Norfolk County Council

# Norfolk Health Overview and Scrutiny Committee

Date: **Thursday 12 May 2022**

Time: **10.00am**

Venue: **Council Chamber, County Hall, Martineau Lane, Norwich**

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

Members of the public or interested parties may, at the discretion of the Chair, speak for up to five minutes on a matter relating to the following agenda. A speaker will need to give written notice of their wish to speak to Committee Officer, Jonathan Hall (contact details below) by **no later than 5.00pm on Monday 9 May 2022**. Speaking will be for the purpose of providing the committee with additional information or a different perspective on an item on the agenda, not for the purposes of seeking information from NHS or other organisations that should more properly be pursued through other channels. Relevant NHS or other organisations represented at the meeting will be given an opportunity to respond but will be under no obligation to do so.

**Membership**

| MAIN MEMBER | SUBSTITUTE MEMBER | REPRESENTING |
|---|---|---|
| Cllr Daniel Candon | *Vacancy* | Great Yarmouth Borough Council |
| Cllr Penny Carpenter | Cllr Carl Annison / Cllr Michael Dalby / Cllr Chris Dawson / Cllr Lana Hempsall / Cllr Jane James | Norfolk County Council |
| Cllr Barry Duffin | Cllr Carl Annison / Cllr Michael Dalby / Cllr Chris Dawson / Cllr Lana Hempsall / Cllr Jane James | Norfolk County Council |
| Cllr Brenda Jones | Cllr Emma Corlett | Norfolk County Council |
| Cllr Alexandra Kemp | Cllr Michael de Whalley | Borough Council of King's Lynn and West Norfolk |
| Cllr Julian Kirk | Cllr Carl Annison / Cllr Michael Dalby / Cllr Chris Dawson / Cllr Lana Hempsall / Cllr Jane James | Norfolk County Council |
| Cllr Robert Kybird | Cllr Fabian Eagle | Breckland District Council |
| Cllr Nigel Legg | Cllr David Bills | South Norfolk District Council |
| Cllr Ian Stutely | Cllr Adam Giles | Norwich City Council |

| | | |
|---|---|---|
| Cllr Richard Price | Cllr Carl Annison / Cllr Michael Dalby / Cllr Chris Dawson / Cllr Lana Hempsall / Cllr Jane James | Norfolk County Council |
| Cllr Sue Prutton | Cllr Peter Bulman | Broadland District Council |
| Cllr Robert Savage | Cllr Carl Annison / Cllr Michael Dalby / Cllr Chris Dawson / Cllr Lana Hempsall / Cllr Jane James | Norfolk County Council |
| Cllr Lucy Shires | Cllr Tim Adams | Norfolk County Council |
| Cllr Emma Spagnola | Cllr Adam Varley | North Norfolk District Council |
| Cllr Alison Thomas | Cllr Carl Annison / Cllr Michael Dalby / Cllr Chris Dawson / Cllr Lana Hempsall / Cllr Jane James | Norfolk County Council |
| **CO-OPTED MEMBER** (non voting) | **CO-OPTED SUBSTITUTE MEMBER** (non voting) | **REPRESENTING** |
| Cllr Edward Back | Cllr Colin Hedgley / Cllr Jessica Fleming | Suffolk Health Scrutiny Committee |
| Cllr Keith Robinson | Cllr Jessica Fleming | Suffolk Health Scrutiny Committee |

**For further details and general enquiries about this Agenda please contact the Committee Officer:**
Jonathan Hall on 01603 679437
or email committees@norfolk.gov.uk

**Advice for members of the public:**
This meeting will be held in public and in person.
It will be live streamed on YouTube and, in view of Covid-19 guidelines, we would encourage members of the public to watch remotely by clicking on the following link: https://www.youtube.com/channel/UCdyUrFjYNPfPq5psa-LFIJA/videos?view=2&live_view=502which

However, if you wish to attend in person it would be most helpful if, on this occasion, you could indicate in advance that it is your intention to do so. This can be done by emailing committees@norfolk.gov.uk where we will ask you to provide your name, address and details of how we can contact you (in the event of a Covid-19 outbreak). Please note that public seating will be limited.

As you will be aware, the Government is moving away from COVID-19 restrictions and towards living with COVID-19, just as we live with other respiratory infections. To ensure that the meeting is safe we are asking everyone attending to practise good public health and safety behaviours (practising good hand and respiratory hygiene, including wearing face coverings in busy areas at times of high prevalence) and to stay at home when they need to (if they have tested positive for COVID 19; if they have symptoms of a respiratory infection; if they are a close contact of a positive COVID 19 case). This will help make the event safe for all

those attending and limit the transmission of respiratory infections including COVID-19.

# A g e n d a

**1. Election of Chairman**

The Chairman to be elected from the Norfolk County Councillors on the Committee.

**2. Election of Vice-Chairman**

The Vice-Chairman to be elected from the Norfolk District councillors on the Committee.

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

**4. Minutes**

To confirm the minutes of the meeting of the Norfolk Health Overview and Scrutiny Committee held on 10 March 2022. (Page 5)

**5. Members to declare any Interests**

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

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

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

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

- Your wellbeing or financial position, or
- that of your family or close friends
- Any body -
    - Exercising functions of a public nature.
    - Directed to charitable purposes; or

- One of whose principal purposes includes the influence of public opinion or policy (including any political party or trade union);
  Of which you are in a position of general control or management.

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

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

**7. Chair's announcements**

| | | | |
|---|---|---|---|
| **8.** | **10:10 – 11:00** | **The Queen Elizabeth Hospital NHS Foundation Trust – progress report** | (Page 15) |
| | **11:00 – 11:10** | **BREAK** | |
| **9.** | **11:10 – 11:55** | **Prison healthcare - access to physical and mental health services** | (Page 33) |
| **10.** | **11:55 – 12:00** | **Norfolk Health Overview and Scrutiny Committee appointments** | (Page 64) |
| **11.** | **12:00 – 12:05** | **Forward work programme** | (Page 66) |
| | | **Glossary of Terms and Abbreviations** | (Page 69) |

**Tom McCabe**
**Head of Paid Service**

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Date Agenda Published: 4 May 2022

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Norfolk County Council

**NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE**
**MINUTES OF THE MEETING HELD AT COUNTY HALL, NORWICH**
**on Thursday 10 March 2022**

**Present:**

| | |
|---|---|
| Cllr Alison Thomas (Chair) | Norfolk County Council |
| Cllr Daniel Candon | Great Yarmouth Borough Council |
| Cllr Penny Carpenter | Norfolk County Council |
| Cllr Brenda Jones | Norfolk County Council |
| Cllr Alexandra Kemp | Borough Council of King's Lynn and West Norfolk |
| Cllr Julian Kirk | Norfolk County Council |
| Cllr Robert Kybird | Breckland District Council |
| Cllr Nigel Legg (until 12 noon) | South Norfolk District Council |
| Cllr Lana Hempsall substitute for Cllr Richard Price | Norfolk County Council |
| Cllr Sue Prutton | Broadland District council |
| Cllr Ian Stutely | Norwich City Council |
| Cllr Emma Spagnola | North Norfolk District Council |

**Co-Opted Members**

| | |
|---|---|
| Cllr Edward Back | Suffolk Health Scrutiny Committee |

| **Also Present in person:** | |
|---|---|
| Cath Byford | Chief Nurse, Norfolk and Waveney CCG (All items) |
| Sadie Parker | Associate Director of Primary Care, Norfolk and Waveney CCG (All items) |
| Fiona Theadom | Interim Head of Primary Care Workforce & Training, Norfolk and Waveney CCG (All items) |
| Dr James Gair | GP and Clinical Advisor, Norfolk and Waveney CCG (Item 7) |
| Dr Jeanine Smirl | GP, CCG Clinical Advisor & Clinical Director of Norwich Primary Care Network, Norfolk and Waveney CCG (Item 7) |
| Maureen Orr | Democratic Support and Scrutiny Team Manager |
| Jonathan Hall | Committee Officer |
| **Present via video link** | |
| Jude Bowler | Interim Head of Commissioning Primary Care, NHS England & NHS Improvement, East of England (Item 6) |
| Ola Sijuwade | Contract Manager – Primary Care, NHS England & NHS Improvement, East of England (Item 6) |
| Paul Higham | Associate Director Primary Care Estates, Norfolk & Waveney CCG (Item 7) |
| Dr Tim Morton | Chair, Norfolk & Waveney Local Medical Committee (Item 7) |

| | |
|---|---|
| David Barter | Head of Commissioning, NHS England & NHS Improvement, East of England (Item 8) |
| Jessica Bendon | Senior Dental Contract Manager, NHS England & NHS Improvement, East of England (Item 8) |
| Tom Norfolk | Joint Chair also Lead Dental Practice Adviser NHS England & NHS Improvement, East of England & is a General Dental Practitioner (Item 8) |
| Suzanne Meredith | Deputy Director of Public Health, Norfolk County Council – Public Health (Item 8) |
| Judith Sharpe | Deputy Chief Executive, Healthwatch Norfolk (Item 8) |

**1. Apologies for Absence and details of substitutes**

**1.1** Apologies for absence were received from Cllr Barry Duffin, Cllr Robert Savage, Cllr Richard Price (substitute Cllr Lana Hempsall), Cllr Keith Robinson and his substitute Cllr Jessica Fleming and Cllr Lucy Shires and her substitute Cllr Tim Adams.

**2. Minutes**

The minutes of the previous meeting held on 4 November 2021 were confirmed by the Committee and signed by the Chair.

In response to item 7.4 of the minutes Cllr Ian Stutely read a statement (Appendix A) from Norwich City Council.

The Chair acknowledged the statement and suggested that housing was an item that the committee consider when considering its forward work programme.

**3. Declarations of Interest**

3.1 Cllr Penny Carpenter disclosed an other interest as a board member of the Norfolk Safeguarding Board (Item 9).

**4. Urgent Business**

**4.1** There were no items of urgent business.

**5. Chair's Announcements**

**5.1** The Chair had no announcements.

**6. Access to Local NHS Primary Care Services for Patients who are British Sign Language (BSL) Users**

**6.1** The Chair welcomed a BSL interpreter for this item. The Committee received a report from Maureen Orr, Democratic Support and Scrutiny Manager, which provided an update on progress with BSL interpreting services for primary care since July 2021. The committee had in July 2021 looked at the wider subject of access to local NHS primary care services for patients with sensory impairments' and it was agreed that today's meeting would focus entirely on the situation for deaf and impaired hearing patients which had been noted as a particular concern.

**6.2** NHS England, NHS Improvement (NHSE&I) and CCG had produced a joint report for the meeting. New contracts to provide interpreting and translation services for primary care in the region had started on 1st November 2021. The contract for

spoken languages went to DA Languages and the contract for non spoken languages (including BSL) went to Language Empire. In January 2022 the CCG acknowledged that the deaf Enhanced Support Service (DESS) arrangements NHSE&I had put in place with DA Languages were not meeting the needs of some deaf patients. This contract was withdrawn and a contract with Deaf Connexions to enable them to offer to facilitate appointment bookings between any of the four primary care services and Language Empire. Language Empire were also using Deaf Connexions interpreters for urgent requests when available and if sourcing an interpreter at short notice was not possible.

The Committee received evidence in person from representatives of Norfolk and Waveney CCG: Cath Byford, Chief Nurse, Sadie Parker, Associate Director of Primary Care and Fiona Theadom, Interim Head of Primary Care Workforce & Training and via video link from representatives of NHS England & NHS Improvement, East of England: Jude Bowler, Interim Head of Commissioning - Primary Care and Ola Sijuwade, Contract Manager – Primary Care.

**6.3** The reports submitted were taken as read and during the ensuing discussion the following points were noted:

- Positive feedback had been received about the new provider of services. GP practice staff were fully engaged and have been keen to put the BSL training into practice.
- Those cohorts that were not able or did not have access to use IT, provision had been made with Deaf Connections in conjunction with Language Empire to provide services.
- Training was a key element for GP practices and although initial training had rolled out, training was a constant priority to ensure everyone was upskilled and updated.
- Out of hours service provision was in the process of being formulated.
- Patient records did reflect that patients were deaf or hard of hearing and that adjustments to records needed to be made by the practice staff to ensure services were delivered. It was acknowledged that some practices did have some work to do around this issue.
- Feedback from patients concerning the service from Language Empire has been good and all standards and response times were being met.
- Due to GP practices using different IT systems it was not always a smooth transition from primary to secondary care for patients records and details. Secondary care providers did have access to GP records but needed to be logged in to the correct system to view.
- Engagement with the deaf community will continue to help shape and improve services in the future.
- Guidance from NHS England was due shortly and any recommendations arising could then be considered to improve services further.

The Chairman concluded the discussion by acknowledging:

- This had been a very pleasing report and progress had been noted. Previous concerns had been taken on board and actioned successfully, although there is still some work to do.
- The new service provider and contract arrangements should be allowed to bed in before any further monitoring and scrutiny by the committee takes place. Feedback from service users will help determine if and when this item will return to the agenda.

The Chairman thanked all those for attending both online and in person and to the BSL interpreter.

## 7. Access to GP primary care in Norfolk & Waveney

**7.1** The Committee received a briefing report by Maureen Orr, Democratic Support and Scrutiny Manager updating members on how GP primary care had coped during the pandemic and how moving forwards the model of provision compared to public wants and needs. Capacity issues around the current position and future needs were also provided. Previous reports since 2014-15 had reflected a shortage of GPs coupled with an increase in demand for services. Since 2015 initiatives to increase GP numbers and improve resilience of general practice by changing the model by which it provides care had been introduced. The establishment of Primary Care Networks in 2019-20 was one of the most significant steps towards change. The pandemic in 2020 did rapidly change the demand of services and methods of accessing.

Sadie Parker, Associate Director of Primary Care advised the committee that there had been an error in the report concerning a piece of data provided. The figure of 85% for face to face appointments achieved was the 2019/20 figure and the current figure was 70% which was around 10% higher than the national average. All other data in the report was accurate.

The Committee received evidence in person from representatives of Norfolk and Waveney CCG: Cath Byford, Chief Nurse, Sadie Parker, Associate Director of Primary Care and Fiona Theadom, Interim Head of Primary Care Workforce & Training, Dr James Gair GP and Clinical Advisor, Dr Jeanine Smirl GP and CCG clinical adviser and Clinical Director of Norwich Primary Care Network and via video link Paul Higham Associate Director Primary Care Estates. Also online representing Norfolk & Waveney Local Medical Committee was the Chair, Dr Tim Morton who is also a practising GP.

**7.2** The Committee received a suggested approach by Maureen Orr, Democratic Support and Scrutiny Manager, on how the Committee might like to examine the situation regarding the access of services at point 3.1 of the report.

**7.3** The following key points were noted during the discussion:

- The committee gave thanks to all those in Primary Care (PC) providing services throughout the Covid 19 Pandemic.
- Whilst Covid restrictions had been lifted generally in the community, NHS infection control measures meant that GP practices were far from being ‘back to normal’ and that care had to be taken still to protect vulnerable patients.
- Vulnerable patients need to feel confident to use GP services again on a face to face basis, so protection measures were essential.
- Primary Care was now provided as a mixed blend of Health Care professionals and that many patients issues could be resolved without having to see a GP.
- Infection control measures were also important to ensure the safety and operational capability of a GP practice. Most practices have small teams and the loss of just one staff member because of Covid created pressures and backlogs.
- There was much to be learnt from the enforced changes created by the pandemic and patients were appreciative of having the opportunity to consult with GPs via video links and phone calls rather than having to come into the surgery.

- A team had been established within the CCG to help maximise the opportunities to provide funding for new PC provision, although most capital funding was provided through developers. New PC provision was centred around priority and the capacity levels of local practices.
- There are 4 new plans in place to provide new PC provision across the county to reflect the growth in housing and to ease areas of pressure, however it was acknowledged that this new provision was not the complete answer to all the issues currently being faced but would ease pressure in the areas of most need.
- GP practices regularly undertook business planning to consider any new intake of patients such as a major housing development. The rate of occupation of new developments was gradual which helped the practices to cope and to plan.
- Some patients with learning difficulties had missed out on health checks during the pandemic, sometimes due to their reluctance to engage as vulnerable cohorts. However, it was expected that 75% of patients entitled to these health checks would received one in the current year and there was the ambition to ensure 100% next year. Many did not need face to face appointments to enable the checks to happen.
- The wellbeing and health of all practice staff was a key element to ensure retention and to aid recruitment, especially of GPs.
- There was a reluctance from medical students to train to become GPs as the training was long (5 years) and involved and there had been great pressure on primary care in recent years.
- Norfolk and Waveney had approximately 500 practising GPs which was not enough to meet demands.
- Medical schools across the country were over subscribed, in some cases many times over, and potentially those seeking a career in medicine often were looking at other sectors as they could not find training places.
- In Norfolk and Waveney 46 out of the 105 practices were training practices. Although GPs often decided to train in the area once qualified they tended to move away to other areas.
- It was thought the Central Government investment in primary care was required as 90% of all consultation that took place in the NHS was at primary care level, however only 10% of overall NHS spend was on primary care.
- The national backdrop of comment, galvanised sometimes by social media, around GP services and their staff was unacceptable and inaccurate and more needs to be done to ensure the general public are better informed.
- GPs and practice staff were unfortunately subject to abuse and unpleasant behaviour from a minority of the public, and this was having an effect, with staff leaving the sector which are then hard to replace.
- It was acknowledged that recruitment and retention of the workforce was challenging. Work was ongoing within the ICS to address the challenges. Additional roles had seen a £14m investment and this type of investment was essential in improving the health and wellbeing of staff to help with retention rates.
- The Chair committed to speaking with the Leader of the County Council on possible opportunities for the County and District Councils to support initiatives that encourage the public to treat front-line staff in healthcare, police and other public services with respect.
- Some GPs were forced to retire, as if they continued to work their pension and tax position become unfavourable. The committee had written to the Secretary of State regarding this issue before but the position was not changing. The committee agreed to write to local MPs about this issue.

- Inequalities in GP services were being addressed by a number of initiatives to concentrate priorities and resource to those most in need.
- A local Primary Care Network was to expand GP training as well as inviting medical students from the UEA to explore the possibilities within primary care. Fellowships were available to newly qualified GPs for 2 years so that they can establish areas of speciality such as alcohol and drug dependency.
- The ageing demographic of NHS staff was a concern for the country and work was ongoing to establish what effect this would have on the provision of future services
- There had been an investment of £14m in additional roles to support GP practices. These roles did not mean that GPs time was freed up but was a reflection of a changing model to provide primary care services.
- It was thought members could help by promoting a respect agenda within their own communities to help the wellbeing of staff working in GP practices.
- A briefing on 'workforce' scheduled for the April 2022 NHOSC Briefing would include assessment of whether the opening of new medical schools in England has had an impact on workforce levels in Norfolk & Waveney.

**7.5** The Chair thanked all those who had taken part in the discussion both online and in person.

The committee took a short break and reconvened at 11.54am

## 8.0 Access to NHS dentistry in Norfolk and Waveney

8.1 The Committee received a report by Maureen Orr, Democratic Support and Scrutiny Manager which updated members on progess regarding access to NHS dentistry across Norfolk & Waveney since September 2020. The report had been collated with input from NHSE&I, the Local Dental Network, Norfolk County Council Public Health, Healthwatch Norfolk and Local Dental Committee. Previously in September 2020, frustration had been expressed at the lack of dentists to treat NHS patients in Norfolk and Waveney and the Covid 19 pandemic had only exacerbated matters, although many of the issues pre dated that period. Progress had been described as slow and changes were needed at a national level to help support the strategy of improvement.

8.2 The Committee received evidence via video link from representatives of NHS England & NHS Improvement East of England, David Barter Head of commissioning and Jessica Bendon Senior Dental Contract Manager, from Local Dental Network (East of England) Tom Norfolk the Joint Chair, Norfolk County Council Public Health Suzanne Meredith, Deputy Director of Public Health and Judith Sharpe, Deputy Chief Executive of Healthwatch Norfolk.

8.3 The committee was advised that 60% of respondents who contact Healthwatch Norfolk over the past 3 months had done so because they were having difficulties accessing NHS dentistry services. The new NHS dentist practice opened at RAF Marham shortly before the start of the pandemic was already full and had a waiting list of 2000 patients. This demonstrated the need and demand which was across the county.

8.4 The Committee received a suggested approach by Maureen Orr, Democratic Support and Scrutiny Manager, on how the Committee might like to examine the situation regarding the access of services at point 3.1 of the report.

8.5 During discussion the following was noted:

- The situation across the county was dire with decay rates up and numbers of children seen by a dentist had halved from 55% to 24% .

- It was acknowledged that the pandemic did create capacity issues with additional infection control measures having to be taken because of the nature of the work and the ease with which this could spread Covid.
- Most infection controls were still in place for dental practices including reducing the numbers allowed to be in a waiting room before treatment.
- Routine check ups had ceased during the pandemic with the priority switching to urgent clinical need.
- Patients seeking treatment who are not with an NHS dentist will be triaged by calling NHS 111 who then allocate those most in need to a NHS dentist. However many patients in this situation found that practices prioritised their own regular patients lists.
- Recruiting new NHS dentists to rural and coastal areas was difficult across the country and Norfolk was not exceptional.
- The NHS contract for dentists was not structured well and it made it unattractive for dentists to treat NHS patients. It was acknowledged that central Government needs to address this issue.
- Brexit had created some issues with regard to numbers of dentists working in the NHS sector as the industry effectively closed down during the first lockdown with many international dentists preferring to be home to support their families during the uncertainly of the pandemic. Many of them had yet to return to the UK and it was felt that many will still not do so.
- A prevention strategy in place was thought to be part of the solution to meet the needs of the public by reducing demand. The two main issues to tackle were tooth decay and gum disease. Decay was created by eating sugars which could be reduced in diets. In addition, the fluoridation of the drinking water supply was also important as studies had shown that in places where fluoridation had taken place, decay rates had fallen.
- Support was required to influence local authorities to consider fluoridation and to bust the myths that surround this issue by educating the public.
- Patients with trauma needs, following an accident for example, were being triaged via 111 to a specialist care team which was provided by a few practices in the county and linked to the hospitals. This service is the first of its kind to be available in the country.
- The committee thought the inclusion of a dental school in Norfolk would help recruitment locally.
- To provide services such as root canal treatment the upskilling and training of local dentists would be required and support was in place to undertake this. Historically this type of treatment had been made available out of area but was increasingly more difficult to commission.
- It was standard practice to commission a new practice for a 3 to 5 years period but once established longer contracts were available. This shorter contract initially gave a practice and the NHS the ability to have break clause if service standards were not met or the provider no longer wish to supply. These contracts would then go back to the market for recommissioning.
- Standard procedure to award a commission of a new practice meant that the whole of the market had to be offered the opportunity. If after this process had taken place a provider had not been secured, commissioners could then follow a direct style of procurement where preferred suppliers could be awarded the contract. This meant that the 3 outstanding commissions in Norfolk & Suffolk would be selected that way as the open market process had not been successful.
- Only 14 practices in Norfolk had received funding from the central government grant of £5.7m for the East of England to provide additional

appointment times at weekends and in the evening during February and March 2022 to reduce waiting lists.

- The NHS contract requires more flexibility to make NHS work more attractive for dentists in the private sector.
- Concerns were raised about the inequalities around accessing services with those who struggled with IT or had no provision and also required phone services to access appointments. However it was acknowledged that the NHS 111 service was free.

The Chairman concluded the discussion by acknowledging:

- Data around the service was nearly 3 years old and needs updating.
- Recruitment to rural and coastal areas are more difficult and more needs to be done to help these locations.

The committee would write to the Secretary of State for Health regarding:-

- Need for a dental school in Norfolk and Waveney to address difficulty of recruiting to a rural area.
- Issues around fluoridation and the need for myth-busting.
- Recruitment and retention and the contract for dental services.

The Chair thanked all those joining online for the item.

**9. Forward Work Programme**

9.1 The Committee received a report from Maureen Orr, Democratic Support and Scrutiny Manager which set out the current forward work programme and briefing details that was agreed subject to the following:

9.2 The Committee **agreed** to the scope for the Cawston Park Hospital Safeguarding Adults Review – Scrutiny of local health and social care partners' joint progress to implement recommendations.

9.3 The Committee **agreed** additionally for the NHOSC Member Briefing:

- <u>April 2022</u> –
  Workforce data – staffing levels, clinical & admin, including current vacancy level' – to include assessment of whether the opening of 5 new medical schools in England have had an impact on workforce levels in Norfolk & Waveney.

9.4 The committee agreed to the forward work programme and in addition:

- <u>14 July 2022 agenda item</u>
  Annual physical health checks for people with learning disabilities - subject to be expanded to include checks for Looked After Children and people with serious mental illness.

9.5

- In addition the committee asked whether Norfolk County Council Public Health could provide annual information on the state of people's health in Norfolk for the committee via the NHOSC Briefing. Any issues arising from that could then be considered for the main scrutiny programme.
- Cllr Stutely requested:
  Information relating to the change to death rates and suicide rates within the drug and alcohol service user cohort since the change from the City Reach service to the Vulnerable Adults Primary Care Service (Norwich), and who monitors this data.
- A copy of the report on progress of the Vulnerable Adults Primary Care Service (Norwich) received by NHOSC in Sept 2021.

**Meeting concluded at 13:05**

Cllr Alison Thomas, Chair

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**HOSC meeting 10 March 2022**

Statement read by Cllr Ian Stutely on behalf of Norwich City Council

Under the Homelessness Reduction Act 2018 there's an obligation for the hospital to inform the LA in advance if a client can't return home (so is facing homelessness) via a 'Duty to Refer' and for the LA to provide advice and assistance.

Emergency banding would be awarded where the client meets the qualification criteria for Norwich Home Options (so not a homeowner, has a local connection, can manage a tenancy etc). These cases tend to be few and far between but where the criteria is met (e.g. a council tenant who can't return to their upstairs flat), we can generally house them very quickly.

The help we can give is dependent upon the individual's needs, their circumstances and, where appropriate, the availability of suitable accommodation.

I have noted there may be misunderstanding among practitioners of the limitations of what accommodation options LAs can provide.

Many of the clients being discharged from Hellesdon will have complex issues, risks, dependencies and vulnerabilities. A high percentage of such clients will not be ready to manage an independent tenancy and either have too high risks or would be unable to cope in temporary accommodation or a hostel. These clients fall between the lines of not being ill enough to need a hospital bed but not being well enough to cope with the unsupported accommodation that we, as a LA, could provide.

In Norwich (which experiences by far the highest volume of all hospital discharges), the only specialist mental health supported accommodation is provided by Evolve (evolveeastanglia.com). Spaces are limited and insufficient to meet demand. Previously, there was 'step down' accommodation in the grounds of Hellesdon hospital, where clients who no longer needed a ward bed but still needed a degree of residential support could be accommodated, pending their health improving to the point where a full discharge was appropriate. It's this lack of 'step-down' accommodation which is the single biggest cause of the issues highlighted. The need for more 'step-down' accommodation has been well known and widely discussed for years, therefore increasing that provision could have a significant and positive impact.

This County Council's 50% cut to the supporting people grant also had a significant negative impact on those who previously benefitted from supported accommodation.

However, I believe it is within the remit of this committee to recommend more step-down accommodation and reinstate fully funded tenancy supported services for vulnerable people. How can we take that forward please?

[ end ]

# The Queen Elizabeth Hospital NHS Foundation Trust – progress report

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

Examination of the Queen Elizabeth Hospital NHS Foundation Trust's (QEH) progress in response to Care Quality Commission (CQC) requirements since the hospital's last report to NHOSC in March 2021.

## 1.0 Purpose of today's meeting

1.1 The purpose of today's meeting is to examine the QEH's progress in addressing the issues raised by the 2019 CQC full inspection report, and subsequent inspections of specific services, alongside dealing with the demands of the Covid 19 pandemic.

1.2 The QEH was asked to provide detailed information for today's meeting on action to meet CQC requirements, current performance and the situation regarding building safety and bids for hospital re-build funding. All the information requested is included in the QEH's report at **Appendix A**.

Representatives from the QEH and the commissioners Norfolk and Waveney Clinical Commissioning Group (CCG) will attend to answer the committee's questions.

1.3 Since 2019 Healthwatch Norfolk (HWN) has been visiting wards at the QEH to gather information on patient experience as and when Covid restrictions allowed. Findings are available on Healthwatch Norfolk's website. In March 2022 HWN completed a project commissioned by QEH to gather feedback from public and patients within its catchment area (including parts of Cambridgeshire and Lincolnshire) regarding how they would like the QEH to communicate with them about general hospital news as well as their care.

A representative from HWN will attend the meeting to speak about the findings.

## 2.0 Background

### 2.1 CQC inspections

2.1.1 Representatives from the QEH last attended NHOSC on 18 March 2021 along with the service commissioners, Norfolk and Waveney Clinical Commissioning Group (CCG), to report on progress in response to CQC

requirements. The report and minutes of the meeting are available through the following link:- NHOSC 18 March 2021

At that stage the hospital remained in special measures (the Recovery Support Programme) where it had been since September 2018 although a limited, focused CQC inspection in September 2020 had found positive progress in various domains within the core services it looked at.

The QEH's report at Appendix A sets out the significant additional progress found by the CQC at its latest inspection in Dec 2021 / Jan 2022. The full CQC report on the latest inspection is available on the CQC website

2.1.3 The CQC assesses services within five domains, 'safe', 'effective', 'caring', 'responsive' and 'well-led'. Within the Medical Care service the rating for 'safe' went down from 'Good' to 'Requires Improvement'. This was the only down-grade within the services inspected in Dec 2021. Medical staff had not achieved 80% compliance for mandatory training. The pressures of the COVID-19 pandemic were a factor in this and the CQC noted there was an action plan to address the issue.

2.1.4 Overall the CQC gave the Trust four 'must do' actions:-

**Urgent and Emergency Care**

- The service must ensure that care and treatment are accessible at the time of need and referral to treatment times and waiting times are in line with national standards.

**Medical Care**

- The trust must ensure daily and weekly checks on resuscitation equipment is maintained in line with trust guidance
- The trust must ensure patient records are stored securely
- The trust must ensure medicines are stored and managed appropriately.

They also gave nine 'should do' actions relating to mandatory and safeguarding training, checks on specialist equipment, recording reasons for prescription of antibiotics, improving the physical environment, recruitment of medical staff, ensuring people can access the service when they need it and ensuring a dedicated pharmacist to support critical care.

2.2 **QEH estate**

2.2.1 The QEH building was constructed with extensive use of Reinforced Autoclaved Aerated Concrete (RAAC) planks (covering 79% of the hospital) which are now subject to risk of failure. On 18 March 2021 NHOSC heard details of the effect that ensuring safety was having on patients and staff, particularly in terms of closures of areas where props needed to be put up to

support the building. This had affected areas such as the intensive care unit, labour ward and paediatric ward and had resulted in cancelled operations.

The committee was aware that a further 8 hospitals were to be added to the 40 already selected for funding to build new or part new hospitals by 2030. The James Paget Hospital, which also has RAAC planks, was one of the 40.

NHOSC agreed to write to the Secretary of State for Health and Social Care and Norfolk MPs urging that the QEH be included in the programme. A copy of the letter to the Secretary of State is attached at **Appendix B**.

In September 2021 the QEH confirmed that it had submitted two expressions of interest to the Department of Health and Social Care, one for a single-phase full new build (the preferred option) and another for a multi-phase development.

The decision on the 8 further hospitals is expected to be announced after 5 May 2022.

2.2.2 Details of the action the QEH has taken to keep the hospital building safe are included in Appendix A.

**3.0 Suggested approach**

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

(a) What steps is the QEH taking to comply with the outstanding 'must do' and 'should do' actions required by the CQC?

(b) The pandemic increased waiting lists across the NHS. When does the QEH expect its referral to treatment and waiting times to be in line with national standards?

(c) At the time of the last report to NHOSC the QEH was looking to develop a school of nursing in partnership with the College of West Anglia. Recruitment to the Nursing Associate Programme was to start in quarter 4 of 2021/22. What progress has there been?

(d) In February 2020 NHOSC heard that the QEH had been identified as one of the least digitally mature healthcare organisations in England. What changes have there been?

(e) What progress has there been in working more closely with the other acute hospitals in Norfolk?

(f) What is the contingency plan to protect patient safety and services should the QEH not be successful in its bid for inclusion in the new hospital programme?

## 4.0 Action

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

| | |
|---|---|
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The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

## NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE

## REPORT FROM THE QUEEN ELIZABETH HOSPITAL KING'S LYNN NHS FOUNDATION TRUST

## FOR THE MEETING ON 12 MAY 2022

- **Action taken in line with CQC requirements since QEH representatives last attended NHOSC in March 2021**

The Trust has continued to demonstrate sustained progress against its 2021/22 Integrated Quality Improvement Plan (IQIP), approving the closure of (69%) of its actions by the end of March 2022. These improvement actions were a combination of CQC Section and Warning Notice conditions and 'must do' and 'should do' actions.

The Trust underwent an unannounced core service and Well-Led CQC inspection in December 2021 and January 2022, with the CQC publishing its inspection findings in February 2022. The CQC report, published in February 2022, confirmed that the Trust had demonstrated significant improvement in the core services inspected (Medicine, Urgent and Emergency Care and Critical Care), all of which were rated 'Good' alongside the Trust's rating for 'Well-Led.' The Trust also secured its first rating of 'Outstanding' for Well-Led for Critical Care.

The Trust is now rated 'Good' for Effective, Caring and Well-Led and its overall rating has improved from 'Inadequate' to 'Requires Improvement'. The Trust's rating of 'Requires Improvement' recognises that only three core services were inspected during this latest inspection, due to the ongoing COVID-19 pandemic and therefore reflects what was technically possible for this inspection.

| | 2019 | | | | | | 2020 | | | | | | 2022 | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Safe | Effective | Caring | Responsive | Well Led | Overall | Safe | Effective | Caring | Responsive | Well Led | Overall | Safe | Effective | Caring | Responsive | Well Led | Overall |
| Medicine | Inadequate →← July 2019 | Inadequate ↓ July 2019 | Requires Improvement →← July 2019 | Requires Improvement →← July 2019 | Inadequate →← July 2019 | Inadequate →← July 2019 | Good ↑↑ Dec 2020 | Requires Improvement ↑ Dec 2020 | Good ↑ Dec 2020 | Requires Improvement July 2019 | Requires Improvement ↑ Dec 2020 | Requires Improvement ↑ Dec 2020 | Requires Improvement ↓ Feb 2022 | Good ↑ Feb 2022 | Good →← Feb 2022 | Good ↑ Feb 2022 | Good ↑ Feb 2022 | Good ↑ Feb 2022 |
| Urgent & Emergency Care | Inadequate →← July 2019 | Inadequate ↓ July 2019 | Requires Improvement ↓ July 2019 | Requires Improvement →← July 2019 | Inadequate →← July 2019 | Inadequate →← July 2019 | Requires Improvement ↑ Dec 2020 | Requires Improvement ↑ Dec 2020 | Good ↑ Dec 2020 | Requires Improvement →← Dec 2020 | Requires Improvement ↑ Dec 2020 | Requires Improvement ↑ Dec 2020 | Good ↑ Feb 2022 | Good ↑ Feb 2022 | Not rated | Requires Improvement →← Feb 2022 | Good ↑ Feb 2022 | Good ↑ Feb 2022 |
| Critical Care | Good July 2015 | Good July 2015 | Good July 2015 | Good July 2015 | Good July 2015 | Good July 2015 | Good July 2015 | Good July 2015 | Good July 2015 | Good July 2015 | Good July 2015 | Good July 2015 | Good →← Feb 2022 | Good →← Feb 2022 | Good →← Feb 2022 | Good →← Feb 2022 | Outstanding ↑ Feb 2022 | Good →← Feb 2022 |

| Trust Overall Rating | Safe | Effective | Caring | Responsive | Well Led | Overall |
|---|---|---|---|---|---|---|
| 2022 CQC Report | Requires Improvement ↑ Feb 2022 | Good ↑↑ Feb 2022 | Good ↑ Feb 2022 | Requires Improvement →← Feb 2022 | Good ↑↑ Feb 2022 | Requires Improvement ↑ Feb 2022 |
| 2019 CQC Report | Inadequate →← July 2019 | Inadequate ↓ July 2019 | Requires Improvement ↓ July 2019 | Requires Improvement →← July 2019 | Inadequate →← July 2019 | Inadequate →← July 2019 |

Following this inspection, the QEH has formally exited the Recovery Support System (formerly known as 'Special Measures') following final approval from the national NHS England/Improvement team.

The Trust was one of the first in the country to be recommended to be lifted out of segment four of the System Oversight Framework (SOF) following the CQC inspection, with a letter confirming the Trust's transition to SOF 3, which means QEH no longer requires 'mandated intensive support' from its Regulator. The Trust's formal Exit meeting took place on 25 April 2022 with the regional and national NHE/I team.

In addition to the positive findings and re-rating by the CQC in February 2022, the CQC has in turn removed 18 of the 22, Section 31 conditions from the Trust's Certificate of Registration and all 16 of the remaining 29A Warning Notice conditions spanning the services of Maternity, Diagnostic Imaging and Medicine.

**Action still to be taken and the timeline for doing so**

The latest CQC report reflects how the organisation's leadership has strengthened and matured over the last two years in conjunction with robust governance and assurance processes, supporting long-term and sustained improvements. The Integrated Quality Improvement Plan has therefore evolved and become a 2022/23 Compliance Plan (IQIP), supporting broader, bespoke Trust Quality Improvement Plans, including Maternity, Radiology, Ophthalmology, Urgent and Emergency Care and Elective Recovery. The Compliance Plan incorporates the remaining 'open' Must and Should Do actions from the 2021/22 IQIP with the 13 new 'must' and 'should do' actions from the latest CQC Report, totalling 35 actions. This is in stark contrast to the original 206 actions from the 2020/21 IQIP.

The 2022/23 Executive-Led Compliance Plan and associated Quality Improvement Plans will be monitored monthly through the Trust's new and strengthened governance

arrangements which were launched in April 2022, with progress reported through to the Trust's Board Sub-Committees and the public Board of Directors meetings on a bi-monthly basis. All CQC actions have completion dates set between April 2022 to March 2023.

The Trust plans to apply for the lifting of 3 of the 4 remaining Section 31 conditions in May 2022.

In order to sustain and embed the clear progress that has been made over the last 2-3 years, the Trust is very clear where additional (yet lighter touch) support is required and the areas in which focus is needed. These areas include:

- Developing a substantive Quality Improvement Team and aiming for over 15% of our staff to have completed quality improvement training in 2022/23
- Further investment in digitising our hospital and providing good information/data
- Investment in a leadership development programme for our 'middle managers' - to be run by the King's Fund - to respond to the feedback from our CQC report and latest National Staff Survey results
- Improving organisational culture, recognising there is more work to do

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

- **Plans for catch-up during 2022 in elective surgery and other services where catch-up is necessary due to the impact of the pandemic**

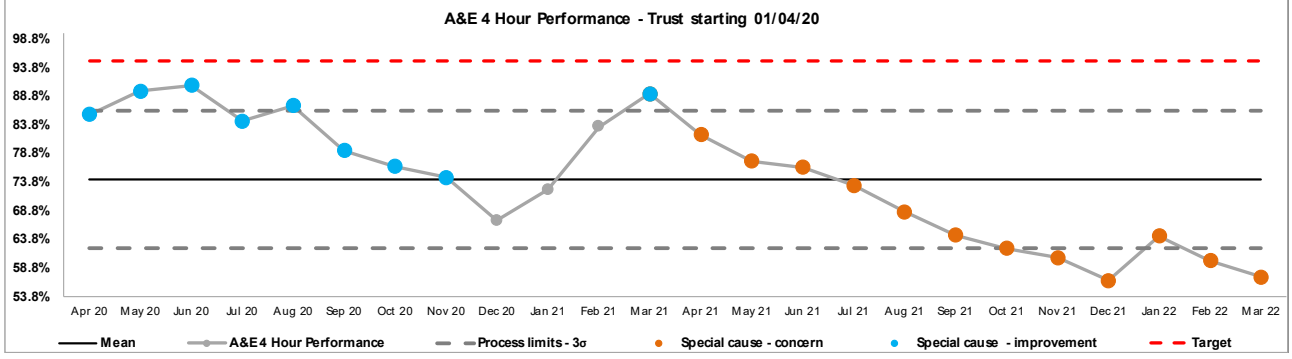
- **Progress on reducing ambulance turnaround times at the hospital**

## Urgent & Emergency Care

Key performance indicators for UEC performance are:

1. Emergency access within 4-hours

| Data To | KPI Description | Target | Current Value | Variance | Assurance | Variation Comment | Target Achievement |
|---|---|---|---|---|---|---|---|
| *Mar-22* | A&E 4 Hour Performance | 95.0% | 57.3% | L | F | Special cause (unexpected) variation - Concern (L) | Variation indicates consistently (F)alling short of the target |

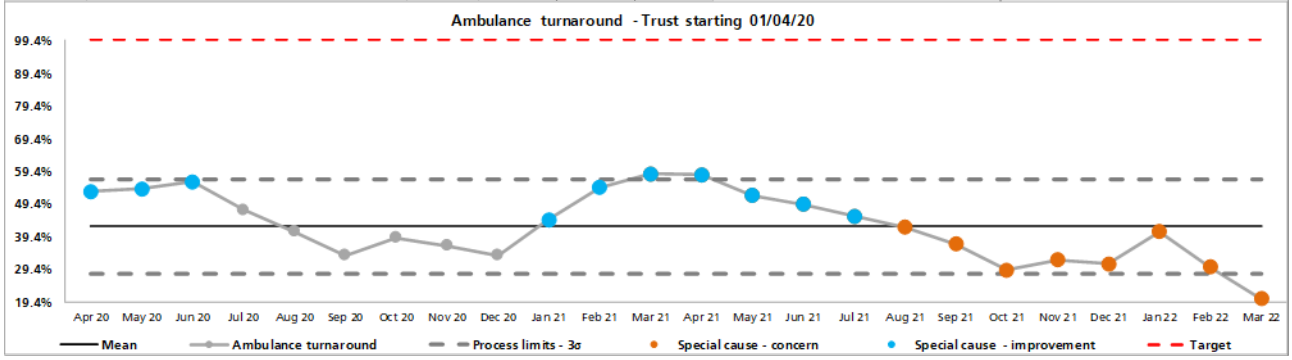


Performance summary:

In March 2022, 7,147 patients attended the Emergency Department (ED), of these 3,052 patients were in the department over four (4) hours before admission, discharge, or transfer. Overall performance was **57.3%** against a standard of 95%. Non-admitted performance was **74.1%** and admitted performance was **37.1%.**

2. Ambulance handover within 15 minutes of arrival

| Data To | KPI Description | Target | Current Value | Variance | Assurance | Variation Comment | Target Achievement |
|---|---|---|---|---|---|---|---|
| *Mar-22* | Ambulance Handovers | 100.0% | 20.4% | L | F | Special cause (unexpected) variation - Concern (L) | Variation indicates consistently (F)alling short of the target |




Performance summary:

In March 2022, there were 1,404 conveyances by EEAST to the Emergency Department.

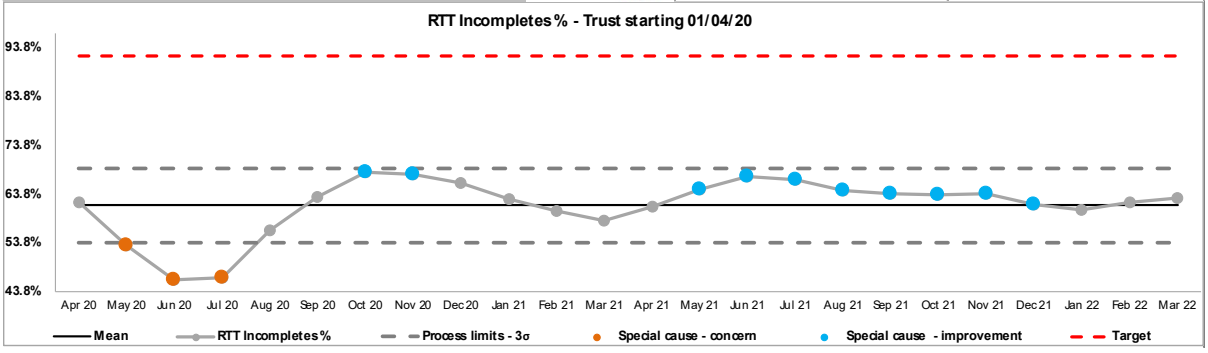
- **20.4%** of all handovers took place within 15 minutes
- **43.9%** of handovers too place within 30 minutes
- **56.3%** of handovers took place within 60 minutes
- **43.7%** of handovers took over 60 minutes

## Elective Care

Key performance indicators for Elective Care performance are:

1. 18 weeks referral to treatment

| Data To | KPI Description | Target | Current Value | Variance | Assurance | Variation Comment | Target Achievement |
|---|---|---|---|---|---|---|---|
| *Mar-22* | 18 Weeks RTT - Incomplete Perf | 92.0% | 62.8% | | F | Common Cause (expected) variation | Variation indicates consistently (F)alling short of the target |



Performance summary:

At the end of March 2022, there were a total of 19,609 patients on the waiting list, of which 7,279 had waited for over 18 weeks from referral, giving performance of 62.9% (unvalidated). The three specialties with the greatest number of patients waiting over 18 weeks were Orthopaedics (1,077), Ophthalmology (1,034) and Cardiology (930).

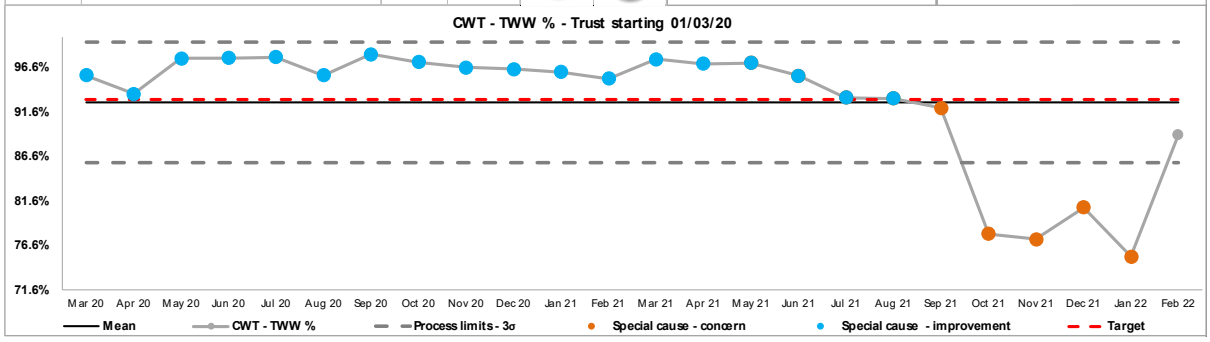
2. Breaches of 52 and 104 Weeks Wait

At the end of March 2022 646 patients were waiting longer than 52 weeks for treatment. The three specialties with the greatest number of patients waiting over 52 weeks are Gynaecology (215), Orthopaedics (219), and ENT (57).

The Trust delivered the national ask of zero patients waiting for treatment above 104 weeks by 31st March 2022, except for patient choice. Two patients expressed choice to wait longer, and both of these patients now have agreed treatment dates in April 2022.

3. Cancer waiting times – 2 week wait from urgent referral for suspected cancer to first outpatient attendance

| Data To | KPI Description | Target | Current Value | Variance | Assurance | Variation Comment | Target Achievement |
|---|---|---|---|---|---|---|---|
| *Feb-22* | Cancer Wait Times - Two Week Wait Performance | 93.0% | 89.0% | | | Common Cause (expected) variation | Variation indicates inconsistently passing and falling short of the target |

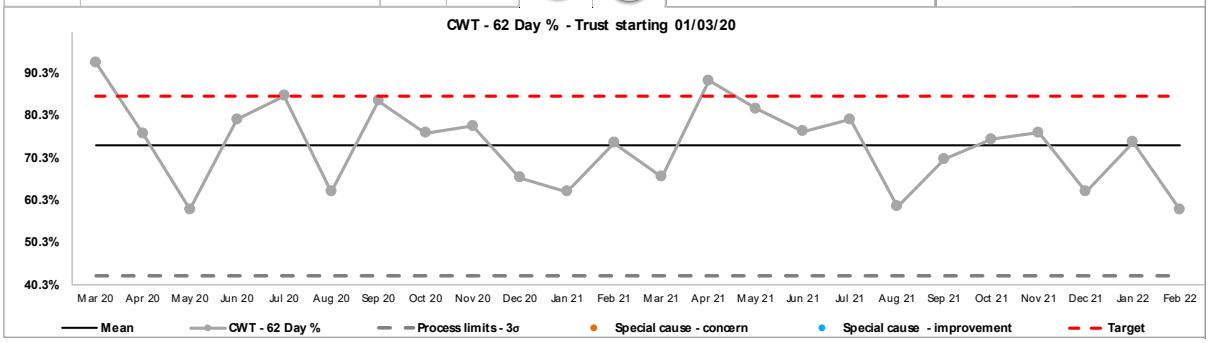



Performance summary:

Performance in February 2022 was 88.97% against the standard of 93%, Staffing shortages and an increase in referrals had resulted in delays. A remedial action plan is in place and the standard is on track for delivery from March 2022 (reported in May 2022).

4. Cancer waiting times – 62 day wait from referral for urgent referral for suspected cancer to the first definitive treatment (all cancers)

| Data To | KPI Description | Target | Current Value | Variance | Assurance | Variation Comment | Target Achievement |
|---|---|---|---|---|---|---|---|
| *Feb-22* | Cancer Wait Times - 62 Day Ref to Treatmemt Performance | 85.0% | 58.0% | | | Common Cause (expected) variation | Variation indicates inconsistently passing and falling short of the target |

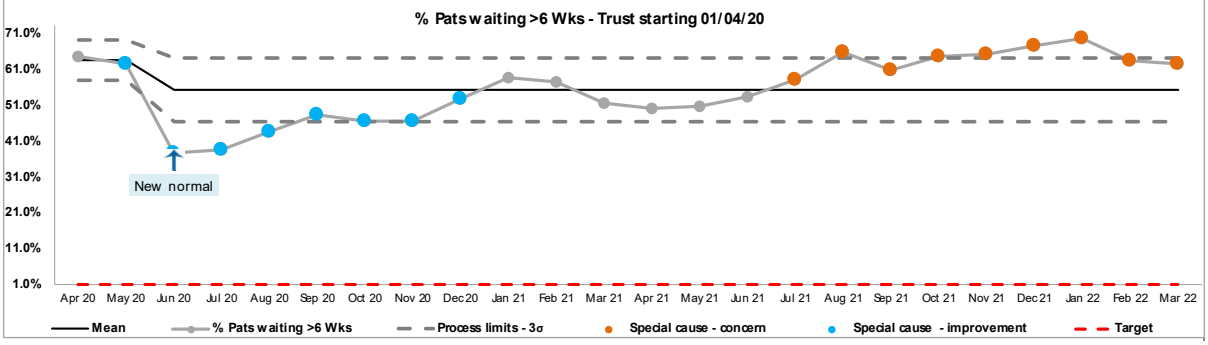



Performance summary:

Performance in February 2022 was 58.00% against the standard of 85%. There were 50 patients treated of which 21 patients breached the 62-day standard, (7 Colorectal 4 Haematology, 3 Head & Neck, 3 Skin, 2 Upper GI, 1 Gynaecology and 1 Lung).

5. Diagnostic waiting times

| Data To | KPI Description | Target | Current Value | Variance | Assurance | Variation Comment | Target Achievement |
|---|---|---|---|---|---|---|---|
| *Mar-22* | Diagnostic Wait Times - % of over 6 Week Waiters | 1.0% | 62.7% | H | F | Special cause (unexpected) variation - Concern (H) | Variation indicates consistently (F)alling short of the target |




Performance summary:

At the end of March 2022, there were 9,010 patients on the DM01 diagnostic waiting list, of which 5,650 had waited over 6 weeks from referral, giving a performance of 62.7% against the 1% standard.

## Quality and Safety

We have improved the timeliness of responses to complaints over the last year. We continue to focus on informal resolution of concerns raised by patients and their families where possible, on the quality of responses to complaints and on learning from complaints. We always offer a meeting to families if they would like to have one.

We introduced a team of Family Liaison Officers (FLOs) in response to feedback from patients and their families about how we could improve communication during this period when visiting has been restricted. This model has now been rolled-out

across Norfolk and Waveney such is its success, and the positive impact of FLOs was referenced in our latest CQC report.

We were one of the first hospitals in the country to complete a Duty of Candour exercise which involved contacting all patients or next of kin of those who contracted COVID in our care, so we could apologise for this and answer any questions. Following this 4-5 month exercise, we published a 'Learning from COVID' report, demonstrating our commitment to openness and transparency.

Mixed sex breaches are being closely monitored as there has been an increase due to the issues of managing the occupancy levels that the Trust has had and our COVID-19 rates.

Falls with harm rates are below that of the national rates, now sitting at 0.28% per 1,000 bed days, however, although the Trust has seen a reduction (0.36 in October 2021) there needs to be continued progress and this remains an area of focus. The rate is similar to neighbouring hospitals.

Dementia screening remains above 90% and has done since March 2021.

VTE screening remains above the 97.2% national threshold – where it has remained since May 2020.

**Finance**

Thanks to the efforts of our staff, QEH has achieved its financial plan and savings plan for the third year running. We were also one of the very few Trusts nationally to continue our Cost Improvement Programme in 2021/22, achieving £6.3m in savings (£0.3m more than plan). The Trust reported a £58k surplus for 2021/22.

The Trust delivered a £44m capital programme in 2021/22, more capital than we have ever had in a single year, to digitise and modernise our hospital through a series of service improvements and to install steel and timber support props where needed to reduce the risk of plank failures in the roof of the buildings to maximise safety (see below for further information about RAAC and the Trust's response to manage and mitigate these risks). QEH has one of the highest capital to turnover ratios in the country, demonstrating both the urgent need for capital investment in our hospital and the confidence in our ability to deliver on the funding timescales required.

Our digital maturity has significantly improved over the last year with almost £6m invested in Electronic Prescribing, Single Sign On and a new Radiology Information System all of which are major steps in the digitisation of our hospital. In addition, the Board has approved £4m capital investment in an Electronic Observations system to bring further improvements to patient care and safety. Implementation of a System-wide Electronic Patient Record is being boosted with support from NHS England/Improvement's Transformation Team who will provide funding and support for the next stage of the digitisation journey.

QEH was awarded £12.9m revenue funding – the largest given to a Trust in the East of England to support elective restoration. This has supported important work to help reduce waiting lists, treat more patients and further improve patient experience.

- **The current situation with regard to staffing and action by the Trust to address shortfalls and relieve pressure as far as possible**

The Trust's main challenge in relation to staffing levels has been the high number of staff off sick due to COVID, with an average of 3.23% of staff absent for this reason in March 2022, and a sickness absence rate of 8.81% (versus our 4.5% target). Staff sickness is a challenge across the region and wider NHS, with absence rates in Norfolk and Waveney for health and social care currently ranging from 3-9+%, with QEH currently at circa 6% for April 2022.

The senior nursing team continue to monitor safe staffing levels three times per day and the Trust greatly appreciated the good will and flexibility of our staff to move to different ward areas to cover any particularly challenged areas of the hospital and to ensure safe staffing.

We continually monitor and respond to staff absences with a focus on ensuring we do all we can to keep our staff at work by promoting and supporting staff wellbeing as a priority. We have an active Occupational Health team supporting staff and their line managers, 20 mental health first aiders, dedicated clinical psychologists to support staff and a nationally-recognised menopause awareness and support programme for our staff. We have recently introduced a new range of benefits to support staff to stay well at work including a midnight café serving hot food through the night, discounted gym memberships which have proven extremely popular and we have extended free car parking for staff for a further year.

Vacancy rates remain below 10% with ongoing challenges with Allied Health Professions, who have a current vacancy rate of 12.9%. Monthly recruitment events are taking place.

Challenges recruiting in specialist areas are consistent with the national shortage of positions in the NHS, notably pharmacy and radiology. Bespoke approaches to recruitment are in place in these areas, and the prospect of system solutions with our neighbouring hospitals is being explored.

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

**RAAC update**

79% of the hospital buildings at QEH have RAAC planks that need monitoring and emergency repairs carried out on a rolling basis. The Trust's dedicated team of surveyors and technicians continue to survey the buildings and identify where failsafes are needed to reduce the risk of plank failures and maximise safety. To date, 99% of wall and 92% of roof plank surveys are complete and the final 8% of surveys are due to be completed by the end of May 2022.

With 1,528 steel and timber support props now in 56 areas of the hospital, QEH has almost three times more props than beds. The Trust is believed to be the most propped hospital in the country.

The number of support props has significantly increased in recent weeks following work to reduce the risk of plank failures and maximise safety. Failsafes are now in place in the gym, the large internal corridor that links the first floor with the ground floor of the hospital which is used as the evacuation route for the hospital in an emergency, the approach corridor of Necton Ward, the Neonatal Intensive Care Unit, the Maternity Bereavement Suite and Brancaster Ward.

QEH has a backlog maintenance challenge of £86m, and 80% of this encompasses high (£61m related to RAAC) or significant (£8m) risks. The Trust estimates it will cost £130m in total to keep the current hospital safe and compliant. The Trust has developed a RAAC business case for £90m for years 2-4 (the business case has been approved by the Trust's Board of Directors and is now with NHSE/I for approval), allowing year 2 of RAAC (£30m) to begin with a rolling programme of failsafes being installed across the first floor of the hospital (comprising 6 wards a year and our operating theatres) as we continue to address the challenges with RAAC. This investment is to maximise safety and does not create additional ward space or capacity.

Whilst installing failsafes minimises the risk of plank failures, it does not extend the life of the hospital. The Government is committed to eradicating RAAC in hospitals by 2035. Our deadline at QEH, based on national expert opinion is 2030, and the only sustainable long-term solution is a new hospital.

It is important we recognise that our poor physical estate has a detrimental impact on the confidence our patients have in our hospital and their care, on staff morale and their wellbeing (as evidenced in our latest National NHS Staff Survey results), on our ability to recruit and retain staff and increasingly on the operational running of the hospital.

**Bringing a new hospital to King's Lynn and West Norfolk**

We want to become the best rural District General Hospital for patient and staff experience and a new hospital is central to achieving this ambition. We have a strong and compelling case. It will cost £800m just to keep the doors of the current hospital open and continue with 'business as usual' until 2030 – almost the same cost as a brand new hospital.

The Trust is doing all it can to secure the funding it so badly needs to bring a new hospital to King's Lynn and West Norfolk. We have unanimous support from our health and care partners across Norfolk and Waveney, Lincolnshire and Cambridgeshire as well as our key partners and stakeholders, including NHOSC, that a new hospital is desperately needed and is the only long-term sustainable solution to the challenges we face.

In September 2021, we submitted two Expressions of Interest to the Department of Health and Social Care in a bid to be one of the Government's eight further new hospital schemes - one for a single-phase full new build (our preferred option) and one for a multi-phase build, part new build and part refurbishment. We submitted two options to give us the very best chance to secure the funding we badly need.

The Trust's Expressions of Interest have been reviewed and considered by the NHS regionally ahead of a decision nationally by the Department of Health and Social Care. We are waiting to find out if we have made the longlist and expect to find out soon – with a final decision on the further eight new hospital schemes is expected later in the year.

Work continues to complete our Strategic Outline Case (SOC) for a new hospital. This remains on track to be completed and considered by our Board in June 2022 this year as planned, which will mean the Trust is 'ready to go' pending an announcement about the eight further new hospital schemes.

- **Any other updates**

1. The Trust has published its Year 3 Corporate Strategy milestones for 2022/23. Among our top priorities for 2022/23 are:

- Ensuring our patients consistency receive timely care (urgent and emergency care, cancer and elective)
- Creating a Quality Improvement Team which will drive our continuous improvement, increase QI capabilities Trust-wide and further increasing capability across the organisation
- Further improving people's experience of working here by listening to and responding to staff feedback, with a specific focus on local and middle managers
- Embedding our new values of kindness, wellness and fairness
- Reducing sickness absence (recognising we are an outlier for this important indicator)
- Further modernising our estate, including maximising the safety of our current hospital and securing a new hospital
- Launching an integrated 3-year Digital and Data Strategy
- Achieving delivery of the Trust's financial plan and capital programme for 2022/23 and the delivery of the £8million Cost Improvement Programme (CIP) savings
- In collaboration with all local Partners, leading on the delivery of Place-Based Care for the benefit of our local population
- Implementing the agreed steps with the three acute Trusts within Norfolk and Waveney to deliver Acute Provider Collaboration

The Trust's full Corporate Strategy document is available on our website and progress against our quarterly milestones is routinely published and discussed at our public Board of Directors meetings.

The Trust would like to formally thank the Norfolk Health Overview and Scrutiny Committee, local councillors, MPs, Healthwatch and wider system partners and key stakeholders for their continued support, which has and continues to be central to our continuous improvement journey.

Norfolk County Council

**Norfolk Health Overview and Scrutiny Committee**
County Hall
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**Direct Dialling Number:** (01603) 228912
**Email:** committees@norfolk.gov.uk

The Rt Hon Matt Hancock MP
Secretary of State for Health and Social Care
Department of Health and Social Care

*Letter sent by email*

29 March 2021

Dear Mr Hancock

**The Queen Elizabeth Hospital, King's Lynn – building safety**

Representatives from the Queen Elizabeth Hospital NHS Foundation Trust (the QEH) attended Norfolk Health Overview and Scrutiny Committee on 18 March 2021. The QEH is a 41-year-old 'Best Buy' hospital constructed with extensive use of Reinforced Autoclaved Aerated Concrete (RAAC) planks (covering 79% of the hospital) which are now subject to risk of failure. We were shocked to learn the day-to-day realities of living with this situation.

There are daily checks of the integrity of the RAAC planks and at time of writing it has been necessary to install 131 props in 41 areas (spanning most areas of the hospital) supporting 90 deflected planks. In the last 10 weeks alone, 50 props have been put up in 16 different areas. They are in busy areas such as the Intensive Care Unit, the labour ward and the paediatric ward. Patients have to be evacuated to other areas until props are put in and then staff and patients, including children, have to work around them for the foreseeable future. It seems to us that this Trust is dealing with crisis on top of the pandemic crisis with no certainty of a proper solution to its totally inadequate estate. The latest closure of the Trust's Intensive Care Unit has had a significant impact on patients and staff, with the unit closed for two weeks while emergency repairs are carried out and these patients (the sickest in the hospital) cared for in theatre recovery and in one case, a neighbouring hospital some 40 miles away.

The Trust has cancelled 40 operations in the last week alone (including the operation of a patient on a cancer pathway) due to the closure of its Intensive Care Unit. There has also been an impact on the Trust's elective surgical programme, as the hospital has lost the opportunity to book around 100 additional patients, elective and day case as a result of the Intensive Care Unit closure.

Propping up the building and moving patients around to keep them safe from the risk of roof collapse has cost the Trust over £1million (of its own capital) over the last year, which includes spend on having a full-time team in place, surveying work and the necessary responses to ensure the safety of the hospital, including temporary props, expert structural engineering advice and the installation of temporary steelworks.

The Trust very much welcomes the £20.6million of national capital it has been awarded in the last week to fund the short-term fixes and improvements needed as surveys identify failings with the roof planks and rapid deterioration of the hospital's estate. It will improve safety in the years to come. What it will not do however, is replace the roof planks or extend the life of the hospital beyond 2030, and nor will this bring any of the many benefits that a new hospital will – including better patient and staff experience, more co-located services, digitisation of the hospital and the wider benefits for the health system and local economy. The Trust has bid for £165million of national capital over three years to help improve the safety of the estate in the short-term, and this included £45million in the first year (with £20.6milion awarded).

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

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

At the end of September 2020, the Trust submitted a compelling case for a new hospital as part of the NHS's response to the Comprehensive Spending Review. Disappointingly, the QEH was not on the list of 40 hospitals included in the £3.7billion building package announced on 2 October 2020. We know that there will be funding to build a further 8 new or part new hospitals by 2030 and that these will be announced in autumn 2021. We strongly urge that the QEH must be one of these 8.

Yours sincerely

Penny Carpenter, Chairman of Norfolk Health Overview and Scrutiny Committee

**Prison healthcare – access to physical and mental health services**

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

Examination of health services provided to prisoners at mainstream prisons in Norfolk.

## 1. Purpose of today's meeting

1.1 To follow up on issues discussed at Norfolk Health Overview and Scrutiny Committee (NHOSC) on 4 February 2021 when the committee first received a report from the commissioners, NHS England and NHS Improvement (NHSE&I).

1.2 NHSE&I commissions all health services for the prisons, including drug and alcohol services but excluding emergency and out-of-hours services, which are provided by the services the CCG commissions for the whole community including the prison population.

For today's meeting NHSE&I was asked to provide a report covering:-

(a) Performance information
    a. Health and Justice Indicators of Performance (HJIP) figures from Oct 2020 to latest available
    b. Recommended actions in relation to healthcare from recent inspection reports and action taken.
(b) Waiting times for access to:-
    a. Mental health services and IAPT (improving access to psychological therapies)
    b. Dental services.
(c) Staffing - current issues relating to staffing of specific healthcare services and action to address them.
(d) User feedback – complaints received and subject of complaints since the last report.
(e) Interpreting services – update on work to review need for interpreting services and accessibility of the services. (This relates to NHOSC's recommendation in Feb 2021, see paragraph 2.1.1 below).
(f) Reception and release arrangements – how are medical records accessed on reception and how are they passed on upon release? (i.e. the speed of communications with community primary care to ensure continuity of care).
(g) How is the sharing of health care information managed between Norfolk & Waveney primary care and prisons out of county when residents of Norfolk & Waveney are sent there (which includes all women prisoners from Norfolk

as there are no women's prisons in the county); both on arrival at prison and on release.

(h) What is the system to ensure continuity of health service treatment when prisoners are moved between prisons?

(i) What is the process for mental health risk assessment and check for learning disabilities / autism upon admission? (i.e. timing of the first and second assessment, the details that are checked at these times)?

(j) Are the mental health assessments that are offered conducted by an RMN mental health nurse rather than an RGN (Registered General Nurse), i.e. someone with the right qualifications and skills for the aspect of health that is being assessed.

(k) Is there a mechanism for prisons and the mental health, drug & alcohol and homelessness services in the community to share information regarding prisoners?

(l) Are Learning Disability nurses employed in any of the prisons? What adjustments are made to the provision of care for prisoners with a learning disability or autism?

NHSE&I's report is attached at **Appendix A** and a representative will attend the meeting to answer NHOSC's questions. NHSE&I is responsible for commissioning the services and for ensuring that providers deliver them in line with the contracts.

NHSE&I also provided an Excel workbook with a large amount of detailed HJIP performance indicator data as at 2021-22 Quarter 3 in each of the three prisons in Norfolk. The workbook is available on request from the Democratic Support and Scrutiny Manager at committees@norfolk.gov.uk. The HJIP year-to-date performance summary for each prison (April – December 2021) has been extracted and collated in the document attached at **Appendix A Annexe 1**.

1.3 The Deputy Governor of HMP/YOI Norwich will also attend the meeting.

Norwich is a reception prison where some prisoners may spend just a few nights after being sentenced and transported from court. They may then be relocated to another prison depending on the security category, nature of the crime, length of sentence and other factors. Norwich is also the site of the only Young Offenders Institute (YOI) in Norfolk.

At the last meeting councillors were interested in training provided to staff at HMP/YOI Norwich and staff's ability to pick up on mental health and physical health needs that prisoners may not have raised during the initial assessments or later. There was also interested in the environment in which the health services are delivered at Norwich prison, particularly the condition of the 24hr healthcare facility.

## 2. Background information

### 2.1 Previous report to NHOSC

2.1.1 The previous report and minutes of the meeting are available via the following link NHOSC 4 Feb 2021 (agenda item 6). On that occasion NHOSC asked NHSE&I to

obtain some additional information for the committee and made two recommendations to the commissioners:-

1. To put in place a performance indicator for monitoring provision and use of interpreting services in prison healthcare.
2. To check whether prison staff at Norwich prison are given the results of their regular Covid 19 tests and advise they should be as a matter of healthcare ethics.

NHSE&I's response, on 18 March 2021, was emailed to NHOSC members at the time and is attached at **Appendix B**. Their report for today's meeting, **Appendix A**, explains that they have ascertained from the healthcare leads at each of the prisons that there are no concerns about the arrangements for accessing translation and interpreting services.

## 2.2 Local Independent Monitoring Boards – reports

2.2.1 Every prison is monitored by an Independent Monitoring Board (IMB) appointed by the Secretary of State from members of the community in which the prison is situated. They are required to report annually on how well the prison has met the standards and requirements placed on it and have right of access to every prisoner, every part of the prison and prison records. Their reports include comments on healthcare.

The most recently published IMB reports for Norwich and Wayland prisons are available via the following links:-

IMB HMP/YOI Norwich 2020-21 report
IMB HMP Wayland 2020-21 report

A link to IMB HMP Bure's report for 2019-20, the latest available, was provided in the last report to NHOSC, 4 Feb 2021.

The IMBs' executive summaries on how well health and wellbeing needs were being met in 2020-21 are set out below. Full details are available through the links above.

### 2.2.2 IMB HMP/YOI Norwich 2020-21 report – summary

The following is taken from the 'Main judgements' section of the 'Executive Summary':-

*"How well are prisoners' health and wellbeing needs met?*

*Trying to observe or source the necessary facts and information to monitor healthcare provision adequately throughout the reporting year has been extremely difficult, forcing the Board to contact the prison group director (PGD), and little information was given to the Board until February 2021. Observations are mainly based on a review of statistical analysis from the annual Health and Justice Indicators of Performance (HJIPs)/ minutes*

*provided and from prisoner comments to the Board/responses to IMB questionnaires. The HJIPs indicate that in the main physical and mental healthcare provision is equivalent to that in the community, apart from dentistry. Although a well-functioning triage system is in place, prisoners comment adversely about GP access but say that good nursing provision is available. Prisoners identify dental provision as inadequate with limited or no access to a dentist, even in an emergency. Immediate and basic life support training is too low (54% of staff as of November 2020) and there is only one nurse trained in suturing.*

*Covid restrictions on loss of regime, including time out of cell and access to activity and exercise, have impacted upon prisoners' wellbeing and mental health. Education and distraction packs in English have been readily available in an attempt to mitigate this effect, but prisoners state that they have been affected by long hours locked in cells with little to do. Gym and exercise classes were suspended. Caseloads for the mental health team are very heavy.*

*Dispensary hatches on the second floor are not easily accessible to all prisoners as there is no lift on B and C wings and the lift on A wing has frequent breakdowns. There is no accessible shower on the healthcare unit."*

2.2.3 **IMB HMP Wayland 2020-21 report – summary**

The following is taken from the 'Main judgements' section of the 'Executive Summary':-

*"How well are prisoners' health and wellbeing needs met?*

*Although the Board has a professional relationship with the head of healthcare, we have found it difficult to get much of an evidenced view on how the health and wellbeing of prisoners has been met. For the second year, unlike the Board's previous experience, we have been excluded from attending any healthcare meetings outwith the prison, although we are hopeful that, as this issue has now been escalated, the NHS commissioner will be more sympathetic to our attendance.*

*Additionally, due to the pandemic, there have been no in-prison meetings. We have, therefore, been largely reliant on those prisoners we have managed to speak to, information from discussions with healthcare staff, and the results of a few questions in our prisoner survey."*

## 2.3 HM Inspectorate of Prisons – reports

2.3.1 HM Inspectorate of Prisons (HMIP) works in conjunction with the Care Quality Commission (CQC) and other bodies when conducting prison inspections. Findings on health, well-being and social care in prisons are available within its reports. The expected standard is:-

*Patients are cared for by services that assess and meet their health, social care and substance use needs and promote continuity of care on release. The standard of provision is similar to that which patients could expect to receive elsewhere in the community.*

2.3.2 **HMIP inspections**

Details of the HMIP inspection regime and links to the last visits made to prisons in Norfolk are included in NHS E&I's report at **Appendix A**. The HMP Bure has received an inspection since the last report to NHOSC. This was on 6 and 23–24 March 2021. The findings in relation to health and care are set out at **Appendix C**. Details of the last inspections at HMP Norwich and HMP Wayland were provided to the committee with the last report to NHOSC in Feb 2022.

## 3. Suggested approach

Members may wish to discuss the following areas with the representatives from NHSE&I & the senior Governor from HMP/YOI Norwich:-

3.1 **NHSE&I**

(a) In March 2021 NHSE&I said "*As we move from managing outbreaks of covid and the vaccination programme, we are prioritising understanding, identifying and treating mental health needs. As part of this we intend to look at offering additional training to all staff (including prison staff) concerning how people who are becoming mentally unwell can be recognised, how they can be helped, and what each person's role is*". What progress has there been across prisons in Norfolk?

(b) What progress has there been locally to make system changes and upgrades so that teams and prisons in Norfolk are able to fully engage with the roll out of the Health and Justice Information System (HJIS) to enable smoother transfer of prisoners' health records to and from health services in the community?

(c) Is it possible to take any further steps to smooth and speed up the transfer of prisoners' healthcare information between community health services and prison health services in advance of the full roll out of HJIS?

(d) Dental Clinic wait times are reported in the Clinic Wait Times section of the HJIP report at Appendix A Annexe A. The east of England average dental clinic wait time for routine care in 2021-22 quarter 3 is shown as 106 days but year-to-date figures shown for local prisons are:-
HMP Bure 7 days
HMP Wayland 0
HMP Norwich 2 days
Can the commissioner explain these figures; how do they relate to prisoners' actual wait times for routine dental care?

**Senior Governor HMP/YOI Norwich**

(e) What proportion of prison officers at all pay bands in HMP/YOI Norwich have received mental health training to enable them to spot possible signs of mental ill-health in prisoners which may not previously have been identified?

(f) Do prison officers receive autism awareness and learning disability awareness training as part of their Assessment, Care in Custody and Teamwork training?

(g) What proportion of prison staff have received basic life support training?

(h) At its last meeting NHOSC noted criticism of the environment in which healthcare services operate at the prison, particularly the 24 hour healthcare facility. Has there been any improvement to the facilities?

(i) The published Independent Monitoring Board report for 2020-21 said "*the healthcare unit, which is intended to cater for a wide range of physical and mental health conditions … on frequent occasions this year all 10 NHS beds have been used by patients with such acute mental health issues that they could not safely remain on the wings or be supported adequately in general accommodation"*. Has the situation been addressed to allow for more varied use of the NHS commissioned enhanced nursing care accommodation?

## 4. Action

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

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|---|---|
| **Meeting/Committee:** | Norfolk County Council Health Overview and Scrutiny Committee |
| **Venue:** | MS Teams |
| **Date:** | April 2022 |

**For further information contact:**

| | |
|---|---|
| Name | Claire Weston |

Contents:

## 1. Introduction

In 2020, NHS England was contacted by the democratic support manager with a request to provide specific information about the healthcare commissioned for the three Norfolk prisons, which is answered in a document sent to her in February 2022 and available on the council's website. The health needs assessments for each prison were also requested and were provided. The head of health and justice (East) attended a meeting of the committee in February 2021. A further request to appear before the committee in May 2022 has been received, and a request for additional information about healthcare in prisons.

NHS England has responsibility for commissioning healthcare for people in custody under the health and Social Care Act 2021. The commissioning team collaborates with other commissioners in relation to services for people in prison (for example, the social care commissioner for the prisons).

## 2. Providers of healthcare in Norfolk prisons

The providers of healthcare services in the prisons as at April 2022 are as follows:

| Prison | Healthcare | Mental healthcare | IAPT | Substance misuse | Dental |
|---|---|---|---|---|---|
| **HMP Norwich** Category B reception | Virgin; now known as HCRG | NSFT | NSFT | Phoenix Futures | CDS |
| **HMP Bure** category C prison holding men convicted of sexual offences | Practice Plus Group | Practice Plus Group | NSFT | Phoenix Futures | CDS |
| **HMP Wayland** category C prison | Practice Plus Group | Practice Plus Group | NSFT | Phoenix Futures | CDS |

Contract review meetings are held regularly to ensure that issues relating to delivery of the contract are discussed, enabling issues (such as prison facilities, availability of prison officers) are explored and developments of the services are reviewed.

Partnership board meetings provide a forum for representatives of all healthcare services to discuss together the delivery of services and issues which they share and are chaired by the governing governor or their nominated representative.

## 3. Description of healthcare services

Prison healthcare services are largely primary care services, with the exception of mental health where the secondary care service is also provided. If prisoners require secondary care (an appointment or treatment at a general hospital), they are referred by the prison healthcare team and taken out to hospital accompanied by prison officers. Although there is a range of healthcare providers in the Norfolk prisons, they work together within each prison to ensure that people receive care to support their health needs while in prison.

The mental health service in HMP Norwich, a reception prison, is provided by the same provider as the Norfolk liaison and diversion service (which operates in police custody, identifying people with vulnerabilities at the point of contact with the criminal justice system, and aims to ensure that people are identified as vulnerable, and signposted to appropriate services). Commissioning a service which integrates the liaison and diversion service with the prison mental health service in the remand prison (HMP Norwich) joins up the mental health care pathway and aligns it with the criminal justice pathway.

## 4. Performance information

Data for a range of indicators is reported quarterly and was provided to the committee in 2019 and 2021. Reporting was suspended at the start of the pandemic, to allow maximum capacity within services for service delivery, and has only recently resumed. The data is used to contribute to an overall understanding of service delivery, but is not in itself an absolute indicator of satisfactory service delivery. An understanding of the effectiveness of services is derived from a range of sources, which include

- Health and Justice Indicators of performance (HJIPs)
- Inspection reports
- Incident reports
- Reporting against the quality schedule of the contract
- Observations made during quality visits

The inspection of prisons includes the inspection of prison healthcare. Healthcare is inspected by the inspectorate of prisons and also by the Care Quality Commission, usually on a 2-3 year cycle. During the pandemic, the inspectorate has suspended its routine cycle of inspections and has replaced this with short scrutiny visits (SSVs). Further details can be found on the HMIP website.

The dates of last inspections for the Norfolk prisons are as follows:

HMP Norwich – full inspection February 2020
https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/hmp-yoi-norwich/

HMP Wayland – Short Scrutiny Visit July 2020 not published; main inspection June 2017
https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/hmp-wayland/

HMP Bure – full inspection March 2021
https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/hmp-bure-2/

The links above will give access to the action plans for each prison, and the response made by the prison service and by the healthcare provider. The inspection of healthcare services in prisons is also undertaken by the Care Quality Commission, which is the regulator of healthcare in England. CQC reports for each of the prisons can be found on the CQC website.

The NHS England health and justice commissioning team makes visits to prisons to directly observe delivery of services and discuss issues with clinical staff. A structured approach is used, to look at specific areas of service delivery. Quality visits have not been possible during the last 24 months, as a result of Covid 19. The HJIPs data for the prisons for the last 12 months is attached at appendix 1. During the pandemic, staff have been depleted due to having Covid, and when at work, have been prioritising managing people with Covid, and managing the vaccination programme. Reporting of data has been deprioritised in the interests of maximising the available capacity for fighting infection and offering vaccines.

As services begin to return to routine functioning, there is a focus on access to mental health services. All prisons are currently able to meet the access target for psychological therapies, which is 75% of all referrals result in an appointment within 6 weeks. Table 1 shows the achievement of the 75%/6 week wait. In addition, referral for mental health assessment results in an appointment within 5 days for most patients. Where this has not happened, the reasons have been sought, and have been given as patient did not attend (further appointment offered), patient preferred to wait and saw the psychologist anyway.

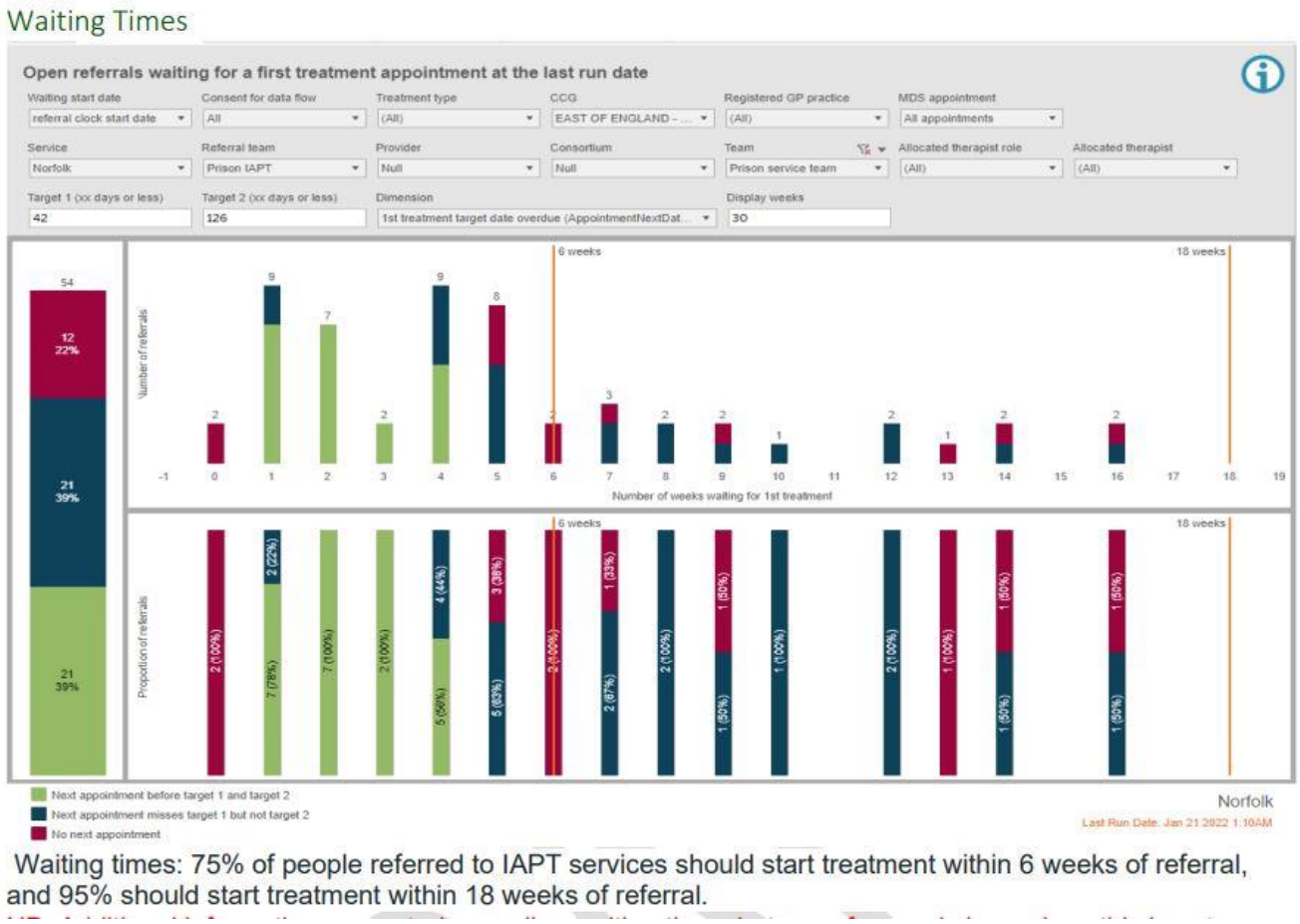


Table 1: current waiting times for IAPT in Norfolk prisons.

Several improvements have been commissioned by the NHS England team during the last year. A day care service has been set up in HMP Norwich by the prison service to support men who are struggling while in prison, and this is supported by a new Wellbeing service which seeks to help people who do not meet the clinical threshold for psychological therapies. This service is also accessible by others who do not meet the threshold but are not using the day care service. The day care service will ensure that when men are not able to engage with usual daily activities because they are not well, there is a place for them to go to receive support during the day, instead of being in their cell. Investment has also been devolved to the mental health provider to increase their work force to have a full-time service lead at the prison.

Access to dental care is also monitored. There is an issue relating to the restoration of dental treatments which applies in community and in prisons, concerning 'aerosol generating procedures' (AGPs) which heighten the risk of Covid infection. AGPs include drilling to fill caries (fillings). To mitigate the risk created by AGPs, there are rigorous guidelines for the ventilation of dental suites, and it is the responsibility of HMPPS to survey dental suites and ensure the correct ventilation arrangements are in place. A programme to complete this is underway, and there are non-standard delays for routine dental examinations in many prisons. Waiting lists are being validated to ensure they are up to date, and people will be seen in order of clinical priority.

## 5. Staffing of healthcare services

Staffing models are expressed in bids to provide the services at the time they are procured. Once appointed, the provider is responsible for ensuring that services are delivered safely and effectively, and for submitting a quarterly report relating to workforce, which allows NHS England to identify any issues relating to staffing. The Norfolk prisons services experience broadly the same issues as community NHS services in respect of clinical staffing; it is challenging to recruit and retain staff, and this is made even more difficult due to the remote rural locations of two of the prisons. Our expectation is that providers will deliver services as described in their contracts and while we acknowledge that problems may be experienced from time to time, providers are asked to propose action plans to resolve access issues, and if they are agreed, to deliver the action plan.

At the start of the pandemic, all healthcare services were suppressed, and many staff have been off sick or isolating since March 2020. This issue is far more significant, in respect of daily staffing of service, rather than vacancies relating to substantive roles.

NSFT provides IAPT services across all three Norfolk prisons and a mental health service at HMP/YOI Norwich only. The mental health team at HMP Norwich is fully staffed and currently there are no staffing issues. Similarly, for the IAPT service the team is fully staffed in all three prisons and there are no staffing issues.

PPG deliver primary healthcare and mental health services at HMP Wayland and HMP Bure. HMP Wayland have the following vacancies:

- 1 full time x Registered General Nurse, Band 5
- 1 full time Mental Health nurse
- 4 Pharmacy technicians

To mitigate against the vacant positions, the existing staff are taking bank shifts to ensure service delivery is not affected.

HMP Bure have the following vacancies:

- 0.25 x Psychiatrist
- 1 x HCA
- 0.4 x GP
- 1 x pharmacy tech lead
- 1 x mental health lead

Bank staff are covering the vacancies until the people are fully recruited into the vacant positions. Core service delivery of both the primary and mental health services has not been affected.

Phoenix Futures provides psychosocial substance misuse services in all three Norfolk prisons, and there are currently no staffing issues in any of the prisons for their service.

HCRG provide the healthcare service in HMP Norwich. They currently have an HCA vacancy, 6 x band 5 nurse vacancies, and a vacancy for medical cover 1 day at the weekend, all of which are covered by agency or bank staff.

**6. <u>Information on assessment of prisoners and the transfer of health records between prisons and on release into the community.</u>**

Please also refer to the report submitted to the committee in February 2021.

6.1 <u>When someone is received into prison for the first time</u>, the position is similar to when someone arrives in a hospital accident and emergency department. The doctors and nurses rely on three sources of information:

- *What the person tells them about their health*
- In prison, everyone who is being received into prison is asked a series of questions about their health, so the prison healthcare team can treat them
- *What they can observe about the person's health, from what they see and from what tests tell them*
- the person undertaking the screening of people coming into prison will note any behaviours or other indicators that are a cause for concern, or which may indicate a health need
- *What they can find out about the person's health, from other people who have observed them*
- In prison, this means that the person undertaking the screening may be given the prison escort record, which could include information about how the person has been while in police custody.

These three sources of information enable the prison healthcare team to manage the person's initial and immediate health needs. During the screening, and in the first hours in prison, the healthcare team will seek to identify any services which the person has engaged with during their time in community, and will contact those services to request access to relevant aspects of the person's clinical record eg prescribing history. This information will be used by healthcare professionals to decide how to treat the person while they are in prison. It is important to recognise that some people do not want their GP to know that they have been sent to prison and will decline to give information about their GP.

Any woman who is sent to prison from a Norfolk court will be held in a prison which is not in Norfolk, (as there are no women's prisons in the county). Their prison clinical record will be created as described above.

Prison healthcare records are created and stored on the prison clinical system, and the system in use in all prisons is SystmOne. This is also the system in use in the community, and about one third of all GP practices use SystmOne.

People who state that they have a mental health condition will be referred to the prison mental health service and will be assessed by a mental health practitioner. The initial (general) health screen which is undertaken for anyone received into prison is undertaken by a registered general nurse.

6.2 <u>When someone is transferred from one prison to another</u> (for example, to a category C prison once they have completed part of their sentence in a category B prison), the sending prison ensures that the SystmOne clinical record has been closed by them, and that it is fully up to date before closing it. In addition, for more complex patients, a comprehensive handover takes place, where a nurse from each of the prisons has a phone call and information is exchanged by secure email, which replicates the process undertaken during an initial screening in a reception prison. HMP Norwich are in the process of further refining this handover process through the work of a multi-disciplinary team, which has monthly meetings. When the person is received by the transferring prison, the receiving prison healthcare team is able to open the record, begin a new episode of care, and continue treatment. They are also able to make further contact with healthcare professionals in the sending prison, to discuss any issues or request further information, if they need to do so.

6.3 <u>When someone who has been convicted and sentenced is released from prison</u>, the prison healthcare team will ensure that the person is aware of their ongoing health needs, and will provide them with a small supply of their prescription medication and about information concerning healthcare services in the place they are released to. If someone is released from prison at the conclusion of a court hearing

(ie held on remand and acquitted, or held on remand and convicted and sentenced but released because time served on remand exceeds the sentence given), the healthcare team will try to ensure that any health needs are managed by giving information to the person ahead of the court hearing, and to the officer escorting them. There is an assessment of anyone going out of prison to court to ensure their healthcare needs are managed.

People released from prison may be seen in the community by their GP or another NHS service, who may want to access further information about their treatment while in prison. This includes community GP services, community substance misuse services, and community mental health services. In this situation, the community health service can contact the prison and there will be a discussion between healthcare professionals in which appropriate information may be shared confidentially, in the interests of continuity of clinical care. There is no standard and routine sharing of healthcare information with other services, such as accommodation.

The prison clinical record is held digitally. When information is shared, parts of the record can be downloaded and emailed using secure encrypted email to the relevant NHS service. Any woman who is sent to prison from a Norfolk court will be held in a prison which is not in Norfolk, as there are no womens prisons in the county. Their clinical record will be created as described above, and on their release back to a Norfolk address, information will be shared with relevant NHS services as described above.

In the last 12 months, NHS England has commissioned Forward Trust, a third sector organisation with a strong position in the delivery of services for people in prison and formerly in prison, to provide a Reconnect service in Norfolk. Reconnect is mentioned in the NHS Long Term Plan and seeks to provide additional support for some people when they leave prison, who may find it challenging to re-engage with community healthcare services. it will be especially valuable to people with mental health conditions who may find it challenging to identify the right service or the motivation to attend for treatment.

6.4 A programme to upgrade the clinical system in use in prisons is underway which will produce a range of benefits. This programme includes a workstream which will mean that while in prison, the person is registered with the prison GP service; this means that when they are released from prison, their record can be transferred to the community GP (in the same way as described above, when people transfer between prisons). This new approach also means that when someone is received into a prison, the person's clinical record from the community can be directly accessed by the prison healthcare service, and it is not necessary to make a manual request for a hard copy (or an extract of the hard copy). The person will have a choice as to whether to register with the prison GP; they may not want to, to protect their confidentiality about a time in prison, or they may want to preserve the registration they have with their community GP, if they expect to be in prison for a short time. The choice of registering with the prison GP service will not affect the care they receive while in prison. It is recommended that anyone who is received into prison, who will be there for a week or more, or who has any significant medical history, or who has been transferred from a secure mental health bed, should register with the prison GP practice. If people opt not to do this at reception, they can change their mind later and register.

## 7. Complaints received and subjects of complaints

The table below shows the total numbers of complaints/concerns received direct by healthcare providers at HMP Bure, HMP Wayland & HMP Norwich.

| 2021-22 | Q1 | Q2 | Q3 |
|---|---|---|---|
| HMP Wayland | 53 | 40 | 52 |
| HMP Bure | 30 | 36 | 28 |
| HMP Norwich | 42 | 41 | 46 |

Reasons for complaints

| | Q1 | Q2 | Q3 |
|---|---|---|---|
| HMP Wayland | • Other – 6<br>• Waiting Times – 3<br>• Staff Competency -1<br>• Staff Attitude- 2<br>• Medication Issues – 19<br>• Medical Records – 1<br>• Discharge Arrangements – 1<br>• Comms/Info – 1<br>• Clinical Care – 12<br>• Appointment Issues - 7 | • Appointment Cancellation – 2<br>• Appointments Issues – 7<br>• Clinical care – 14<br>• Comms/Info-1<br>• Process -1<br>• Medication – 13<br>• Staff Competence – 1<br>• Waiting Times - 1 | • Appointments -9<br>• Clinical Care – 20<br>• Comms/Info- 1<br>• Confidentiality -1<br>• Medication- 15<br>• Staff Attitude -3<br>• Staff Competence-2<br>• Waiting Times-1 |
| HMP Bure | • Appointments – 6<br>• Clinical Care- 6<br>• Confidentiality -1<br>• Process Failure-1<br>• Medical Records- 1<br>• Medication – 7<br>• Staff Attitude- 3<br>• Other -4<br>• Waiting Times-1 | • Appointments-1<br>• Clinical Care-25<br>• Confidentiality – 1<br>• Medication – 7<br>• Other-2 | • Appointments – 2<br>• Clinical Care -17<br>• Comms/Info – 2<br>• Medical Records-2<br>• Medication-5 |
| HMP Norwich | Details not provided | • Clinical -20<br>• Communication- 3<br>• Process/System – 14<br>• Staff Attitude -3<br>• Other-1 | • Other -6<br>• Staff Attitude – 7<br>• Process/System – 13<br>• Communication-4<br>• Clinical-16 |

NHS England monitors and seek assurance on patient experience within all commissioned health and justice healthcare services. Monitoring and reviewing complaints is one of the ways by which NHS England ensures that feedback from service users is used to drive quality improvement.
Providers are required to provide assurance that:

- service users are aware of how to raise complaints/concerns confidentially
- complaints information is readily available to service users and in accessible formats including how to escalate complaints/concerns externally to NHSEI and parliamentary ombudsman if service users are not satisfied with the outcome of internal investigation
- complaints/concerns are acknowledged and investigated in a timely manner.
- lessons are learned from complaints.

The CQC reviews the process which is available to prisoners to raise complaints, and the responses they receive from providers, when they make inspections of prison healthcare.
Complaints are reviewed and monitored via contact review meetings, quality schedule submissions, and quality assurance visits. Service users are also able to raise complaints directly with NHSEI complaints team. Where available, this information is shared at prison health and social care partnership board meetings. NHSEI review all concerns received and raised by other stakeholders.

## 8. Learning disability

Each prison healthcare team must provide a service for people with a learning disability. It is important to note that identifying learning disability can take time and may not be immediately obvious. People with learning disabilities may be highly moved to conceal this while in prison, to prevent them being identified as vulnerable among other prisoners. The role of the NHS is to ensure there are services available to assess people for learning disability, to prescribe relevant medications, and to refer to relevant services for support. In recent years, there has been a strong move away from medicalisation of learning disability, which is also relevant in prison.

PSO 07/215 states:

'• *All prisoners should be formally screened for potential learning disabilities or difficulties on first arrival to custody.*
*Information on disabilities from assessments on arrival should be recorded on Prison -NOMIS, including when a prisoner indicates that they do not have a disability or opts not to disclose. This should be updated if they later disclose, learn of or develop a disability. Reception staff to update Prison -NOMIS following interview.*
• *When a prisoner transfers to another prison, information about their physical, mental and/or sensory disability, or their learning disability or difficulty, should be passed to the receiving prison. Reception staff to request Custody Office to follow up with sending prison, as necessary*
• *Formal procedures for declaring a disability after arrival should be in place, promoted and known by staff and prisoners.*
• *There should be formal protocols for reception staff, including health services staff, to share relevant information with other appropriate staff that satisfy Prison Service Instruction 25/2002 guidelines [protection and sharing of confidential health information].*
• *Reception, first night and induction procedures should offer additional, tailored support to address the individual needs and/or anxieties of disabled prisoners. All 'early days' staff must ensure reasonable adjustments are identified and made.*
• *The induction process should cover the help available for prisoners with a disability. Staff must provide information on available help in reception and first night, and whenever it is requested*
• *Induction procedures, prison information and notices should be reviewed to ensure that they can be understood by, and meet the needs of, prisoners with a disability, including those with learning difficulties'*.

We do not collect information about the employment of RLDNs in the healthcare services, although we know that some providers do have input from RLDNs. Providers are commissioned to provide appropriate support to people with a learning disability and this could be provided by nurses with a mental health nursing qualification taking a lead role with appropriate clinical support and leadership.

NHS England has commissioned an external agency to undertake a review of how prison healthcare services identify and people with learning disabilities in all prisons, and where gaps are that need prioritisation so that people are supported while in prison.

**9. Use of interpreting services by healthcare staff in prisons**

At the February 2021 meeting there was a recommendation relating to the use of interpreting services: 'To put in place a performance indicator for monitoring provision and use of interpreting services in prison healthcare'. The response was sent in written form after the meeting:

*This was considered by the commissioning team at a meeting on 17/3/21. The team agreed that access to healthcare for all is a priority and that access for people with limitations on communication warrants review, although this issue has not been raised in health needs analyses or in serious incidents reports. Within our work programme for 21-22 we will look at ways of understanding whether all interpreting services needed are available and accessed appropriately by service providers. We will also review health needs assessments to identify any unmet health need as a result of under provision of interpreting services*.

We have ascertained from each healthcare lead that there are no concerns about the arrangements for accessing translation and interpreting services:

**HMP Norwich***: Language Line is used in the prison, and first and foremost in Reception. Clinical notes will evidence this so that further consultations are aware to use this facility. In addition, we are publishing a leaflet that we scrutinised in the last Clinical Governance meeting which assists in describing what services we can provide and how to access them. The leaflet uses pictures mainly rather than grammar and will be made available to all new receptions going forward. We initially put together a pamphlet that became too long winded and would probably not be read after the first few pages thus we reverted to a very simple and effective leaflet.*

**HMP Wayland and Bure:** *I can confirm we use Language Line for interpreting services. We call a number, give a code and state which language is required. This is a service we pay for as a provider.*

- Ends -

**Health and Justice Indicators of Performance – data collated from East of England performance report, Quarter 3 2021-22 YTD = year to date in quarter 3, i.e. April – December 2021**
**Note: The percentages shown in this table are the percentage achieved of the eligible / relevant population.**
**Wait times are shown in days.**

| Area | Measure Description | National Average (Quarter 3) | Regional Average Quarter 3) | HMP Bure YTD Performance | HMP Wayland YTD Performance | HMP/YOI Norwich YTD Performance |
|---|---|---|---|---|---|---|
| General Population Statistics | Total Population | 613 | 646 | 411 | 592 | 651 |
| | New Receptions | 86 | 91 | 0 | | 137 |
| | Transfers | 45 | 43 | 15 | 50 | 18 |
| | Discharges | 84 | 53 | 9 | 26 | 104 |
| | Mental Health Population | 48 | 44 | 20 | 55 | 66 |
| | Dementia Population | 1 | 2 | 2 | 0 | 1 |
| | Depression Population | 136 | 150 | 96 | 187 | 232 |
| | Mental Health Caseload | 91 | 55 | 28 | 79 | 125 |
| | LD Population | 11 | 13 | 10 | 12 | 22 |
| | MH Remissions | 0 | 0 | 0 | 0 | 0 |
| | 1st Reception screens | 99.4% | 98.9% | 100.0% | 97.0% | 99.5% |
| | 2nd Reception screens | 94.4% | 93.2% | 96.9% | 98.9% | 78.0% |
| Non Cancer and Blood Borne Virus | Abdominal Aortic Aneurysm (AAA) Screening Uptake | 5.5% | 6.4% | 0.0% | 11.1% | 6.8% |

| Area | Measure Description | National Average (Quarter 3) | Regional Average Quarter 3) | HMP Bure YTD Performance | HMP Wayland YTD Performance | HMP/YOI Norwich YTD Performance |
|---|---|---|---|---|---|---|
| Related Health Screenings | Retinal Screening Uptake | 8.1% | 3.4% | 11.5% | 0.0% | 14.6% |
| | Chlamydia Screening Uptake | 7.8% | 6.5% | 8.8% | 3.0% | 19.2% |
| | NHS Prison Physical Health Check Screening Uptake | 10.9% | 31.6% | 44.8% | 10.6% | 51.4% |
| | Tuberculosis (TB) Screening Uptake | 94.1% | 81.3% | 99.2% | 95.8% | 99.9% |
| | Hepatitis B testing offered | 97.9% | 98.7% | 100.0% | 95.9% | 95.9% |
| | Hepatitis B - HBsAg Uptake | 66.5% | 60.3% | 98.8% | 85.1% | 23.1% |
| | Hepatitis C testing offered | 96.2% | 98.1% | 99.2% | 97.0% | 99.9% |
| | Hepatitis C - HCV Ab | 69.9% | 68.5% | 98.5% | 88.9% | 27.5% |
| | Hepatitis C - HCV PCR | 40.5% | 43.2% | | 16.7% | 65.8% |
| | Hepatitis C - Referral | 66.4% | 87.5% | | | 89.5% |
| | HIV Testing - Uptake | 67.2% | 67.7% | 97.7% | 87.7% | 27.5% |
| Cancer Related Screenings | Breast Cancer Screening (female estate only) | 3.9% | 100.0% | | | |
| | Cervical Cancer Screening (female estate only) | 10.5% | 2.1% | | | |
| | Bowel Cancer Screening | 9.0% | 17.9% | 10.4% | 3.6% | 9.2% |
| Childhood Immunisations & | Flu Vaccination uptake | 28.1% | 29.7% | 34.5% | 14.6% | 37.3% |
| | MMR uptake | 0.7% | 0.3% | 4.7% | 0.4% | 0.1% |

| Area | Measure Description | National Average (Quarter 3) | Regional Average Quarter 3) | HMP Bure YTD Performance | HMP Wayland YTD Performance | HMP/YOI Norwich YTD Performance |
|---|---|---|---|---|---|---|
| All Routine Vaccinations | Men ACWY Vaccination Uptake | 1.2% | 0.0% | 2.5% | 2.2% | 0.0% |
| | Shingles uptake | 3.7% | 9.3% | 14.3% | 0.0% | 0.0% |
| | Hepatitis B Vaccination uptake | 5.1% | 5.3% | 14.0% | 1.5% | 6.4% |
| | Td/ IPV Vaccination Uptake | 0.4% | 0.2% | 1.5% | 0.0% | 0.2% |
| | Hepatitis A Vaccination Uptake | 1.4% | 2.5% | 0.6% | 0.1% | 10.6% |
| | Pneumococcal Polysacharide Vaccination (PPV) Uptake | 1.6% | 1.6% | 7.7% | 6.5% | 0.2% |
| | Pertussis Vaccination uptake (female estate only) | 9.7% | | | | |
| Medicines Management | In-Possession Medication (Arrivals) | 92.9% | 86.5% | 96.9% | 97.5% | 98.8% |
| | In-Possession Medication (Pre-existing population) | 97.4% | 98.4% | 99.7% | 99.8% | 98.2% |
| | Receipt of Medication | 32.5% | 21.5% | 36.1% | 34.8% | 21.8% |
| | Supply on Transfer | 58.9% | 69.2% | 51.6% | 73.0% | 79.2% |
| | Supply on Discharge | 65.0% | 62.9% | 67.7% | 18.5% | 95.0% |
| | Medicines Reconciliation | 87.8% | 74.4% | 97.7% | 95.6% | 95.2% |
| Mental Health | Care Programme Approach (CPA) on Arrival | 2.5% | 0.8% | 4.6% | 3.5% | 0.0% |

| Area | Measure Description | National Average (Quarter 3) | Regional Average Quarter 3) | HMP Bure YTD Performance | HMP Wayland YTD Performance | HMP/YOI Norwich YTD Performance |
|---|---|---|---|---|---|---|
| | Care Programme Approach (CPA) application in Prison | 0.3% | 0.1% | 0.0% | 0.0% | 1.2% |
| | Care Programme Approach (CPA) 6 Month Reviews | 26.3% | 30.2% | 33.3% | 56.3% | 16.4% |
| | Care Programme Approach (MH) Annual Physical Health Check | 16.1% | 31.2% | 16.7% | 100.0% | 0.0% |
| | MH Discharge Summary | 78.2% | 92.6% | 97.9% | 96.3% | 83.7% |
| | MH Transfer Assessments | 1 | 0 | 0 | 1 | 1 |
| | MH Transfer <=14 days | 0 | 0 | 0 | 0 | 1 |
| | MH Transfer between 15 days & 28 days | 0 | 0 | 0 | 0 | 0 |
| | MH Transfer between 29 days & 56 days | 0 | 0 | 0 | 0 | 0 |
| | MH Transfer between 57 days & 84 days | 0 | 0 | 0 | 0 | 0 |
| | MH Transfer between 85 days & 140 days | 0 | 0 | 0 | 0 | 0 |
| | MH Transfer – > 140 days | 0 | 0 | 0 | 0 | 0 |
| | Assessment in Care and Separation Unit for MH patients | 44.2% | 100.0% | 0.0% | | |
| | Self-Harm & Suicide Prevention - Mental Health Assessment | 67.9% | 90.0% | 77.8% | 81.0% | 99.7% |
| | Constant Supervision MH Assessments | 61.2% | 100.0% | 0.0% | | 114.3% |

| Area | Measure Description | National Average (Quarter 3) | Regional Average Quarter 3) | HMP Bure YTD Performance | HMP Wayland YTD Performance | HMP/YOI Norwich YTD Performance |
|---|---|---|---|---|---|---|
| | LD/ Potential LD Prevalence | **1.4%** | **1.0%** | 3.6% | 0.7% | 2.2% |
| | Wait time to see Psychiatrist | **25** | **11** | 2 | 7 | 21 |
| Dentistry | Band 1 Treatments | **9** | **17** | 12 | | 52 |
| | Band 2 Treatments | **8** | **3** | 1 | | 1 |
| | Band 3 Treatments | **4** | **5** | 2 | | 2 |
| Smoking | Smoking Prevalence | **60.6%** | **36.8%** | 6.1% | 30.2% | 40.8% |
| | Smoking Cessation Uptake | **5.7%** | **6.5%** | 0.0% | 0.5% | 4.4% |
| Drug & Alcohol Related Treatment (DART) | DART 5 Day Reviews | **90.8%** | **94.0%** | | | 94.7% |
| | DART 13 Week Reviews | **67.9%** | **79.4%** | | 46.6% | 79.8% |
| | DART - Alcohol Screening | **79.8%** | **74.8%** | 98.5% | 69.2% | 43.4% |
| Clinic Wait Times | General Practice Clinic (Dr) Wait Time For Routine Care | **13** | **6** | 6 | 4 | 1 |
| | General Practice Clinic (Dr) Wait Time For Urgent Care | **1** | **1** | 0 | 1 | 1 |

| Area | Measure Description | National Average (Quarter 3) | Regional Average Quarter 3) | HMP Bure YTD Performance | HMP Wayland YTD Performance | HMP/YOI Norwich YTD Performance |
|---|---|---|---|---|---|---|
| | Dental Clinic Wait Time For Routine Care | 91 | 106 | 7 | | 2 |
| | Dental Clinic Wait Time For Urgent Care | 5 | 3 | 0 | | 1 |
| | Substance Misuse Clinic Wait Time For Routine Care | 2 | 2 | 0 | 1 | 0 |
| Clinic Cancellations | General Practice Clinic (Dr) Cancellations – Prisons | 0 | 0 | 0 | 0 | 0 |
| | Dental Clinic Cancellations – Prisons | 0 | 0 | 0 | | 0 |
| | Nurse Led Clinic Cancellations – Prisons | 0 | 0 | 0 | 0 | 1 |
| | Substance Misuse Clinic Cancellations – Prisons | 0 | 0 | 0 | 1 | 0 |
| | Mental Health Clinic Cancellations – Prisons | 0 | 2 | 0 | 4 | 0 |
| Clinic Patient Activity (Inc. patient cancellations) | General Practice (Dr) Booked Appointments | 277 | 237 | 76 | 161 | 375 |
| | Dental Clinic - Booked Appointments | 105 | 66 | 51 | | 108 |
| | Nurse Led Clinic Booked Appointments | 1384 | 1068 | 1829 | 666 | 332 |
| | Substance Misuse Clinic Booked Appointments | 361 | 155 | 0 | 126 | 834 |
| | Mental Health Clinic Booked Appointments | 378 | 179 | 15 | 559 | 467 |

**NHS England & NHS Improvement response to information requests and recommendations made by Norfolk Health Overview and Scrutiny Committee on 4 February 2021**

(Provided by Claire Weston on 18 March 2021)

| | |
|---|---|
| Request for additional information from NHSE&I, as follows:-<br><br>• A) Numbers of prison officers who have received mental health awareness training. *Please provide numbers and as a percentage of total number of prison officers*<br>• B) Details of the training given to prison officers to spot prisoners' health needs, mental and physical.<br><br>• C) Details of the work programme to update SystmOne so that people are registered with a GP prior to release from prison. | A) and B) This information is not collected or held by NHS England, as HMPPS is responsible for training prison officers. All officers at bands 3, 4 and 5 are required to undertake training for Assessment, Care in Custody and Teamwork (ACCT), a process that ensures that risks shown by prisoners are recorded, shared and managed. The ACCT training includes awareness of mental health. Uptake of ACCT training is reviewed by HMPPS in each prison, and the governor and her team for each prison will expect to see full compliance by all officers at the relevant grades.<br><br>As we move from managing outbreaks of covid and the vaccination programme, we are prioritising understanding, identifying and treating mental health needs. As part of this we intend to look at offering additional training to all staff (including prison staff) concerning how people who are becoming mentally unwell can be recognised, how they can be helped, and what each person's role is.<br><br>C) HJIS is a major programme of NHS Digital which will produce significant changes in the way clinical information is managed throughout the prison system. Details can be reviewed here: https://digital.nhs.uk/services/health-and-justice-information-services . It is planned to produce the following benefits:<br><br>• patient records can be transferred between health and Justice organisations<br>• records can be passed back to community NHS services when leaving the Justice system<br>• patients can register with a Justice healthcare team as their registered GP services for continuity of care<br>• access to NHS Spine services such as PDS, e-RS, EPS etc |

| | |
|---|---|
| | The overall leadership of this programme lies with a central team of NHS England. The NHS England (East) team are fully engaged with the programme and are currently implementing local system changes and upgrades to ensure that teams and prisons are able to fully engage with the roll out of HJIS. |
| • D) Details of the communication possible between SystmOne in prisons and SystmOne in the community. | D) When someone is received into prison from community, the prison healthcare service will request information about conditions for which they were being treated when they were in community and for which they continue to need treatment while in prison. Prison healthcare practitioners have a professional duty to ensure that they access information which they need in order to provide treatment. Community primary care records have not been routinely sent to a prison when someone is remanded or sentenced to prison custody. Reasons for this include the person declining to give consent to their record being shared (to ensure that when they return to community, their GP is not aware that they have been in prison), and because it is not possible under the current configuration of clinical systems in use. The HJIS programme (reference above) includes the implementation of a solution to this issue, facilitating the sharing of a patient's record. This is a national programme requiring the co-ordination of systems which have been set up in isolation from each other, and therefore a major programme to facilitate interoperability. |
| • E) Information on the point at which prisoners are told how to complain about healthcare services. | E) The Prison Complaints Policv Framework (4.6) states '*Prisoners must be informed about the complaints procedures during the 'early days' stages of their time in custody*' (www.gov.uk). Prisoners have two different routes for making complaints about healthcare. They may complain direct to the healthcare service, which is likely to result in a quicker response and resolution of the issue, or they may send a complaint direct to NHS England. This option may be preferred but in order to investigate, NHS England will need to obtain clear consent for investigation, and will request information from the local prison healthcare provider. This will then be reviewed and a response will be sent. The number of complaints, and their themes (if any) are discussed with providers at contract review meetings to inform service developments which meet the needs of prisoners. Complaints are an important aspect of understanding a service user's experience of care, and therefore important context for quantitative data reported by providers. |

| | |
|---|---|
| • F) Information on the point at which prisoners are given details of the interpreting service that can assist them with making complaints.<br><br>• G) Waiting times for Improving Access to Psychological Therapies (IAPT) one year ago, before the effects of the pandemic.<br><br>Recommendations to NHSE&I, as follows:-<br><br>1. To put in place a performance indicator for monitoring provision and use of interpreting services in prison healthcare.<br>2. To check whether prison staff at Norwich prison are given the results of their regular Covid 19 tests and advise they should be as a matter of healthcare ethics | F) PSI 07/215 (3.36) states that information should be available in a variety of formats and languages reflecting the make up of the prison population as soon as possible after entry into prison. Early days in custody: PSI 07/2015, PI 06/2015 - GOV.UK (google.co.uk)<br><br>G) The average wait time for the IAPT service in the Norfolk prisons in the period Jan - March 2020 was 45 days. IAPT services have a standard that 75% of people referred to IAPT services should start treatment within 6 weeks of referral, and 95% should start treatment within 18 weeks of referral. In the last two years, NHS England has allocated additional funding for the commissioning of psychological therapies, although the Norfolk prisons already had an IAPT service at the time NHS England became the commissioner in 2013. As the numbers with Covid reduce and services are restored, there will be a focus on mental health, including access to psychological therapies, to ensure that people in the Norfolk prisons are able to access care they need.<br><br>Response: this was considered by the commissioning team at a meeting on 17/3/21. The team agreed that access tol healthcare for all is a priority and that access for people with limitations on communication warrrants review, although this issue has not been raised in health needs analyses or in serious incidents reports. Within our work programme for 21-22 we will look at ways of understanding whether all interpreting services needed are available and accessed appropriately by service providers . We will also review health needs assessments to identify any unmet health need as a result of under provision of interpreting services.<br><br>Response: the testing of prison officers for covid is not a responsibility of NHS England. A response was provided by a deputy governor at HMP Norwich shortly after the meeting stating that officers were offered regular testing and informed that they would be contacted if the test was positive. Those testing negative are not contacted. |

**Extracts from Report on a scrutiny visit to HMP Bure by HM Chief Inspector of Prisons, 16 and 23–24 March 2021**

Health care

3.18 Strategic oversight arrangements were good, so that the prison, health commissioners, Practice Plus Group (PPG) and respective health providers delivered effective health careservices, underpinned by shared contingency planning. In our survey, 64% of prisoners said that the overall quality of health services was good.

3.19 The prison and its health partners, with advice from Public Health England, were well prepared to manage outbreaks of communicable diseases and the prison had successfully contained a recent outbreak of COVID-19, so that most of the prison population had been protected. At the time of our visit, no prisoners were COVID-19 positive or symptomatic.

3.20 There were highly visible markers for social distancing; hand sanitiser and personal protective equipment (see Glossary of terms) were accessible; and there were suitable reverse cohorting and isolation arrangements.

3.21 The schedule of COVID-19 vaccination of prisoners was in line with that in the local community. Priority groups two to nine comprised 381 prisoners, of whom 33% were clinically vulnerable. Of the 249 prisoners offered the first vaccine to-date, 98% had taken it.

3.22 Primary care services had been affected by the pandemic restrictions. Wherever possible, they were delivered on the wings, although confidential GP triage consultations by telephone had proved unsatisfactory. Full primacy care services had now resumed and were very good, with no waiting list to see a GP.

3.23 During our visit, the optician was offering clinics over the whole week and had cleared the waiting list. Other waiting lists were being reduced as we visited, including the list for dental aerosol generating procedures (AGPs). The number of community dental services sessions was doubling from April, to drive down the AGP list. The floor covering of the dental surgery was split and rising, increasing the risk of infection and introducing a potential trip hazard.

3.24 Norfolk County Council had continued to offer social care assessments throughout the pandemic, with these being undertaken remotely. However, of the 11 prisoners on the referral list for assessment at the time of our visit, eight had waited longer than three months and one had been waiting since 2018, which was unacceptable (see key concern and recommendation S4).

3.25 At the time of our visit, two prisoners had a social care package (see Glossary of terms) provided by PPG. Social care was led by an occupational therapist (OT), who made referrals and advised on solutions to enable prisoners to live independently. The OT had provided training for ‘buddies’ and support in developing their roles, so the social care provided was professionally overseen and of good quality.

3.26 Prisoners with formal do-not-resuscitate arrangements in place because of long-term, lifelimiting conditions had agreed to this information being shared in the prison (via the daily briefing), so that all staff involved in their care were aware of their wishes.

3.27 The PPG mental health team of nurses and a psychiatrist had a caseload of over 30 active patients at any one time, with inactive ones being monitored. The team had introduced a pre-admission questionnaire to acquire data from sender prisons on incoming prisoners with mental health problems, as information in the prisoner escort records was insufficiently detailed. This enabled better identification of risks by reducing the likelihood of missing salient pre-admission information.

3.28 All arrivals at the prison were promptly screened by primary care and mental health staff jointly, increasing the likelihood of identifying undisclosed or undiagnosed vulnerabilities which otherwise might be missed, and a daily duty worker triaged new referrals. Therapies were solution based, with monitoring of those with serious and enduring mental disorders.

3.29 The wellbeing service team of psychological therapists from Norfolk and Suffolk NHS Foundation Trust helped around 50 prisoners, using cognitive therapies to promote resilience to unacceptable emotions, and counselling for those with trauma-related psychological problems.

3.30 Few prisoners (two at the time of our visit) received opiate substitution therapy. They were well supported by Recovery Inside (RI), from Phoenix Futures. RI had 93 prisoners on the caseload, of whom 65 were in therapy and 28 were listed for pre-release support.

3.31 RI recovery workers had been unable to provide individual and group substance misuse therapies during the recent outbreak, so they had prioritised prisoners before release and the most vulnerable. During the pandemic, working materials had been adapted to use in-cell and recovery workers visited the cells, when possible, to encourage engagement with the work. Peer workers continued to inform new prisoners of RI services but were restricted from offering peer support groups at this time.

3.32 PPG pharmacy services were busy, with approximately 82% of the population receiving medication, 68.3% of whom had medicines in-possession, and all of the latter had an up-todate risk assessment. Careful oversight made sure that trends in prescribing were used to improve practice.

3.33 During the restrictions, there had been a small increase in requests for pain medications because of muscle aches and pains, probably caused by a lack of exercise at this time. Prisoners were able to obtain vitamin D free from the prison shop, which was a vital preventative measure for those unable to access enough sunlight each day.

3.34 Medicines were administered safely and confidentially from two hatches in the health centre. While not ideal, some prisoners received medicines at their cell door;

two pharmacy technicians administered these from a lockable trolley, with good officer support.

**Norfolk Health Overview and Scrutiny Committee appointments**

**Report by Maureen Orr, Democratic Support and Scrutiny Manager**

The Committee is asked to appoint Members to act as links with the CCG and local NHS provider organisations.

## 1. Link roles

1.1 Norfolk Health Overview and Scrutiny Committee (NHOSC) appoints link members to attend local NHS meetings held in public in the same way as a member of the public might attend. Their role is to observe the meetings, keep abreast of developments in the organisation for which they are the link and alert NHOSC to any issues that they think may require the committee's attention.

1.2 This may involve attending local NHS meetings in person or online.

1.3 A nominated Member or a nominated substitute may attend in the capacity of NHOSC link member. Other Members of NHOSC may attend CCG or local NHS provider trust meetings as members of the public if they wish.

1.4 The link roles and the Members who currently hold them are listed below:-

| CCG / Provider Trust | Governing Body / Board meeting schedule | Current NHOSC link |
|---|---|---|
| Norfolk and Waveney CCG (& subsequently Norfolk and Waveney integrated Care Board from 1 July 2022, pending legislation) | Every other month, usually on the last Tuesday, 1.30 – 4.00pm (online) | Chair of NHOSC<br><br>(substitute – Vice Chair of NHOSC) |
| Queen Elizabeth Hospital NHS Foundation Trust | Monthly, on the first Tuesday, 10.00am (online) | Julian Kirk<br><br>(substitute - Alexandra Kemp) |
| Norfolk & Suffolk NHS Foundation Trust | Every other month, usually on the fourth Thursday, 12.30pm (online) | Brenda Jones<br><br>(substitute - Daniel Candon) |

| | | |
|---|---|---|
| Norfolk & Norwich University Hospitals NHS Foundation Trust | Usually every other month, on the first Wednesday, 9.30am (online) | Dr Nigel Legg |
| James Paget University Hospitals NHS Foundation Trust | Every other month, usually on the last Friday, 10.00am (online) | Penny Carpenter<br><br>(substitute – Daniel Candon) |
| Norfolk Community Health and Care NHS Trust | First Wednesday of every month except Jan & Sept, 9.30am (online) | Emma Spagnola |

**3. Action**

3.1 The Committee is asked to:-

(a) Confirm the continuation of named link councillors in their roles or appoint different councillors and appoint substitutes as the committee wishes.

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# Norfolk Health Overview and Scrutiny Committee
## Forward Work Programme 2022

**ACTION REQUIRED**

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

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

### Proposed Forward Work Programme 2022

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

| *Meeting dates* | *Main agenda items* | *Notes* |
|---|---|---|
| 14 July 2022 | Children's neurodevelopmental disorders -waiting times for assessment & diagnosis – follow up to 15 July 2021 NHOSC<br><br>Annual physical health checks for people with learning disabilities, Looked After Children and people with severe mental illness – to examine progress. | |
| 8 Sept 2022 | Health and care for adults with learning disabilities / autism - local health and social care partners' joint action following the recommendations of the Cawston Park Hospital Safeguarding Adults Review. | |

**Information to be provided in the NHOSC Briefing 2022**

Jun 2022 - **Eating disorders** - Update on information provided to NHOSC on 4 Nov 2021, showing the trend in the data since then (monthly), including:-

- Numbers of people referred, all ages and services
- Numbers of assessments carried out, all ages and services

- Performance against waiting time standards in the adults' and children's service for both urgent and routine referrals.
- Waiting list sizes in the adults' and children's services
- Waiting times from referral to assessment and from assessment to treatment in the adults and children's services.
- Occupied bed days and out of area bed days
- Numbers of patients admitted to acute hospitals with an eating disorder diagnosis (not the primary reason for admission) and the lengths of stay
- Eating disorder bed days per 1000 registered population (13 – 17years) in Norfolk & Waveney and the East of England.
- Workforce data - staffing levels, clinical & admin, including current vacancy level and information about retention of staff (turnover in the service) for the adults' and children's services.
- Information on management of the workforce to staff the expanding Eating Disorders services without taking away from other local mental health services.
- Feedback from service users and their families about their experience of the service.
- Management of Really Sick People with Anorexia Nervosa – has a current policy been put in place at the Queen Elizabeth Hospital in respect of children and young people?
- Progress with investment in the services, expansion of services at the right level to meet need (community and in-patient services) and prevent acute needs arising.
- Transition between children's and adults' eating disorders services, including for those coming in to the county to college / university and those going out to study in other parts of the country?

- **Cawston Park Hospital Safeguarding Adults Review** – update from Norfolk Safeguarding Adults Board on action underway to address the recommendations.
  (See also 'Health and care for adults with learning disabilities' scrutiny item scheduled for Sept 2022 agenda – scrutiny of health & social care action)

Aug 2022

- **Cawston Park Hospital Safeguarding Adults Review** – update from Norfolk Safeguarding Adults Board on action underway to address the recommendations.

- **Overview of people's health in Norfolk** – annual update from Norfolk County Council Public Health

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

| | | |
|---|---|---|
| Norfolk and Waveney CCG | - | Chair of NHOSC<br>(substitute Vice Chair of NHOSC) |
| Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust | - | Julian Kirk<br>(substitute Alexandra Kemp) |
| Norfolk and Suffolk NHS Foundation Trust (mental health trust) | - | Brenda Jones<br>(substitute Daniel Candon) |
| Norfolk and Norwich University Hospitals NHS Foundation Trust | - | Dr Nigel Legg |
| James Paget University Hospitals NHS Foundation Trust | - | Penny Carpenter<br>(substitute Daniel Candon) |
| Norfolk Community Health and Care NHS Trust | - | Emma Spagnola |

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**Norfolk Health Overview and Scrutiny Committee 12 May 2022**

Glossary of Terms and Abbreviations

| | |
|---|---|
| ACWY | A meningitis vaccination, protecting against 4 strains of bacteria |
| AGP | Aerosol generating procedure (in dentistry) |
| ACCT | Assessment, care in custody and teamwork – a training process for Prison Officers |
| CCG | Clinical Commissioning Group |
| CDS | Community Dental Services – an employee owned social enterprise community interest company providing clinical dental and Oral Health Promotion services |
| CIP | Cost Improvement Programme |
| CQC | Care Quality Commission – the independent regulator of health and social care in England. Its purpose is to make sure health and social care services provide people with safe, effective, high quality care and encourage care services to improve. |
| CWT | Cancer waiting time |
| DART | Drug, alcohol and related treatment |
| DM01 | A monthly collection of diagnostics waiting times and activity |
| ED | Emergency Department |
| EEAST | East of England Ambulance Service NHS Trust |
| ENT | Ear, nose & throat |
| EPS | Electronic prescription service |
| eRS | Electronic referral services – for hospital or clinic appointments |
| FLO | Family Liaison Officer |
| HCRG | New brand name for Virgin Care from December 2021. An independent provider of healthcare services. Owned by Twenty20 Captial |
| HJIP | Health & Justice Indicators of Performance |
| HJIS | Health & Justice Information System |
| HMIP | Her Majesty's Inspectorate of Prisons |
| HMP | Her Majesty's Prison |
| HMPPS | Her Majesty's Prison and Probation Service |
| HWN | Healthwatch Norfolk |
| IAPT | Improving Access To Psychological Therapies |
| IMB | Independent Monitoring Board - every prison is monitored by an Independent Monitoring Board (IMB) appointed by the Secretary of State from members of the community in which the prison is situated. They are required to report annually on how well the prison has met the standards and requirements placed on it. |
| IQIP | Integrated Quality Improvement Plan |

| | |
|---|---|
| KPI | Key Performance Indicator |
| LD | Learning disability |
| MH | Mental health |
| MMR | Measles, mumps, rubella |
| NHSE&I EoE | NHS England and NHS Improvement, East of England. One of seven regional teams that support the commissioning services and directly commission some primary care services and specialised services.<br><br>Formerly two separate organisations, NHS E and NHS I merged in April 2019 with the NHS England Chief Executive taking the helm for both organisations. |
| NSFT | Norfolk and Suffolk NHS Foundation Trust |
| OT | Occupational Therapist |
| PDS | Personal Demographics Service – the national electronic database of NHS patient details |
| PGD | Prison Group Director |
| PPG | Practice Plus Group – and independent provider of health care services formerly known as Care UK. Rebranded in 2020. |
| Prison-NOMIS | Prison National Offender Management Information System |
| PSO | Prison Service Order |
| QEH | Queen Elizabeth Hospital, King's Lynn |
| RAAC | Reinforced autoclaved aerated concrete |
| RGN | Registered General Nurse |
| RI | Recovery Inside – service provided by Phoenix Futures. A substance misuse therapy service for prisoners |
| RLDN | Registered Learning Disability Nurse |
| RMN | Registered Mental health Nurse |
| RTT | Referral to treatment (waiting time) |
| SOC | Strategic Outline Case |
| SOF | System Oversight Framework |
| SSV | Short scrutiny visit |
| Td/IPV | Vaccine protecting against tetanus, diptheria and polio |
| TWW | Two week wait (a cancer waiting time target) |
| UEC | Urgent and emergency care |
| VTE | Venous thromboembolysim – the disease process relating to blood clots that form within veins |
| YOI | Youth offenders institute |