Norfolk County Council

Norfolk Health Overview and Scrutiny Committee

Date: **Thursday, 26 October 2017**

Time: **10:00**

Venue: **Edwards Room, County Hall, Martineau Lane, Norwich, Norfolk, NR1 2DH**

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

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

Membership

Main Member	Substitute Member	Representing
Michael Chenery of Horsbrugh	Mr S Eyre	Norfolk County Council
Ms E Corlett	Ms C Rumsby/Miss K Clipsham	Norfolk County Council
Mrs S Young	Mr S Eyre	Norfolk County Council
Mr F Eagle	Mr S Eyre	Norfolk County Council
Mr A Grant	Mr S Eyre	Norfolk County Council
Mr D Harrison	Mr T Adams	Norfolk County Council
Mrs B Jones	Ms C Rumsby/Miss K Clipsham	Norfolk County Council
Mrs L Hempsall	Mr J Emsell	Broadland District Council
Dr N Legg	Mr C Foulger	South Norfolk District Council
Ms J Brociek-Coulton	Ms L Grahame	Norwich City Council
Mr R Price	Mr S Eyre	Norfolk County Council
Mrs M Fairhead	Vacancy	Great Yarmouth Borough Council
Mr P Wilkinson	Mr R Richmond	Breckland District Council
Mr G Williams	Vacancy	North Norfolk District Council
Mrs S Fraser	Mr T Smith	King's Lynn and West Norfolk Borough Council

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

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

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A g e n d a

1		**To receive apologies and details of any substitute members attending**	
2		**NHOSC Minutes of 7 September 2017**	**Page 5**
3		**Declarations of Interest** If you have a **Disclosable Pecuniary Interest** in a matter to be considered at the meeting and that interest is on your Register of Interests you must not speak or vote on the matter. If you have a **Disclosable Pecuniary Interest** in a matter to be considered at the meeting and that interest is not on your Register of Interests you must declare that interest at the meeting and not speak or vote on the matter In either case you may remain in the room where the meeting is taking place. If you consider that it would be inappropriate in the circumstances to remain in the room, you may leave the room while the matter is dealt with. If you do not have a Disclosable Pecuniary Interest you may nevertheless have an **Other Interest** in a matter to be discussed if it affects - your well being or financial position - that of your family or close friends - that of a club or society in which you have a management role - that of another public body of which you are a member to a greater extent than others in your ward. If that is the case then you must declare such an interest but can speak and vote on the matter.	
4		**Any items of business the Chairman decides should be considered as a matter of urgency**	
5		**Chairman's Announcements**	
6	**10-10 to 11.05**	**Norfolk and Waveney Sustainability & Transformation Plan - progress update** Appendix A **(Page 17)** - STP response to comments made by NHOSC on 8 December 2017 Appendix B **(Page 21)** - STP Executive Lead's report	**Page 13**

	11.05 to 11.15	**Break at the Chairman's Discretion**	**Page**
7	**11.15 to 12.05**	**Ambulance response times and turnaround times in Norfolk** Appendix A **(Page 40)** - East of England Ambulance Service NHS Trust report Appendix B **(Page 50)** - Norfolk and Norwich University Hospitals NHS Foundation Trust's report	**Page 31**
8	**12.05 to 12.15**	**Forward work programme**	**Page 58**
		Glossary of terms and abbreviations	**Page 60**

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Date Agenda Published: 18 October 2017

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Norfolk County Council

NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE
MINUTES OF THE MEETING HELD AT COUNTY HALL, NORWICH
on 7th September 2017

Present:

Michael Chenery of Horsbrugh	Norfolk County Council
Ms E Corlett	Norfolk County Council
Mr F Eagle	Norfolk County Council
Mrs M Fairhead	Great Yarmouth Borough Council
Mrs S Fraser	King's Lynn and West Norfolk Borough Council
Mr A Grant	Norfolk County Council
Mr D Harrison	Norfolk County Council
Mrs B Jones	Norfolk County Council
Dr N Legg	South Norfolk District Council
Mr R Price	Norfolk County Council
Mrs J Brociek-Coulton	Norwich City Council
Mr P Wilkinson	Breckland District Council
Mrs S Young	Norfolk County Council

Also Present:

Karin Bryant	Assistant Director of Clinical Commissioning, NHS Norwich CCG
Nicki Rider	Integrated Commissioning Manager, Education Inclusion Service, Children's Services, Norfolk County Council
Melanie Craig	Chief Officer, Great Yarmouth and Waveney CCG
Tracy McLean	Head of Children, Young People and Maternity Services for Norfolk and Waveney
Jonathon Williams	Chief Executive, East Coast Community Healthcare
Louise Denby	Deputy Director, Health Improvement and Children's Services, East Coast Community Health Care
Trevor Wang	Family Voice
Hayley Huckle	Parent from SENsational parents group
Rupert	Parent from Unique Children in Norwich group
Timothy Shayes	Head of Transformation, North Norfolk CCG
Anne Borrows	Acting Assistant Director, Clinical Transformation, North Norfolk CCG
Mark Burgis	Chief Operating Officer, North Norfolk CCG
David Russell	Cromer Town Council
Alan Hunter	Head of Service (Children), Norfolk Community Health and Care NHS Trust
Dr Michelle Trollope	Clinical Psychologist, Joint Clinical Lead for the ASD Diagnostic Pathway, Norfolk Community Heath and Care NHS Trust
Clare Smith	Parent and Director of Asperger Training Services
Anne Ebbage	Autism Anglia
Maureen Orr	Democratic Support and Scrutiny Team Manager
Chris Walton	Head of Democratic Services
Karen Haywood	Democratic Support and Scrutiny Team Manager

1. Apologies for Absence

Apologies for absence were received from Glyn Williams (North Norfolk District Council) and Lana Hempsall (Broadland District Council).

2. Minutes

The minutes of the previous meeting held on 20th July 2017 were confirmed by the Committee and signed by the Chairman.

3. Declarations of Interest

There were no declarations of interest.

4. Urgent Business

There were no items of urgent business.

5. Chairman's Announcement

5.1 Visit to the East of England Ambulance Service, NHS Trust Emergency Operations Centre, Hellesdon.

The Chairman reminded the Committee that a visit to the Emergency Operations Centre had been arranged for the afternoon. The Committee had 'Ambulance response and turnaround times' on the agenda for 26 October and the visit would provide useful background information.

A further visit was to be arranged for Members who were unable to attend today:-
Julie Brociek-Coulton
Michael Chenery of Horsbrugh
Emma Corlett
Brenda Jones

6 Children's Speech and Language Therapy

6.1 The Committee received a suggested approach by Maureen Orr, Democratic Support and Scrutiny Team Manager, to a report from commissioners on access to and waiting times for children's speech and language therapy (SLT) in Norfolk.

6.2 The Committee received evidence from

- Karin Bryant, Assistant Director of Clinical Commissioning, NHS Norwich CCG
- Nicki Rider, Integrated Commissioning Manager, Education Inclusion Services, Children's Services NCC,
- Melanie Craig, Chief Officer, Great Yarmouth and Waveney CCG,
- Tracy McLean, Head of Children, Young People and Maternity Services for Norfolk and Waveney,
- Jonathan Williams, Chief Executive, East Coast Community Healthcare,
- Louise Denby, Deputy Director Health Improvement and Children's Services, East Coast Community Healthcare.
- Trevor Wang - Family Voice

- Hayley and Rupert - Parents

6.3 The following key points were noted:

- Karin Bryant informed the Committee that the changes to the model of service had been undertaken following best practice guidance from the Royal College of Speech and Language therapists in order to achieve the best possible outcomes and support for children and young people. She said that the model was working well and performance was improving, although it was acknowledged that the implementation of the system had been challenging and had taken a while to bed in.

- Feedback from service users had highlighted a degree of dissatisfaction with the changes to the service citing a lack of individualised care and a move towards more group based support.

- Karin Bryant said that it was important that families were engaged with any changes to the service and feedback was welcomed in order that the service could be improved. Work was being undertaken to look at improving engagement with families and a Task and Finish would be established. A Stakeholder group would also be established to bring together providers, commissioners and families.

- In response to a query as to whether the service was 'therapy' or 'consultation' based, Louise Denby said that it was a combination of both. She acknowledged that some families had experienced more changes than they would have liked and while there would inevitably be some staff changes in the service they would seek to keep this to a minimum and have consistency over therapists visiting families wherever possible.

- Following concerns raised by the Committee that some families were seeking private support, Nicki Rider said that all children were assessed according to clinical need however there were some families that would wish for more services than their child had been assessed as needing.

- In response to a query as to whether the service had previously been under commissioned, Louise Denby said that there had been more demand in the system than the service had capacity to deliver. She stressed however that this under commission would not affect the interaction that would have been made at the assessment stage. Therapists would put forward a package based on need, not what was available.

- Following an issue raised by the Committee regarding KPI 4b (The number of new EHCPs that required SaLT input) Karin Bryant said that this figure of 62% had improved and data for August indicated that the figure now stood at 92.4%.

- The Committee queried whether children who were discharged early would then automatically return to the 'back of the queue' in seeking an assessment. In response, Louise Denby said that a child may be discharged while work was being undertaken on their case however, they would come back into the system once recommendations had been successfully implemented. She explained that there were two waiting lists; one for new referrals and one for those on review.

- In response to a question as to why it had taken so long for the service to improve, Karin Bryant acknowledged that there had been problems in the first 6 months of the new contract however the situation had improved significantly since then. The establishment of a Children and Young Peoples' network to include children and young people commissioners and providers would be an important forum in driving these improvements. Since moving to a single commissioning model it was now easier to look at complaints across the whole of the County and to consider any emerging themes and localised issues.

- The Committee welcomed Trevor Wang from Family Voice to the meeting. Trevor Wang welcomed the creation of a stakeholder group, which he said had previously been missing from the process but expressed some concerns that the system based approach still wasn't working, with many families waiting longer than the target time. Communication was a key concern for families and there was a strong sense of confusion as to whether the service was a therapy or consultation service and the existence of two waiting lists, one for new referrals and one for those on review, was not widely known amongst families. He stressed that early intervention was important, and vital, as otherwise children were being placed in emotional and educational difficulties which could manifest itself in behavioural problems later on.

- The Committee welcomed two parents to the Committee who had experience of using the new service. One parent said that communications had been poor, the service was not very child centred, or friendly, with a focus on targets and 'getting the job done' and that there was not enough time allowed for the service to build trust with the child. The second parent explained the circumstances surrounding her son, and how she had now turned to private sessions to support his SLT needs. In response to the issues raised Jonathon Williams said that there was a need to be cautious about commenting on individual cases however, he believed that the service was now starting to get on top of the situation and that they would think about how this would now be further improved going forward. He stressed that he was proud of the professionals involved in the service.

- In response to a question as to whether East Coast were the best people to deliver the service, Karin Bryant said that the service had been subject to a procurement process with input from bodies, such as Family Voice, and that she considered they were doing a good job. The contract would end at May 2020 and there was an option to extend this until 2022. Before considering any extension they would seek the evidence based views of families and stakeholder groups.

- The Committee said that they had no criticism of individual therapists, who were doing a fantastic job, however concerns still remained about the service being commissioned. It was agreed that the issue be brought back to Committee at a future meeting to update them on the progress of the services across Norfolk, in terms of performance and the new initiatives to establish a stakeholder group and a task & finish group to address issues.

6.4 The Committee **agreed** that the commissioners and providers attend a future meeting to update NHOSC on the progress of the services across Norfolk, in terms of performance and the new initiatives to establish a stakeholder group and a task & finish group to address issues.

7 Consultation of the future of Benjamin Court healthcare unit, Cromer

7.1 The Committee received a suggested approach by Maureen Orr, Democratic Support and Scrutiny Team Manager, to a consultation from the North Norfolk Commissioning Group.

7.2 The Committee received evidence from Timothy Shayes, Head of Transformation, North Norfolk CCG; Anne Borrows, Acting Assistant Director, Clinical Transformation, North Norfolk CCG and Mark Burgis - Chief Operating Officer, North Norfolk CCG.

7.3 The following key points were noted:

- David Harrison welcomed the proposed changes in the consultation and in particular the provision for palliative care at Benjamin Court.

- Mark Burgis informed the Committee that he appreciated that there may be some anxieties locally about the changes however he believed that it presented an exciting opportunity. In response to a question as to whether he was confident that the proposals would meet future needs in light of the changing demographic, he said that intermediate beds would be available in Kelling and North Walsham and local feedback had indicated that people generally wanted to continue to be cared for at home.

- In response to a question Timothy Shayes said that training would be provided for nurses to provide palliative care within the unit although many already provided such care in the community.

- David Russell from Cromer Town Council attended the meeting and raised concerns over the non-provision of respite beds in the proposal and asked for further clarification on the provision of integrated healthcare between Benjamin Court and Cromer Hospital. In response Timothy Shayes said that the vision was to create a new community hub of integrated health and social care with discussions taking place with the Norfolk and Norwich Hospital to provide some services at Benjamin Court. It was noted that respite care was provided through Norfolk County Council and there were no proposed changes to this provision.

7.4 Members of the committee made supportive comments about the Benjamin Court Steering Group's preferred options for the future use of Benjamin Court. NHOSC agreed no formal comments in response to the consultation.

The Committee **agreed** to ask for an update on progress when changes at Benjamin Court had been implemented.

8 Children's autism and sensory processing assessment/sensory integration therapy.

8.1 The Committee received a report by Maureen Orr, Democratic Support and Scrutiny Team Manager to a report from Commissioners on access to autism services and sensory processing assessment/sensory integration therapy in central and west Norfolk.

8.2 The Committee received evidence from:

- Melanie Craig - Chief Officer, Great Yarmouth and Waveney CCG
- Tracy McLean - Head of Children, Young People and Maternity Services for Norfolk and Waveney, hosted by Great Yarmouth and Waveney CCG.
- Alan Hunter - Head of Service (Children), Norfolk Community Health and Care NHS Trust
- Dr Michelle Trollope - Clinical Psychologist, Joint Clinical Lead for the ASD Diagnostic Pathway, Norfolk Community Health and Care NHS Trust.

8.3 The following key points were noted:

- Melanie Craig informed the Committee that there had been a significant increase in demand for the service in the last five years and it was clear that services had not kept up with demand. In anticipating the question of whether they had commissioned enough, she said that they hadn't. Moving forward they were now addressing the backlog which had been unacceptable for families and children. A more strategic approach to providing the service would now be taken and she was confident that with the additional investment provided that this would dramatically improve waiting times. Support for families would continue and it was important that improved communication was part of any changes. There would also be an increase in oversight and monitoring and these principles would be applied to managing the waiting list.

- Melanie Craig said that while there had been additional investments made in the past these had not been sufficient. She acknowledged that co-ordination with the County Council services had not been adequate in the past but that this was now in a stronger position than previously. There was a need for a more strategic approach to be taken across all 5 CCGs around planning and working with partners.

- Dr Trollope explained that there were two separate pathways each with a separate waiting period. The first pathway was referral to a Paediatrician which would take up to 18 weeks. After that the child would be transferred to the Autistic Spectrum Disorders (ASD) pathway and join the waiting list for an ASD assessment. She acknowledged that for families the waiting starts at the point they are referred the Paediatrician. Delays had occurred in the ASD assessment and diagnosis pathway due to a previous lack of clinicians.

- Dr Trollope acknowledged that the pathways appeared cumbersome but explained that initial assessment by a Paediatrician was essential to rule out other developmental and medical conditions, especially in the first 5 years of life. The service was working with Paediatricians to shorten the pathway through skilled triage, especially for children over 5 years, which could see them referred on more quickly to the ASD assessment pathway. Work was also underway to standardise the recording of information in the Paediatrician pathway so that it was more meaningful for those working in the ASD pathway.

- Following concerns raised by the Committee that the system did not appear to be very 'child- centred', Dr Trollope said that one of the main themes that had been raised was families having to repeat their 'story' at different stages of the pathway. She reiterated that it was important for children, especially those under the age of 6 to first see a Paediatrician before entering the ASD assessment / diagnosis pathway. Alan Hunter explained that the assessment and diagnosis of ASDs was complex and it was necessary for children to have two assessments by two professionals before the diagnosis could be

made. In response to an earlier question regarding transition of children when they reached 18 years, Dr Trollope said that no child who was waiting for ASD assessment would be discharged if they turned 18 before assessment / diagnosis was completed. It was sometimes possible for young people just under 18 years old to be referred to the Aspergers Service.

- In response to concerns raised by a parent as to the sensory and integration aspects of the service, Alan Hunter said that he was conscious that young people with autism often had unique sensory skills and the service would be discussing with commissioners the potential for adding more sensory expertise to the assessment team.

- Although she could not divulge the level of additional investment proposed at this stage, as it was still subject to negotiation, Melanie Craig informed the Committee that it would be significant and would focus on additional capacity, specialist support and positive support for families. While the team had not previously had enough resources to deal with the level of demand and backlog the extra funding would allow an increase in capacity to deal with this. There would also be increased monitoring of waiting lists and a more intelligent use of information in order to be more pre-emptive in directing resources.

- In response to a query as to whether schools were engaged in providing support Dr Trollope said that they provided an assessment service suggesting what support would be useful for a young person and that they would work with schools where possible.

- Anne Ebbage from Autism Anglia attended the meeting. She said that she was pleased to hear that the service would be working to shorten waiting lists and stressed that there was increasing demand for autism to be diagnosed. She said that the Voluntary Sector were not funded to provide services and many working in the sector did not have the necessary qualifications to provide the support that parents were looking for, particularly in their own homes.

- Clare Smith, Parent and Director of Asperger Training Services, attended the meeting and raised concerns about the length of time taken to do ASD assessments in Norfolk. In Teeside her daughter had been diagnosed within 4 months of referral. . In response Dr Trollope said that delays had been as a result of there not being enough clinicians to undertake assessments and while any potential delays needed to be communicated to families this delay shouldn't be two years. Responding to an issue regarding staff having left the Asperger Service Norfolk, Dr Trollope said that she understood that this was still a fully functioning service albeit with depleted resources at the moment.

- Melanie Craig pointed out that the NHS leads for the assessment and diagnosis of ASDs. The Local Authority is the lead agency for the provision of any support that comes after diagnosis.

- Responding to an issue from the Committee regarding equality of access for children and young people without strong advocates, Tracy McLean said that this was an issue that they would give consideration to, particularly when working with young people on how to influence services for the future.

8.4 The Committee **agreed** that the commissioners and providers attend a future meeting to update NHOSC on progress with commissioning additional capacity for the service and the situation in terms of reducing waiting times for assessment and diagnosis.

9 Forward work programme

9.1 The Committee received a report from Maureen Orr, Democratic Support and Scrutiny Team Manager, that set out the current forward work programme.

9.2 The forward work programme was **agreed** as set out in the agenda papers with the addition of:

26 Oct 2017 – Norfolk and Waveney Sustainability Transformation Plan

- Progress update. Members of Suffolk Health Scrutiny Committee to be invited to attend NHOSC on an informal basis on this occasion, to represent Waveney.

Children's speech & language services & Children's autism services (central & west Norfolk) to be added to a future agenda (to be programmed).

Benjamin Court, Cromer – NHOSC to receive a progress update when changes have been implemented.

Chairman

The meeting concluded at 13.10 pm

Norfolk and Waveney Sustainability & Transformation Plan – progress update

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

The committee will receive an update on progress with the Norfolk and Waveney Sustainability & Transformation Plan to date and the timetable for consultation with health scrutiny on proposed changes arising from the Plan.

1. Background

1.1 On 8 December 2016 Norfolk Health Overview and Scrutiny Committee (NHOSC) and invited Members of Suffolk Health Scrutiny Committee representing the Waveney area received a report from the Norfolk & Waveney Sustainability & Transformation Plan (N&W STP) Lead with copies of the N&W STP October 2016 Submission (v1.4) and the 'In Good Health' summary published in November 2016. The report is available on the Norfolk County Council website:- NHOSC 8 December 2016 (agenda item 6).

1.2 The committee made comments to the N&W STP Executive Board and received responses in a letter dated 3 February 2017 (copy attached at **Appendix A)**, which was included in the NHOSC Briefing 23 February 2017. NHOSC was also assured on 8 December 2016 that any specific proposals for substantial changes to health services that might emerge from the N&W STP at a later date would be subject to consultation with health scrutiny in the usual way.

1.3 Arrangements were made with Suffolk Health Scrutiny Committee to prepare terms of reference for, and nominate Members to, a potential Norfolk and Waveney Joint Health Scrutiny Committee, which will meet on a task & finish basis as and when required. The potential Norfolk and Waveney Joint Health Scrutiny Committee was to receive any consultation for substantial changes across the full N&W STP area or across any smaller area within the STP footprint that could not be fully covered by either the existing Great Yarmouth and Waveney Joint Health Scrutiny Committee or NHOSC.

1.4 To date the N&W STP partners have not brought forward proposals for specific substantial changes for which consultation with health scrutiny is required, so the potential Norfolk and Waveney Joint Health Scrutiny Committee has not yet been convened.

1.5 Over the past year health scrutiny Members in Norfolk and Waveney have been kept up-to-date with progress of the N&W STP via the NHOSC Briefing and the Great Yarmouth & Waveney Joint Health Scrutiny Committee Information Bulletin. There have also been progress reports at Norfolk Health

and Wellbeing Board's meetings in public and Healthwatch Norfolk held a public meeting about the STP in Norwich on 17 July 2017.

1.6 During summer 2017 N&W STP was rated as 'advanced' in NHS Improvement's national assessment of progress. The rating was awarded following an assessment in three broad areas: hospital performance, patient-focused change and transformation. The rating qualified Norfolk and Waveney's health and social care system for between £1m and £5m in capital funding, which was be used to fund mental health beds in west Norfolk, a key area of focus for the STP.

Dr Wendy Thomson, Managing Director of Norfolk County Council, stood down as Executive Lead for the STP and Antek Lejk, Chief Officer of NHS North Norfolk CCG and NHS South Norfolk CCG was appointed to the role. Former Secretary of State for Health Patricia Hewitt was appointed as independent Chair.

2. Purpose of today's meeting

2.1 Antek Lejk, Executive Lead for N&W STP, and Jane Harper Smith, Programme Director, will update Members on progress to date and provide information on the schedule for consultation with health scrutiny about any specific proposals for substantial changes to services that may emerge from the STP.

2.2 Members of Suffolk Health Scrutiny Committee who represent the Waveney area, and who have been nominated for the potential Norfolk & Waveney Joint Health Scrutiny Committee, have been invited to attend and will have the opportunity to ask questions and make comments alongside NHOSC Members.

2.3 Information about the N&W STP schedule for consultation with health scrutiny will help Members to plan the health scrutiny forward work programme for the coming months as the intention is for NHOSC and the potential Norfolk & Waveney JHSC to meet on the same dates.

3. Suggested approach

3.1 Members may wish to discuss the following areas with the N&W STP Lead:-

(a) It is understood that the STP Executive Board is not a collective decision-making body. No funding or service changes can be approved by the STP partnership as it stands, but only by the governing bodies of each of the constituent organisations. In this situation, who is ultimately accountable for the delivery of the N&W STP?

(b) How has public and stakeholder engagement helped to shape the N&W STP so far?

(c) When the STP partners move to consultation on proposals for significant changes to services, which body will be responsible for the

consultation and which body (or bodies) will make the decisions on how to proceed once the consultation results have been considered?

(d) With the increasing pressures on NHS and council budgets, is the N&W STP progressing quickly enough to ensure the sustainability of local health and social care services to 2021?

(e) Are the STP partners assured that they will be able to access funds to cover additional costs during the transition to sustainable services?

(f) NHS England and NHS Improvement are introducing system-wide control totals for STP areas to sit alongside the individual control totals for the NHS organisations within them. Control totals set targets for the maximum deficit or minimum surplus achieved within a set timeframe. The intention of setting a system-wide control total is to reduce the incentive for individual organisations to optimise their own financial position at the expense of the wider system. Has the N&W STP area agreed a system-wide control total?

(g) In October 2016 the N&W STP acknowledged 'no consensus currently regarding integrated commissioning of health and care'. Has there been progress in this area?

(h) The local NHS and Norfolk County Council published a Local Digital Roadmap (LDR) 'Connected Digital Norfolk & Waveney (available on the Healthwatch Norfolk website http://www.healthwatchnorfolk.co.uk/ingoodhealth/). It sets out ambitions for digital connections across services to be achieved by 2021, with key milestones along the way and specific priorities for the STP. The July 2017 Healthwatch Norfolk report on the working relationships between GPs and secondary care recommended to the STP Executive Board and STP ICT workstream that ;System leadership is required to co-ordinate information systems in Norfolk across health services'. Are the priorities within the Norfolk & Waveney LDR proceeding as planned?

(i) Workforce availability has been an area of concern to NHOSC since its 'NHS Workforce Planning in Norfolk' scrutiny report published in July 2015. What specific actions have the STP partners taken in this area since December 2016?

(j) Mental health services were identified in the October 2016 N&W STP for additional investment of £14.1m by 2020-21 (to meet the NHS Five Year Forward View requirements) plus an additional £1.9m per annum via the Local Transformation Plan for Children & Adolescents Mental Health Services (CAMHS). Given the scope for whole system savings through addressing mental health needs at an early stage, and the recent return of Norfolk & Suffolk NHS Foundation Trust to special measures, do the STP partners consider that enough additional investment is being made in this area?

4. Action

4.1 NHOSC may wish to:-

(a) Make comments to the STP Executive Board, including any comments made by Waveney Members of Suffolk Health Scrutiny Committee.

(b) Seek an indication of the date by which the STP partners will be ready to consult with health scrutiny about proposed substantial changes to services, so that the Norfolk & Waveney Joint Health Scrutiny Committee can convened at the appropriate time.

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Norfolk County Council

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Councillor Michael Carttiss
Chairman of HOSC
Via email Michael.carttiss@norfolk.gov.uk

3 February 2017

Dear Michael

I am writing in response to the report of comments from Norfolk Health Overview and Scrutiny Committee regarding the Norfolk & Waveney Sustainability & Transformation Plan, dated January 12th. These comments related to the December 8th NHOSC meeting that I attended with Roisin Fallon-Williams.

Thank you for providing us with the opportunity to share and discuss progress with you and thank you also for the report of comments which I have shared with the STP Executive at a meeting on January 20th.

I know that you understand that our planning for how services will change over the next five years is at an early stage and securing feedback this early is very helpful as we further develop our plans as a system.

Key priorities over the next two to three months include completing a refresh of the Five Year financial plan, then detailed planning for each of the work streams to match the financial plan, identifying the resources to shape and deliver the proposals from within the system, establishing effective governance arrangements with a clear focus on clinical input and involving a wide range of stakeholders through robust communications and engagement plans. I believe that we will then be well placed to deliver on our aspirations.

In terms of the committee's specific comments:

1. *The STP should be developed alongside other Central and Local Government and NHS strategies (such as the Government's plans for 7 day working in all sectors of the NHS and the operating plans of the NHS which were not directly a part of the STP).*

Our STP is informed by a wide range of other strategies and we are engaging with all relevant partners at a senior level to ensure alignment with these. The NHS Two Year Operational Plans and the NHS Contracting Round were both concluded after the October 21st STP submission, and thus further refinement is now required.

NHS Two Year Operational plans were agreed over a longer timeframe to increase and cement the alignment to the longer-term objectives of the STP. We are now undertaking further work to review our STP in light of these Two Year Operational plans to maintain this alignment, in particular reviewing demand, activity and financial assumptions.

2. *Breaking down barriers in the provision of care is fundamental to success, particularly between GPs and hospitals, physical and mental health and between health and social care. This includes the barriers to the transfer of digital information between organisations.*

The revised governance arrangements for the STP bring together senior executives and clinicians across all sectors and settings to develop system-wide solutions to the challenges we face. For example the Clinical and Care Reference Group includes GPs, Medical Directors and social care leads and the Delivery Board includes workstream leads from a wide range of the constituent organisations as well as senior clinicians from primary and secondary care.

In terms of the barriers to the transfer of digital information, our Local Digital Roadmap "Connected Digital Norfolk & Waveney" has been published on the Healthwatch website - www.healthwatchnorfolk.co.uk/ingoodhealth. This document sets out the plans for NHS Paper Free at the Point of Care, and to improve digital interactions between primary and secondary care.

3. *It might take significantly longer than the 5 year timescale of the STP before the fundamental changes that the STP intended to bring about are viewed by the public as a success or a failure.*

The STP has to address system challenges in both the short, medium and longer term in line with the Nationally Mandated targets set out in Five Year Forward View and it will continue to evolve and flex in response to further changes over time.

We will set local milestones over the next five years years to deliver the Five Year Forward View and will track the pace of delivery and the degree of success in terms of patient and public satisfaction, achievement of National Targets, achievement of local milestones and financial sustainability. We will use these milestones to assess progress and adjust our approach accordingly, using strong input from our Stakeholder Board and the Clinical and Care Reference Group.

4. *There are questions around how acute services will be able to meet demand before the real improvements to the public's health materialise and the economic modelling that has been done around early intervention strategies.*

There are several approaches within the STP to deal with Acute Hospital demand for both Elective and Non Elective work in addition to the public health interventions. These include;

- A dedicated work stream focusing upon developing more out-of-hospital services to reduce Emergency and Urgent Care Demand including Integrated Multi-Disciplinary Health and Social Care Teams focussing upon patients with existing Long Term Conditions, and increasing Hear and Treat and See and Treat by the Ambulance Service to name a few.
- Increasing access to Primary Care Services and General Practice
- Early intervention through Case Management of vulnerable Groups
- Rapid Access to community services with a 2 hour response
- Earlier intervention by social care working within the integrated teams.

This will mean more patients will be treated in the community and closer to home, offering benefits to the patient and reducing demand on acute hospitals.

In addition, a further dedicated Demand Management workstream has now been established to address the current elective demand and meet the

Referral to Treatment challenges as an immediate priority. This will be achieved by offering more patient choice and the three acute hospitals working more efficiently together. Increasing capacity within Primary Care will also assist with this and plans are currently being drawn up for the GP Five Year Forward View.

5. *Providing greater public and in-patient access to therapies that tackle mental health issues at an early stage should be addressed as a strategic issue.*

The Five Year Forward View sets out the National targets for improving access to Mental Health Services, which we are well placed to meet. The Mental Health work stream includes a wide range of initiatives to improve access to therapies in primary and community care, urgent care and secondary care. These are being prioritised as early initiatives and work on many of these is already underway. We already have Transformation Funding for Early Intervention in Psychosis services, Integrated Perinatal Mental Health and improving access to Child and Adolescent Mental Health Services.

We have also bid in the latest round for Improving Access to Psychological Therapies targeted at patients with Long Term Conditions to improve compliance and reduce A&E attendances and a further bid for Integrated Mental Health Liaison Services.

6. *People with mental health problems do not have access to health services on a parity with the population as a whole, resulting in significantly shorter life expectancy and often inappropriate treatment. These inequalities should be addressed by integrating mental health with other services.*

The Mental Health workstream has proposed Parity of Esteem as one of its key priorities in line with the Five Year Forward View. This will include improving how mental health is treated across primary and secondary care; a focus on psychological therapies to support patients with long term conditions; improving psychiatric liaison with acute services and integrating mental health into perinatal services.

7. *The reference in the STP Workforce workstream to resilience training for staff should be explained so that its connection to the NHS Five Year Forward View is understood and it is not seen as referring to the whole workforce.*

The Workforce workstream is currently being scoped ahead of more detailed planning and to align to the Local Workforce Action Boards. The role and audience for resilience training will be clarified as part of the detailed planning work.

8. *The impact of the STP on third sector organisations should be recognised.*

We are working with partners from the third sector and have invited the Chief Executives of Community Action Norfolk and Momentum (Norfolk) and the Chair of Carers Council for Norfolk as members of the STP Stakeholder Board to represent the third sector and help identify and manage the impact of the STP.

I hope that this letter has helped to reassure you that the feedback and concerns of Norfolk Health Overview and Scrutiny Committee are being addressed. I look forward to sharing further progress with you in the coming months.

Yours sincerely

Dr Wendy Thomson CBE
Managing Director

in good health

Norfolk and Waveney Sustainability and Transformation Plan Progress Update

1. Reason for the report

1.1 The purpose of this paper is to update members of the Norfolk Health Overview and Scrutiny Committee (NHOSC) on the Norfolk and Waveney Sustainability and Transformation Plan (N&W STP), with a focus upon our STP Delivery Plan, in line with the Next Steps of Five Year Forward View and the priorities set out in the last report presented on 8 December by Wendy Thomson. This has been supported by short written updates in NHOSC briefings

2. Report summary

2.1 This report provides information on STP delivery. It outlines the main transformation deliverables that the STP workstreams are focused on and the key challenges faced by system partners in delivering these changes.

3. Specific areas of interest for NHOSC

3.1 NHOSC have asked for specific details on the progress of the N&W STP in the form of a number of questions. These are questions are set out in bold below, with the response which will be discussed further on the day.

3.2 **An update on the rate of progress since the last report from the N&W STP to NHOSC on 8 December 2016**

3.2.1 The recent published ratings for STPs across England confirmed that Norfolk and Waveney **STP was rated as category 2 - 'advanced'** out of four categories, with category 4 being 'needing the most improvement'. This means that the N&W STP has a strong foundation upon which to work and further develop our plans with stakeholders and the public to deliver sustainable transformation. We now aspire to become an Outstanding STP - category 1.

In June 2016 we developed our **STP Delivery Plan** which sets out the programme of work which we intend to deliver over the next four years upto 2020 and the key milestones. Our STP Delivery Plan was agreed by the STP Chairs Oversight Group, the STP Executive and NHS England in the Summer and we are due to publish our plan shortly.

Progress against our plan will be monitored quarterly by NHSE and at our recent meeting with Dr Paul Watson on Friday 13th October 2017 he commended the Norfolk and Waveney STP on the 'very impressive progress' which has been made and the strong programme of work.

3.2.2 Appendix 1 outlines the key STP priorities against each of the four STP work streams, together with the respective Senior Responsible Officer and workstream leads for each.

3.2.3 Information on our STP delivery plan, which is all subject to further engagement and consultation, and due to be published shortly is provided below.

3.3 Progress on STP delivery

The main areas we have made progress on are as follows; -

- Developing our plans for a single strategic commissioning approach (Section 3.4)
- Strengthening our governance by establishing a Chairs Oversight Group and appointing Rt Hon Patricia Hewitt as our STP Independent Chair.
- Developing our STP Delivery Plan and Programme of work upto 2020.
- Developing our plans for Prevention, Primary and Community Care (Section below)
- Progressing plans for Acute Services and for the three hospital to work more as a chain of hospitals, where it makes clinical and financial sense to do so.
- Developing plans to improve mental health services (See below)
- Managing demand and implementing plans to reduce unnecessary hospital admissions
- Reviewing our financial plans for 17/18 and beyond to mitigate against any slippage and ensure they are robust.
- Securing transformation funding nationally of £1.7million revenue and £4m Capital to assist in rolling out the programme of work.

3.3.1 Primary and Community Care

A new Director of Primary Care, Sadie Parker, has recently been appointed to lead the transformation around Primary Care across the STP in line with the GP Five Year Forward View. A Head of Strategic Planning has also been appointed.

As a result we propose to refocus the work stream with a stronger emphasis on primary care. Sadie will take responsibility for driving the changes needed to ensure services meet the needs of local communities and ensure services are clinically sustainable.

We are proposing to develop up to 20 integrated neighbourhood teams delivered by Multispecialty Community Providers (MCPs) to improve access, ensure consistency and reduced variation across Norfolk and Waveney.
The main purpose of this approach is to ensure patients receive more seamless care at the right time and wherever possible and appropriate closer to home.

In line with our STP submission in October 2016 this represents a key shift in the way services are delivered across Norfolk and Waveney. MCPs involve groups of GPs combining with other services such as community health services, pharmacists and mental health and social care to provide integrated community services.

As part of delivering sustainable services for local communities we propose to deliver the following changes in primary care by using an MCP approach, following local engagement and communication sessions, in line with ‘The Changing Face of Primary Care’. Where appropriate we will create community hubs for community services to be

accessed locally. We are currently working with our estates teams to identify potential sites for consultation.

Change 1 Active signposting across the STP Footprint to help people access the most appropriate services

Change 2 New consultation types to ensure 50% of the public have access to evening and weekend appointments by March 2018 and 100% by March 2019

Change 3 Reduce the number of people who do not attend their appointment

Change 4 Develop the primary care workforce through education and training to reduce pressure on GPs

Change 5 Introduce new ways of working to support practices to become more streamlined particularly around back office and reception functions

Change 6 Staff development to increase staff satisfaction and retention of staff

The STP partnership will continue to seek the views of the public in determining the exact service model within different communities and looking to other STPs across the country where we can learn from their models and adapt them to suit our communities

3.3.2 Prevention

Prevention is a strong focus of our STP plan with projects being implemented around those areas for which there is a strong evidence base and will have the greatest impact upon people's health.

Change 1 Expanding the diabetes prevention programme to reduce Type 2 Diabetes across the whole STP. This includes rolling out a tool across General Practice to identify those people who are most at risk of developing diabetes.

Change 2 Optimising care for patients with existing long term conditions, through improved secondary prevention and reducing complications of the disease.

Change 3 Developing with stakeholders and the public a systematic social prescribing offer

Change 4 Targeted lifestyle interventions to help people reduce smoking and alcohol consumption

Change 5 Extension of the Weight Management Service

3.3.3 Acute Care

The acute care work stream has several key deliverables which include;-

- Reviewing certain acute services to improve clinical sustainability across Norfolk and Waveney, particularly where there are national shortages of certain professional staff (ie Cardiology, Urology and Radiology)

- Where appropriate reconfigure services to deliver the most efficient, effective and safe services across the three hospitals by working more closely together, particularly around elective care.

- Provide some services in a community setting where the majority of services don't need to be provided in a hospital setting (ie ENT and Dermatology).

- Reviewing the recommendations of the Lord Carter review and where appropriate driving efficiencies in back office functions.

We have procured and appointed a supplier, Attain, who commenced on 10th October 2017 to assist us with developing a series of detailed options on service changes, for consultation towards the end of this year, which we will bring back to HOSC.

3.3.4 Cancer

We also have a large programme of work around improving outcomes for patients with cancer including prevention, reducing waiting times, earlier detection through screening and better follow up.

3.3.5 Maternity Services

In Maternity services we have just compiled our programme of work with services users. A final draft will be prepared for further consultation by the end of October.

Our proposed improvements in Maternity Services are based upon delivering the National Strategy around Better Births.

3.3.6 Demand Management

Through the **Demand Management workstream,** system partners are focused on Improving the management of planned care, to deliver consistent approaches and equitable access to providers, and to deliver the maximum 18 week waiting time standard by October 2018.

This is being driven by close, collaborative working across the three acute sites. Another key objective is reducing urgent and emergency activity through improved demand management (supporting the other work streams to deliver admission avoidance schemes) and reduced length of stay.

3.3.7 Urgent and Emergency Care

The most comprehensive transformation within the NHS needs to take place around how we manage the growing demand for urgent and emergency care, in particular for those aged over 65 who make up 1 in 4 of our population.

Our **Urgent and Emergency Care** transformation programme includes:

- The roll-out of the digital 111 service.
- Clinical triage in the 111 service; we have already exceeded the national target 30% of calls being reviewed by a clinician and are now putting in plans to increase this to 50% over this winter.
- The expansion of urgent treatment centres - with a target of 25% of the population to have access to a centre by March 2018
- Work to avoid unnecessary admissions including the implementation of the new ambulance response programme and a Falls Vehicle with rapid response
- The new streaming models in Accident & Emergency (A&E)
- Improving intermediate care in the community.
- There is also a system focus on improving the flow of patients through hospital to avoid delays and we have recently been commended by the Secretary of State for the significant improvements we have made in this regard.
- Implementing Discharge to Assess and the Trusted Assessor Model.

3.3.8 Mental Health

Some of the deliverables of the **Mental Health workstream** include;

- Developing an action plan in response to the recent CQC report.
- Supporting community and primary care to provide mental health support at an early stage, in particular for people with psychosis
- Increasing community based treatment for children and young people with mental health problems
- Reducing acute hospital use for people of all ages with reported mental health problems, including those with dementia
- Re-designing the Mental Health Crisis Pathway to support better access to care in the community and ensure people get the care they need during crisis. We will shortly be engaging with people about these services and establishing crisis cafes
- Mental health practitioners to work alongside emergency services in Accident and Emergency Department providing 24 hour cover within the Norfolk and Norwich Hospital by January 2018
- Peri-natal mental health (supporting women with post-natal depression and prebirth depression) which has already secured funding nationally.

3.4 STP Risks and challenges

The key risks and challenges for system partners are:

• Achieving the scale and pace of change within the available resources
• Implementing the changes to ensure a sustainable workforce
• Developing our digital maturity across Norfolk and Waveney as a key enabler to Change

These are all on our risk log and we have a series of actions in place to address these risks.

3.3 **What is planned by way of specific proposals for substantial changes to service**,

3.3.1 The N&W STP Executive are fully aware of their statutory duties around engagement and consultation. To this end, the STP executive have appointed a Director of Communications and Engagement (part time) who is leading this work across the STP, with support from leads in the local authorities and the NHS. The STP Executive have been fully briefed on the key areas of engagement and consultation. A new STP Communications and Engagement Strategy has been approved by the STP Executive and will be published shortly. This will set out a timetable over the next twelve months for engagement work.

3.3.2 The appointment of the STP's Independent Chair Patricia Hewitt, who has a wealth of experience in public consultation and engagement, has strengthened this crucial element of the work of the STP.

3.3.3 The STP Executive has received the terms of reference for the newly established joint Norfolk and Waveney committee, who will be responsible for the consultation, for understanding the timetable for decision-making and for understanding how decisions will be made.

3.3.4 The N&W STP is not yet ready to begin pre-consultation work towards a formal public consultation on any area of work within each of the key workstreams (see Appendix 1 for details). Each workstream has a dedicated communications and engagement specialist working with them now to develop a clear timeline for engagement work. This will begin in earnest with six joint events being run with Healthwatch Norfolk at the end of November 2017, focussing on primary (GP) care and hospital services, specifically cardiology, urology and radiology.

3.4 **How well do the various CCG commissioning and NHS Trust operating plans, the Norfolk Health and Wellbeing Strategy and the County Council's social care plans fit with the STP**?

3.4.1 The commissioners of health and social care in Norfolk and Waveney recognise the opportunities to work more effectively together whilst valuing local priorities and local system working. In September, all five CCG Governing Body meetings in public considered a new commissioning approach with the formation from October 2017 of the new single Joint Strategic Commissioning Committee (JSCC).

3.4.2 There are many decisions we take together and many issues we resolve as one wider system. This 'STP-wide' approach to commissioning provides an opportunity to formalise our closer working arrangements. We aim to improve our efficiency, effectiveness and speed of action by streamlining our decision-making processes, working in a Joint Strategic Commissioning Partnership (JSCP) across the five CCGs. These consist of NHS Great Yarmouth and Waveney CCG, NHS North Norfolk CCG, NHS Norwich CCG, NHS South Norfolk CCG and NHS West Norfolk CCG (together "Norfolk and Waveney CCGs"). Where practicable we will do things once across the STP footprint, where a system-wide approach is more appropriate. Not only will this deliver better value

for money, we believe this will lead to greater consistency, equity and greater clarity within Norfolk and Waveney.

3.4.3 In order to deliver this working in the most effective way, strategic commissioning decisions will be made by a single Joint Strategic Commissioning Committee (JSCC) which will have delegated authority from the Norfolk and Waveney CCG's Governing Bodies to make decisions against a defined set of responsibilities.

3.4.4 CCG Governing Bodies have been asked to approve that new terms of reference for the JSCC and to include these in each CCG's constitution so that the JSCC becomes a formal joint committee of each Governing Body with authority to make decisions as delegated to it. The plan is that this new JSCC will meet in public from April 2018.

3.4.5 This proposal comes with a very clear understanding, articulated by every CCG on behalf of their local populations, which is that localised commissioning works and will continue as before. In many circumstances localised commissioning led by local clinicians with the engagement of patients and stakeholders has delivered considerable benefits. This proposal does not seek to dilute locality-based commissioning, rather to strengthen our work where shared interests and shared contracts are concerned.

3.4.6 There will be a Lead CCG Chief Officer for strategic commissioning. This will be chosen from one of the existing Norfolk and Waveney CCG Accountable/Chief Officers. This person will be expected to regularly liaise with the other Norfolk and Waveney Chief Officers on the work of the JSCC and work with them to communicate a clear view on all issues that arise at the JSCC. The details of this arrangement will be set out in an MOU which will be worked on by the JSCC and the Norfolk and Waveney CCGs.

3.5 **Breaking down the barriers between primary and secondary care, physical and mental health and health and social care, particularly in respect of the transfer of digital info between organisations**

3.5.1 We recognise that progress around our five key digital programmes remains mixed with slow progress on the development on an integrated electronic patient record (EPR) which has interoperability across the STP footprint. This has been predominantly because we are still awaiting confirmation of national capital funding and also revenue funding of £2.5million for primary care from NHS England.

3.5.2 Several capital bids have been submitted for national transformation funding to enhance our digital maturity and this was prioritised over all other capital bids by the STP Executive. To date no capital funding has been received. We continue to campaign at a National Level to secure funding.

3.5.3 However whilst we wait for national funding we continue to progress a range of issues within our control. In October we have appointed a **Chief Information Officer** as a joint appointment across the STP and NNUH to lead and progress our agenda. We have already appointed Erika Denton as our interim **Clinical Chief Information Officer.** In the meantime we have also appointed Mark Avery for 2 days a week from the EAHSN to reassess our **digital maturity assessment** and develop an option appraisal for an integrated EPR system.

3.5.4 In the meantime we continue to make progress with several digital programmes including rolling out ECLIPSE which is a sophisticated clinical monitoring tool which we are

using to provide an **electronic diabetes early intervention tool** across the STP as part of the £700k received for early intervention for diabetes.

3.6 Workforce

3.6.1 A dedicated workshop was held in July to assess all aspects of workforce across the STP, and a new workforce lead for the STP has been appointed. The draft Workforce Strategy will be considered by the STP Executive in October. This is likely to result in a refresh of the work programme for the STP Workforce Group given the significant workforce challenges across both Health and Social Care, in the short, medium and longer term.

3.6.2 A range of specific initiatives in primary care are being taken forward in line with the GP Practice Forward View, with a focus on resilience, sustainability, transformation, demand management and clinical variation. A recent success was the award of £2.2 million funding to enable the international recruitment of GPs to support local workforce challenges across Norfolk and Waveney.

3.6.3 Alongside this, we have continued to work with union representatives, and plan to increase union engagement in the STP.

3.7 Third sector engagement

3.7.1 A key workstream for the STP is our Stakeholder Board, chaired by Graham Creelman. This meets monthly and provides an overview of engagement and communication plans to ensure that effective engagement and consultation takes place.

3.7.2 The Stakeholder Board engages with key stakeholders from district councils, the voluntary and community sector and Healthwatch Norfolk and Suffolk, plus other key stakeholder groups in Norfolk and Waveney. To date they have reviewed and commented on our plans for Social Prescribing and mental health service developments, including our new perinatal mental health service, which is one of the first in the country. In the last month they have commented on the STP Communications and Engagement Strategy.

3.7.3 In March 2017, the STP ran three key engagement events with voluntary sector partners across Norfolk and Waveney in partnership with Community Action Norfolk (CAN). A full report has been produced from these events and reviewed by our STP Stakeholder Board. This will be published soon by CAN, and will be used to inform the work of the work streams to ensure full consideration is given to the critical role that the voluntary sector plays in service provision, particularly to some of our most vulnerable groups.

Antek Lejk
Norfolk and Waveney STP Lead
October 2017

Appendix 1

1. Prevention, Primary and Community Care workstream

The key objectives of the Prevention, Primary and Community Care workstream include:

• Improving the prevention, detection and management of major chronic illnesses
• Increasing individual and community capacity for self-care
• Developing a social prescribing model
• Developing and implementing a primary care provision model that improves access and capacity and addresses retention and recruitment in line with the GP 5 Year Forward View
• Developing and implementing optimal integrated care models (Multispecialty Community Providers) by locality to ensure consistency and reduced variation across Norfolk and Waveney

Roisin Fallon-Williams, Chief Executive of Norfolk Community Health and Care, is the SRO and **Catherine Underwood**, Director of Health Integration at Norfolk County Council, is the Lead for this workstream.

2. Demand Management workstream

The key objectives of the Demand Management workstream include:

• Managing the flows of patients into elective care by:
- Reviewing procedures of limited clinical value in line with national guidance
- Ensuring CCGs adopt consistent clinical policies and procedures across the system where appropriate
- Ensuring effective pathways are in place
- Ensuring consistent approaches to demand and referral management and reducing unnecessary variation in referral
• Ensuring there is good access to a range of providers and encouraging more delivery in the community where appropriate
• Ensuring our provider infrastructure has the capacity to deliver the care it needs and ensure equitable access
• Ensuring we have good quality, consistent, up to date data systems that help us track, review and adjust patient flows

Antek Lejk, Chief Officer for North Norfolk and South Norfolk CCGs is the SRO, and **Mark Burgis**, Chief Operating Officer for North Norfolk CCG, is lead for this workstream.

3. Acute Care workstream

The key objectives of the Acute Care workstream include:

• Developing the strategic direction for acute services delivery and exploring opportunities for back office efficiencies between the acute, community and mental health providers
• Reducing urgent and emergency activity through improved demand management (supporting the other work streams to deliver admission avoidance schemes) and reduced length of stay
• Ensuring acute clinical service sustainability at an STP footprint level across the key nominated specialty areas and their interdependencies by working collaboratively across

the three sites

Christine Allen, Chief Executive of James Paget University Hospitals is the SRO, and **Andrew Palmer**, Director of Performance & Planning, James Paget University Hospitals, is lead for this workstream.

4. Mental Health workstream

The key objectives of the Mental Health workstream include:

• Offsetting and reducing the growth in out of area bed days
• Increasing recording of dementia, improving access to support and reducing the use of residential and acute care
• Supporting community and primary care to provide mental health support at an early stage
• Increasing community based treatment for children and young people with mental health problems
• Reducing acute hospital use for people of all ages with reported mental health problems, including children and young people and dementia

Julie Cave, Acting Chief Executive of Norfolk and Suffolk NHS Foundation Trust is the SRO,
and **Jocelyn Pike**, Chief Operating Officer for South Norfolk CCG, is lead for this workstream.

5. Enabling Workstreams

Further workstreams have also been established to ensure that the delivery of the STP is supported by system-wide approaches to Workforce, Estates, ICT, Finance and Communication.

Ambulance response times and turnaround times in Norfolk

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

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

1. Background

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

1.2 NHOSC returned to the subject of ambulance services in February 2015 because it was aware that response times in Norfolk were still below locally agreed trajectory standards (which were lower than national standards) in some areas. At this stage NHOSC widened its focus to look at county-wide ambulance response times and the turnaround performance at the Queen Elizabeth (QEH) and James Paget (JPUH) hospitals as well as the NNUH and at performance against specific stroke standards (Stroke 60 and Stroke Care Bundle) which had been a matter of concern for NHOSC during its scrutiny of stroke services in Norfolk in 2013-14.

1.3 NHOSC received reports from The East of England Ambulance Service NHS Trust (EEAST), the NNUH and North Norfolk CCG in October 2015 and October 2016 about the continuing challenges facing the ambulance service, the urgent and emergency care system and the wider health and social care system and actions underway to address the issues affecting patient flow. The following link will take you to the 13 October 2016 report to NHOSC (agenda item 7, page 46)
http://norfolkcc.cmis.uk.com/norfolkcc/Meetings/tabid/70/ctl/ViewMeetingPublic/mid/397/Meeting/518/Committee/22/Default.aspx

1.4 The figures presented to NHOSC in October 2016 showed that a significant number of ambulance hours continued to be lost because of delays at the county's acute hospitals, particularly between arrival and handover of patients.

With regard to ambulance response times, EEAST was seeing a sustained recovery in performance from March to October 2016 following a challenging winter period.

It should be noted that EEAST is expected to meet the national response time standards on a regional level and not on a county or locality level, but CCG locality response time figures are available. In terms of the 8 minute (Red 1&2) response standard for potentially life-threatening emergencies the most challenged geographic areas were North Norfolk and South Norfolk:-

		Minutes to arrival on average (Sept 2015 – Aug 2016)
Red1 - cardiac arrest / not breathing	North Norfolk	10:07
	South Norfolk	09:50
Red 2 – all other potentially life threatening emergencies	North Norfolk	12:43
	South Norfolk	11:31

1.5 North Norfolk was also the most challenged area in terms of the Stroke 60 standard (the percentage of Face Arm Speech Test (FAST) positive stroke patients (assessed face to face) potentially eligible for stroke thrombolysis, who arrive at a hyper stroke centre (HASU) within 60 minutes of call). At the time of reporting in 2016 the latest figure showed less than 20% meeting the Stroke 60 standard in North Norfolk. Driving time to the nearest HASU was a major factor in this.

EEAST pointed out that the Stroke 60 performance figures could not tell us what the outcome was for patients. That also depended on the timeframe within which patients received the most appropriate treatment when handed over to the care of the acute hospitals. EEAST assured NHOSC that it meets monthly with the commissioners and discusses Stroke 60 misses in detail, specifically looking at why the miss occurred, if there was any patient harm and to look for any patterns that could result in actions to improve.

1.6 In October 2016 NHOSC also heard that:-

- EEAST was undertaking a sustained recruitment drive to increase frontline staffing. There were 180 trainee ambulance staff undertaking student placements at UEA and the first cohort were due to qualify in January 2017.
- Demand on the 999 service had continued to increase, with a 15.31% increase in Red calls (potentially life threatening emergencies) over the 12 months to August 2016.
- The NNUH was the busiest emergency department in the eastern region and one of the busiest in the country. Ambulance arrivals at the hospital from 3 April – 11 Sept 2016 were up 2.35% on the same period in 2015.

- EEAST was in the upper percentile of ambulance trusts in relation to the number of patients to whom it provided alternatives to transport to hospital.
- The project for an Ambulatory Care and Diagnostic Centre at the NNUH had been put on hold but increased assessment on arrival, ambulatory care and the availability of the Urgent Care Centre at the hospital had helped with a reduction in admissions to A&E.

The Committee considered that the closure of the NNUH's Henderson Unit (at the Julian Hospital site in Norwich) in October 2016 could have implications for ambulance turnaround and patient flow times through the NNUH during winter 2016-17.

Given the ongoing pressures on the ambulance service, urgent and emergency and the wider health and social care system, NHOSC requested to be updated on the ambulance response and turnaround situation in a year's time.

2. National ambulance standards – old and new

2.1 On 13 July 2017 NHS England announced **new** national ambulance standards (the Ambulance Response Programme (ARP)). All of the ambulance trust in England will be aiming to implement the new standards before winter 2017. The aim nationally is for:-

- Faster treatment for those needing it to save 250 lives a year
- An end to "hidden waits" for millions of patients
- Up to 750,000 more calls a year to get an immediate response
- New standards to drive improved care for stroke and heart attack

'Hidden waits' refers to the current situation where one in four patients who need hospital treatment undergo a wait after the existing 8 minute target is met because the vehicle dispatched, such as a bike or car, cannot transport them to A&E. Under the new system an emergency response will be expected to reach the most seriously ill patients (category 1) in an average time of 7 minutes. There is an additional category 1 transport standard to ensure that these patients also receive early ambulance transportation. For the three other categories, if a patient is transported to hospital, only the arrival of the transporting vehicle will stop the 'clock', rather than the arrival of the first vehicle.

Under the old system three or four vehicles could be sent to the same 999 call to be sure of meeting the 8 minute target and nationally one in four are stood down before reaching their destination. The new system should free up more vehicles and staff to respond to emergencies.

2.2 The changes also introduced mandatory response time targets for all patients who dial 999. Under the old system half of all ambulance calls nationally were classed as 'green' and not covered by any national target.

2.3 Condition specific measures are also being introduced which will track the time from 999 call to hospital treatment for heart attacks and strokes, where a prompt response is particularly critical. A new set of pre-triage

questions will identify those patients in need of the fastest response. By 2022 the aim is for 90% of eligible heart attack patients to receive definitive treatment (balloon inflation during angioplasty at a specialist heart attack centre) within 150 minutes. 90% of stroke patients should also receive appropriate management (thrombolysis for those who require it, and first CT scan for all other stroke patients) within 180 minutes of making a 999 call. Under the old system that happened for less than 75% of stroke patients nationally.

2.4 The **new response time standards** are:-

Call category	**% of calls in this cat-egory**	**National Standard**	**How long does the ambulance service have to make a decision?**	**How will this be measured?**
1 Calls about people with life-threatening injuries & illnesses	8%	7 minutes mean response time 15 minutes 90th centile response time (i.e. these type of calls will be responded to at least 9 out of 10 times before 15 minutes)	The earliest of:- • The problem is identified • An ambulance response is dispatched • 30 seconds from the call being connected	The first ambulance service-dispatched emergency responder arrives at the scene of the incident There is an additional Category 1 transport standard to ensure that these patients also receive early ambulance transportation
2 Emergency calls	48%	18 minutes mean response time 40 minutes 90th centile response time (i.e. these type of calls will be responded to at least 9 out of 10 times before 40 minutes)	The earliest of • The problem being identified • An ambulance response is dispatched • 240 seconds from the call being connected	If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle counts. If the patient does not need transport the first ambulance service-dispatched responder at the scene of the incident counts
3 Urgent calls	34%	120 minutes 90th centile response time (i.e. these type of calls will be responded to at least 9 out of 10 times before 120 minutes		
4 Less urgent calls	10%	180 minutes 90th centile response time (i.e. these calls will be responded to at least 9 out of 10 times before 180 minutes)		

2.5 The link below will take you to short animations on the NHS England website which illustrate how the new standards work:-
https://www.england.nhs.uk/urgent-emergency-care/arp/

2.6 For **ambulance turnaround at hospitals**, the **current standards** (which have not been altered by the introduction of the new national standards) are:-

(a) 15 minutes - The time from ambulance arrival on the hospital site to the clinical handover of the patient (also known as 'trolley clear'). **The hospital is responsible for this part.**

(b) 15 minutes - The time from clinical handover of the patient to the ambulance leaving the site (also known as 'ambulance clear'). **The ambulance service is responsible for this part.**

2.7 For **ambulance response** to patients, the **old national standards**, which were applicable in the timeframe covered by EEAST's report (at Appendix A*)* were:-

Red calls (2 categories)

Reaching 75% of Red 1 and Red 2 calls within 8 minutes

Providing a transportable resource for 95% of Red 1 and Red 2 calls within 19 minutes of request.

Red 1 – patient suffered cardiac arrest or stopped breathing - two resources should be dispatched to these incidents where possible.

Red 2 – all other life threatening emergencies.

Green calls (four categories)

Reaching 75% of Green 1 calls in 20 minutes and 75% of Green 2 calls in 30 minutes.

Reaching 75% of Green 3 calls in 50 minutes OR a phone assessment from the clinical support desk[1] within 20 minutes

Reaching 75% of Green 4 calls in 90 minutes OR a phone assessment from the clinical support desk within 60 minutes.

Green – non life threatening emergencies

Both the Red categories were national requirements but the four Green categories are locally agreed.

2.8 In relation to stroke the applicable service standards for the period of EEAST's report (Appendix A*)* were:-

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

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

Stroke Care Bundle - The percentage of suspected stroke patients (assessed face to face) who receive an appropriate care bundle. (As per National Ambulance Clinical Performance Indicator Care Bundle). The compliance performance standard is 95%.

2.9 The ambulance service provided by EEAST for Bedfordshire, Hertfordshire, Essex, Norfolk, Suffolk and Cambridgeshire is commissioned jointly by all 19 Clinical Commissioning Groups (CCGs) in the area. Ipswich and East Suffolk CCG is the co-ordinating commissioner. EEAST has previously reported that it is not commissioned (i.e. not funded) to a level to enable it to deliver all the national standards. It has worked closely with commissioners to understand what level of funding would be needed at individual CCG level to meet mandated national targets. It reported to NHOSC in October 2016 that given the rural nature of Norfolk the gap between resources and what would be needed to deliver the national standards across this county is significant and that it actively engages with local schemes in rural communities to ensure that where a life is threatened a rapid response from within the community can occur.

2.10 On 18 August 2017 the Health Service Journal referred to an unpublished report by consultants ORH in August 2016 which highlighted a large gap between existing staffing capacity and the level needed if EEAST was to achieve the 2017-18 targets set out by commissioners. NHS England and NHS Improvement have commissioned an Independent Service Review (also by ORH) to understand what capacity and funding the trust requires to meet demand. The Independent Service Review is underway but may not be complete by the date of today's meeting.

3. Purpose of today's meeting

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

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

- Policy on transport of mental health patients in crisis.

EEAST's report is attached at **Appendix A**.

3.2 Although ambulance turnaround figures for all three acute hospitals are included in EEAST's report, the NNUH has been invited to report and to attend today's meeting as the largest hospital in Norfolk and consequently the one where potentially the most hours could be lost in ambulance delays. The NNUH has been asked to update the committee on activity at the hospital in the past year to improve performance in terms of ambulance turnaround and patient flow through urgent and emergency services.

The NNUH's report is attached at **Appendix B**.

3.3 North Norfolk CCG has also been invited to today's meeting as the lead commissioner of the NNUH and one of the 19 regional CCGs who jointly commission the ambulance service.

North Norfolk CCG can answer the committee's questions on the success of the measures to tackle the causes of delay in all aspects of the urgent and emergency care system in central Norfolk.

4. Suggested approach

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

4.2 **East of England Ambulance Service NHS Trust**

(a) Are you satisfied that all the health and social care agencies whose co-operation is necessary to resolve the issue of ambulance delays at hospitals are actively and adequately addressing their part of the problem?

(b) In October 2016 EEAST reported to NHOSC about its sustained recruitment drive to increase frontline staffing and at that stage there were 180 trainee ambulance staff undertaking student placements at UEA. Has EEAST continued to be successful in recruiting trainees and experienced staff and what is the situation with staff retention?

(c) Is EEAST satisfied that the balance between experienced paramedics and trainees in the workforce is manageable in terms of providing satisfactory training and of delivering the service to meet rising demand?

(d) Given that fact that national standards cannot be met in some rural localities without significant additional funding, the work of community first responders is crucial (see paragraph 2.1 above). What does EEAST do to ensure that volunteers are properly supported?

(e) Presuming that the results of the Independent Service Review (see paragraph 2.6) are not yet available, what is EEAST's current plan for recruitment and retention of staff within current funding levels?

(f) What are the implications of the **new** national ambulance standards (the Ambulance Response Programme) in terms of resources required?

(g) The **new** national standards include an additional Category 1 transport standard to ensure that these patients receive early ambulance transportation. What is that standard?

(h) It appears that the new national standards for heart attacks and strokes will require measurement of the patient's pathway from 999 call to definitive treatment in the acute hospital. How will this measurement be arranged locally?

(i) What is EEAST's involvement in the transport of patients in mental health crisis to the acute hospitals and to acute beds at mental health hospitals after a Mental Health Act assessment? What criteria are used to assess the urgency of transporting a person in mental health crisis to hospital?

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

(j) Are you satisfied that all the health and social care agencies whose co-operation is required to manage demand for acute care are actively and adequately addressing their part of the problem?

(k) What was the effect of the closure of the 24 bed Henderson re-ablement unit in October 2016 on the flow of patients through the NNUH's urgent and emergency care services?

(l) Now that the NNUH is no longer in special financial measures, will the project for an Ambulatory Care and Diagnostic Centre go ahead?

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

(m) When do the CCGs expect the report of the Independent Service Review (see paragraph 2.10 above) to be available? Will the report be made public? Are there any early indications of the actions that the commissioners and EEAST will need to take in response to the findings of the review?

(n) What are the implications of the new national ambulance standards from the CCGs' point of view?

(o) Given the requirement for ‘parity of esteem’ between physical and mental health, what is the commissioners’ view on the way ambulance transport is provided for individuals in mental health crisis? (see 4.2(i) above)

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Report by the East of England Ambulance Service NHS Trust

The Ambulance Response Programme (ARP)
The Ambulance Response Programme is a national programme aiming to help patients get the right response, first time. More details about ARP are in members' packs.

Every ambulance service is England is moving across to ARP this year. The East of England Ambulance Service NHS Trust (EEAST) has planned to go live on the 18th October. The key changes are:

- Call handlers have a new way of managing calls to allow earlier identification and recognition of life-threatening conditions and more time to assess patients who do not have life-threatening conditions
- Call categories and response standards will change; simplifying the system and ensuring all calls are reported against nationally.
- Due to the change in standards and response model, EEAST will be transferring much of its existing staffing from Rapid Response Vehicles (RRV) to ambulances to facilitate an increase in ambulance cover. This will mean a reduction in cars and every ambulance service is going through a similar change in response mix.
- End to end system standards for stroke and heart attack patients.

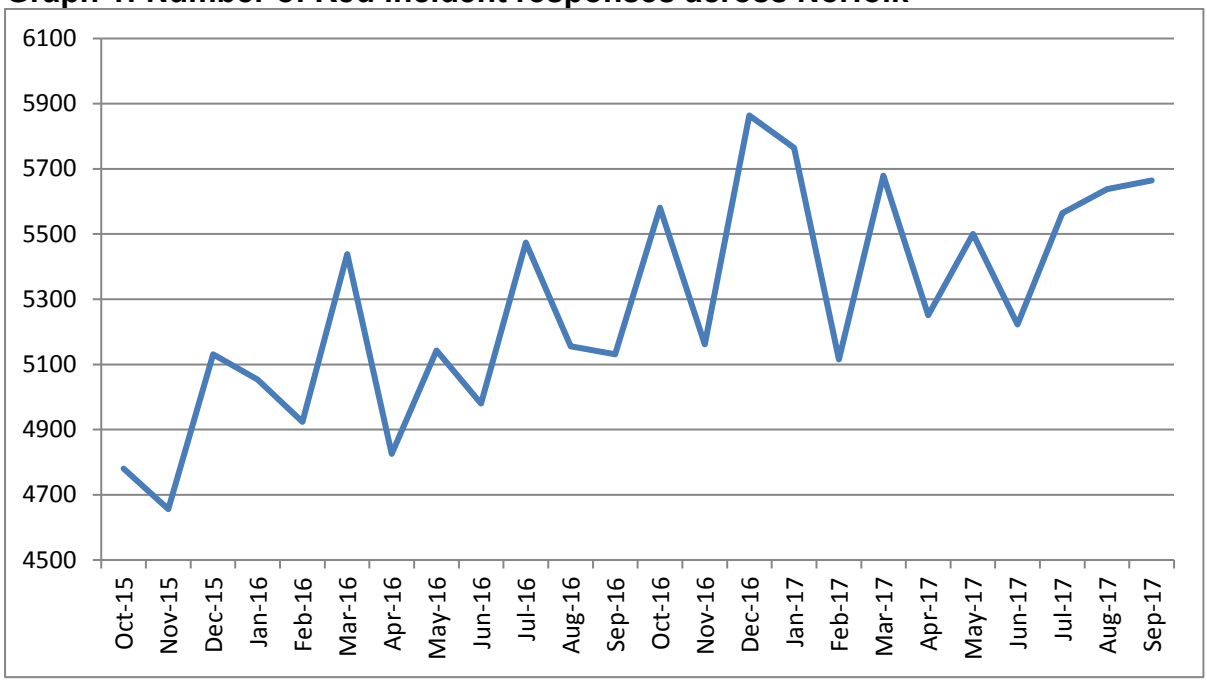
Demand and performance
EEAST is commissioned at a regional level, not on a CCG level. The new ambulance standards under ARP cannot be compared to the existing standards as the call categories and associated response times are significantly different.

The number of incidents EEAST responds to in Norfolk has fallen by around 4% over the last two years. However the number of high acuity patients (Red calls, which could be potentially life threatening) has risen by around 18% (see graph 1).

So whilst the fall in overall demand is welcome, the surge in high acuity patients has added significant pressure on the service, as these patients need a faster response and often multiple emergency responses.

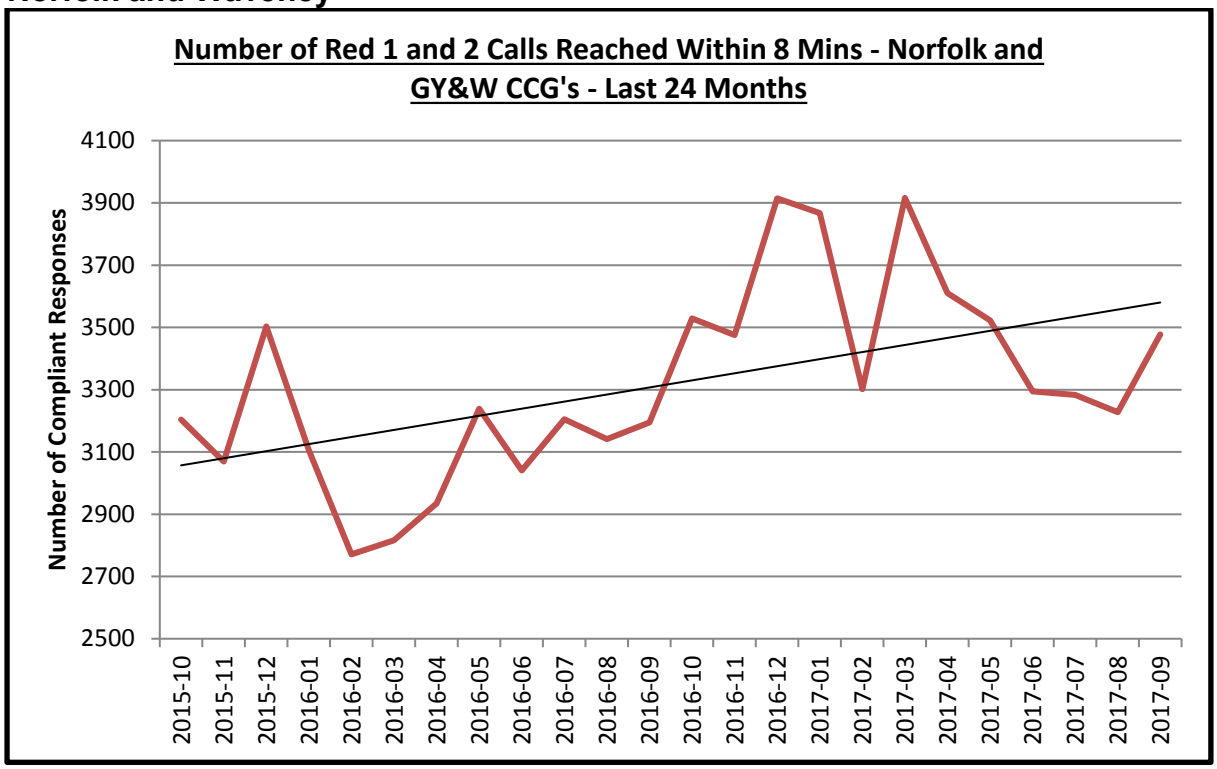
Performance is also impacted on by hospital handover delays and student abstractions (releasing students to complete their education and studies). These issues are covered later in the report.

Graph 1: Number of Red incident responses across Norfolk



Despite the significant rise in high acuity patients, EEAST has seen a sustained improvement in the number of Red call patients being reached within eight minutes across Norfolk and Waveney (see graph 2)

Graph 2: number of Red call patients being reached in 8 minutes across Norfolk and Waveney



Despite the improvement in the number of patients being reached in 8 minutes, and as a result of the pressure from the increasing levels of Red calls, we have seen a slight worsening of response times across Norfolk as table 1 shows.

Table 1: Average response times to Red calls in Norfolk by CCG area

Month Year	Great Yarmouth and Waveney	North Norfolk	Norwich	South Norfolk	West Norfolk	Grand Total
2015-10	00:07:33	00:11:35	00:06:08	00:10:26	00:08:55	00:08:39
2015-11	00:07:15	00:11:56	00:06:27	00:10:52	00:08:39	00:08:47
2015-12	00:07:34	00:11:10	00:06:32	00:10:17	00:07:58	00:08:32
2016-01	00:08:23	00:12:44	00:07:14	00:11:22	00:09:01	00:09:33
2016-02	00:08:39	00:13:26	00:08:03	00:12:07	00:10:18	00:10:15
2016-03	00:09:43	00:14:31	00:08:59	00:13:12	00:11:22	00:11:20
2016-04	00:07:45	00:13:00	00:07:16	00:11:18	00:09:43	00:09:33
2016-05	00:07:38	00:11:43	00:07:12	00:11:29	00:09:02	00:09:12
2016-06	00:08:14	00:13:02	00:07:12	00:11:28	00:09:38	00:09:43
2016-07	00:08:33	00:13:42	00:07:41	00:12:05	00:10:10	00:10:10
2016-08	00:08:16	00:12:30	00:07:00	00:11:40	00:09:49	00:09:39
2016-09	00:07:24	00:12:42	00:07:15	00:11:18	00:08:48	00:09:18
2016-10	00:06:58	00:12:00	00:06:53	00:12:16	00:09:18	00:09:17
2016-11	00:06:26	00:11:40	00:06:41	00:10:49	00:09:03	00:08:42
2016-12	00:06:27	00:11:57	00:06:30	00:10:37	00:08:43	00:08:40
2017-01	00:06:55	00:12:07	00:06:32	00:11:02	00:08:45	00:08:51
2017-02	00:06:57	00:11:58	00:06:53	00:11:26	00:09:03	00:09:05
2017-03	00:07:05	00:11:25	00:06:20	00:10:35	00:08:15	00:08:35
2017-04	00:06:51	00:11:36	00:06:06	00:10:29	00:08:34	00:08:31
2017-05	00:07:27	00:12:13	00:06:44	00:11:22	00:09:36	00:09:12
2017-06	00:07:23	00:12:34	00:07:09	00:11:16	00:09:35	00:09:20
2017-07	00:08:18	00:13:55	00:07:11	00:12:06	00:10:12	00:10:04
2017-08	00:08:28	00:13:31	00:07:38	00:12:00	00:10:24	00:10:12
2017-09	00:07:46	00:13:15	00:07:08	00:11:13	00:09:30	00:09:30
Grand Total	**00:07:41**	**00:12:31**	**00:07:01**	**00:11:22**	**00:09:21**	**00:09:22**

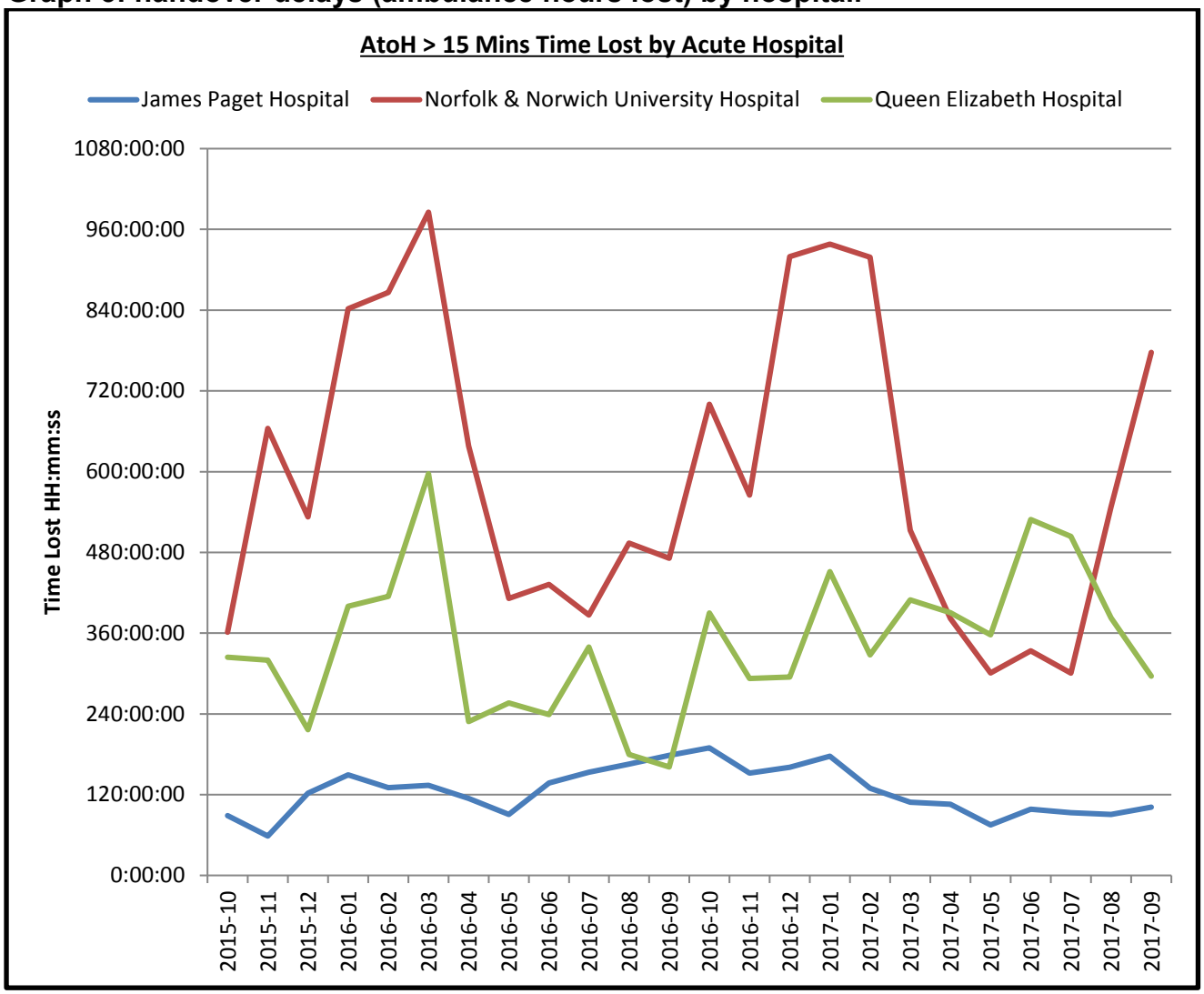
Hospital handovers

EEAST currently treats around 50% of its patients without conveying them to hospital. This is either through hear and treat services over the phone or see and treat face to face with the patient in their home or at the scene of the incident.

Hospital handover delays have a direct impact on response times. Where there are increased hospital handover delays it means we have fewer resources to send to patients.

Graph 3 shows the amount of hours lost at each of the hospitals over the last two years (hours which are over the 15 minute handover standard). As this graph shows, there have been spikes in handover delays each winter. Each 12 hours lost is the equivalent to taking off one double staffed ambulance for a 12 hour shift.

Graph 3: handover delays (ambulance hours lost) by hospital.



In the first five months of the financial year EEAST lost almost 4,500 hours (or the equivalent of 374 ambulance shifts) across the three Norfolk & Waveney hospitals. This is discussed at each of the A&E Delivery Boards and discussions/actions taken to reduce the impact for patients waiting in the community. We work closely with hospital teams to identify where any improvements can be made; some of these already include alternate pathways or destinations within the hospital such as the UCC or Ambulatory Emergency Care (AEC).

We have recently introduced a dedicated resource to treat our fallen and elderly patients. This is a collaborative scheme with our colleagues at NCH&C who provide an occupational therapist to respond with us as part of a team. This has been operating across the central Norfolk system since January and has now been funded outside of the core contract by Norwich CCG until the end of the financial year.

We have also received additional funding via the STP to put on two further resources over the winter period until the end of March 2018. This has been a very positive addition to our provision to patients, and had reduced emergency admissions to fallen and sub-acute elderly patients that might otherwise have been taken to hospital.

We have seen some 500 patients in this time with a near 70% non-conveyance rate for this cohort of patients. This model has been praised by patients, commissioners, and networks as a great example of collaborative working across a system to improve patient outcomes and experience. Due to the success of the Norfolk model, this is also being replicated in a number of CCG areas across the EEAST region.

NHS Improvement recently published a video about the impact of handover delays, featuring the story of a patient called Matthew. It can be viewed here: https://improvement.nhs.uk/resources/matthews-story/

NHS Improvement have also published a good practice guide on improving patient flow. They have also launched a 'fit to sit' campaign which encourages health professionals, including paramedics, to put an end to patients lying down on trolleys and stretchers if they are well enough to sit. This aims to help prevent loss of muscle strength, promote a speedier recovery, help patients get home sooner and save lost time to the 999 system.

The Hospital Ambulance Liaison Officer (HALO) role at the NNUH remains pivotal for the hospital and EEAST. They provide an early warning of impending activity, data collection and validation, welfare support and direct and visible contact with the hospital teams. This cover is provided 20 hours per day/7 days per week. The recent visit from the Emergency Care Improvement Programme support team highlighted the good work that they do in support of patient flow and experience. They have also started to support streaming to other departments and provide immediate operational leadership for cohorting decisions. This is still, however, funded outside of the core contract and will cease again at the end of the financial year should this not be resolved through the contracting round.

Recruitment and retention

Norfolk & Waveney are currently over-established by approximately 12% (80 staff). There is a funded budget for 618 staff and currently there are 700 in post. However, over a quarter of these staff are on a student pathway. That might be student paramedic, student technician or specialist paramedic programmes.

The student paramedic programme commenced some four years ago, and we have been successful in recruiting, and retaining, significant numbers. This is in part due to the positive relationship that we have with the University of East Anglia (UEA). The most challenging aspect for EEAST is that in year two of the student paramedic programme the staff member is either away at university or on placement for 44 weeks. This in effect takes our over-establishment position to an under-establishment position by about 15%.

We have also been successful in employing a number of graduate paramedics from UEA that we had supported with placements at EEAST during their studies. Of the 28 places offered, we employed 26. This is another example of our relationship with UEA and a testament to the hard work that our mentors have put into to help develop these staff.

We have enjoyed a period of stable workforce movements in the past year, with most leavers due to retirement, ill health or career opportunities. Our attrition rates have reduced and we have a waiting list of staff wanting to commence training or transfer into Norfolk & Waveney from other parts of the Trust.

We are awaiting the results of the Independent Service Review, commissioned by our regulators, to identify if we need to recruit more staff into Norfolk & Waveney. This is planned to report in the coming weeks.

Estates and fleet transformation
EEAST is planning a £42 million investment in its estates over the next five years. This strategy is looking at how we are going to develop a better estate and facilities for staff, and one that is more cost effective.

Currently EEAST spends the most percentage of its non-pay spend on its estate out of any ambulance service in England. This means that we are spending more on our estate than we could be and we could deliver a better service to our staff from implementing a modern estate with make ready facilities.

The existing estate does not support the requirements of a modern ambulance service. A final set of proposals are being drawn up around where 18 depots will be located and the supporting network of community ambulance stations and shared facilities. This will improve staff access to line managers and enable EEAST to develop better health and wellbeing facilities which we can't do on our existing estate. This is about making the most of our estate and working with partners to share more facilities and buildings to help increase our presence in the local community, especially in more rural areas.

Each depot would incorporate the following:
• Staff facilities for the centrally reporting complement of staff for the 'cluster' served by that depot;
• Local management staff for that 'cluster';
• A make ready centre (ie a centre where ambulances are prepared for the crew in terms of washing and stocking) for all fleet vehicles assigned to that 'cluster'; *and*
• Local workshop facilities as suitable for on-site (*or adjacent*) servicing, maintenance and repair of the fleet vehicles assigned to the 'cluster'.

We could not replicate this on the scale of the existing number of reporting ambulance stations. As a result most of our staff currently have to come into work and prepare the ambulance before they respond to patients – clearly an ineffective use of a clinician's time. By moving to a depot model, we can employ ambulance fleet assistants to wash and stock the ambulances, working in the right facilities, so they are ready for the clinicians to use.

The new estate is expected to enable service delivery improvements by reducing the amount of time crews are out of service for issues that can be managed more effectively and efficiently. This reduced out of service time will provide some additional resourcing to support overall improvement but at lower estate costs with improved facilities for staff. This model allows for the provision of a more comprehensive support and well-being package for staff which will support our efforts to reduce sickness and improve retention.

Each depot would serve a 'cluster' network of Community Ambulance Stations. However, the wide geography operated by the Trust means that some outlying community ambulance stations will need to have vehicles based at them and therefore incorporate some measure of local staff reporting. This is particularly important in more rural areas, especially in parts of Norfolk, for example Cromer.

We will need to review what the estate requirements are for the cluster network of supporting Community Ambulance Stations in each area. Our aim is to invest to extend our reach into the local community. We are also looking to work collaboratively with our partners, especially police and fire colleagues to share facilities where possible as we already successfully do in some parts of the region. In Norfolk, we are already well placed as we have existing depots in both Longwater and Waveney. Work to review where we need the cluster of community ambulance stations in Norfolk has not begun.

A good example of this is the new depot in Stevenage. This investment programme has seen the ambulance service extend its reach into the community by developing a new depot in Stevenage and retaining the existing facilities at Stevenage fire station and Letchworth as community ambulance stations.

Both NHS England and NHS Improvement are seeking an improvement in efficiency and a reduction in variation across Ambulance Trusts as identified by the recent National Audit Office report debated by the Public Accounts Committee on the 20th March 2017. This plan was also requested by the CCGs as part of the Trusts Remedial Action Plan in 2016/17.

Stroke Performance
EEAST is measured against two stroke targets. One is around the level of care given (called the stroke bundle) and the second is a time response based target (called stroke 60).

The stroke care bundle target measures if EEAST delivered the right clinical care to each patient. As can be seen from table 2, EEAST across Norfolk and Waveney has excellent care bundle results. The target is 95% achievement of the stroke care bundle.

Table 2: stroke care bundle results by CCG

	April 2017	**May 2017**	**June 2017**	**July 2017**	**Year to date**
Great Yarmouth & Waveney	100.0%	100.0%	100.0%	100.0%	100.0%
North Norfolk	96.0%	100.0%	100.0%	100.0%	99.0%

Norwich	100.0%	100.0%	100.0%	100.0%	100.0%
South Norfolk	95.5%	100.0%	100.0%	100.0%	98.9%
West Norfolk	100.0%	100.0%	100.0%	100.0%	100.0%

The current stroke 60 target is the percentage of Face Arm Speech Test (FAST) positive stroke patients (assessed face to face) potentially eligible for stroke thrombolysis, who arrive at a hyperacute stroke centre within 60 minutes of call; this should happen 56% of the time.

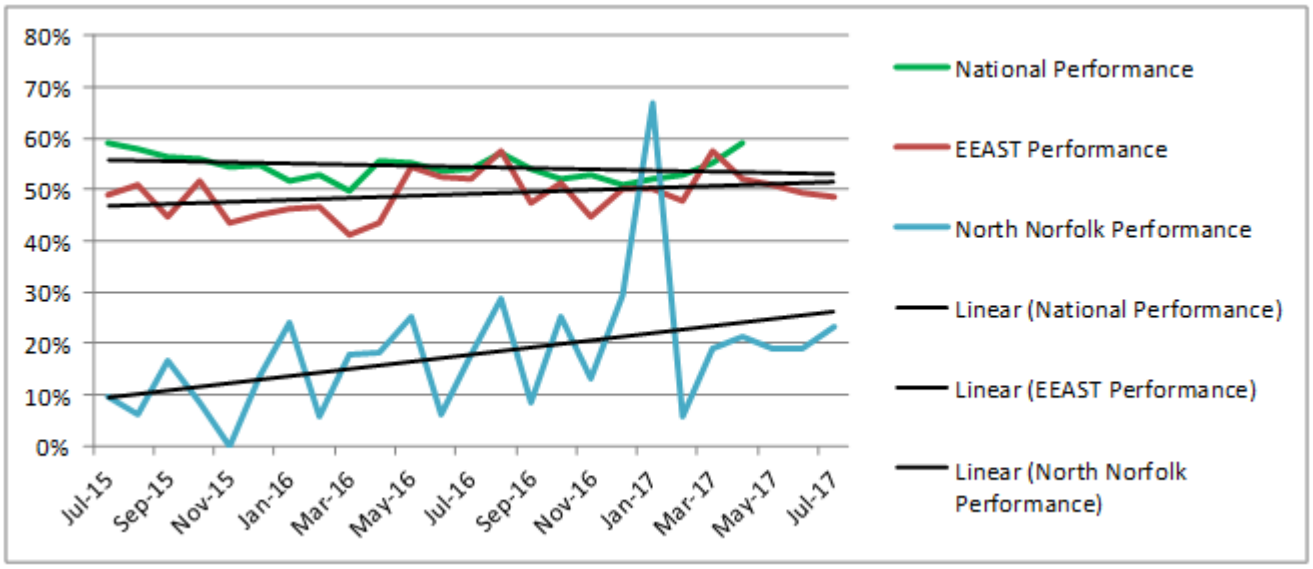
This target is not outcome based and takes no account of the end to end care the patient receives. However, evidence shows that the quicker a patient receives specialist treatment for a stroke, the better their outcome. Therefore under ARP and the new ambulance standards, the NHS will measure the proportion of patients that receive appropriate treatment - that is, thrombolysis where appropriate, or first CT scan for those where it is not - within 180 minutes of making a 999 call, with an expectation that 90% of patients will meet this standard by 2022.

The existing stroke 60 target remains a challenge, due to a number of factors, not least the rural nature of the area. There are some areas of North Norfolk where it is impossible to get a patient to hospital in under 60 minutes.

We review all missed stroke 60 calls internally and with commissioners to identify whether there was any patient harm as a result of the delayed response. We have reviewed North Norfolk as it is historically the most difficult area to deliver.

Over the previous two year period North Norfolk Stroke 60 performance is below both regional and national levels, the exception being January 2017 where 66.7% was achieved. This is likely to be due to that month having the lowest patient numbers over the period. The trend for North Norfolk is encouraging and from graph 4 it is noticeable that performance is increasing, recognising not to the national standard.

Graph 4: Stroke 60 performance nationally, regionally and in North Norfolk



From our investigations the findings causing the delays were as follows:

- Calls coded as Green wait longer for resources especially at times of demand surges
- RRV's attending first and then awaiting ambulance back up
- Geographical challenges
- Prolonged on scene times with FAST positive patients
- Delays at acute and system wide pressures
- Gap in knowing what the HASU outcome was

As a result, we have implemented a series of actions to be taken, which will also support potential improvements across all CCG areas:

- Emergency Operation Centre (EOC) processes being reviewed
- Communication with RRV clinicians to increase understanding of back up processes
- Work with Stroke Network around areas where there is delay in calling 999
- Continued work with external stakeholders to improve collaborative and communicative approach to system pressures
- Direct feedback given to crews where reviews show prolonged on scene times
- Trust review of on scene times
- Collaborate with HASU's regarding patient outcome and link ambulance and acute hospital data together to enable a potential system outcome (complete at NNUH – requires more sustainable process as currently manual not automatic)

Mental Health Pathways

EEAST are currently working with commissioners and partners in NSFT to review and identify gaps in the transport pathway for mental health patients. Currently there is confusion on some types of journeys, particularly out of area transfers and out of hours requests for transport. We have an agreed transport/referral mechanism for those patients that require a formal assessment in a section 136 facility, which

ensures a smooth and planned transition for these patients. This is received well by the NSFT professionals involved.

The confusion is within some patient transfers to places such as the Julien Hospital or the facility at Mundesley. The ongoing work is aimed at identifying how journeys should be provided, as some currently sit outside of the EEAST contract. ERS and our commissioners are also engaged with these discussions. EEAST will be hosting a workshop event to identify the most appropriate transport pathway for each type of patient.

Appendix B

Our Vision
To provide every patient with the care we want for those we love the most

Norfolk and Norwich University Hospitals NHS
NHS Foundation Trust

AMBULANCE HANDOVER AT NNUH - REPORT TO NHOSC 26th OCTOBER 2017

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

For: Norfolk Health Overview and Scrutiny Committee 26th October 2017.

The NNUH have been asked to update the committee on the measures that have been put in place to improve ambulance handover performance.

Background

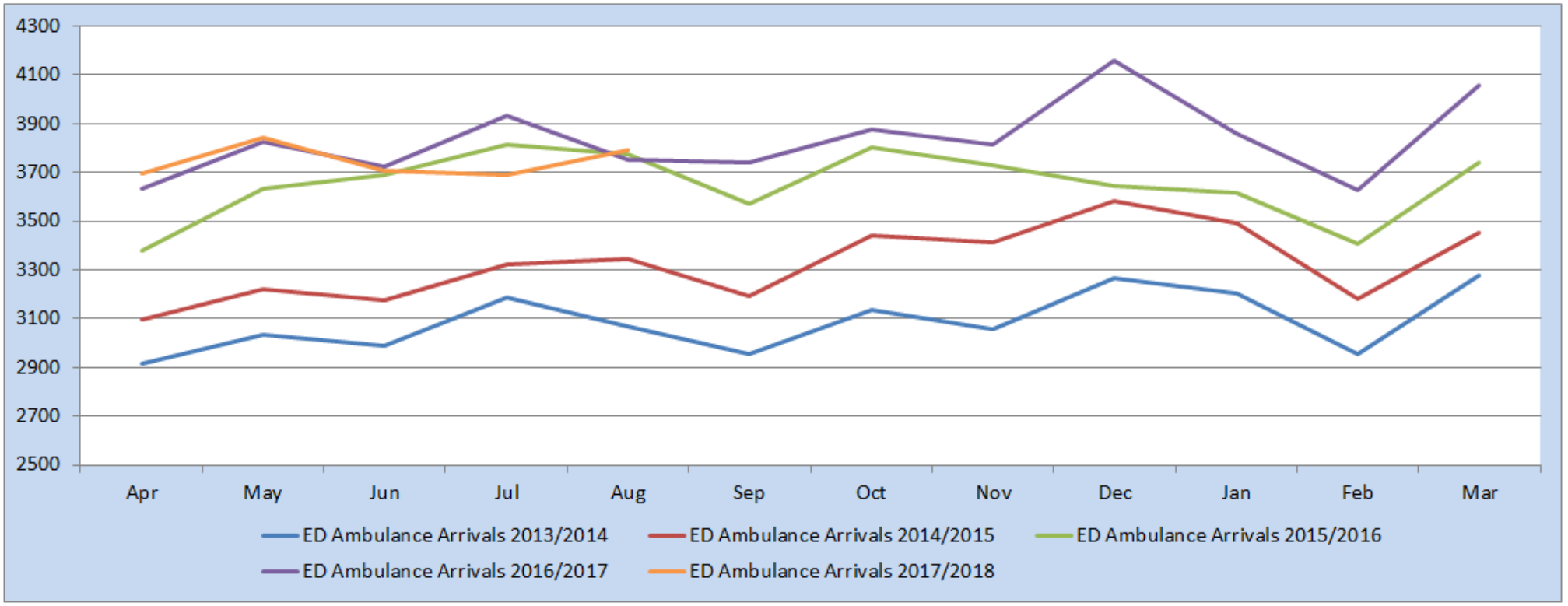
The NNUH is the busiest hospital in the eastern region in terms of ambulance arrivals. When ambulance handover delays occur at the NNUH it is usually as a consequence of reduced flow throughout the Hospital and/or a significantly higher than expected demand on the emergency admission areas. The attendances at the A&E department are predicted to rise by 2.5% in 2017/18. In the period 1April – 31 August there has been a 3% increase in attendances

Whist overall the ambulance attendances to the NNUH in 2017 have remained at 2016/17 levels, July saw a significant decrease in the number of patients arriving via ambulance against the same period of 16/17.

Ambulance Activity

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

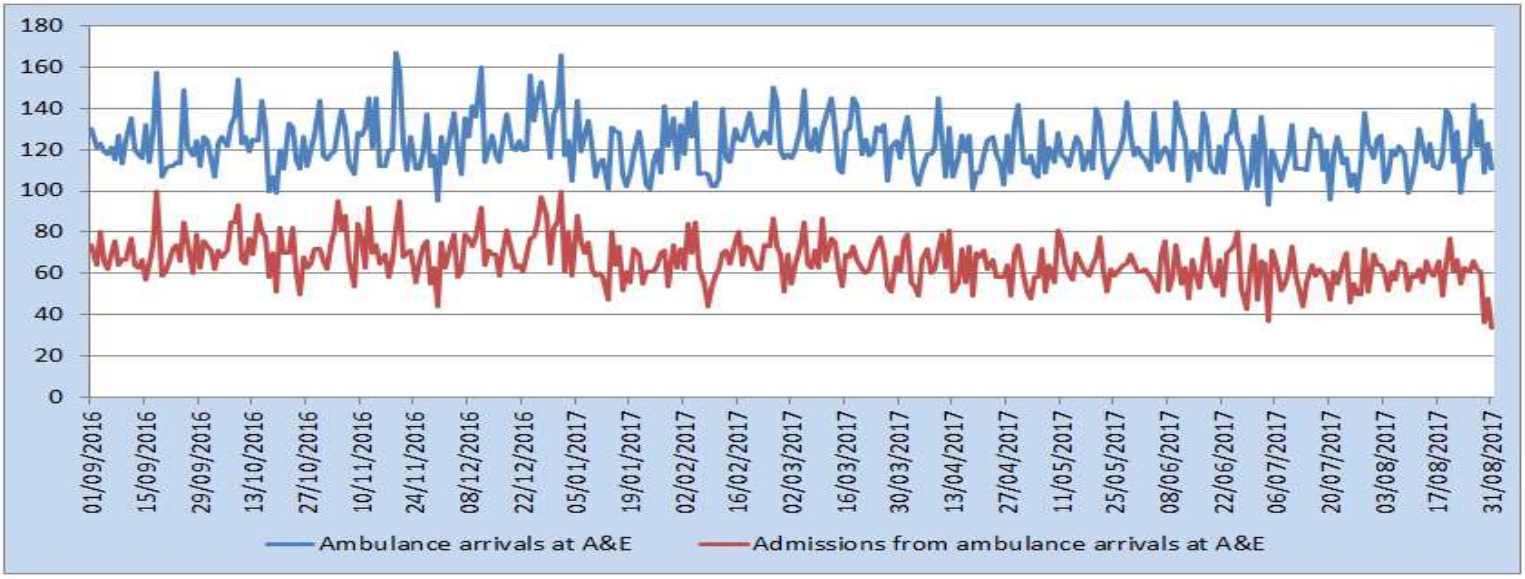
Table 1. Ambulance arrivals at ED April 2013 – August 2017.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
ED Ambulance Arrivals 2013/2014	2915	3035	2991	3185	3069	2955	3137	3059	3264	3201	2957	3278	37046
ED Ambulance Arrivals 2014/2015	3099	3218	3173	3325	3343	3195	3440	3411	3582	3494	3180	3451	39911
ED Ambulance Arrivals 2015/2016	3377	3634	3687	3814	3772	3573	3804	3728	3645	3615	3405	3741	43795
ED Ambulance Arrivals 2016/2017	3635	3824	3722	3932	3754	3740	3875	3811	4158	3860	3626	4057	45994
ED Ambulance Arrivals 2017/2018	3697	3844	3706	3692	3791								18630

Ambulance arrival at A&E to admission

Table2. A&E ambulance arrivals at A&E to admission September 2016 – August 2017.



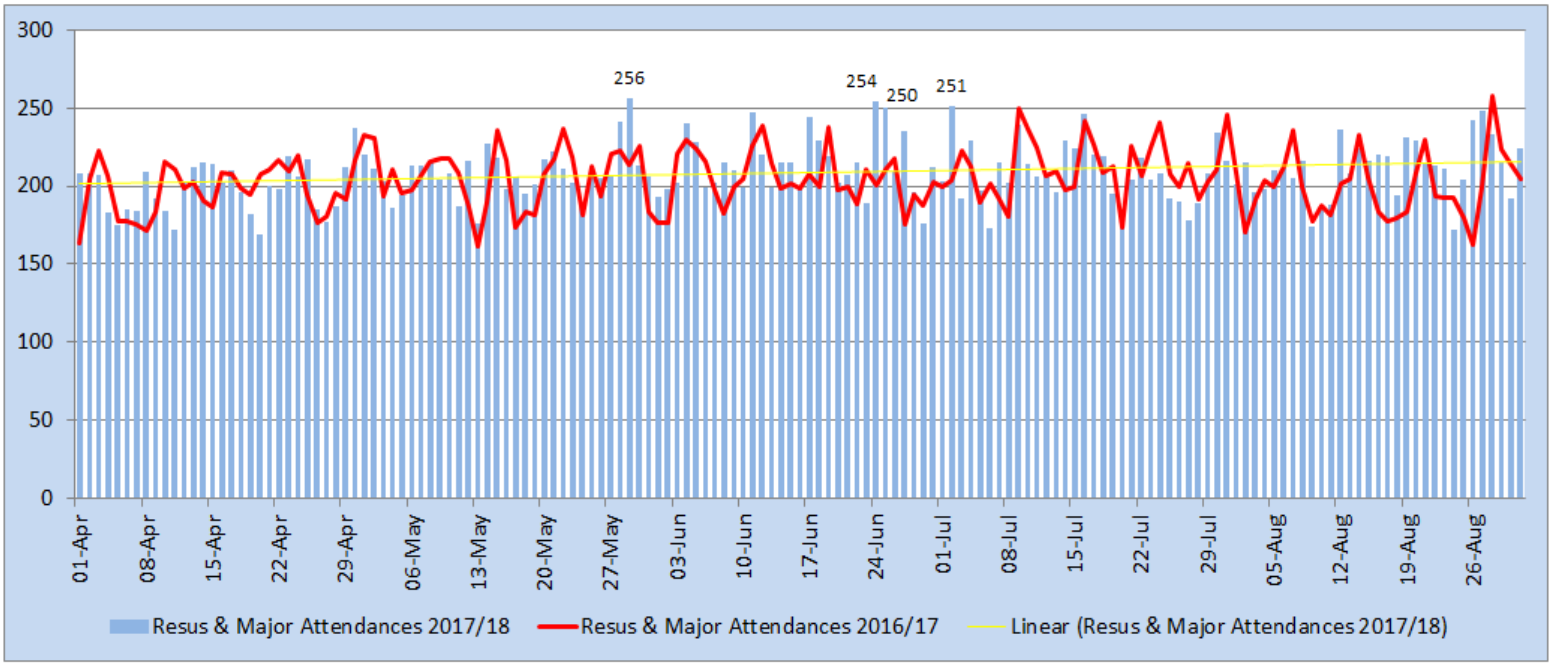
During the period 1 September 2016 – 31 August 2017, the rate of admission of ambulance arrivals at A&E has remained at an average of 54%. The vast majority of those patients admitted have been seen in either the Majors or Resus areas of the A&E department.

Acuity

Patients requiring Resus or Majors are the patient group with the highest acuity and immediate/urgent care requirements. There has been a 4.5**%** increase in combined majors/resus attendances 1 April – 31 August 2017 versus the same period of 2016.

This increase represents an additional 1421 resus/majors patient attendances compared with the same period in 2016. That is an average of 9 additional resus/majors patients per day. Assuming that, on average, 180 minutes are required for resus and majors patients, 9 additional patients per day represents 27 additional hours of clinical time in A&E every day. If there is not a consistent uninterrupted outlet to the emergency admission areas it is likely that this level of demand will result in a congested A&E and 4 hour standard breaches and ambulance handover delays.

Table 3. Resus & Major A&E attendances April – August 2017.



Ambulance Handover Performance

The period December 16- February 17 was one of the most challenging in terms of volume and complexity of attendance at the NNUH. Since February the performance against the 15 minute handover standard within the NNUH has slowly improved.

Table 4. Ambulance handover performance April 2016 – August 2017

NNUH Ambulance Handover	
Month	**<15 Min Handover**
Apr-16	**69.51%**
May-16	**76.57%**
Jun-16	**73.11%**
Jul-16	**74.88%**
Aug-16	**71.08%**
Sep-16	**71.84%**
Oct-16	**65.66%**
Nov-16	**72.16%**
Dec-16	**63.23%**
Jan-17	**64.90%**
Feb-17	**61.01%**
Mar-17	**74.06%**
Apr-17	**77.22%**
May-17	**80.70%**
Jun-17	**78.53%**
Jul-17	**81.73%**

The % arrival to handover performance <15 minutes at A&E only at the NNUH compares favourably with other Trusts in the region.

15 Minute Handover % Trends

A to H %<15 m in A&E of those recorded	2016/17								2017/18				
Hospital ED	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**	**April**	**May**	**June**	**July**	**August**
Addenbrookes Hospital	51.9%	44.0%	45.3%	45.9%	43.2%	38.7%	46.2%	50.8%	48.9%	47.1%	43.1%	46.3%	44.2%
Basildon & Thurrock Hospital	40.0%	32.1%	32.8%	35.1%	32.7%	36.7%	36.2%	41.7%	43.1%	38.7%	40.6%	39.9%	46.0%
Bedford Hospital South Wing	60.1%	54.8%	51.4%	63.5%	53.0%	59.7%	58.8%	62.0%	63.8%	66.5%	72.3%	65.1%	72.0%
Broomfield Hospital	47.9%	43.7%	39.3%	49.0%	42.2%	41.2%	44.4%	45.1%	46.4%	45.6%	36.6%	41.7%	42.6%
Colchester General Hospital	27.3%	31.2%	27.3%	30.8%	18.2%	22.8%	27.3%	30.1%	21.6%	19.4%	15.9%	15.3%	16.9%
Hinchingbrooke Hospital	27.8%	28.2%	30.5%	31.3%	24.9%	23.0%	21.1%	25.7%	22.2%	24.9%	23.8%	30.8%	52.9%
Ipswich Hospital	33.7%	33.3%	36.7%	34.8%	32.7%	27.2%	29.1%	34.9%	36.8%	39.3%	38.9%	39.8%	37.2%
James Paget Hospital	43.8%	38.8%	40.5%	46.3%	45.3%	48.9%	46.2%	48.5%	50.6%	53.3%	48.1%	50.8%	51.2%
Lister Hospital	13.7%	12.9%	11.0%	13.8%	11.2%	11.3%	10.6%	43.9%	80.4%	65.7%	75.4%	69.5%	62.3%
Luton And Dunstable Hospital	46.5%	51.4%	48.3%	51.4%	47.4%	45.9%	43.3%	43.8%	45.7%	52.2%	46.9%	50.6%	44.1%
Norfolk & Norwich University Hospital	44.6%	44.8%	38.4%	56.0%	45.9%	46.4%	42.1%	57.3%	58.7%	66.5%	62.2%	63.7%	56.6%
Peterborough City Hospital	47.1%	44.3%	37.4%	33.6%	24.6%	27.1%	34.7%	34.4%	34.8%	33.3%	41.8%	40.5%	36.6%
Princess Alexandra Hospital	36.4%	29.7%	30.4%	26.1%	21.7%	23.4%	25.2%	34.3%	31.6%	30.8%	28.3%	31.1%	31.4%
Queen Elizabeth Hospital	36.3%	36.1%	24.9%	26.8%	28.1%	25.3%	23.2%	19.6%	21.7%	22.0%	18.0%	17.2%	16.1%
Southend University Hospital	44.1%	36.7%	31.0%	36.1%	30.5%	46.1%	43.9%	50.0%	57.8%	44.5%	41.5%	44.1%	38.8%
Watford General Hospital	21.1%	18.9%	14.6%	21.2%	16.4%	14.8%	17.4%	24.0%	20.5%	26.1%	31.6%	25.2%	19.5%
West Suffolk Hospital	28.0%	28.9%	29.4%	28.8%	31.7%	34.3%	28.9%	32.1%	35.1%	31.6%	34.5%	31.2%	26.5%

The latest EEAST data for the month of August 2017 shows that the NNUH was the most responsive hospital in terms of recording activity with 97% of ambulance journeys having a recorded handover time. The NNUH was also the most active in eastern England with 1000 recorded ambulance arrivals more than the second busiest (Addenbrookes).

The NNUH completed more successful <15 minute handovers in August than any other trust in the region and only 2 hospitals had a better % performance against this standard. However, due to the volume of patients attending the NNUH,

Acute	Total Num of transports into A&E only	% Compliance of handover times recorded in A&E	Arrival to Handover Hours lost in A&E	Arrival to Handover % within 15 minutes in A&E	Arrival to Handovers over 30 minute in A&E	Arrival to Handovers over 60 minute in A&E	Handover to Clear % within 15 minutes in A&E	Handover to Clears over 30 minute in A&E	Handover to Clears over 60 minute in A&E	Handover to Clear Hours lost in A&E	% of handovers 60 mins+ in A&E	% of clears 60 mins+ in A&E
Addenbrookes Hospital	2716	97.13%	137	44%	79	0	34%	102	2	246	0.0%	0.1%
Basildon & Thurrock Hospital	2287	86.01%	137	46%	144	11	35%	95	3	139	0.6%	0.2%
Bedford Hospital South Wing	1556	90.36%	39	72%	34	2	50%	85	3	89	0.1%	0.2%
Broomfield Hospital	2343	94.07%	223	43%	266	40	30%	312	12	255	1.8%	0.5%
Colchester General Hospital	2543	93.00%	527	17%	542	155	51%	86	4	117	6.6%	0.2%
Hinchingbrooke Hospital	999	96.20%	66	53%	71	4	34%	52	1	87	0.4%	0.1%
Ipswich Hospital	2242	94.51%	241	37%	218	70	28%	182	0	235	3.3%	0.0%
James Paget Hospital	1999	97.15%	83	51%	24	2	25%	60	3	195	0.1%	0.2%
Lister Hospital	2536	93.97%	138	62%	116	31	58%	97	11	116	1.3%	0.5%
Luton And Dunstable Hospital	2474	78.94%	173	44%	194	10	52%	183	6	153	0.5%	0.3%
Norfolk & Norwich University Hospital	3747	97.52%	414	57%	499	145	50%	65	0	205	4.0%	0.0%
Peterborough City Hospital	1935	86.67%	293	37%	375	74	33%	68	1	150	4.4%	0.1%
Princess Alexandra Hospital	1767	87.10%	258	31%	336	67	39%	158	12	144	4.4%	0.8%
Queen Elizabeth Hospital	1833	83.52%	371	16%	380	129	66%	34	0	61	8.4%	0.0%
Southend University Hospital	2552	88.56%	307	39%	368	76	47%	165	8	167	3.4%	0.4%
Watford General Hospital	2261	83.99%	554	20%	631	195	65%	78	2	81	10.3%	0.1%
West Suffolk Hospital	1795	90.47%	206	26%	218	35	48%	75	3	110	2.2%	0.2%
Grand Total	**37585**	**89.09%**	**4176**	**41.49%**	**4495**	**1046**	**44.16%**	**1897**	**71**	**2557**	**3.07%**	**0.21%**

Major Actions Implemented to improve ambulance handover and improve patient pathways - August 2017

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

Local plans to improve urgent and emergency care are embedded within a system wide recovery plan that is led by CCGs and has agreed contractual performance trajectories.

A summary of the most recent actions within the NNUH that will assist with ambulance handover is shown below:

1. Revised referral criteria have significantly increased activity in the Urgent Care Centre.

2. Expanded focus on Ambulatory Emergency Care has seen a reduction in emergency admissions of circa 10% in the last 12 months.

3. The arrival at A&E to inpatient admission conversion rate has reduced from 27% to 23%.

4. A revised GP streaming protocol was introduced in September 2017. Some estate modification is being planned to enhance this service within this financial year.

5. A clear focus on inpatients in hospital for greater than 14 days has resulted in earlier discharge and has reduced bed occupancy significantly. This has allowed opportunity for further development of ambulatory care pathways.

6. An enhanced leadership model has been introduced within A&E empowering a “floor co-ordinator” to lead the ED teams 24/7.

7. Internal professional standards have been introduced with clear expectations for each specialty in terms of supporting the A&E team.

8. A revised escalation policy has been developed to improve responsiveness to activity spikes and periods of pressure.

9. A “Red to Green” initiative has been introduced to ensure that aims to reduce internal and external delays as part of the SAFER patient flow bundle.

10. A Care Homes Selection service has been a success and will be expanded to 40 patients per month to include the CHC Discharge to Assess cohort from 11th September 2017.

11. Recruitment of 2 additional ED consultants is in progress. There is a further European recruitment initiative for ED consultants planned for 24th – 27th September 2017

12. Older Peoples Medicine have created an Older Peoples Assessment Service (OPAS) and Older Peoples Ambulatory Care (OPAC) to speed up and increase access to specialist geriatric intervention.

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 2017-18

Meeting dates	*Briefings/Main scrutiny topic/initial review of topics/follow-ups*	*Administrative business*
7 Dec 2017		
11 Jan 2018	*Children's autism services (central & west Norfolk) – assessment & diagnosis – an update from commissioners and providers*	*Date subject to NHOSC's confirmation*
22 Feb 2018	*Continuing healthcare – an update on progress since Feb 2017.*	*Provisional*
5 April 2018	*Children's speech and language services – progress update since 7 September 2017*	*Date subject to NHOSC's confirmation*

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

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

Clinical Commissioning Groups

North Norfolk	-	M Chenery of Horsbrugh (substitute Mr D Harrison)
South Norfolk	-	Dr N Legg (substitute Mr P Wilkinson)
Gt Yarmouth and Waveney	-	Mrs M Fairhead (substitute Mr A Grant)

West Norfolk	-	M Chenery of Horsbrugh (substitute Mrs S Young)
Norwich	-	Ms E Corlett (substitute Ms B Jones)

NHS Provider Trusts

Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust	-	Mrs S Young (substitute M Chenery of Horsbrugh)
Norfolk and Suffolk NHS Foundation Trust (mental health trust)	-	M Chenery of Horsbrugh (substitute Ms B Jones)
Norfolk and Norwich University Hospitals NHS Foundation Trust	-	Dr N Legg (substitute Mr D Harrison)
James Paget University Hospitals NHS Foundation Trust	-	Mrs L Hempsall (substitute Mrs M Fairhead)
Norfolk Community Health and Care NHS Trust	-	Mr D Harrison (substitute Mrs L Hempsall)

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Norfolk Health Overview and Scrutiny Committee 26 October 2017

Glossary of Terms and Abbreviations

A&E	Accident And Emergency
AEC	Ambulatory emergency care
AtoH	Arrival to handover (time between the arrival of ambulance at hospital to the handover of the patient to the hospital's care)
ARP	Ambulance response programme
ASD	Autistic Spectrum Disorders
CAMHS	Child And Adolescent Mental Health Services
CAN	Community Action Norfolk
(Lord) Carter Review	A review of operational efficiency in acute hospitals; report published February 2016 following two years of work with Trusts across England
CCG	Clinical Commissioning Group
CHC	Continuing healthcare
CT	Computerised tomography scan – uses x rays and a computer to make images of the inside of the body
EAHSN	Eastern Academic Health Science Network
ED	Emergency department
EEAST	East of England Ambulance Service NHS Trust
EHCP	Education health and care plan
EOC	Emergency operations centre
ENT	Ear, nose & throat
EPR	Electronic patient record
ERS	ERS Medical – provides a range of specialist patient transport and courier services to the NHS and wider healthcare sector
FAST	Face Arm Speech Time (to call 999) – test for diagnosis of stroke
GP	General Practitioner
HALO	Hospital Ambulance Liaison Officer
HASU	Hyper Acute Stroke Unit
ICT	Information And Communication Technology
JHSC	Joint Health Scrutiny Committee
JPUH	James Paget University Hospital
JSCC	Joint Strategic Commissioning Committee (of the 5 CCGs in Norfolk and Waveney)
JSCP	Joint Strategic Commissioning Partnership
KPI	Key performance indicator
LDR	Local Digital Roadmap
MCP	Multispeciality Community Provider
MOU	Memorandum of understanding
NCH&C	Norfolk Community Health and Care NHS Trust

NHOSC	Norfolk Health Overview and Scrutiny Committee
NNUH (N&N, NNUHFT)	Norfolk and Norwich University Hospitals NHS Foundation Trust
N&W STP	Norfolk and Waveney Sustainability & Transformation Plan
OPAC	Older people's ambulatory care
OPAS	Older people's assessment service
QEH	Queen Elizabeth Hospital, King's Lynn
RRV	Rapid response vehicle
SAFER patient flow bundle	A practical tool to reduce delays for patients in adult inpatient wards (excluding maternity):- S – Senior Review – all patients will have a senior review before midday by a clinician able to make management and discharge decisions A – All patients will have an expected discharge date and clinical criteria for discharge set by assuming ideal recovery and assuming no unnecessary waiting F – Flow of patients to commence at the earliest opportunity from assessment units to inpatient wards. Wards routinely receiving patients from assessment units will ensure the first patient arrives on the ward by 10am E – Early discharge – 33% of patients will be discharged from base inpatient wards before midday R – Review – a systematic multi-disciplinary team review of patients with extended lengths of stay (>7 days – also known as 'stranded patients') with a clear 'home first' mind set
SLT / SaLT	Speech and language therapy
SRO	Senior responsible officer
STP	Sustainability & transformation plan
UCC	Urgent Care Centre
UEA	University of East Anglia