Norfolk County Council

Norfolk Health Overview and Scrutiny Committee

Date: **Thursday 5 September 2019**

Time: **10.00am**

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

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

Those members of the public or interested parties who have indicated to the Committee Officer, Hollie Adams (contact details below), before the meeting that they wish to speak will, at the discretion of the Chairman, be given a maximum of five minutes at the microphone. Others may ask to speak and this again is at the discretion of the Chairman. 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 Michael Chenery of Horsbrugh	Cllr David Bills / Cllr Penny Carpenter / Cllr Graham Middleton / Cllr Thomas Smith / Cllr Fran Whymark	Norfolk County Council
Cllr Fabian Eagle	Cllr David Bills / Cllr Penny Carpenter / Cllr Graham Middleton / Cllr Thomas Smith / Cllr Fran Whymark	Norfolk County Council
Cllr Emma Flaxman-Taylor	*Vacancy*	Great Yarmouth Borough Council
Cllr David Harrison	Cllr Tim Adams	Norfolk County Council
Cllr Brenda Jones	Cllr Julie Brociek-Coulton / Cllr Emma Corlett	Norfolk County Council
Cllr Chris Jones	Cllr Julie Brociek-Coulton / Cllr Emma Corlett	Norfolk County Council
Cllr Alexandra Kemp	Cllr Anthony Bubb	Borough Council of King's Lynn and West Norfolk
Cllr Robert Kybird	Cllr Susan Dowling	Breckland District Council
Cllr Nigel Legg	Cllr David Bills	South Norfolk District Council
Cllr Richard Price	Cllr David Bills / Cllr Penny Carpenter / Cllr Graham Middleton / Cllr Thomas Smith / Cllr Fran Whymark	Norfolk County Council
Cllr Sue Prutton	Cllr Peter Bulman	Broadland District Council
Cllr Jane Sarmezey	Cllr Matthew Fulton-McAlister	Norwich City Council
Cllr Emma Spagnola	Cllr Wendy Fredericks	North Norfolk District Council

Cllr Margaret Stone (Chairman)	Cllr David Bills / Cllr Penny Carpenter / Cllr Graham Middleton / Cllr Thomas Smith / Cllr Fran Whymark	Norfolk County Council
Cllr Sheila Young	Cllr David Bills / Cllr Penny Carpenter / Cllr Graham Middleton / Cllr Thomas Smith / Cllr Fran Whymark	Norfolk County Council

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

Hollie Adams on 01603 223029

or email committees@norfolk.gov.uk

Under the Council's protocol on the use of media equipment at meetings held in public, this meeting may be filmed, recorded or photographed. Anyone who wishes to do so must inform the Chairman and ensure that it is done in a manner clearly visible to anyone present. The wishes of any individual not to be recorded or filmed must be appropriately respected.

A g e n d a

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

2. Minutes

To confirm the minutes of the meeting of the Norfolk Health Overview and Scrutiny Committee held on 25 July 2019. (Page 5)

3. Members to declare any Interests

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

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

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

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

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

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

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

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

5. **Chairman's announcements**

6. **10:10 – 11:00** **Access to palliative and end of life care** (Page 16)

Progress since October 2018

Appendix A – STP Palliative Care Collaborative's report (Page 22)
Appendix B – Response to outstanding questions from NHOSC 18 Oct 2018 (Page 39)
Appendix C – Notes of NHOSC visits to palliative and end of life care services (Page 44)

7. **11:00 – 11:50** **Physical health checks for adults with learning disabilities** (Page 52)

Progress since September 2018

Appendix A – Commissioners' report (Page 57)
Appendix B – Healthwatch Norfolk report (Page 83)

11:50 – 12:00 **Break**

8. **12:00 – 12:55** **Ambulance response and turnaround times in Norfolk** (Page 86)

Progress since February 2019

Appendix A – Joint NHS partners' report (Page 90)
Appendix B – Norfolk Swift Response – adult social care briefing (Page 99)

Chris Walton
Head of Democratic Services

County Hall
Martineau Lane
Norwich
NR1 2DH

Date Agenda Published: 28 August 2019

IN TRAN communication for all	If you need this document in large print, audio, Braille, alternative format or in a different language please contact Customer Services on 0344 800 8020 or Text Relay on 18001 0344 800 8020 (textphone) and we will do our best to help.

Norfolk County Council

NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE
Minutes of the meeting held in the Council Chamber, County Hall
on 25 July 2019 at 10am

Members Present:

Cllr Margaret Stone (Chairman)	Norfolk County Council
Cllr Nigel Legg (Vice-Chairman)	South Norfolk District Council
Cllr Michael Chenery of Horsbrugh	Norfolk County Council
Cllr Fabian Eagle	Norfolk County Council
Cllr Emma Flaxman-Taylor	Great Yarmouth Borough Council
Cllr Brenda Jones	Norfolk County Council
Cllr Chris Jones	Norfolk County Council
Cllr Alexandra Kemp	Borough Council of King's Lynn and West Norfolk
Cllr Richard Price	Norfolk County Council
Cllr Jane Sarmezey	Norwich City Council
Cllr Sheila Young	Norfolk County Council

Substitute Members Present:

Cllr Tim Adams for Cllr David Harrison	Norfolk County Council
Cllr Helen Crane for Cllr Robert Kybird	Breckland District Council

Also Present:

Melanie Craig	Chief Officer, Norfolk and Waveney CCGs
Ross Collett	Director of Commissioning, NHS West Norfolk CCG
Dr Mark Funnell	Partner, Vida Healthcare
Anna Morgan	Director of Workforce, Norfolk and Waveney STP
Dr Tony Palframan	Chair of Norfolk and Waveney STP Mental Health Forum
Melvyn Peveritt	Head of Finance, Vida Healthcare
Jocelyn Pike	Chief Operating Officer, South Norfolk CCG
Cllr Thomas Smith	County Councillor for Gaywood South
Bohdan Solomka	Medical Director, Norfolk and Suffolk NHS Foundation Trust
Alex Stewart	Healthwatch Norfolk
Glyn Watkins	Chairman of Fairstead Patient Participation Group
Fiona Theadom	Contract Manager, NHS England & NHS Improvement East of England
Emma Wakelin	Head of Workforce Transformation, Norfolk and Waveney STP
Prof. Jonathan Warren	Chief Executive, Norfolk and Suffolk NHS Foundation Trust
Ana Weston	Head of People and Governance, Vida Healthcare
Maureen Orr	Democratic Support and Scrutiny Team Manager
Chris Walton	Head of Democratic Services
Hollie Adams	Committee Officer

1 Apologies for Absence

1.1 Apologies were received from Cllr David Harrison (Cllr Tim Adams substituting), Cllr Robert Kybird (Cllr Helen Crane Substituting), Cllr Sue Prutton and Cllr Emma Spagnola.

1.2 The Chairman welcomed new Member Cllr Jane Sarmezey and substitute Member Cllr Helen Crane to the meeting.

2. Election of Vice-Chairman

2.1 The Chairman nominated Cllr Nigel Legg, seconded by Cllr Michael Chenery of Horsbrugh. Cllr Nigel Legg was duly elected as Vice-Chairman for the ensuing Council year

3. Minutes

3.1 The minutes of the previous meeting held on 30 May 2019 were agreed as an accurate record and signed by the Chairman

4. Declarations of Interest

4.1 Cllr Sheila Young declared a non-pecuniary interest as Chairman of West Norfolk Patient Partnership

5. Urgent Business

5.1 There were no items of urgent business.

6. Chairman's Announcements

6.1 The Chairman had no announcements

7. Future of primary care (GP) services for residents of Fairstead, King's Lynn

7.1.1 The Committee received the consultation from Vida Healthcare supported by West Norfolk Clinical Commissioning Group regarding their preferred option of closure of Fairstead Surgery and expansion of Gayton Road Health Centre and St Augustine's branch surgery.

7.1.2 Officers introduced the report to Members:

- The Chief Officer, Norfolk and Waveney CCGs, had met with Officers and the practice team at Fairstead Surgery to look at the process and the needs of the local area
- The Director of Commissioning, NHS West Norfolk CCG, reported there was a national change in the delivery of primary care; branch surgeries tended to be less financially sustainable and did not deliver the best model of support. The proposed model followed clinical best practice
- Issues related to the Fairstead site dated back to 2012 and a number of options had been looked at since this time
- The Officer from Healthwatch Norfolk gave feedback about the independent consultation they were running which would end on 30 August 2019:
    - 151 responses had been received, two thirds of which were paper based; a Facebook advert publicising the consultation had received 1200 hits
    - Links to the consultation were sent to parish clerks and an advert was

circulated to partners and published on the Healthwatch and Clinical Commissioning Group websites. The consultation was promoted in local newspapers, the EDP, and on Kings Lynn FM.

- Pop up events were held on the Fairstead Estate to engage with residents, and a specific consultation was held with the West Norfolk Deaf Association

7.1.3 Cllr Thomas Smith spoke as local Member for Gaywood South:

- Statistically, this was one of the more deprived areas in the County; the existing Fairstead surgery was in a prime location in relation to the school and homes, and had good parking facilities; the new location had limited parking and the nearest public carpark was some walk away, and the layout of Gayton surgery was not ideal for wheelchair users
- Cllr Smith noted that the consultation posed only one option for residents and felt closure would impact on local people through increased cost of access via bus, and decreased convenience; he felt the changes may encourage some people to access A&E, which was within walking distance, rather than Gayton road which required a bus journey
- Cllr Smith noted patients were content with the level of care at Fairstead Surgery and that patient choice should be taken into account.

7.1.4 Glyn Watkins, Chairman of Fairstead Patient Participation Group spoke on behalf of the Group:

- He noted that the merged Vida surgeries would not be inspected unless triggers for inspection were made.
- Mr Watkins raised concerns from the Patient Participation Group, following information gathered from a Freedom of Information request which showed that the premises plan of the Fairstead Surgery used for the renovation drawings by the Cambridge architects in 2015 was not to scale. This had impacted on the costing of renovations.
- Mr Watkins felt that a refurbishment of the current site could be done for around £50,000 and a new build would therefore not be required as suggested by Vida;
- He also felt that no constructive dialogue had been held between Vida, local residents and the CCG;
- The Patient Participation Group had produced a study including the views of 500 patients which they had submitted to HealthWatch highlighting the unwillingness of Vida to engage with the Patient Participation Group
- Mr Watkins felt that Vida had not openly and transparently discussed other options for the Fairstead site

7.2 During discussion the following points were noted

- King's Lynn and West Norfolk Borough Council had offered funding for improvements to Fairstead Surgery; the Chief Officer, Norfolk and Waveney CCGs, thanked the Borough Council and offered to meet them to discuss options for the site. Ongoing revenue costs were usually more challenging than capital costs. An expanded model of care and clinical team to help people manage conditions and address prevention and inequality would only be possible in a much bigger team, possible at Gayton Road surgery
- The Director of Commissioning, NHS West Norfolk CCG, clarified that Vida Healthcare declared Fairstead Surgery non CQC compliant because the building did not meet all of the CQC criteria related to size of rooms for operative procedures, layout of walls, corridor widths for disabled access, and protective covers on radiators; non-compliance did not relate to quality of care.
- Members queried whether accessibility issues caused by closing the surgery and asking Fairstead residents to travel to the other facilities outweigh the accessibility

issues within the Fairstead Surgery building.

- Issues of parking at Gayton surgery were discussed; staff parking had been moved off-site to create an extra 20 patient parking spaces and the expansion plans included more patient parking; moving staff parking off-site had shown positive improvements
- Members asked for assurance that communications would continue with the Patient Partnership Group
- Members queried whether the expanded surgeries would be able to deal with the additional demand and future growth; the Partner, Vida Healthcare, would try to move patients to the most convenient site according to where they lived to increase capacity at Gayton Road
- Cllr Smith reported that car ownership per household in Fairstead was below the national average and the busiest bus route in Kings Lynn was through Fairstead Estate
- The Partner, Vida Healthcare, confirmed there was no financial reason behind the closure of Fairstead Surgery and it was not related to the retirement of Dr Ahmed who owned the site
- The Chief Officer, Norfolk and Waveney CCGs, clarified in response to a question, that the enhanced offer at Gayton surgery could be quantified by increased opening hours and increased availability of daytime and emergency appointments which would help reduce the risk of people going to A&E; the larger site could also provide a wider breadth of services.
- A Member noted that there were Care Homes near the Fairstead Surgery. The Partner, Vida Healthcare, reported that half of those registered at Fairstead Surgery were from local care homes. Gayton Road would listen to patients' concerns about accessing the surgery and come up with solutions, including visiting patients at home if required, and was in contact with Dementia Friends and other organisations to ensure the site was as accessible as possible
- Vida Healthcare was looking at ways to enhance the services offered such as supporting long term conditions out of the community centre and providing services from other sites during transition
- Of all patients who lived in Fairstead, 2100 were registered at Fairstead, and 2400 were registered at Gayton Road

7.3 The Committee **RECOMMENDED** that the CCG and Vida Healthcare meet with King's Lynn and West Norfolk Borough Councillors to explain and discuss the proposed option for the future of primary care service for residents of Fairstead.

8. Norfolk and Suffolk NHS Foundation Trust

8.1 The Committee discussed the report received as a follow-up to previous scrutiny of Norfolk and Suffolk NHS Foundation Trust (NSFT) and examination of the Trust and commissioners' response to the report of the Care Quality Commission's (CQC) inspection between 3 and 27 September 2018, published on 28 November 2018

8.2 During discussion the following points were noted

- Officers confirmed there had been 5 serious incidents across the Trust, of which 2 were in Norfolk and Waveney, since the Committee last met. A Mortality Review Group was in place to receive reports from the Serious Incident Review Group. The Mortality Review Group also reported to the Quality Committee and gave quarterly reports to the Board.
- Improvements had been made by making changes to governance structure, informed by the structure in East London Foundation Trust, and looking at

innovative ways of disseminating learning to staff

- Cllr Chenery reported that his visit to the new Samphire ward in West Norfolk had been positive and that positive changes were being seen across West Norfolk
- A discussion was held on how out of area placements would be reduced; the Chief Executive of NSFT reported that out of area placements had now reduced to just over 50 but he acknowledged this was still too high. The Chief Nurse would write to all patients placed out of area to apologise and give her contact number
- A 17-bed ward was due to be opened at Hellesdon Hospital, and enhancements were planned to the community offer. The Chief Executive of NSFT had spent time with the central team and the Medical Director for Sheffield looking at ways to reduce out of area placements
- Money had been identified to invest in the central team and support people with emotional dysregulation to maintain good health in the community. A Community Personality Disorder Officer had been recruited, and personality disorder training was being rolled out across CCG (Clinical Commissioning Group) teams.
- Funding had been agreed through the Sustainability and Transformation Partnership (STP) for a crisis house in Central Norfolk for step up and down provision and to support additional resource for mental health liaison services in acute hospitals. Funding had also been received from a Public Health England homelessness bid
- Measurement of staff morale was queried; the Chief Executive of NSFT replied that staff morale was surveyed yearly by the Trust and the NHS; the Trust would survey a percentage of staff monthly to see if measures to improve morale were working
- Methods used to keep people safe while on the referral waiting list were queried; the Medical Director of NSFT reported that people were now assessed face to face, moving away from phone assessments; this took longer but resulted in a higher quality assessment. Harm reviews of patients on the waiting list were regularly carried out by a multi-disciplinary team to prioritise who was most urgent.
- The Chief Executive of NSFT reported that in order to improve, the Trust would move away from year to year aims and look at realistic stretch aims, such as improving skills, inspiring staff, improving governance, reducing waiting lists, improving staff recruitment and retention and reducing out of area placements
- In future years, the Chief Executive of NSFT hoped to see an increase in staff morale measured by NHS and NSFT staff surveys, a reduction to 0 out of area placements, higher reporting of incidents and lower reporting of incidents of harm, among other outcomes
- A Member queried how staff vacancy rate and stress related absences would be addressed; the Chief Executive of NSFT reported that 200 more clinical staff had been recruited than a year ago and an influx of 30-40 of newly qualified nurses were expected; despite this there were a high number of vacancies to meet and a recruitment strategy was in place. He hoped to reduce stress related absence as much as possible, but was also keen to avoid presenteeism and work to improve morale would be key; the NSFT had held a stand at a recent psychology and psychiatry event to promote vacancies which received some interest
- A Member noted that dementia and later life services had the second longest waits for assessment and asked how Officers would address this; the Chief Executive of NSFT reported that the assessment for dementia was complex and the wait included the time until end of assessment. Primary care were being supported to take on diagnostic support for dementia patients in some cases to help reduce waiting lists
- A Member queried staff caseloads; the Chief Executive of NSFT reported that high caseloads were impacted by the referral rate increasing by around 30-40

more patients every other month than patients being discharged; support at primary care would help reduce the flow into mental health services.

- The Chief Operating Officer, South Norfolk CCG, reported that from October 2019 a primary care model of multi-agency, community based mental health provision would be rolled out, which would support individuals with mild to moderate mental health issues which could be better managed in primary care; it would involve partners involved with wider determinants of health, such as social care and housing, and would be rolled out gradually so it could be refined
- The Medical Director of NSFT confirmed that psychologists on the Samphire Ward were permanent staff; Officers were looking at the wider skill mix of staff, including offering student associateships and psychologist associateships; the University of East Anglia would offer a training course for clinical associate psychologists
- The Chairman queried the delay in discharge in some areas of the County. The Medical Director of NSFT reported that having 7-day decision making, Medical Directors reviewing discharge decisions, addressing risk aversity to discharge, a well-staffed community discharge team and appropriate step-down provision would help support discharge delays
- The provider information request had been received therefore the next CQC inspection was expected around October 2019
- Seclusion and restraints had been reducing; monitoring of patients' health after rapid tranquilisation and during seclusion had improved; this had been implemented using change ideas working with staff

8.3 The Committee:

- **ASKED** NSFT to return to NHOSC with an update after publication of the next Care Quality Commission full inspection report, expected by October 2019.
- **AGREED** that An NHOSC Members' visit to Samphire Ward, the new facility at Chatterton House, King's Lynn, would be arranged

9. Local action to address health and care workforce shortages

9.1.1 The Committee received the report examining the Norfolk and Waveney Sustainability Transformation Partnership workforce workstream's local action to address and mitigate the effects of national workforce shortages affecting health and care services. This report followed on from discussions held at the meeting on 30 May 2019.

9.1.2 The Director of Workforce, Norfolk and Waveney STP gave a presentation to Members (see appendix A)

- There were over 50,000 people and 3000 vacancies in the Norfolk and Waveney workforce. Nationally, training places had reduced, and there was decreased interest in health and care as a career
- A rise in stress related illness was being seen in staff
- The nursing shortage was one of the main areas of focus in Norfolk and nationally
- A Norfolk and Waveney workforce strategy was being developed and would be finalised by autumn 2019, through engaging with staff
- A partnership was being set up to bring in apprenticeships across organisations

9.2

During discussion the following points were noted

- A Member queried the attrition rate of trainee nurses; the Director of Workforce, Norfolk and Waveney STP did not have the rates but felt it was likely to be worse than last reported as there was a national group focussing on attrition; the Director of Workforce, Norfolk and Waveney STP was due to join this group, and noted that

it was partly to do with cost, related to loss of the bursary, and placement areas not being robust enough; she would bring back learning from group meetings to the local workforce action group

- The James Paget had developed scholarships and carer progression opportunities for students and best practice was being looked at to help prevent drop-outs
- The Director of Workforce, Norfolk and Waveney STP reported in response to a query about steps being taken by Officers to engage with staff; an online conversation had been held and was being analysed. The Head of Workforce Transformation, Norfolk and Waveney STP, reported that the online conversation was live for 4 weeks; 91 organisations across Norfolk engaged, with 4000 visits to the platform, 586 active participants, 117 ideas, 309 comments and 2000 votes. Analysis of the conversation would be fed back to staff for further comment
- The Director of Workforce, Norfolk and Waveney STP, agreed it was important to promote Norfolk and Waveney as an attractive place to live and work; once people moved to Norfolk and Waveney they tended to stay so work on retention, such as developing part time roles, promoting vacancies through good links with national organisations, and growing our own workforce through training and apprenticeships, would be key to addressing vacancies, especially in hard to recruit areas
- A number of nurses had been recruited from the Philippines for the Queen Elizabeth Hospital, and it was queried what would be done to support them; the Director of Workforce, Norfolk and Waveney STP, reported that the hospital had chronic nursing vacancies for some time, so this would support them to address this. Education teams would support the new nurses with the training they would require to register with the Nursing and Midwifery Council and provide them with a thorough induction
- Financial incentives for people to work in hard to recruit areas were queried; the Director of Workforce, Norfolk and Waveney STP confirmed that where there were specific shortages, incentive packages were sometimes used. Officers were currently working with the Queen Elizabeth and James Paget Hospitals to put “grow your own” processes in place and maximise on apprenticeship opportunities
- In response to a query about work with schools, the Head of Workforce Transformation, Norfolk and Waveney STP, reported that there had been a dedicated health ambassador at West Norfolk CCG for the past 3 years working closely with schools, job centre plus, further education colleges, individuals and at careers fares; a bank of health ambassadors were in place to promote the benefits and variety of roles in the health services. Technical levels were being launched by the Government, and a proposal was being developed for health-based courses
- The Director of Workforce, Norfolk and Waveney STP, reported that learning had been taken from the staff consultation which highlighted a demand for more flexibility. There was no upper age limit for working in the NHS; flexible options needed to be introduced to suit everyone at each point in their life
- The cost of travelling for students was noted; the Director of Workforce, Norfolk and Waveney STP was expecting national support for students and would also be looking at the possibility of training outposts in locations across Norfolk. The Open University already supported students in Kings Lynn
- The Director of Workforce, Norfolk and Waveney STP, clarified that carers were not included in the staff conversation, but Officers were working with the voluntary sector to understand the needs of the unpaid workforce to ensure the strategy reflected their needs
- The Chairman asked about the effect of paramedics being encouraged to take up roles elsewhere in the workforce; the Director of Workforce, Norfolk and Waveney STP, wanted to look into ways for people to stay with their current employers but

have placements with other employers, for example through part time placements

9.3 The Committee **ASKED for**:

(a) Information from a national study on where healthcare professionals choose to work and why to be shared with NHOSC Members (i.e. the reasons why so few from the study were choosing East Anglia as the place they wished to live and work), so that County and Borough Councillors can consider what more their councils can do to attract people to the area.

(b) Representatives from the STP workforce workstream to return to NHOSC next year (2020) with an update on local actions to mitigate the effects of national workforce shortages

10. Forward Work Plan

10.1 The Committee considered and discussed the forward workplan

10.2.1 Cllr David Harrison was standing down from his role as link member with Norfolk Community Health and Care NHS Trust; the Committee **CONFIRMED** appointment of Cllr Emma Spagnola to this role

10.2.2 The Committee **APPOINTED** Cllr Robert Kybird as substitute link member with South Norfolk CCG.

10.2.3 It was agreed that the next meeting of the Committee, due to be held on the 10 October 2019, would be held at 2pm.

10.3 The forward workplan was **AGREED** with the following additions:

a) <u>23 Jan 2020</u>
- The Queen Elizabeth Hospital NHS Foundation Trust – response to the CQC report

b) <u>To be scheduled in 2020</u>
- Norfolk and Suffolk NHS Foundation Trust – response to the CQC report
- Local action to address health and care workforce shortages

c) <u>Items for NHOSC Briefing</u>
- Update on the process around provision of healthcare infrastructure
- Update on NHS medicines shortages
- *Potentially* include information arising from a UEA wellbeing event in November 2019
- Information on public health role in relation to air pollution.

d) <u>Visits to be arranged</u>
- Cromer Hospital – Norfolk and Norwich University Hospitals NHS Foundation Trust
- Samphire Ward (new facilities), Chatterton House, King's Lynn – Norfolk & Suffolk NHS Foundation Trust

Chairman

The meeting ended at 13:05

in good health
The Norfolk and Waveney Health and Care Partnership

Workforce Update

21st June 2019

By Anna Morgan
STP Director of Workforce

Workforce - What's the problem?

in good health
The Norfolk and Waveney Health and Care Partnership

National Picture

- Staffing is the make-or-break issue for the NHS in England…and Social Care
- Across NHS trusts there is a shortage of more than 100,000 staff. Based on current trends, the projected gap between staff needed and the number available could reach almost 250,000 by 2030.
- Many of the same issues are affecting the social care workforce: for example, vacancies in adult social care are rising, currently totaling 110,000, with around 1 in 10 social worker and 1 in 11 care worker roles unfilled.
- National picture is 33% of Registered Nurses (RNs) due to retire shortly

Local Picture

- 100K unpaid carers
- Social Care – establishment = 24,500 (including direct care/nursing)
  - 1,200 direct care vacancies
  - 50 Registered Nurse vacancies
- Health – establishment = c30,000 (Acute/Community/Primary Care/Mental Health/CCG/East of England Ambulance Service EEAST)
  - c2,000 + vacancies (800+ Registered Nurses/200 medical)
- Retirement projections – nearly a quarter of paid Carers and 17% of adult nurses are due to retire in the next 5 years based on a retirement age of 60 years. The actual figure might be even higher due to early retirements, especially for nurses and midwives with a special class status (e.g. up to 35% for midwives)

How did we get here?

in good health
The Norfolk and Waveney Health and Care Partnership

- Fragmentation of responsibility for workforce issues at a national level;
- Poor workforce planning based on establishments and roles rather than on person centered care and the skills and competencies required;
- Cuts in funding for training places (central investment in education and training has dropped from 5% of health spending in 2006/7 to 3% in 2018/19, had the previous share of health spending been maintained, investment would be £2bn higher).
- Investment in workforce and organisations has been focused on secondary care and not primary care (historically)
- Restrictive immigration policies exacerbated by Brexit;
- High numbers of doctors and nurses leaving their jobs early (work/life balance, lack of flexibility, and increasing demand are main contributors)
- Impact of cost improvement programmes on Provider organisations, uncertainty of contracts and tendering has led to significant reductions in workforce and a lack of confidence and ability to plan for the future.

What's the impact?

in good health
The Norfolk and Waveney Health and Care Partnership

- Current workforce shortages and increasing demands are taking a significant toll on the health and wellbeing of staff
- Growing waiting lists
- Deteriorating care quality
- Health and Care roles are unattractive therefore we are unable to recruit or we attract people with insufficient qualifications, values and behaviors
- Risk that some of the £20.5bn secured for NHS front-line services will go unspent: even if commissioners have the resources to commission additional activity, health care providers may not have the staff to deliver it
- The close interrelationship between the NHS and social care is highlighted and in particular to ensure that addressing shortages in the NHS must not come at the expense of the already stretched social care workforce.

Policy Direction

- The NHS long-term plan sets out the ambitions for the health service in the context of the recent funding settlement. Local plans must be clearly linked to a strategy to address the workforce crisis; a credible workforce strategy will need to plan for a degree of oversupply of NHS staff.
- Five key tests – address workforce shortages in the short term; address workforce shortages in the long term; support new ways of working; address race and gender inequalities in pay and progression; strengthen workforce and service planning at all levels of the system.
- The NHS Interim People Plan was launched on 3rd June 2019 to tackle the range of workforce challenges in the NHS with a particular focus on the actions for this year.

People Plan Themes –

- Making the NHS the best place to work
- Improving NHS leadership culture
- Addressing workforce shortages
- Developing a new operating model for workforce
- Delivering 21st century care

What do we need to do? ……..National Workforce Strategy

- Increase the number of nurses joining the NHS from training, reduce the drop-out rate during training by a third
- Increase the financial support to nursing students with 'cost of living' grants of around £5,200 a year on top of the means-tested loan system
- Covering the costs of tuition fees, to triple the number of nurses training as postgraduates
- The availability and quality of clinical placements is another key priority for reform
- International recruitment will need to play a substantial role in the NHS workforce implementation plan
- Increase the number of GPs
- Make substantial progress towards a new model of general practice with an expanded multidisciplinary team drawing on the skills of other health care professionals
- Attention to equality & inclusion, pay, pension and work life balance
- Invest in the development of existing staff, CPD and Appraisal
- Prioritise compassionate and inclusive leadership

What should we be doing? Development of vision and long term plan for Workforce in Norfolk and Waveney

Development of system strategy and plan for transforming our workforce

- In development – seeking views of multiple stakeholders
- Draft for consultation in Autumn
- Will align to national workforce strategy themes BUT will prioritise innovation, new ways of working and be driven by the needs of our local population

Strategy must be

- Brave, innovative & forward thinking
- Inclusive of the broad spectrum across health and care
- Inclusive of paid and unpaid workforce
- Realistic and solutions focused, what is within our gift to influence and challenge?
- Move away from traditional workforce planning to one driven by patient centered care and population health management data
- Seek organisational and stakeholder commitment to stand together and invest in our future workforce
- Inclusive of prevention, embrace non medical models of care particularly for mental heath
- Committed to embedding fully inclusive models of supervision/handover for our workforce paid and unpaid

What are we already doing?

- c150 Trainee Nursing Associates completing 1st year of 2 year training programme
- c56 Advanced Care Practitioners in training
- Joint posts for Advanced Nurse Practitioners (ANPs) in Primary Care in progress
- Rotational programme pilot for specialist paramedics in community settings commences in July (phase 1)
- Systems Leadership programmes in place and established Organisational Development (OD) network
- Staff engagement methodology launched - #WeCareTogether
- TNA partnership developing Trainee Nursing Associate (TNA) growth trajectory for next 3-5 years
- Nursing & Midwifery Council (NMC) approval gained for our TNA programme
- Project Manager appointed to strengthen TNA placements
- Development of system approach to increasing Clinical Psychologists and implementing a Trailblazer for the new CAP (Clinical Associate Psychologist) role has commenced working with Provider organisations and UEA
- Workforce Strategy in development, engagement activities in place – draft for consultation (Sept/October)
- Primary Care Workforce plan in place and delivering against retention targets

Actions July onwards

in good health
The Norfolk and Waveney Health and Care Partnership

- Develop a workforce dashboard across health & care to give Norfolk and Waveney Health and Care Partnership Exec clear sight of workforce performance
- Form a workforce operational steering group & workforce governance structure
- Launch workforce strategy in Autumn and monitor action plan

- Workforce Director Objectives:
  - ✓ Develop workforce strategy – clear deliverables in next 2-5 years
  - ✓ Chair Local Workforce Action Board (LWAB) and deliver the 4 ambitions – all health & care organisations represented and make joint decisions on Workforce Development Fund spend
  - ✓ Provide workforce leadership to Executive team – connect local and national strategy to STP/ICS
  - ✓ Expand Trainee Nursing Associate Programme at scale and pace – building our next generation of nurses
  - ✓ Support the success of the Clinical Care and Transformation Group – building momentum of clinical leadership/engagement
  - ✓ Chair the Social Partnership Forum (SPF) – co-production with unions
  - ✓ Work with Directors of Nursing (DoNs) to review safer staffing & education support – setting local benchmarks
  - ✓ Deliver stories on peoples experience of health & care to the oversight group – building momentum and engagement with service users/patients…our people
  - ✓ Lead the development of a business case to support Population Health Management in Norfolk and Waveney – enabling workforce transformation around the needs of our population

9

Access to palliative and end of life care

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

Examination of the progress made by NHS commissioner and provider partners to improve palliative and end of life care services for adults in Norfolk.

1.0 Purpose of today's meeting

1.1 The committee will have the opportunity to examine progress to improve specialist and generalist palliative and end of life care commissioned and provided for adults in Norfolk.

1.2 The NHS partners were asked to provide the refreshed *Norfolk and Waveney STP Palliative and End of Life Care Strategy for Adults 2019 – 2024*, which includes a gap analysis between currently commissioned services and the levels required, and next steps towards delivering the objectives of the strategy. The 86 page document is available on the Norfolk Health Overview and Scrutiny Committee (NHOSC) website via the following link:- https://norfolkcc.cmis.uk.com/norfolkcc/Meetings/tabid/128/ctl/ViewMeetingPublic/mid/496/Meeting/1557/Committee/22/Default.aspx

The partners were also asked to provide a paper detailing progress since their last report to Norfolk Health Overview and Scrutiny Committee (NHOSC) on 18 October 2018. Their report is attached at **Appendix A,** which also includes a summary version of the *Norfolk and Waveney STP Palliative and End of Life Care Strategy for Adults 2019 – 2024* at Appendix 1.

1.3 In October 2018 NHOSC agreed that issues for the next meeting would include (not exclusively):-

- Night time service
- Consistency of services
- Advocacy for families
- Choice of place of care

The NHS partners have been asked to address these issues in their report and will be in attendance to answer Members' questions. Adult social care's perspective will also be represented by the Deputy Director of Integration.

1.4 NHOSC also agreed in October 2018 that input from Norwich Consolidated Charities would be sought for today's meeting. (See paragraph 2.4 below).

2.0 Background

2.1 Previous report to NHOSC

2.1.1 As well as a paper on current provision from the NHS partners, the last report to NHOSC on 18 October 2018 included:-

- Definitions of palliative and end of life care
- National guidance on appropriate levels and standards of care
- Details about enabling patients' choice of where to die
- Information about hospice care
- Outlines of the systemic issues which affect people's experience of palliative and end of life care
- Background of previous reports health scrutiny
- The NHS's previous needs assessments and ambitions dating back to 2004
- Assessment of the rate of progress

The October 2018 report is available on Norfolk County Council's website:- NHOSC 18 October 2018

2.1.2 There were a number of questions in the 'suggest approach' section of the October 2018 NHOSC paper that the committee did not have time to fully explore at the meeting. The NHS attendees were asked to provide written responses to those questions. Responses were received on 2 April 2019 and are attached at **Appendix B.**

2.2 NHOSC Member visits

2.2.1 In October 2018 NHOSC also agreed that Members should visit palliative and end of life care services to get a better understanding of the issues. Visits were arranged as follows:-

28 Nov 2018 – Priscilla Bacon Centre, Norwich
5 Dec 2018 - The Norfolk Hospice, Tapping House, Hillington, King's Lynn
28 Jan 2019 - East Coast Hospice Ltd, Gorleston (a visit with the charity that intends to provide a hospice at Hopton)

Notes of the three visits are attached at **Appendix C.**

2.3 Previous report to Great Yarmouth and Waveney Joint Health Scrutiny Committee

2.3.1 When NHOSC met in October 2018, procurement was underway in the Great Yarmouth and Waveney CCG area to commission adult community services and adult specialist palliative care services under a new contract from April 2019.

On 3 January 2019 the CCG announced that East Coast Community Healthcare (ECCH) community interest company had won the contract and the new specialist palliative care service for patients would be delivered in partnership with St Elizabeth's Hospice, Ipswich. It was to be a consultant led community-based service with 24/7 access to advice and specialist palliative care beds provided within a community hospital, hospice or accredited care home setting.

2.3.2 On 12 July 2019 Great Yarmouth and Waveney Joint Health Scrutiny Committee (GY&W JHSC) met with representatives of ECCH, St Elizabeth's Hospice and the CCG commissioners to examine progress with service provision under the new contract. The report received by GY&W JHSC including full details of the extent of the new service, is available via the following link (agenda item 6):- https://norfolkcc.cmis.uk.com/norfolkcc/Meetings/tabid/128/ctl/ViewMeetingPublic/mid/496/Meeting/1511/Committee/25/Default.aspx

GY&W JHSC noted significant progress in the provision of palliative and end of life care services in Great Yarmouth and Waveney. The committee asked the CCG and ECCH to consider enhancing the support/training/guidance provided to families and carers when a person dies, working with other agencies (e.g. police and ambulance) to promote more use of the 24/7 advice line.

The joint committee also agreed to examine the service again in 12 months' time, to include scrutiny of performance and demands on the service, utilisation of the 24/7 advice line, advance care planning and quality accounts.

2.4 **Input from Norwich Consolidated Charties**

2.4.1 As agreed by NHOSC on 18 October 2018, Norwich Consolidated Charities was approached for comments regarding end of life care and how it could be improved from their perspective as an enhanced sheltered housing provider.

2.4.2 Doughty's, which is accommodation with care provided by Norwich Consolidated Charities, is registered with the 'Six Steps to Success in End of Life Care' programme. In May 2019 the Manager of Doughty's, while emphasising that other providers may also provide high quality end of life care without being part of the 'Six Steps' programme, provided the following points about Doughty's experience:-

Background

- Doughty's is registered with the 'Six Steps to Success in End of Life Care' programme: http://www.sixsteps.net/
- There is a considerable amount of work for an organisation to register with the programme and ongoing actions are required to maintain registration annually.

Main hurdles

- Organisations need to have the resources and be prepared to make an ongoing commitment to the programme, i.e. dedicated staffing, training days and reports as well as the actual work to embed and practice the methodology. It can't be a tick box exercise. A number of smaller organisations have failed the registration process as they underestimate how involved the process is.

How to improve end of life care

- Organisations may need additional support from CCGs and local authorities to implement good end of life care programmes as they do require additional resources.

2.5 **Care Quality Commission inspection report for the Queen Elizabeth Hospital – 'inadequate' rating for end of life care**

2.5.1 On 24 July 2019 the Care Quality Commission published the report of its inspection of The Queen Elizabeth Hospital, King's Lynn, between 5th March and 24th April 2019. The CQC's summary of its findings was as follows[1]:-

> "The rating for end of life care went down to inadequate overall. Safety remained requires improvement. Effective remained inadequate, responsive went down from good to inadequate and well led went down from requires improvement to inadequate. Caring remained good. Use of the individualised plan of care (IPOC) had not been embedded throughout the trust which meant patients did not always receive person-centred care that met their needs. Not all records reviewed contained documentation about ceilings of treatment. Palliative consultant staffing was not in line national guidance and senior leadership did not take ownership of end of life care or have sufficient oversight of performance within the service. We were not assured that risks were escalated appropriately. There had been a failure to address previous concerns. There remained a lack of ownership and oversight for the service, end of life care was not seen as a priority. There was no stable leadership team to support and promote end of life care. Data provided to demonstrate key performance metrics was inaccurate. There was no effective strategy in place for end of life care. There had been no improvement in the development or engagement of the strategy."

Commissioning representatives will be in attendance at today's meeting. Representatives from the Queen Elizabeth Hospital will attend NHOSC in January 2020 when all the trust's issues, including end of life care, can be discussed.

3.0 Suggested approach

3.1 As the Great Yarmouth and Waveney Joint Health Scrutiny Committee has recently examined this subject within its area and intends to follow up on

[1] The CQC inspects and rates service providers under five headings 'Safe', 'Effective', 'Responsive', 'Caring' and 'Well Led'. Taken together these produce the overall rating.

progress in 12 months' time, **you may wish to focus on the service in the rest of Norfolk** at today's meeting.

3.2 After the NHS partners have presented their report you may wish to explore the following areas:-

(a) The commissioners have indicated that they intend to commission a new integrated model of palliative and end of life care in Norfolk, to be implemented by March 2021.

What is the scope for reducing the gap between required levels of specialist palliative care provision and the levels currently commissioned in advance of that date?

(b) Documents and tools to support advance care planning for end of life care have been available Norfolk for some time but take-up and successful use of these tools appears to be limited.

What more can the partners do to promote and embed the new ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) when introducing it in 2020?

(c) The *Norfolk and Waveney STP Palliative and End of Life Care Strategy for Adults 2019 – 2024* states that there is a shortfall of 7.4 specialist palliative care consultants across Norfolk and Waveney and that 'recent CQC inspections have focused on the paucity of provision across the patch and this is an area that requires urgent attention' (page 23).

Given the size of the shortfall and the current workforce shortages across the NHS, what more can the partners do to reduce this gap in the short term?

(d) The *Norfolk and Waveney STP Palliative and End of Life Care Strategy for Adults 2019 – 2024* (page 22) notes that the shortfall of specialist palliative care in-patient (hospice) beds is between at least 47 - 67 beds (only 30 beds are available for the system).

What can be done to speed up the provision of additional hospice / specialist palliative care beds?

(e) In October 2018 NHOSC heard about the systemic challenges in Norfolk around planning, budgets and information sharing that particularly affect the discharge of palliative and end of life patients from acute hospitals? (See paragraph 2.5.1 of the report to NHOSC 18 October 2018)

What has changed in the systems for discharge of end of life patients at each of the three acute hospitals since October 2018?

(f) The NHS partners' report (Appendix A, paragraph 5.1) states that night time provision in the west and east of the county is provided by Marie Curie. What is the nature and extent of this provision?

(g) To what extent is the need for more mental health support for end of life patients and their families, especially where there are already known mental health issues or other underlying stresses within the family, being considered within the current work to remodel adult mental health services in Norfolk?

4.0 Action

4.1 The committee may wish to consider whether to:-

(a) Make comments and / or recommendations to the commissioner or providers of palliative and end of life services based on the information received at today's meeting.

(b) Ask for further information via the NHOSC Briefing or to examine specific aspects of palliative and end of life services at a future meeting.

IN TRAN communication for all	If you need this report in large print, audio, Braille, alternative format or in a different language please contact Customer Services on 0344 800 8020 or Text Relay on 18001 0344 800 8020 (textphone) and we will do our best to help.

Access to Palliative and End of Life Care

Introduction

This report builds upon previous submissions to Norfolk HOSC and responses made since the meeting in October 2018 and documents progress made. Section 1 introduces the Norfolk and Waveney STP Palliative and End of Life Care Strategy, sections 2-9 address questions from HOSC and sections 10-11 provide information on how the public are engaged with palliative and end of life services.

1. Norfolk and Waveney STP Palliative and End of Life Care Strategy (2019-2024) and Current Service Provision

1.1 The Sustainability and Transformation Partnership (STP) Norfolk and Waveney Palliative and End of Life Care Strategy has been produced by the Palliative and End of Life Collaborative Group with representatives from CCGs, Providers, Local Authorities, Charitable Trusts, Public Health, Carers and the UEA Research Centre and Community.

1.2 The Collaborative Group was recognised as an STP work stream mid-2018, as part of the Primary and Community Care work stream. The STP wide Strategy will be formally launched in autumn 2019. (Please refer to the Norfolk HOSC 5 September 2019 webpage for the full Strategy document and Appendix 1 to this paper for the draft public facing leaflet)

1.3 The Strategy sets out the local vision for palliative and end of life care which is fundamentally built upon the National Six Ambitions for Palliative and End of Life Care and contains details of how we intend to transform services and why. It builds on the work of the Collaborative Group and the Lord Lieutenant's Palliative Care Forum.

1.4 The Strategy provides us with the mandate and the vision for tackling service variation across the three main local systems in Norfolk and Waveney over the next five years. Any developments have to take into account the NHS Long Term Plan and the creation of Primary Care Networks.

1.5 The following delivery phases are set out in the Strategy:

- Phase 1 – Launch and set up the change programme
- Phase 2 – Design and align commissioning (until March 2020)
- Implementation of new model (by March 2021)

1.6 The vision of new, more integrated, pathways across the STP are set out on pages 7-8 of the Strategy and page 4 of the draft public facing leaflet.

1.7 The work streams of the Strategy change programme are as follows:

- **Commissioning a new integrated model** including specialist enhanced and generalist services consistent with the nationally defined palliative and end of life pathway. This includes service design with Primary Care Networks,
- **Documentation and tools** to review, design and implement documents and tools such as Yellow Folders/Thinking Ahead document to support more advance care planning, rollout of ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) and streamlining current forms and policies e.g. verification of death,
- **Education and workforce** to and refresh the STP approach to training across all settings, including the implementation of the ten core competencies for palliative and end of life care,
- **Clinical working group** to coordinate themes from Care Quality Commission visits across provider settings and to improve pain relief and prescribing in community care settings,
- **Community Engagement and Compassionate Communities** working with service users, carers and the public to promote death and dying,
- **Digital working group** to develop new and innovative ways of working to coordinate care through digital utilisation, and
- **Psychology and bereavement** working group to scope the unmet need for psychological and bereavement services across Norfolk and Waveney.

2. Consultant and High Level Staff in Palliative and End of Life Care

2.1 Gaps in consultant posts in palliative care were identified as a result of the mapping exercise to inform the strategy. Local areas are working to increase capacity.

2.2 In West Norfolk, there is support for a specialty middle grade doctor to become a consultant in the future and thinking creatively about how to make posts more attractive.

2.3 In Great Yarmouth and Waveney there is 1.7 WTE medical consultant, one nurse consultant in post from September 2019, 0.2 WTE GP Fellow and plans for a GP trainee starting in February 2020. Recruitment of a community nurse specialist and counsellor has been successful. The hospital palliative care team based at James Paget University Hospital (JPUH) will have in-reach support from consultants to provide the specialist palliative care component.

3. Provision of Hospice/Specialist Palliative Care Beds

3.1 In Great Yarmouth and Waveney, patients have access to specialist beds within Beccles Hospital and St Elizabeth's Hospice; North Norfolk and West Norfolk residents have access to the Norfolk Hospice, Tapping House. South Norfolk patients have access to St Nicholas' Hospice.

3.2 Priscilla Bacon Norfolk Hospice plans to have 24 beds in the future when it moves to new premises adjacent to the Norfolk and Norwich University Hospital (NNUH) site.

3.3 In Central Norfolk area, significant investment has been made in a Hospice at Home service. This is providing more capacity with enhanced palliative and end of life support and care in the patient's own home, as well as a new patient and carer helpline.

3.4 In West Norfolk, Tapping House offers an in-patient unit which will increase from six to eight beds. Referrals to this unit are generally split evenly between community admissions (avoiding unnecessary conveyance to acute hospital) and referrals from the Queen Elizabeth Hospital Kings Lynn (helping to support patient choice about their preferred place of care).

3.5 In addition to this, the Swaffham and Litcham Home Hospice, which has provided a service to the local community in that area for several years, is also commissioned to provide a variety of support services.

4. Resolving Systematic Challenges in Norfolk and Waveney

4.1 Since the establishment of the Palliative Care Collaborative, barriers between providers and commissioners have been removed and partners are working towards the shared outcomes and a shared clinical model.

4.2 We have system wide agreement to implement the ReSPECT process, to plan a person's clinical care in the event of a future emergency if they are unable to make or express choices. It results in a document that contains the person's wishes and care preferences along with appropriate clinical recommendations.

4.3 Planning meetings between NNUH and JPUH palliative consultants, as well as oncology consultants, to identify ways of working together to benefit of patients are being established.

4.4 The STP Programme sub group clinical work stream met and have progressed the access to medications in each locality, the standardised use of the syringe driver and community drug chart as well as working with stakeholders on the Individualised Plan of Care updates.

4.5 At the NNUH there an integrated end of life fast track discharge team which endeavours to assess and discharge patients to their home or preferred place of care in the shortest time possible. The discharge team consists of specialist nurses and have been joined by a full time "palliative" social worker and assistant practitioner, whose posts were originally funded by Macmillan and in 2019 the NNUH took over the funding of these posts.

4.6 To support service consistency, in central and west areas, patients are reviewed daily, as required, with no break in service. Telephone advice is available overnight if needed. NNUH offers a seven day service with 2 Specialist Palliative Care nurses and one consultant on duty at weekends between 9am – 5pm.

5. Night Time Services

5.1 Night time provision is delivered in Norfolk and Waveney in Great Yarmouth and Waveney and in West Norfolk by Marie Curie and in the Central Norfolk area by Hospice at Home.

5.2 Adult Social Care also can provide night sits across Norfolk via the Emergency Duty Team and through the Enhanced Home Care Service, based on particular criteria. Specialist advice, hour of hours, is also available to professionals in the three areas of Norfolk.

6. Advocacy

6.1 Advocacy is part of the daily work of the Specialist Palliative Care team (NNUH). This is where advance care planning and individual end of life care planning particularly help ensure the patient is at the centre of all care and that their needs and wishes and choices, along with their families, are heard and adhered to in a realistic and supportive way.

6.2 The ReSPECT process, which will be launched in spring 2020 enables the individual and caregivers to have vital conversations about end of life wishes. Social Work teams also support and advocate for patient care.

7. Preferred Place of Care (PPOC)

7.1 This is explored at entry to the community service and is further reviewed on a regular basis between the patient and the multidisciplinary team. NNUH take PPOC very seriously and every opportunity is taken to try and ensure this happens for all patients.

7.2 Unfortunately there is not always the availability of care or a bed at a specific location when the patient requires it. NNUH has a dedicated discharge team who provide a six day service to provide co-ordination of preferred place of care via fast track services and who work closely with commissioners to secure funding for care home placement or care at home provision.

7.3 Preferred of place of care has become integrated into daily practice and is the basis of the Trust's ward "board rounds" and "Red to Green" processes which are the multidisciplinary processes to ensure everything is being done to discharge the patient to their preferred place of care.

7.4 The Specialist Palliative Care team has representatives from the discharge team who attend the multidisciplinary team and palliative social worker to ensure everything possible is done to get patients to the preferred place of care.

7.5 Additionally case notes are reviewed when patients failed to be discharged to their PPOC and died within the Trust and this is consultant led.

8. Provision in Great Yarmouth and Waveney

8.1 Great Yarmouth and Waveney's Community Service is delivered by East Coast Community Heath CIC in partnership with St Elizabeth's Hospice. They provide a community generalist service available for palliative and end of life patients via an integrated model. The specialist service has a Community Nurse

Specialist allocated to each Primary Care Network (PCN) with an average expected caseload of 25 patients.

8.2 These services are available during day time hours, seven days a week. In addition to this there are Day Services for clinical interventions and symptom management, night sits provided by Marie Curie and six specialist palliative care beds at Beccles Hospital. A 24/7 advice line supports patients, carers and professionals across Great Yarmouth and Waveney.

8.3 There is also consultant in-reach to the James Paget University Hospital, 24/7 on call access, attendance at MDTs and a joint approach to planning and delivering care to the system, in collaboration with care homes and other agencies.

9. Mental Health Support

9.1 STP Partners are keen to address mental health needs of both the patient and their families and also where there are known mental health issues.

9.2 The National Audit of Care at the End of Life (NACEL) was commissioned in October 2017 by the Healthcare improvement partnership (HQIP) on behalf of NHS England and the Welsh Government to improve the quality of care of people at the end of life in acute, mental health and community hospital. The audit monitors progress against the five priorities of care set out in the One Chance to Get it Right and NICE Quality Standard 144, within the context of NICE Quality Standard 31. NG31 aims to improve end of life care for people in their last days of life by communicating effectively and involving them and the people important to them in decisions and maintaining their comfort and dignity.

9.3 One example of where Norfolk and Suffolk Foundation Trust (NSFT) colleagues are engaged is with ReSPECT work stream of the Strategy in enabling patients with Mental Health to articulate their wishes for the end of life care.

9.4 In addition to this the Psychological and Bereavement Working Group is to encourage joint working across health, social care, education and the non-statutory sector, in order to develop a local vision and a plan which will appropriately support patients and their families who are accessing Palliative, End of Life and Bereavement Care.

9.5 In Great Yarmouth and Waveney a counsellor has been appointed, who is working with patients as well as bereaved families as part of the Specialist Palliative Care team. Some spiritual care support is available as well.

10. Commissioning Support to Queen Elizabeth Hospital, King's Lynn

10.1 In July 2019 the Care Quality Commission recommended that the QEHKL remain in Special Measures and overall, its CQC rating remains as Inadequate.

10.2 A recent service mapping workshop in the West identified that Tapping House would like to work more closely with QEHKL in knowledge exchange and supporting patients on the wards.

10.3 Due to increasing the number of beds commissioned at Tapping House, the team will be able to have the capacity to work with QEHKL. Identifying commissioning gaps that may exist in the Integrated Palliative Care service will also support the QEHKL by enabling patients to be supported effectively in the community/at home and thus, stratifying the patients who are admitted.

10.4 The ReSPECT process is also part of CQC actions plans and quality improvement plans, within providers, so QEHKL will also be implementing this process.

10.5 West Norfolk established the Integrated Palliative Care Service in 2016. This is provided by Norfolk Community Health and Care NHS Trust (NCH&C) in partnership with Tapping House, Marie Curie, Norfolk County Council (Social Services) and works closely with GPs / Community practitioners and the Queen Elizabeth Hospital.

10.6 This new model includes a Coordination Centre (to manage referrals via one route), and co-location of practitioners at Tapping House, such as Consultants, Specialist Palliative Care Nurses, Hospice at Home team (including night sitting), day therapy, complementary therapy, Social Care and bereavement support. The team works closely with the community nursing and therapy team. Consultant and specialist palliative care nursing resource supports patients within the QEHKL.

11. Dying Matters and Compassionate Communities

11.1 The experience of people in the last stage of life is also a significant theme in the strategy. Research from Dying Matters shows that around 70% of people would prefer to die at home, yet around 50% currently die in hospital. Implementing the strategy should reduce the number of people who die in hospital.

11.2 Through the Community Engagement and Communities working group, we will look to service users, carers and the public to promote positive death within their community and oversee system wide approach to palliative care volunteers.

11.3 Dying Matters Awareness Week took place in May 2019 at the Forum as a public awareness event, with information packs available for the public. It included participation from pupils at Norwich School who have undertaken a project on death, dying and suicide, stall holders and organisations from Norfolk and Waveney. Feedback from students in paramedic and social care was positive regarding learning about compassion and about end of life care, which was deemed to be invaluable to their training.

11.4 A key component of the work stream will be the networking of volunteers across the area including GP Patient Participation Groups. An example of this is the Wymondham Practice volunteers being trained to help people complete Advance Care Plans.

11.5 Compassionate Communities UK is a charity that has been set up to implement the Compassionate City programme, as well as provide practice expertise in the

public health approach to end of life care and embed it in health and social care education programmes.

11.6 Compassionate Communities' work has joined up with the Engagement work stream of the Strategy to look, more holistically at the information and advice available to the public on death and dying, to review discharge processing to ascertain if community support can help reduce the number of people that die in hospital waiting to be transferred home or to another preferred place of death.

11.7 This work connects to Voluntary Services at NNUH, the Butterfly coordinators, Continuing Health Care, and the Specialist Palliative Care team, as well as, community-based end of life doulas and trained soul midwives.

11.8 Initial meetings have taken place in association with UEA Health and Social Care Partners, NCH&C, and NSFT to devise a brief psychological intervention for people receiving palliative and end of life care and/or their family. The intervention is based on the importance of offering brief, targeted psychological support at the time of need, as opposed to the current wait time of 12-16 weeks for an extended course of treatment. It reflects the NHS long-term plan in promoting more coaching type models of support.

12. Conclusion

12.1 Norfolk and Waveney partners are pleased with the progress towards a single vision for patients and carers, as articulated in the Strategy. The collaboration which has produced the Strategy will continue into the design and implementation of the change programme. There is recognition by all partners that there are improvements to be made in palliative care and end of life services, but also, positively, that this journey has started in earnest.

13. Appendix

13.1 Appendix 1: Draft Palliative and End of Life Care Strategy (2019-2024) Public Leaflet

Gita Prasad
Assistant Director of Strategic Commissioning, NHS Norwich CCG and the STP Palliative Care Collaborative

in good health
The Norfolk and Waveney Health and Care Partnership

Norfolk and Waveney STP Palliative and End of Life Care Strategy for Adults - 2019 – 2024 A Summary

in good health
The Norfolk and Waveney Health and Care Partnership

Contents

Welcome to…

The Norfolk and Waveney Sustainable Transformation Partnership (STP) Palliative and End of Life Collaborative Group (Collaborative Group) strategy for palliative and end of life care for adults, our Collaborative Group is made up of the following organisations:

- Commissioners: Norwich, North Norfolk, Great Yarmouth and Waveney, South Norfolk and West Norfolk Clinical Commissioning Group, Norfolk County Council and Suffolk County Council
- Norfolk Public Health and Suffolk Public Health
- Providers: James Paget University Hospital NHS Foundation Trust, East Coast Community Healthcare CIC, Norfolk Community Health and Care NHS Trust, Norfolk and Norwich University Hospital NHS Foundation Trust, IC24, East of England Ambulance Trust, The Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust, Norfolk and Suffolk NHS Foundation Trust
- Charitable Trusts: Macmillan Cancer Support, Big C, Marie Curie, Priscilla Bacon Centre, Priscilla Bacon Norfolk Hospice Care Ltd, St Nicholas Hospice Care, St Elizabeth Hospice, East Coast Hospice and Norfolk Hospice (Tapping House) and Swaffham and Litcham Hospice
- Education and Research Body: University of East Anglia Research Centre.

The Collaborative Group would like to introduce you to our jointly developed and refreshed summary document of our Palliative and End of Life Care strategy for adults.

This booklet is an introduction to the strategy, we have tried to make sure this is in as Plain English. The full strategy is available online or for a paper copy or alternative formats (such as large print or other languages) telephone 01603 613325.

Palliative and End of Life Care is one of the most challenging aspects of acute (hospital) and community based care – delivering good care which provides support and dignity to patients and their families at the end of their lives. The majority of individuals state their Preferred Place of Death would be outside a hospital setting (National Survey of Bereaved People (VOICES): England, 2015). Admission to Emergency Departments (ED) is often the only alternative for a patient at home living with chronic serious illness and yet, it is widely known hospitals are not the best place for a patient in need of palliative care.

Death and dying is inevitable. Palliative and end of life care is a priority for our STP which requires co-operation with partners across both health and social care, statutory and voluntary sector organisations, people with personal and professional experience, and everyone speaking with one voice. More must be done to ensure that high quality, accessible palliative and end of life care is consistently better for all of us.

Our Strategy on a Page

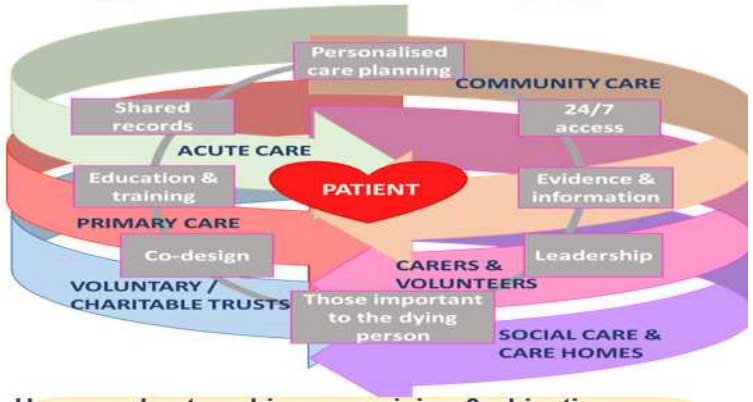
This is our strategy and (proposed) model of delivering palliative care in Norfolk and Waveney

Norfolk and Waveney STP Palliative and End of Life Strategy 2019 – 2024 – On a page

Vision: Through a new integrated palliative and end of life model of care we will ensure people and their carers/family receive care and support that is coordinated and which meets their individual needs - irrespective of care provider, diagnosis, circumstance or place of residence in Norfolk and Waveney from diagnosis through to bereavement.

Objectives for delivering an integrated model:

- Consistency across Norfolk and Waveney for palliative care provision e.g. inequity in 24/7 professional advice line, carers advice line, Hospice at Home, Social care Services, dedicated enhanced palliative care beds, psychological and bereavement services
- Capacity to provide palliative and end of life care e.g. develop the workforce across health and social care workforce, Supporting VCSE development, training and developments and assess the need for more specialist beds
- Co-ordinated approach to information/documentation, workforce (including volunteers), education, systems, audit research, performance and complaints and patient engagement
- Compliance in regards to helping people take control such as ability to access personal health budgets for palliative or end of life care
- Partnership working and pathway development with other work streams i.e. Care Homes
- Partnership working with health and social care sector and VCSE
- Social Engagement with community partnerships such as different faiths and culture groups
- Consistent approach to person centred outcome measures e.g. population needs assessment, monitoring and benchmarking
- Financial balance through a decrease in hospital admissions e.g. emergency admissions compared to PPOD



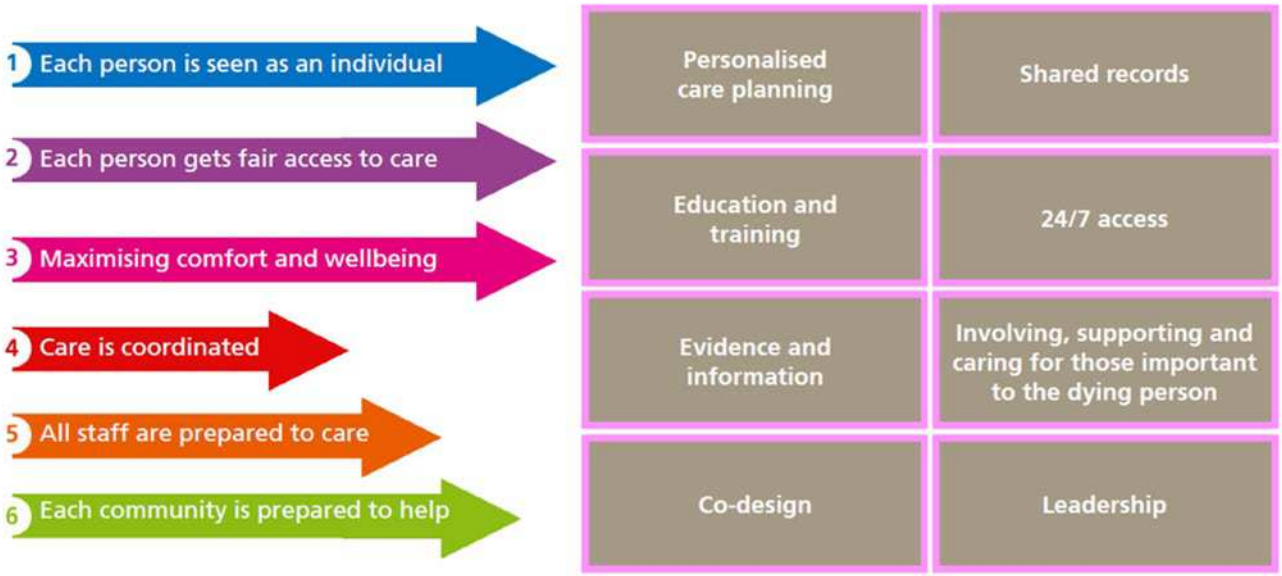
How we plan to achieve our vision & objectives:

- Leadership and coordination via the STP Palliative and End of Life care Collaborative Group
- Commissioners, health and social care providers and voluntary groups working collaboratively to develop and deliver an integrated model for Palliative & End of Life Care through aligning services across Norfolk and Waveney
- Collaborative working with Primary Care Networks, Public Health and the University of East Anglia Research Centre to ensure we are continuously ensuring population health needs are met.
- Increasing system awareness and appropriate utilisation of commissioned palliative care services
- Delivery via the 7 Collaborative working groups.
- Interface with other STP workstreams e.g. Workforce, Care Homes and Dementia

The Norfolk and Waveney Picture

The 'Ambitions for Palliative Care and End of Life' provides a framework for local action to improve the quality and accessibility of Palliative and End of Life Care. The framework consists of 6 ambitions with eight foundations that need to be in place to support achievement.

The 6 Ambitions for Palliative & End of Life Care are;



What our Norfolk and Waveney Palliative and End of Life Care Provision looks like now

Health and social care services for people living in the Norfolk and Waveney STP area are provided by a large number of organisations and these organisations are generally represented on the Collaborative Group.

Across the STP area there are:

- 5 Clinical Commissioning Groups (CCGs) - West Norfolk CCG, Great Yarmouth and Waveney CCG and a Central group (North Norfolk, Norwich and South Norfolk CCGs).
- 108 primary care general practices
- 3 acute trusts - the James Paget University Hospital (JPUH) based in Great Yarmouth, the Norfolk and Norwich University Hospital Foundation Trust (NNHUFT) located on the outskirts of Norwich and the Queen Elizabeth Hospital (QEH) in King's Lynn

- People living in West and South Norfolk may be geographically closer to and may choose to receive acute care services from hospitals outside of their STP area, including Addenbrookes Hospital in Cambridge, Papworth Hospital in Papworth Everard, Cambridgeshire and the West Suffolk Hospital in Bury St Edmunds.
- Community services are primarily provided by 2 community trusts - the Norfolk Community Health Care & Trust (NCHC) and the East Coastal Community Trust (ECCH)
- The Norfolk and Suffolk Foundation Trust (NSFT) is the largest provider of Mental Health (MH) services across the STP area
- 111 and Out of Hours GP (OOH) is provided by IC24
- Emergency response by the East of England Ambulance Service NHS Trust (EEAST)
- Norfolk County Council and Suffolk County Council fund a proportion of social care which is means tested. Many people fund their own care. Social care across Norfolk & Waveney footprint is provided by around 570 registered independent care providers. This consists of 400 residential care homes, 67 of which provide nursing care, 150 domiciliary care agencies, 22 supported living schemes, 24 Extra Care services and 1 Shared Lives scheme. There is also an increasing number of people who receive Direct Payments and use that to employ their own staff as Personal Assistants. This is a small but growing part of the care workforce that is almost completely overlooked.
- Hospice provision is currently provided by 4 organisations – Priscilla Bacon Centre, St Nicholas Hospice Care, St Elizabeth Hospice and The Norfolk Hospice (Tapping House)
- In addition, there are a number of voluntary sector and charitable trusts, who are key to supporting health and social care services
- Unpaid Carers & Volunteers
- Future Provision: Priscilla Bacon Norfolk Hospice Care Ltd and East Coast Hospice

To develop a service for patients, carers and their loved ones across Norfolk and Waveney the Collaborative Group is recommending that together, the system works towards one model of care therefore one service whilst recognising local diversity,

People who face a progressive life limiting illness require different levels of health and social care at different points in their life. As well as receiving treatment specific to their underlying life limiting condition they are likely to have palliative and end of life care needs. Many patients are well cared for by their teams but occasionally will need enhanced and/or specialist care at some point.

Why we need to change

Within Norfolk and Waveney we have a higher than average ageing population, with more people living longer but with more complex illnesses. We have a skilled workforce which is ageing and recruitment is a big challenge.

Nationally, Norfolk and Waveney is in a unique position as the specialist palliative care unit within Central Norfolk is 100% funded by the NHS and the other hospices receive differing NHS contributions. This both leads to challenges and opportunities. The current Priscilla Bacon Centre will move to a new provision adjacent to the NNUH site within the next 3 to 5 years. The new site has capacity for 24 specialist palliative care beds therefore the system (including voluntary sector partners) will work together to best optimise this opportunity. These beds will also be known as hospice beds.

Our vision, Model and Delivery

Our vision, included in the Ambitions for Palliative & End of Life Care document states that:

> "Death and dying are inevitable. Palliative and end of life care must be a priority. The quality and accessibility of this care will affect all of us and it must be made consistently better for all of us."

People living with a palliative illness is and those approaching the end of their lives, deserve and have a right to appropriate care, compassionately delivered by the health and social care workforce and informal carers. The primary aim is to ensure that all people with palliative and end of life care needs in Norfolk and Waveney can say:

> "I can make the last stage of my life as good as possible because everyone works together confidently, honestly and consistently to help me and the people who are important to me, including my carer(s)."

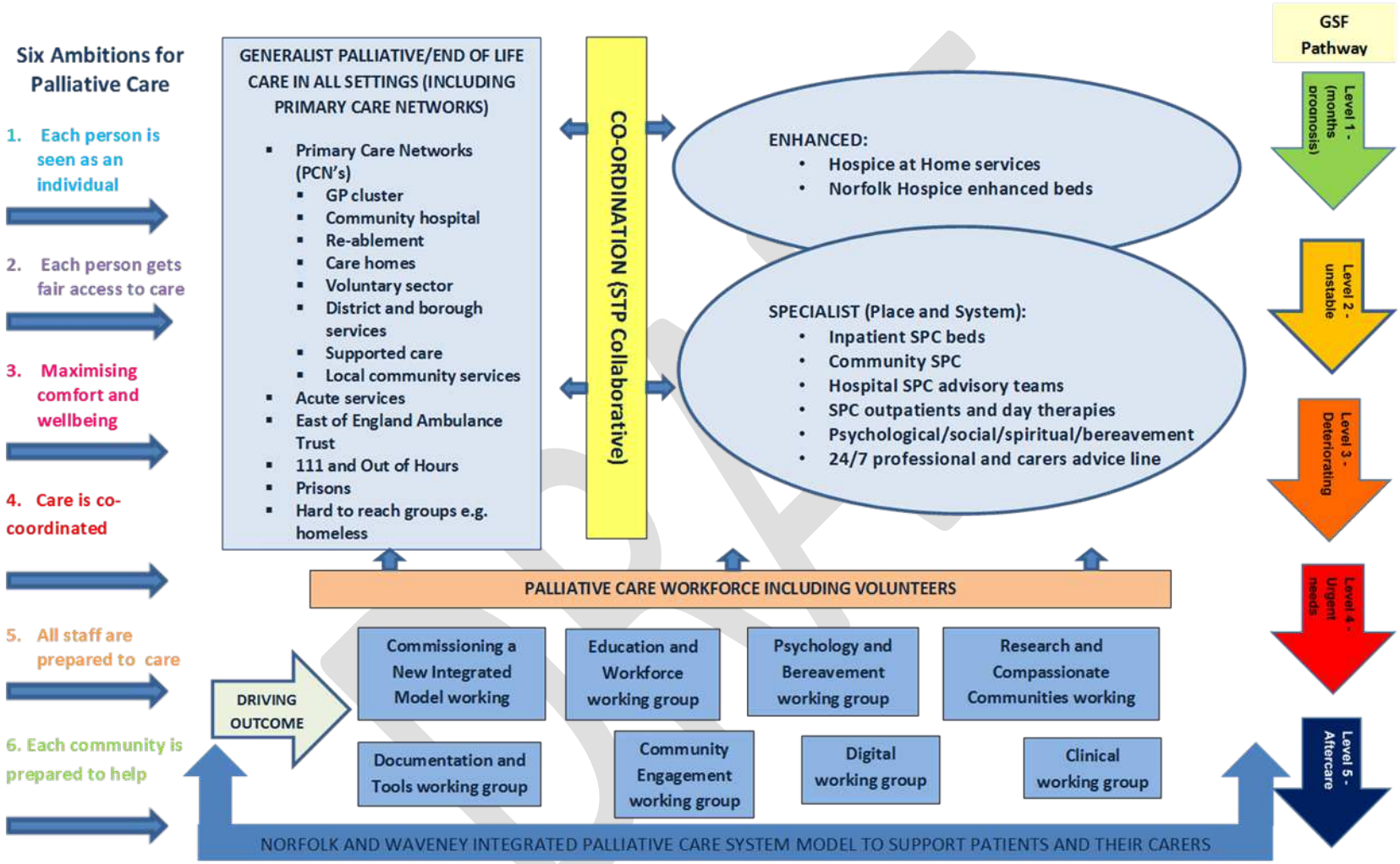
For the Collaborative Group, our local vision is:

Through a new integrated palliative and end of life model of care we will ensure people and their carers/family receive care and support that is coordinated and which meets their individual needs - irrespective of care provider, diagnosis, circumstance or place of residence in Norfolk and Waveney from diagnosis through to bereavement.

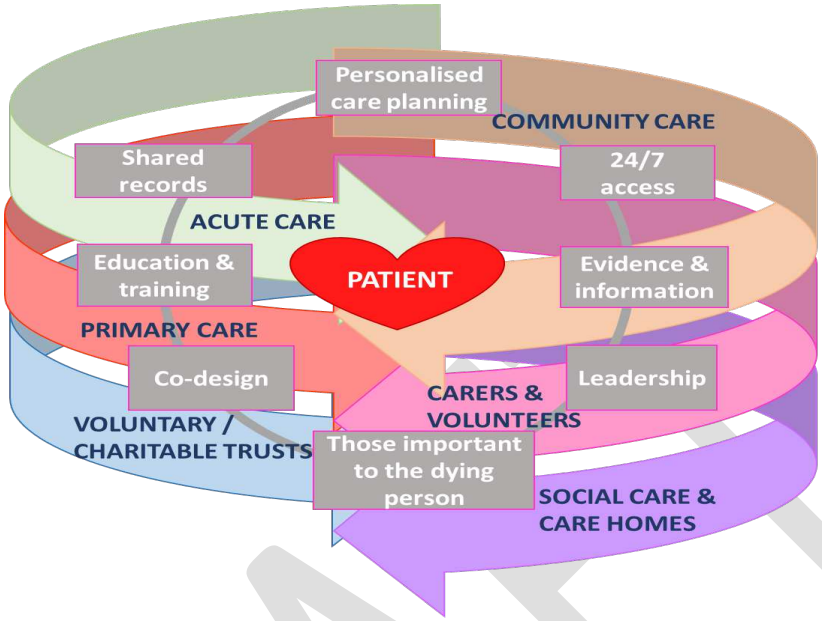
Our Model

Our model is underpinned by the six ambitions. The following diagrams illustrate what, how, and where our integrated model will deliver.

The diagram below illustrates the way services might provide different types of care as decided by local negotiation. Within Norfolk and Waveney specialist palliative care providers will be involved in providing and leading the provision of some aspects of palliative and end of life care and locally it will be determined which services are enhanced and which are led specialist and generalist teams.


Six Ambitions for Palliative Care
1. Each person is seen as an individual
2. Each person gets fair access to care
3. Maximising comfort and wellbeing
4. Care is co-coordinated
5. All staff are prepared to care
6. Each community is prepared to help
GENERALIST PALLIATIVE/END OF LIFE CARE IN ALL SETTINGS (INCLUDING PRIMARY CARE NETWORKS)
Primary Care Networks (PCN's)
GP cluster
Community hospital
Re-ablement
Care homes
Voluntary sector
District and borough services
Supported care
Local community services
Acute services
East of England Ambulance Trust
111 and Out of Hours
Prisons
Hard to reach groups e.g. homeless
CO-ORDINATION (STP Collaborative)
ENHANCED:
Hospice at Home services
Norfolk Hospice enhanced beds
SPECIALIST (Place and System):
Inpatient SPC beds
Community SPC
Hospital SPC advisory teams
SPC outpatients and day therapies
Psychological/social/spiritual/bereavement
24/7 professional and carers advice line
GSF Pathway
Level 1 - (months prognosis)
Level 2 - unstable
Level 3 - Deteriorating
Level 4 - Urgent needs
Level 5 - Aftercare
PALLIATIVE CARE WORKFORCE INCLUDING VOLUNTEERS
DRIVING OUTCOME
Commissioning a New Integrated Model working
Education and Workforce working group
Psychology and Bereavement working group
Research and Compassionate Communities working
Documentation and Tools working group
Community Engagement working group
Digital working group
Clinical working group
NORFOLK AND WAVENEY INTEGRATED PALLIATIVE CARE SYSTEM MODEL TO SUPPORT PATIENTS AND THEIR CARERS

How we will deliver the new model



To develop a model across Norfolk and Waveney it is essential we work towards one service, **our** one model of care. This will make sure everyone has fair access to our end of life and palliative care services.

The Collaborative Group, will work with the ICS and LDG's to develop the palliative and end of life care model to ensure service delivery is designed and implemented at all three levels (ICS, LDG and PCN). For PCNs this could include physiotherapists, occupational therapists, social care and spiritual/psychological services with experience and skills in palliative and end of life care with access to VCSE, working as an integrated team to deliver the new model of palliative and end of life care by 2024.

IN TRAN®
communication for all

If you want to speak to someone or request the form in another format, please call Laura McCartney-Gray on 01603 751638 laura.mccartney-gray@nhs.net

Submitted by the Head of Palliative Care, Norfolk Community Health and Care NHS Trust, 2 April 2019

Outstanding questions from NHOSC 18/10/18 (responses in bold)

Strategic and systemic issues

(a) What are the main barriers to providing palliative and end of life care in line with NICE and commissioning guidance?

Since the establishment of the Palliative Care Collaborative there are no barriers between providers and commissioners and everyone is working towards one model. There are however gaps that need to be addressed. The gap analysis will be integral to the Palliative and End of Life Care Strategy and priorities will be set.

(b) Bearing in mind that social care is means tested and NHS care is not, do the STP representatives think there would be scope for pooling the multiple health and social care funding streams for palliative patients into integrated funding across health and social care for those in the last few months of life? (To resolve some of the issues set out in paragraph 2.5.1)

The Palliative Care Collaborative is now working closely with social care and are looking at a social care charter these debates will be had.

(c) Is it possible to promote a culture where the community GP / community matron / hospice staff / social worker can reach into the hospital to retrieve their end of life patients home, or as close to home as can be achieved?

This is already happening via Hospice at Home in West and Central and a lot of focus is on this at present.

Within the East the creation of an integrated discharge hub at the JPUH (albeit pilot) is refocusing hospital discharge. As part of the new model of care, increased focus is given to in reach, with community liaison staff actively notifying community staff of unplanned admissions, facilitating community staff to engage proactively with the acute trust to facilitate timely, early discharge.

(d) When will the Electronic Palliative Care Co-ordination System (EPaCCS) be introduced in Norfolk to enable multiple agencies to build pooled assessment and knowledge of patients' needs?

The Digital Subgroup Workstream will be looking at this and how this can be supported. Interim measures are being researched but no date has been set due to the complexity of this.

Specialist palliative care (SPC)

(e) The gap analysis between current SPC capacity and the 2012 SPC Commissioning Guidance (Appendix A, page 4 -6), shows that Norfolk and

Waveney has 9.2 full time equivalent (fte) fewer Consultants in Palliative Medicine and 3.2 fte fewer Additional Supporting Doctors than the guidance suggests it needs. The STP partners' report alludes to the national shortage of consultants and doctors and mentions work being undertaken to look at other models of care that are successful elsewhere (Appendix A, page 8, paragraph (d)).

Is it possible to provide good quality specialist palliative care with lower levels of highly qualified staff than the current national commissioning guidance requires?

Further work is being undertaken to look at decreasing the consultant gap and work is being undertaken to look at the nurse consultant role. However this will be to enhance services as it is essential that the right number of qualified staff are in place to support and educate new roles and develop not only the workforce but ensure patients receive the skills of specialist palliative care consultants.

(f) Commissioning Guidance for Specialist Palliative Care (December 2012) says that an SPC team should be a multi-professional team of whose members should have had training and experience in SPC some of whom should be accredited specialists (e.g. consultants). The defined staff requirements are for physicians and nurses as core specialists, with physiotherapists, occupational therapists and social workers as part of the core team. Pharmacists, dieticians, lymphoedema specialists, psychologists, administrative support, chaplains or spiritual care professionals are required as part of the team, possibly as part-time or extended team members.

To what extent do SPC multi-disciplinary team services in Norfolk meet the staffing guidelines in terms of core team physiotherapists, occupational therapists and social workers, and in terms of the allied professionals (pharmacists, dieticians, etc)

There are no national guidelines for this area.

(g) The commissioning guidance for SPC does not use the term 'enhanced palliative care' but the STP's new model of care (Appendix A, page 2) has it overlapping with both specialist palliative care and end of life care in all relevant care settings (i.e. generalist palliative care). What is the difference between 'specialist' and 'enhanced' palliative care?

Within the commissioning guidance it stipulates local areas can term the middle section how they wish. Enhanced care is when staff have more competencies than staff working in generalist settings and they provide support to complex patients but may only require short term intervention from some specialist professionals rather than long term intervention or all of the specialist MDT to provide support.

(h) The STP partners' report says that specialist level <u>in-patient</u> palliative care may be delivered by the expert team in a person's usual place of residence in

some rural localities (Appendix A, page 3). How does this work in terms of the equipment that may be needed to ensure that the patient is comfortable? What is the difference between this service and 'hospice at home' or 'enhanced palliative care'?

The current Hospice at Home service both in Central and the West is an enhanced service. On occasions patients that should require a specialist inpatient bed may choose to stay at home. They then would require support of the Community Nursing and Therapy Team, Hospice at Home and often domiciliary visits from the specialist palliative care consultant. With regards to equipment, this would be ordered as through normal process.

Hospice provision

(i) Norfolk is far below the numbers of specialist palliative care in-patient beds that the 2012 Commissioning Guidance would suggest it needs. There are no in-patient beds within the Great Yarmouth and Waveney area, which would be expected to be an area of high need for palliative care in terms of indices of deprivation and incidence of cancer.

What can be done to increase provision of hospice beds?

From 1 April 2019, 6 Specialist inpatient beds will be available at Beccles Hospital for specialist palliation in partnership with St Elizabeth Hospice. ECCH is committed to working with partners to increase specialist palliative care bed provision and to realise an ambition of the people of Great Yarmouth and Waveney to have a hospice within the locality.

(j) How does 'Hospice at Home' compare to a hospice in-patient service and how many patients can the central and west Norfolk services support at home at any one time?

A community patient cared for by Hospice at Home can expect up to 3 visits during the day depending on their needs and preferences. Additionally some night sits are available but on an every night basis. Care is delivered in most instances by health care assistants who support both the patients physical care needs in terms of hygiene, pressure ulcer prevention and mobilisation as well as their emotional needs and the needs of their families. Staff have excellent communication skills and are proactive in establishing the patients priorities of care and also discussing fears and anxieties. Support is offered by a registered nurse on assessment or review as the patient's needs increase and the health care assistant's will keep the registered nurse updated on a daily basis. The Hospice at Home team should have access to the Chaplaincy Service, Complementary Therapy, Occupational Therapy, Physiotherapy and Specialist Social Worker however some outreach is limited due to resource, medical management including symptom control. Furthermore, the generalist community

nurses are responsible for urgent medication needs which can involve delays, often due to location.

Hospice at Home Central is commissioned to see 15 new referrals per month as per service specification. Currently the stats suggest the referrals far exceed this. We should have a rolling caseload of 8 patients however again the team is exceeding capacity. In answer to what is the difference, patient's wishes / choices, preferred place for care and death are supported, aids emotional /psychological support, build up that therapeutic patient / team relationship of trust and mutual respect, supports the significant other to in turn support the dying person. Following the death of the person, the families are supported in their bereavement by the team negating pressure on other psychological services.

Generalist palliative care and end of life care

(k) To what extent is palliative care support in the community available at night?

During the meeting Becky did mention that there were 3 night time nurses on duty in central Norfolk, but the question applies to the whole county.

In addition to the 3 nurses for Central Norfolk we have 2 registered nurses on duty 8pm-8am in West Norfolk – there is 24/7 generalist nursing support in place.

ECCH is reorganising community services to wrap community teams around the developing primary care networks. The reorganisation of reactive and proactive teams will increase support beyond core hours for palliative patients. The reorganisation increases the staffing establishment at night; this is further supported with St Elizabeth One Call advice line which will mobilise community staff as required.

(l) The Gold Standards Framework (GSF) requires GPs to identify palliative care patients potentially entering the last 12 months of life and plan care with the patient / family and a multidisciplinary team (e.g. district nursing, hospital specialists etc.). General practice is under pressure with recruitment difficulties and rising demand. Are commissioners aware to what extent individual practices across the county meet the requirements of the GSF?

Yes, Commissioners are aware as an audit was undertaken in 2018 and shared. Work is being undertaken to implement The Quick Practice Guide for GSF- Specialist Nurses and Community Nurses support these meetings too.

Equity of service

(m) To what extent have the commissioners / STP mapped the inequities in end of life provision across Norfolk in terms of availability / waiting times for specific services, e.g. district nurses for care at home, provision of syringe drivers for

pain relief, waiting times for nursing home beds?

A needs analysis has been undertaken against the Ambitions of Palliative Care framework. The findings of this have influence the strategy and priorities will be determined

(n) How far will the STP's plans for palliative and end of life care improve equity of provision proportionate to needs across the county (including hospice care)?

The whole plan is about equity and ensuring hard to reach groups are included in the plan

(o) Do the commissioners / STP partners know how many palliative / end of life patients do not receive NHS funded care because their combination of needs are too complex for any one of the NHS services on offer? (e.g. an NHS community bed / service; an NHS mental health bed / service).

Until we have completed the Population Based Needs Assessment which again is influencing the Strategy we will be unable to determine the above.

Learning from families

(p) To what extent do the commissioners engage with the families of palliative / end of life patients who do not receive NHS funded end of life care (e.g. too mentally complex for NHS community care; too physically complex for NHS mental health care) to receive their feedback about their experience?

Within the system work is being undertaken in regards to learning from deaths and we would expect to see issues such as the above fall out of these reports if there are significant gaps in the system.
We have recently shared the fam care survey amongst staff where we can learn from bereaved viewpoints. Voices is also undertaken and we as a system look at palliative care complaints and learn from them. We also engage with many hard to reach groups such as people with mental health issues so we believe we learn from many families

Norfolk Health Overview and Scrutiny Committee

Notes of visit to Norfolk Community Health and Care NHS Trust's Priscilla Bacon Centre, Unthank Road, Norwich, 28 November 2018

Attendees: Cllr Michael Chenery of Horsbrugh
Cllr Emma Corlett
Cllr Frank O'Neill

Maureen Orr – Democratic Support and Scrutiny Team Manager

The visit was hosted by Becky Cooper, Head of Palliative Care, Norfolk Community Health and Care NHS Trust. Members saw the day service / community service / bereavement service centre, the in-patient unit and the hospice at home administrative base and met staff in each of those areas.

Points arising during the visit:-

1. Priscilla Bacon Lodge currently has 16 in-patient beds. The new facility to be built near the N&N hospital will also have 16 beds but the intention is to expand it to 24 beds. These extra beds would need to be commissioned.

2. There is potential for the current unit at Unthank Road to be put to a different health use, possibly for neurological patients. However, no decisions have yet been made about future use of the buildings.

3. Since the NHOSC meeting on 18 October 2018 Norfolk County Council Adult Social Care has introduced an enhanced social support service for last days of life. Becky Cooper will be working with counterparts at County Hall to make sure the NHS and social care services work together.

4. Mental health practitioners from Norfolk and Suffolk NHS Foundation Trust are liaising with staff at the Priscilla Bacon Centre to work with individuals and families who need their expertise.

5. The centre has 120 volunteers who help patients at mealtimes and serve drinks from the drinks trolley.

6. The *Norfolk and Waveney STP Ambitions for Palliative and End of Life Care Delivery Plan 2017 – 2020 version 7* will be ready for circulation to NHOSC Members in the new year.

7. At the time of the visit the in-patient unit was full. Waiting lists vary (8 people waiting the previous week; no-one waiting so far in the week of the visit). The unit takes patients from the N&N, JPH and QEH hospitals as well as from the community.

8. The centre finds that many younger adults approaching the end of life, and younger families, prefer death not to happen at home.

9. After a patient's death the family is contacted by letter 6 weeks later to offer support.

10. Becky Cooper would like to scope out all the bereavement services available in Norfolk. (She has heard there are estimated to be about 70 organisations in the voluntary / charitable sector).

The main message that staff in the family support psychological / bereavement service was:-

That more recognition is needed that the end of a patient's life affects the whole family profoundly and more mental health support is needed particularly for those families where there are already mental health issues or other underlying stresses. This should be seen as a preventative service, which could prevent even more serious mental health or other social issues in individuals and families at a later date (i.e. investing in this service could provide savings for health and social care in the longer term).

Norfolk Health Overview and Scrutiny Committee

Notes of visit to The Norfolk Hospice, Tapping House, Wheatfields, Hillington, King's Lynn, PE31 6BH, 5 December 2018

Attendees: Cllr Michael Chenery of Horsbrugh
Cllr Sue Fraser
Cllr Graham Middleton
Cllr Sheila Young

Maureen Orr – Democratic Support and Scrutiny Team Manager

The visit was hosted by Lyndsay Carter, Chief Executive of The Norfolk Hospice. Members were shown around the building, including the office base for the West Norfolk Integrated service with Norfolk Community Health and Care NHS Trust, the community and day service area, the inpatient unit, the charity's fundraising area and the parts of the building that have yet to be developed.

Points arising during the visit:-

1. Lyndsay Carter provided the attached diagram setting out the palliative and end of life care system in west Norfolk called the West Norfolk Integrated Palliative Care Service (WNIPCS), of which the Norfolk Hospice is a large part. The system also includes Norfolk Community Health and Care NHS Trust (NCH&C), Marie Curie and various other partners (e.g. Nelson's Journey). The hospice is to start running Motor Neurone Disease (MND) clinics with the local MND specialist team at the hospice in 2019. They are also in conversation with the Quiddenham children's hospice to host family bereavement services next year.

2. The inpatient unit at Tapping House is funded and provided solely by The Norfolk Hospice charity. There are currently 7 – 8 beds (it started with 4 in 2017). The hospice is Consultant Nurse led. Consultant Nurses can prescribe medication and provide all palliative care services except invasive treatment such as blood transfusion.

3. The hospice also purchases GP support from Southgates Medical Centre, King's Lynn, a maximum of 10 hours per week, and can call on the NCH&C Consultant Team in the integrated service to in reach into the In-patient Unit (IPU) if required.

4. The WNIPCS palliative care service provides a hospice at home service, rehabilitative Day Therapies, pre and post bereavement support, Social Workers, Counsellors and Chaplaincy. Two thirds of the staff in the service are employed by The Norfolk Hospice. There are also 350 volunteers providing homesit services, bereavement and complimentary therapies to patients in their own home or in the hospice.

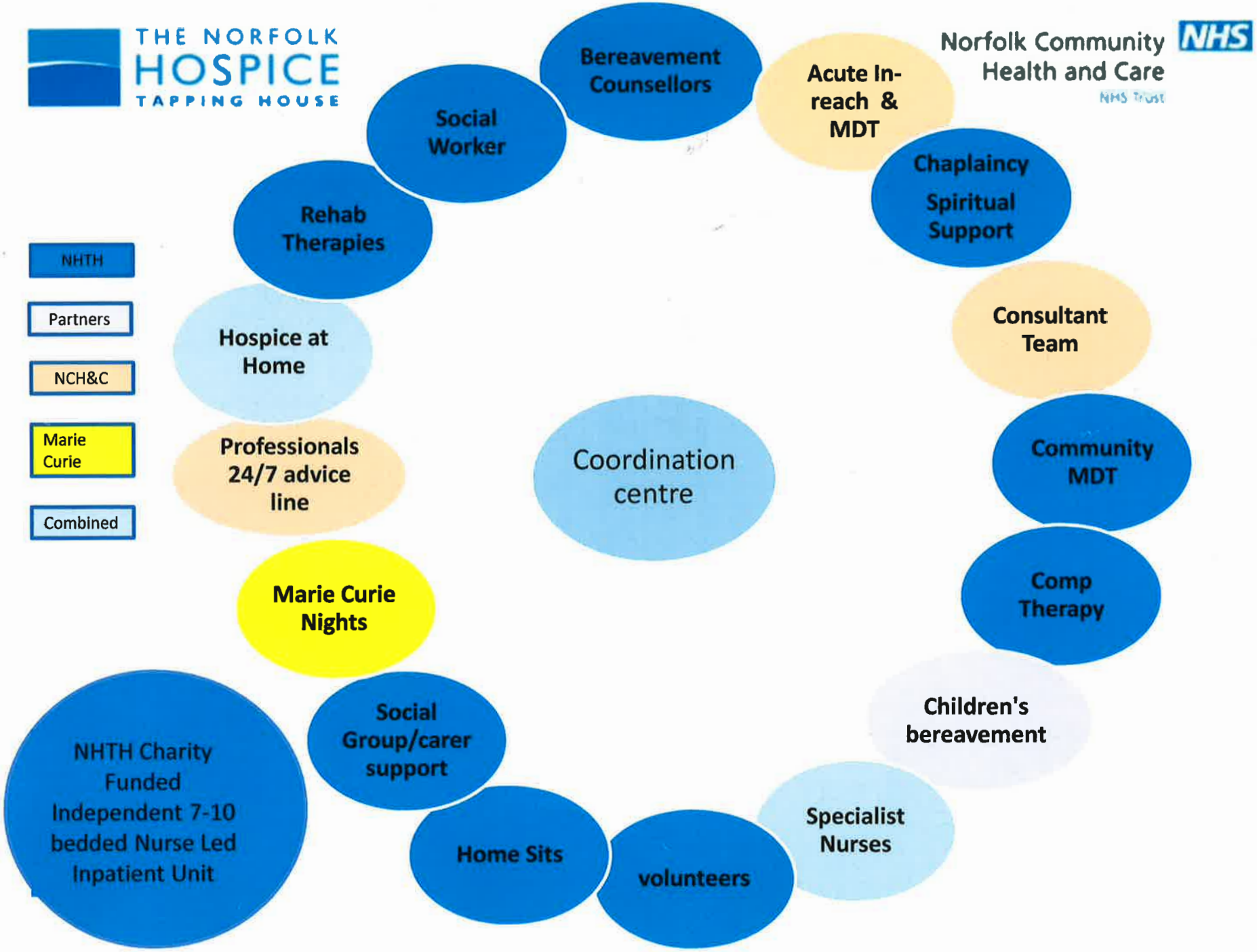
5. The NHS commissions The Norfolk Hospice for services via sub contract from NCH&C to support the WNIPCS. In effect the charity provides services

to the value of approximately £700k per annum which would otherwise need to be paid for by the NHS. The IPU costs another £1,200,000. The hospice receives approximately 31% financial contribution from the NHS on top of this.

6. In the Norfolk and Waveney Sustainability Transformation Partnership (STP) *Ambitions for Palliative and End of Life Care Delivery Plan 2017-2020* document The Norfolk Hospice, Tapping House, is classed as an 'Enhanced palliative care' service but there is a case for classing it as 'Specialist palliative care'.

7. The Norfolk Hospice takes patients aged 18 and upwards. It is interested in developing transitional services (between children's and adults palliative care).

8. There are gaps in bereavement care, and 24 hour access to services in the community in west Norfolk.


THE NORFOLK HOSPICE
TAPPING HOUSE
Norfolk Community Health and Care
NHS
NHS Trust
NHTH
Partners
NCH&C
Marie Curie
Combined
Bereavement Counsellors
Social Worker
Rehab Therapies
Hospice at Home
Professionals 24/7 advice line
Marie Curie Nights
NHTH Charity Funded Independent 7-10 bedded Nurse Led Inpatient Unit
Social Group/carer support
Home Sits
volunteers
Specialist Nurses
Children's bereavement
Comp Therapy
Community MDT
Consultant Team
Chaplaincy Spiritual Support
Acute In-reach & MDT
Coordination centre

Norwich Health Overview and Scrutiny Committee (NHOSC)
Great Yarmouth and Waveney Joint Health Overview and Scrutiny Committee (GY&W JHSC)

Notes of a meeting with East Coast Hospice Ltd, at the Conservative Association building, Gorleston, on 28 January 2019

Present:-

East Coast Hospice Ltd:	Jenny Beesley Sue Marshall	Chairman Project Administrator and PA to the Chairman & Board
Health scrutiny committee Members:	Cllr Nigel Legg Cllr Emma Flaxman-Taylor Cllr Keith Robinson	Chairman of GY&W JHSC, Vice Chairman of NHOSC GY&W JHSC and NHOSC GY&W JHSC
Also present:	Cllr Penny Carpenter	Norfolk County Council and Great Yarmouth Borough Council (attending in a personal capacity)
Officers present:	Abhijit Bagade Nicola Coburn Maureen Orr	Consultant in Public Health Medicine, Norfolk County Council (NCC) Public Health Officer, NCC Democratic Support and Scrutiny Team Manager, NCC

Jenny Beesley, Chairman of East Coast Hospice Ltd, gave a presentation on the charity's plans for the independent hospice Margaret Chadd House and details of progress to date. Brochures and leaflets setting out the charity's vision and plans were distributed.

The following points were mentioned during answers to questions:-

1. East Coast Hospice Ltd (ECH) owns the land at Hopton on which the 10 bed hospice will be built. Planning permission for a hospice on the site has been granted in perpetuity.

2. Archaeological digs on the site have cost £300k.

3. ECH intends to purchase another piece of land beside the one they already own. They are looking to complete the purchase in 5 years and the farmer will continue to farm in the meantime.

   The plan is for a teaching block, café and farm shop on this second piece of land, which will encourage links with the local community.

4. The plan includes a shepherd's hut in the grounds of the hospice where patients can safely sleep out if they wish to (with alarms for alerting staff etc.)

5. ECH intends to run the hospice independently, without reliance on NHS funding.

6. The plan is for a link with Consultants in palliative care at the Norfolk and Norwich Hospital and for links with East Coast Community Healthcare so that District Nurses will be familiar with the hospice patients and will be able to pick up supplies from the hospice on occasion.

7. There will be a day care unit in a separate part of the building from the in-patient unit. There will also be a mortuary unit where bereaved relatives / friends can visit their loved one. The plan is for different styles of furniture in the different units within the hospice.

8. ECH plan to have transport to take patients home and to provide 48 hours of care at home until NHS community services take over.

9. The plan is for an in-house laundry and for food to be provided for patients' relatives and staff as well as for patients.

10. The building will have a first story with offices, meeting rooms and a lecture theatre.

11. The sluice room will have a system to pulp and dispose of all waste. ECH has easement agreement to connect with Beacon Park pumping station.

12. The building will have ground source heating, which is expensive to install but cheaper in the long run.

13. ECH is paying the fees of architects, quantity surveyors etc. as it goes along and has negotiated fixed price contracts with contractors. The build and equip cost is expected to be £5.2m.

14. It is expected to cost £2.5m per annum to run the hospice. The project requires a good funding infrastructure. There are currently 17 shops bringing in money and 29 staff including accountant and fund raising team.

15. ECH is applying for for Community Infrastructure Levy (CIL) from Waveney District Council. Any opportunities to apply for funding via Great Yarmouth Borough Council would be welcomed.

16. ECH has received the written support of GY&W CCG and local MPs for the hospice project. The charity intends to apply for grant funding from the Department of Health and Social Care and further support from MPs could help. Cllr Legg offered to raise the matter with the MP for South Norfolk.

    Action - Jenny Beesley to provide Cllr Legg with details of what ECH is seeking from the Department of Health and Social Care.

17. ECH hopes that there will be a better relationship between the charity and the James Paget Hospital in the future. Negative publicity does not help fund-raising.

18. ECH plans to lay foundations for the building this year. Tender documents will be ready by May 2019. It is expected that this step will boost fund-raising. ECH intends to use a private firm for building control.

19. The timeline for completion and opening of the hospice facilities is dependent on fund-raising. The build itself should take approximately 18 months from the start date.

20. The plan is for the hospice to serve all of Great Yarmouth & Waveney and beyond into Broadland and South Norfolk.

Physical health checks for adults with learning disabilities

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

Progress on work to improve the take-up of physical health checks for adults with learning disabilities in Norfolk and the quality of health checks received.

1. Purpose of today's meeting

1.1 The committee will have the opportunity to discuss the progress towards improving the take-up and quality of learning disability health checks (age 14 and up) with the Norfolk and Waveney commissioners.

1.2 The commissioners (the Norfolk and Waveney CCGs) have been asked to provide:-

- Latest verified figures for the numbers of adults with learning disabilities on GP registers and the numbers and percentages attending for an annual health check, broken down by CCG area and individual GP practice.

- A progress update including:-
  - Data verification and accuracy (including accuracy of GP registers in comparison with local authority registers)
  - Provision of training to GPs and practice staff
  - Information for patients and families
  - Increasing up-take of learning disability health checks across GP practices
  - Local quality incentive schemes

The commissioners' report is attached at **Appendix A.**

The CCG and GP practice data is for the year 2018-19. It was not possible to make meaningful comparisons with previous years' data because of the extent of changes to the registers and records of health checks delivered as a result of the CCG and GP practices' data cleansing exercise.

1.3 Healthwatch Norfolk is assisting the CCGs on the learning disability programme by carrying out community engagement. It was awarded £2,000 towards this from the Baily Thomas Trust[1] in March 2019.

[1] The Bailey Thomas Charitable Fund is a grant making registered charity which was established primarily to aid the research into learning disability and to aid the care

Some of the award has been used to work with Opening Doors[2] to get feedback and stories from people with learning disabilities on their experience of health checks.

Also, Healthwatch's 'Enter & View' programme for 2019-2020 is focussed on residential care homes for people with learning disabilities, which should provide further information on people's experiences of these health checks.

Healthwatch Norfolk was invited to submit a paper for the committee based on the information it has gathered so far (attached at **Appendix B**).

The committee will also see a short video presentation featuring a self-advocate from Opening Doors speaking about their experience of the health check.

2. Background

2.1 Previous examination by NHOSC and action by the Health and Wellbeing Board

2.1.1 The last report to NHOSC on physical health checks for adults with learning disabilities was on 6 September 2018. The report and minutes are available on the County Council website. At that meeting NHOSC agreed:-

- That the Chairman would write to the Chairman of the Health and Wellbeing Board recommending it to examine what it can do to
  - Raise awareness amongst people with learning difficulties, aged 14 years or over, and families, that the annual health check is an entitlement and they should be getting it.
  - Support the provision of Learning Disability health checks across general practice.

- That the CCG and Healthwatch Norfolk consider working together on how barriers preventing people coming forward for a Learning Disability health check can be overcome.

The CCGs and Healthwatch Norfolk are working together and Health and Wellbeing Board examined the issue at its meeting on 10 July 2019.

2.1.2 The report received by the **Health and Wellbeing Board** HWB is available on the County Council website (agenda item 14) and the presentation received at the meeting is attached as Appendix 1 to the commissioners' report at Appendix A. Members of the HWB, from each

---

and relief of those affected by learning disability by making grants to voluntary organisations working in this field.

[2] Opening Doors is a Norfolk based user led organisation for people with learning disabilities.

of the NHS commissioning and service providing organisations in the county, all the district councils, the county council, the police, independent care providers and the voluntary sector were encouraged to take the following specific actions to promote uptake of learning disability health checks across the county.

2.1.3 On 6 September 2018 NHOSC also asked for regular progress updates during the year to Sept 2019, via the NHOSC Briefing. These were provided in the Dec 2018, April 2019 and July 2019 NHOSC Briefings. Copies are available from the Democratic Support and Scrutiny Team Manager (committees@norfolk.gov.uk) on request but the latest information is provided in the CCG's report at Appendix A.

2.2 What do the health checks involve?

2.2.1 Physical health checks for people with learning disabilities are delivered by GP practices. The practices are encouraged to identify all patients aged 14 and over with learning disabilities, to maintain a learning disabilities register and to offer the checks to individuals annually. The service is classed as an 'Enhanced Service' and practices can decide whether or not they wish to enter into a contract to deliver it.

2.2.2 The learning disabilities annual health check process is outlined on the NHS website , including the following details of what happens during the check:-

During the health check, the GP or practice nurse will:

- *do a physical check-up, including weight, heart rate, blood pressure and taking blood and urine samples*
- *talk to you about staying well and if you need any help with this*
- *ask about things that are more common if you have a learning disability, such as epilepsy, constipation or problems with swallowing.*
- *talk to you about your medicines*
- *if you have a health problem such as asthma or diabetes, the GP or nurse will check how it's going*
- *check to see if you have any other health appointments, such as physiotherapy or speech therapy*
- *ask if family and/or carers are getting the support they need*
- *help make sure that things go well when children move to adult services at the age of 18*

If your learning disability has a specific cause, the GP or practice nurse will often carry out additional tests if there are any other health risks.

For people with Down's syndrome, for example, they may do a test to see if the thyroid gland is working properly.

You'll be asked for your consent (permission) to share information with other services that provide your care. This will help you get the right support if you go to a hospital, for example.

The GP or practice nurse will also give you health information, such as advice on healthy eating, exercise, contraception or stopping smoking.

3. Suggested approach

3.1 After the CCG representatives have presented their report, the committee may wish to discuss the following areas:-

(a) When NHOSC first looked at this subject in February 2018 it was clear that the data on numbers of people with learning disabilities on GP registers were unreliable, which undermined the credibility of the information presented about how many people with learning disabilities were actually receiving the annual health checks to which they were entitled. NHOSC also heard that this problem was national, not just in Norfolk, and that work to audit and improve the data was underway.

How much more reliable is the Norfolk and Waveney data now?

(b) Is the data quality sufficient for the CCGs to accurately monitor performance against the 2019-20 target of health checks being delivered to 75% of adults with learning disabilities?

(c) The commissioners' report (Appendix A, paragraph 2) says that the CCGs are currently working with the local authority to develop a data sharing agreement to ensure that no patients with a learning disability or autism are missed off the GP registers.

When is the data sharing agreement expected to be in place?

(d) The last progress briefing for NHOSC (July 2019) said that "on the whole most practices across Norfolk have increased the number of health checks being delivered and are on track to meet the increased target of 75% set by NHS England for 2019-20".

Can alternative arrangements be made within the new Primary Care Networks for patients of practices who are not close to meeting the target?

(e) If people attend a different GP practice for a learning disability health check, rather than their usual one, what would be the arrangements for that practice accessing the patient's records and communicating with the patient's usual practice on any follow-up action required?

(f) To what extent have people with learning disabilities and their families / carers / advocates been involved in producing the new series of information leaflets about the health checks?

(g) The last progress briefing for NHOSC (July 2019) said that senior management would be considering whether had copies of the new information leaflets and literature packs would be made available to GP practices (printing cost £10k plus). Has the decision been made?

(h) How do practices decide who is the most appropriate clinician to carry out an individual's annual health check (GP or practice nurse) and is there monitoring in place to ensure that health checks are picking up conditions for which patients then receive treatment?

4. Action

4.1 Following the discussions with representatives at today's meeting, Members may wish to consider whether:-

(a) There is further information or progress updates that the committee wishes to receive at a future meeting or in the NHOSC Briefing.

IN TRAN communication for all	If you need this report in large print, audio, Braille, alternative format or in a different language please contact Customer Services on 0344 800 8020 or Text Relay on 18001 0344 800 8020 (textphone) and we will do our best to help.

NHS
Great Yarmouth and Waveney
North Norfolk, South Norfolk
Norwich, West Norfolk
Clinical Commissioning Groups

Briefing for Norfolk Health Overview and Scrutiny Committee

Physical health checks for people over the age of 14 with learning disabilities and autism in Norfolk and Waveney

1. Introduction

Norfolk Health Overview and Scrutiny Committee (NHOSC) have requested an overall annual update on progress on work to improve the uptake of physical health checks for adults with learning disabilities and autism in Norfolk and the quality of health checks received.

2. Background

Following the report made to members in September 2018 CCGs have continued to work on improving the increase and the quality of Learning Disability (LD) health checks across the STP.

During the year, all practices were written to asking them to cleanse their LD data and to identify any anomalies. They were also advised on how to record the number of LD health checks completed and the number of LD and autism patients on the practice register. The CCGs continue to repeat this exercise every quarter identifying practices showing anomalies in data recording from the performance information that we receive from NHS England.

Work has been carried out in partnership with local authority to share LD registers for reconciliation purposes. In June 2019, the local authority shared anonymised list sizes with practices to compare numbers. The CCG and local authority are currently working together to develop a data sharing agreement so that patient-identifiable lists can be shared directly with each practice for further reconciliation and to ensure no patients with a learning disability or autism fall through the gap. However, the number of people with a learning disability or autism will never be exactly the same between GP practices and the local authority as the assessment criteria is different for both organisations. This is in the early stages and a working group is being convened to develop the information sharing protocol and we would hope that this will be in place within the next three months.

3. Performance and activity

Significant progress has been made in the last 12 months on raising the importance of LD health checks among practices and the difference these can make to the health and quality of life of

individuals living with learning disabilities or autism. The CQC have also supported the CCGs on this agenda and have made it a key area of the practice inspection programme. We are also grateful to NHOSC who wrote last year to the chair of the Norfolk Health and Wellbeing Board asking what their members could do to raise the profile of LD health checks within their organisations. The health and Wellbeing Board invited a presentation on the LD programme in July 2019, which was received very positively, and each health and wellbeing board member gave their commitment to increase LD and autism awareness amongst their organisations (Appendix 1 – Presentation to Health and Wellbeing Board).

The work to date has definitely had a positive impact on the LD health checks performance, we are pleased to report against an overall target of 55% Norfolk, and Waveney STP achieved 62% with four of the CCGs individually achieving higher than the 55% target set.

A further breakdown of the 2018/19 data is shown in the tables below:

NHS Digital LD Health Check data 2018-19 *			
	Number of patients on LD register in 2018/19	Number of LD patients who received a health check in 2018/19	% of LD patients who received a health check in 2018/19
Great Yarmouth and Waveney CCG	1472	853	**58%**
North Norfolk CGG	1052	795	**76%**
Norwich CCG	1455	740	**51%**
South Norfolk CCG	1134	789	**70%**
West Norfolk CCG	841	508	**60%**
Norfolk and Waveney STP Total	5954	3685	**62%**

*Methodology – Numerator: The total number of health checks completed by each CCG over the 12-month period (2018/19) Denominator: The total list size for Q4 for each CCG. Q4 list size data was used for the denominator as it is the most recent and the most accurate following work to ensure practices are entering the correct list sizes on CQRS.

Top three performing practices for each CCG area 2018-19			
Great Yarmouth and Waveney CCG	High Street Surgery 89%	Bridge Road Surgery 88%	The Park Surgery 86%
North Norfolk CGG	Market Surgery 96%	Aldborough Surgery 95%	Hoveton & Wroxham Medical Centre 92%

Norwich CCG	Thorpewood Medical Centre 92%	Magdalen Medical Practice 86%	Lawson Road Surgery 79%
South Norfolk CCG	Grove Surgery 98%	Chet Valley Medical Practice 94%	Hingham Surgery 91%
West Norfolk CCG	Campingland Surgery 90%	Watlington Medical Centre 89%	Feltwell Surgery 85%

Appendix 2 is a list of all practices across the STP showing their annual LD health checks data. The CCGs can identify from this data, on a quarterly basis, which practices are not performing as well. Contact is then made with the practice offering support to help improve their performance.

The CCGs are more confident now that this data is correct and has been verified with the practices and cross-referenced against other NHSE data sources.

4. Progress and actions to date

Following the release of the NHS Long Term Plan the National target for LD health checks has been increased to 75%. Practices voluntarily sign up to deliver this service and currently all practices in Norwich are delivering LD health checks (with the exception of UEA who advise that their population does not have a need). The Norfolk and Waveney LD working group have been working to implement schemes to increase uptake of LD health checks. Below is an update on the key areas of progress:

Action	Update
Provision of training to GPs and Practice Staff	• Royal College of General Practitioners (RCGP) toolkit has been condensed into a manageable leaflet and shared with all GP practices across the STP to highlight key messages and learning. This is being re-formatted to be added to Knowledge Anglia. • RCGP step-by-step guide to performing an LD health check has also been distributed to all practices across the STP and is available to access on Knowledge Anglia. • The STP has secured funding from Health Education England to deliver some specific training for practice nurses on the delivery of LD health checks. Those nurses that participate in the initial training will then go on to train other staff across the GP Provider Organisations (GPPOs). • CCGs have provided regular updates and information session at practice Protected Time for Learning and medibites sessions.

LQUIS – Local Quality Incentive Scheme	• Norwich CCG are piloting for 6 months a local quality incentive scheme (LQUIS) for learning disabilities. Practices will be paid a one off flat rate payment to carry out a range of activities that improve the way that they carry out health checks as well as improving internal processes including working with colleagues across health and social care. The scheme commenced in March 2019 and will be evaluated in October 2019. • If results of the LQUIS are successful, then the scheme will be rolled out across the STP. • Currently all Practices in Norwich (apart from UEA who do not deliver the LD health check DES due to their patient population) are signed up and engaged in the scheme. • All practices have completed a self-assessment audit tool where they rate the current quality of their LD health checks service. All submitted are being collated and reviewed by the CCG. Actions and will then be identified to practices in order to improve the quality of LD health checks.
Information for patients and families	• A series of 16 easy-read information resources designed by Ace Anglia have been adapted for Norfolk and Waveney STP use. They cover information such as healthy eating, sexual health, a reminder to book your health check etc. These have been made available to all practices electronically via Knowledge Anglia. The literature has been co-produced with people living with a learning disability. • The current Easy Read LD health checks invitation letter that is available for practices across the STP is being reviewed and improved with service users in partnership with Healthwatch. • A Mencap video, informing patients of health checks, has been rolled out across STP and practices have been encouraged to include the video on their social media and practice webpages.
Making Reasonable Adjustments	• To highlight an example of making reasonable adjustments; Thorpewood Surgery in Norwich invite their LD patients for a health check by telephone so that the patient has an opportunity to ask any questions. The clinician will offer a Saturday or Sunday appointment when the practice is quieter or will attend the patient's home (including weekends) if they would prefer. The clinician will also offer a flu vaccine at the same time if appropriate. This service has been put forward for a Parliamentary Health Service Award and the practice achieved 100% uptake of health checks during 2018/19. • Many GP practices across Norfolk and Waveney will visit their LD care homes to deliver health checks in-

	house, flu vaccinations will also be offered at the same time. The Beaches Medical Centre in Great Yarmouth and Waveney CCG send photographs of the visiting clinician a few weeks before the home visit so that patients can prepare themselves and know whom to expect.
LeDeR - Learning Disability Mortality Review	• This is a National programme aiming to make improvements to the lives of people with LD by publishing a local report annually giving recommendations based on LD mortality reviews in Norfolk and Waveney. South Norfolk CCG lead on this project across the STP. • The fourth annual review is in draft form and shows that people with LD are dying younger than the general population (an average of 59 years) and from preventable conditions. This means that work to increase the uptake of LD health checks must continue in order detect problems early, signpost, and educate on living a healthy lifestyle to prevent early deaths in this cohort of patients. • Norfolk and Waveney currently a backlog of mortality reviews due to staffing issues. NHSE have allocated £5m nationally to fund reviews, this money will assist CCGS to tackle the backlog of outstanding reviews, which will create more learning that can be applied to caring for people with LD.
Transforming Care Programme	• In line with the Transforming Care Programme the LD Care Pathway Redesign Group met this month to discuss progress. • An Admission Avoidance/Discharge Pathway protocol has been collaboratively produced and approved at the working group. • The pathway encourages primary care to use LD health checks as a way of identifying additional needs and referral follow up in order to identify conditions earlier and prevent unplanned admission to hospital. The initial primary care element of the protocol has been strengthened to ensure practices are providing a quality service and making reasonable adjustments. • STP communication and engagement teams will assist in facilitating staff understanding of the new admission avoidance pathway once it has been released for implementation. A communication will be put into appropriate newsletters and targeted emails will be sent to appropriate staff/organisations.

5. Priorities of action for the next six months are:

- Following the NHS Long Term Plan and development of primary care networks, who went live from the 1 July 2019, it is planned that once they are settled they will be in a position to support their member practices by offering additional support as well holding practices to account for their performance.

- Piloting of the ‘Sunflower Charter’ in selected GP practices. These practices will need to demonstrate that they are making reasonable adjustments for their patients and adhering to accessible service standards to achieve status.

Progress on this work is being monitored by the Primary Care Commissioning Committee of each CCG.

in good health

The Norfolk and Waveney Health and Care Partnership

Physical Health Checks for Adults with a Learning Disability

Increasing the uptake

Areas of high LD prevalence in Norfolk and Waveney

in good health
The Norfolk and Waveney Health and Care Partnership

England Baseline – 0.5%

- West Norfolk – 0.6%
- South Norfolk – 0.6%
- Norwich – 0.7%
- Great Yarmouth and Waveney – 0.6%
- North Norfolk – 0.8%

Why are health checks for people with a Learning Disability important?

- The current average life expectancy in Norfolk and Waveney for someone with a Learning Disability (LD) is 59 years old*.
- The most common causes of LD deaths are preventable. These are constipation and dysphagia (difficulty swallowing).
- Annual LD health checks can help to detect health issues early on and educate patients on how to live a healthy lifestyle (exercise, healthy eating etc.).

* Norfolk and Waveney Learning Disability Mortality Review 2019 (median age of deaths between 1st April 2017 – 31st December 2018)

in good health
The Norfolk and Waveney Health and Care Partnership

Why are health checks for people with a Learning disability important?

- Health checks for people with learning disabilities are really important because they can pick up problems early while preventing future conditions through promotion of a healthy lifestyle leading to an increase in life expectancy, improved quality of life for the patient, and a reduction in unplanned hospital activity and emergency social care.

in good health
The Norfolk and Waveney Health and Care Partnership

What is being done across the STP?

The following are brief headlines from work streams that have been undertaken by the working group recently:

- Reconciling Local Authority LD registers with primary care registers to identify unknown patients with LD so they can be invited for a health check. Anonymised numbers have been shared with practices while a data sharing protocol is being developed between the CCGs and Local Authority to allow the sharing of patient identifiable data.

- A suite of easy read literature has been adapted for use in Norfolk and Waveney and is currently being printed for distribution to practices and advocacy groups.

- The recently released RCGP toolkit for delivering LD health checks has been condensed into a leaflet to make it easier for clinicians to gain the key messages and learning points.

What is being done across the STP?

• A local scheme is being piloted in Norwich. Working with practices to do things differently to improve the way they carry out LD health checks as well as improving internal processes.

• A scheme to stop the over medication of people with LD is being rolled out across Norfolk and Waveney (STOMP). Practices are being supported to identify their LD patients who have been prescribed psychotropic medications and will review them with an aim to reduce the medication where appropriate.

• An annual report into LD mortalities (LeDeR) has been published and the learning will be discussed at the working group and recommendations for improving quality of care will be made to primary care colleagues.

How health and wellbeing board members can help?

CCGs –

- CCG chairs can emphasise in CCG, GP Provider Organisation, and Primary Care Network meetings the importance of Annual LD health checks.
- Primary care teams can ensure practices are LD friendly/accessible and have a robust recall system in place. Encouraging practices to contact patients by their preferred method (telephoning has shown to increase uptake compared to letter).
- Encourage practices to make reasonable adjustments by utilising improved access and home visiting to deliver LD health

How health and wellbeing board members can help?

Local Authority (Adults) –

- Adult LD services to encourage their service users to have their annual health check and help them to fill in the pre-check questionnaire
- Make carers/support workers aware of the annual LD health check scheme and educate about the importance of ensuring the patient attends their appointment.
- Support with the distribution of easy-read LD literature promoting LD health checks and associated literature about healthy lifestyles/ health plans.
- Encourage key workers/support workers to include annual health checks within support plans

in good health
The Norfolk and Waveney Health and Care Partnership

How health and wellbeing board members can help?

Local Authority (Adults) continued –

- Social workers to help people with LD to become familiar and comfortable with the concept of having an annual health check by having a discussion about what to expect.
- Social workers to arrange for service users to attend their health check by helping them to book their appointment and by accompanying the service user to the GP practice.

in good health
The Norfolk and Waveney Health and Care Partnership

How health and wellbeing board members can help

Local Authority (Children and Young People) –

- Key workers/social workers to work to prepare children under 14 years for their annual health checks so that they know what to expect and know the importance of attending annually.
- Ensure carers/support workers aware that children/young people will become eligible for the annual LD health check scheme at 14 years and the importance of attending annually.
- Encourage key workers/support workers to include annual health checks within support plans and ensure they continue to attend during transition from child to adult services.

in good health
The Norfolk and Waveney Health and Care Partnership

How health and wellbeing board members can help?

Voluntary Sector/ Advocacy groups –

- Continue to spread the message among service users and their carers of the importance attending the LD health check annually.
- Promote easy-read LD literature promoting LD health checks and associated literature about healthy lifestyles/ health plans.
- Assist people with LD to attend their appointments by linking in with community transportation services
- Show the promotional Mencap video to service users and put the video on social media pages (Appendix A of cover sheet)

in good health
The Norfolk and Waveney Health and Care Partnership

How health and wellbeing board members can help

Secondary care –

- Educate staff on the importance of people with LD having an annual health check. Include as part of induction programme.
- Work with primary care to ensure robust referral pathways and making reasonable adjustments for cancer screening procedures where appropriate.
- Display easy read posters/materials promoting LD health checks in areas likely to be visited by people with LD or their carers.
- Utilise the skills of LD Acute Liaison Nurses whose role is to make sure patients with LD have a good, as possible, stay in hospital.

How health and wellbeing board members can help

Community teams -

- Include attendance at annual LD health check as part of MDT care plans.
- Speak to people with LD and their carers about health checks and promote uptake.

Everybody

- Make every contact count - Keep the importance of LD health checks at the forefront when planning care for people with an LD.
- Share Mencap video on your websites and social media pages.
- Use and display the easy read LD literature wherever possible (Appendix B of cover sheet has more information)

in good health
The Norfolk and Waveney Health and Care Partnership

Norfolk and Waveney GP Practices Learning Disability Health Check Data 2018-19

Clinical Commissioning Group Level - per quarter

	Quarter	MEASURE											
	Q1		Q1 Total	Q2		Q2 Total	Q3		Q3 Total	Q4		Q4 Total	Total	Total
CCG	LDHC001_(	LDHC001_(Register)		LDHC001_(	LDHC001_(Register)		LDHC001_(	LDHC001_(Register)		LDHC001_(	LDHC001_(Register)		Checks	Percentage
Great Yarmouth and Waveney	120	1367	8.8%	201	1396	14.4%	242	1448	16.7%	290	1472	19.7%	853	58%
North Norfolk	83	1076	7.7%	114	1206	9.5%	279	1150	24.3%	319	1052	30.3%	795	76%
South Norfolk	107	1102	9.7%	109	1078	10.1%	219	1197	18.3%	354	1134	31.2%	789	70%
Norwich	125	1446	8.6%	126	1424	8.8%	161	1440	11.2%	328	1455	22.5%	740	51%
West Norfolk	69	860	8.0%	94	778	12.1%	106	815	13.0%	239	841	28.4%	508	60%

North Norfolk CCG area

	Quarter												
	MEASURE												
	Q1		Q1 Total	Q2		Q2 Total	Q3		Q3 Total	Q4		Q4 Total	Comments
PRACTICE_NAME	LDHC001_ (Checks)	LDHC001_ (Register)		LDHC001_ (Checks)	LDHC001_(Register)		LDHC001_ (Checks)	LDHC001_(Register)		LDHC001_(Checks)	LDHC001_(Register)		
HOLT MEDICAL PRACTICE	3	71	4.2%	1	69	1.4%	33	69	47.8%	23	68	33.8%	We continue to work with the Cromer practice to try to get them more engaged in the accuracy of their LD data. The CQC have also raised this issue on their inspection and they were recently rated as Requires Improvement. The CCG will continue to work with them.
CROMER GROUP PRACTICE	0		0.0%	13	127	10.2%	7	48	14.6%	3	3	100.0%	
SHERINGHAM MEDICAL PRACTICE	9	72	12.5%	8	73	11.0%	1	75	1.3%	37	74	50.0%	
STALHAM STAITHE SURGERY	8	38	21.1%	5	48	10.4%	2	47	4.3%	10	43	23.3%	
MARKET SURGERY	2	87	2.3%	2	87	2.3%	65	98	66.3%	23	96	24.0%	
HOVETON & WROXHAM MEDICAL CENTRE	0	67	0.0%	2	68	2.9%	7	68	10.3%	40	53	75.5%	
LUDHAM AND STALHAM GREEN SURGERIES	4	28	14.3%	5	28	17.9%	1	30	3.3%	9	28	32.1%	
DRAYTON & ST FAITHS MEDICAL PRACTICE	1	75	1.3%	0	75	0.0%	26	74	35.1%	20	78	25.6%	
REEPHAM & AYLSHAM MEDICAL PRACTICE	9	67	13.4%	10	64	15.6%	4	59	6.8%	22	59	37.3%	
BRUNDALL MEDICAL PARTNERSHIP	0	32	0.0%	3	32	9.4%	10	32	31.3%	9	32	28.1%	The practice recognise that their uptake is low they have invited patients via letter and telephone but they are finding they have a high rate of non-attendance. The CCG will continue to support the practice in looking at alternative ways to increase take up.
WELLS HEALTH CENTRE	0	12	0.0%	0	12	0.0%	0	12	0.0%	1	12	8.3%	
MUNDESLEY MEDICAL CENTRE	4	121	3.3%	17	120	14.2%	25	120	20.8%	45	111	40.5%	
FAKENHAM MEDICAL PRACTICE	2	61	3.3%	0	61	0.0%	23	63	36.5%	28	65	43.1%	
BIRCHWOOD MEDICAL PRACTICE	21	100	21.0%	12	99	12.1%	14	101	13.9%	10	78	12.8%	
COLTISHALL MEDICAL PRACTICE	0	19	0.0%	2	19	10.5%	2	19	10.5%	7	19	36.8%	
PASTON SURGERY	7	87	8.0%	11	86	12.8%	24	87	27.6%	9	86	10.5%	
BLOFIELD SURGERY	5	37	13.5%	4	37	10.8%	11	44	25.0%	5	42	11.9%	
ACLE MEDICAL PARTNERSHIP	6	81	7.4%	13	81	16.0%	15	84	17.9%	15	84	17.9%	
ALDBOROUGH SURGERY	2	21	9.5%	6	20	30.0%	9	20	45.0%	3	21	14.3%	
	83	**1076**		**114**	**1206**		**279**	**1150**		**319**	**1052**		

Great Yarmouth and Waveney CCG area

	Quarter												
	Q1		Q1 Total	Q2		Q2 Total	Q3		Q3 Total	Q4		Q4 Total	Comments
PRACTICE_NAME	LDHC001_(Checks)	LDHC001_(Register)		LDHC001_(Checks)	LDHC001_(Register)		LDHC001_(Checks)	LDHC001_(Register)		LDHC001_(Checks)	LDHC001_(Register)		
BEACHES MEDICAL CENTRE	10	90	11.1%	5	90	5.6%	18	150	12.0%	15	144	10.4%	
EAST NORFOLK MEDICAL PRACTICE	9	153	5.9%	8	154	5.2%	12	155	7.7%	15	139	10.8%	
THE MILLWOOD PARTNERSHIP	16	98	16.3%	19	105	18.1%	25	106	23.6%	28	111	25.2%	
COASTAL VILLAGES PRACTICE	3	85	3.5%	15	99	15.2%	15	93	16.1%	11	95	11.6%	
THE PARK SURGERY	13	110	11.8%	34	111	30.6%	2	111	1.8%	65	133	48.9%	This is a single-handed practice with a low patient population, the CCG is encouraging the practice to increase uptake of LD health checks, however this is a particular practice who does not easily engage with the CCG.
FLEGGBURGH SURGERY	0	8	0.0%	0	9	0.0%	1	9	11.1%	0	8	0.0%	
ALEXANDRA & CRESTVIEW SURGERIES	11	121	9.1%	6	125	4.8%	15	127	11.8%	11	136	8.1%	
BECCLES MEDICAL CENTRE	4	96	4.2%	8	96	8.3%	6	96	6.3%	18	96	18.8%	This practice has been carrying out the LD health checks and this was verified by a visit by the CCG. The practice have not been coding the data correctly the CCG continue to work with them on how the data should be recorded.
LONGSHORE SURGERIES	0	15	0.0%	2	15	13.3%	3	15	20.0%	0	14	0.0%	
BRIDGE ROAD SURGERY	10	49	20.4%	13	52	25.0%	12	55	21.8%	17	59	28.8%	
VICTORIA ROAD SURGERY	4	89	4.5%	9	87	10.3%	31	89	34.8%	24	94	25.5%	
SOLE BAY H/C	1	19	5.3%	3	19	15.8%	2	19	10.5%	4	19	21.1%	
HIGH STREET SURGERY	6	90	6.7%	24	90	26.7%	32	93	34.4%	26	99	26.3%	
KIRKLEY MILL HEALTH CENTRE	4	86	4.7%	17	86	19.8%	17	68	25.0%	12	68	17.6%	
BUNGAY MEDICAL CENTRE	7	54	13.0%	5	58	8.6%	6	56	10.7%	14	56	25.0%	The CCG is aware that the performance is low for this practice, in the last 12 months they have had a number of GPs and nurses leave and they have been unable to recruit to the vacancies. The practice are committed, this is purely a resource issue and the CCG will continue to support them.
CUTLERS HILL SURGERY	1	38	2.6%	2	33	6.1%	1	33	3.0%	0	31	0.0%	
ROSEDALE SURGERY	3	79	3.8%	1	79	1.3%	34	84	40.5%	23	85	27.1%	
ANDAMAN SURGERY	2	37	5.4%	14	37	37.8%	7	38	18.4%	3	38	7.9%	
NELSON MEDICAL PRACTICE	16	50	32.0%	16	51	31.4%	3	51	5.9%	4	47	8.5%	
	120	**1367**		**201**	**1396**		**242**	**1448**		**290**	**1472**		

South Norfolk CCG area

	Quarter	MEASURE										
	Q1		Q1 Total	Q2		Q2 Total	Q3		Q3 Total	Q4		Q4 Total	Comments
PRACTICE_NAME	LDHC001_(Checks)	LDHC001_(Register)		LDHC001_(Checks)	LDHC001_(Register)		LDHC001_(Checks)	LDHC001_(Register)		LDHC001_(Checks)	LDHC001_(Register)		
GROVE SURGERY	2	67	3.0%	1	66	1.5%	50	65	76.9%	2	56	3.6%	
CHET VALLEY MEDICAL PRACTICE	1	50	2.0%	3	50	6.0%	15	53	28.3%	31	53	58.5%	
ORCHARD SURGERY	6	69	8.7%	5	76	6.6%	9	76	11.8%	15	71	21.1%	
LAWNS PRACTICE	14	47	29.8%	5	46	10.9%	6	48	12.5%	7	48	14.6%	
PARISH FIELDS PRACTICE	2	32	6.3%	2	31	6.5%	8	29	27.6%	10	29	34.5%	
ATTLEBOROUGH SURGERY	14	113	12.4%	15	114	13.2%	17	114	14.9%	15	112	13.4%	
OLD MILL AND MILLGATES MEDICAL PRACTICE	5	45	11.1%	1	45	2.2%	4	45	8.9%	1	42	2.4%	
LONG STRATTON MEDICAL PARTNERSHIP	8	47	17.0%	4	49	8.2%	14	54	25.9%	13	49	26.5%	
MATTISHALL SURGERY	11	43	25.6%	2	44	4.5%	9	47	19.1%	14	49	28.6%	
SCHOOL LANE SURGERY	1	59	1.7%	0	60	0.0%	6	61	9.8%	14	52	26.9%	
E HARLING & KENNINGHALL MEDICAL PRACTICE	3	28	10.7%	9	28	32.1%	6	29	20.7%	5	29	17.2%	
WYMONDHAM MEDICAL PARTNERSHIP	5	113	4.4%	21	104	20.2%	9	107	8.4%	56	107	52.3%	
CHURCH HILL SURGERY	6		0.0%	3		0.0%	1		0.0%	0	0	0.0%	The CCGs quality team has been trying to engage with this practice to look at their data recording issues. From the verified data it is obvious that they are completing health checks but unfortunately there is an error in the way they are manually recording their LD register.
THEATRE ROYAL SURGERY	9	76	11.8%	15	79	19.0%	12	77	15.6%	17	76	22.4%	
ELMHAM SURGERY	1	65	1.5%	2	65	3.1%	4	66	6.1%	18	67	26.9%	
WATTON MEDICAL PRACTICE	5	85	5.9%	2	84	2.4%	0	82	0.0%	43	82	52.4%	
HUMBLEYARD PRACTICE	1		0.0%	9		0.0%	14	80	17.5%	34	37	91.9%	The practice are carrying out LD health checks which has been verified by the CCG. However, there continues to be issues with how the practice are recording their LD data. The CCG continue to advise the practice every quarter on the errors they are making with their data entry.
HEATHGATE MEDICAL PRACTICE	0		0.0%	3		0.0%	1		0.0%	1	36	2.8%	The practice are carrying out LD health checks which has been verified by the CCG. However, there continues to be issues with how the practice are recording their LD data. The CCG continue to advise the practice every quarter on the errors they are making with their data entry.
HARLESTON MEDICAL PRACTICE	8	50	16.0%	6	50	12.0%	19	50	38.0%	14	55	25.5%	
HINGHAM SURGERY	1	20	5.0%	0	22	0.0%	3	22	13.6%	16	22	72.7%	
SHIPDHAM SURGERY	0	24	0.0%	0	18	0.0%	0	19	0.0%	15	19	78.9%	
WINDMILL SURGERY	2	20	10.0%	0	20	0.0%	0	20	0.0%	1	18	5.6%	
SCHOOL LANE PMS PRACTICE	2	19	10.5%	0	16	0.0%	1	18	5.6%	2	15	13.3%	
TOFTWOOD MEDICAL CENTRE	0	30	0.0%	1	11	9.1%	11	35	31.4%	10	10	100.0%	
	107	**1102**		**109**	**1078**		**219**	**1197**		**354**	**1134**		

Norwich CCG area

	Quarter	MEASURE										
PRACTICE_NAME	Q1 LDHC001_ (Checks)	LDHC001_(Register)	Q1 Total	Q2 LDHC001_(Checks)	LDHC001_ (Register)	Q2 Total	Q3 LDHC001_ (Checks)	LDHC001_(Register)	Q3 Total	Q4 LDHC001_(Checks)	LDHC001_(Register)	Q4 Total	Comments
ST STEPHEN'S GATE M/PRACT	6	58	10.3%	3	63	4.8%	6	53	11.3%	24	59	40.7%	
CASTLE PARTNERSHIP	20	100	20.0%	11	100	11.0%	16	101	15.8%	21	98	21.4%	
MAGDALEN MEDICAL PRACTICE	3	110	2.7%	2	110	1.8%	36	112	32.1%	56	113	49.6%	
OLD CATTON MEDICAL PRACTICE	0	30	0.0%	0	30	0.0%	2	37	5.4%	5	37	13.5%	
TRINITY & BOWTHORPE MEDICAL PRACTICE	7	119	5.9%	5	110	4.5%	2	121	1.7%	9	140	6.4%	
HELLESDON MEDICAL PRACTICE	10	80	12.5%	15	79	19.0%	8	77	10.4%	18	84	21.4%	
ROUNDWELL MEDICAL CENTRE	1	59	1.7%	1	59	1.7%	2	63	3.2%	35	61	57.4%	
TAVERHAM PARTNERSHIP	0	61	0.0%	2	59	3.4%	11	61	18.0%	23	64	35.9%	
LAKENHAM SURGERY	38	80	47.5%	7	79	8.9%	0	79	0.0%	0	79	0.0%	
WENSUM VALLEY MEDICAL PRACTICE	1	151	0.7%	0	157	0.0%	1	161	0.6%	2	143	1.4%	
OAK STREET MEDICAL PRACT.	2	36	5.6%	3	32	9.4%	2	65	3.1%	6	59	10.2%	
THORPEWOOD MEDICAL GROUP	0	78	0.0%	0	72	0.0%	2	71	2.8%	57	64	89.1%	
BACON ROAD MEDICAL CENTRE	4	72	5.6%	13	68	19.1%	5	49	10.2%	11	51	21.6%	
NEWMARKET ROAD SURGERY	1	20	5.0%	3	20	15.0%	1	13	7.7%	5	13	38.5%	
EAST NORWICH MEDICAL PARTNERSHIP	0	54	0.0%	0	54	0.0%	1	54	1.9%	1	54	1.9%	East Norwich recognises that they need to do more to improve their LD performance. From may 2019 they have employed an LD nurse champion who has been undertaking meet and greet coffee mornings for patients with LD. This is to enable LD and autism patients to be comfortable with attending the practice and undergoing a health check.
THE LIONWOOD MEDICAL PRACTICE	5	57	8.8%	5	57	8.8%	6	58	10.3%	9	58	15.5%	
LAWSON ROAD SURGERY	9	85	10.6%	19	78	24.4%	19	77	24.7%	13	76	17.1%	
PROSPECT MEDICAL PRACTICE	1	66	1.5%	1	66	1.5%	25	66	37.9%	12	71	16.9%	
WOODCOCK RD SURGERY	0	19	0.0%	3	19	15.8%	3	14	21.4%	2	23	8.7%	
WEST POTTERGATE MED PRAC	7	27	25.9%	6	27	22.2%	1	27	3.7%	4	27	14.8%	
NORWICH PRACTICES HEALTH CENTRE	0		0.0%	10		0.0%	4		0.0%	2		0.0%	The CCG have verified that NPL are undertaking their LD health checks and they are performing at around 60%, however there appears to be an IT issue in CQRS that we are trying to resolve.
BEECHCROFT AND OLD PALACE	10	84	11.9%	17	85	20.0%	8	81	9.9%	13	81	16.0%	
	125	**1446**		**126**	**1424**		**161**	**1440**		**328**	**1455**		

West Norfolk CCG area

	Quarter	MEASURE										
PRACTICE_NAME	Q1 LDHC001_(Checks)	LDHC001_(Register)	Q1 Total	Q2 LDHC001_(Checks)	LDHC001_(Register)	Q2 Total	Q3 LDHC001_(Checks)	LDHC001_(Register)	Q3 Total	Q4 LDHC001_(Checks)	LDHC001_(Register)	Q4 Total	Comments
GRIMSTON MEDICAL CENTRE	0	41	0.0%	0		0.0%	0		0.0%	29	49	59.2%	This practice, like most increases their activity in the last quarter and the CCG continue to advise them to carry out LD health checks throughout the year.
BRIDGE STREET SURGERY	10		0.0%	17		0.0%	0		0.0%	0	6	0.0%	The practice are carrying out LD health checks which has been verified by the CCG. However, there continues to be issues with how the practice are recording their LD data. The CCG continue to advise the practice every quarter on the errors they are making with their data entry.
HEACHAM GROUP PRACTICE	0		0.0%	0		0.0%	0	38	0.0%	0		0.0%	The CCG over the last 12 months has tried to support the practice in encouraging them to undertake LD health checks. The CCG has made available training sessions and support information, however the practice continue to preform poorly. The CCG is now in discussions on whether the improved access provider and PCNs could invite this practice's patients to undertake an LD health check.
UPWELL HEALTH CENTRE	0	45	0.0%	0	45	0.0%	1	46	2.2%	13	43	30.2%	
WATLINGTON MEDICAL CENTRE	3	30	10.0%	10	28	35.7%	6	30	20.0%	5	27	18.5%	
VIDA HEALTHCARE	16	241	6.6%	28	190	14.7%	19	192	9.9%	55	190	28.9%	
LITCHAM HEALTH CENTRE	0		0.0%	1		0.0%	14		0.0%	0	8	0.0%	It is verified that the practice are undertaking LD health checks, the CCG continue to work with them on how they are recording the LD data.
ST JAMES MEDICAL PRACTICE	20	150	13.3%	23	152	15.1%	23	150	15.3%	6	149	4.0%	
CAMPINGLAND SURGERY	1	28	3.6%	0	28	0.0%	3	28	10.7%	22	29	75.9%	
MANOR FARM MEDICAL CENTRE	2	34	5.9%	0	34	0.0%	2	34	5.9%	14	28	50.0%	
HOWDALE SURGERY	0	18	0.0%	1	19	5.3%	0	15	0.0%	0	14	0.0%	The CCG is aware that performance is low and contact is made every quarter with this practice to encourage improving performance. However, this is a practice that does not easily engage with the CCG.
GREAT MASSINGHAM SURGERY	2	36	5.6%	4	36	11.1%	2	32	6.3%	8	32	25.0%	
BURNHAM SURGERY	0		0.0%	0	9	0.0%	0	0	0.0%	0	0	0.0%	The CCG over the last 12 months has tried to support the practice in encouraging them to undertake LD health checks. The CCG has made available training sessions and support information, however the practice continue to preform poorly. The CCG is now in discussions on whether the improved access provider and PCNs could invite this practice's patients to undertake an LD health check.
FELTWELL SURGERY	1	12	8.3%	2	14	14.3%	1	13	7.7%	7	13	53.8%	
SOUTHGATES SURGICAL & MEDICAL CENTRE	2	80	2.5%	0	80	0.0%	3	95	3.2%	47	106	44.3%	

ST CLEMENTS SURGERY	10	42	23.8%	3	42	7.1%	6	45	13.3%	14	45	31.1%	The CCG over the last 12 months has been trying engage the practice in entering and verifying their LD data. The practice responded in the past quarter, however there is more work to be done. The CCG will continue to work with the practice to ensure that they improve their performance.
BOUGHTON SURGERY	0		0.0%	0		0.0%	0		0.0%	2	2	100.0%	
THE WOOTTONS SURGERY	0	16	0.0%	0	16	0.0%	0	16	0.0%	8	24	33.3%	
PLOWRIGHT MEDICAL CENTRE	2	22	9.1%	0	20	0.0%	9	20	45.0%	4	20	20.0%	
THE HOLLIES SURGERY	0	12	0.0%	3	12	25.0%	1	12	8.3%	2	12	16.7%	
ST JOHN'S SURGERY	0	53	0.0%	2	53	3.8%	16	49	32.7%	3	44	6.8%	
	69	**860**		**94**	**778**		**106**	**815**		**239**	**841**		

Annual Health Checks for People with a Learning Disability: an update for HOSC

Date: 21st August 2019

1. **Background**

At the HOSC of September 2018, the committee recommended that Healthwatch Norfolk should work with the Clinical Commissioning Groups (CCGs) to raise awareness of the importance of Annual Health Checks for people with a learning disability.

2. **Action taken**

Healthwatch Norfolk met with representatives of Norfolk's CCGs to discuss ways to increase uptake of Health Checks, aligned to the CCGs Learning Disability (LD) Working Group Action Plan. Healthwatch Norfolk proposed engaging and co-producing a programme of work with people with learning disabilities, Experts by Experience, their carers and/or advocates to:

- Create and delivering an LD Health Check Communication and Engagement Plan
- Produce tailored, localised materials (based upon the MenCap Health Checks packs) in Easy Read
- Develop and deliver; peer training on getting an annual Health Checks, feeling unwell and what to do, training for housing and care providers on annual Health Checks, a Healthy Eating & Healthy Weight materials pack and training session and a Physical Activity & Postural Support materials pack and training session

The CCGs were supportive of the proposal but unable to fund it. In view of the 50% reduction in Healthwatch Norfolk's core funding in 2019, several applications were made to charitable trusts. These applications were unsuccessful since such trusts will not fund activity or services that are a statutory responsibility nor will they fund a local Healthwatch because of its' statutory remit. It was therefore necessary to revise the scope and scale of the work to:

- Raising awareness of Health Checks
- Supporting the CCGs with the learning disabilities programme through community engagement
- Gathering feedback on Health Checks literature
- Using the focus of Healthwatch Norfolk's 'Enter and View' programme for 2019-2020 on residential care homes for people with learning disabilities, to enquire about access to Health Checks

3. Progress

3.1 In January 2019 a programme of Enter & View visits to residential care homes for adults with learning disabilities started and to date 6 Enter & View visits have been carried out. Healthwatch Norfolk will be training 5 new members of staff plus more volunteers in Enter & View, with more visits planned.

3.2 Healthwatch Norfolk applied for charitable funding and were successful in being awarded £2,000 from the Baily Thomas Trust in March 2019 towards community engagement about Annual Health Checks.

3.3 In April 2019 our volunteers helped to review some of the Health Checks literature. Their comments were shared at a meeting about developing literature for people in Norfolk. Healthwatch Norfolk is working with the CCGs and partners to co-design a Health Check invitation letter that all GP Practices will have access to.

3.4 We asked Opening Doors to get some feedback on experiences of Health Checks. Opening Doors talked about Health Checks at their conference on 1st May 2019. The feedback on Health Checks was mixed:

"I had a letter to tell me to have a health check"

"They could not weigh me at my health check because they had no scales for my wheelchair"

"The doctor listened to me and my supporter. They took me off meds I no longer needed"

"I have a good relationship with staff at the GP surgery"

"I wasn't confident to say I wanted the health check to stop"

"My check was only 5 minutes long"

"My doctor wrote me up a pass to join the local gym"

"I had to take off my trousers. I got really upset they didn't explain why I had to be undressed"

4. Concerns

4.1 Healthwatch Norfolk has received reports of concerns and complaints regarding the quality of Annual Health Checks e.g. the component parts of a Health Check, what should happen vs what actually happens etc. Advice has been sought from the CCGs and NHS England.

4.2 Annual Health Checks are mandated to the CCGs, not to GP Practices; practices sign up to the scheme i.e. it is voluntary. This raises a concern regarding equity of access to a preventive service for a cohort of people experiencing health inequalities and premature mortality (as referred to in the findings of the Learning Disability Mortality Review), since this service is not offered by other providers. For example, Healthwatch Norfolk does not believe a similar arrangement would be proposed or

accepted by the clinical community if the cohort were women aged 25 to 64 years and the preventive service was cervical screening.

5. Key points for consideration

Healthwatch Norfolk considers the following are important considerations for commissioners and providers of Annual Health Checks:

- There is a focus upon the **quality of Annual Health Checks**
- The necessary attention is paid by providers to the statutory duty to make **reasonable adjustments** in the provision of Annual Health Checks to people with learning disability, including adherence to the **Accessible Information Standard** DCB1605 Accessible Information
- Ensuring people with learning disabilities and autism are effectively engaged in the **local 5-year Long Term Plan** and equal partners in the co-production of specific plans for services for people learning disability and autism

5. Ongoing work

Healthwatch Norfolk will continue their plan of community engagement to March 2020, gathering feedback from people with a learning disability on:

- The quality of the Health Check experience [aligned to the CCGs plans for a Quality Checker initiative]
- The reasonable adjustments made by providers and adherence to the Accessible Information Standards [aligned to the roll-out of the Sunflower Charter Mark] and meeting people's communication needs [see Annex A]

Annex A Additional information on meeting communication needs: Health Passports

In January 2019 Healthwatch Norfolk gathered some feedback on the then draft National Patient Safety Strategy. People with a learning disability told us that using Health Passports (or Health Books) for health and care appointments and treatments helps with better communication. Improved communication helps people feel and stay safe. Health Passports can be very useful when preparing for, going to and following up a physical Health Check. People with learning disabilities told us that not everyone has a Health Passport and often health care staff do not use the Health Passport.

Health and social partners across Norfolk were asked to fund a peer-led audit of Health Passport. Self-advocates at Opening Doors have started this work which has been funded by:

Queen Elizabeth Hospital	North Norfolk CCG & South Norfolk CCG	East of England Ambulance Trust
James Paget Hospital	Norwich CCG	Norfolk Community Health & Care
Norwich & Norfolk Hospital	Great Yarmouth & Waveney CCG	East Coast Community Healthcare
Norfolk & Suffolk Mental Health Trust	West Norfolk CCG	Norfolk County Council

Ambulance response times and turnaround times in Norfolk

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

Examination of action to improve ambulance response and turnaround times since February 2019 and preparations for winter 2019-20.

1. Purpose of today's meeting

1.1 The focus areas for today's meeting are:-

- The action taken by the East of England Ambulance Service NHS Foundation Trust (EEAST) and the wider health and care system in Norfolk to address issues that could affect the ambulance service performance in Norfolk.

- The interface between EEAST and other specific agencies, e.g. NHS 111; adult social care.

- EEAST and the wider health and care system's preparations for winter 2019-20 in the context of maintaining ambulance service performance.

1.2 EEAST,.the five Norfolk and Waveney Clinical Commissioning Groups (CCGs) and the Norfolk and Norwich University Hospitals NHS Foundation Trust have been asked to provide the following information:-

- An update on ambulance response and turnaround times at all 3 acute hospitals in Norfolk
- An update on the progress / outcomes of the system-wide project to improve ambulance performance in Norfolk
- Plans to help patient flow in winter 2019-20
- Progress with pathways for mental health patients
- The interface between EEAST and the NHS 111 service

The NHS organisations have provided the report at **Appendix A**.

1.3 In the context of examining issues in the wider health and care system that could affect ambulance service performance, Norfolk County Council Adult Social Care has provided a paper at **Appendix B** regarding the Norfolk Swift Response (Swifts and Night Owls) service and how it can be contacted by the ambulance service and others.

1.4 Norfolk Constabulary has also been invited to give its perspective on ambulance response, particularly in relation to people in mental health crisis. Its report is attached at **Appendix C.**

1.5 Representatives from EEAST, the Clinical Commissioning Groups, the Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH) and Norfolk County Council Adult Social Care will attend the meeting to answer Members' questions.

The NNUH is the only one of the three acute hospitals in Norfolk that has been asked to attend. This is on the basis that the NNUH is the busiest hospital in the region in terms of arrivals by ambulance and delays at the hospital therefore have the greatest potential to affect ambulance response times.

Members will see from the NHS partners' report at Appendix A patient handover delays at the Queen Elizabeth Hospital, King's Lynn (QEH) are a significant issue. Representatives from the QEH will attend NHOSC in January 2020 to discuss all the challenges faced by the hospital, including those in the emergency department.

The figures in Appendix A show that James Paget Hospital performs relatively well in term of ambulance arrival to patient handover times.

2. Previous report to NHOSC

2.1 Norfolk Health Overview and Scrutiny Committee (NHOSC) has had concerns about ambulance response times and turnaround times in Norfolk for a considerable period of time and has frequently returned to the subject.

The subject was last on NHOSC's agenda on 28 February 2019; the report and minutes of the meeting are available on the County Council website (agenda item 6). The committee heard that:-

- Demand was continuing to rise
- Staff recruitment was challenging, but
- There was an improving trend in response time for C1 and C2[1] calls in the Norfolk and Waveney area.

The new national response time standards, which were introduced in October 2017, were expected to take 2 years to implement. EEAST had a contract with its commissioners based on a performance trajectory at a regional level.

A significant amount of time was being lost because of delays between arrival of ambulances and handover of patients at the county's hospitals, particularly the NNUH and Queen Elizabeth Hospital, King's Lynn (QEH):-

[1] C1 – Category 1 - Calls about people with life-threatening injuries & illnesses (7 minutes mean response time)
C2 – Category 2 – Emergency calls (18 minutes mean response time)

- NNUH - hours equivalent to 23 double staff ambulance shifts lost per week on average
- QEH – hours equivalent to12 double staffed ambulance shifts lost per week on average.

EEAST also reported in February 2019 that it had few primary pathways available to prevent some patients from being conveyed to the acute hospital emergency departments for mental health assessments, especially outside of normal working hours. The acute hospital emergency departments were not the best place for these assessments to be done. Some progress had been made with Norwich-based services but more was needed, and in the rest of the county.

4. Suggested approach

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

(a) The NHS partners' report says that in terms pathways available for ambulance staff to use for mentally ill patient 'a lack of capacity to meet the need appears to be embedded within the locality' (Appendix A, paragraph 5).

To what extent is this situation being addressed in the current work to remodel adult and children's mental health services?

(b) The NHS partners' report says that Norfolk and Waveney has been best performer across the EEAST area for category 2 (e.g. heart attack, stroke, sepsis or major burns) performance in each of the past 6 months but the figures at Appendix A paragraph 2 show that EEAST missed its C2 trajectory target in the months from April to July.

Do the commissioners consider that ambulance response times are moving in the right direction quickly enough?

(c) The 'Source of referrals – County' pie chart in Appendix C (paragraph 3.3) shows that just 3% of referrals to Norfolk County Council's Swifts service come from the ambulance service.

Could EEAST make more use of this service to avoid unnecessary conveyance of patients to hospital?

What are the barriers preventing EEAST referrals to this service and other admission avoidance initiatives in the county?

(d) To what extent does EEAST work with Norwich Escalation Avoidance Team (NEAT) and any other similar services in the county to avoid unnecessary conveyance of patients to hospital?

(e) What progress has there been towards arranging for EEAST to have access to mental health practitioners in its control rooms to support staff when they receive calls from people in mental health crisis.

(f) To what extent are ambulance crews enabled to respect end of life patients' wishes as expressed in Advanced Care Plans or living wills?

(g) To what extent does NNUH consider delays in the emergency department, and the knock-on effect on the ambulance service, when determining the number of diagnostic tests that are necessary for patients?

5. Action

5.1 The committee may wish to consider whether to:-

(a) Make comments and / or recommendations based on the information received at today's meeting.

(b) Ask for further information for the NHOSC Briefing or to examine specific aspects of ambulance response and turnaround times in Norfolk at a future committee meeting.

IN TRAN communication for all	If you need this document in large print, audio, Braille, alternative format or in a different language please contact Customer Services on 0344 800 8020 or Text Relay on 18001 0344 800 8020 (textphone) and we will do our best to help.

in good health

Norfolk & Waveney Ambulance Update: NNUH and Central Norfolk System

5 September 2019

1. Executive Summary

1.1. The purpose of this paper is to provide an update and overview of Ambulance Performance across the Norfolk and Waveney locality; mainly focused on the Central System and the Norfolk and Norwich University Hospital (NNUH). The following core areas are included in the paper:

- Ambulance response and turnaround times at all 3 acute hospitals in Norfolk
- Progress & outcomes of the system-wide project in Norfolk
- Plans to help patient flow in winter 2019-20
- Progress with pathways for mental health patients including alternative conveyance
- The interface between EEAST and the NHS 111 service/adult social care
- Future plans and projects

1.2. The ambulance response programme (ARP) standards were introduced in October 2017, and aim to get the right vehicle in the right place at the right time. The Ambulance Trust (EEAST) has a contract with commissioners based on a performance trajectory associated with these standards; as does the NNUH is relation to the handover time elements. The latter is one of the high profile standards closely overseen by the NHS England & Improvement regulator teams. The main measurables include:

Category	Examples/explanation	Standard
In the Community -		
1. Life-threatening and needing immediate intervention and/or resuscitation	Cardiac or respiratory arrest	Respond in 7 minutes on average; and 90% of all calls in 15 minutes
2. Emergency for a potentially serious condition that may require rapid assessment, urgent on-scene intervention and/or urgent transport	Heart attack, stroke, sepsis or major burns	Respond to Category 2 calls in 18 minutes on average, and respond to 90% of Category 2 calls in 40 minutes
3. Classified as urgent. They are problems (not immediately life-threatening) that need treatment to relieve suffering	Pain control and transport or clinical assessment and management at the scene	The national standard states that all ambulance trusts must respond to 90% of Category 3 calls in 120 minutes
4. Ambulance calls are for incidents that are not urgent but need assessment (face-to-face or telephone) and possibly transport within a clinically appropriate timeframe.	Falls, generally unwell	90% of Category 4 calls should be responded to within 180 minutes
Pre/At Hospital -		
Handover to the assessment nurse/doctor	i.e. when the ambulance crew clinically hands over to the Emergency Department and the button is pressed on the computer	<15 minutes from arrival to handover (clock starts automatically)

Handover to clear	i.e. after handover how long before the crew have cleaned the ambulance and re-stocked etc and are ready to leave for another call	<15 minutes from handover time to clicking 'trolley clear' on the computer system

1.3. In Norfolk like other rural areas it is a challenge for EEAST to meet these standards consistently; this has been compounded by the pressures from handover delays at the hospitals. However, significant progress has been made across the trusts and performance reflects this.

1.4. One of the most significant impacts is the integrated working between the different providers across the system. All teams have pulled together to jointly work on initiatives and pathways for example the Rapid Assessment and Treatment redesign at NNUH and the EEAST-led Transformation work with system partners such as the admission avoidance scheme with EEAST and NCH&C and alternative ambulance dispositions other than ED. This reflects the common ambition to minimise ambulance delays of any kind based on the acceptance by all parties that the patient at the greatest risk is the person unattended in the community.

1.5. This cultural shift and shared purpose is driving a new era of joint working and problem solving, which is having demonstrable benefits on improving delivery and patient experience. The specific performance data and initiative detail is included in the following sections, followed by a brief summary of next steps and future plans.

2. Performance Overview:

2.1. The performance headlines include a positive improvement in all categories against the trajectories; whilst it is recognised that these are not national standards, these do represent an improving picture for not only the FYTD, but also in the past 12 months. This is directly linked to the positive recruitment which has allowed a greater ambulance provision. For comparison, Norfolk & Waveney have consistently been the best performer across EEAST for C2 performance in each of the past 6 months.

Standard	Trajectory	April	May	June	July
C1 Mean	08:27	07:52	07:57	08:12	08:16
C1 90th	16:25	14:47	15:14	15:40	15:49
C1T Mean		12:34	11:59	12:34	12:50
C1T 90th		22:14	22:29	23:08	23:44
C2 Mean	19:51	22:12	22:28	22:47	23:48
C2 90th	00:42:43	00:44:46	00:46:15	00:45:53	00:50:47
C3 90th	01:52:06	02:32:04	02:28:26	02:31:52	03:23:05
C4 90th	03:41:07	02:45:14	02:13:02	02:42:12	03:44:03

EEAST are also measured on conveyance and non-conveyance rates. The table below indicates the calendar year to date performance and shows that only around 60% of patients are transported to one of our acute hospitals.

Breakdown	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	YTD Total
Hear and Treat %	7.34%	6.36%	5.87%	5.24%	4.90%	5.08%	4.57%	5.62%
See and Treat %	33.24%	33.92%	32.79%	33.97%	34.27%	34.10%	35.40%	33.96%
Conveyed %	59.43%	59.72%	61.34%	60.79%	60.83%	60.83%	60.03%	60.42%

2.2. Despite some significant improvements, particularly at the NNUH, the pressure to sustain the changes continues with weekly ambulance handover flash reports for QEHKL and NNUH to NHSE/I. The core focus is to continue to improve the current position and ensure we are in a stronger position going into this winter.

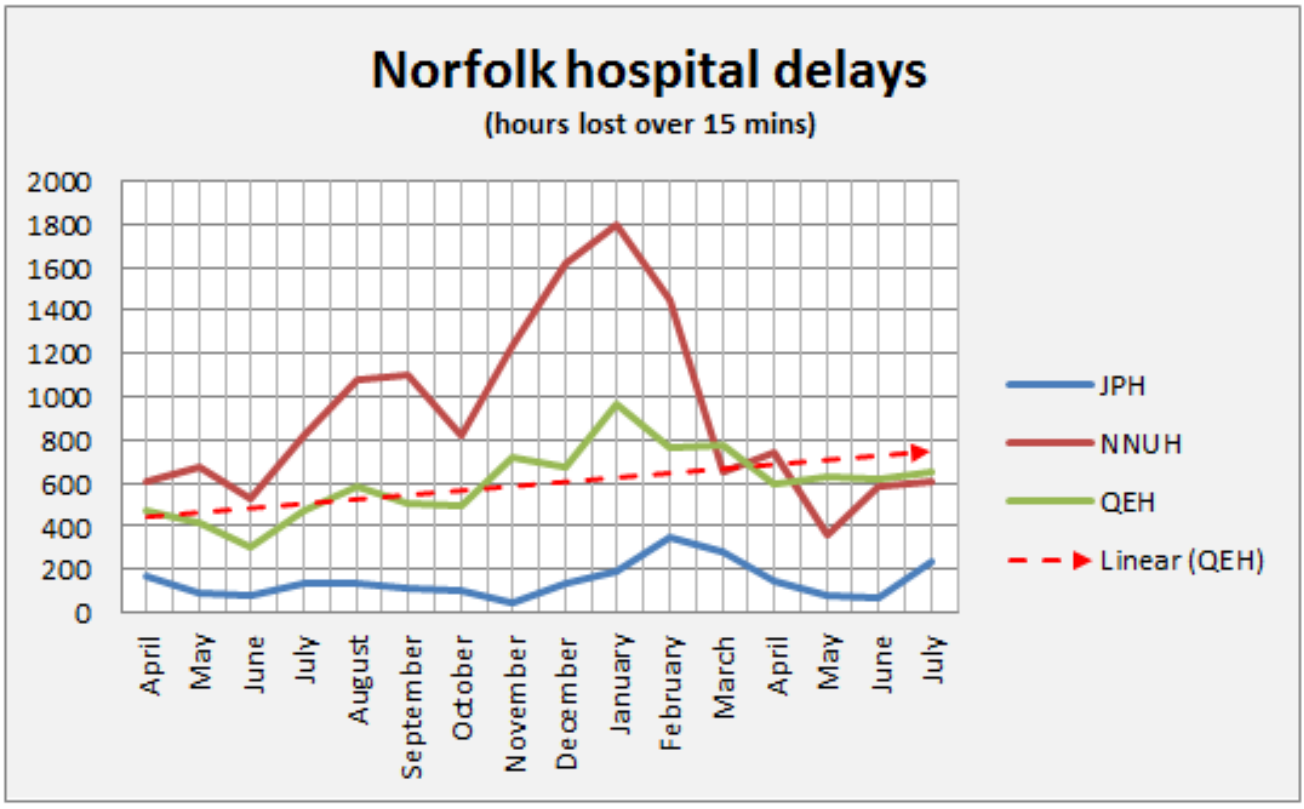
2.3. EEAST has seen a sustained improvement in its performance in the last few months as our recruitment has become more successful, and our restructure has allowed us to get more sustainability built into daily operations. However, there are further improvements required. In Norfolk & Waveney the four main challenges to performance are: -

1. Disproportionate delays experienced at the front door of acutes, most notably Queen Elizabeth Hospital, Kings Lynn (see below). This has the single biggest impact on our ability to deliver a safe service, not just through lost ambulance hours, but also through its unpredictability and therefore difficulty in predicting the delays.
2. Continuing student ambulance paramedic training (training requires EEAST to take them off front line duties so they can attend University)
3. Year on year increase demand on the 999 service, including an increase in primary care conditions
4. Rurality and Road infrastructure

3. Hospital handover delays have a direct impact on ambulance resourcing, performance and patient experience. When a crew is delayed at a hospital it means that it is not available to respond to a patient in the community. This becomes a significant issue at times of increased demand or if multiple ambulance crews are delayed at hospitals. There is also a secondary effect in that calls queue and the only available despatch at times is from those ambulances which become available at a hospital and this impacts on the travel time to many locations across the area with the obvious elongation of drive times often on narrow and challenging roads. The table below shows the average handover time taken per patient to handover per acute.

Average Arrival To Handover Time in HH:mm:ss								Up to 18.08.19
Acutes	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
James Paget Hospital	00:17:25	00:23:13	00:20:15	00:16:40	00:14:36	00:14:23	00:19:17	00:17:58
Norfolk & Norwich University Hospital	00:38:54	00:35:49	00:21:20	00:23:16	00:16:58	00:20:57	00:21:21	00:25:31
Queen Elizabeth Hospital	00:47:16	00:44:11	00:40:43	00:36:28	00:36:10	00:35:57	00:38:23	00:39:52
Grand Total	00:34:32	00:34:24	00:27:26	00:25:28	00:22:35	00:23:46	00:26:20	00:27:47

To put this into context, you will see that the graph below showed that in January 2019 EEAST lost 3,000 hours in arrival to handover delays over 15 minutes in Norfolk. This equates to 250 double staffed ambulance 12-hour shifts - or 8 full front-line ambulance shifts lost every day of the week. Since then, the efforts of the system (particularly the NNUH) has reduced this by over half to just over 1400 lost hours over 15 minutes in July. However, ambulance delays at hospitals tend to reflect the wider demand and pressures on the urgent and emergency care system, and not just the ED department. The graph below shows the step-change improvement from the NNUH, but the increasing trend seen at QEH now eclipsing those previously experienced at the NNUH.



EEAST works closely with every hospital to ensure delays are minimised and has good relationships with all three. EEAST also participates in the system and operational resilience meetings working alongside colleagues from the acute, community and 111 providers. Handover delays are not isolated to Norfolk, but are replicated across our region and nationally, although Norfolk does have an above average problem.

4. **Projects and Progress (including Winter Resilience Planning):**

4.1. There are a number of initiatives in place; these include;

- Access to alternative conveyance destinations in each hospital other than ED (OPED/AEC) – this has proved successful at the NNUH, so is being rolled out to QEH & JPH as geriatricians become recruited. The AEC model is already in place at QEH & JPH and has had early success at the NNUH. This avoids the need for a patient to be taken through the ED system and can be directed to a speciality team as soon as is possible in their journey.

- Access to wider range of alternatives to conveyance (this is currently being scoped to pass through to a single NEAT model via a 111 option); this is intended to reduce the time spent by ambulance crews trying to access a variety of community providers, thereby releasing capacity back into the system. Ideally this would need to be an extended service throughout the week, including evenings, but the ambition is that this can become a 7 day service as soon as possible.

- Introduction of NEAT practitioners in the 999-control room to intercept lower acuity callers following initial triage (this is planned for a 'test of change' pilot over 4 days in September).

- The rotation of extended trained paramedics through the NCH&C speciality teams; this will enhance their skills, but also introduce greater reliability to treat patients safely in their own homes with specialist paramedics. This has started with positive feedback so far from EEAST & NCH&C staff, as well as from patients. The initial rotations will include palliative care, NEAT, community nursing, and acute & chronic respiratory care.

4.2. Winter resilience:

- NNUH are building additional ward capacity and redesigning the flow in and out of the Acute Medical Unit; this will aid us with capacity in ED to offload but also more timely release of crews from AMU

- The Frailty OPED model is being expanded into the weekend following recent pilots – this supports EEAST by having access to a consultant over the phone, which can avoid conveyances

- Each of the System Oversight, Resilience and Transformation (SORT) groups has a work plan that includes resources and new ways of working. These are based on experiences from previous winters and include more proactive planning like 'Perfect Week' initiatives to create capacity before the festive period

- New fleet of ambulances will be in place before winter and EEAST has had a successful recruitment campaign achieving establishment levels in Norfolk & Waveney

4.3. As a system the winter monies have been prioritised for the highest impact best value schemes, which include:

Norfolk and Waveney Central System Winter Funding Schemes 2019/20
AA3 - 12 month test of change initiative to enable community clinicians to work alongside EEAST clinical coordinators in ECAT to transfer appropriate cases to community services via NEAT to prevent inappropriate conveyances and support admission avoidance. AA1 - Additional Home ward capacity
DC1 - Pump priming to enable South Norfolk NEAT to continue to end of the financial year
AA2 – Additional admission avoidance capacity in North and South Norfolk
AA11 – Proactively reviewing population health management data (GEMIMA) and working with GP practices in North Norfolk to identify frail individuals for holistic assessment and identification/resolution of unmet needs to prevent healthcare crisis developing
WE1 - Dedicated resource for evaluation of Winter projects to inform long term commissioning
AA12 - To increase capacity in the existing CLT/EIT team as an interim measure pending the co-produced redesign of the front and back door patient pathways within the NNUH
DC7 - Continuation of NCH&C Integrated Operations Centre covering Inpatients and CN&T
AA4 - Vouchers for flu vaccines for third sector staff and volunteers
AA5 – Collaborative scheme between NNUH Respiratory Team & Primary Care for high risk asthma patients (alternative conveyancing)
NN1 – Additional APNP cover at NNUH to enable robust 24/7 cover for 6 months to respond to anticipated acute Paediatric Winter activity (faster release of crews)
NN6 – Long term infrastructure for flu POCT testing at NNUH
DC4 – Residential short term dementia bed provision. This scheme funds top up fees to provide 5 short term dementia beds for the STP (alternative conveyancing)

5. Mental Health Pathways

A number of challenges remain with access to appropriate support and pathways for mental health patients within the Norfolk footprint. These are aligned to the well documented challenges faced by NSFT where a lack of effective community response has been a historical issue for several years. Many of these are more apparent in the out of hours periods. These challenges include;

- A lack of capacity to meet the need appears to be embedded within the locality with EEAST front-line clinicians being unable to access the pathway outlined within MIDOS. This impacts upon on scene times where crews can be delayed on scene for several hours in an attempt to identify the most appropriate outcome for their patient. Currently we are unable to identify any community based Older adult or CYP service to meet out of hours need.
- The advice given to EEAST clinicians from MH professionals at times highlights the lack of service provision and response, often advising that the patient should be conveyed to nearest ED as the only pathway option. Currently Norfolk and Waveney only have one of three hospitals as a “Core 24” provider.

- Another challenge within Norfolk is around the provision and capacity of S136 suite, the availability of suites local to the presenting patient is limited with patients being conveyed across the locality - a person detained within Kings Lynn may well be transported to Great Yarmouth as the nearest suite with capacity. This will increase risk for both EEAST and Norfolk police whilst extending the call cycle time dramatically. The protracted journey times also contribute to a poor patient experience with patients being conveyed significant distances outside of their local area.

Patients presenting in Wisbech are currently able to access the 24/7 First response Service that is now being recognised within the NHS long-term plan as the preferred best practice model. (Wisbech whilst within EEAST's "West Norfolk" locality sits under the Cambridgeshire and Peterborough STP). Whilst this meets the need for patients presenting with isolated MH need, the patients that present with associated physical health needs, the local ED seems resistant to this conveyance due to the geography rather than the needs of the patient.

EEAST has been an active participant within both the Norfolk monitoring and strategic MH groups. Recently the strategic group (Crisis Care Concordat) has been moved to sit within a new Group; the "Norfolk Crisis Group" which is CCG led. The new crisis group is looking to develop community-based response in line with the aims and deliverables of the NHS long term plan.

EEAST continue to have a good relationship with Norfolk police and the local AMHP team; local leads have developed a good working practice that looks to support all along with meeting the presenting needs of our patients. The work undertaken in the past 12 months to support patients detained under the MHA (Section 135, 136, 2) has shown an improved response from EEAST to all requests. Transport for mental health patients has since been included within the non-emergency patient transport service tender recently awarded by the CCG.

The future is mapped with the additional funding and clear aims outlined within the NHS long term plan. EEAST are involved at local regional and national level in the workstreams aligned to ambulance Trusts. As a regional provider EEAST are placed in the position of being able to compare and contrast the progress being made within the six STP footprints around MH. A degree of concern around the pace of movement within Norfolk system is felt at present, given the historical lack of community provision the challenge around workforce and existing resources within the local MH provider supports these concerns.

Currently a scoping exercise is being undertaken to support the development of the MH support within EEAST's three AOC's. This exercise supports the workstream outlined within the NHS long term plan and is in line with the implementation framework that has been set by NHS England.

6. EEAST Interactions:

6.1. NHS 111 service: EEAST worked with IC24 throughout the last winter to increase the validation times for lower acuity (C3/4 patients) so that patients were managed most appropriately through the 111 service. This has proved successful in reducing the 111 to 999 transfer rate, and therefore overall 999 demands; this is now embedded as business as usual. EEAST & IC24 continue to work together to improve the patient journey.

IC24 has also provided direct access to EEAST crews to book an OOH base appointment without the need to speak directly to a GP. This has proved to be a successful collaboration.

6.2. Social Care: Operationally the teams work closely together and access services directly using the DOS but also through NEAT and 111. This includes services such as NFS, SWIFT and NIGHT OWLS , which all support admission avoidance

7. Summary and Next Steps

7.1. In conclusion, despite a number of logistical and operational challenges there continues to be a lot of ongoing work and improvements; which are reflected in the current performance position.

7.2. The priority is preparing for winter and building the resilience in advance by redesigning pathways in advance. The EEAST-led Transformation Nous and STP transformation strategy work provide a good platform to build from. The effort needs to be concentrated on the following over the coming months:

- Reducing variation and not having significant failures on singular days e.g. weekends
- Expanding and embedding the admission avoidance and alternative conveyance work
- Focus on the >15 minute handover delay reduction not just the over the hour issues
- Targeting 111 processes to reduce dispositions
- Revised STP UEC Plan – integrate into local delivery plans
- Head of Integrated Discharge Role – to release capacity for ED to prevent ambulance delays
- Cromer Integrated Urgent Care model
- Review and refresh the Directory of Service for alternative pathways (reference Suffolk Model)

7.3. Having the dedicated ‘winter teams’ and SOAR/SORT is key to this work as collectively they will drive forward collaborative change and work in partnership.

Briefing Note for Norfolk Health Overview and Scrutiny Committee (NHOSC)

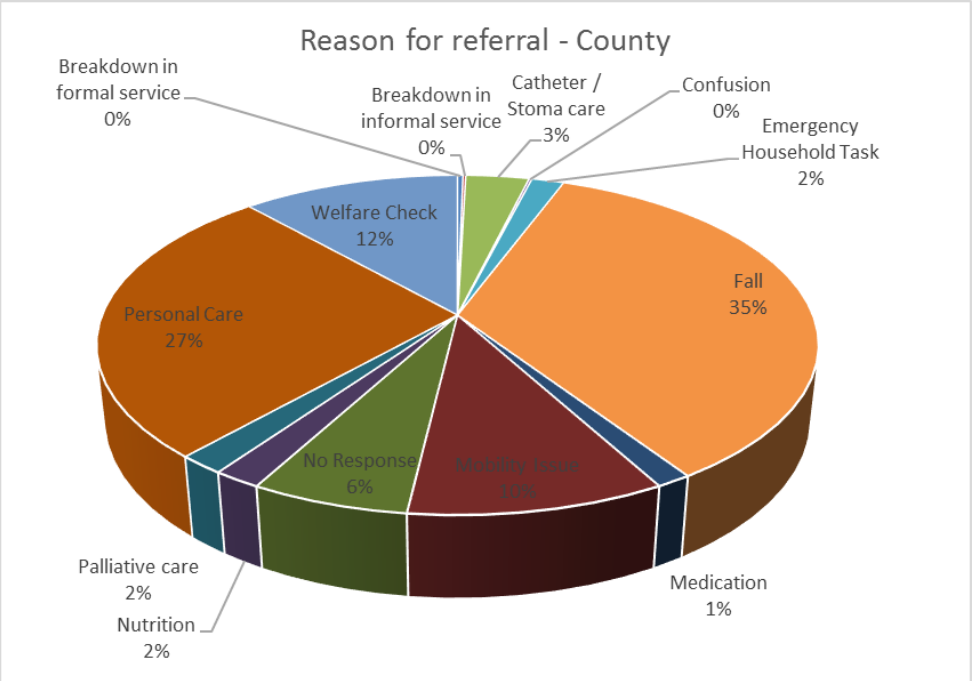
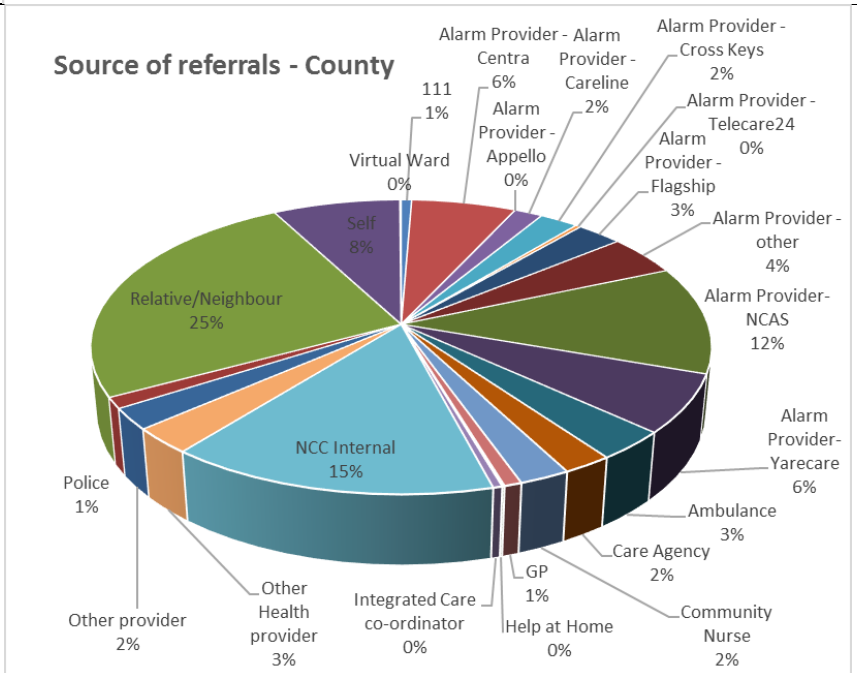
5 September 2019

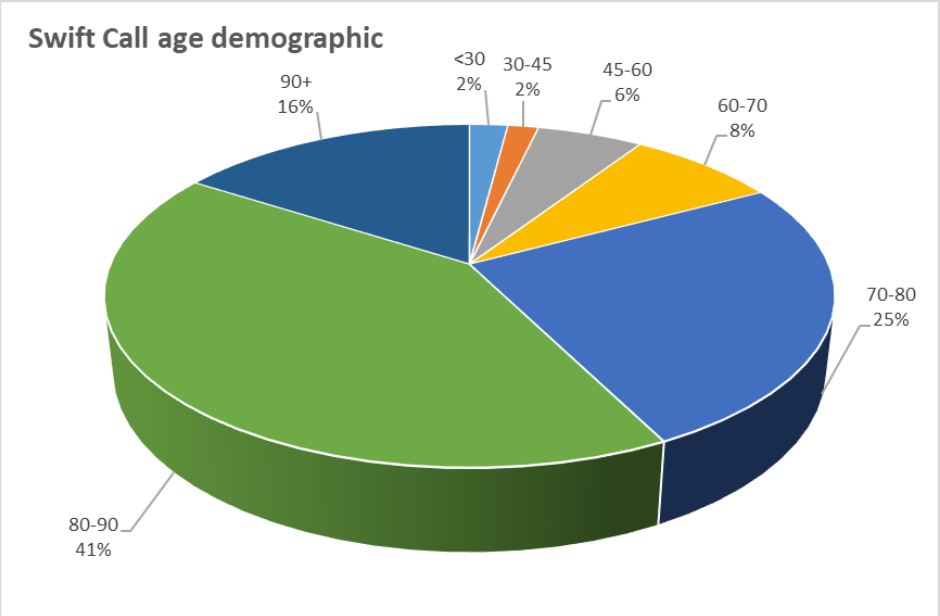
Reducing Hospital Admissions - Norfolk Swift Response (Swifts / Night Owls)

1	**Reducing Hospital Admissions**
1.1	The Norfolk County Council Adult Social Services department supports and invests in many services and interventions that contribute to delivering its overarching Promoting Independence strategy, as well as helping to reduce hospital admissions and expediate discharges, including through the Better Care Fund. These include: • Home based reablement • Accommodation based reablement • Development workers • Sensory support • Assistive technology • Supported Care (in the North and South) - for people who are experiencing a deterioration in their health; provides immediate and short term (maximum of seven days) health and social care support to help them to regain their independence as their health improves. • Social Prescribing • Enhanced Home Support Service • Trusted Assessment Facilitators • Enhanced Care in Care Homes – resulting in a reduction in non-elective admissions from care homes • Norwich Emergency Avoidance Team (NEAT) • Swifts/Nightowls.
2	**Swifts/Nightowls**
2.1	Norfolk County Council invests £1.5m a year in a 24-hour, 365 day a year service which provides help, support and reassurance if a person has an urgent, unplanned need at home but doesn't need the emergency services. This could be because they have had a fall, or if their carer is suddenly taken into hospital and they need help with personal care, meal preparation etc. This service is the Norfolk Swift Response (Swifts / Night Owls) and is part of the Adult Social Services Early Help and Prevention offer. The Swift service was set up in 2007-8.

	As far as we are aware Norfolk are the only Council providing such a service in the country.
2.2	The following can get assistance from Norfolk Swifts • Older people • People with physical illness or disabilities • People with learning difficulties • People with mental health problems Norfolk Swift Response is a free service for people living in Norfolk. People do not have to be eligible for social care funding to use it. People can contact Norfolk Swift Response on 0344 800 8020.
2.3	There are four teams of two people working in the Swifts/Nightowls across Norfolk at any point in time.
2.4	Swift / Night Owls will attend a person who has fallen, if requested, if the person has not suffered an injury or has any medical symptoms that have been exacerbated by the fall. The team work in pairs and carry special lifting equipment to help make moving people as safe as possible.
2.5	If the person has suffered an injury or needs medical assistance or advice, the Swifts should not attend as although they are taught First Aid they are not medically trained.
2.6	If Swifts have been called to visit a person who has fallen, and that person is clearly stating that they are uninjured, they will visit if they can attend within an hour. If this is not possible owing to other commitments the Swifts call handler will ask the person, or the person calling on their behalf, to call for paramedic assistance. The ambulance service then triage the call and once they have assessed the potential impact of that person remaining on the floor for over an hour can refer to the Swift Service for assistance. The call handlers for the Swift Response service keep the ambulance service updated and feedback the outcome of the visit. If any injury or medical change is reported before or during the visit the paramedics would be called.
2.7	If the call is a “non-response” ie the alarm service cannot make contact as the person cannot hear or communicate, the Swifts will decline the referral if they cannot arrive within an hour of the request and it is not possible to ascertain if the person requires medical attention. If “non-response” calls are triaged by the ambulance service, the Swifts can attend.

2.8	**Case study** When Fred (73) had a fall, he pressed his alarm pendant for help. He wasn't injured and didn't need an ambulance, so the Norfolk Swift team came to help him. They used inflatable lifting equipment to help him up off the floor and made sure he was okay. Because Fred had had a previous fall, the Swifts suggested a referral to the Falls Team to look at ways of reducing the risk of falls around the home.
2.9	Norfolk Swift Response is monitored, regulated and inspected by the Care Quality Commission.
3	**Referrals and Benefits**
3.1	The Swifts service is an important element of preventing hospital admissions and in helping support people to live in their own homes. Swifts took 12,421 referrals in 2018-19. When the Swifts visit people, they ask them what they would have done if the Swifts hadn't been able to attend. Based on this information, in 2018-19 the service prevented: • 3,184 calls to Community Health • 6,036 calls to the emergency services • 1,419 hospital admissions. The largest proportion of visits were to people who had fallen (35%), and then to people who needed personal care (27%). 35% of calls were from alarm providers and 25% from relatives or neighbours.

3.2	
3.3	
3.4	**Swifts/Nightowls Call Age Demographic** The largest proportion of calls are for people aged 80-90 years:



4	**Service User Feedback**
4.1	A summary of the feedback from the questionnaires completed by service users and their families in 2018 is: • the service overall was rated as Excellent by 84.62% of the people • 76.92% of people are extremely likely to recommend Swift / Night Owls to friends and family if they need similar care or support, and • 94.87% felt it was easy for them to arrange the Swift/Night Owl team to visit.
5	**Financial Savings/Cost Avoidance**
5.1	When the Swifts visit people, they ask them what they would have done if the Swifts hadn't been able to attend. We have used this information as our basis for the estimation of the savings. We have taken: the Swifts annual statistics (which are shared with the CCGs) about what we have prevented; Regional or National statistics about outcomes if for example an ambulance is called out; and then used Regional or National unit costs to calculate the savings. We had to make some assumptions. The estimation does not include any costs of discharges/assessments by Adult Social Services if a person goes in to hospital nor an estimate of the cost of the proportion of people that would then probably go on to have a long-term package/other services if they were admitted, egs residential care, accommodation based reablement etc.

	Our estimate of the monetary returns on an investment of £1.5m in Swifts/Nightowls, is approximately £3.8m pa. Therefore arguably it is understated but demonstrates **that for every £1 Adult Social Services invest, the health and social care system saves at least £3.51 gross or £2.51 net** from the Swifts/Nightowls service.
6	**Telephone calls**
6.1	There are two telephone lines that go through to the Swifts/Nightowls. If those lines are busy, the call diverts to the phone number for Norfolk First Support, the reablement service. This means that during the day (09:15-18:00) six telephone numbers would have to be busy before an engaged tone is heard. At night the two Swift lines that are operated as the reablement service is not 24/7. Occasionally a person may end a call before we can answer it. As can be seen in paragraph 3.1 the service takes a significant number of telephone calls and referrals.

Janice Dane
Assistant Director for Early Help and Prevention
Adult Social Services, Norfolk County Council
2 August 2019

Report from Norfolk Constabulary to the Norfolk Health Overview and Scrutiny Committee for their meeting on 5th September 2019 examining ambulance response and turnaround times

In reply to the invitation received from NHOSC to provide a perspective on ambulance response, particularly in relation to people in mental health crisis, we submit the following report which focuses on four specific areas relevant to policing:

1) Transport for patients who have been detained under Section 136 of the Mental Health Act to a Place of Safety.
2) Patients who have been detained under the Mental Health Act in a police custody suite who require transfer to an inpatient psychiatric unit.
3) Patients who require emergency medical assessment/treatment at an acute hospital emergency department.
4) Norfolk mental health crisis pathways.

1) Transport for patients who have been detained under Section 136 of the Mental Health Act to a Place of Safety.

Local and national protocols state that patients who have been detained under Section 136 of the Mental Health Act should be conveyed to a Place of Safety by ambulance. They should only be transported in a police vehicle if they present a high risk of violence which would make it unsafe for an ambulance to be used or if an excessive delay in an ambulance attending would be detrimental to the patient's wellbeing. In line with national ambulance response times for Section 136 cases, EEAST aim to respond to any request received from the police following a Section 136 detention within 30 minutes.

The table below shows the percentage of patients detained under Section 136 MHA in Norfolk who were transported to a Place of Safety in a police vehicle due to ambulance delays since 2017:

	% of Section 136 MHA patients who were transported to a Place of Safety in a police vehicle due to excessive ambulance delays
2017/18	28%
2018/19	11%
2019/20 (1st quarter)	7.5%

Norfolk Constabulary is pleased to report to NHOSC that the majority of people who have been detained under Section 136 of the MHA in Norfolk are now conveyed to the Place of Safety by ambulance.

2) Patients who have been detained under the Mental Health Act in a police custody suite who require transfer to an inpatient psychiatric unit

The data below was provided for the April 2019 NHOSC internal briefing for the purpose of examining the availability of acute mental health beds. It details all of the cases in 2018 when an individual who was detained in a Norfolk police custody suite after being arrested for a criminal matter was subsequently admitted to a psychiatric inpatient unit under the Mental Health Act.

The data set identifies if the patient was admitted to an inpatient unit with the Norfolk and Suffolk NHS Foundation Trust area or if they were admitted to an 'out of area' hospital. It also details the additional time that the patient spent in police custody after the bed had been identified, whilst transport was awaited.

The data has been included again within this report to highlight the transportation delays that often occur when patients require transfer from a police custody suite to a psychiatric inpatient unit. In most cases, when a patient is admitted to a hospital within Norfolk or Suffolk they will be conveyed by EEAST. When patients are admitted to an 'out of area' bed a private ambulance provider will be used. In a small number of the cases detailed below the patient was transferred in a police vehicle. This was a decision that was made in the patient's best interests to secure their earliest possible access in-patient care, when significant ambulance delays were experienced.

The data shows that lengthy transport delays are often encountered for 'out of area' transfers, when private providers are used. Slow transfer times for admissions to local hospitals when transport is provided by EEAST are also common. These ambulance delays extend the overall time that acutely unwell people are spending in police cells.

Month	Number of hours taken for a bed to be identified following the MHA assessment (to the nearest 15 mins)	Location of the bed	Number of additional hours once bed had been identified until person was released from police custody for transfer to hospital (to the nearest 15 mins)
Jan-18	13 hrs 45 mins	Within trust	3 hours
Jan-18	5 hrs 30 mins	Out of area	4 hrs 15 mins
Jan-18	1 hour	Within trust	1 hr 30 mins
Jan-18	6 hrs 15 mins	Out of area	17 hrs 15 mins
Jan-18	4 hrs 30 mins	Within trust	3 hrs 15 mins
Jan-18	45 mins	Within trust	2 hrs 30 mins
Feb-18	5 hours	Within trust	8 hrs 30 mins

Feb-18	30 mins	Within trust	7 hrs 30 mins
Feb-18	18 hrs 40 mins	Out of area	5 hours
Feb-18	14 hours	Within trust	2 hours
Feb-18	3 hrs 45 mins	Within trust	5 hrs 45 mins
Mar-18	1 hrs 15 mins	Within trust	8 hrs 15 mins
Mar-18	1 hour	Within trust	15 mins (transported by police)
Mar-18	1 hour	Within trust	11 hours
Mar-18	2 hours	Within trust	15 mins (transported by police)
Mar-18	19 hrs 15 mins	Within trust	5 hours
Mar-18	Immediately available	Within trust	1 hrs 45 mins
Mar-18	45 mins	Within trust	5 hours
Mar-18	1 hour	Within trust	15 hrs 30 mins
Mar-18	20 hrs 45 mins	Out of area	4 hours
Apr-18	Immediately available	Within trust	15 mins (transported by police)
Apr-18	4 hrs 30 mins	Within trust	6 hrs 15 mins
Apr-18	15 hours	Within trust	8 hrs 15 mins
Apr-18	2 hrs 30 mins	Within trust	3 hrs 45 mins
May-18	1 hour	Within trust	3 hrs 30 mins
May-18	30 mins	Within trust	1 hour
May-18	2 hrs 30 mins	Out of area	18 hrs 45 mins
Jun-18	8 hrs 30 mins	Within trust	1 hour
Jun-18	6 hours	Within trust	1 hr 30 mins
Jun-18	45 mins	Within trust	2 hours
Jun-18	2 hrs 45 mins	Within trust	15 mins
Jun-18	45 mins	Within trust	2 hours
Jul-18	45 mins	Within trust	8 hrs 45 mins
Aug-18	Immediately available	Within trust	45 mins
Aug-18	4 hrs 15 mins	Out of area	5 hrs 30 mins
Aug-18	Immediately available	Within trust	1 hr 15 mins
Aug-18	Immediately available	Within trust	15 mins (transported by police)
Aug-18	2 hrs 45 mins	Within trust	8 hrs 15 mins
Aug-18	18 hrs 15 mins	Out of area	4 hrs 45 mins
Sep-18	1 hr 30 mins	Within trust	30 mins
Sep-18	30 mins	Within trust	1 hour
Sep-18	17 hours	Within trust	9 hrs 30 mins
Sep-18	2 hrs 45 mins	Within trust	15 mins (transported by police)
Oct-18	4 hours	Within trust	17 hours (private ambulance)
Oct-18	4 hours	Within trust	1 hr 30 mins
Nov-18	6 hours	Out of area	37 hours
Nov-18	3 hrs 30 mins	Out of area	18 hours
Nov-18	30 mins	Within trust	5 hours
Nov-18	8 hrs 30 mins	Out of area	16 hours
Dec-18	Immediately available	Within trust	3 hrs 15 mins
Dec-18	7 hrs 30 mins	Within trust	1 hr 45 mins
Dec-18	45 mins	Within trust	3 hrs 15 mins

Dec-18	21 hrs 30 mins	Out of area	6 hrs 15 mins

3) Patients who require emergency medical assessment/treatment at an acute hospital emergency department.

Police officers will regularly have contact with people who have physical or mental health concerns who require medical assessment and/or treatment. On occasions police officers will convey members of the public in police vehicles to emergency departments due to slow EEAST response times. Unfortunately our recording systems do not allow us to accurately report how frequently this occurs but brief details of some known cases that have occurred in 2019 are included below:

- Female who had taken an overdose was transported to ED by police officers after EEAST quoted a 5 hour response time.
- Male with a head injury was transported to ED by police officers after EEAST quoted a 6 hour response time.
- Female with significant self-harm cuts and suspected overdose was transported to ED after EEAST quoted a response time of between 3 – 5 hours.
- Female with head injury was transported to ED by police officers due to EEAST anticipated delays of 5+ hours.
- Male with a head injury was transported to ED by police officers following quoted EEAST delay of 6 hours.
- Female with strangulation injury following domestic incident was transported to ED by police officers after EEAST quoted a 5 hour response time.
- Male who had taken an overdose was transported to ED by police officers due to EEAST reporting likely response time of 8+ hours.

4) Norfolk mental health crisis pathways

We support the views expressed by EEAST to NHOSC in February 2019 that crisis care pathways for mental health patients, particularly outside of normal working hours, are lacking in Norfolk. This can often lead to patients being conveyed by EEAST or police officers to acute hospital emergency department due to lack of alternative suitable pathways. It also increases the number of people that police officers detain under Section 136 of the Mental Health Act, in the absence of a safe alternative option. This in turn increases demand on EEAST as an ambulance will be required to transport the patient to the Place of Safety. In addition, we are becoming increasingly concerned about Section 136 suite capacity in Norfolk. It is now common that S136 patients are being conveyed greater distances across Norfolk and Suffolk to access a vacant Section 136 suite, which increases demand on EEAST due to extended journey times. Whilst we recognise that this is not a matter that is being examined by NHOSC at their meeting on 5th September, we feel that it is important to highlight this wider system issue due to the significant impact that it has on EEAST, in turn affecting their turnaround and response times.

Norfolk Constabulary would like to thank NHOSC for giving us the opportunity to contribute to these important discussions.

Inspector Lucy King
Mental Health and Learning Disabilities Lead
Norfolk Constabulary

Norfolk Health Overview and Scrutiny Committee

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

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

Proposed Forward Work Programme 2019

Meeting dates	*Briefings/Main scrutiny topic/initial review of topics/follow-ups*	*Administrative business*
10 Oct 2019 ***2.00pm start***	Children's speech and language therapy (central and west Norfolk) – update since 28 Feb 2019 Adult autism – access to diagnosis – to examine waiting times to diagnosis. City Reach service – to examine concerns regarding staffing levels and patient safety.	
28 Nov 2019	Access to NHS dentistry – progress since report to NHOSC on 11 April 2019 Eating disorder services – progress since report to NHOSC on 11 April 2019	
23 Jan 2020	The Queen Elizabeth Hospital NHS foundation Trust – response to the Care Quality Commission report – progress report	

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

Provisional dates for reports to the Committee / items in the Briefing 2019

19 Mar 2020 (Agenda item)	- Norfolk and Suffolk NHS Foundation Trust – response to the CQC report
July 2020 – date to be confirmed (Agenda item)	- Local action to address health and care workforce shortages – update

Other activities

Visit arranged for **Tues 1 Oct 2019** 2.00 – 4.00pm	-	Cromer Hospital – Norfolk and Norwich University Hospitals NHS Foundation Trust
Visit to be arranged	-	Samphire Ward (new facilities), Chatterton House, King's Lynn – Norfolk & Suffolk NHS Foundation Trust
Visit to be arranged	-	Follow-up visit to the Older People's Emergency Department (OPED), Norfolk and Norwich hospital to be arranged after expansion works are completed in 2019-20.

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

Clinical Commissioning Groups

North Norfolk	-	Emma Spagnola (substitute David Harrison)
South Norfolk	-	Dr Nigel Legg (substitute Robert Kybird)
Gt Yarmouth and Waveney	-	Emma Flaxman-Taylor
West Norfolk	-	Michael Chenery of Horsbrugh (substitute Sheila Young)
Norwich	-	Margaret Stone (substitute Brenda Jones)

Norfolk and Waveney Joint Strategic Commissioning Committee

Link	-	Margaret Stone
Substitute for meetings held in west and north Norfolk	-	Michael Chenery of Horsbrugh
Substitute for meetings held in east and south Norfolk	-	Dr Nigel Legg

NHS Provider Trusts

Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust	-	Sheila Young (substitute Michael Chenery of Horsbrugh)

Norfolk and Suffolk NHS Foundation Trust (mental health trust)	-	Margaret Stone (substitute Brenda Jones)
Norfolk and Norwich University Hospitals NHS Foundation Trust	-	Dr Nigel Legg (substitute David Harrison)
James Paget University Hospitals NHS Foundation Trust	-	Emma Flaxman-Taylor
Norfolk Community Health and Care NHS Trust	-	Emma Spagnola

IN TRAN communication for all	If you need this document in large print, audio, Braille, alternative format or in a different language please contact Customer Services on 0344 800 8020 or Text Relay on 18001 0344 800 8020 (textphone) and we will do our best to help.

Norfolk Health Overview and Scrutiny Committee 5 September 2019

Glossary of Terms and Abbreviations

A&E	Accident and emergency
AEC	Ambulatory Emergency Care
AMHP	Approved Mental Health Practitioner
AMU	Acute Medical Unit
ANP	Advanced Nurse Practitioner
AOC	Ambulance operations centre (3 across EEAST)
APNP	Advanced Paediatric Nurse Practitioner
ARP	Ambulance response programme
C	Category
CCG	Clinical Commissioning Group
CCORD	Clinical Co-ordinator – in context of ambulance service - senior paramedic who is part of the ECAT team, providing over-the-phone medical advice to callers
CLT	Community Liaison Team
CN&T	Community Nursing & Therapy
COPD	Chronic Obstructive Pulmonary Disease
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.
CQRS	Calculating Quality Reporting Service – performs a check against the GP practice's local learning disability register to ensure that practices cannot claim payment for more learning disability health checks than there are patients on their local learning disability register
CYP	Children and young people
DBS	Disclosure and Barring Service – makes decisions about whether individuals should be barred from engaging in regulated activity (e.g. working with vulnerable groups, including children)
DESs	Directed enhanced services – each year NHSE/I offers practices a suite of services, Directed Enhanced Services, and practices choose which ones, if any, they wish to provide. Once agreed NHSE/I puts in place contractual documentation with the practice covering DESs.
DOS	Directory of services
ECAT	Emergency Clinical Advice Team
ECCH	East Coast Community Healthcare
ECH	East Coast Hospice Ltd
ED	Emergency department
EEAST	East of England Ambulance Service NHS Trust

EIT	Early intervention team
EIV	Early intervention vehicle - staffed with technician and therapist aimed at arranging community support for elderly patients who may not need to be conveyed to hospital. Able to arrange access to therapy, home based care and equipment. 1 car in the Norfolk region.
EPaCCS	Electronic Palliative Care Coordination System
FTE	Full time equivalent
FYTD	Financial year to date
GEMIMA	An NHS business information system to support, analyse and monitor health and social care commissioning
GP	General Practitioner
GPPO	GP Provider Organisation
GSF	Gold Standards Framework – a model that enables good practice to be available to all people nearing the end of their lives, irrespective of diagnosis. It provides a framework for a planned system of care in consultation with the patient and family. It promotes better coordination and collaboration between healthcare professionals and helps to optimise out-of-hours care to prevent crises and inappropriate hospital admissions
GY&W JHSC	Great Yarmouth and Waveney Joint health Scrutiny Committee (which includes Members from Norfolk and Suffolk Health overview and Scrutiny Committees)
HALO	Hospital Ambulance Liaison Officer
HQIP	Healthcare improvement partnership
HWN	Healthwatch Norfolk
IC24	Integrated Care 24 (a not for profit social enterprise organisation providing GP out of hours and NHS 111 services in Norfolk)
ICE	In case of emergency – function on most smart phones with details of medical conditions which can be accessed without the phone being unlocked
ICS	Integrated Care System
IPOC	Individualised plan of care
IPU	In-patient unit
JPUH / JPH	James Paget University Hospital
LD	Learning Difficulties / Disability
LDG	Local Delivery Group
LeDeR	Learning disabilities mortalities (an annual report)
LQUIS	Local quality incentive scheme
MDT	Multi Disciplinary Team
MH	Mental health
MHA	Mental Health Act
MHT	Mental health trust

MIDOS	My Directory of Service – information search tool which will enable care navigators to search for a wide range of health, community and voluntary services across Norfolk
MND	Motor neurone disease
NACEL	National Audit of Care at the End of Life
NCH&C (NCHC)	Norfolk Community Health and Care NHS Trust
NEAT	Norwich Escalation Avoidance Team
NEAAT	Norfolk Emergency Admission Avoidance Team – able to sign post crews to community services to avoid admissions / facilitate appointments with GPs / Norwich Escalation Avoidance Team
NG	NICE Guidance
NHOSC	Norfolk Health Overview and Scrutiny Committee
NHSE/I	NHS England and NHS Improvement
NICE	National Institute for Health and Care Excellence
NNUH (N&N, NNUHFT)	Norfolk and Norwich University Hospitals NHS Foundation Trust
NSFT	Norfolk and Suffolk NHS Foundation Trust (the mental health trust)
N&W STP	Norfolk and Waveney Sustainability & Transformation Plan / Partnership
OOH	Out of hours
OPAS	Older people's assessment service
OPED	Older People's Emergency Department
OSC	Overview and Scrutiny Committee
PCN	Primary Care Network
POCT	Point of Care Test (i.e. a blood test on an ambulance or in the patient's home or Emergency Department when you take the sample and analyse it there and then instead of sending it to the lab)
PPOC	Preferred Place of Care
PPOD	Preferred Place of Death
QEH / QEHKL	Queen Elizabeth Hospital, King's Lynn
RCGP	Royal College General Practitioners
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment
RRV	Rapid response vehicle – paramedic car, unable to transport patients to hospital
S136	The police can use section 136 of the Mental Health Act to take people to a place of safety when they are in a public place. They can do this if they think the person has a mental illness and is in need of care.
SOAR	System Operations, Assurance and Resilience
SORT	System Oversight, Resilience and Transformation

SPC	Specialist palliative care
STOMP	Stopping Over Medication of People with a Learning Disability
STP	Sustainability & transformation plan / partnership
Swifts	Norfolk Swift Response (Swifts / Night Owls) is part of the Adult Social Services Early Help and Prevention offer. A 24 hour, 365 day a year service which provides help, support and reassurance if a person has an urgent unplanned need at home but doesn't need the emergency services.
Transformation Nous	Consultants in healthcare (established 2015) – operational transformation and delivery of strategy
UEA	University of East Anglia
UEC	Urgent and emergency care
UTC	Urgent treatment centre – minors department of A&E, or separate service dealing only with less acute illness
VCSE	Voluntary community and social enterprise
WNIPSC	West Norfolk Integrated Palliative Care Service
WTE	Whole time equivalent
YTD	Year to date