hyper acute and acute stroke services, including emergency ambulance transport to hospital and access to scans and thrombolysis where necessary?
iii) Is there suitable integration of computer systems across the county to share patients' blood test results and other relevant electronic patient data to assist in urgent treatment of stroke?
iv) What more can be done to improve rehabilitative stroke services?
v) What is being done to address staffing levels in stroke units?
vi) What are the future plans for hyper acute stroke services in Norfolk?
vii) Could there be more consistency in the services available to stroke survivors in the community across Norfolk?
viii) What opportunities exist for co-ordination of services to stroke patients between the NHS and social care?
ix) What is the situation regarding commissioning of stroke care services to meet current and future levels of demand?

People to speak to

- The Stroke Association
- Other patient / carer representatives or groups
- The Director of Community Services
- Norfolk and Waveney Local Medical Committee

- The commissioners
  - NHS England East Anglia Local Area Team
  - Norwich CCG – hyper acute, acute and rehabilitative contract with the Norfolk and Norwich Hospital, which subcontracts rehabilitative work to Norfolk Community Health and Care
  - West Norfolk CCG – hyper actue, acute and rehabilitative contract with the Queen Elizabeth Hospital
  - Great Yarmouth and Waveney CCG – hyper acute, acute, inpatient rehabilitative and early supported discharge contract with the James Paget University Hospital and rehabilitative contract with East Coast Community Healthcare)

- The providers
  - East of England Ambulance Service NHS Trust (EEAST)

- Norfolk and Norwich University Hospital (N&N)
- The Queen Elizabeth Hospital (QEH)
- The James Paget University Hospital (JPH)
- Norfolk Community Health and Care (NCH&C)
- East Coast Community Healthcare (ECCH)
- Third sector providers (e.g. The Stroke Association and Headway brain injury charity)

Other sources of information

Relevant published material, e.g. the World Health Organisation report on stroke prevention

Style and approach

- Panel-style meetings with witnesses
- Visits to acute and rehabilitative stroke units

Planned outcomes

A report to Norfolk Health Overview and Scrutiny Committee with the Task and Finish Group's findings and recommendations, if necessary, on how the services could be improved for the benefit of patients.

Deadlines and timetable

It is expected that the task and finish group will report back to Norfolk Health Overview and Scrutiny Committee by 10 July 2014.

(Deadline for pre agenda meeting 5 June 2014; deadline for final report 1 July 2014)

Detailed work programme will depend on availability of witnesses and emerging findings.

Terms of reference agreed by	**Date**
Norfolk Health Overview and Scrutiny Committee	10 October 2013

Information received by Stroke Services in Norfolk Scrutiny Task & Finish Group

1. Briefing by the Scrutiny Support Manager (Health), 23 September 2013

2. Report for Norfolk Health Overview and Scrutiny Committee (NHOSC) stroke services scrutiny task & finish group 10 January 2014, The Stroke Association

3. 'Our Life After Stroke Campaign', The Stroke Association, 2013

4. 'Feeling Overwhelmed', The Stroke Association, 2013

5. 'Short Changed by Stroke', The Stroke Association, 2013

6. 'Struggling to Recover', The Stroke Association, 2013

7. 'Prevention of Cardiovascular Disease, Pocket Guidelines for Assessment and Management of Cardiovascular Risk, Predicting Heart Attack and Stroke Risk', World Health Organization, 2007

8. East of England Ambulance Service NHS Trust report to task & finish group 31 January 2014

9. Drive Time to Nearest Stroke Unit, East of England Ambulance Service NHS Trust

10. Stroke 60 DSA/RRV Response Analysis – October & November 2013, East of England Ambulance Service NHS Trust

11. Pre hospital thrombolysis in acute stroke – Results of the PHANTOM-S pilot study, American Academy of Neurology 2013, provided by East of England Ambulance Service NHS Trust

12. Royal College of Physicians' National Guideline for Stroke 2012

13. Social care and stroke, briefing paper by Scrutiny Support Manager (Health), 21 February 2014

14. Norfolk Community Health and Care NHS Trust – Paper for HOSC regarding Stroke Services 14 February 2014

15. East Coast Community Healthcare – Waiting Times for Community Stroke Patients, 14 February 2014

16. Health Needs Assessment – Stroke or Transient Ischaemic Attacks (TIA), Norfolk Public Health, January 2014

16.1 & a presentation by Dr Kadhim Alabady

17. Extract from Harvest Report to Norwich CCG 25 March 2014 – NNUH stroke performance

18. NHS 111 stroke pathway – summary received 3 April 2014

19. Norfolk and Waveney Local Medical Committee's answers to questions posed by the Stroke Services Scrutiny Task & Finish Group – received 3 April 2014

20. Sentinal Stroke National Audit Programme (SSNAP):-
Clinical audit July – September 2013 public report
Clinical audit October – December 2013 public report

21. Minutes of task & finish group meetings:-

21.1 23 September 2013

21.2 16 December 2014 – meeting with Norwich CCG; West Norfolk CCG; Great Yarmouth and Waveney CCG; Cardiovascular Strategic Clinical Network

21.3 10 January 2014 – meeting with The Stroke Association; Headway; East of England Stroke Forum

21.4 31 January 2014 – meeting with NeuroRehabilitation Manager, Oliver Zangwill Centre for Neuropsychological Rehabilitation; NNUH; East of England Ambulance Service NHS Trust

21.5 21 February 2014 – meeting with Community Services, Norfolk County Council; Norfolk Community Health and Care NHS Trust; East Coast Community Healthcare; Norfolk Independent Care

21.6 3 April 2014 – meeting with Norfolk Public Health; Norfolk and Waveney Local Medical Committee; Norfolk Carers Support; service user and carer; Housing Standards Manager, South Norfolk Council

22. Notes of task & finish group visits:-

22.1 Norfolk Community Health and Care NHS Trust – Norwich Community Hospital, Beech Ward and Early Supported Discharge office

22.2 14 November 2014 – JPUH stroke unit visit

22.3 18 November 2013 – NNUH stroke unit visit

22.4 18 November 2013 – QEH stroke unit visit

22.5 27 January 2014 - NHS 111 visit, Hellesdon Health Emergency Operations Centre

Delayed Discharge from Hospitals in Norfolk

Report by the scrutiny task & finish group

The report of the scrutiny task & finish group on Delayed Discharge from Hospitals in Norfolk is presented to Norfolk Health Overview and Scrutiny Committee (NHOSC) for approval and endorsement of the recommendations.

1. Introduction

1.1 On 16 January 2014 NHOSC agreed to establish a joint scrutiny task and finish group with members from the former Community Services Overview and Scrutiny Panel to look at the issue of delayed discharges from hospitals in Norfolk.

1.2 The group's report is attached at Appendix A. The report includes details of the membership of the group and its terms of reference as well as its conclusions and recommendations.

2. Action

2.1 NHOSC is asked to:-

(a) Approve the task and finish group's report and endorse its recommendations.

(b) Direct the recommendations to the appropriate organisations, as set out in the report, asking them to respond in writing by 30 September 2014 setting out:-
   a. Whether or not each recommendation is accepted;
   b. A detailed explanation for any that are not accepted;
   c. A deliverable plan for implementing those that are accepted;
   d. Details of how successful implementation will be measured.

(c) Send a copy of the task and finish group's report to the Care Quality Commission for information.

(d) Send a copy of the task and finish group's report to Norfolk MPs for information.

(e) Receive a report on the responses to the recommendations at a future meeting after 30 September 2014.

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

Appendix A

Community Services Overview and Scrutiny Panel
Norfolk Health Overview and Scrutiny Committee

Delayed Discharge from Hospitals in Norfolk
Task and Finish Group Report

July 2014

Contents

Report of the Delayed Discharge from Hospital in Norfolk Task & Finish Group

1. Introduction

1.1 In January 2014 Community Services Overview and Scrutiny Panel and Norfolk Health Overview and Scrutiny Committee (NHOSC) set up a joint scrutiny task and finish group to examine the situation regarding delayed discharge from hospitals in Norfolk.

1.2 During a discussion on ambulance turnaround at the Norfolk and Norwich hospital (NNUH) in November 2013 NHOSC had heard that the level of delayed discharges from the hospital were running at an average of approximately 50 per day. The Committee was also aware that reducing delayed transfers of care from the N&N was a high priority for phase two of Project Domino. Phase one of Project Domino had been running since November 2012 with the aim of improving the efficiency of the central Norfolk urgent care system. It involved all the relevant local NHS and social care agencies.

1.3 Community Services Overview and Scrutiny Panel (the OSP) was also aware of the situation regarding delayed discharge from hospital and wished to look at the role played by Norfolk County Council Community Services. Both the OSP and the HOSC knew that the NHS expected to face significant pressures over the winter period. They also knew about national policy to establish a substantial Better Care Fund from existing health and social funding streams. This was a potentially de-stabilising development but also an opportunity for the local health and social care agencies to address the pressures in new ways.

1.4 Our joint scrutiny task and finish group was asked to:-

- examine the current situation regarding delayed discharges from the acute, mental health and community hospitals in Norfolk.
- examine the work underway to improve the flow of patients from the hospitals.
- make recommendations, if appropriate, about how the situation might be improved.

Our full terms of reference are attached at Appendix 1.

1.5 Our group included eight County Councillors, four from NHOSC and four from the OSP, and one co-opted member from Healthwatch Norfolk. The members were:-

Cllr Shelagh Gurney (Chairman)
Cllr Brian Hannah

Cllr Michael Chenery of Horsbrugh
Cllr Harry Humphrey
Cllr Alexandra Kemp
Cllr Nigel Legg
Christine MacDonald – Healthwatch Norfolk
Cllr Margaret Somerville (Vice Chairman)
Cllr Tony Wright

1.6 Our scrutiny was conducted through four panel style meetings at County Hall during which we met the following people from the relevant organisations:-

Lorrayne Barrett	-	Head of Social Care (East), Norfolk County Council (NCC); also attended on behalf of Great Yarmouth and Waveney Clinical Commissioning Group (CCG)
Katherina Brady	-	County Manager, Norfolk First Support, NCC
Wayne Bunn	-	Performance Manager, Norfolk Community Health and Care
Kathy Chapman	-	Director of Operations, Norfolk and Suffolk NHS Foundation Trust (NSFT)
Chris Cobb	-	Director of Medicine and Emergency Services
Chris Collict	-	British Red Cross support in the home, Co-ordinator, NNUH
Jo Cook	-	Head of Social Care (Northern), NCC
Jonathon Fagge	-	Chief Executive Officer, Norwich CCG
Jo Fisher	-	Assistant Director for Integrated Services - West Locality, Norfolk Community Health and Care (NCH&C) and NCC (Social Care)
Tracey Flemming	-	Head of Discharge & Therapeutic Services, NNUH
Denise Forder	-	County Manager, Norfolk First Support
Cursty Pepper	-	Divisional Manager, The Queen Elizabeth Hospital NHS Foundation Trust (QEH)
Catherine Underwood	-	Director of Integrated Commissioning, NCC
Mark Walker	-	Assistant Director, Norwich Locality, NCH&C
Sue Watkinson	-	Interim Director of Operations, James Paget University Hospitals NHS Foundation Trust (JPUH)
Jane Webster	-	Head of Commissioning, NHS West Norfolk CCG
Andrea Wright	-	Head of Service – Mental Health Partnership

1.7 Minutes of all our meetings are available on request from the Scrutiny Support Manager (Health). All of the information we received is referenced in Appendix 2 and is also available from the Scrutiny Support Manager (Health).

1.8 We want to acknowledge right at the start of our report that the issue of hospital discharge has been high on the agenda of health and social care agencies in Norfolk for years and much has already been done to minimise delays through joint working. We also know that hospitals in Norfolk are not out of line with others across the country in terms of levels of delayed discharge. The hospitals, the County Council and the NHS commissioning organisations deserve recognition for what they have already achieved in this area.

1.9 However, it takes constant vigilance to maintaining a smooth flow of patients through the health and social care system and very efficient co-ordination between the many different organisations involved. Across Norfolk, and especially at the Norfolk and Norwich hospital, the system runs 'hot' most of the time. By this we mean that bed occupancy rates are high and lengths of stay in hospital are short. This is good in terms of efficient use of resources but it also means that a glitch in the system can all too soon manifest itself in ambulances queuing at A&E and cancellations of pre-arranged operations.

1.10 We recognise that there are unprecedented pressures on both social care and the NHS because of financial constraints and growing demand for care. In this climate it is increasingly important that patients to move through the system without delay and receive care in the right setting for their needs. We know that all the agencies in Norfolk recognise the challenge and that reducing delayed discharge remains high on their agenda.

2. Definition of delayed discharge

2.1 There are two terms used in relation to patients whose stay in hospital extends beyond the point where the hospital believes its services are required:-

- Delayed discharge
- Delayed transfer of care

We found that these terms are used interchangeably. 'Transfer of care' refers to the fact that a person will be moving from the hospital into other care arrangements, whether provided in NHS establishments, care homes or as a package of care in their own home. .

2.2 We received two definitions. Firstly there was 'delayed discharge' as

defined by the Community Care (Delayed Discharges etc.) Act 2003 (the Act). The Act requires the NHS to notify social services of a patient's likely need for community care services on discharge and to give 24 hours notice of actual discharge. It also requires local authorities to reimburse the NHS Trust for each day that an acute patient's discharge is delayed where the sole reason for that delay is the responsibility of social services. This is a narrow definition as there are, of course, many other reasons why a patient may be delayed in hospital after they are medically fit to leave.

Representatives from Norfolk County Council Community Services (adult social care) explained that there are differences in how the three acute hospitals in Norfolk record delayed discharges under the Act but in general the process is as follows:-

a. A referral (called a section 2) is received by the social work team from the ward
b. Initial contact is made with ward to establish if the person is medically stable and fit to be assessed and further details are taken. This is within 24 hours or sooner
c. The case is allocated to a social care practitioner
d. Following allocation an assessment should take place within three working days under the Delayed Discharges Act, where someone is medically stable, and discharge arranged

If ongoing NHS health interventions are still required e.g. physiotherapy / occupational therapy or a Continuing Health Care assessment is needed, then the section 2 timeframe is suspended until these processes have been completed.

The financial penalties that Norfolk County Council is liable to pay under the Act have never actually been enforced by the NHS in Norfolk.

2.3 Secondly there was 'delayed transfer of care' as defined by the Department of Health for monthly situation reports across the NHS. Whereas the Act focuses only on patients delayed in the acute hospitals due to waiting for social care, the monthly situation report identifies all patients who are in the wrong care setting (acute or non acute, including community and mental health settings) for their current level of need irrespective of who is responsible for the delay. The definition of delayed transfer of care in this context is:-

a. A clinical decision has been made that the patient is ready for transfer AND
b. A multi-disciplinary team decision has been made that the patient is ready for transfer AND
c. The patient is safe to discharge/transfer.

2.4 It was clear to us that to fully appreciate the impact of delayed discharge in hospital and to meet our terms of reference we needed to look at information under the wider definition of 'delayed transfer of care' not just at 'delayed discharge' under the Community Care (Delayed Discharges etc.) Act 2003

2.5 We were struck by the complexity of the discharge process and the number of factors, organisations and teams that can potentially contribute to delay. Across the three acute hospitals we found that patients were recorded as waiting for:-

- Social services funded placements
- Social services packages of care
- Community hospital rehabilitation beds
- Community equipment / adaptations
- Specialist NHS hospital beds
- Pre-NHS Continuing Healthcare checklist
- Full NHS Continuing Healthcare assessment
- Environmental visits
- Private care packages
- Because of patient / carer choice
- Disputes
- A self funded placement
- Awaiting mental health assessment
- Awaiting equipment for home

Clearly, despite the Act and the situation report guidance, there is inevitably room for variation in the way that the hospitals record delays.

2.6 The three acute hospitals in Norfolk all work with Norfolk County Council as the social care authority and in our opinion it would be better and clearer for all concerned if there was a standardised method of recording delayed discharges from hospitals across the County.

3. The situation in Norfolk

3.1 Mindful of the potentially uncertainty around the definition of delayed discharge, we asked the three acute hospitals trusts, the community hospital trust and the mental health trust to give us figures showing the numbers of recorded delayed discharges, for whatever reason, for the period 1 August 2013 to 31 January 2014 and also a snapshot of the situation on Monday 27 January 2014 (a randomly chosen date) in terms of:-

- the number of patients who were determined medically fit for discharge from hospital, but were not discharged, and for what reason (e.g. waiting for social

care, waiting for NHS continuing care, waiting for NHS community care, waiting for mental health, delayed through patient choice).

- the number of patients who were recorded as delayed discharges in accordance with the Delayed Discharges Act 2003.

We also asked them to supply us with the number of complaints related to delayed discharge from hospital and a summary of the subject of those complaints.

3.2 **Norfolk and Norwich University Hospital NHS Foundation Trust**

3.2.1 The Norfolk and Norwich Hospital's (NNUH) snapshot of the situation on 27 January 2014, showed 19 patients recorded as delayed under the Act but 34 patients in total delayed at the hospital. The details are shown in Tables 1 and 2 below:-

Table 1 – Delayed Discharges (as defined by the Act) at the Norfolk and Norwich Hospital on 27 January 2014

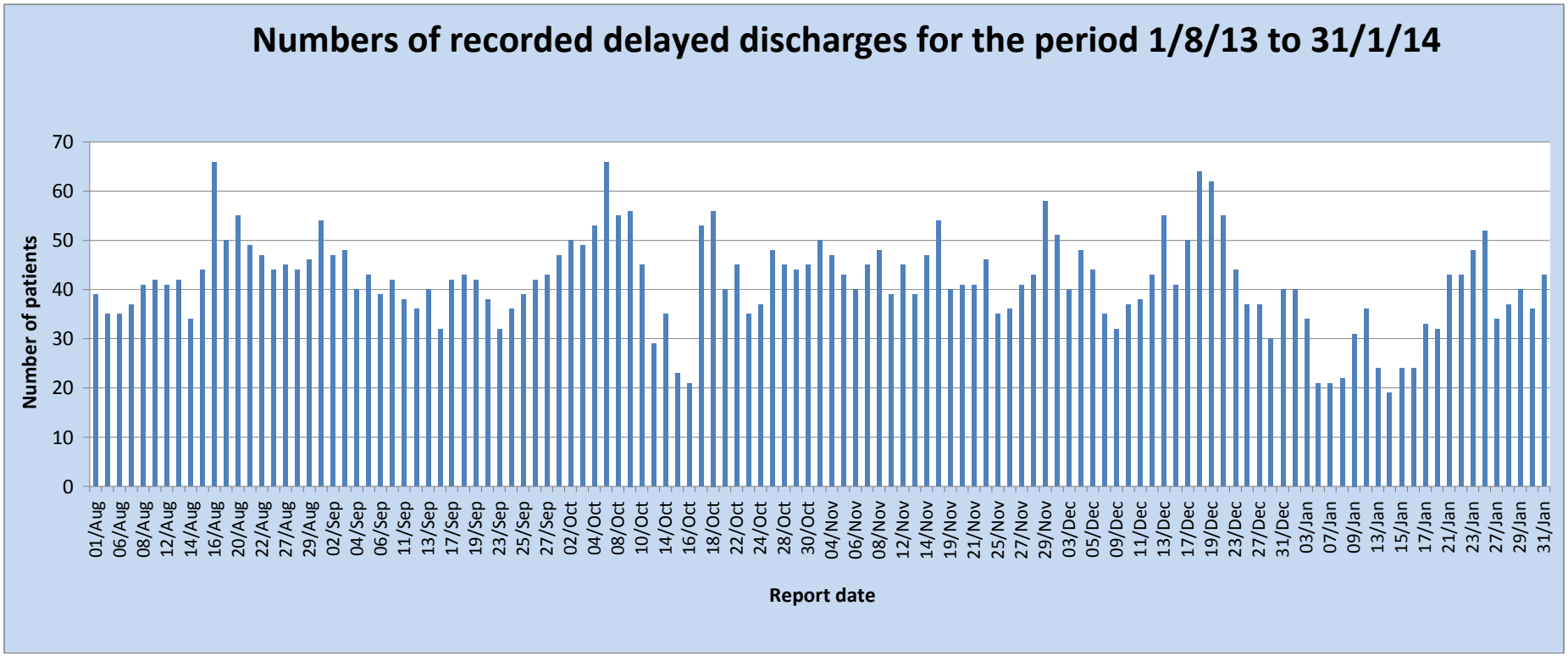
Reason for Delay	**Number of patients**
Waiting for residential Care Home placement	1
Waiting for Nursing Home placement	5
Waiting for a Rehabilitation bed	6
In assessment	7
TOTAL	**19**

Table 2 – Delayed transfers of care (for any reason) at the Norfolk and Norwich Hospital on 27 January 2014

Reason for Delayed Transfer Of Care	**Number of patients**
ACB3 - Awaiting specialist hospital Norfolk	2
COM2 - Community bed – listed for rehab (CLT)	13
NHS3 – Continuing Care eligible awaiting Commissioner	4
REL2 - Patient/family exercising choice	4
SS3 - Social Services: Awaiting Package of Care	2
SS4 - Social Services: Awaiting Residential Home placement	1
SS5 - Social Services: Awaiting Nursing Home placement	4
OOC3 - Out of County: Awaiting Package of Care	1
OOC5 - Out of County: Awaiting Nursing Home placement	1
OOC6 - Out of County: Listed for rehab	2
	34

3.2.2 The picture for delayed transfers of care (for any reason) at the NNUH across the six months from August 2013 to January 2014 is shown in the graph overleaf. It ranges from about 65 people on the worst days to about 21 on the best days. On average were always between 30 and 40 people delayed at the NNUH during this period, which equates to more than 1 ward effectively out of action at all times.

Norfolk and Norwich University Hospital NHS Foundation Trust



3.2.3 In relation to complaints about delayed discharge, representatives from the NNUH explained that it is much more common to receive complaints from families who feel that a patient's hospital stay was too short. They felt that more should be done to educate the public to expect care in the community rather than in hospital. In the period from 1 August 2013 to 31 January 2014 the NNUH received 6 complaints about delays in discharge, which appear to relate mainly to discharge process on the day.

The NNUH pointed out to us that the effect of delayed discharge is, however, reflected in many other complaints and most obviously in those from patients whose admission for surgery is cancelled because all the beds are already occupied by other patients, some of whom no longer need the services of the acute hospital.

3.4 **James Paget University Hospitals NHS Foundation Trust**

3.4.1 Like the NNUH the JPUH does not receive many complaints directly about delayed discharge. There have only been three in the past two years.

3.4.2 The JPUH gave us the overall numbers of patients delayed, for whatever reason, at the hospital in the period from August 2013 to January 2014:-

Month	**Number of patients delayed**	**Number of days**
August 2013	35	677
September 2013	50	906
October 2013	29	935
November 2013	35	718
December 2013	24	626
January 2014	27	703
Total	200	4565

3.4.3 They also gave us snapshot of all patients delayed at the hospital on 27 January 2014, including the reasons for the delays. There were 12 patients delayed on that day; the details are shown in Table 3 overleaf:-

Table 3 – Delays at the James Paget Hospital 27th January 2014

Adm Date	Medically Fit Date	Discharge Date	Verified DTOC	Delayed Discharge Reason Code	Attributable To
12/01/2014 22:55	15/01/2014 09:00	05/02/2014 15:58	Y	A - Assessment	NHS
02/12/2013 13:50	06/01/2014 11:00	07/02/2014 16:30	Y	G - Patient/Family Choice	NHS
30/12/2013 21:20	27/01/2014 11:00	09/02/2014 09:00	Y	A - Assessment	NHS
06/01/2014 22:40	16/01/2014 11:00	03/02/2014 15:30	Y	A - Assessment	Both
16/01/2014 21:40	27/01/2014 11:00	25/02/2014 16:45	Y	G - Patient/Family Choice	NHS
16/01/2014 14:24	27/01/2014 11:00	12/02/2014 16:50	Y	A - Assessment	NHS
18/01/2014 11:56	23/01/2014 09:05	04/02/2014 14:37	Y	F - Community Equipment/adaptions	NHS
19/01/2014 02:30	27/01/2014 11:00	06/02/2014 11:57	Y	A - Assessment	NHS
19/01/2014 23:00	21/01/2014 11:00	31/01/2014 19:00	Y	A - Assessment	Social Care - Non DTOC
05/12/2013 23:55	06/01/2014 11:00		Y	A - Assessment	Both
26/12/2013 22:55	22/01/2014 11:00	05/02/2014 11:00	Y	A - Assessment	NHS
01/01/2014 15:30	23/01/2014 11:00	07/02/2014 17:00	Y	A - Assessment	NHS

3.4.4 We were conscious that the JPUH, like the Queen Elizabeth Hospital, King's Lynn, receives a significant proportion of its patients from outside of Norfolk and this adds to the complexity of dealing with patient discharge. The JPUH works with the social care authorities in both Norfolk and Suffolk and with the full range of NHS organisations in both counties.

The JPUH gave us the weekly numbers of patients delayed at the hospital from August 2013 to May 2014 broken down by county (Norfolk and Suffolk) along with the reasons for the delays. There were no patients delayed at the hospital by waiting for social care from either county according to the definition of Community Care (Delayed Discharges etc.) Act 2003, which allows three working days between allocation of a case and the social care assessment taking place.

There were, however, some delays in both counties caused by waiting for joint health and social care assessments. From the figures we were given, an average 1.46 patients per week were delayed by waiting for joint assessment by health and social care in Norfolk and 1.42 patients per week in Suffolk.

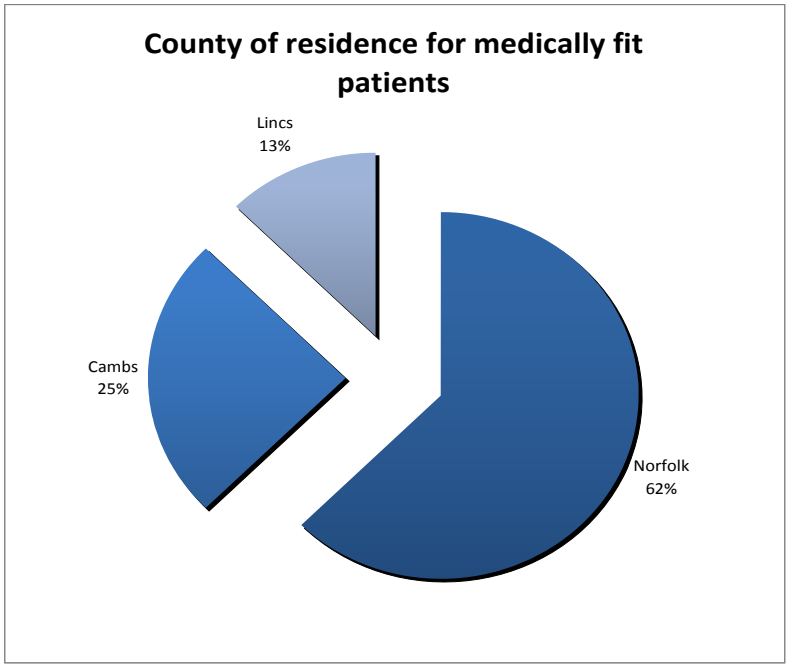
The vast majority of delays at the JPUH are due to NHS processes such as community health care assessment and NHS community care placement. The figures we received showed an average of 17.65 Norfolk patients and 16.42 Suffolk patients per week delayed at the JPUH due to NHS processes.

3.5 **The Queen Elizabeth Hospital, King's Lynn**

3.5.1 Managing delayed discharge at the Queen Elizabeth Hospital (QEH) is especially complex because the hospital serves the population of parts of three counties, Norfolk, Cambridgeshire and Lincolnshire, which involves liaison with multiple social are authorities and NHS community care organisations. There QEH told us there are on average 30-32 delays on the list, with 12 of those reportable under the Act. This is a great improvement on last year at the QEH when delayed transfers of care were running at 80 on average.

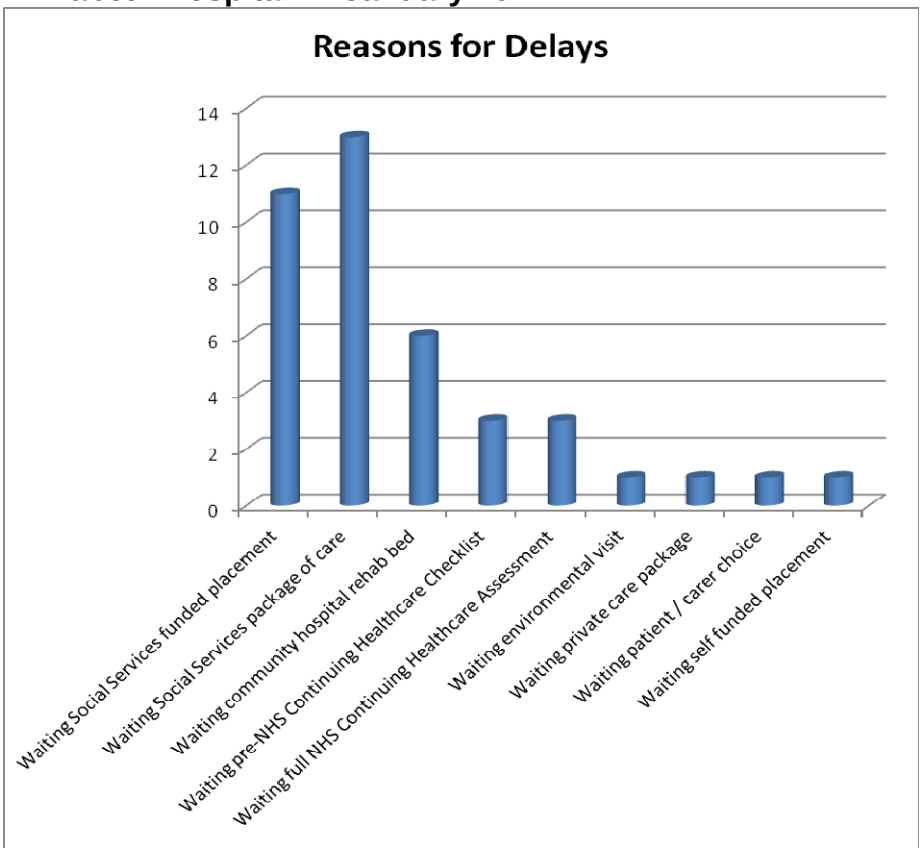
On 27 January 2014 the QEH had a total of 40 patients who were medically fit for discharge but were delayed, for whatever reasons. The chart below shows the split in delayed discharges between the three counties on 27 January 2014.

27 January 2014

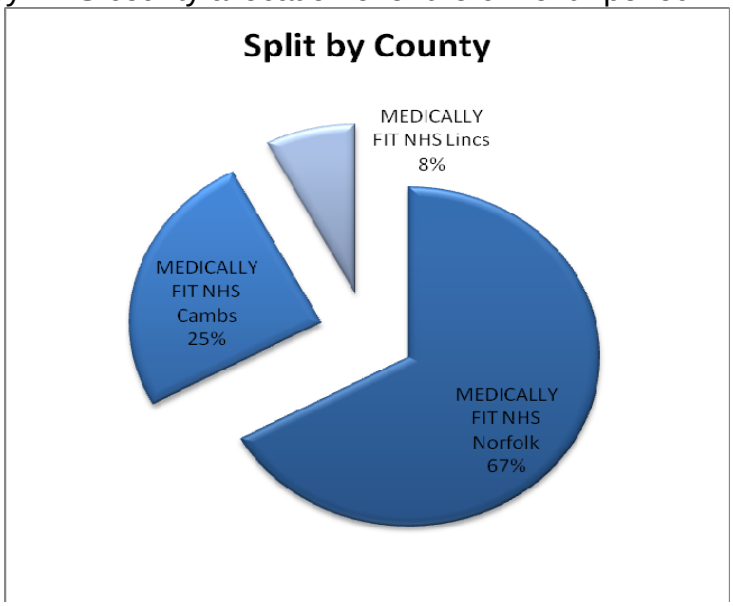


3.5.2 The reasons for the delays on 27 January are shown in the chart below. The hospital told us that only 15 out of the 40 delays on this day would be counted under the Community Care (Delayed Discharges etc.) Act 2003.

Queen Elizabeth Hospital 27 January 2014

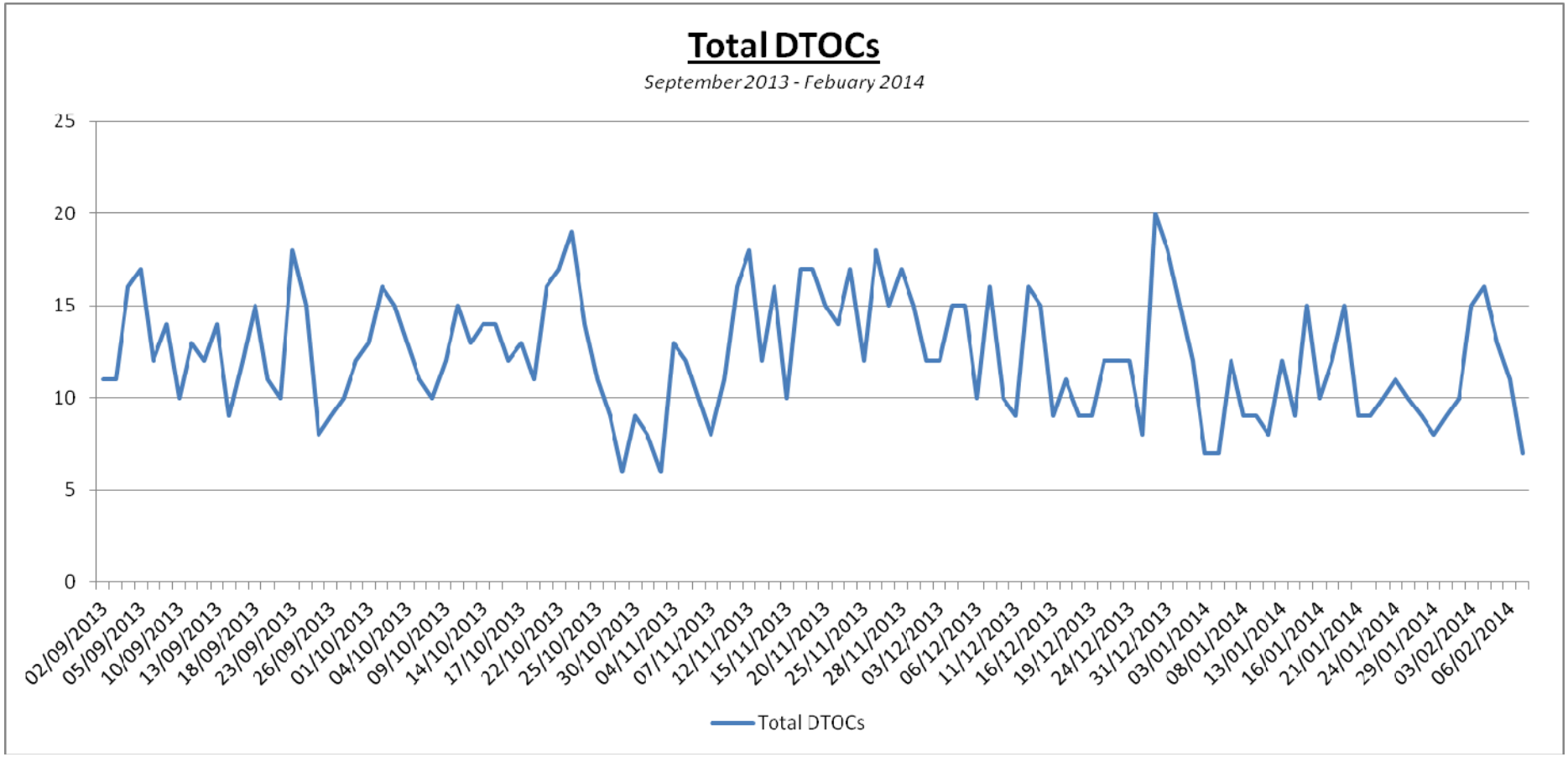


3.5.3 The QEH also gave us its figures for the 6 month period from September 2013 to February 2014. There were a total of 1388 days of delayed transfers of care in this period. The chart below shows the split by NHS county allocation over the 6 month period.

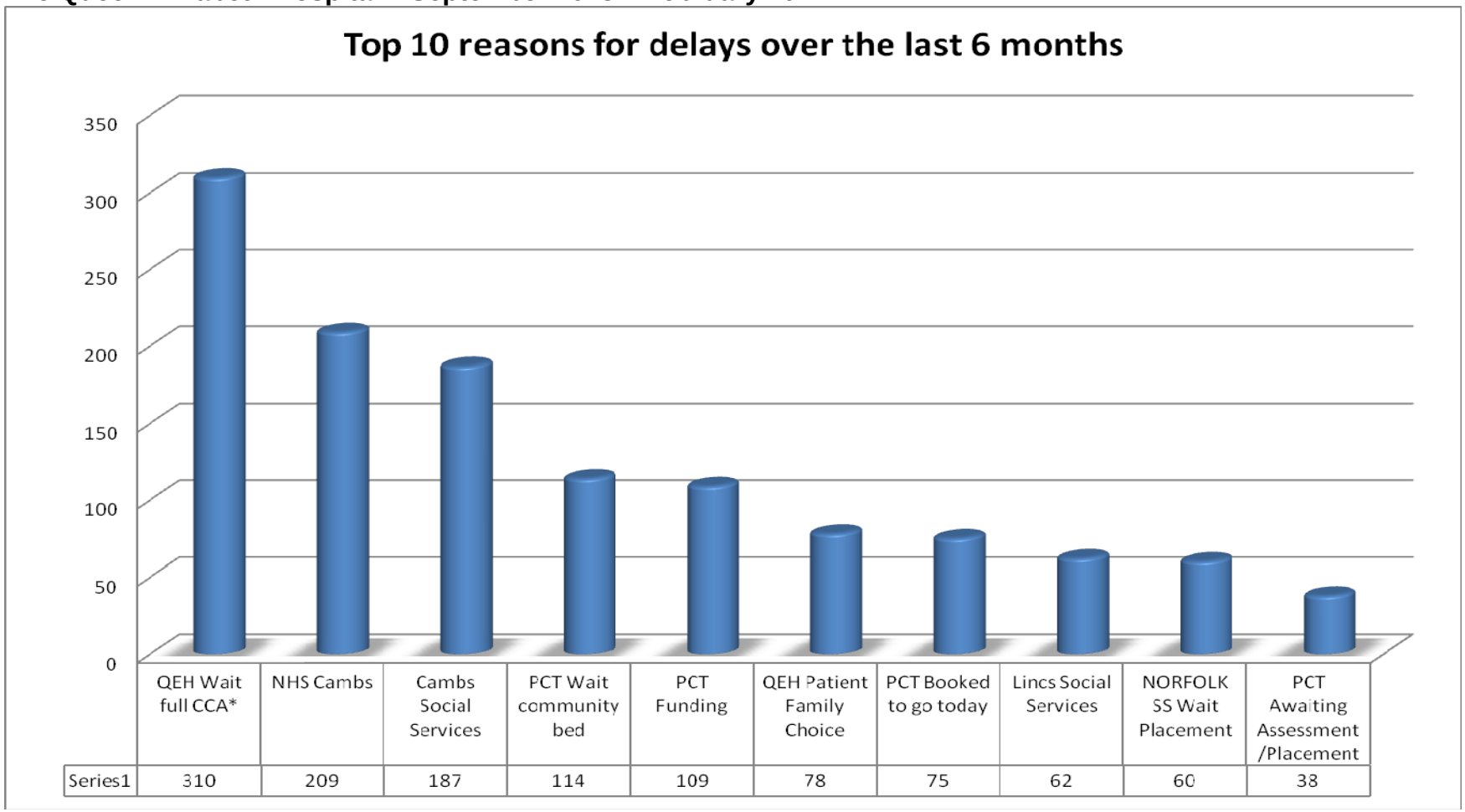


3.5.4 The graphs overleaf show the number of delayed discharges at the Queen Elizabeth Hospital, for whatever reason, in the six months from September 2013 to February 2014 and the top ten reasons for those delays The overall number ranged from the lowest level of 6 to the highest of 20. The mean number of delays was slightly over 12.

The Queen Elizabeth Hospital – Delayed transfers of care



The Queen Elizabeth Hospital – September 2013 – February 2014



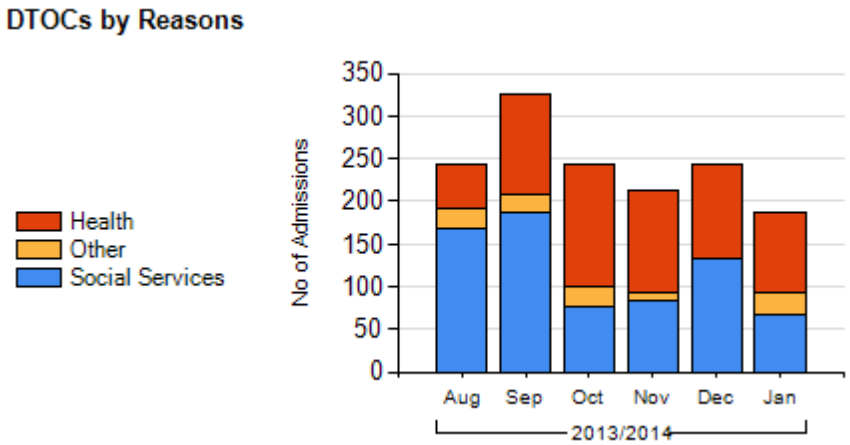
3.5.5 The QEH had received 7 complaints over the past year specifically about delays in discharge. The issues were mainly about processes on the day of discharge, not about patients being kept in hospital longer than was necessary.

3.6 Community Hospitals

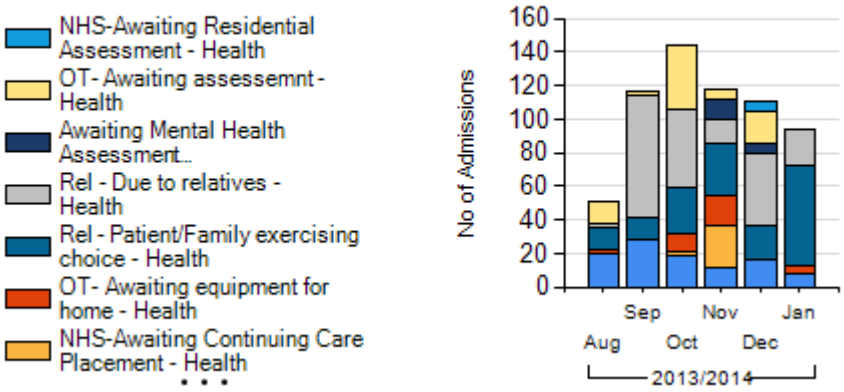
3.6.1 The Community Care (Delayed Discharges etc.) Act 2003 gives NHS acute hospital trusts the power to impose penalties on the County Council for failing to provide timely social care, but does not give the same powers to NHS community trusts when delays occur at community hospitals. Norfolk Community Health and Care NHS Trust (NCH&C) does not therefore record delayed discharges in line with the Act but in line with NHS monthly situation report definitions, which cover the wider causes of delayed transfer of care.

3.6.2 NCH&C gave us details of the delays at all their hospitals for the 6 months from August 2013 to January 2014 including the reasons for the delay. It is worth noting that there is no agreed verification process between NCH&C and Norfolk County Council adult social care for delayed discharges. This is an area that the two organisations have been working on to ensure that the data is correct. All the following statistics are based on NCH&C's perception of the situation:-

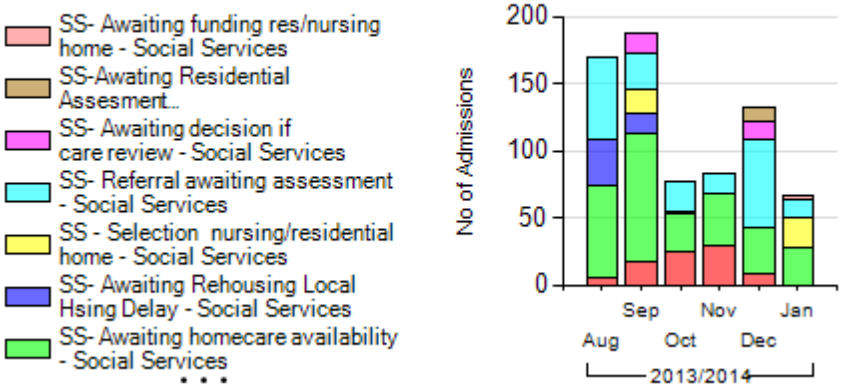
NCH&C – community hospital delayed transfers of care Aug 13 – Jan 14



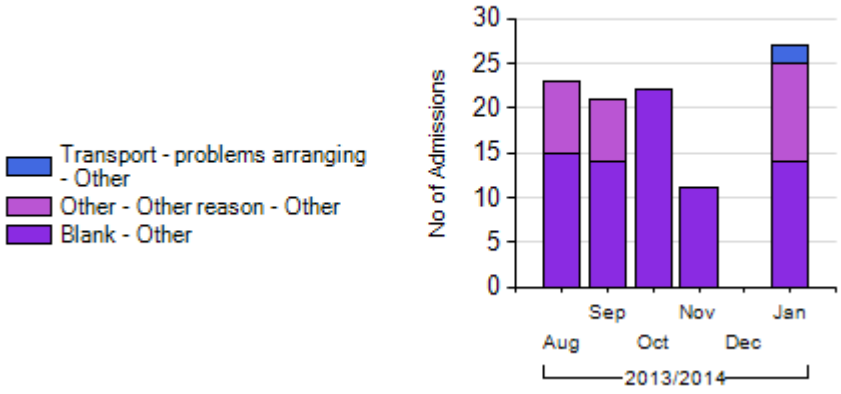
Health DTOCs by Reasons



Social Services DTOCs by Reasons

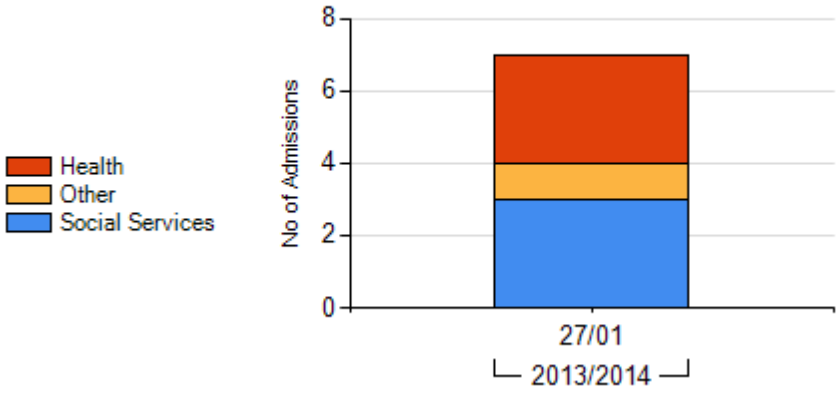


Other DTOCs by Reasons

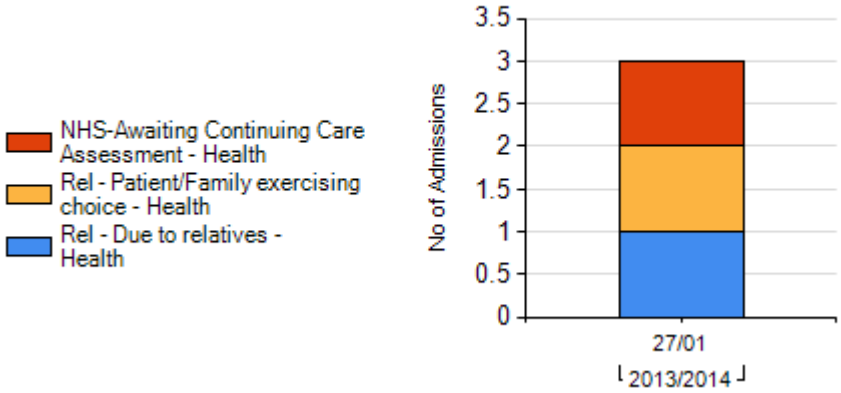


3.6.3 NCH&C also gave us a snapshot of the situation on 27 January 2014, when there were a total of 7 patients delayed at the community hospitals for the reasons shown below:-

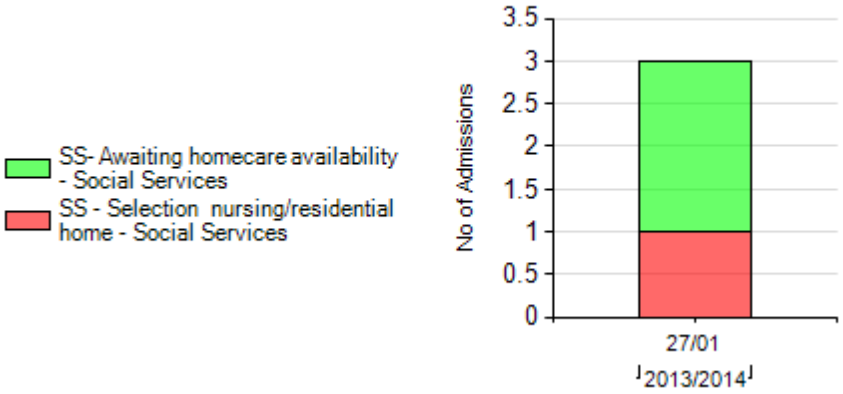
DTOCs by Reasons



Health DTOCs by Reasons



Social Services DTOCs by Reasons



3.6.4 NCH&C also gave us an update on the situation as at 5 March 2014 when there were 14 patients delayed at the community hospitals:-

3 - waiting for social care
10 - waiting for NHS services
1 - reason for delay was unknown

3.7 **Mental Health Hospitals**

3.7.1 As with the NHS community hospital sector, NHS mental health hospitals are not included in the provisions of the Community Care (Delayed Discharges etc.) Act 2003 and have no power to charge the social care authority for patients delayed in the mental health hospitals for reasons relating to social care.

Norfolk and Suffolk NHS Foundation Trust (NSFT) collects data on delayed transfers of care in relation to the monthly NHS situation reports and gave us snapshot information on patients delayed at the mental health hospitals across Norfolk and Suffolk, for whatever reason, on 27 January 2014. There were 8 patients delayed in mental health wards in Norfolk and 3 of the delays were attributable to social care. The table overleaf shows the reasons for the delays on 27 January:-

Norfolk and Suffolk NHS Foundation Trust – Delayed Transfers of Care - Monday 27-01-2014

Number	Ward Name	Locality	Delayed Code	Delayed Description	Attributable To
1	Sandringham Ward	Central	B1	Awaiting public funding	Social Care
2	Yare LSU	Secure Services	D1	SS - Awaiting funding res/nursing home	Social Care
3	296 Drayton High Ward	Central	G1	20 NHS-Patient or Family Choice	NHS
4	Reed Ward	Central	D2	07 NHS-Awaiting Nursing home placement/availability	NHS
5	AMH Northgate Ward (NORTHW)	Suffolk West	I1	Housing	NHS
6	Rose Ward	Central	D2	07 NHS-Awaiting Nursing home placement/availability	NHS
7	Rose Ward	Central	D2	07 NHS-Awaiting Nursing home placement/availability	NHS
8	Blickling Ward	Central	D1	SS - Awaiting funding res/nursing home	Social Care
9	Willow Ward (WILLW)	Suffolk East	D1	Awaiting residential home placement or availability	Social Care
10	Willow Ward (WILLW)	Suffolk East	G1	Patient or Family choice	NHS
11	LD 7 Airey Close (7ACW)	Suffolk East	D1	Awaiting residential home placement or availability	Social Care
12	Willow Ward (WILLW)	Suffolk East	D1	Awaiting residential home placement or availability	Social Care
13	LD 3 Walker Close (B3W)	Suffolk East	D1	Awaiting residential home placement or availability	Social Care
14	Willow Ward (WILLW)	Suffolk East	D1	Awaiting residential home placement or availability	Social Care
15	Avocet Ward (AVOW)	Suffolk East	D1	Awaiting residential home placement or availability	Social Care

Key to ‘Delayed codes’ overleaf

Key – Delayed Codes

	Attributable to NHS	Attributable to Social Care	Attributable to both
A. Awaiting completion of assessment	✓	✓	✓
B. Awaiting public funding	✓	✓	✓
C. Awaiting further non-acute (including community and mental health) NHS care (including intermediate care, rehabilitation services etc)	✓	×	×
D i). Awaiting residential home placement or availability	✓	✓	×
D ii). Awaiting nursing home placement or availability	✓	✓	✓
E. Awaiting care package in own home	✓	✓	✓
F. Awaiting community equipment and adaptations	✓	✓	✓
G. Patient or Family choice	✓	✓	×
H. Disputes	✓	✓	×
I. Housing – patients not covered by NHS and Community Care Act	✓	×	×

3.7.2 The Trust also told us that 82 patients had been delayed in mental health hospitals across Norfolk and Suffolk in the six months between August 2013 and January 2014 and there had been a total of 3,688 days of delayed transfer of care.

Clearly, some mental health patients are delayed in hospital for an extraordinarily long time. When we met a representative from NSFT on 6 March 2014 we were given a list of current cases of delayed transfers of care. This included a case of someone delayed by 236 days by waiting for a nursing home placement and another of someone delayed by 139 days due to patient or family choice. The Trust pointed out that delays of this duration are not usual.

3.7.3 NSFT has a performance target of less than 7.5% of occupied bed days to be classified as delayed transfer of care. It was meeting the target in all areas of Norfolk. The area under greatest pressure in Norfolk was the central area where 6.33% of occupied bed days were classified as delayed transfer of care.

4. Managing discharges and reducing delays

4.1 As the information in section 3 demonstrates, all the hospitals are keeping detailed records of delayed discharges / transfers of care and the reasons why they occur. We did not get the impression that there is any shortage of information in this field. We were also reassured that the high priority that both health and social care give to patient flow and the good relationships that they appear to have. Having said that, it takes more than good relationships to solve the complex problems of patient flow.

4.2 Social care and health working together

4.2.1 Each of the acute hospitals has a social work team based in hospital and managing discharges with health colleagues. The social work teams are made up of managers, social workers, assistant practitioners, integrated care co-ordinators and practice consultants, all of whom are County Council employees. In addition there are social workers who specifically manage discharges from the community hospitals. There are regular discharge meetings / teleconferences attended by team managers / practice consultants with health colleagues to resolve delays in any part of the system. Depending on the hospital, these occur daily to three times per week. The number of referrals to the hospital discharge teams are as follows:-

a. NNUH
   2012 = 3211
   2013 = 2317(Jan-Sept)

b. QEH
2012 = 2119
2013 = 1577(Jan-Sept)
c. JPUH
2012 = 2898 (50%Suffolk/50%Norfolk)
2013 = 2283 (Jan-Sept).

4.2.2 Planning beds (beds in residential or nursing homes that are bought specifically for people to be discharged from hospital) are used widely by the hospital social work teams to allow people to be discharged while arrangements are being made for their return home or transfer of care. People may go to planning beds while equipment for their care is installed at home, or while they wait for a residential placement or for social care support to be arranged. Patients are moved to their next place as soon as possible but they can remain in a planning bed for up to six weeks.

Planning beds are block purchased at various locations across the county and there is additional spot purchasing as required. Most of the beds are in central and north Norfolk. In March 2014 there were 30 ring fenced planning beds in use in the following locations:-

Block planning beds

Name of Home	Type of Bed	Locality	Number of Beds Ring Fenced
Halvergate House	SN	Northern	2
Larchwood	SR/HD	Norwich	1
Twin Oaks	SN	Norwich	3
Whitehall Lodge	SR/HD	Norwich	2
			8

Norse planning beds

Name of Home	Type of Bed	Locality	Number of Beds Ring Fenced
Cranmer House	SR/HD	Northern	4
Ellacombe	HD	Norwich	1
Somerley	SR	Norwich	3
Munhaven	DE	Northern	1
Rose Meadow	SR	Northern	2
Springdale	SR	Northern	2
Beauchamp House	2 x SR & 1 x DE	Southern	2
Harker House	1 x SR & 1 x DE	Southern	1
Linden Court	SR	Southern	2
Philadelphia House	SR	Norwich	1
Priorsmead	SR	Southern	1
Sydney House	SR	Northern	2
Mountfield	DE	Norwich	1
			22

4.3 **The acute hospitals**

We were told about reviews and improvements that have already happened or were being introduced across the health and social care pathways connected to the three acute hospitals. We noted that there are a diverse range of innovations underway at the three hospitals and in the surrounding health and social care systems:-

4.3.1 **NNUH**

a. Within the central belt covering the NNUH there is a significant commitment from all partners led by Norwich CCG to Project Domino which is focussing service improvements around urgent care and patient flow.
b. Direct access to Norfolk First Response by health professionals has reduced the proportion of referrals to the social work team.
c. Development of operational progress reports and daily meetings to tackle delays.
d. Introduction of ward attached social workers across the hospital
e. Faster timescale from referral to allocation.
f. Autonomy given to front line social workers to manage demand and key relationships with wards.
g. Engagement with Mental Health Liaison Services to improve collaborative working.
h. Planning beds flow and community hospital delays managed through NNUH – provides an 'acute' culture and oversight of flow.
i. Developing out of hospital NHS Continuing Care model.
j. Weekend discharge team (social workers, physiotherapists and occupational therapists) running as a 6 month pilot over winter 2013/14.
k. Introduction of Cystic Fibrosis Specialist Social Worker (Children and Adults).
l. Refreshing Social Worker and Multi Disciplinary Team response / pathway to emergency areas and admission avoidance work ongoing.
m. Standard Operating Procedure for hospitals being led by NNUH team manager.
n. Offering hours on weekends and bank holidays as required.
o. Review of Direction of Choice policy.
p. Integrated Care Coordinator worker at hospital.

4.3.2 **QEH**

a. The pathway for Norfolk First Response has been shortened so that therapists can book directly without a social work assessment.
b. More of the Assistant Practitioners are based in the hospital than previously thus assisting with team capacity within the hospital.
c. There is an additional Assistant Practitioner post in the Rapid

Assessment Team funded by the CCG, working with nurses and therapists in an integrated team whose role is to assess and send home people who come to the “front door” of the hospital, so they are not admitted. Social care skills and information have been useful to the team and have enabled solutions for some people to be found that otherwise would not have been.

d. Offering hours on weekends and bank holidays as required.
e. A Saturday working pilot clearly linked in with the Rapid Assessment Team and the therapists.

4.3.3 **JPUH**

a. Direct referrals for care packages (non-complex) via Occupational Therapists to Norfolk First Support and Suffolk's Home First.
b. Ward attached Social Worker pilot on ward 4.
c. Daily Board Round attendance on 12 wards (some 8:30 am starts).
d. Commenced Flexible Working Policy (which allows for attendance at early morning board rounds).
e. Reduction in attendance at weekly Multi Disciplinary Team meetings in light of board rounds.
f. Norfolk and Suffolk case Monitoring system, including reinstatements of care/simple assessments.
g. Streamlined – Delayed Transfers Of Care meetings.
h. Continuing Health Care (CHC) check list consistently applied and timeframes for this reduced.
i. Networking between Business Support and Wards improved around information gathering prior to sending Section 2, i.e. CHC funded clients.
j. Early Intervention Team referral service expanded to incorporate Accident and Emergency plus Early Assessment Discharge Unit.
k. Pilot for referrals from fracture clinic.
l. Offering hours on weekends and bank holidays as required.

The representative from the JPUH also told us in February 2014 that the situation could be improved by creating a patient flow co-ordinator role to liaise between social services and mental health and a senior nurse was due to start in this role shortly.

4.4 **Norfolk First Response**

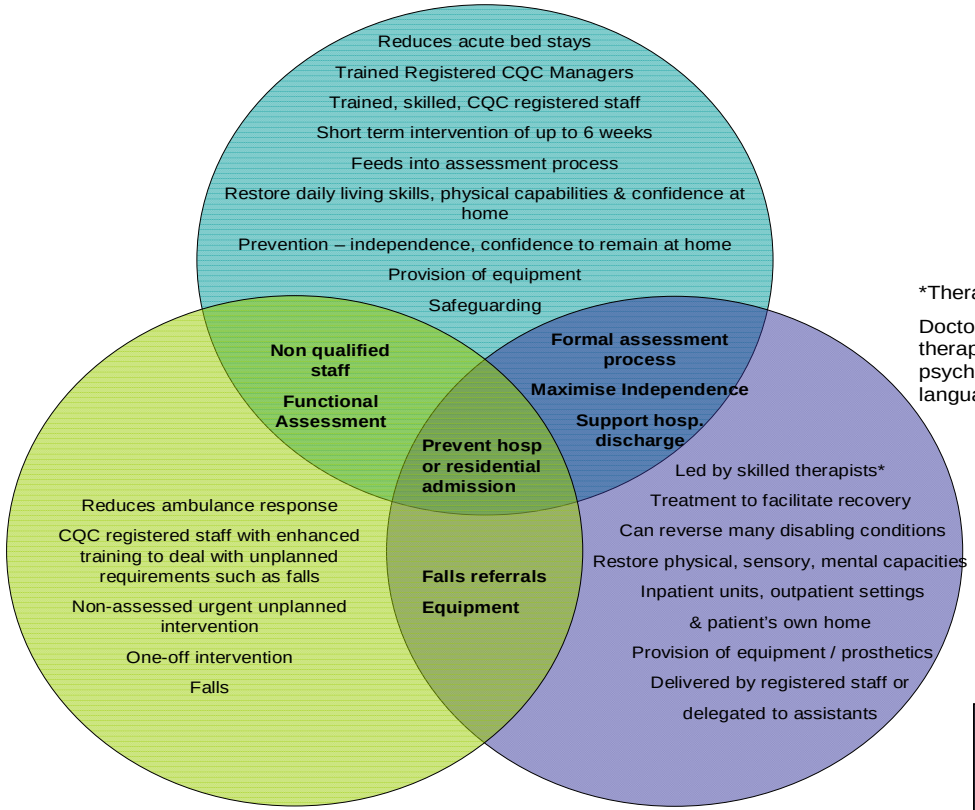
4.4.1 We met managers from Norfolk First Response, which incorporates two services:-

- Norfolk Swift Response (Swifts and Night Owls) – unplanned response service and admission avoidance
- Norfolk First Support – assessment and reablement service

The services were remodelled in April 2013 to work more effectively together and to provide planned and unplanned social care and assessment to people 24/7. It was hoped to integrate with community health services but no conclusions have been reached on how this should be done, whether by closer working, co-location or fully integrated teams. In the meantime Norfolk First Support has been designed and aligned geographically around the 19 Community Health provider hubs, which has enabled the service and staff to work in partnership with multi-disciplinary teams across health and social care whilst retaining close links with social work locality teams. The diagram overleaf illustrates how the health and social care rehabilitation, reablement and unplanned services relate to each other:-

Definition of Reablement, Unplanned and Rehabilitation needs

Reablement
Social Care Services



*Therapists:-

Doctors, nurses, Occupational therapists, physiotherapists, dieticians, psychologists, podiatrists, speech & language therapists, social workers

Unplanned
Health & Social Care
Crisis Support /
Rapid Response

Rehabilitation
Health Services

4.4.2 Norfolk Swift Response, the unplanned needs service, has been designed to provide support 24/7 across the County, co-locating with community nursing teams wherever possible. This allows for the most appropriate response to a person's initial crisis, preventing admission to hospital if appropriate. The service responds to urgent or unplanned needs which could range from a fall to providing support for up to 72 hours until an appropriate solution or resolution has been achieved to meet the person's needs. There is a single telephone number for the service and referrals are received from:-

- NHS 111
- Alarm providers
- Ambulance service
- Care agencies
- Community nurses
- GPs
- Integrated care co-ordinators
- Norfolk County Council staff
- Police
- Relatives and neighbours
- Self referrals

Norfolk Swift Response is a free service. Prior to 2013 it was funded in 6 month blocks, which made it difficult to promote as there could never be certainty that it would continue long enough to justify expenditure.

4.4.3 Since April 2013 Norfolk First Support, the assessment and reablement service, has been free for the first 6 weeks and people have not had to be FACs (Fair Access to Care Assessment) eligible at substantial or critical levels to qualify for it. This has, of course, increased the numbers who are able to access it. Referrals are accepted from the hospitals, ward staff, physiotherapists, community health staff and social care but not from the general public. The hospitals can refer people direct to the service without a social work assessment and people are discharged from hospital to their home setting.

Community nurses have provided some training to NFS staff to enable them to meet some health needs (e.g. applying dressings).

The decision to make Norfolk First Support more widely accessible followed a pilot at the NNUH which showed that the service could provide a saving of 3 acute bed days for non-complex discharges. As well as enabling swifter discharge the service also reduces dependency on longer term domiciliary care services. Between April 2013 and February 2014 the service estimates it has saved 6,624 bed days and £1,424,800 across Norfolk. The breakdown of savings

across the three acute hospitals is shown in the tables below:-

Norfolk & Norwich Hospital

Cost savings for NFS direct referral discharges from NNUH				
	Number of discharges	Bed days' saved per referral	Total 'bed days' saved	Total savings @ £200 per day
Service started on requested date	1477	3	4431	£886,200
Service started 1 day after requested date	10	2	20	£4,000
Service started 2 days after requested date	5	1	5	£1,000
Service started later than 2 days after requested date	9	0	0	£0
Total	1501		4456	£891,200

The Queen Elizabeth Hospital

Cost savings for NFS Direct referral discharges from QEH				
	Number of discharges	Bed days' saved per referral	Total 'bed days' saved	Total savings @ £200 per day
Service started on requested date	399	3	1161	£232,200
Service started 1 day after requested date	4	2	8	£1,600
Service started 2 days after requested date	1	1	1	£200
Service started later than 2 days after requested date	7	0	0	£0.00
Total	399		1170	£234,000

James Paget Hospital

Cost savings for NFS Direct referral discharges from JPH				
	Number of discharges	Bed days' saved per referral	Total 'bed days' saved	Total savings @ £200 per day
Service started on requested date	332	3	996	£199,200
Service started 1 day after requested date	1	2	2	£400
Service started 2 days after requested date	0	1	0	£0
Service started later than 2 days after requested date	11	0	0	£0
Total	344		998	£199,600

4.4.4 There are severe financial pressures on all County Council services, including social care. It was proposed in the 'Putting People First' consultation that the contribution from the CCGs for NFR services in 2015-16 should increase by £3 million to £4.3 million. If this funding is not forthcoming it has been proposed that the planned and unplanned element of NFR would become purely community resources, no

longer providing a service to the acute hospitals.

4.4.5 Social care representatives told us that the overall trend in referrals is upwards, taking the hospital social work teams and Norfolk First Response as a whole. More importantly, the cases are becoming more complex. There are a greater number of safeguarding referrals and those requiring a Mental Capacity assessment.

4.5 Winter pressure initiatives

4.5.1 Each of the three urgent care systems in Norfolk receive additional funding each year to help meet the extra demand that cold winter weather can bring. Earlier in 2013 there were concerns at national level about how the NHS would cope with demand in winter 2013-14. Different initiatives were put in place around the three acute hospitals in Norfolk. As it turned out, it was a relatively mild and uneventful winter in our part of the country.

4.5.2 Norwich CCG told us how the Project Domino Programme Board, with delegated authority from Central Norfolk Urgent Care Clinical Network, had agreed projects funded via winter pressure funding in 2013-14. The following projects were aimed at improving the flow of patients out of the NNUH:-

1. Placement without prejudice
2. Discharge facility
3. Home based therapy
4. Additional community beds
5. Norfolk first support
6. Discharge co-ordinators
7. Procured bed management

The projects experienced recruitment issues preventing them from achieving the scale of outcomes and benefits described in their business cases; however, as a group they did contribute to improved patient flow throughout the system.

Based upon the data available in March 2014, the following was achieved:

- The total number of patients discharged from the hospital increased by **1779** across January and February compared to the same period in 2013.
- The number of bed days lost to delays within NCH&C

community beds was **211** days less than predicted across January and February.

- The average length of stay within community hospitals reduced from the year average of 24 days to an average of **19.6 days** in February.

4.5.3 Across the county, we heard how winter pressures funding had been used to employ social workers to work at weekends. Representatives from the acute hospitals told us how useful this was and they felt that funding should be provided to employ social workers and occupational therapists 7 days a week all year round.

There were other examples of good use of winter pressures money, such as the 'virtual ward' in west Norfolk and rapid response teams in Great Yarmouth and Waveney and central Norfolk.

4.5.4 We learnt that the timing of the winter pressures allocations had been a problem this year. The funding handed down from national level to Clinical Commissioning Groups (CCGs) had arrived with just 1 month's notice of the amount that they could expect. They did not actually get the money until December, which meant there was very little time for the hospitals and other provider organisations to recruit staff and get services up and running.

The CCGs have been assured that they will receive notice of winter pressures funding much earlier in 2014 (June has been mentioned) so that appropriate planning is possible.

4.6 **Voluntary services**

4.6.1 We heard about the voluntary agencies that help people coming home from hospital. The British Red Cross and Age UK are very active in this field but there are a wide range of others that the hospitals can call upon from time to time (e.g. SSAFA (Soldiers and Sailors Families Association) / British Legion; Home Front).

4.6.2 We met a representative of the British Red Cross Support at Home service who works with the NNUH to facilitate discharges. The service receives funding from Norfolk County Council and its computers and phones are supplied by NNUH. 80% of referrals to the service come from Occupational Therapists.

4.6.3 Support at Home can help in cases where discharge is particularly difficult, e.g. where there are mental health problems, alcohol or drug abuse. It offers whatever help is needed, which may be befriending, or assistance with processes such as applying for housing and benefits, or picking up and delivering equipment etc. It also works with churches that provide pastoral care. The support lasts for six weeks during which time people are helped to rehabilitate and do

things for themselves.

4.6.4 Support at Home's aim is to move into admission prevention work, taking referrals from GPs and the police but that will require more resources.

5. What more could be done

5.1 During our discussions we asked the representatives from health, social care and the other organisations we met what they thought were the main sticking points in the system. We were particularly interested in areas that are not already being adequately addressed.

5.2. Facilities for people with mental health problems

5.2.1 From what we heard during our meetings, discharge of patients with mental health issues is a significant and growing problem and a lot more needs to be done to tackle it. The difficulties arise both with patients who have organic mental health problems (i.e. dementia) and those who have functional mental health problems (i.e. psychosis).

5.2.2 Discussions with the representatives from NSFT and the acute hospitals highlighted the following constraints:-

- There is a shortage of suitable accommodation for people with mental health problems.

- More residential services for short term rehabilitation of people with mental health problems are needed (i.e. enabling people to stay for periods of no more than 1 year).

- There is a difficulty for patients with dementia in accessing the right residential home to meet their needs or receiving the right levels of dementia care at home. Dementia provision needs to be looked at.

- The process for approving funding needs to be more streamlined between Norfolk County Council social care and NSFT. It would be particularly helpful if the process for funding short-term residential care or rehabilitation could be made quicker.

- Reliable access to social work practitioners on the older people's mental health wards would help. This has proved successful in the eastern locality where NSFT is currently funding a social worker, but NSFT says it cannot continue this funding.

- There is a need for a mechanism to assist with cases where there is a dispute with benefits. At present there is no mechanism for getting people out of hospital while an appeal is still ongoing.

5.2.3 There are some block booked beds available for the discharge of

people with mental health problems. The Mental Health Partnership has 14 beds in Norwich (Omnia run by MIND) and 7 in Great Yarmouth (Stepping Out) which can take placements for 12 weeks to 6 months. In the north and west of the county there are spot purchased beds only. More capacity is needed and work is ongoing to develop facilities in north and south Norfolk, including Diss, Thetford and Wymondham. Rehabilitation is offered in some supported housing in the west, north and east of the county.

On 8 July 2014 the Head of Service, Mental Health Partnership, provided information on the current cost of block purchased mental health rehabilitation beds as opposed to spot purchased beds:-

Block purchased = £742.22 per week (7 days)
Spot purchased = £586.56 per week (7 days)

NSFT confirmed that people from Norfolk are not sent to rehabilitation facilities out-of-county to facilitate discharge from hospital.

5.2.4 The difficulties of discharging people of no fixed abode also came up initially in our discussions about mental health. At the time we met NSFT there were 6 people of no fixed abode delayed in the mental health hospitals. Homeless people, whether with mental health problems or not, are particularly difficult to discharge safely.

5.3 **Facilities for bariatric patients**

5.3.1 The acute hospitals representatives highlighted the difficulties faced when placing bariatric patients in nursing or residential care homes. The QEH told us that there is only 1 home in its catchment area that can accommodate bariatric patients.

5.3.2 We are aware that reducing obesity is one of the three priorities in the Norfolk Health and Wellbeing Strategy 2014-17 and that all the relevant health and social care partners have signed up to the strategy. We think it is right to put effort and resources into reducing this problem but it is also clear that the commissioners of health and social care, and all the provider organisations, need to keep a close eye on the trend in obesity. If the initiatives to reverse the rising trend of obesity are not successful then more facilities for bariatric patients will need to be provided in the community and independent sectors, or there will be even longer delays in hospital for this group of patients in future. This applies to facilities for bariatric patients with or without dementia.

5.4 **Continuing Health Care Assessment**

5.4.1 The Community Care (Delayed Discharges etc.) Act 2003 addresses delay in assessment for or provision of social care but it does not cover delay caused by waiting for continuing health care assessment.

Continuing health care is provided for people who have an ongoing, potentially life-long, need for health care and it is an NHS responsibility. There are slightly different arrangements for the funding and delivery of continuing care assessments across the three hospitals. At the NNUH a hospital team carries out the assessments and paperwork is passed to the Commissioning Support Unit, which ratifies the assessment, assists with placements and takes the lead on any additional funding through the high cost panel. At the JPUH the assessment team is joint funded by the hospital and the CCG and the commissioners review the funding before placing the patient in an appropriate care environment. In the QEH the discharge planning team also does continuing health care assessments and then liaises with the Commissioning Support Unit similarly to the NNUH.

5.4.2 We are aware that continuing health care is a complex area but it strikes us that delays to patients in this situation are particularly unfortunate. It means that some of the most disabled patients are in the acute care setting, which is probably one of the least comfortable for them, for longer than they need to be.

5.4.3 Several of the health and care representatives told us about work to integrate health and social care assessments. We think that this should be given priority so that all patients receive timely assessment, whether for continuing health care, mental capacity or social care.

5.5 We also explored numerous areas where it was clear that substantial work had already been done:-

5.6 **Admission avoidance**

5.6.1 Several of the acute hospital and social care representatives that we met emphasised the importance of doing everything possible to safely prevent admissions to hospital. This has been and continues to be a priority area.

5.6.2 In central Norfolk, for instance, an Urgent Care Unit, was established at the NNUH to help manage minor illnesses and avoid admissions to hospital over the winter period. Between 20 January 2014 and 31 March 2014 1675 were seen by the primary care team in the UCU instead of A&E. 92.72% were successfully discharged home. The UCU also provided community support to A&E in the form of an Early Intervention Team (EIT) pathway which aimed to provide concurrent assessment within the A&E department to increase the number of successful discharges. Over the 3 months the team was able to discharge 303 people direct from A&E which was an increase of 86 discharges when compared with the previous EIT pathway.

5.6.3 One simple but effective measure put in place at the NNUH during winter 2013-14 was the provision of a Health Care Assistant with a car. People who arrived at A&E but on assessment were found to

have no immediate need for acute care could be transported and helped back into their home by the Health Care Assistant.

5.6.4 We heard that some of the most vulnerable people are admitted to hospital after 6.00pm, when other services to whom they are known are closed and there is therefore no practical alternative. If mental health and other services in the community were available for longer it could help keep vulnerable people out of hospital, which would be better for them and less costly overall.

5.6.5 It appears to us that there is merit in the idea of all the services (e.g. GP practices, care homes, hospitals, community health and social care services working together to identify vulnerable people as a focus for admission avoidance work. There could also be advance discharge planning for these individuals so that a plan is to hand in the event that they need to be admitted to hospital for unavoidable reasons. Effective arrangements for their discharge could then start to be made from day one of their stay in hospital.

5.6.6 The local plans for the Better Care Fund (paragraph 6) demonstrate that health and social care commissioners in Norfolk certainly intend to focus on preventing admissions where it can be safely done.

5.7 **Medicines to take out of hospital**

5.7.1 We were interested in the process of providing medicines for people to take out of hospital because some of us know from personal experience that it can be slow.

5.7.2 We were assured by all the NHS acute hospital and social care representatives that this process is not a significant contributor to delayed discharge. Any delays in medication to take out tend to be counted in hours, not in days.

5.7.3 They also assured us that processes in the hospitals are improving both in terms of getting prescriptions to the pharmacy sooner and in delivering the medicines to the patient more quickly so that they can leave earlier in the day. The NNUH told us about its new e-prescribing system which avoids the need for physical transfer of the prescription from ward to pharmacy. Medication can be ordered in advance of the day of discharge. In some cases it may be possible to start planning medicines to take out right at the start when the patient is admitted to hospital.

5.7.4 The fact that people often feel they are kept waiting around on the day of discharge, whether for medicines, transport or for other reasons, may be partly to do with communication. Patients may be told in the morning that they are going home but not told about all the processes that have to happen first and how long they are likely to take.

5.8 **Patient choice and financial considerations**

5.8.1 We explored the question of individuals who may be reluctant to leave hospital, or families who may want them to stay in as long as possible, because hospital care is free and they would have to pay for social care if they came out.

5.8.2 The health and social care representatives told us that this is not, on the whole, a major contributor to delayed discharge. The issue of people refusing to go, or exerting their right to choice over where they go to an unreasonable extent, is covered by a protocol called 'Direction of Choice' which is used in the hospitals. It involves issuing letters to the patient and involving them and their family in a case review. We were assured it is needed in only a very small percentage of cases.

5.9 **Readmissions**

5.9.1 Although our remit was to focus on the subject of *delayed* discharge, we were conscious that very few patients complain of being kept too long in hospital but some complain of being discharged too soon. We asked the hospital representatives about readmission rates, as these can indicate when people are discharged too soon. We were assured that readmission rates at Norfolk hospitals are not out of line with national averages. We learned that:-

- The NNUH is in the top decile of hospitals in England for low rates of readmission
- Readmission rates at the JPUH are marginally lower than the national average.
- In the first two months of operation of the virtual ward in west Norfolk 120 patients had been discharged with only 1 readmission.
- Last year NSFT readmitted 7% of patients within 30 days. The national average for mental health hospitals is 8%, with a variance between 4 and 15%.

6. Integration of Services and the Better Care Fund

6.1 At the start of our scrutiny we were aware that the Department of Health and the Department for Communities and Local Government had set out their expectations for health and social care services to deliver integrated services through a pooled budget agreement, the Better Care Fund (BCF). Nationally the figure for the BCF was set at £3.8 billion in 2015-16. It was to include limited new money, with the funding mainly being drawn from existing health and social care budgets:-

£1.1 billion existing transfer from health to social care
£130 million Carers' Breaks funding
£300 million Clinical Commissioning Group (CCG) re-ablement

funding
£350 million capital grant funding (including £220 million Disabled Facilities Grant)
£1.9 billion from NHS allocations

6.2 One of the national requirements for the BCF was that it achieves 7 day services to support timely discharges from hospital and prevent unnecessary admissions. The level of delayed discharges was to be one of the key performance indicators (KPIs) for the BCF and there was a possibility that an element of the funding would be held back if KPIs were not achieved.

6.3 The focus of the BCF was to strengthen community services, particularly for frail older people and people with long term conditions. Funding was to be top-sliced from CCG budgets and savings were expected to come from acute care. NHS England said that it expected a 15% reduction in acute hospital spending. Understandably, there were reservations about this in the acute hospital sector where finances are already under pressure. We were, however, pleased to note that both health and social care in Norfolk were approaching the BCF with a positive attitude and we got the impression that they were keen to make it work.

6.4 The Norfolk health and social care authorities agreed a BCF of £62,461,000 in 2015-16. They also agreed to use £5,644,000 in 2014-15 in transition to the BCF, which was more than they were actually required to commit for that year. The Norfolk Health and Wellbeing Board signed off the plan on 1 April 2014.

The Norfolk BCF plan directly supported discharge by:-

1. The provision of 7 day services to support effective discharge
2. Further integrating reablement services into the wider system
3. Strengthening of intermediate care and planning bed provision
4. Working with independent care services as part of the pathway
5. Working with voluntary and community services to support people most at risk.

6.5 There has been speculation in the national press that the launch of the BCF could be delayed because of concerns that across the country there is not enough detail in the plans to demonstrate how savings will be made. However, the commissioners in Norfolk have informed us that at the time of writing (5 June 2014) there is nothing to indicate a delay to starting the BCF from April 2015.

6.6 Whatever the national situation regarding the BCF, it was clear to us that the health and social care commissioners in Norfolk see integration and transformation of the services as a good way to meet growing demand and financial pressures. They have assured us that they will start to put their plans for further

integration into action during 2014-15 and that progress in this year is not dependent on the formal pooling of funds envisaged in the BCF. Much has already been done to integrate services by working jointly rather than merging organisations. Fully integrated budgets for stroke health and social care commissioning would be another step forward.

6.7 The health and social care systems around all three acute hospitals in Norfolk are committed to moving towards 7 day working. The Great Yarmouth area is one of the national early adopters for the Seven Day Services Transformational Improvement Programme, which should provide cost : benefit information on which others can draw.

We can see that it does not make sense for the acute hospitals to admit patients on 7 days a week and discharge only on 5 days. Going without the necessary social care, mental health and community support on two days a week is a recipe for delayed discharge.

We also recognise that moving to 7 day services is not easy and contract negotiations with staff are required. Norwich CCG is aiming for the necessary services to run between 8am and 8pm seven days a week, which would cover a very high proportion of demand.

6.8 Several of the health representatives we met emphasised that with the introduction of the Better Care Fund they would like to see a systematic reassessment and redesign of services across health and social care, so that the money is spent to the greatest possible effect.

6.9 'Systematic' is the key word. We agree that the BCF pooled fund, whenever it begins, should be spent on a coherent set of services that have been designed to meet the objectives. It should not be spent on a series of small unrelated projects in the different localities.

7. Conclusions

7.1 Firstly, we would like to acknowledge the dedication and professionalism of the health and social care teams across Norfolk who are constantly working to minimise delays in the system and to help people move to the right care setting after hospital. We also applaud the vast amount of work that has already been done to improve the flow of patients across the health and social care system, especially the new initiatives that were introduced in winter 2013-14.

7.2 There are three health systems operating within Norfolk based around the three acute hospitals and the CCGs who commission them; central around the NNUH (Norwich, North Norfolk and South Norfolk CCG), east around the JPUH (Great Yarmouth and Waveney CCG)

and west around the QEH (West Norfolk CCG). There is a single social care authority, a single mental health provider, two NHS community care providers, seven district housing authorities and numerous voluntary agencies. All of these separate organisations have a vital or important role to play in the flow of patients. It is essential for them to work together and put the interests of the whole system above individual organisational interests. We also think that it is important for the three systems to share their innovations with each other and encourage best practice right across Norfolk.

7.3 Severe financial constraints on the County Council and, to a lesser extent, on the NHS mean that new ways of working have to be found. The Better Care Fund is the latest vehicle for making change happen and we welcome the fact that health and social care intend to further integrating services in 2014-15 in advance of the formal establishment of the BCF in April 2015.

7.4 We think that the principle behind the Better Care Fund is sound. Unplanned acute care is by far the most expensive and the need for it has to be reduced. The best way to do that is to put more funding into redesigned preventative services, community health, mental health and social care services to keep people safe and well at home. There will be no additional money in the foreseeable future, so the whole system has to become more efficient and the available funding has to be focused more on prevention and health and social care in the community.

7.5 It is not clear to us how NHS community services and the County Council's Norfolk First Response service fit together. We also have some concerns that the police appear to be more heavily involved in first response to people with mental health problems than is perhaps appropriate. It does appear that there is room for rationalisation of services. Traditional health and social care roles need to change so that services such as assessment and support after discharge from hospital can be delivered seamlessly. We appreciate that redesigning the workforce is not an easy process and that change to front line services for vulnerable people needs to be handled extremely carefully. We know there is a good relationship between health and social care services in Norfolk and we hope that further integration both in hospital and in the community will be achieved.

7.6 We know that the NHS is already considering how to increase diagnostic and clinical decision making capabilities in the community and we were very interested in the idea of acute sector geriatricians providing out-reach support in community settings. We were equally interested in the idea that the community has much to teach the acute sector in terms of the level of risk that can be successfully managed outside of hospital. Job shadowing or rotation of staff between the community and acute settings, and into mental health settings, could foster a better understanding of each other's roles and what could be

achieved across the system as a whole.

7.7 As we do not have completely integrated systems in Norfolk, good co-ordination of discharges across the multi-disciplinary teams remains vital. We would encourage health and social care to make sure that in each situation there is one named co-ordinator who is clearly in charge of the discharge process.

7.8 We were encouraged to hear about voluntary sector involvement in resolving cases of delayed discharge and we know that commissioners intend to consider the role of voluntary services in the system redesign process.

7.9 Discharge of patients with mental health problems strikes us as the area most urgently in need of the commissioners' attention. More residential / nursing home accommodation for people with dementia and more short term supported accommodation for people leaving hospital with other mental health problems is required. Norfolk has an ageing population and the numbers of people with dementia are certain to grow. We know that commissioners are already well aware of the situation and would urge them to invest in services to cater for people with dementia in the community. Commissioners may also wish to consider connections between additional short term supported accommodation and other initiatives, such as care farming, for people with mental health problems. This could improve the well-being and safeguarding of service users as well as increasing local jobs and infrastructure.

NSFT has assured us that patients are never sent to rehabilitation facilities out of county in order to facilitate discharge from hospitals in Norfolk. We understand that patients in need acute psychiatric care are sometimes place outside of the county if local beds are not available.

7.10 We were very interested in the work that has already been done to identify patients with complex needs where it could be predicted that admission to hospital would end in a delayed discharge. It makes sense to target these people with the health and social care support to avoid admission to hospital unless it is clinically necessary. GP practices, care homes, health and social care in the community and the hospitals themselves could identify such patients and work together to address their needs. We would like to see such practice develop across the county.

7.11 We were also interested in the work of early intervention teams and rapid action teams to help people avoid the need for admission to hospital. We were pleased to hear about the liaison between NHS 111 and these teams.

7.12 We were surprised that the NHS received its annual winter pressures

funding so late in 2013 and are reassured that the funding will be announced and made available to CCGs and providers much earlier this year. It is very important that the services get more planning time in order to realise the maximum benefit from the funding.

7.13 Several of the health representatives told us that it would be better if the measures put in place for winter pressures and at other pressure points during the year, e.g. seven day working for social care, could continue all year round. The idea of continuity appeals to us. The process of starting and stopping services must absorb some of the resources and it does not help communication between health and social care teams, with the wider health and social care system, or with the public. We would like to see initiatives that were successfully introduced in 2013-14 continue all year round, as part of a redesigned system within the available health and social care budgets.

7.14 We welcome the fact that Norfolk's planning for use of the Better Care Fund includes strengthened support for carers and improved access to flexible respite. Carers play a vital role both in avoiding admissions to hospital and in allowing people to be safely discharged. We hope that more support for carers will be available soon.

8. Recommendations

8.1 Delayed discharge / transfer of care is clearly a high priority subject for the health and social care services and much is already being done. There are just a few areas where we would like to make suggestions for additional action. Our recommendations are listed below.

Recommendation		To
1.	That the three acute hospitals and Norfolk County Council Adult Social Care adopt a standardised consistent method of recording delayed discharges from hospitals across the County.	NNUH JPUH QEH Norfolk County Council - Adult Social Care
2.	That the CCGs and Norfolk County Council Public Health produce a strategy for educating the public on the benefits of receiving health care at home rather than in hospital and include education about the use of NHS 111 and the 999 service.	CCGs Norfolk County Council - Public Health
3.	That the CCGs take the lead in working GPs, health and social care organisations to identify patients with particularly complex needs to: (a) target early intervention / preventative measures and support towards those people (b) put an individual discharge plan in place to be used in the event of hospital admission (c) ensure that the plan is available to those who will need to access it in the event of an emergency out of hours or within working hours (d) ensure that effective arrangements for discharge can start as soon as the patient is admitted.	CCGs
4.	That more accommodation suitable for people with mental health needs is commissioned to enable speedier discharge of patients with dementia and with functional mental health conditions and that commissioners consider connections between this accommodation and other initiatives for people with mental health problems, such as care farming, to improve the well-being and safeguarding of service users and to increase local jobs and infrastructure.	CCGs Norfolk County Council - Adult Social Care

5.	That the redesign and integration of health and social care services and the other changes envisaged in the Better Care Fund planning should go ahead without delay.	CCGs Norfolk County Council – Adult Social Care
6.	That in each multi-disciplinary team situation health and social care should ensure there is always one named co-ordinator clearly in charge of the discharge process.	Acute hospitals (x 3) Norfolk County Council – Adult Social Care NCH&C ECCH NSFT
7.	That nursing and other relevant staff in community, acute and mental health settings rotate or undertake job shadowing to foster a better understanding of each other's roles and what could be achieved across the system as a whole.	Acute hospitals (x 3) NCH&C ECCH
8.	That the three health systems in Norfolk, which are based around the three acute hospitals working with social care, share their innovations with each other to encourage best practice right across Norfolk.	Acute hospitals (x3) Norfolk County Council – Adult Social Care

Terms of Reference

Norfolk County Council

Community Services Overview and Scrutiny Panel & Norfolk Health Overview and Scrutiny Committee

Terms of reference for scrutiny of

Delayed discharge from hospital in Norfolk

Scrutiny by

Joint task and finish group

Membership of joint task and finish group

8 County Councillors; 4 from Community Services Overview and Scrutiny Panel, 4 from Norfolk Health Overview and Scrutiny Committee (no requirement for the membership to be in line with the political balance of Norfolk County Council).

Healthwatch Norfolk to be invited to nominate a co-opted, non voting member.

The chairman of the task and finish group to be a member of either Community Services Overview and Scrutiny Panel or Norfolk Health Overview and Scrutiny Committee.

Reasons for scrutiny

On 28 November 2013 Norfolk Health Overview and Scrutiny Committee (NHOSC) heard that the level of delayed discharges from the Norfolk and Norwich hospital has been running at approximately 50 per day (80 on peak days, 35 on the lowest days). These are people who are medically fit to leave hospital but are delayed because of waiting for:-

- Assessment for NHS continuing health care
- A bed in an NHS community hospital where they will receive rehabilitative care
- Social services assessment

NHOSC also heard that a high priority for phase two of Project Domino (a project which has been working since November 2012 to improve the efficiency of the central Norfolk urgent care system) would be to reduce delayed transfers of care at the N&N.

NHOSC was aware that the numbers of delayed discharges at the N&N are no higher than last year but was also aware that all hospitals in Norfolk expect to face significant emergency pressures over the coming winter. Efficient flow of patients through the health and social system is therefore increasingly crucial.

NHOSC decided that it wished to scrutinise the issues around delayed discharges from hospitals across Norfolk, which encompass NHS services and social care services. The

scrutiny was scheduled for NHOSC's meeting on 27 February 2014.

On 10 September 2013 Community Services Overview and Scrutiny Panel asked for a report on discharges from acute hospitals. The report, to focus on the way that County Council social services work with NHS services to facilitate discharges from hospital, was scheduled for 4 March 2014.

Following an Overview and Scrutiny Strategy Group meeting on 3 December 2013 the Chairmen of NHOSC and Community Services OSP agreed to suggest that a single, joint task and finish group of members from the committee and the panel should scrutinise the subject.

Purpose and objectives of study

The Task and Finish Group's objectives will be:-

- To examine the current situation regarding delayed discharges from the acute, mental health and community hospitals in Norfolk.
- To examine the work underway to improve the flow of patients from the hospitals.
- To make recommendations, if appropriate, about how the situation might be improved.

Issues and questions to be addressed

- Is the funding which has been transferred from the NHS to adult social care (approx £15 million in Norfolk in 2013/14) helping to facilitate discharges from hospital?
- What more could be done on integration of health services and / or health and social care services that would help to address issues surrounding delayed discharges from hospital.
- What planning is underway for use of Norfolk's share of the national £3.8bn integration transformation fund? (This fund will be available in 2015-16 for joint NHS/local authority commissioning of integrated health and social care services. About £2bn of the national pot will come from the budgets of NHS clinical commissioning groups, which are spent mainly on acute hospital services).
- Is 7 day working a practical prospect for health and social care services?
- To what extent does delayed discharge from mental health beds affect discharge from the acute hospitals?

People to speak to

- Norfolk County Council Community Services
- Norfolk and Norwich Hospitals NHS Foundation Trust
- The Queen Elizabeth NHS Foundation Trust
- James Paget University Hospitals NHS Foundation Trust
- Norfolk and Suffolk NHS Foundation Trust
- Norfolk Community Health and Care (community hospital provider)
- Norwich CCG (leading on Project Domino)
- West Norfolk CCG

- Great Yarmouth and Waveney CCG

Style and approach

Panel-style meetings to receive reports and to discuss the issues with NHS and social care representatives.

Planned outcomes

A report to both Norfolk Health Overview and Scrutiny Committee and Community Services Overview and Scrutiny Panel outlining the current situation, planned improvements and any recommendations that task and finish group may wish to make.

Deadlines and timetable

The County Council has decided to cease operating an executive/scrutiny model and implement a committee system of governance with effect from the AGM in May 2014. This task and finish group is therefore expected to report back to Community Services OSP in April (*meeting date to be agreed)* and to NHOSC on 17 April 2014. If this is not possible due to availability of witnesses and / or members, the group may report back as appropriate within the County Council's new governance structure later in the year.

The timetable will be determined by availability of Members and witnesses. The aim will be to complete the work within two meetings (potentially on 3/2/14 pm and 6/3/14 am).

Terms of reference agreed by	**Date**
Community Services Overview and Scrutiny Panel	7 January 2014
Norfolk Health Overview and Scrutiny Committee	16 January 2014

Appendix 2

Information received by Delayed Discharge from Hospital in Norfolk Scrutiny Task & Finish Group

1. ‘Working with Health to Improve Discharge from Hospital’ – briefing paper by Director of Community Services – received 3 February 2014

2. ‘Evidence summary, Making best use of the Better Care Fund, Spending to save?’ – The King’s Fund, January 2014, Laura Bennett and Richard Humphries

3. Hospital delayed discharge – information received on 6 March 2014
   NNUH
   JPUH
   QEH

4. Delayed discharge from community hospitals – information received from NCH&C 6 March 2014

5. Monthly Delayed Transfer of Care SitReps – definitions and guidance, version 1.07 – received 6 March 2014

6. Delayed discharge and mental health – information received from NSFT on 6 March 2014

7. Direction of Choice flow chart – received 6 March 2014

8. Numbers, locations and occupation rates of planning beds – received 6 March 2014

9. Details of voluntary groups involved in discharge processes – received 6 March 2014

10. ‘Implications of the Better Care Fund for delayed discharge from hospital’ – report by the Director of Integrated Commissioning – received 9 April 2014

11. ‘Domino 2 update’ – report by Norwich CCG, received on 9 April 2014

12. Norfolk First Response – information briefing from the County Managers, received on 9 April 2014

13. ‘Hospital discharge: the patient, carer and doctor perspective’ January 2014 – BMA Patient Liaison Group

14. Delays at the JPUH August 2013 – May 2014, broken down by county and cause of delay (NHS or joint NHS and social care)

15. Minutes of task & finish group meetings:-

    3 February 2014

6 March 2014
9 April 2014
29 May 2014

Norfolk Health Overview and Scrutiny Committee appointments

Report by Maureen Orr, Scrutiny Support Manager (Health)

The Committee is asked to appoint Members to joint committees and other roles.

1. Appointments

1.1 The following lists show the roles to which NHOSC makes appointments, the names of members who currently serve in these roles and the vacancies that exist.

1.2 **Clinical Commissioning Group links** (1 for each CCG)
Link members are nominated to attend CCG meetings held in public in the same way as a member of the public might attend. Their role is to observe the CCG meetings, keep abreast of developments in the CCGs area and alert NHOSC to any issues that may require the committee's attention.

The nominated member or a nominated substitute may attend in the capacity of NHOSC link member. It is not essential for NHOSC to nominate substitute CCG links but it may nominate substitutes if it wishes. The CCG meetings are open to the public and other members may therefore attend as members of the public if they wish.

North Norfolk CCG
NHOSC link
Mr J Bracey

South Norfolk CCG
NHOSC link
Dr N Legg
(Substitute – Mr R Kybird)

Great Yarmouth and Waveney CCG (meets monthly at Beccles)
NHOSC link
Vacancy

West Norfolk CCG
NHOSC link
Mr M Chenery of Horsbrugh

Norwich CCG
NHOSC link
Vacancy

(Substitute – Mrs M Somerville)

1.3 **Provider Trust links**

James Paget University Hospitals NHS Foundation Trust – Board of Directors meets monthly and Governors Council meets every other month at the hospital
NHOSC link
Mr C Aldred

Norfolk Community Health and Care NHS Trust
NHOSC link
Mrs J Chamberlin
(Substitute – Mrs M Somerville)

Norfolk and Norwich University Hospitals NHS Foundation Trust
NHOSC link
Dr N Legg
Mrs M Somerville

Norfolk and Suffolk NHS Foundation Trust
NHOSC link
Michael Chenery of Horsbrugh

The Queen Elizabeth Hospital NHS Foundation Trust
NHOSC link
Mrs A Claussen Reynolds

1.4 **Great Yarmouth and Waveney Joint Health Scrutiny Committee**
Meets quarterly. Nominations are not required to be in line with the political balance of Norfolk County Council. Other members of NHOSC can substitute for the joint committee members as and when required.

NHOSC appointees (3)
(nominated at NHOSC on 29 May 2014)
Mr M Carttiss
Mr C Aldred
Mrs S Weymouth

2. Follow-up to the Liver Re-section Services Joint Scrutiny Committee

2.1 The Liver Re-section Services Joint Scrutiny Committee was established in 2013 by NHOSC, Suffolk Health Scrutiny Committee and Cambridgeshire Adults Wellbeing and Health Overview and Scrutiny Committee on a task and finish basis. Its task was to receive and scrutinise proposals for reconfiguration of liver re-section services in the three counties and make recommendations to NHS England.

2.2 This was completed by December 2013 but as one of the joint committee's recommendations was not accepted the joint committee entered into a local resolution process with NHS England, in line with the Local Authority (Public Health, Health and Wellbeing Boards and

Health Scrutiny) Regulations 2013. Agreement was reached on 2 April 2014, which was the end point for the formally constituted joint committee.

2.3 Part of the resolution was that the members of the former joint committee would meet again with NHS England, representatives from Cambridge University Hospitals NHS Foundation Trust and any other appropriate stakeholders to discuss the implementation of the reconfiguration plan.

The meeting will be arranged at an appropriate stage and members of the former joint committee will be invited to attend. The intention is that they will meet with the NHS representatives on the basis of a scrutiny working group, with members from Cambridgeshire, Suffolk and Norfolk reporting back to their respective health scrutiny committees on NHS England and Cambridgeshire University Hospitals NHS Foundation Trust's progress with the reconfiguration. The Norfolk members concerned are:-

Michael Chenery of Horsbrugh
Miss Alexandra Kemp
Mrs Margaret Somerville
(Substitute for all members:- Dr Nigel Legg)

3. Action

3.1 The Committee is asked to:-

(a) Nominate link members for Great Yarmouth and Waveney and Norwich CCGs.

(b) Confirm the continuation of the other CCG and provider trust link members in their roles or appoint different members (see paragraphs 1.3 and 1.4).

(c) Confirm that members of the former Liver Re-section Services Joint Scrutiny Committee (see paragraph 2.3) will attend a meeting regarding implementation of the liver re-section service, which will be their final duty in connection with the joint committee.

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

Norfolk Health Overview and Scrutiny Committee

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

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

Proposed Forward Work Programme 2014

Meeting dates	*Briefings/Main scrutiny topic/initial review of topics/follow-ups*	*Administrative business*
4 Sept 2014	System-wide review of health services in west Norfolk – an update from West Norfolk CCG. Health and Wellbeing Strategy 2014-17 – a progress update from the Health and Wellbeing Board. Changes to Mental Health Services in West Norfolk – consultation by the CCG and Norfolk and Suffolk NHS Foundation Trust on potential closure of inpatient facilities Changes to mental health services in central Norfolk – an update on the implementation of the Norfolk and Suffolk NHS Foundation Trust Service Strategy 2012-16 in the central Norfolk locality. Policing and mental health – a briefing by Mr Stephen Bett, Police and Crime Commissioner for Norfolk.	
16 Oct 2014	Availability in the local NHS of NICE recommended treatments and drugs Stroke services in Norfolk – responses to the recommendations of the scrutiny task & finish group Delayed discharge from hospitals in Norfolk – responses to the recommendations of the scrutiny task & finish group NHS Complaints handling in Norfolk – to receive Healthwatch Norfolk's report.	*Dependent on NHOSC endorsement of task & finish group reports, 17/7/14*

27 Nov 2014		

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

Provisional dates for reports to the Committee 2014

NHOSC Scrutiny Task and Finish Groups

Task & finish group	Membership	Progress
Stroke Services in Norfolk	Cllr John Bracey Cllr Michael Chenery of Horsbrugh Cllr Nigel Legg Cllr Margaret Somerville (Chairman) Cllr Tony Wright Alex Stewart – Healthwatch Norfolk	The Group is on schedule to report back to NHOSC in July 2014.
Delayed discharge from hospital in Norfolk (joint task & finish group with Community Services OSP)	From NHOSC:- Cllr Michael Chenery of Horsbrugh Cllr Alexandra Kemp Cllr Nigel Legg Cllr Tony Wright From Community Services OSP:- Cllr Shelagh Gurney Cllr Brian Hannah Cllr Harry Humphrey Cllr Margaret Somerville	The Group is on schedule to report back to NHOSC in July 2014

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

Clinical Commissioning Groups

North Norfolk - Mr J Bracey

South Norfolk	-	Dr N Legg (substitute Mr R Kybird)
Gt Yarmouth and Waveney	-	***Vacancy***
West Norfolk	-	M Chenery of Horsbrugh
Norwich	-	***Vacancy***

NHS Provider Trusts

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

Norfolk Health Overview and Scrutiny Committee 17 July 2014
Glossary of Terms and Abbreviations

A&E	Accident and Emergency
AC	Audit compliance
AMH	Adult mental health
BASP	British Association of Stroke Physicians
BCF	Better Care Fund
CA	Case ascertainment
CCA	Continuing care assessment
CCG	Clinical Commissioning Group
CHC	Continuing Healthcare
CLAHRC	Collaboration for Leadership in Applied Health Research and Care
CLT	Community Link Team
CQC	Care Quality Commission
CT	Computerised tomography scan – uses x rays and a computer to make images of the inside of the body
DE	Dementia
DSA	Double staffed ambulance
DToC	Delayed Transfer of Care
EAAT	East Anglia Area Team (NHS England)
ECCH	East Coast Community Healthcare
EEAG	External Expert Advisory Group
EEAST	East of England Ambulance Service NHS Trust
EIT	Early Intervention Team
ESD	Early Supported Discharge
FACS	Fair Access to Care Services
FAST	Face Arm Speech Time (to call 999) – test for diagnosis of stroke
FTE	Full time equivalent
GP	General practitioner
HASU	Hyper acute stroke unit
HD	High dependency
HEOC	Health and Emergency Operations Centre (ambulance service)
HOSC (OSC)	Health Overview and Scrutiny Committee
HSC	Health Scrutiny Committee
JPUH	James Paget University Hospital
KPI	Key performance indicator
LDC	Local Dental Committee
LDN	Local Dental Network
LSU	Low secure unit

MDT	Multi Disciplinary Team (acute hospitals)
NCC	Norfolk County Council
NCH&C (NCHC)	Norfolk Community Health and Care NHS Trust
NFS	Norfolk First Support
NHOSC	Norfolk Health Overview and Scrutiny Committee
NHS	National Health Service
NNUH (N&N, NNUHFT)	Norfolk and Norwich University Hospitals NHS Foundation Trust
NIC	Norfolk Independent Care
NICE	National Institute for Health and Care Excellence
NSFT	Norfolk and Suffolk NHS Foundation Trust (the mental health trust)
OT	Occupational Therapist / Therapy
OSP	Overview and Scrutiny Panel
PCT	Primary Care Trust (abolished on 31 March 2013)
PPCI	Primary percutaneous coronary intervention
PRISMA	Preferred reporting items for systematic reviews and meta-analysis approach
PT	Physiotherapy
QEH	Queen Elizabeth Hospital, King's Lynn
QOF	Quality outcomes framework
RCP	Royal College of Physicians
RRV	Rapid response vehicle
SINAP	Stroke improvement national audit programme
SN	Standard nursing
SLT / SALT	Speech and language therapy
SSNAP	Sentinel Stroke National Audit Programme
SR	Standard residential
SS	Social services
SSAFA	Soldiers and Sailors Families Association
SU	Stroke unit
TC	Team centred
Thrombolysis	Breakdown of blood clots by pharmacological means
TIA	Transient ischaemic attack – a temporary inadequacy in blood circulation in part of the brain, usually caused by a tiny clot. Causes symptoms similar to a stroke.
UCU	Urgent Care Unit