Norfolk County Council

Norfolk Health Overview and Scrutiny Committee

Date: **Thursday, 24 May 2018**

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
Mrs J Brociek-Coulton	Ms L Grahame	Norwich City Council
Michael Chenery of Horsbrugh	Mr S Eyre/Ms C Bowes	Norfolk County Council
Ms E Corlett	Miss K Clipsham/Mr M Smith-Clare	Norfolk County Council
Mr F Eagle	Mr S Eyre/Ms C Bowes	Norfolk County Council
Mrs M Fairhead	Vacancy	Great Yarmouth Borough Council
Mrs S Fraser	Mr T Smith	Borough Council of King's Lynn and West Norfolk
Mr G Middleton	Mr S Eyre/Ms C Bowes	Norfolk County Council
Mr D Harrison	Mr T Adams	Norfolk County Council
Mrs L Hempsall	Mr J Emsell	Broadland District Council
Mrs B Jones	Miss K Clipsham/Mr M Smith-Clare	Norfolk County Council
Dr N Legg	Mr C Foulger	South Norfolk District Council
Mr R Price	Mr S Eyre/Ms C Bowes	Norfolk County Council
Mr P Wilkinson	Mr R Richmond	Breckland District Council
Mrs A Claussen-Reynolds	Mr M Knowles	North Norfolk District Council
Mrs S Young	Mr S Eyre/Ms C Bowes	Norfolk County 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 **Election of Chairman**
To elect a Chairman for the ensuing Council year.

2 **Election of Vice Chairman**
To elect a Vice-Chairman for the ensuing Council year.

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

4 **NHOSC minutes of 5 April 2018** **Page 7**

5 **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.

6 **Any items of business the Chairman decides should be considered as a matter of urgency**

7 **Chairman's Announcements**

8	**10.10-11.10**	**Access to NHS dentistry in West Norfolk**	**Page 15**
		Appendix A (Page 21) - report from NHS England Midlands and East	
		Appendix B (Page 27) - report from Healthwatch Norfolk	
		Appendix C (Page 69) - report from Norfolk Local Dental Committee	
	11.10-11.20	**Break at Chairman's discretion**	**Page**
9	**11.20-12.10**	**Ambulance response and turnaround times in Norfolk**	**Page 73**
		Appendix A (Page 81) - previous briefings to NHOSC members	
		Appendix B (Page 87) - report by East of England Ambulance Service NHS Trust	
		Appendix C (Page 105) - report by Norfolk and Norwich University Hospitals NHS Foundation Trust	
		Appendix D (Page 113) - report from regional Delays Workshop 23 March 2018	
10	**12.10-12.20**	**Norfolk Health Overview and Scrutiny Committee appointments**	**Page 115**
		Appointment of Members to:- (a) Great Yarmouth and Waveney Joint Health Scrutiny Committee (b) Link roles with local NHS clinical commissioning (c) Link roles with NHS provider trusts	
11	**12.20-12-30**	**Forward work programme** To agree the committee's forward work programme	**Page 119**
		Glossary of terms and abbreviations	

Chris Walton
Head of Democratic Services
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Date Agenda Published: 15 May 2018

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Norfolk County Council

NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE
MINUTES OF THE MEETING HELD AT COUNTY HALL, NORWICH
on 5 April 2018

Present:

Michael Chenery of Horsbrugh (Chairman)	Norfolk County Council
Mrs J Brociek-Coulton	Norwich City Council
Mrs A Claussen-Reynolds	North Norfolk District Council
Ms E Corlett	Norfolk County Council
Mr F Eagle	Norfolk County Council
Mrs S Fraser	King's Lynn and West Norfolk Borough Council
Mr D Harrison	Norfolk County Council
Mrs L Hempsall	Broadland District Council
Dr N Legg	South Norfolk District Council
Mr R Price	Norfolk County Council
Mr M Smith-Claire (substitute for Mrs B Jones)	Norfolk County Council
Mr P Wilkinson	Breckland District Council
Mrs S Young	Norfolk County Council

Also Present:

Julie Cave	Interim Chief Executive, Norfolk and Suffolk NHS Foundation Trust
Josie Spencer	Interim Chief Operating Officer and Deputy Chief Executive, Norfolk and Suffolk NHS Foundation Trust
Dr Kapil Bakshi	Deputy Medical Director, Norfolk and Suffolk NHS Foundation Trust
Helen Stratton	Deputy Chief Executive and Chief Finance Officer, South Norfolk CCG (lead CCG for mental health in Norfolk and Waveney)
Dr Tony Palframan	South Norfolk Clinical Commissioning Group and Chair of Norfolk and Waveney Mental Health Network
Brenda Jones	A Member of the Committee whom was substituted for this meeting
Sheila Preston	Member of the public
Maureen Orr	Democratic Support and Scrutiny Team Manager
Chris Walton	Head of Democratic Services
Tim Shaw	Committee Officer

1A Apologies for Absence

1A.1 Apologies for absence were received from Mrs M Fairhead, Great Yarmouth Borough Council, Mrs B Jones, Norfolk County Council (who was present in the meeting after having been substituted) and Mr G Middleton, Norfolk County Council.

1B North Norfolk District Council Representation

1B.1 The Committee was informed that North Norfolk District Council had recently appointed Mrs A Claussen –Reynolds as their main member and Mr M Knowles as their substitute member.

1B.2 The Chairman welcomed Mrs Claussen-Reynolds back to the Committee.

2. Minutes

2.1 The minutes of the previous meeting held on 22 February 2018 were confirmed by the Committee and signed by the Chairman.

3. Declarations of Interest

3.1 Mrs J Brociek-Coulton declared a personal interest as a member of UNISON and a member of the Labour Party which was affiliated to the Campaign to Save Mental Health Services in Norfolk and Suffolk.

Ms E Corlett declared a personal interest as a member of UNISON and a member of the Labour Party which was affiliated to the Campaign to Save Mental Health Services in Norfolk and Suffolk.

Mr M Smith-Claire declared a personal interest as a member of the Labour Party which was affiliated to the Campaign to Save Mental Health Services in Norfolk and Suffolk.

4. Urgent Business

4.1 There were no items of urgent business.

5. Chairman's Announcements

5.1 There were no Chairman announcements.

6 Norfolk and Suffolk NHS Foundation Trust – mental health services in Norfolk

6.1 The Committee received a suggested approach by Maureen Orr, Democratic Support and Scrutiny Team Manager, to the Clinical Commissioning Groups' and Norfolk and Suffolk NHS Foundation Trust's responses to recommendations on mental health services in Norfolk made by NHOSC in December 2017 and an update on progress with the Improvement Plan to address issues identified by the Care Quality Commission in July 2017.

6.2 The Committee received evidence from Julie Cave, Interim Chief Executive, Norfolk and Suffolk NHS Foundation Trust, Josie Spencer, Interim Chief Operating Officer and Deputy Chief Executive, Norfolk and Suffolk NHS Foundation Trust, Dr Kapil Bakshi, Deputy Medical Director, Norfolk and Suffolk NHS Foundation Trust, Helen Stratton, Deputy Chief Executive and Chief Finance Officer, South Norfolk CCG (lead CCG for mental health in Norfolk and Waveney) and Dr Tony Palframan**,** South Norfolk Clinical Commissioning Group and Chair of Norfolk and Waveney Mental Health Network. The Committee also heard from Mrs Sheila Preston, speaking as a member of the public.

6.3 The following key points were noted:

- The speakers explained the action taken by the NSFT to address the list of 'must dos' and 'should dos' contained in the CQC inspection report.
- NSFT had written to the CQC explaining the action taken and was expecting a written response.
- A full re-inspection of NSFT's services was expected in autumn 2018.
- The Care Quality Commission (CQC) and NHS Improvement (NHS I) were monitoring the NSFT's progress.
- The speakers said that the Trust had established a Recruitment and Retention Group to focus attention on staffing shortages throughout the NSFT, one of the most significant issues of concern.
- There were many ongoing initiatives around filling vacancies, skill mixing and general recruitment and retention. However, Norfolk remained a difficult area in which to recruit and retain clinical staff and there were overall shortages of qualified staff with specialist skills.
- In recent months, inadequate staffing levels and the need for environmental improvements had resulted in the closure of 36 inpatient beds at various locations across the NSFT area, 28 of which were temporary. There were a number of reasons for the closures, including the need to increase staffing levels and to invest significant amounts of money on improving the environment and safety for patients, such as by providing single sex accommodation and removing ligature risks.
- Mrs Sheila Preston, speaking as a member of the public, asked the speakers what steps the NSFT would take to keep people safe and boost care whilst the 36 beds were temporarily closed.
- In reply, the speakers said that the NSFT remained committed to finding in-patient beds for all who needed them. The review of all seclusion facilities across the Trust was complete and all environments were physically compliant and safe. The NSFT planned to create additional seclusion facilities in Great Yarmouth and Waveney and in West Norfolk by late spring 2018.
- The majority of bed closures were in Suffolk and included the temporary closure of a psychiatric intensive care unit (PICU) based at Ipswich Hospital.
- In the Great Yarmouth and Waveney locality, St Catherine's Way ward at Gorleston (a short-term, rehabilitation service for patients preparing for discharge) had temporarily closed because of concerns about staffing levels and the building not being fit for purpose as an inpatient unit. Following the closure of the ward in autumn 2017, day facilities were provided from this location as part of a pilot project. A long-term decision on the future of the use of the site, and whether it should continue to be used as a community base, would be taken in the next six months.
- Good progress had been made in upgrading facilities in community areas throughout the NSFT. This work would be completed by late spring 2018.

- Since the publication of the agenda papers, the Department of Health had agreed to provide funding for a Community Wellbeing Hub in Norwich to serve people with mental health needs.
- The establishment of the hub (which was previously referred to as a Crisis Café or a Crisis Hub and had been reported to Members by email on 3 April 2018) was part of the action to enable NSFT to manage within existing bed numbers, following a bed review at the Trust in early 2017.
- Members hoped that plans for similar hub arrangements could be put in place in the west and in the east of the county (with public transport made available to the hubs).
- Members were informed that the NSFT bid to the Department of Health for emergency capital funding of £5.2m for safety improvements was not accepted in 2017/18. The speakers said that the NSFT was working to progress a resubmission as early as possible in 2018/19. This was now one of the main subjects of discussion that the NSFT was having about mental health service funding for the financial year 2018/19 with South Norfolk CCG (the lead commissioners for mental health services in Norfolk).
- The funding discussions between the NSFT and South Norfolk CCG had centered on the cost differentials between in-Trust placements and out-of-Trust placements which had implications for the number of sustainable beds that the NSFT could provide.
- The speakers updated the Committee on the number of placements of patients in out-of-Trust care. They said that there were currently 11 out-of-Trust care placements in the Norfolk and Suffolk area, 22 out-of-area placements for non-clinical reasons and an additional 26 specialist placements. The monthly out of-Trust placement figures for the past six months were set out in Appendix C to the report.
- The Committee suggested that the local NHS should reimburse travel costs to families of service users who were placed in out-of-area beds due to the unavailability of local beds (i.e. to the families of those placed out-of-area for non-clinical reasons).
- The speakers said that the STP mental health work stream allowed for the provision of rehabilitation beds as an alternative to hospital admission.
- Rehabilitation beds were provided in the Norwich area by Evolve, which was an accredited supplier of supported lodgings with Norfolk County Council. The service provided short say accommodation and support for NSFT adult patients who were deemed ‘medically fit’ for discharge from the Trust’s inpatient units or out of area placements. The service provided for adults who had temporary problems with accommodation. Access to the service was managed by NSFT and NCC staff operating from Hellesdon Hospital.
- The speakers agreed to let Members know the length of time adults could stay in the rehabilitation beds provided by Evolve in the Norwich area.
- It was noted that Members of the Committee had recently visited mental health services at Hellesdon Hospital and Julian Hospital, Norwich and at the Fermoy Unit, King’s Lynn to learn more about the range of services that the NSFT provided.
- The Committee was informed that the 16 bed inpatient service at Chatterton House, Kings Lynn was scheduled for completion during the first quarter of 2019 and that the NSFT had made significant improvements in community facilities for families to make use of the Fermoy Centre prior to its closure. Following the closure of the Fermoy Centre the building would be available for other NHS purposes.
- The speakers said that a new Patient Journey Tool (mentioned in the report) supported clinicians and their managers in monitoring caseloads and in

improving compliance on a number of measures, including risk assessments. The NSFT was working towards an optimum caseload of 35 cases.

- The speakers said that a second round of staff training sessions on the use of the Lorenzo electronic records system had begun. The use of the system remained a key risk in the NSFT risk register and was carefully monitored. The existing contract for the use of the system was due for renewal in the next 3 years by which time changes were expected to be made to meet the particular requirements of mental health trusts such as the NSFT.
- The Committee was informed about moves to develop collaborative partnerships with GPs on issues of mental health. It was pointed out that GP practices were working with South Norfolk CCG (the lead CCG for mental health in Norfolk and Waveney) to identify how nurses, pharmacists and other allied professionals working in GP surgeries could better signpost patients to the Wellbeing Service.
- The Chairman asked the speakers if they considered the NSFT to be too large an organisation. In reply, the speakers acknowledged that the NSFT covered a large geographical area and that the size of the Trust was an issue that was being considered.
- The speakers said that service user and carer forums were in place and were open to everyone who wished to participate. The Trust was taking stock of what public participation had worked best in the recent round of public consultation and how to address any shortcomings to make the next sessions as co-produced as possible and allow for the greatest possible public involvement.

6.4 The Committee agreed to ask the NSFT to provide information on:-

- **The cost differential between in-Trust placement and out-of-Trust placement.**
- **How long service users were able to stay in Evolve's rehabilitation beds in Norwich.**

6.5 The Committee agreed to write a letter in support of the resubmission of a bid by the NSFT to the Department of Health for emergency capital funding of £5.2m in 2018-19, with copies sent to the Norfolk MPs, the bid having been unsuccessful in 2017/18.

6.6 The Committee recommended to the CCGs and NSFT that the local NHS should reimburse travel costs for families of service users who were placed in out-of-area beds due to unavailability of local beds (i.e. placed out-of-area for non-clinical reasons).

6.7 The Committee agreed to receive the CQCs feedback on NSFT's progress with 'must do' actions in the NHOSC Briefing and to decide when to schedule 'NSFT – mental health services in Norfolk' in NHOSC's forward work programme after the feedback was received.

7 The Health and Wellbeing Board and Health Overview and Scrutiny

7.1 The Committee received a briefing report by Maureen Orr, Democratic Support and Scrutiny Team Manager, about the complementary roles of the Health and Wellbeing Board and Health Overview and Scrutiny.

7.2 No suggestions were made for changes in the relationship between the Health and Wellbeing Board and the Health Overview and Scrutiny Committee.

7.3 The Committee agreed to note the briefing document that could be found at Appendix A to the report.

8 Norfolk Health Overview and Scrutiny Committee appointments

8.1 The Committee received a report from Maureen Orr, Democratic Support and Scrutiny Team Manager, that sought appointments of link members with local Trusts and commissioning bodies.

8.2 The Committee agreed to make the following appointments:-

1. **Norfolk and Waveney Joint Strategic Commissioning Committee link member:-**
    a. **For meetings held in the west of the county – Michael Chenery of Horsbrugh.**
    b. **For meetings held in the east of the county – Dr Nigel Legg.**

2. **James Paget University Hospitals NHS Trust:-**
    a. **Link member – Marlene Fairhead.**
    b. **Substitute link member – Mike Smith-Clare.**

The Committee also agreed to defer the appointment of a substitute link member with Great Yarmouth and Waveney CCG until after May 2018.

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 Committee agreed the forward work programme subject to the following:-

1. **District Direct pilot.**
   The May 2018 NHOSC Briefing should include an update on the funding situation as well as an evaluation of the pilot.

2. **Children's speech and language services.**
   A process was required for taking the names and contact details of those who were turned away from over-subscribed drop-in sessions. This process would be suggested to the service providers and commissioners before the Committee meeting on 12 July 2018.

3. **Implementation of the suicide prevention action plan.**
   On the understanding that both the Communities Committee and the Health and Wellbeing Board had suicide prevention on their agenda (and due to NHOSC's wider scrutiny of the NSFT) it was agreed that NHOSC would raise specific issues with the Communities Committee and Health and Wellbeing Board rather than schedule this subject in the NHOSC forward work programme.
   Members were asked to raise any issues that arose from information contained in the April NHOSC Briefing with Maureen Orr.

4. **Older People's Emergency Department (OPED), Norfolk and Norwich hospital.**

It was agreed to take up the hospital's invitation for Members to re-visit the OPED when renovation work was complete.

Chairman

The meeting concluded at 1 pm

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Access to NHS Dentistry in West Norfolk

Suggested approach from Maureen Orr, Scrutiny Support Manager

An examination of access to NHS dentistry in the West Norfolk area, including for the families of service personnel.

1. Background

1.1 Norfolk Health Overview and Scrutiny Committee (NHOSC) added 'Access to NHS Dentistry in West Norfolk' to its forward work programme in October 2017. This followed Communities Committee's consideration of the 'Norfolk Armed Forces Community Covenant Strategy and Action Plan' on 6 September 2017. Communities Committee noted that there was an issue regarding access to NHS dental services for the families of service personnel in West Norfolk which required scrutiny.

NHOSC agreed to look not only at the service families issue but also at access for the wider public in West Norfolk as councillors were aware of instances where residents had difficulty finding an NHS dentist in the area.

1.2 NHS dental services in Norfolk are commissioned regionally by NHS England Midlands and East (East) (M&E(E)). The local dental practices are independent businesses working under contract for the NHS. The contract is determined at national level.

1.3 NHOSC last received a report on access to NHS dentistry (across the whole county) in July 2014. At that stage there did not appear to be any major problems regarding access to routine dental care, although the LDC mentioned there were some issues with availability of restorative dentistry at hospital, availability of general anaesthetic services at hospital for patients with special needs, availability of periodontal / endodontic specialists and variable provision of domiciliary dental care.

1.4 Norfolk Local Dental Committee (LDC) confirmed in July 2014 that communication between local dentists and the NHS England M&E(E) commissioners was generally good and problems could be addressed and dealt with where possible.

1.5 Members of NHOSC also received the updated Oral Health Needs

Assessment for East Anglia (OHNA) by email in October 2014, with a summary in the NHOSC Briefing in November 2014. With regard to access, key messages in the OHNA were:-

- Dental service provision in East Anglia bears little relation to oral health need. There are discrepancies between the availability of services and need, and patients do not always get the right care when they access dental services.
- People in marginalised or deprived groups in East Anglia are more likely to have poor oral health and less likely to access services.
- Compared to the national average the number of children in East Anglia who receive preventative treatments was low.

More specifically for Norfolk:-

- There was good provision of NHS dentistry in some areas with material and social deprivation (e.g. Great Yarmouth) but provision was low in others (e.g. King's Lynn and Thetford).
- King's Lynn was amongst the areas with the lowest percentage of child population visiting an NHS dentist (less than 60%).
- Less than 50% of the adult population in King's Lynn had visited an NHS dentist in the previous 2 years. (The OHNA contained no information on the numbers of people using private dentistry).
- The percentage of dental treatment courses with domiciliary visits was lower than the English average in all areas except for Broadland, Great Yarmouth and South Norfolk. (The OHNA contained no information about whether the patients with most need for domiciliary service were able to access it).

A link to the 2014 OHNA is included in NHS England M&E(E)'s report at Appendix A.

Further information about dental health in children and young people in West Norfolk (and the rest of the county) is available in the following link to the Norfolk Joint Strategic Needs Assessment Briefing Document:-
http://www.norfolkinsight.org.uk/resource/view?resourceId=1584

1.5 Healthwatch Norfolk selected 'Dental services in West Norfolk' as one of its priority areas for in-depth research in 2017-18. It has been gathering feedback about dental services for children and young people in West Norfolk to identify where improvements could be made. The actions / recommendations from its report are:-

Regarding access for families of service personnel at RAF Marham

- Using the Armed Forces Covenant, local dentists will be asked to offer places for families of current serving personnel to ensure they are not disadvantaged, as a first step to improving access

for families. To achieve this, we recommend that an event is to be held where dentists can attend the Base and offer places where families can “sign up”.

- To assist with the issue of transport Healthwatch Norfolk has identified a contact at West Norfolk Community Transport and will meet them to discuss next steps and introduce them to RAF Marham’s Community Development Officer in order to discuss potential solutions / routes.

- NHS England to consider patient registration to enable patient records (both military and civilian population) to follow the patient if they were to be moved or be stationed in a new area.

Regarding access for the wider population

- NHS England to consider looking at the current service provision in Norfolk and an updated Oral Health Needs Assessment should be carried out.

- Healthwatch to share individual service provider feedback with the local dental practices (where it has obtained specific feedback) along with the report, for information / comment.

- Service feedback will be added to Healthwatch’s internal evidence database and published on its public-facing website (where it has consent to do so), which will enable the public to make informed decisions about their and their children’s dental care.

- The findings of Healthwatch Norfolk’s ‘mystery shopping’ exercise will be shared with NHS England Midlands and East as they manage service listings on NHS Choices. When contacting dental practices directly with the feedback received, Healthwatch Norfolk will also share findings specific to their service with the recommendation to update and keep this page updated, given that it is the public-facing resource for finding NHS services in the local area.

The Healthwatch report will be shared with the local Professional Dental Network, Care Quality Commission, Public Health (Norfolk County Council), NHS England and any other relevant stakeholders.

1.6 NHS England M&E(E), Healthwatch Norfolk and representatives from RAF Marham and the Norfolk County Council Armed Forces Covenant Team have met to understand and look for solutions to the access issues that exist for the families of service personnel at RAF Marham.

2.0 Purpose of today's meeting

2.1 The focus for today's meeting is on access to NHS commissioned dental services in West Norfolk. Preventative services, including the Norfolk Health Child Programme and oral health promotion services in Children's Centres and schools, are commissioned by Norfolk County Council Public Health and are within the remit of the Community Services Committee.

2.2 NHS England M&E(E) has been asked to supply the following information for the West Norfolk area:-

- The number and location of dental practices offering NHS dentistry
- The number of dentists providing NHS dentistry
- The population per dentist
- The number and location of practices currently able to take on new patients
- The trend in child and adult access rates
- The trend in child and adult dental health
- Orthodontic treatment waiting times

NHS England M&E(E)'s report is attached at **Appendix A** and a representative will attend the meeting to answer Members' questions.

2.2 Healthwatch Norfolk and RAF Marham will present jointly to NHOSC including the following information:-

- Healthwatch Norfolk's report on the findings of its research into access for children and young people in West Norfolk and its recommendations for action
- Progress towards improved access to dental services for the families of service personnel at RAF Marham.

Healthwatch Norfolk's report is attached at **Appendix B** and representatives from Healthwatch Norfolk and RAF Marham will attend the meeting to answer Members' questions.

2.3 Norfolk Local Dental Committee was asked to provide its comments about provision of dental services in West Norfolk. Its report is attached at **Appendix C** and a representative will attend the meeting to address any questions that may arise.

3.0 Suggested approach

3.1 After hearing from the representatives of NHS England M&E(E), Healthwatch Norfolk and RAF Marham and Norfolk Local Dental Committee NHOSC may wish to explore the following areas:-

(a) Does NHS England M&E(E) consider that sufficient dental

services have been commissioned to cover the west Norfolk area?

(b) West Norfolk has fewer NHS dentists per head of population than the average for Norfolk and the Midlands and East area and on 4 May 2018 only one practice in the area was taking on new NHS patients. Given that dental practices are independent businesses and the General Dental Services contract is agreed at national level, how can NHS England M&E(E) support local practices to expand services, particularly in geographic areas of highest need?

(c) Given the increasing difficulty in recruiting dentists, which is referred to in the Local Dental Committee's report (Appendix C), can NHS England M&E(E) do anything to speed up the time taken for an NHS performer number to be provided to dentists coming into the UK for the first time, or take any other measures to improve workforce supply?

(d) Does NHS England M&E(E) have any data, or any way of collecting data, about the proportion of residents who use private dentistry in West Norfolk and the proportion who do not use dental services at all?

(e) NHS England M&E(E)'s report says that orthodontic services within West Norfolk are 'limited'. Is an orthodontic service generally considered a specialist service for which people are expected to travel or should a full service be available within the district?

(f) Healthwatch Norfolk's report mentions that using the Armed Forces Covenant local dentists will be asked to offer places for families of current serving personnel and there is a recommendation for an event to be held at the RAF Marham base to facilitate this. When is this expected to take place?

(g) How does NHS England M&E(E) work with local planning authorities and others (such as the Ministry of Defence) to plan for future need for dental services in West Norfolk?

4.0 Action

4.1 NHOSC may wish to:-

(a) Make comments to the commissioners based on the information received at today's meeting.

(b) Support the recommendations that Healthwatch Norfolk made to the NHS commissioners:-

- NHS England to consider patient registration to enable patient records (both military and civilian population) to follow the patient if they were to be moved or be stationed in a new area.

- NHS England to consider looking at the current service provision in Norfolk and an updated Oral Health Needs Assessment should be carried out.

Or make additional recommendations.

(c) Ask for an update in the NHOSC Briefing or for a future meeting regarding progress with provision for families of service personnel at RAF Marham.

(d) Ask for further information for the NHOSC Briefing or to examine other aspects of dental services at a future committee meeting.

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NHS England Report for General Dental Services (West Norfolk)

Norfolk County Council Health and Scrutiny Committee

May 2018

Current NHS Dental Services provision in West Norfolk

In hours dental care is commissioned across the West Norfolk Clinical Commissioning Group (CCG) area. This includes both routine and urgent dental care delivered by general dental practices and urgent care by the dental access centre.

There are 13 contracts providing dental care in West Norfolk through General Dental Service (GDS) contracts including one dental prototype.

The contracts deliver general dental services, including routine care and urgent care. Two contracts have small orthodontic elements (teeth straightening). Each contract is commissioned to deliver Units of Dental Activity (UDAs) for general dental services and Units of Orthodontic Activity (UOAs) for orthodontic services.

The total spend for primary care dental services in West Norfolk in 20117/18 was £6,149,573.8 for 209,718 UDAs and 838 UOAs.

Contract delivery has been mixed over the last two years. Where a contract fails to deliver the commissioned units of activity, NHS England can agree with the contractor to reduce the contracted activity. NHS England will then determine if additional activity will need to be commissioned and propose the most effective and efficient way to accomplish this.

Practices taking on patients

Dental practices are able to open and close their lists to new patients and do not require consent from NHS England to do this.

On 4 May 2018 there was one practice taking on patients in West Norfolk:

Grange Dental Surgery, Lynn Road, Snettisham, Kings Lynn PE31 7QB

List of dental practices and performance data in the West Norfolk area are in appendix 1.

Population per dentist

The Oral Health Needs Assessment for East Anglia reports the number of dentists per 100,000 of population.

Table 1. The number of dentists with NHS activity Cambridgeshire, Norfolk, Peterborough, Suffolk and Great Yarmouth and Waveney March 2007 and March 2012

	March 2007			March 2012		
	Total number of dentists	Population per dentist	Dentists per 100,000 of population	Total number of dentists	Population per dentist	Dentists per 100,000 of population
England	20,160	2,518	40	22,920	2,279	44
Norfolk	301	2,444	41	350	2,186	46
Peterborough	90	1,861	54	88	1,971	51
Suffolk	249	2,335	41	315	1,911	52
Great Yarmouth and Waveney	92	2,305	43	129	1,664	60

Source: NHS Dental Statistics for England: 20011-12. Annex 2: PCT & SHA Factsheet, Activity Statistics.

Recent data from NHS Digital Statistics for England 2016/17 provides data of dentist per 100,000 of population by CCG area.

The total number of dentists for West Norfolk CCG 61, population per dentist 2855 and 35 dentists per 100,000 of population. There are 1,930 dentists in Midlands and East – East, 2,223 patients per dentist and 45 dentists per 100,000 of population.

Trend in child and adult dental access rates

NHS Dental Statistics: 2017-18, Second Quarterly Report shows that access rates in West Norfolk are much lower than Norfolk, East and England

Table 2: Patients seen in the previous 24 months and child patients seen in the previous 12 months as a percentage of the population, by patient type and CCG

	Children (0-17)			Adults (18+)			Total		
	30 Jun 2017	30 Sep 2017	31 Dec 2017	30 Jun 2017	30 Sep 2017	31 Dec 2017	30 Jun 2017	30 Sep 2017	31 Dec 2017
NHS West Norfolk CCG	38.7	39.3	39.3	40.1	39.9	39.6	39.8	39.8	39.6
Norfolk	55.2	55.8	56.2	56.2	56.1	56.1	56.0	56.1	56.1
East	55.5	56.1	56.3	52.0	52.0	52.0	52.7	52.8	52.9
England	57.7	58.0	58.2	51.0	50.0	50.9	52.4	52.4	52.4

Source: NHS Dental Statistics: 2017-18, Second Quarterly Report

Dental access rates for both adults and children in West Norfolk is less than Norfolk, East and England.

Reasons for not accessing NHS dental services are multifactorial and can include patients reporting that they had no need to go to the dentist/nothing wrong with my teeth, not being able to find an NHS dentist, afraid of going to the dentist, not being able to afford NHS charges, forgetting or haven't got round to it, had a bad experience with a dentist, don't see the point in going to the dentist, or haven't got time to go

NHS England will continue to work with NHS dental providers and stakeholders in West Norfolk.

Trend in child and adult dental health

Information about oral health of adults and children in East Anglia can be found in the Oral Health Needs Assessment for East Anglia 13 October 2014.

Oral Health Needs Assessment Appendix 2

Review of PDS orthodontic services across East (including West Norfolk)

Limited orthodontic provision is available in Primary Care in West Norfolk, with patients requiring orthodontic treatment accessing care in Cambridgeshire & Peterborough, North Norfolk, and the Norwich area.

NHS England undertook an orthodontic audit in 2016. The majority of practices providing orthodontic care reported manageable waiting lists (72% of practices in West Norfolk, North Norfolk, Norwich and Cambridgeshire and Peterborough reported that 100% of patients received orthodontic treatment within 18 weeks of assessment).

NHS England is currently reviewing orthodontic provision to understand and determine the future commissioning need of the population across East.

Debbie Walters, Contract Manager, Primary Care Dental May 2018

Appendix 1. List of dental practices and performance data in the West Norfolk area

Contractor(s)	Surgery Name	Address		Total Contracted UDA 17/18	Contracted UOA April 2017 to March 2018	15-16 % (UDA)	15-16 Performance (UDA)	16-17 % (UDA)	16-17 Performance (UDA)	% contracted and carry forward UDA achieved up to March 18	undelivered UDAs (up to 100%)
Whitecross Dental Care Limited	Oradental	115-117 High Street	Kings Lynn	41356.00		95.65	Under	57.69	Under	58%	17470.8
Whitecross Dental Care Limited	Coastal Dental Practice	Common Road	Snettisham	15000.00		93.45	Under	73.42	Under	69%	4597.2
IDH Limited	Purfleet Dental Practice	10 - 11 Purfleet Street	Kings Lynn	34178.00		85.40	Under	71.15	Under	63%	12581.4
Dr P Vaid, Dr S Radia and Dr S Shah	Clarence House Dental Practice	39 High Street	Downham Market	38332.00		95.35	Under	96.12	On Target	86%	5498.4
Mr M Eyrumlu and Mr A Eyrumlu	Gayton Road Dental Practice	Gayton Road	Norfolk	22000.00		92.29	Under	101.09	On Target	92%	1701.4
Hunstanton Dental Practice	Hunstanton Dental Practice	38 Northgate	Hunstanton	10400.00		99.85	On Target	100.20	On Target	99%	73.2
Mazdak Eyrumlu and Azad Eyrumlu	Direct Dental Services	107 Wootton Road	Kings Lynn	16000.00		96.10	On Target	97.96	On Target	58%	6658.8
MR IS SMITH	Grange Dental Surgery	Lynn Road	Snettisham	11455.00		81.25	Under	99.12	On Target	79%	2451
Riverside Dental Surgery	Riverside Dental Surgery	7B King Street	Kings Lynn	2583.00	129.00	95.54	Under	99.67	On Target	90%	256.4
MR N LAWRENCE	Lynn Road Dental Practice	51 53A Lynn Road	Kings Lynn	16273.00		98.11	On Target	96.98	On Target	86%	2224.4
MRS AM RAE	Hall Farm Dental Surgery	Roydon Hall	Roydon	612.00	709.00	91.86	Under	100.98	On Target	87%	81.2
MR WK DRYDEN	Castle Rising Dental Surgery	Castle Farm Barn	Castle Rising	1529.00		91.04	Under	79.03	Under	94%	87.4
MR JC HOLMES	John Holmes Dental Surgery	3 The Pightle	Swaffham	NA							

Appendix 2.

Oral Health Needs Assessment for East Anglia 13 October 2014

Dental services for children and young people in West Norfolk

Fennie Gibbs, Information Analyst

Please contact Healthwatch Norfolk if you require an **easy read**; **large print** or a **translated** copy of this report.

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April, 2018

Contents

Your voice can make a difference...

healthwatch Norfolk

Healthwatch Norfolk works with health and social care services in Norfolk to make sure that your views and experiences make a difference to the services we all use.

Call us on 0808 168 9669

Website: www.healthwatchnorfolk.co.uk Email: enquiries@healthwatchnorfolk.co.uk

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Who we are and what we do

Healthwatch Norfolk is the local consumer champion for health and social care in the county. Formed in April 2013, as a result of the Health and Social Care Act, we are an independent organisation with statutory powers. The people who make decisions about health and social care in Norfolk have to listen to you through us.

We have five main objectives:

1. Gather your views and experiences (good and bad)
2. Pay particular attention to underrepresented groups
3. Show how we contribute to making services better
4. Contribute to better signposting of services
5. Work with national organisations to help create better services

We are here to help you influence the way that health and social care services are planned and delivered in Norfolk.

Acknowledgements

We are extremely grateful to all the members of the public in West Norfolk who took the time to share their experiences of dental care for their children. We would also like to acknowledge all of the people and organisations who worked on our behalf to promote our project, disseminate surveys, and encourage parents/guardians to have their say, namely the local schools, nurseries, children's centres and libraries who all played a huge part in the success of this project.

Special thanks go to Rosie Sherrell who worked at Healthwatch Norfolk as an intern when the project was being scoped and contributed significantly at this point, and then again as the project was finishing and she worked very hard to carry out the "mystery shopping" exercise to highlight the availability of services in the West Norfolk area.

Summary

NHS dental services for children and young people in West Norfolk became one of Healthwatch Norfolk's three priority projects for 2017-18, following local anecdotal intelligence and other external sources of data which highlighted concerns around experiences of and access to local NHS dental services.

When scoping this project, RAF Marham and the Norfolk Armed Forces Covenant Board contacted us about similar issues that the military families were facing around difficulties with accessing local NHS dental services, especially given the rural nature of the area.

We carried out a survey to understand the experiences of, and access to, NHS dental services in West Norfolk by surveying parents/guardians about their children's dental care. We also conducted a "mystery shopping" exercise to enable us to understand the availability of services in the West Norfolk area and the accuracy of information presented online, compared to the information presented over the phone.

Altogether, 314 responses to the survey from parents/guardians were received and analysed, which equated to 606 children and young people. 66% take their children to the dentist every six months (209) and a further 14% take them every year. Interestingly, 15% said their children had never visited the dentist for the following reasons: availability of NHS services, age of children, quality of services and cancellations of appointments.

Over a quarter (26%) of our respondents have to travel over 10 miles to get to their children's dental practice and unsurprisingly, the majority of the respondents have to drive to get there.

Sixty-nine percent (69%) of parents/guardians felt that it was *easy* or *very easy* to book an appointment for their children. Interestingly, although this rating was predominantly positive, appointments featured heavily in the open questions as a barrier to dental care for their children.

The majority of respondents (84%) rated their overall experience of their children's dentist as *good* or *very good*, compared to just 6% who rated the service as one or two stars (*very poor* or *poor*). Issues in lower rated reviews related to appointments and quality of service. Appointments remained an issue in some of the higher rated reviews, but areas of good practice featured also. Positives of overall experience included quality of service, involvement of the children and the environment/facilities.

Respondents were asked two questions about the barriers to NHS dental care for children and young people in West Norfolk and these were open questions so they could share anything that was important to them. Issues surrounding accessing NHS dental care for their children related to appointments, availability of NHS services, location/transport and information/advice. These categories often interlinked and particular issues for those on the RAF Marham Base and other remote villages were highlighted given that not everyone can drive and the public transport is limited.

Unsurprisingly, the most common suggestion for overcoming barriers was around commissioning, predominantly more services in the local area as noted by 24

respondents, with a further 47 simply stating that more practices, spaces or dentists were needed in general.

More availability of appointments in general and more out of school or work hours appointments were highlighted specifically as a way of overcoming barriers. Finally, improvements to information and advice was also welcomed.

The “mystery shopping” exercise we conducted echoed parents/guardians experiences of inconsistent information provided online compared to when they contacted the dental practices directly. Only three of the 13 NHS dental practices that we identified in the scoping stages, provided information on the telephone that matched NHS Choices and/or their own website.

Furthermore, clear issues with availability of services in West Norfolk were noted. Only four out of 13 dental practices were accepting children at the time of the exercise. One of these four would only accept children as NHS patients if their parent/guardian was at the practice as a private patient.

Long waits for appointments – another issue identified by parents/guardians in the survey – were apparent also. Of the four dental practices accepting children, the earliest available appointment was in June/July 2018, with the longest wait being until August 2018.

To conclude findings showed a positive overall experience in general, especially praise for staff members. Having said that, there are clear barriers to accessing NHS dental care for children and young people in West Norfolk, stemming from key areas such as, the availability of NHS dental services, in particular services in the local area to where the parents/guardians live, which went hand-in-hand with transport problems for some; the availability of appointments, and more specifically fitting the appointments around school or work hours; cancellations and long waits for appointments and finally, information/advice around taking their children to the dentist and availability of services.

Particular issues noted by the families in RAF Marham in the survey conducted by the Norfolk Armed Forces Covenant Board last year, seemed to be replicated by the families in this survey, but more importantly, there seems to be a wider issue of access in the civilian population of West Norfolk as well as the military families.

1. Why we looked at this

1.1 Background to the project

The topic of NHS dental services in West Norfolk was first highlighted through several Board Intelligence Reports which picked up on local anecdotal intelligence as shared by members of the public, but also through national data sets where data for Norfolk could be extracted. Notably, the GP Patient Survey which reports on a section about NHS dentistry, continually showed findings that experiences of NHS dental services in West Norfolk were much lower than the other four Clinical Commissioning Group areas in the county (Ipsos Mori, 2017). Whilst data showed this was the case, it did not reveal the reasons behind the low overall experience.

Following this, West Norfolk dentistry became one of Healthwatch Norfolk three priority projects for 2017-18. Subsequently, a scoping exercise was carried out from July to October to determine the focus of the project and based on the evidence we found, we decided to focus the project around access to and experiences of NHS dental services in West Norfolk, for children and young people (anyone under the age of 18 years old).

1.2 Children's oral health

Children and young people aged 17 years and under are able to access free dental care and therefore have the right to good quality NHS services. They also often rely on their parents or guardians in order to attend a dental practice, given that younger children do not have access to transport, for example. Therefore, aside from the service being available for the children (in an accessible location), parental attitudes towards oral health and dental services, such as poor childhood experiences leading to anxiety in later life, may impact on the children obtaining access to services, possibly impacting on their children's oral health.

Furthermore, poor oral health can impact on many factors in a child's life from eating, sleeping and playing to speaking, socialising and is a leading cause of young people's admissions to hospital (Norfolk County Council, 2016). Additionally, poor oral health can impact on health problems in later life, with evidence showing associations between oral diseases and other major chronic diseases such as diabetes, cardiovascular diseases, cancers and respiratory diseases (Public Health England, 2014, cited in Norfolk County Council, 2016).

Tooth decay is one of the most common oral diseases which affects many individuals and is strongly associated with the consumption of fizzy drinks and sugary food items (Crosse, 2014). Although this may be a chronic disease, through patient or parental action, it is largely preventable (Norfolk County Council, 2016).

Whilst prevalence of tooth decay has decreased substantially over the past 20 years across England, 27.9% of five year olds still had tooth decay in 2012, with Norfolk only proving to be slightly below the average with 27.2% of five years olds experiencing tooth decay (Gummerson & Gilbert, 2014). Statistics, however, can mask inequalities among small numbers and small areas of those in the county

(Crosse, 2014). Children and adults living in social and/or material deprivation as well as those in at-risk groups, such as those living with a disability, bear the burden of disease (Crosse, 2014). The Child Dental Health Survey (HSCIC, 2015) also notes that children from lower income families, which was based on eligibility for free school meals, are more likely to have poor dental health that other children of the same age.

Where the dental decay average for five year olds in Norfolk was 27.2% in 2012, as detailed above, local data shows that prevalence varies from area to area within the county with dental decay being above the England average in three local authority areas: Norwich, North Norfolk and Kings Lynn and West Norfolk (Gummerson & Gilbert, 2014).

1.3 Dental access and attendance

Children should ideally see a dentist at least once a year (Norfolk County Council, 2016). Some dentists however recommend that they have more regular check-ups (Norfolk County Council, 2016). Oral health promotion features in the county's Healthy Child Programme and encouragement to register children with a dental practice and advice is given to parents by the time the child is one years old, through the health visiting teams (Norfolk County Council, 2016).

King's Lynn and West Norfolk is amongst one of the areas with the lowest percentage of the child population visiting an NHS dentist (less than 60%) (Crosse, 2014). Concerns around dental attendance has also featured in the Eastern Daily Press recently which revealed that according to NHS Digital (2017), only 56% of Norfolk's children had attended a dentist in a 12 month period (Carroll, 2018).

Furthermore, children whose parents reported that their child went to the dentist for regular check-ups experienced less tooth decay than children who only went when their child has trouble with their teeth, or did not go at all (12% compared to 22%) (HSCIC, as cited by Norfolk County Council, 2016).

In the Oral Health Needs Assessment for East Anglia (Crosse, 2014), it was noted that unsurprisingly, access to services for children is affected by the distance to which they have to travel to visit a dentist. Of course, this is the same for adults and is reasonable to assume that often, parents will be the ones attending the dentist with the children.

This is supported by the Local Government Association (LGA, 2017) who have suggested that rural areas have worse access relating to the distance to primary care services, such as dentists. This can lead to "distance decay" which refers to the longer the distance that the individual lives from the service they wish to access, the less they may use said service.

Rural locations also leads to the need for either owning or having access to a car, or accessing public transport links. The latter is often scarce in rural areas (LGA, 2017). This impacts on the ability to access services at all, particularly for young

individuals who are yet to drive, or parents/guardians who cannot drive or do not have access to a car.

1.4 RAF Marham

Our concern around children and young people's access to services, particularly given the rural nature of West Norfolk, was echoed by RAF Marham and the Norfolk County Council Armed Forces Covenant Board. In early 2017, they approached Healthwatch Norfolk to discuss some work they were undertaking to explore access to dental services for the families of the service personnel, due to issues being raised.

For dental services, the service personnel's families cannot utilise the Ministry of Defence provided service but instead have to access services within the local community. Furthermore, this large operational Base – which is due to expand further in 2018 - is located in a remote part of the county, with local towns (typically where dental services are found) are only accessible with a car or through the limited bus service, making accessing services difficult for those families based in RAF Marham.

As at this point we had not undertaken any work surrounding dental services, but given that RAF Marham is situated in West Norfolk and we were due to commence a project to explore this topic, we supported the Armed Forces Covenant Board by offering guidance around survey design in order for them to obtain some facts and a better understanding of the service personnel's families experiences of accessing the local services and the possible issues.

The findings of the survey they carried out showed that of the 136 respondents, unsurprisingly, 42% travel more than 10 miles to attend their dental practice. Of these 57 respondents, the average distance travelled was 26 miles with one individual travelling 175 miles, back to their hometown, to attend the dentist with their family. Key themes around barriers to dental care emerged relating to distance to travel and means of getting there, as many families do not drive or have limited access to a vehicle, the lack of public transport, limited availability of an NHS dentist, availability of appointments outside working hours and lack of continuity of dental care, given that records do not follow the family and service personnel move Base frequently.

As a result of their findings, the Armed Forces Covenant Board wrote some papers around dental health care options, including possible service provision applications (B. Herron, personal communication, 21 March 2018). Additionally, this topic has since featured at several local committees, such as the East of England Local Dental Professional Network (September, 2017) and the Norfolk County Council's Communities Committee (September 2017 and March 2018).

In March 2018, the Communities Committee was presented with the Annual Report of the Norfolk Armed Forces Community Covenant 2017-18 paper (Norfolk County Council, 2018) which detailed their priorities for the year. Here, access for service personnel families to dental care was addressed, highlighting that re-deployed

families often struggle with accessing local, affordable dental care (p.18) and the frequency of their re-deployment results in issues such as being faced with long waiting lists and reduced access to treatment.

Discussions have continued with the Armed Forces Covenant Board and RAF Marham to ensure that the families of the service personnel are heard within our project.

1.5 Aims, objectives and key lines of enquiry

The aim of the project was to listen to the parents/guardians views on access to and experiences of NHS dental care for their children in West Norfolk and utilise this intelligence to make improvements to the services, for the people in the county. Additionally, to further understand the availability of services in the area, a "mystery shopping" style exercise was conducted.

We wanted to:

- Understand more about the local area of Kings Lynn and West Norfolk and access to services and experiences of services, for children, young people and families, including what services people are using, how far they are travelling This will in turn add to our evidence database at Healthwatch Norfolk.
- Understand whether issues highlighted are particular to service personnel families or the wider area.
- Understand the reasons why overall experiences of dental services in West Norfolk may be lower than other areas of the county (as shown in the GP Patient Survey).
- Understand whether provision matches local need or if the issues surrounding perceived access stems from a lack of accurate and up-to-date information, as the key directory for informing parents/carers about accessing NHS dental services – NHS Choices – is regularly utilised by Healthwatch Norfolk. Additionally, NHS England signpost patients to this resource and so it remains an important source of information. (*see* Section 2 for information).

2. Current services in West Norfolk

2.1 How NHS dental services are commissioned

NHS England buys (commissions) dental services and since April 2013, the responsibility has sat with the NHS England East Anglia Area Team. They are also responsible for the commissioning of specialist, community and out of hours dental services.

2.2 The types of NHS dental services

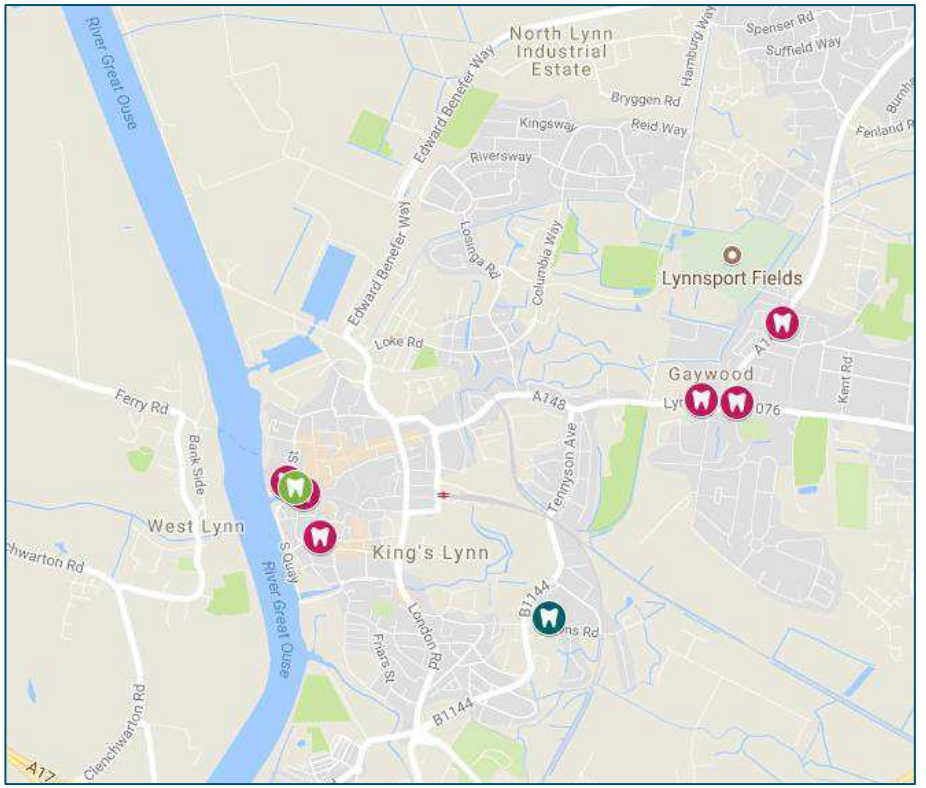
NHS dental services are typically provided by "high street" practices working under General Dental Service non-time limited contracts (Crosse, 2014). At the time of undertaking the project, through researching NHS Choices and liaising with the Care Quality Commission, we identified 13 "high street" practices in West Norfolk that have contracts to provide NHS dental care to children and young people. This is subject to change over time.

However, some people may not be able to attend a general dental practice, for a number of reasons and would be referred onto a more specialised service, which is provided by Norfolk Community Health and Care (NCHC).

In West Norfolk, there are two clinics which provide special care dentistry services – St James Dental Clinic, King's Lynn and Swaffham Community Hospital.

There is also one Dental Access Centre in West Norfolk, based in King's Lynn which provides emergency dental advice and treatment to patients who live in Norfolk, but do not have a regular dentist and this service is provided by NCHC.

Please see map provided on the following page, for all of the NHS services in West Norfolk.



Location of NHS dental practices in West Norfolk. Pink are the “high street” dental practices, light green is the emergency dental access centre and the blue icons are the community dental settings which deliver the special care dentistry service.

In focus: Location of the NHS dental practices in King’s Lynn town centre.

2.3 Finding an NHS dental service in West Norfolk

Dental services differ from other primary care services such as General Practice, because there is no need to register with a dentist in the same way. With dental services, you are not bound by a catchment area according to where you live. You simply find a dental practice which is convenient for you and see if they have space to see you.

If you do not have a dental practice or are new to the area, then you can use the NHS Choices directory to find a dentist near you (www.nhs.uk). NHS Choices is the official website for the NHS, used to provide information to help individuals to make informed choices about their health and wellbeing. The service directory lets you find, choose and compare health and social care services provided in England by the NHS.

The dental services directory, much like those for other services, details particular services within your search area and provides information about how and where to access them. NHS Choices should tell you information about whether the dental practice is accepting new patients (children, adults and exempt adults), referrals, offer urgent appointments and other service related information to help you choose where to seek dental healthcare.

If however, the dental practice has not been updated within 90 days, the NHS Choices automatically "greys" out the service, so as to not display incorrect information.

Therefore, this source offers an important channel for individuals, parents and carers alike to find out where they may be able to go to access dental care and it is imperative that this is kept up-to-date, as much as possible, especially as it is the recommended resource by NHS England to use to find an NHS dentist near you.

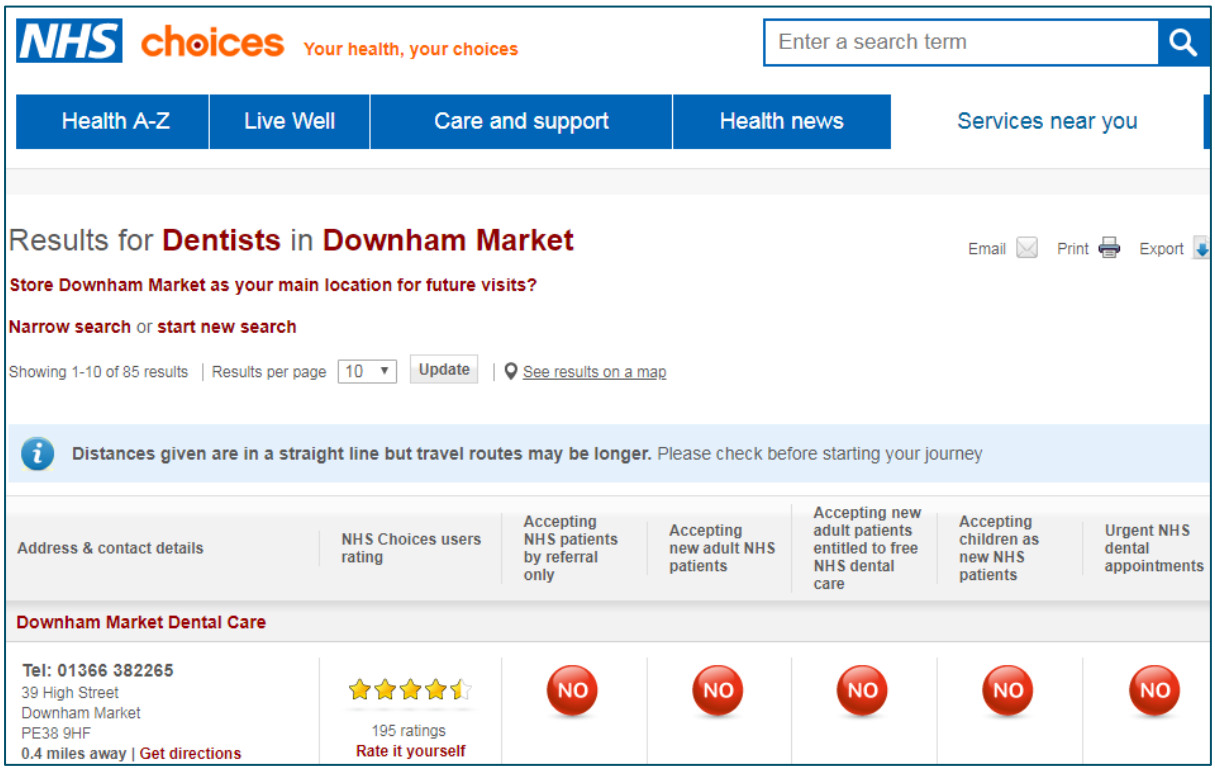


Fig 1. Results for dentists in Downham Market (example) on NHS Choices.

3. How we did this

3.1 The parent/guardian survey

3.1.1 Designing the survey

The survey consisted of a mixture of 18 open and closed questions to enable us to gather quantitative (numerical) and qualitative (narrative) feedback. The survey was divided into five sections, as follows:

1. Information about the children
2. Access to NHS dental services for their children
3. Experience of NHS dental services for their children
4. Barriers to NHS dental care for their children
5. Personal information about the parent/guardian

The questions were developed by Healthwatch Norfolk, based on the survey developed for RAF Marham families' experiences of NHS dental services as noted in *section 1.* This was to enable us to make comparisons from the military families to the wider civilian population of West Norfolk.

Both a digital and printed version of the survey was produced, to maximise our ability to distribute and promote the project.

You can see the full version of the survey in the Appendix.

3.1.2 Data collection

All schools in West Norfolk were contacted as we believed this would be an effective way of disseminating our survey to as many families as possible. Twenty schools agreed to support the project by sending out paper surveys and/or details of the online survey, to parents/guardians via the pupils. This included nurseries, primary schools, high schools and special educational needs settings, across West Norfolk. Children's Centres and the Oral Health Promotion team in West Norfolk also promoted the project through their links.

Further promotion took place through a press release in the local news publications; entries into local organisation newsletters and face-to-face at libraries and engagement events.

We also promoted the survey on the Healthwatch Norfolk social media channels, namely Twitter and Facebook.

Surveys were available online and in hard copy format and completed hard copies were returned using a Healthwatch Norfolk stamped addressed envelope. They were then kept in a locked drawer for the duration of the project. Online responses were stored on a password protected system. All data were destroyed immediately following the publication of this report.

3.1.3 Analysis

Hard copy surveys were inputted alongside the online responses to facilitate analysis. Responses to closed questions were counted and reported using descriptive statistics (e.g. percentages).

Open questions were analysed using qualitative content analysis. Feedback was grouped into categories consisting of similar responses and the numbers of responses relating to each category were then counted in order to identify the categories which were the most important to the respondents.

A workshop was then undertaken with Healthwatch Norfolk colleagues, to enable external scrutiny and validation of the emerging categories. At this point, the categories were further refined.

3.1.4 Strengths and limitations

The sample for this project relied on those parents/guardians who volunteered to complete the survey and so may not be truly representative of the general population. However, the purpose of the survey was to capture feedback of local parents/guardians and their experiences of accessing NHS dental services for their children in West Norfolk. This did not matter if they do or do not take their children to the dentist; responses were welcomed from all.

The survey enabled respondents to share in-depth detail about their views and experiences through the use of open questions, so they were able to highlight what really matters to them. It is important that the local decision makers recognise that every comment is important and valid and a useful resource for improving the quality of local services.

3.1.5 Ethical considerations

Data for this piece of work were collected anonymously, with explicit informed consent and stored securely in line with the principles set out in the Data Protection Act 1998, taking into consideration the updated General Data Protection Regulations. As a statutory organisation, Healthwatch Norfolk has an obligation to ask equality and diversity questions, such as age and gender, to demonstrate how the organisation is engaging with individuals from all of Norfolk's local communities. All personal questions were clearly displayed as being optional and also included a "prefer not to say" response.

3.2 Dental availability "mystery shopping" exercise

The "mystery shopping" style exercise was conducted to enable us to understand the availability of services in the West Norfolk area and the accuracy of information presented online. We conducted this at the very end of the project, to enable the most up-to-date information to be presented alongside our findings, as we appreciate it is just a snapshot in time and becomes outdated very quickly.

Details of the services offered by the 13 "high street" dental practices identified settings (p. 7-8) were compared, by looking at the information provided on the NHS Choices website, their own website (if they had one) and then by telephoning the dental practices directly. We used a script posing as a customer requiring identical services from each practice, to ensure consistency across the exercise (*see* Appendix for the full script used).

4. What we found out

4.1. The parent/guardian survey

4.1.1 Who responded to our survey

Altogether, 339 parents/guardians completed the survey. Twenty-five (25) responses were excluded from analysis due to various reasons such as not giving consent or using private services. Analysis took place on 314 responses from those who were parents/guardians of 606 children and young people (0-17 years old) in total. The figure below displays the number of children in each age range.

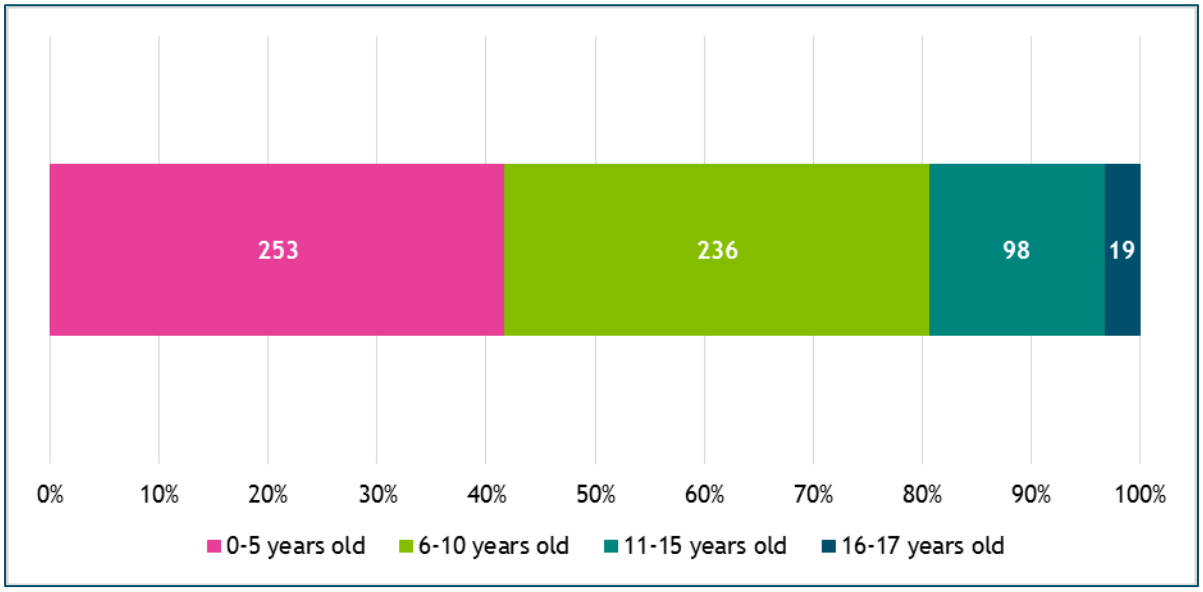


Fig 2. The number of children in each age range.

4.1.2 Dental attendance

Of the 314, 66% of parents/guardians take their children to the dentist every six months (209) and another 14% take them every year (43). However, interestingly 15% of respondents said that their children had never visited the dentist.

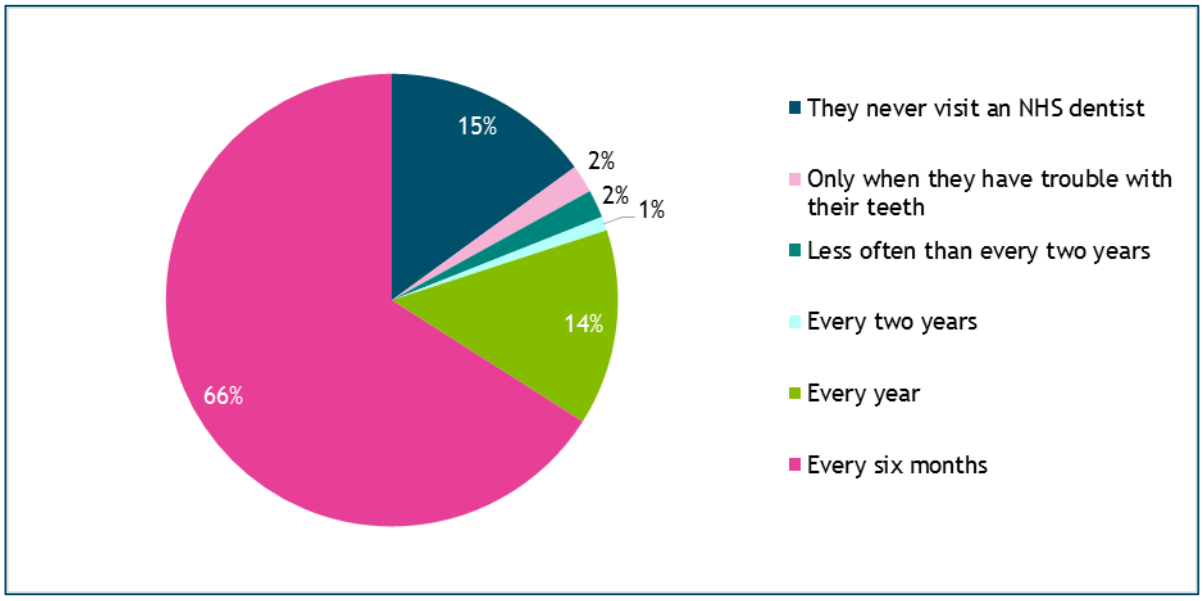


Fig 3. The frequency of dental attendance for children and young people.

Reasons why parents/guardians do not take their children to an NHS dentist (aside from the excluded respondents who take their children to private services) were explored and two notable themes emerged. Firstly, the **availability of NHS services** was noted by 26 respondents, relating to services accepting patients, finding a service accepting patients in the local area and the long waiting lists. **Age** of the children was also noted as a reason why they hadn't visited an NHS dentist (13 respondents). This usually related to the dental practice recommending an age at which the child should first attend. It appeared that this recommendation varied from practice to practice. Also age related, was the parents/guardians knowledge of when is right to take their child to the dentist.

Availability of NHS services

- *"I have not been able to find one local enough to take myself or my daughter under NHS."*
- *"I have been waiting for my NHS dentist to take on new patients so I can get my children registered. Been waiting 2+ years now."*
- *"Too long waiting lists in UK, so we go abroad."*

Age

- *"When registering at the dentist we were told that she didn't need to go until she was two years of age. So she hasn't had an appointment yet as she is only 16 months."*
- *"Have been to register but told they can't be seen until they are 3 years old???"*
- *"I didn't think they had to see a dentist till they were older."*

Other reasons for not attending NHS services

- Quality: *"It is due to the dire NHS dental services in the area that we choose to go private…"*
- Registration: *"not registered, their registration lapsed."*
- Cancellations: *"I signed him up to the dentist when he was 14 months old. He had an appointment made for 2 months later. This was then cancelled. I visited the dentist rather than talking on the phone and was told I'd have to wait until the following month to make an appointment. No reason why. So I did, this was eventually made for when he was 23 months old! But within weeks of making this appointment, I received another letter saying the appointment was cancelled due to unforeseen circumstances."*

4.1.3 Travel to the dental practice

Respondents shared how far they travel to take their children to the dentist and the most common distance was 6-10 miles (77 respondents), shortly followed by 2-5 miles (72 respondents). Surprisingly, over a quarter of respondents (69 respondents, 26%) have to travel over 10 miles to get to their children's dental practice.

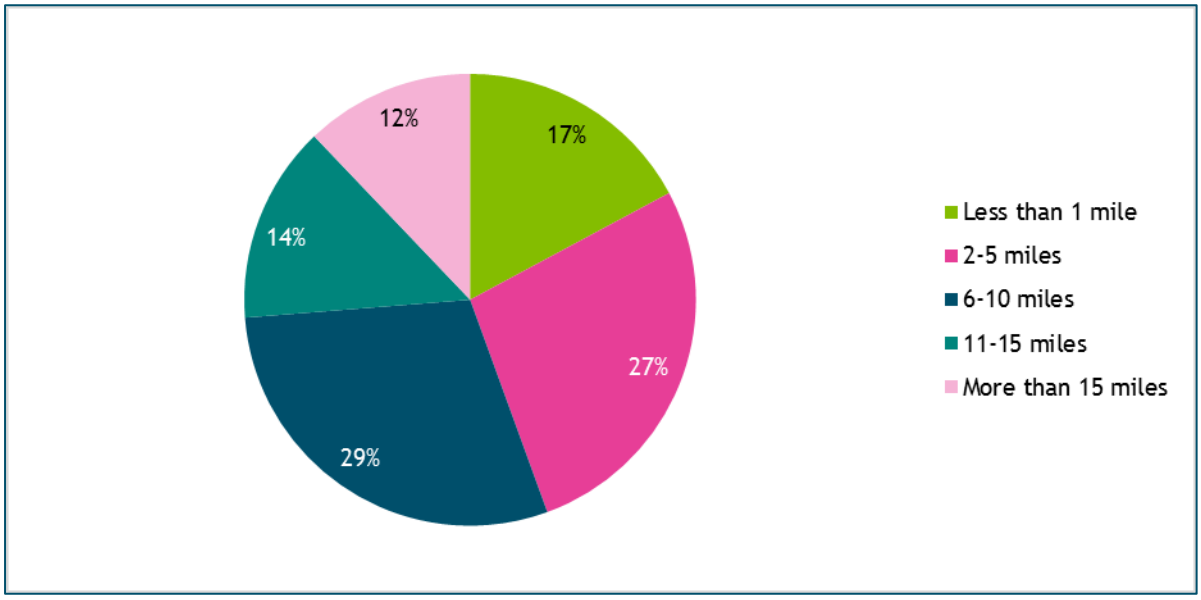


Fig 4. Distance travelled by respondents for their children to attend the dentist.

For those who travel over 15 miles to the dentist, the average distance was 23 miles, with one individual (from RAF Marham) travelling over 100 miles back to their hometown to take their children to the dentist.

Of those who answered how they travel to their children's dentist, most parents/guardians take the car (221 respondents, 84%), with some who walk (32 respondents, 12% and two who rely on the bus.

4.1.4 The current dental practice

Booking appointments

Respondents were asked to select which NHS dental practice in West Norfolk their children attend and the following questions relate to their experience of that specific service.

Sixty-nine percent of respondents (69%) felt that it was *easy* or *very easy* (181) to book an appointment for their children. Conversely, 17% found it *difficult* or *very difficult* to book an appointment (43 respondents). Interestingly, although their experiences of the booking system was predominantly positive, appointments featured heavily in the open questions in *section* 4.5 as a barrier to dental care for their children.

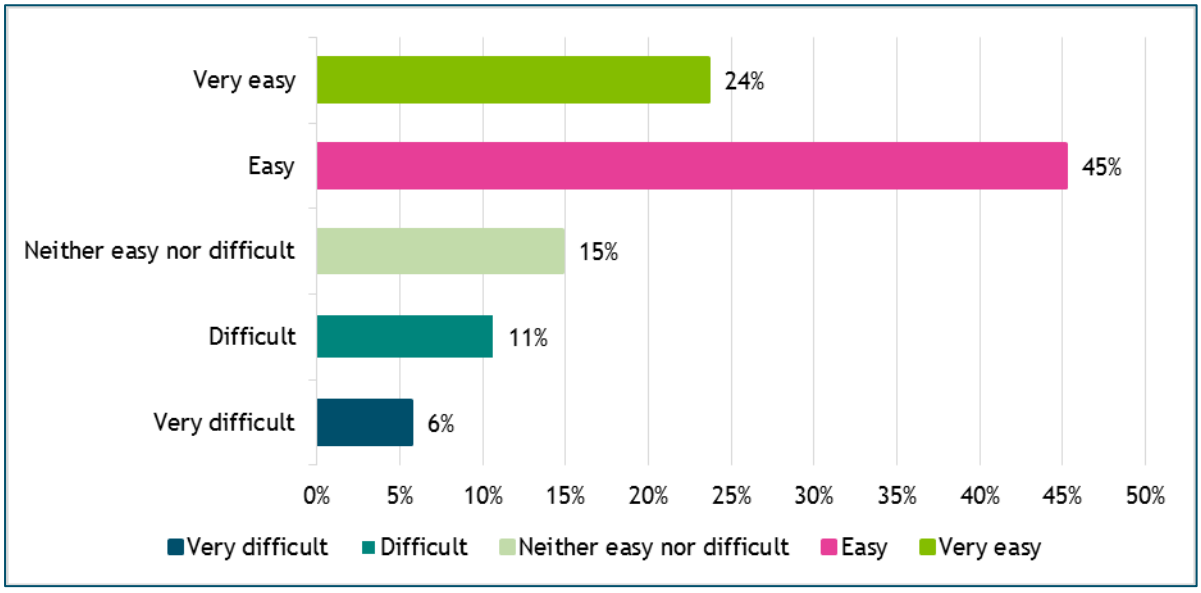


Fig 5. Respondents rating how easy it is for them to book an appointment for their children.

Overall rating

The majority of respondents (84%) rated their overall experience of their children's dentist as *good* or *very good*, compared to just 6% who rated the service as one or two stars (*very poor* or *poor*).

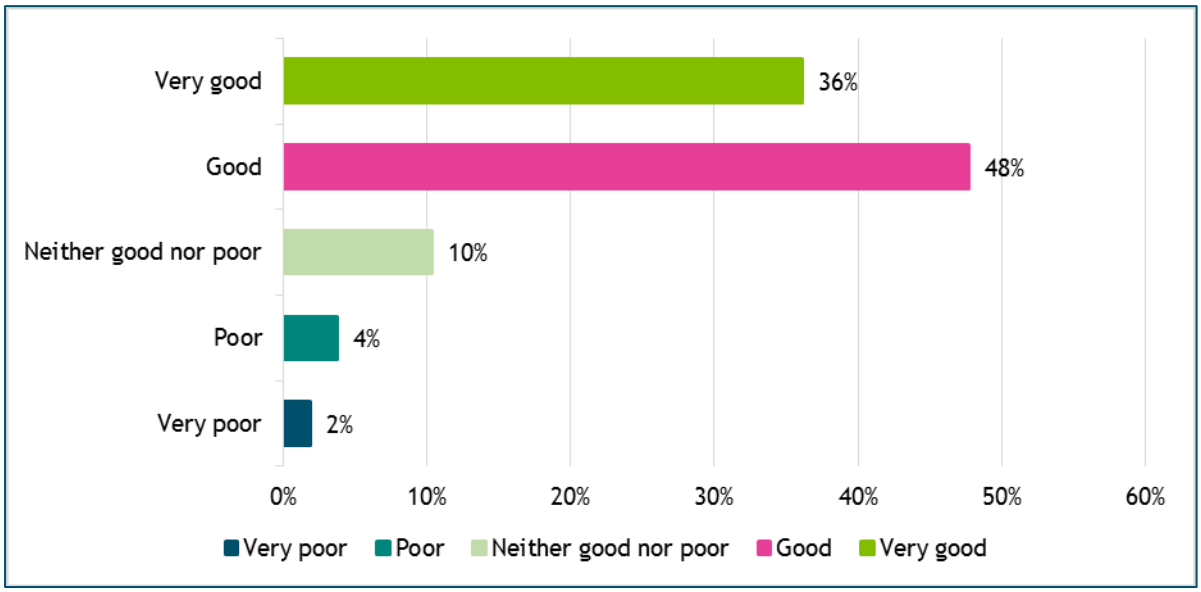


Fig 6. Respondents rating their overall experience of their children's dentist.

Respondents were asked to explain their rating. This was an open style question to allow parents/guardians to share whatever felt important to them.

Of the 42 respondents who rated the service 1-3 stars (*very poor* to *neither good nor poor*), 35 highlighted a range of issues, which were grouped into two main categories: ***appointments*** and ***quality of service***.

Appointments

Nearly half of the respondents who rated their overall experience 1-3 stars (17) detailed issues to do with their appointments. In several cases, they mentioned more than one element of the appointment and this was coded accordingly.

Ten parents/guardians felt that they had to wait a long time for an appointment for their children and for some (eight respondents), appointments were then cancelled, sometimes at short notice. This was a particular issue when trying to rebook and then being told that they had to wait several more months to be seen.

- *"We waited 3 years to be accepted at this dentists. We have been with them for about 2 years and had 1 appointment. The following 3 appointments have been cancelled via text/email with no reason."*
- *"Booking an appointment for 6 months' time is fine, but they're appointments are always cancelled a month before and rebooked for 2-3 months after the cancelled appointment date. Not a great experience really."*
- *"Took almost 11 months after registering to get our first appointment. Appointments cancelled at short notice after arrangements have been made for time off school/work."*

Another area of the appointment, which parents/guardians paid particular attention to, was the difference in dentists from one visit to the next (five respondents), which they spoke of in a negative manner, predominantly.

- *"Most times we go to the dentist we see a different dentist. This is hard for children as its reassuring when they can see the same person each time."*
- *"Every time we go we see someone different in different rooms etc. Not very consistent when getting a child settled in."*

Finally, waiting times once present in the dental practice, was noted by three respondents as a problem.

- *"Always need to wait more than 15 min. Can't have any plans after dentist because you never know how long it takes."*
- *"We had to wait 7 weeks for an appointment then waited over an hour and half past our appointment to be seen. I never even registered my second child as I was not happy with their service."*

Quality of service

Ten detailed comments revealed some issues around the perceived quality of care received at the dental practice which also includes lack of information/advice given.

- *"In and out, no advice given to children like we used to get."*
- *"My children's dentist doesn't seem particularly thorough, it's literally a peek inside their mouths."*
- *"Appointment is rushed and no time for oral hygiene advice or prevention strategy."*

- *"Current dentist lacks the care and attention of our previous dentist. Standard of acceptable teeth appears to be much lower."*
- *"Feedback from the dentist on oral care is inconsistent from one dental appointment to another. I personally have reservations whether my son is accessing good quality dental care."*

Respondents who rated the experience of their children's dentist 4 or 5 stars (*good* or *very good*) and shared in more detail why they gave such a rating (152 parents/guardians), highlighted several positive aspects of the service, however, in some cases, there still seemed to be negative aspects relating to appointments.

The main categories which these responses were grouped into, were: ***appointments, quality of service, involvement and environment/facilities***.

Appointments

Forty-five (45) noted appointments within their answers. As mentioned, there still appeared to be experiences of long waits for appointments (both routine and emergency), cancellation of appointments and availability of appointments around school or work hours. However, many noted positive experiences relating to appointment availability, children seeing the same dentist each time and waiting times in the practice being short.

- *"I struggle to get a dentist appointment when required. I waited 6 months for my children's appointment 2 weeks before they cancelled it and because it was only routine. They are now waiting another 3 months as it's the next available I could have."*
- *"It is difficult to get an appointment after 4pm (after school), the dentist only works certain days as well and its difficult to fit around work and school."*
- *"Dentist is good but if you need an emergency appointment you can't get one easily. Normally 2/3 week wait."*
- *"We have had a good experience overall at our dental practice. My son needed an emergency appointment one day and we were seen that evening after he finished school. I have never had a need to complain about any aspect of our care."*
- *"I have always found that the appointments are running on time and we don't have to wait too long (crucial with young children!)"*
- *"Good service and we see the same dentist at every visit and have a good rapport with her."*
- *"Our experience has always been positive. Easy appointment making, text reminder. Very friendly and informative staff and dentists. The place is extremely clean and seems excellently run! The kids are always happy to go here."*

Quality of service

Twenty-nine parents/guardians shared details about the quality of the service their children receive, including the dentist engaging with the children, the appointment being thorough and offering information/advice.

- *"Very good friendly dental practice and thorough looking at my daughters teeth."*
- *"Very good service and they are assisting and supporting her while trying to give up sucking her thumb."*
- *"Attentive to her and always gives her good dental advice about cleaning not sucking thumb etc."*
- *"They take the time to explain to my children the best ways to take proper care of their teeth."*

Involvement

Linked to quality of service is involvement, both of the parents/guardians in their child's care but more important in terms of involving the children in their own care. This was noted by ten respondents who rated their overall experience of their children's dental practice as 4 or 5 stars.

- *"Very attentive towards our child, explaining what's happening to him. Informing the parent of what's happening throughout."*
- *"I am pleased they ask my daughter questions rather than just me. My daughter likes going to the dentist as she gets to pick a sticker."*
- *"Excellent dentist, very calm, very reassuring. Explains fully to my child what she is doing so he feels calm."*
- *"The dentist makes our children feel at ease and speaks directly to them (i.e. not as a third person while speaking to their mum). The girls have the reward stickers!"*

Environment/facilities

A few respondents noted the cleanliness and calmness of the dental practice that their children attend. The physical accessibility of the practice was noted and one suggested a way of improving the practice for children.

- *"Easy, friendly and clean."*
- *"Access for buggy's and pushchairs is a problem with dentists on the upper floors but now they have extended the reception area there is space to leave them now at least. The practice is always clean and well equipped."*
- *"The dentists surgery is clean and bright although it would be nice if there was a few more toys or a fish tank or something to keep them busy while we wait."*
- *"The practice has a very calm atmosphere and everyone are very kind."*

Across all reviews, both negative and positive, the majority of parents/guardians praised staff. There were a few cases where staff were unengaging with children, uncooperative or sometimes rude, but typically the staff were "good with children", "patient", "friendly", "professional", "thorough", "informative" and "put the children at ease".

4.1.5 Barriers to NHS dental care for children and young people in West Norfolk

We posed two open questions that respondents could write whatever felt relevant to them, regardless of whether they take their children to the dentist or not, relating to barriers to NHS dental care for their children and how these barriers could be overcome to make it easier for them to access NHS dental care.

Given that parents/guardians could answer this questions regardless of whether their children attend a dentist or not, there is likely to be crossover with the answers given and emerging themes, particularly from *section 4.2* where reasons why the parents/guardians didn't take their children to the dentist were explored. Additionally, if they do attend a dental practice with their children but there feel there are some issues, these may have also been shared in *section 4.4.2*.

149 parents/guardians responded to this question highlighting several issues as barriers to accessing NHS dental care for their children, but the top three broad categories related to ***appointments***, ***availability of NHS services*** and ***location/transport***. Often these three also interlinked.

<u>Appointments (66 respondents)</u>

Nearly half of the respondents (44%) detailed issues regarding the appointments for their children as barriers to accessing NHS dental care, such as:

- Long waiting times from booking an appointment to attending the dentist (both routine and emergency), especially to fit in around school or work hours.
  - *"Long waiting time. Months before appointments are available I called over Christmas to book an appointment, hoped for Feb 1/2 term, but they couldn't be seen till May."*
  - *"Trying to book appointment in holiday time or after school can sometimes be a problem."*
  - *"Can find it takes a while to wait for an appointment. Had to wait 3 months for a check up. Being part of the RAF community, we move frequently."*
  - *"Finding an NHS dentist and then getting an appointment. We are an RAF family and have to move about every 2 years."*
  - *"Have a long time to wait if you need to rearrange an appointment."*
  - *"For emergency appointments can wait 2 weeks or longer! Appointments available. Late night appointments not available."*
  - *"Appointments need to be booked a long time in advance."*

- Cancellations of appointments
  - *"Just the cancelling of appointments. Last time, I was left a voicemail to say it was cancelled and when I returned to make another one I was told that I didn't turn up for an appointment!"*

- Referrals to other dental services such as orthodontists and hospitals (6 respondents)
  - *"Long wait on referrals for the dentist to hospitals."*
  - *"Long waiting lists for orthodontists (12 months)."*
  - *"When my eldest daughter required a brace I had to travel out of county to Cambridge - 45 mins by car for a 10 minute appointment every 3 months*

and I was lucky to get appointments at weekends as others have had to go during the day which takes a child out of school for half a day and also I lose half a day pay. Therefore it would probably have been cheaper to pay for the service."
- *"There are no NHS orthodontists in West Norfolk - we are going to have to travel to Norwich and I believe that we will have to go fairly regularly."*

- Waiting times whilst in the practice waiting to be seen (2 respondents)
  - *"Too long to wait in waiting room with children."*

Availability of services (61 respondents)

Given that 26 respondents had not taken their children to the dentist because of availability of NHS services and long waiting lists, it is unsurprising that this is one of the top barriers perceived by parents/guardians in West Norfolk. Again, respondents here noted issues around findings an NHS dentist with spaces, others noted the availability **in their local area.** Finally, long waiting lists in order to be able to register to be seen by a dentist at the practice was noted.

- *"I haven't been able to get my daughter in the dentist as they are full."*
- *"Too long waiting lists. No appointments available nearby. Travel too far."*
- *"Can't find a dentist taking on NHS patients."*
- *"Finding an NHS dentist and then getting an appointment. We are an RAF family and have to move about every 2 years."*
- *"My husband is in the military so we can expect to move frequently. Finding a dental practice who are accepting NHS patients can be difficult."*
- *"Unable to find a good dentist (with vacancies) closer to home."*
- *"Not enough services in the local area."*

Location/transport (22 respondents)

The majority of the respondents to this survey (84%, 221) answered that they have to rely on a car, in order to get to their children's dental practice. Additionally, barriers around appointments and availability of services, both highlighted aspects relating to location and transport, from orthodontist referrals being out of county or in Norwich to NHS services being available in their local area.

Particular issues around location and transport alone are due to some parents/guardians not being able to drive or do not have access to a vehicle at all times and so have to rely on public transport or fitting in appointments around other members of the family.

This was a particular issue for those on the RAF Marham Base and other remote villages where people do not drive and buses are limited.

- *"Got to fit my son's dentist in when his dad finishes work, as I don't drive and the local bus to Downham Market is very limited."*
- *"When I couldn't drive I have to rely on buses. The bus from Marham only goes to Kings Lynn."*
- *"Transport would be difficult if I did not drive and husband was deployed (RAF). Not many local NHS dental services."*

- *"Making sure I have transport to get there. With husband working in the RAF - stationed away from home - we may only have access to a car not very often."*
- *"Limited places for NHS for children locally. Not prepared to go more than 10 miles to visit dentist. Don't think it's practical."*

Other barriers to accessing dental care in West Norfolk

As noted by 13 parents/guardians in *section 4.2*, age was highlighted as a barrier to accessing NHS dental care for their children. Firstly, due to practice policy relating to age of accepting children to attend the dentist, which seemed to vary and secondly, due to lack of knowledge that parents/guardians had around when to start taking their children.

- *"Even though our child had teeth since she was 3 months old our dentist advised us that she didn't need seeing till she was 2 years of age."*
- *"Have been told in past, son was too young to book an appointment for when he was 2."*
- *"Our dentist wouldn't register our youngest until he was 3. I would have liked him to have been seen at a younger age."*
- *"I don't really know when the best time to take them is, I dont want to pay unneccessary costs if they are still too young but I haven't had any info really."*

In addition, other areas regarding information and advice was the inconsistency and accuracy of information online, predominantly NHS Choices information around the availability of services in the area and the difference in information they got when ringing the dental practice, directly.

- *"Having correct information on NHS Choices, I found the information provided wasn't necessarily the same when I phoned the practice. When phoning the practices the phones were often left ringing and ringing, no answer phone facilities."*
- *"Advice online seems to be different from advice given at surgery."*

Finally, others noted administration and organisational elements as a barrier, such as text reminders not being linked to the whole family and splitting families up, both different members of the family having different dentists within a practice, and also different members of the family having to attend different practices.

4.1.6 How these barriers could be overcome

Unsurprisingly, the most common suggestion for overcoming barriers to accessing dental care in West Norfolk for children and young people was around commissioning (71). Three respondents suggested bringing back school dentistry as that would help with the issues around appointment availability outside of school hours. Of the 71, 24 specifically stated that more services were needed **in the local area** with the rest simply stating that more practices, spaces or dentists were needed in general.

- *"More local services available."*
- *"A dental service in Marham for non-driven would be helpful."*
- *"NHS practices readily available in the area."*
- *"Having a dentist in the community we live in (RAF Marham) would help overcome some barriers."*
- *"The area needs more dentists."*

More availability of appointments in general and more out of school hours or out of hours (evening/weekend) appointments were highlighted as a way of overcoming these barriers.

- *"More dentists working after 5pm and or weekends."*
- *"Maybe staying open slightly longer once or twice a week to allow the children to visit the dentist without having to take them out of school, something the school isn't very happy about when you have to do this."*
- *"More availability of appointments and orthodontists."*
- *"More appointments in an emergency."*

Improvements to information and advice regarding options of NHS dental services in the area and when these become available were raised by some respondents. Additionally, information about when to take their children and advice around oral health was also welcomed by parents/guardians.

- *"Clear guidance for parents and receptionist of when a child should start going to the dentist."*
- *"I don't know anything about dentist options, when it comes to my children, so maybe some info regarding available dentists."*
- *"Website search for dentists with NHS availability for children - could sign up for alerts so that when suitable dentist advertising places you would know straight away."*
- *"Accurate information available through NHS Choices, working in the dental industry, I am aware the information is updated by the practices themselves, whilst there is now a warning that shows if they haven't updated information in the last 90 days, it doesn't necessarily guarantee accuracy. I found 111 very helpful and raising awareness of the service for advice/accessing emergency facilities would be helpful."*

Other ways of overcoming barriers were suggested such as online booking systems, keeping families together, reduce the cancellation of appointments, ability to book appointment with another dentist if assigned one isn't available, access to dentist downstairs or lift to consultation rooms upstairs and training of staff.

- *"Be more readily available and send automatic appointments or reminders like the opticians do."*
- *"Be like GP surgery if your Dr not there or no appt to see them, alternative GP found could be like this with dentists."*
- *"Having access to a dentist on a ground floor instead of taking four very small children upstairs."*

4.2 In focus: RAF Marham

Twelve respondents explicitly identified as living on the RAF Marham Base and/or being part of a service person's family. All of these respondents noted barriers to care relating to availability of services locally, transport and appointments. Again, these interlink.

Because of the nature of the RAF lifestyle, regular moving makes it difficult to get regular dental care due to issues with patient records not following the patient, availability of NHS services and then once registered, if able at all, the availability of appointments within a reasonable time frame.

In addition to this, if able get an appointment, many noted the location of the Base in relation to the local towns where the dental practices are, such as Downham Market, King's Lynn and Swaffham; the distance they have to travel to their nearest practices and the limited bus service and therefore the need to be able to drive.

However, for many, they do not drive, or only have access to one car and so they have to rely on this limited bus service or arrange appointments around their family members deployment or work arrangements.

> *"When I couldn't drive I have to rely on buses. The bus from Marham only goes to Kings Lynn."*
>
> *"Transport would be difficult if I did not drive and husband was deployed (RAF). Not many local NHS dental services."*
>
> *"I can't drive so appointments have to be made around husband's work."*
>
> *"Making sure I have transport to get there. With husband working in the RAF - stationed away from home - we may only have access to a car not very often."*

For this group of respondents who answered the questionnaire, there was only one suggestion for overcoming barriers to accessing NHS dental care for their children: **more local services.**

> *"Have an NHS dentist service on camp or closer."*
>
> *"Having a dentist in the community we live in would help overcome some barriers."*
>
> *"An NHS accessible dentist for all military personnel and dependents within quarters would be easier. There are a lot of people I know who either can't get a local dentist or travel a great distance."*
>
> *"Dentist on camp."*
>
> *"A more local service to RAF Marham."*
>
> *"Allowing military dependent children to use on-base facilities?"*

4.3 "Mystery shopping" exercise

All 13 "high street" dental practices were included in this exercise, to compare the accuracy of information provided online (NHS Choices and their own websites) compared to telephone calls directly to the service and ultimately, the availability of services in West Norfolk. This exercise was carried out between 26 March 2018 and 06 April 2018.

4.3.1 Information provided

Some of the dental practices did not have their own website (five settings) and 10 of the 13 practices had inaccurate or missing information on either their website or NHS Choices when we contacted them directly by telephone.

Only three of the 13 "high street" dental practices provided us with information on the telephone that matched the information displayed on their website or on the NHS Choices website.

4.3.2 Who are accepting NHS children patients?

According to NHS Choices, five practices were accepting children, with a further three being accepted as a result of a dental practitioner referral (eight in total). Four were not accepting children and one did not have any information provided.

When carrying out this exercise, looking at the dental practices own websites, as mentioned five did not have one, a further five provided no information as to whether they were accepting NHS children patients or not and the final three all stated that they were not accepting children. One of these when calling, did in fact have spaces to accept children, therefore showing a further inaccuracy of information.

However, when telephoning the dental practices directly, using a script to ensure consistency across the exercise (*see* Appendix for the full script used), we found very different results:

Only four of the 13 "high street" dental practices that have NHS contracts for children in West Norfolk were accepting children. However, one of these will **only** accept a child for NHS services, if their parent/guardian uses the service as a paying private customer (this service is predominantly private, but has capacity for NHS places for children only).

4.3.3 Further questions based on survey results

Given that this exercise was carried out at the end of the project, we had analysed the survey data and were aware of the emerging themes surrounding appointments

– specifically, long waits for appointments – and, inconsistencies in age of acceptance regarding children.

As a result, when telephoning the dental practices, we also asked those that were accepting NHS children patients (four practices), whether they had a minimum age of when a child would be able to attend their dental practice and when the next available appointment would be if we were to book at that point.

Two of the practices said that a child could attend "as soon as comfortable", one said "as soon as teeth appear" and the final practice said that children could attend at any age.

In line with findings from parents/guardians, there does seem to be waits for appointments at the practices accepting children. Of the four currently accepting children, the earliest available appointment was advised as being in **June/July 2018**, with the longest wait being until **August 2018**. One dental practice said that the child had to register before being advised when the next available appointment would be.

4.3.4 Further observations from the "mystery shopping" exercise

Through the parent/guardian survey, respondents also noted issues around contacting the dental practices and getting through to talk to someone. Thus, we recorded how long it took for the dental practice to answer the phone, whether we had to telephone repeatedly to get through and whether the dental practice provided an answerphone if there was no answer.

Five of the 13 dental practices answered first time. Two had to be called several times and the calls were not answered until the 4th and 5th calls, respectively.

When getting through to speak to someone, most calls were answered in under one minute, but some calls took a lot longer with one taking six minutes before the call was answered.

The five who answered the phone first time meant that we were not able to record whether they had an answerphone or not. Of the remaining eight dental practices, five had an answerphone, with one detailing the NHS 111 service. One did not have an answerphone at all. Interestingly, two dental practice detailed a call back service, which was activated when there was no-one to answer our phone call.

4.4 Summing up the findings

To conclude, from the findings, the majority of parents/guardians who take their children to the dentist have a *good* or *very good* overall experience and similarly, find it easy to book an appointment at the dentist. Across the detailed experiences, staff members from receptionists to dentists were praised for their positive attitudes towards their children, including being “friendly”, professional”, thorough” and “good with children”.

Having said that, there are clear barriers to accessing NHS dental care for children and young people in West Norfolk which stem from key areas such as, the availability of NHS dental services, in particular services in the local area to where the parents/guardians live, which went hand-in-hand with transport problems for some; the availability of appointments, and more specifically fitting the appointments around school or work hours; cancellations and long waits for appointments and finally, information/advice around taking their children to the dentist and availability of services.

These findings from the parents/guardian were echoed in the “mystery shopping” exercise we conducted at the end of the project which showed that very few dental practices were actually accepting children and those that were could not offer an appointment for another two to four months.

Additionally, information/advice offered through NHS Choices and dental practice websites was often missing and/or when comparing to contacting the dental practices directly there were often inconsistencies in the information provided.

Difficulties in contacting dental practices, as noted by parents/guardians was also replicated in this exercise as several of the practices did not answer first time, some offered a call back service as no-one could answer the phone and some calls took a number of minutes to be answered.

Particular issues noted by the families in RAF Marham in the survey conducted by the Norfolk Armed Forces Covenant Board last year, were replicated by the families in this survey, but more importantly, there is evidence showing that there is a wider issue of access in the civilian population of West Norfolk as well as the military families.

5. What next?

5.1 What we have done with the findings

- We have met with RAF Marham's Community Development Officer, Norfolk Armed Forces Covenant Board and the NHS England Commissioning Contracts Manager for dental services to discuss next steps.
- Working closely with the NHS England Commissioners have enabled us to increase their awareness of the importance of our work – dental services in the county, including the issues faced by those that live on the RAF base.
- We have identified the need for some short term plans whilst pursuing the longer term goals for military families, of increased service provision.
- We have started to build relationships with CQC and have an information sharing process in place, in line with Data Protection principles which will inform our respective work programmes. This report along with specific service related reviews of concern (and good practice) will be shared directly with them.
- We are supporting the NHS England procurement processes regarding Special Care Dentistry and Out of Hours dental services, through promotion on our website, possibly hosting a patient forum and also we will be sharing the report including individual feedback with these commissioning managers to ensure patient feedback is taken into account.

5.2 What we will be doing with the findings

Evidence…	**Recommendation/action…**
We have continued discussions throughout the project with RAF Marham, given the issues they raised with us and this has featured in our work and findings.	We will be presenting the report alongside Wing Commander Stewart Geary (RAF Marham) at the Norfolk Health Overview and Scrutiny Committee (HOSC) in May. NHS England representatives will be attending.
Military families highlighted issues accessing services in the local area, especially given the location of the RAF base, the transient nature of forces families and issues around finding NHS dental services who are accepting patients and then the long waits for appointments. Patients should be able to access a service at the point they left it if they are accessing treatment. Currently, patient records for dental services don't follow the patient if they move.	Using the Armed Forces Covenant, local dentists will be asked to offer places for families of current serving personnel to ensure they are not disadvantaged, as a first step to improving access for families. To achieve this, we recommend that an event is to be held where dentists can attend the Base and offer places where families can "sign up".
	To assist with the issue of transport, we have identified a contact at West Norfolk Community Transport. We will meet with them to discuss next steps and introduce them to the RAF Marham's Community Development Officer in order discuss potential solutions/routes.

	NHS England to consider patient registration to enable patient records (both military and civilian population) can follow the patient if they were to move or be stationed in a new area.
One of the biggest barriers was the availability of NHS dental services, especially in the local area. This leads to parents being unable to take their children to the dentist, and those who have been able to access NHS dental care still experienced long waits to attend or having to travel further to an available service for their children.	NHS England to consider looking at the current service provision in Norfolk and an updated Oral Health Needs Assessment should be carried out.
From undertaking this work, we have had a range of experiences of NHS dental services and have received specific feedback about most practices in West Norfolk, which haven't been detailed explicitly in this report.	Individual service provider feedback will be shared with the local dental practices (where we have obtained specific feedback) along with the report, for information/comment.
	Service specific feedback will also be added to our internal evidence database and be published on our public-facing website (where we have obtained consent to do so) which will enable the public to make informed decisions about their and their children's dental care.
Inconsistencies and inaccuracies of information provided online (NHS Choices and dental practices own website) were found when telephoning the dental practices in West Norfolk directly. This was highlighted by parents/guardians in the survey and echoed in the "mystery shopping" exercise.	The findings from the "mystery shopping" exercise will be shared with NHS England Midlands and East as they manage the service listings on NHS Choices. When contacting dental practices directly with the feedback we received, we will also share findings specific to their service with the recommendation to update and keep this page updated, given that it is the public-facing resource for finding NHS services in the local area.

In addition to the recommendations and actions to be taken, the report will be shared with the Local Professional Dental Network, Care Quality Commission, Public Health (Norfolk County Council), NHS England, Healthwatch England and any other relevant stakeholders, so they are aware of what people are saying about NHS dental services in West Norfolk.

6. References

Carroll, A. (2018). *Crisis warning as four in 10 children in Norfolk and Suffolk do not visit a dentist*. Retrieved from http://www.edp24.co.uk/news/health/shock-figures-show-almost-135-000-children-went-12-months-without-a-check-up-in-norfolk-and-suffolk-1-5429754

Crosse, A. (2014). *Updated final oral health needs assessment for East Anglia Area Team*. Retrieved from https://www.healthysuffolk.org.uk/uploads/Updated-Oral-Health-Needs-Assessment-East-Anglia-October-2014.pdf

Gummerson, C. & Gilbert. H. (2014). *Health needs assessment: Norfolk healthy child programme for children from birth to five years*. Retrieved from http://www.norfolkinsight.org.uk/jsna/childhood-health-wellbeing/childhood-health/general-health

Health and Social Care Information Centre (2015). Children's Dental Health Survey 2013. Country Specific Report: England. Retrieved from, content.digital.nhs.uk/catalogue/PUB17137/CDHS2013-England-Report.pdf

Ipsos Mori. (2017). *GP patient survey*. Retrieved from https://gp-patient.co.uk/

Local Government Association. (2017). *Health and wellbeing in rural areas*. Retrieved from https://www.local.gov.uk/health-and-wellbeing-rural-areas

Norfolk County Council. (2016). *Norfolk JSNA briefing document*. Retrieved from http://www.norfolkinsight.org.uk/resource/view?resourceId=1584

Norfolk County Council. (2018). *Communities Committee: Agenda Document Pack*. Retrieved from http://norfolkcc.cmis.uk.com/NorfolkCC/Document.ashx?czJKcaeAi5tUFL1DTL2UE4zNRBcoShgo=2Av7b%2fYe7d%2f5yAqKwC2zC%2fS7FX21X%2fFajkhcvVCfZw7%2b61kvGZJzhw%3d%3d&rUzwRPf%2bZ3zd4E7Ikn8Lyw%3d%3d=pwRE6AGJFLDNlh225F5QMaQWCtPHwdhUfCZ%2fLUQzgA2uL5jNRG4jdQ%3d%3d&mCTIbCubSFfXsDGW9IXnlg%3d%3d=hFflUdN3100%3d&kCx1AnS9%2fpWZQ40DXFvdEw%3d%3d=hFflUdN3100%3d&uJovDxwdjMPoYv%2bAJvYtyA%3d%3d=ctNJFf55vVA%3d&FgPlIEJYlotS%2bYGoBi5olA%3d%3d=NHdURQburHA%3d&d9Qjj0ag1Pd993jsyOJqFvmyB7X0CSQK=ctNJFf55vVA%3d&WGewmoAfeNR9xqBux0r1Q8Za60lavYmz=ctNJFf55vVA%3d&WGewmoAfeNQ16B2MHuCpMRKZMwaG1PaO=ctNJFf55vVA%3d

7. Appendix

Can you help us?

Healthwatch Norfolk would like to understand more about NHS dental services for children and young people (anyone under the age of 18) in West Norfolk, whether they are accessible and your views and experiences of your children's NHS dental care. Your answers will help us to find out what is working well and what needs to be improved. There are 11 short questions to answer and the survey should take around 5-10 minutes to complete.

All responses will be anonymous. We will publish the feedback we collect about specific services on our public facing website and we will use the information you provide in a project about dental services for children and young people in West Norfolk, that will be shared with the local decision makers who are responsible for planning and delivering NHS dental services in your area. You will not be named at any point and we will take great care to make sure that nobody will be able to find out who said what.

All information will be stored securely and will be destroyed at the end of the study, once the final report has been published. Once we receive your completed survey it may not be possible for it to be withdrawn.

About Healthwatch Norfolk

Healthwatch Norfolk is the consumer champion for health and social care in the county. We are here to help you have your say about the way that health and social care services are planned and delivered in Norfolk. For more information, please visit: www.healthwatchnorfolk.co.uk

Questions?

If you have any questions, please contact Fennie Gibbs, Healthwatch Norfolk Information Analyst, as follows:
Freephone: 0808 168 9669 **Email**: enquiries@healthwatchnorfolk.co.uk

Please read the following bullet points and select your choice below:

- I understand the purpose of this project
- I understand participation is voluntarily
- I understand all responses will be anonymous
- I understand my experiences may be used in future reports, publications, articles or presentation by Healthwatch Norfolk
- I understand that I can withdraw from this project at any time during completion. However, once Healthwatch Norfolk receive my completed survey it may not be possible for it be be withdrawn
- I agree to take part in this project

☐ Yes *Please continue to question 1.*
☐ No *Thank you for your time, please dispose of this survey*

1. Do you have any children under the age of 18?

- ☐ Yes *Please continue to question 2.*
- ☐ No **Please read the statement at the bottom of the page.*

2. How old is your child(ren)? Please select one age band for each child you have. If you don't have all five children, please leave the rows blank:

	0-5 years old	6-10 years old	11-15 years old	16-17 years old
1	☐	☐	☐	☐
2 (if applicable)	☐	☐	☐	☐
3 (if applicable)	☐	☐	☐	☐
4 (if applicable)	☐	☐	☐	☐
5 (if applicable)	☐	☐	☐	☐

If you have more than five children under 18, please tell us their ages…

3. How often does your child(ren) visit an NHS dentist? Please select one option:

- ☐ Every six months
- ☐ Every year
- ☐ Every two years
- ☐ Less often than every two years
- ☐ Only when they have trouble with their teeth
- ☐ They never visit an NHS dentist because they are registered with a private dentist **Please read the statement at the bottom of the page.*
- ☐ They never visit an NHS dentist for another reason (please explain below):

***Thank you for your time. This survey is for parents/carers of children under the age of 18 and the experiences of these NHS dental services in West Norfolk. If you would like to leave a review about adult NHS dental services in the county, or any other NHS funded health service or public funded social care service in Norfolk, you can do so at our website: www.healthwatchnorfolk.co.uk*

4. What is the name of your child(ren)'s NHS dental practice?

- ☐ Castle Rising Dental Surgery
- ☐ Coastal Dental Practice, Snettisham
- ☐ Direct Dental Care, Gaywood
- ☐ Downham Dental Practice
- ☐ Downham Market Dental Care
- ☐ Gayton Road Dental Care, Gaywood
- ☐ Hall Farm Dental Surgery, Roydon
- ☐ Hunstanton Dental Practice
- ☐ Kings Lynn Dental Access Centre
- ☐ Lynn Road Dental Practice, Gaywood
- ☐ Mydentist - High Street - Kings Lynn
- ☐ Mydentist - Purfleet Street - Kings Lynn
- ☐ Riverside Dental Practice, Kings Lynn
- ☐ The Dental Surgery - 3 The Pightle, Swaffham
- ☐ The Grange Dental Surgery, Snettisham
- ☐ Townley Dental Centre (Upwell Health Centre), Upwell
- ☐ Other (please describe below)

5. Roughly how far do you travel to your child(ren)'s dentist?

- ☐ Less than 1 mile
- ☐ 2-5 miles
- ☐ 6-10 miles
- ☐ 11-15 miles
- ☐ More than 15 miles (please describe roughly how many miles you travel):

6. How do you travel to your child(ren)'s dentist?

- ☐ Bus
- ☐ Car
- ☐ Taxi
- ☐ Walk
- ☐ Other (please describe):

7. How easy do you find it to book an appointment for your child(ren)? Please select one option:


Very Difficult


Difficult


Neither good nor poor


Easy


Very Easy

8. How do you rate your experience of your child(ren)'s current dentist? Please select one option:


Very Poor


Poor


Neither good nor poor


Good


Very Good

9. Please share your experience of your child(ren)'s dentist in more detail. If you need more space to share your experience, please continue on the back of the last page of the survey:

10. What barriers do you face when trying to access NHS dental care for your child(ren)?

11. How could these barriers be overcome to make it easier for you to access NHS dental care for your child(ren)?

About you

Thank you for sharing your experiences with us. We would now like to ask some further questions about you, on the following pages**. You do NOT have to answer these questions if you do not want to** but any information you give us will help us to make sure that we are representing local people effectively. Your personal information will remain confidential.

12. What is the first half of your postcode? *(e.g. NR18)*

13. What was your age on your last birthday?

14. What is your gender?

- ☐ Female
- ☐ Male
- ☐ Prefer not to say

15. Is your gender identity the same as the gender you were assigned at birth?

- ☐ Yes
- ☐ No
- ☐ Prefer not to say

16. What is your sexual orientation?

- ☐ Bisexual
- ☐ Gay or lesbian
- ☐ Heterosexual or straight
- ☐ Prefer not to say
- ☐ Other (please describe):

17. Do you have any physical or mental health conditions or illnesses lasting, or expected to last for 12 months or more?

- ☐ Yes
- ☐ No
- ☐ Prefer not to say

18. What is your religion?

- ☐ No religion
- ☐ Buddhist
- ☐ Christian (all denominations)
- ☐ Jewish
- ☐ Hindu
- ☐ Muslim
- ☐ Sikh
- ☐ Prefer not to say
- ☐ Any other religion (please describe):

19. What is your ethnic group? Choose one section from A to E, then tick one box which best describes your ethnic group or background:

A. White

- ☐ English/Welsh/Scottish/ Northern Irish/British
- ☐ Irish
- ☐ Gypsy or Irish Traveller
- ☐ Any other white background

B. Mixed/Multiple

- ☐ White and Black Caribbean
- ☐ White and Black African
- ☐ White and Asian
- ☐ Any other Mixed/Multiple background

C. Asian/Asian British

- ☐ Indian
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ Chinese
- ☐ Any other Asian/Asian British background

D. Black/African/Caribbean/Black British

- ☐ African
- ☐ Caribbean
- ☐ Any other Black/African/Caribbean/Black British background

E. Other ethnic group

- ☐ Arab
- ☐ Any other ethnic group
- ☐ Prefer not to say

If other, please describe:

Script used for the "mystery shopping" exercise

"Hi, I was wondering if you are accepting NHS patients?

I am moving to West Norfolk soon and will need a dentist for my family, there's three of us.

My partner is exempt from paying as he has a HC2 form. I would be paying.

At what age do you accept children, my daughter is 1 year old?

…

How long you think I'll have to wait for an appointment once I'm registered?"

Report by Nick Stolls, Secretary, Norfolk Local Dental Committee

Report to Norfolk County Council Health Overview and Scrutiny Committee.

It is nearly four years since I last reported to HOSC about the status of NHS dentistry in Norfolk so it might be helpful to update the Committee.

In my previous report I suggested that work was underway to introduce a new NHS dental contract but progress was slow. Progress is being made but neither the Dept of Health and the profession are eager to see something introduced with too much haste otherwise we might end up with something like the existing contract which is neither good for the profession or the patients as we will discover later. The new contract is unlikely to be rolled out much before 2020 and will have a much greater emphasis on prevention with capitation most likely to be introduced so patients can register with a practice and feel a relationship with their practice in much the same way as they have with their general medical practice. This is in stark contrast to the current situation whereby patients are only the responsibility of the practice whilst they are undergoing a course of treatment and the practice has no responsibility for them after that course of treatment is completed. It is unlikely that the funding will be expanded from its current fixed level which offers a practice a capped budget to provide NHS care at their practice. Once they have hit their target there is little chance that additional funding for that year will be forthcoming to allow more patients to be seen - indeed this has been the experience within Norfolk over the past decade. The inflexibility in the current system is severely detrimental to providing NHS dental care across England and Wales and the situation experienced in West Norfolk highlights this.

Perhaps I could draw some particular issues to the Committee's attention.

1. Current issues facing NHS dental practice. Since my last report there has been an increasing difficulty in recruiting NHS dentists to Norfolk. This is true for all the other professions as well and in some ways may be a Brexit effect but more likely because of the changing attitude of young graduates to working in a predominantly rural part of the UK. The larger urban parts of the country have less of a recruitment problem. The impact of struggling to fill a position can have an immediate impact on a practice trying to hit its contracted target but also the negative effect of having to turn patients away from a practice can be equally demoralising for that practice's staff. This recruitment problem has been compounded by a very specific issue in the past 2 years when EU/EEA graduates coming to the UK for the first time and who have agreed to join a practice have had to wait for many months to obtain an NHS performer number. Without a performer number a dentist can only work on a private basis. In April 2016 NHSE contracted Capita to provide the service of managing the NHS performers list and we have seen waiting times increase from the 2 month turn around before 2016 to often 8 to 10 months. This means that a dentist is waiting to start at a practice, the surgery is available, the support staff are in place, there are patients desperate to access treatment but because of the incompetence of Capita there are unacceptable delays. There are other issues which have made the achievement of delivering the NHS dental contract more challenging over the past 4 years. This is highlighted by the level of claw back of funds from NHS practices across Norfolk which

increased from the 2015/16 figure of £1.1m to £1.64m in 2016/17. Claw back is the term given to the repayment of the funds if the practice is found to have under delivered on its contract at year end. The 50% increase in the past year reflects both the problems facing NHS dental practices but also the inflexibility of the current contract. £1.64m could provide a significant amount of additional NHS dentistry if it could be redistributed across the region more efficiently. In my 2014 report I noted that there was a vacancy for a restorative consultant within the county at the Norfolk and Norwich hospital and that there was nowhere for NHS patients to be referred if they required specialist endodontic (root treatment) or periodontal (gum treatment) advice or treatment. The situation has not changed and the only option patients have is alternative treatments, usually extractions or a private referral. The lack of progress in all of these elements within NHS general dental practice is of great concern to the profession and might help explain the difficulty patients are having in accessing NHS dental care in the county.

2. Current issues being faced by NHS patients. The current NHS dental contract has always made accessing a dental practice more problematic for patients since its introduction in 2006. Without registration, patients have no right of treatment from a dentist or practice unless they are undergoing a course of treatment. Efforts have been made to assist patients but with the change in roles of PALS who in the past would help patients find a practice for any that had difficulty accessing one, their only options now are to use the NHS Choices website which indicates practices in the vicinity of the patient and whether they are taking on new patients. In the event of an emergency a patient can call 111 and the service might be able to find a practice for that patient but both of these options are far from satisfactory and patients may have to rely on phoning round practices and then often having to travel many miles to a practice that might have spare capacity. This situation is of great concern for both the profession and patients but it helps to paint a picture of the challenges facing patients in the north west Norfolk region of our county.

3. Current issues between the profession and commissioners. It will be for the NHS England commissioners to identify and explain the challenges they face in commissioning a flawed service for the population of Norfolk and indeed Suffolk, Cambridgeshire/Peterborough and Essex within the same commissioning area. The profession have continued to have dialogue with the commissioners at regular meetings to discuss the problems highlighted earlier and to an extent they are restricted by the national guidance provided by NHSE but also the regulations by which NHS dentistry is commissioned and contracted. To be able to move funding from a practice who has indicated they won't be able to use it all in the current year to another practice who will over perform in that same year has proved elusive and rarely happens, hence the massive clawback mentioned previously. Only when a practice gives up their contract and reverts back to a private arrangement does the NHS funding become available on a recurrent basis and so can be recommissioned in an area where additional demands have been identified by the Oral Health Needs Assessment. Sadly contracts are being given back by practices, who have decided to not subcontract from the NHS any more, on a greater frequency, such is the frustration that the profession are finding with the current system. The situation faced by relatives of service personnel at RAF Marham is sadly all too common. In the county there are housing estates being built which bring a large influx of new patients into the area but little attention is given to the additional dental resources that will be needed locally to address

this population increase. Without registration patients are taken on at a practice for a course of treatment on a 'first come, first served' basis and examples of patients having to make long journeys to access dental care occur too frequently. NHSE have introduced a committee made up predominantly of clinicians in each Area Team region known as the Local Dental Network (LDN), not to be confused with the Local Dental Committee who represent NHS dentists in the county, and it is they who provide clinical commissioning advice to the non clinical commissioners. The LDN is a relatively new group but is finding its feet and is chaired by Tom Norfolk, a dentist from Suffolk. They advise the commissioners but can't mandate.

4. Future challenges. Where to start? Child oral health is a particular concern within the county. This is being addressed by regular meetings between Norfolk County Council Public Health department and NHSE commissioners, facilitated by Norfolk Local Dental Committee and efforts are being made to bring the Oral Health provision of the children in the county on par with those in Suffolk and Cambridgeshire/Peterborough by aiming oral health promotion at the very early years children and their parents.

A number of large contracts within the county are soon to be reprocured and that of the Special Care dentistry contract may well have an impact on the delivery of child oral health in the county. The collective ambition is that we will see a reduction in the appalling numbers of children being admitted to hospital for a general anaesthetic to have multiple rotten teeth removed, often before they are 5 years old.

Orthodontic provision across the county is soon to be reprocured and this together with that of Special Care dentistry has the potential for destabilising these two essential elements of NHS dentistry in county for a period of time if the recommissioning is not managed well.

Staffing at NHS England is facing increasing challenges with a reduction in the staffing budgets. The consequent impact on staffing numbers has an inevitable effect on the ability to manage the recommissioning of services together with contract management across the county in an efficient manner that addresses the problems raised in this report to improve access for NHS patients across the county and in particularly north west Norfolk.

Ambulance response times and turnaround times in Norfolk

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

Examination of the trends in ambulance response and turnaround times in winter 2017-18 and action to improve performance.

1. Background

1.1 Norfolk Health Overview and Scrutiny Committee (NHOSC) added 'Ambulance response times and turnaround times in Norfolk' to its forward work programme in February 2018 following concerns about performance around Christmas and New Year (raised in Parliament in January) and a locally reported discrepancy between handover delays recorded by the East of England Ambulance Service NHS Trust (EEAST) and figures recorded by Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH) and passed on to NHS England.

NHOSC Members received information about the response to the Christmas and New Year performance issues in the February 2018 NHOSC Briefing and about the recording of handover delays in the April 2018 NHOSC Briefing. The briefings are attached at **Appendix A**. The February Briefing also included the key actions agreed by the NHS in the region following a Risk Summit held on 31 January 2018.

1.2 NHOSC has had concerns about ambulance response times and turnaround times in Norfolk for a considerable period of time and has returned to the subject frequently over the past decade. As well examining the ambulance service, NHOSC has focused on the NNUH's process for receiving patients who arrive by ambulance.

More patients arrive at the NNUH by ambulance that at any other hospital in the eastern region. Although the '% arrival to handover performance <15 mins at A&E only' figures for the NNUH compare favourably with other hospitals the volume of patients means there is potential to produce significant loss of ambulance service hours if patient hand-overs are delayed.

NHOSC has also received regular updates on the situation regarding delays at the other two acute hospitals in Norfolk, where ambulance arrivals are far fewer.

The committee has long recognised that, to an extent, ambulance delays at

hospitals and their knock-on effect on the service's capacity to respond to new calls, are symptomatic of pressures across the local health and social care system. They are not necessarily within the power of the hospitals or the ambulance service to resolve by themselves.

1.4 The last report to NHOSC was on 26 October 2017 when EEAST reported on the new national Ambulance Response Programme (ARP), which aims to help patients get the right response from the ambulance service, first time.

Initiatives to improve performance during winter 2017-18 included:-

- Early Intervention Vehicles (EIV) - in central Norfolk and Great Yarmouth and Waveney. The EIV was staffed by paramedics, NHS community occupational therapists and hospital physiotherapy staff to support the urgent needs of frail patients and help them stay at home, where appropriate.
- Patient Safety Intervention Teams (PSITs) – launched in December 2017 these teams deployed to trusts across the area where handover delays were causing ambulances to be delayed. The teams were in place until March 2018 as part of EEAST's winter plan. NHOSC received a briefing about their activity in the February NHOSC Briefing (included in **Appendix A**).

1.5 On 26 October 2017 NHOSC heard:-

- EEAST was awaiting the results of an **Independent Service Review** (ISR) which had been commissioned by NHS England and NHS Improvement to determine the level of resources needed by the service.

  The ISR report was published on 11 May 2018 and is available on EEAST's website http://www.eastamb.nhs.uk/EEAST-ISR-Report-March-2018.pdf . The principle findings were:-

  - That EEAST requires more investment to increase staffing and capacity to improve the service.
  - It is estimated that approximately 330 additional whole time equivalents will need to be in post at the end of three years, recognising that it will take a further two years to ensure any new paramedics are qualified and registered.
  - An extra 160 double staffed ambulances will need to be on the road by the end of the 2019/20 financial year.

  EEAST and the commissioners have signed a six-year contract to enable the service to achieve this. It will see funding rise from the £213.5m spent in 2017/18 to £225m in 2018/19. Subject to activity profiles remaining as predicted, it will then rise again to £240m in 2019/20. This follows significant increases in funding over the past two years.

  EEAST is aiming to recruit and train in excess of 1300 new staff

over three years to ensure it can sustain its current level of staffing as well as grow capacity by 330.

- The Norfolk and Norwich Hospitals NHS Foundation Trust (NNUH)'s report on its most recent actions to assist with ambulance hand-over, including its new Older People's Assessment Service (OPAS) and Older Peoples Ambulatory Care (OPAC) to speed up and increase access to specialist geriatric intervention. NHOSC Members visited the Older People's Emergency Department (OPED) on 26 January 2018 and a follow-up visit is to be arranged.

NHOSC asked EEAST to consider involving service users in a workshop that they were arranging on the conveyance of mental health patients to hospital and other facilities. (See paragraph 3.1 below).

North Norfolk CCG was also asked to ensure that outstanding Freedom of Information requests from Cromer Town Council regarding fine monies to EEAST and the NNUH under the former financial penalties regime received a response. The CCG provided a response in November 2017.

1.6 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.

2. National ambulance standards

2.1 New national **response time** standards (the Ambulance Response Programme (ARP)) were introduced in England in winter 2017:-

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?**
C1 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
C2 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	The earliest of • The problem being identified • An ambulance response is dispatched	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

		minutes)	• 240 seconds from the call being connected	
C3 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		
C4 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)		

2.2 Condition specific measures were also being introduced to 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 was to be introduced to identify those patients in need of the fastest response. By 2022 the aim was 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 were 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. EEAST will be measured from April 2018 against the new outcome based target for stroke, which replaces the previous Stroke 60 time based target.

The **Stroke Care Bundle** target still applies - 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%, which has been consistently met and exceeded in Norfolk and Waveney.

2.3 For **ambulance turnaround at hospitals**, the standards were not altered by the introduction of the ARP. They 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.**

3. Purpose of today's meeting

3.1 EEAST has been asked to report today with information in terms of:-

- An update to the statistical and other information provided for NHOSC in October 2017:-
  - Demand in Norfolk – trend

    - Response time performance in Norfolk – trend
    - Stroke performance in Norfolk - trend
    - Hospital handovers – trend for the 3 acute hospitals in Norfolk (arrival to handover & handover to clear)
    - Staff recruitment & retention – update
    - Estate & fleet transformation – update
    - Mental health pathways – update
- New Standard Operating Procedure (SOP) for handovers at the hospitals and how it differs from the old arrangements
- New Delayed Arrival to Handover (Keeping patients in the community safe) Protocol introduced in Feb 2018
- Report & action plan of the Risk Summit which looked into delays in service around Christmas and New Year.
- Independent Review of Resources report (a link to the report is provided in paragraph 1.5 above)

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

3.2 Although ambulance turnaround figures for all three of Norfolk's acute hospitals are included in EEAST's report, the NNUH has been invited to report and to attend today's meeting as the one that receives the by far most arrivals by ambulance. The NNUH has been asked to update the committee on activity since the last report in October 2017.

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

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. The CCG has been asked to provide the report / action plan from a regional Delays Workshop held on 23 March 2018 (**Appendix D**).

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 Norfolk's hospitals are actively and adequately addressing their part of the problem?

(b) Given that the 'Delayed Arrival to Handover (Keeping Patients in the Community Safe) Protocol' introduced in February 2018 has relied on an extremely high and potentially unsustainable level of escalation by EEAST leaders to ensure the necessary action occurs

to release their crews, what can be done to enable the necessary action further down the management line.

(c) Does EEAST consider that the increased investment in its service following the Independent Service Review to enable it to achieve the Ambulance Response Programme standards in all parts of Norfolk? If not will there be specified standards for the more rural localities?

(d) What are the local arrangements for implementing the new outcome based targets for heart attacks and strokes in terms of the patient's pathway from 999 call to definitive treatment in the acute hospital? (See paragraph 2.2 above)

(e) What specific changes have been made to the pathways for conveyance of mental health patients to hospital and other facilities?

(f) Does EEAST intend to continue provision of Early Intervention Vehicles in central Norfolk and Great Yarmouth and Waveney?

(g) There will be significant additional investment in the ambulance service following the recommendations of the Independent Service Review, to enable recruitment of an additional 330 staff and 160 double staffed ambulance. EEAST's paper (Appendix A) makes it clear that the service in Norfolk is already fully staffed. What difference will the new investment make to ambulance performance in this county?

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

(h) The NNUH has increased its A&E capacity with the opening of the Older People's Emergency Department and other measures and the number of arrivals by ambulance at the hospital fell slightly in 2017-18 compared with the previous year but still there was a high level of ambulance delay. Does the NNUH consider that delays in patients leaving the hospital are a greater part of the problem than processes at the 'front door'?

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

(i) Do the commissioners consider that the slight reduction in numbers of arrivals by ambulance at the NNUH this year point to success of measures to support and treat people at home in central Norfolk? If so, can more be done to support similar measures in Great Yarmouth and Waveney and West Norfolk where numbers of arrivals by ambulance are still increasing?

5. Action

5.1 The committee may wish to consider whether to:-

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

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

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

1. Extract from Norfolk Health Overview and Scrutiny Committee Briefing 22 February 2018

EEAST – performance over the Christmas period and subsequent action

Following an issue raised in the House of Commons on 17 January 2018 by Norwich South MP Clive Lewis regarding pressures on the East of England Ambulance Service NHS Trust (EEAST), the timing of the Trust's move to REAP (Resource Escalation Action Plan) highest state of emergency and the effect on patients, EEAST issued a letter to stakeholders, including the Chairman of Norfolk Health Overview and Scrutiny Committee on 18 January 2018. The letter, which was circulated to NHOSC Members for information on 22 January 2018 is attached at **Appendix 1.**

In response to recent concerns about ambulance services in the East of England, the NHS within the region held a **Risk Summit** on Tuesday 30 January 2018. Co-hosted by NHS Improvement and NHS England, the summit was attended by representatives from the East of England Ambulance Service Trust (EEAST), its lead commissioner Ipswich and East Suffolk Clinical Commissioning Group, the Care Quality Commission, Healthwatch Suffolk, Norfolk and Norwich University Hospitals NHS Foundation Trust, Mid Essex Hospital Services NHS Trust, Queen Elizabeth NHS Foundation Trust and Health Education England.

The Risk Summit identified a number of actions that were needed to secure greater resilience for regional ambulance services. Some of these actions are for the East of England Ambulance Services Trust (EEAST) and some actions are for the wider NHS.

The key actions were as follows:

1. EEAST will deploy additional staff and vehicles between now and Easter. This will include securing additional vehicles from independent providers
2. EEAST will improve its ability to forecast demand as part of strengthened winter planning
3. EEAST will take steps to improve staff availability at peak times, including action to improve staff health through flu vaccination and reviewing the Trust's leave policy
4. Local hospitals will be asked to accept prompt handover of patients from ambulance crews in order to release the crews for other calls
5. EEAST will improve its internal escalation procedures to deal with periods of high pressure
6. CCGs and other providers of NHS care across the region will implement measures to moderate the use of ambulance services, using safe alternatives wherever possible
7. Any Serious Incidents that occurred over the winter period will be subject to a thorough review process to ascertain whether patients were harmed.

There was to be a follow up meeting in a fortnight to review progress with each of these actions. NHS Improvement and NHS England were also to establish enhanced monitoring to ensure each action is fully implemented over the coming months.

As mentioned in EEAST's last report to NHOSC in October 2017, an Independent Service Review by the consultants ORH which was commissioned by NHS England and NHS Improvement to understand what capacity and funding the service needs to enable it to perform at an acceptable level. The results have not yet been published but are expected to be available in March 2018.

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2. Extract from Norfolk Health Overview and Scrutiny Committee Briefing 22 February 2018

East of England Ambulance Service NHS Trust (EEAST) Patient Safety Intervention Teams to assist with handover delays

Members were informed in the January 2018 NHOSC Briefing regarding about the launch of the East of England Ambulance Service NHS Trust's (EEAST) Patient Safety Intervention Teams (PSITs) to help with winter pressures at hospitals. Five teams of three started working across EEAST's area in mid December 2017.

A PSIT is a mobile, self-sufficient response team capable of deploying, firstly within their local area, or wider to support cross boundaries, where handover delays are causing us to be delayed to patients waiting in the community. The teams include a team leader and 2 clinicians. Their working brief falls into 2 clear pathways when responding to handover delays. The team leader will be supporting the clinicians and also liaising with HALO's and hospital staff. The clinicians on the team would be responsible for the safe cohorting of up to 6 patients, with the support of the hospital staff, using trolley cots and equipment carried within the PSIT vehicle. The PSIT staff are clearly identifiable and are dispatched to hospitals by a Tactical Commander as part of EEAST's escalation procedures. The teams also offer EEAST a range of options in the event of other incidents. The teams are in place until the end of March 2018 as part of EEAST's winter plan.

EEAST has produced the following information on local PSIT's activity from mid December 2017 to 8 January 2018:-

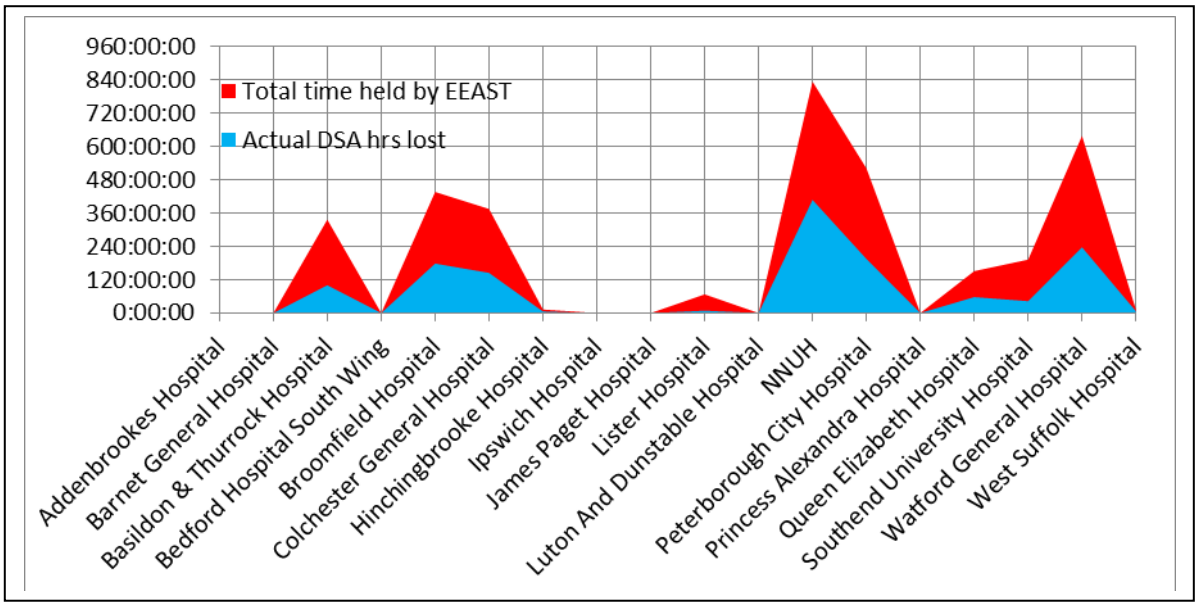
PSIT interventions at NNUH 11/12/17 to 8/1/18

PSIT has been active since 11/12/17, although their use at NNUH was delayed until partnership working could be formally agreed so their first day of operations at NNUH was the 18/12/17.

It is staffed by a team leader and to clinicians (paramedic and Associate practitioner).
The Team has now been deployed to the NNUH times and they have cohorted a total of **343** patients to allow ambulances to be returned to treat patients in the community.
PSIT have reduced potential ambulance delays be over 50% whilst they have been deployed.

During this time PSIT have saved **425** hours which otherwise would have been taken up by the ambulances. This is the equivalent of **37** full 12 hour shifts which in turn means that this has benefited approximately **277** patients who will have received a more timely response.

The table below shows the reduction in ambulance time that the PSIT have made. If PSIT had not have been utilised then the ambulance hours lost waiting handover at hospital would have been the red line, instead the actually hours lost was the blue line a clear reduction across all of the acute trusts that they have attended.



(Unvalidated data)

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3. Extract from Norfolk Health Overview and Scrutiny Committee Briefing 5 April 2018

Ambulance performance and turnaround

In January and February 2018 there were questions in Parliament and media reports about the East of England Ambulance Service NHS Trust's (EEAST) performance over the Christmas period and into January, including reports of a discrepancy in the recording of ambulance delays at the Norfolk and Norwich hospital (N&N) as well as the effect of ambulance delays on patients.

Ambulance performance and turnaround is on NHOSC's agenda for 24 May 2018, when representatives from EEAST, the Clinical Commissioning Groups and the N&N, the region's busiest A&E department, will attend to answer Members' questions.

In the meantime, the N&N was asked to explain the process for recording ambulance arrival to patient handover times at the hospital and how the reported discrepancy occurred between the N&N and EEAST's figures from 26 Dec 2017 to 21 Jan 2018.

The N&N has provided the following information about the ambulance arrival to handover and handover to clear (i.e. clear = ambulance ready for departure) recording process:-

> 'From an EEAST perspective, all ambulance vehicles have an electronic system tracking in the cab. This system has a push button function that EEAST push to declare arrival when the ambulance wheels come to a stop at the NNUH. The same system records the point that a patient is transferred from EEAST equipment to NNUH equipment and this is the formal handover time. EEAST also record, on the same tracking system, the point that the ambulance is resupplied and the crew are clear to leave the NNUH site: this is the arrival to clear point. These timings captured by EEAST are the data reported regionally and nationally in respect of the performance of arrival to handover and arrival to clear times.
>
> From an NNUH perspective, the symphony IT system is used to record the arrival handover time along with any other interventions within the ED (Emergency Department) as well as the time that the patient leaves the department. Symphony is updated by both clinical and nursing staff and is also used for patients that do not arrive via ambulance.
>
> Currently, all patients attending Children's ED (ChED) and Older Peoples Emergency Department (OPED) are firstly registered onto the symphony system at the point of entry to the ED. Children are then escorted through to ChED, unless there is a requirement for heightened intervention in Resuscitation.
>
> Patients over the age of 80 have an initial Rapid assessment to ensure that they are suitable for OPED and are transferred as soon as possible. Our Geriatricians and nursing staff work closely with ED clinicians and carry out the initial assessment and identify those who are suitable to go straight to an OPED cubicle to continue their assessment.'

Questions about the recording discrepancy from 26 December 2017 to 21 January 2018 and ambulance service performance and turnaround over the Christmas and New Year period can be addressed at NHOSC on 24 May 2018.

NHS
East of England
Ambulance Service
NHS Trust

Headquarters
Melbourn ambulance station
Whiting Way
Melbourn
Cambridgeshire
SG8 6NA

Tel: 0845 6013733

Date : 18 January 2018

Sent via email

Dear colleague,

We are writing to update you on how we have been performing over the Christmas period and the steps we are taking to manage high levels of demand.

Like all ambulance trusts, the Christmas period was exceptionally busy. We planned for this. We had more crews out on our roads, more clinical advisors in the control room, and liaison officers and patient safety intervention teams at acute hospitals. We also encouraged people to help us by looking after themselves, and – when clinically appropriate - make their own way to hospital.

Every day over this period a Gold Commander worked with our executive management team to discuss steps we can take to continue to prioritise our most critically ill and injured patients.

There was a sharp rise in demand just after Christmas and this resulted in a significant increase in handover delays at hospitals. This means it takes longer for our ambulance crews to respond to the next patient.

We also remained in close contact with our NHS partners about pressures they were experiencing to ensure any emerging trends were addressed.

On 27 December we highlighted the rising demand and handover delays through the system wide winter room, which includes clinical commissioning groups, hospitals, NHS Improvement and NHS England. We formally wrote to regulators that same day about the impact of handover delays.

We continued to have daily reviews and on 31 December it was clear that the forecasted activity would mean that we would come under extreme pressure. Consequently, the decision was taken Resource Escalation Action Plan (REAP), a national escalation plan which helps ensure we prioritise the most critically ill patients in periods of high demand. During that 24-hour period we received 4,800 calls - the first time this level of demand had occurred over the festive period.

From the 27 December to 15 January we had more than 50,000 calls. Unfortunately, a small proportion of patients waited significantly longer for an ambulance response than was acceptable. The Trust has made it a key priority to thoroughly analyse each of these patients' cases. The review of those analyses are due to be complete in January. It is worth noting any cause of death not certified by a doctor can only be established if there is a coroner's case.

When we are experiencing extreme pressure there are daily reviews to ensure all actions are carried out and were effective. We have planned a debrief internally as well as a system wide debrief. We will also invite an independent review of the festive plan and the actions taken against our winter plan.

We are aware of the claims made in the House but note no complaints have been received from patients or their families at this time. Nor have any concerns been expressed internally through our line management, whistleblowing or freedom to speak up processes.

For your added information REAP predates the introduction of Ambulance Response Programme (ARP) and the Trust continues to use the REAP plan as its guidance to escalate its status. As all Trusts were already on REAP 3 (Severe Pressure), opportunities for mutual aid did not exist other than in border areas which we operate as a matter of normal operation. It is worth noting that military aid can only be requested through the MAC protocol.

Please do get in touch with Taya Cleghorn, Executive Assistant if you require further information on 01763 268742 or taya.cleghorn@eastamb.nhs.uk.

Sincerely

Robert Morton
Chief Executive

Report by the East of England Ambulance Service NHS Trust
May 2018

Introduction

This is an update to give members information on demand and response times, as well as updates on stroke performance, staff and recruitment and the trends for the three hospitals.

We have included information about winter 2017/18 and the risk summit held on 30 January.

EEAST is commissioned at a regional level, not on a CCG level. The new ambulance response programme (ARP) standards, introduced in October 2017, cannot be compared to previous standards and the Trust is not commissioned to deliver the ARP standards. These national standards, which will take two years to implement properly, aim to get the right vehicle in the right place at the right time.

For clarity, on the left are last year's figures across Norfolk, the whole region and as a percentage over the period February to March. On the right-hand side are this year's figures.

Norfolk	Calls	Incidents
Feb-17	13528	10153
Mar-17	14595	11206
Apr-17	13944	10510

Norfolk	Calls	Incidents
Feb-18	15200	10169
Mar-18	17067	11391
Apr-18	15269	10683

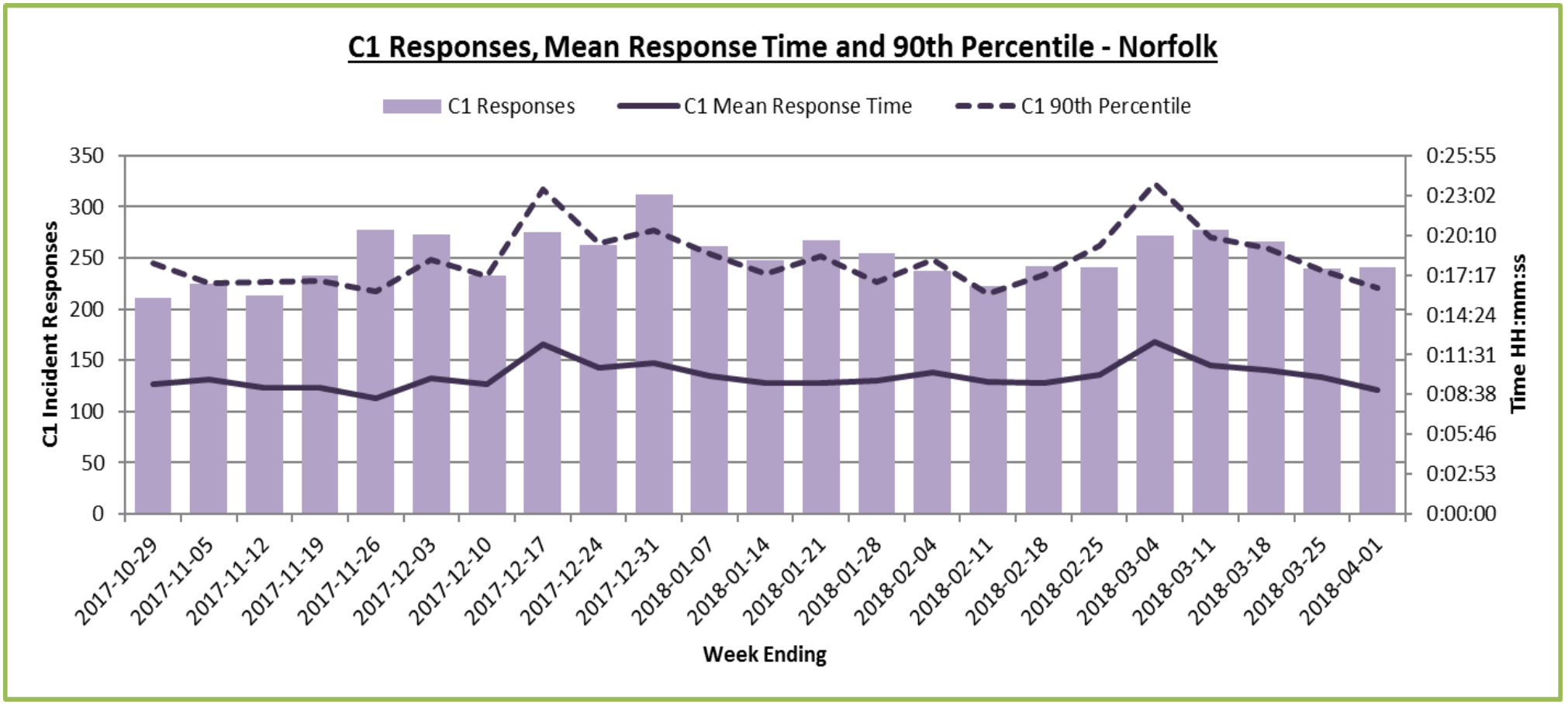
Trust	Calls	Incidents
Feb-17	89715	61086
Mar-17	95119	66198
Apr-17	91725	62340

Trust	Calls	Incidents
Feb-18	96257	62232
Mar-18	106335	69091
Apr-18	94364	64643

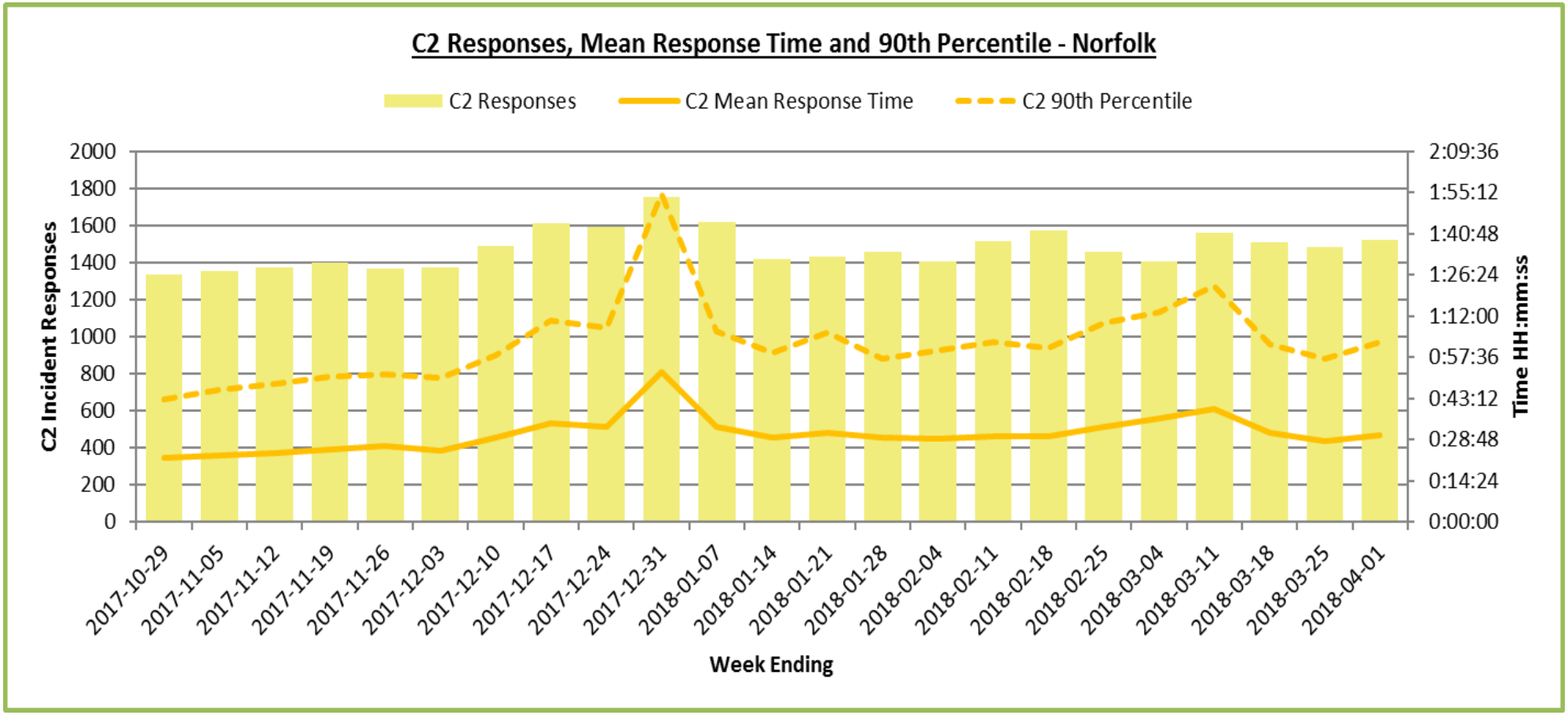
Norfolk % of all Trust count	Calls	Incidents
Feb-17	15.08%	16.62%
Mar-17	15.34%	16.93%
Apr-17	15.20%	16.86%

Norfolk % of all Trust count	Calls	Incidents
Feb-18	15.79%	16.34%
Mar-18	16.05%	16.49%
Apr-18	16.18%	16.53%

The graph below shows the number of C1 responses by week from 22 October 2017 to 1 April 2018 and the C1 mean response time and C1 90% Percentile for Norfolk. On average, there are 252 C1 responses per week in Norfolk. There has been a steady decline in both C1 mean and C1 90th percentile in March (lower is better).



The graph below shows the number of C2 responses by week from 22 October 2017 to 1 April 2018 and the C2 mean response time and C2 90% Percentile for Norfolk. On average, there are 1478 C2 responses per week in Norfolk. There has been a declining trend in both C2 mean and C2 90th percentile in March (lower is better). Peak response times week ending 31.12.2017 were also in the busiest week for C2 responses and some increase in response times was seen in early March due to snow and bad weather.



Stroke Performance

EEAST is measured against two stroke targets. One is around the level of care given (called the stroke bundle). From April this year EEAST will be measured against the proportion of patients that receive appropriate treatment, according to the latest guidance. These outcomes are thrombolysis or first CT scan within 180 minutes of making a 999 call, with an expectation that 90% of patients will have these standards met by 2022.

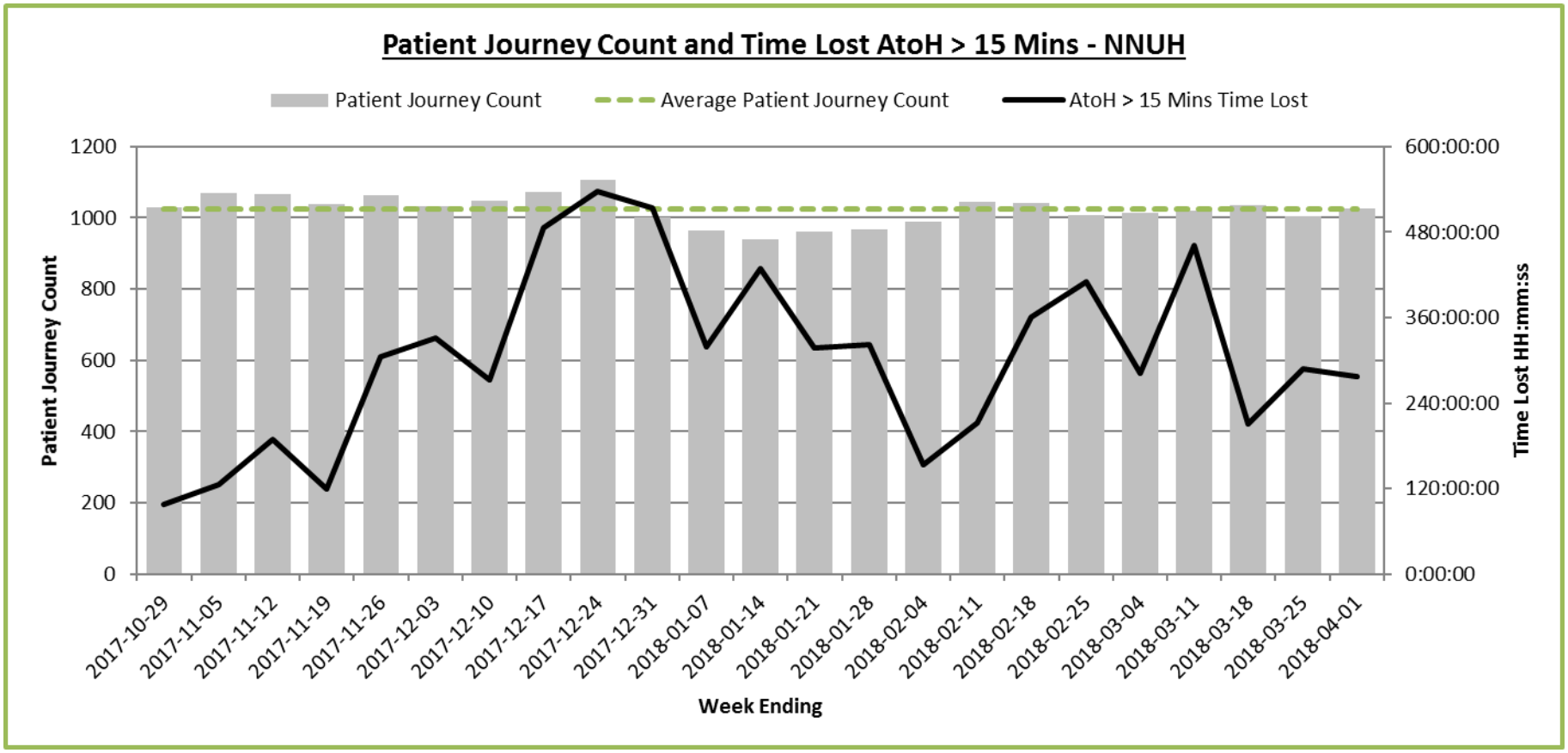
The stroke care bundle target measures if EEAST delivered the right clinical care to each patient. As can be seen from table below, EEAST across Norfolk and Waveney has excellent care bundle results. The target is 95% achievement of the stroke care bundle.

Stroke care bundle results in Norfolk and Waveney CCGs

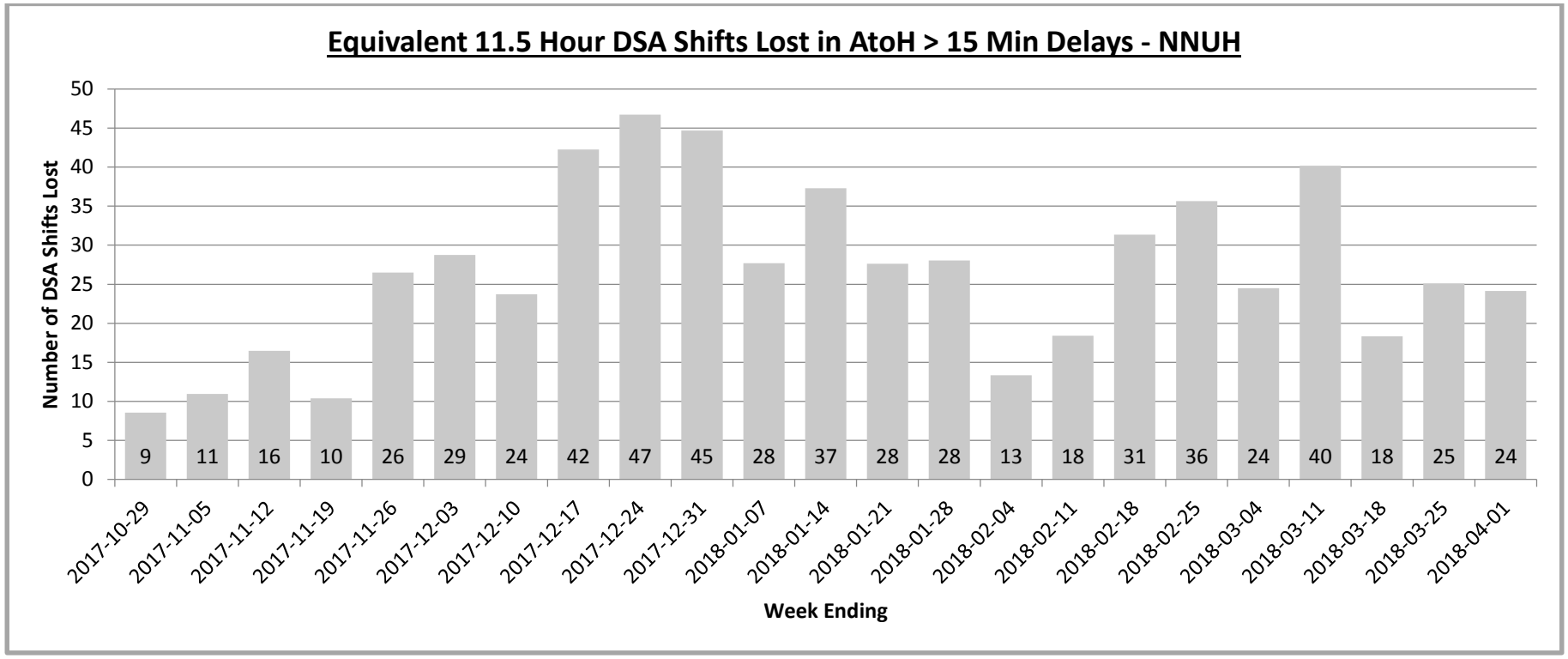
CCG	YTD until March 2018
GYW	99.1%
North Norfolk	99.6%
Norwich	99.4%
South Norfolk	99.1%
West Norfolk	100.0%

As you can see, the standard of care provided by paramedic and technician crews across Norfolk & Waveney remains excellent, as it has done for the past year.

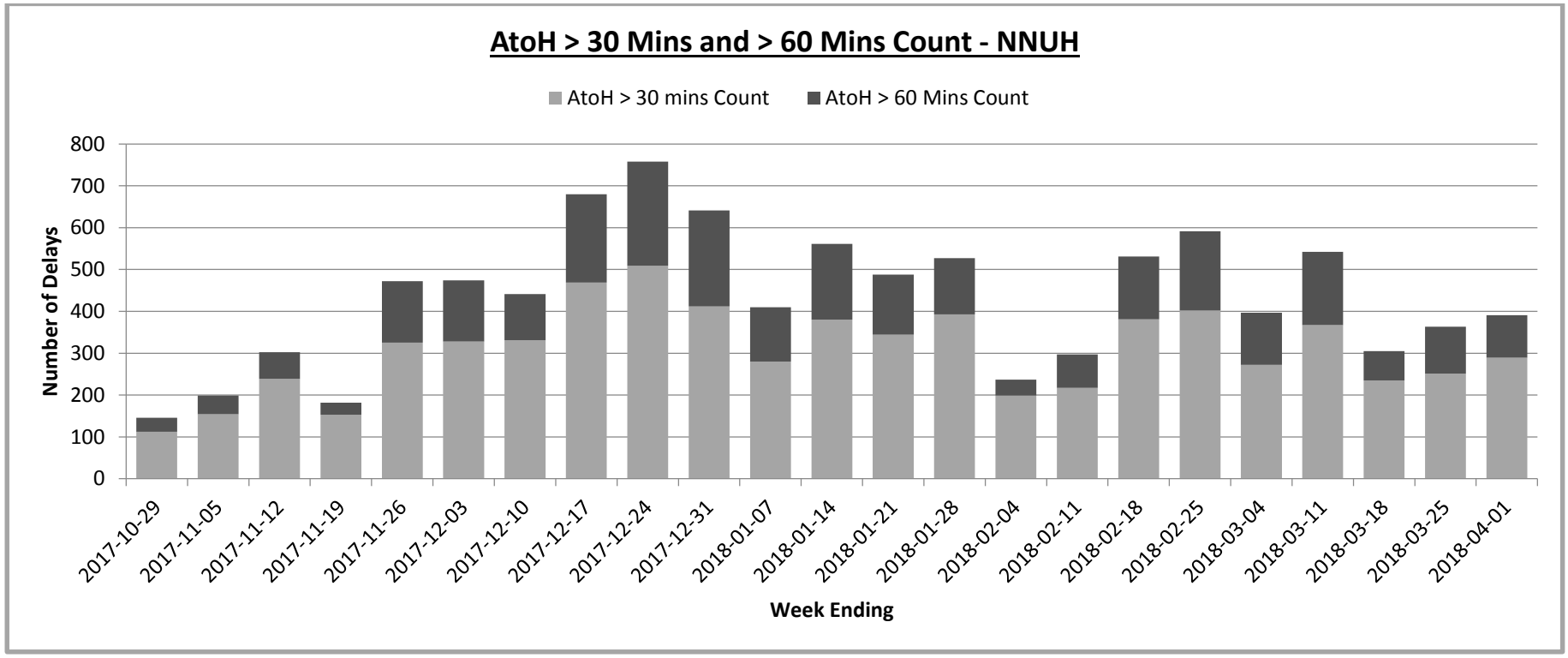
This graph shows the patient journey count into NNUH by week from 22.10.2017 to 01.04.2018. The average patient journey count was 1024 and this was exceeded in 13 weeks. Arrival to Handover (AtoH) > 15 mins time lost peaked at 537 hours WE 24.12.2017 and on average, 305 hours were lost a week over the 23 week review period.



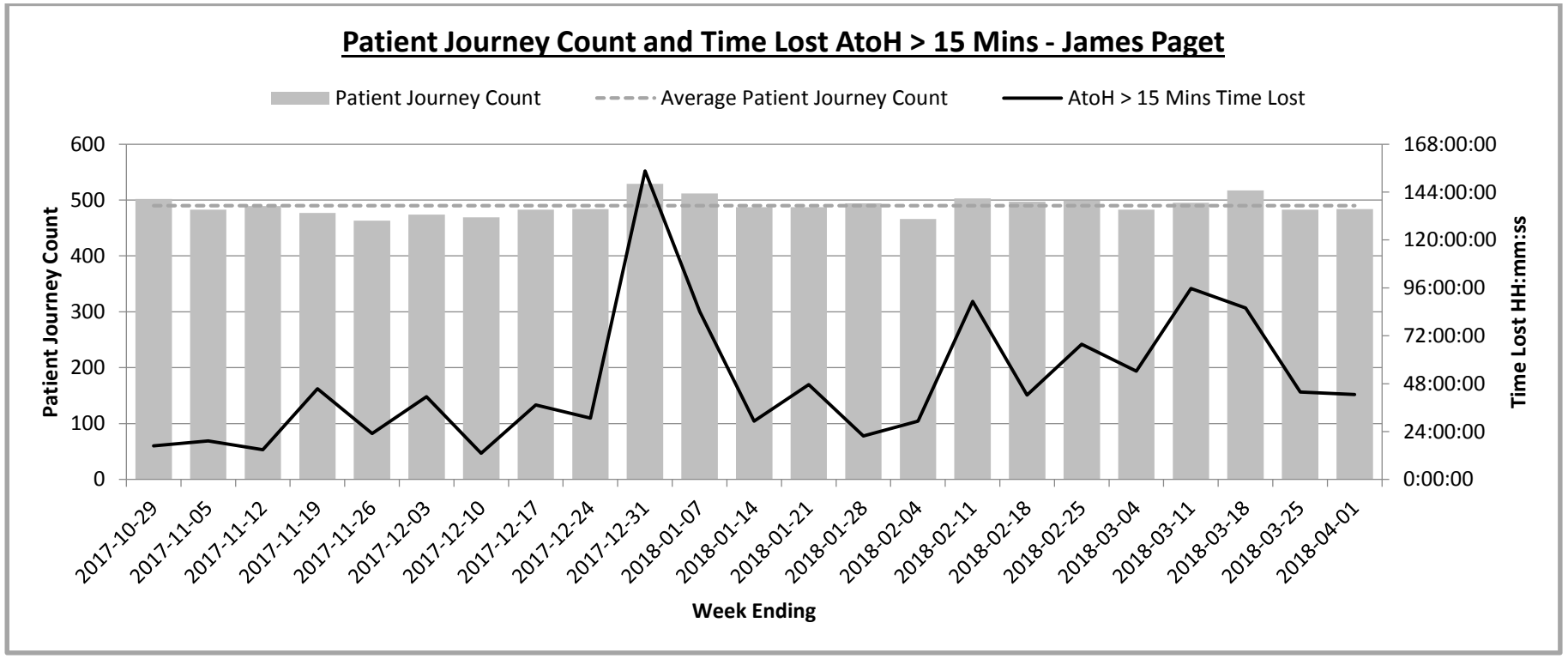
This graph shows equivalent number of 11.5 hour DSA shifts lost in AtoH > 15 min delays at the NNUH from 22.10.17 to 01.04.18. On average, 27 shifts were lost per week due to AtoH delays however, as many as 47 shifts were lost in one week (WE 24.12.2017).



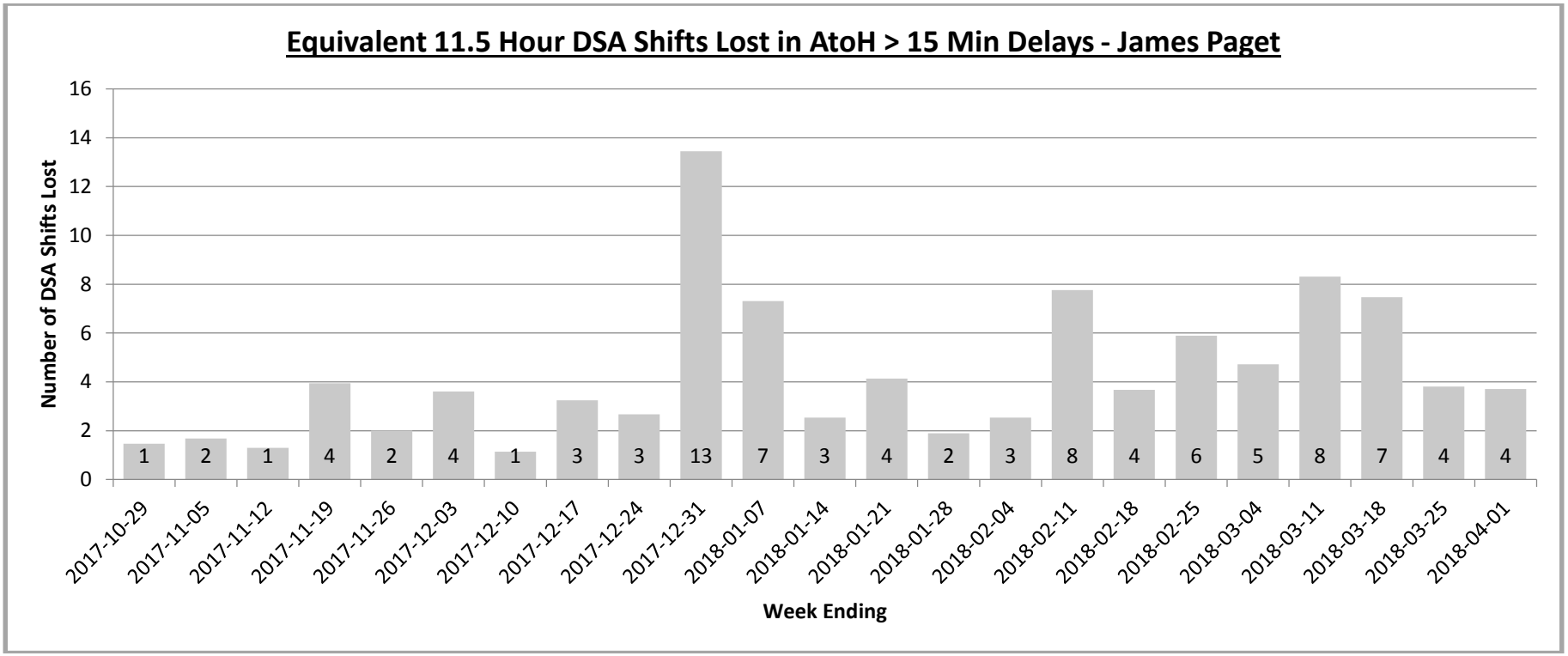
This graph shows the number of occasions where AtoH was > 30 mins and AtoH was greater than 60 mins. There were 7042 AtoH delays > 30 mins from 22.10.2018 to 01.04.2018 (30% of all patient journeys) and 2893 AtoH delays > 60 mins in the same time frame (12% of all patient journeys).



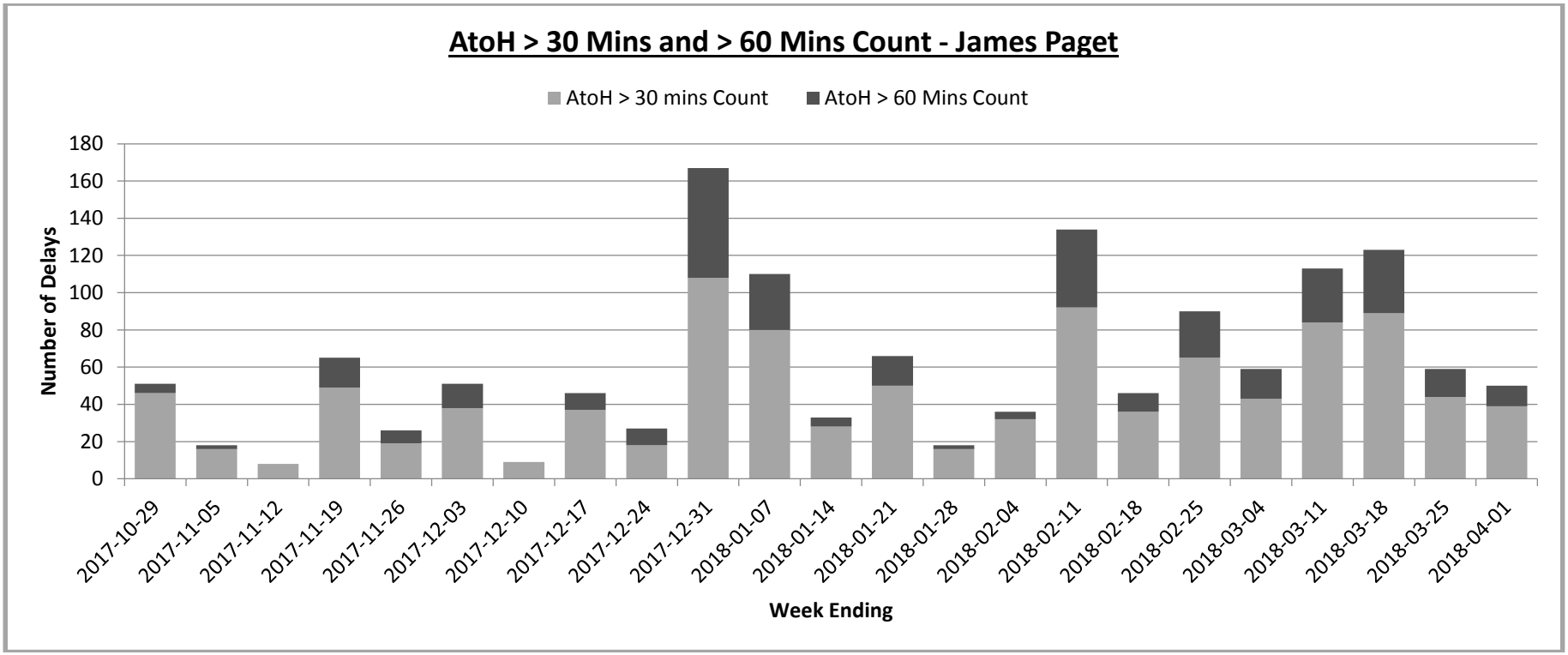
This graph shows the patient journey count into James Paget by week from 22.10.2017 to 01.04.2018. The average patient journey count was 490 and this was exceeded in 9 weeks. AtoH > 15 mins time lost peaked at 154 hours WE 31.12.2017 and on average, 49 hours were lost a week over the 23-week review period.



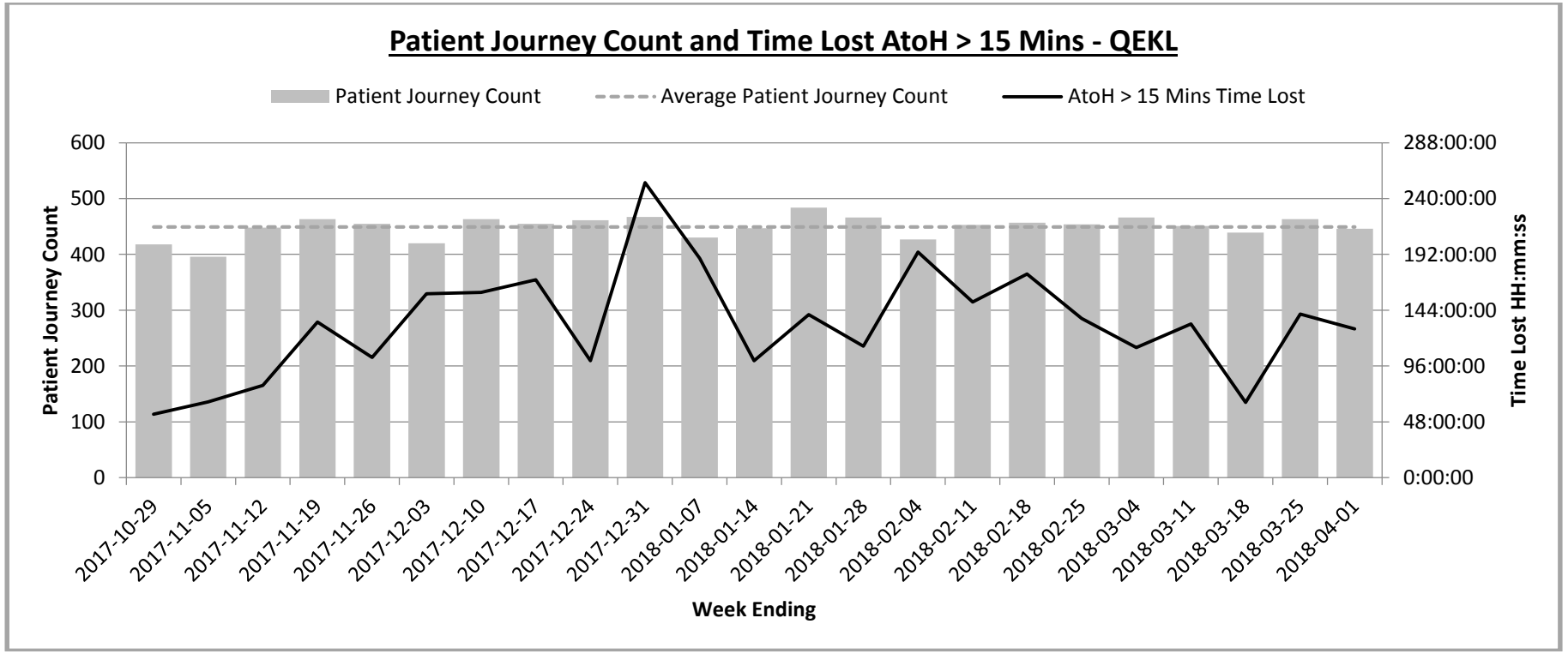
This graph shows equivalent number of 11.5 hour DSA shifts lost in AtoH > 15 min delays at James Paget from 22.10.17 to 01.04.18. On average, 4 shifts were lost per week due to AtoH delays however, as many as 13 shifts were lost in one week (WE 31.12.2017).



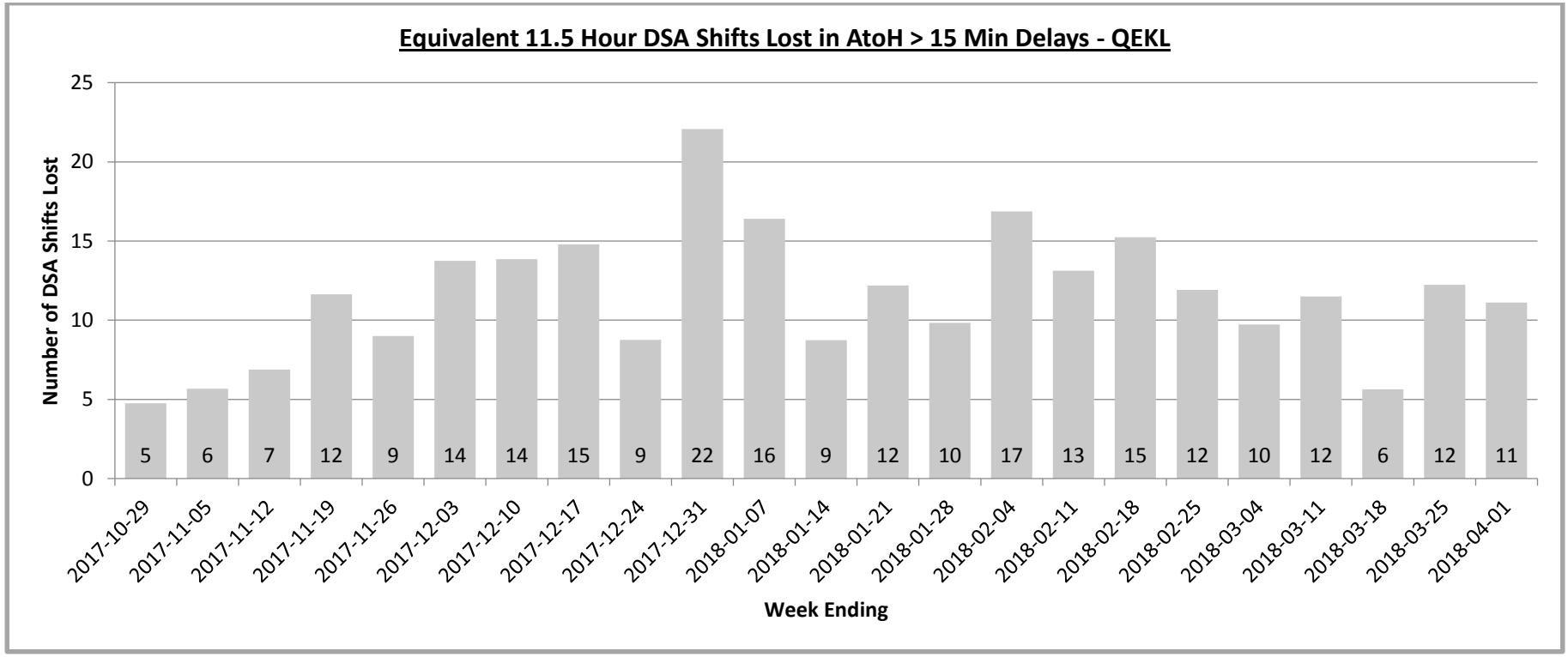
This graph shows the number of occasions where AtoH was > 30 mins and AtoH was greater than 60 mins. There were 1046 AtoH delays > 30 mins from 22.10.2018 to 01.04.2018 (9.3% of all patient journeys) and 359 AtoH delays > 60 mins in the same time frame (3.2% of all patient journeys).



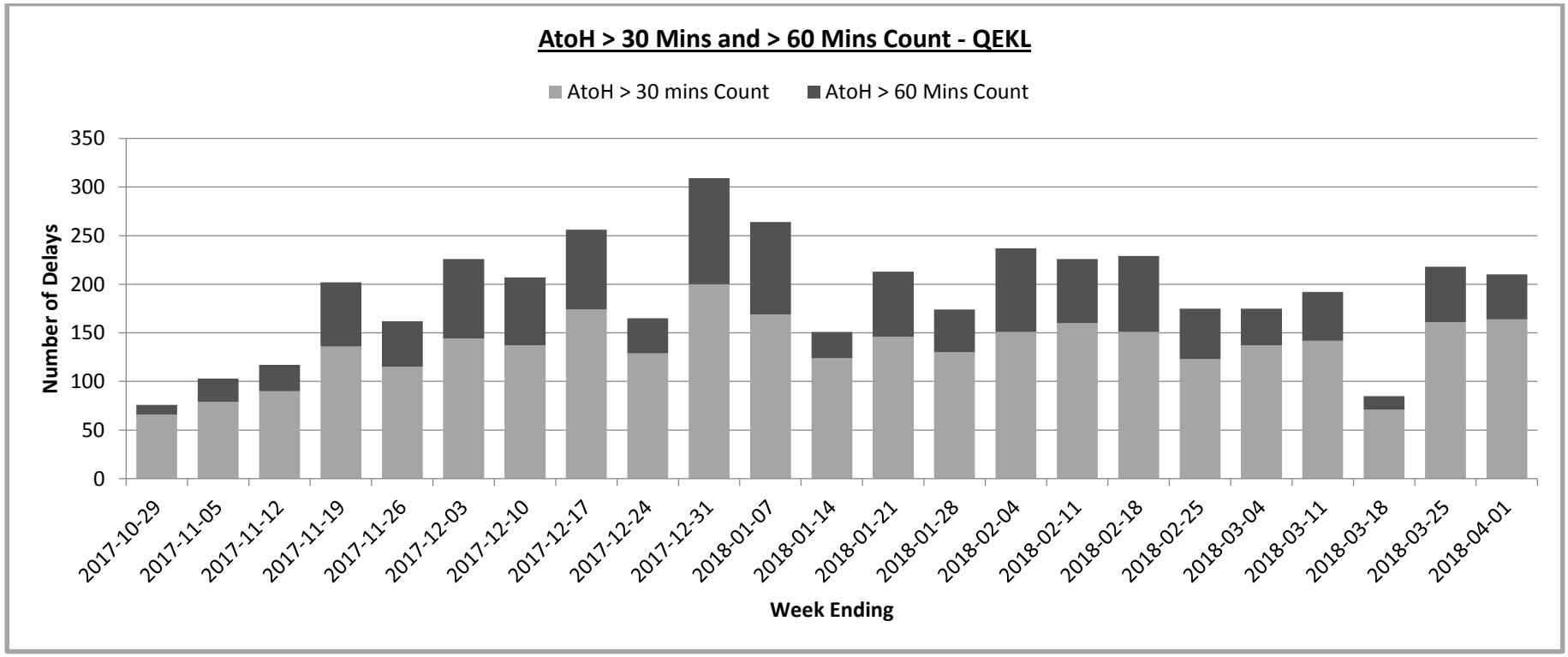
This graph shows the patient journey count into Queen Elizabeth King's Lynn (QEKL) by week from 22.10.2017 to 01.04.2018. The average patient journey count was 449 and this was exceeded in 14 weeks. AtoH > 15 mins time lost peaked at 253 hours WE 31.12.2017 and on average, 133 hours were lost a week over the 23 week review period.



This graph shows equivalent number of 11.5 hour DSA shifts lost in AtoH > 15 min delays at QEKL from 22.10.17 to 01.04.18. On average, 12 shifts were lost per week due to AtoH delays however, as many as 22 shifts were lost in one week (WE 31.12.2017).



This graph shows the number of occasions where AtoH was > 30 mins and AtoH was greater than 60 mins. There were 3099 AtoH delays > 30 mins from 22.10.2018 to 01.04.2018 (30% of all patient journeys) and 1273 AtoH delays > 60 mins in the same time frame (12% of all patient journeys)



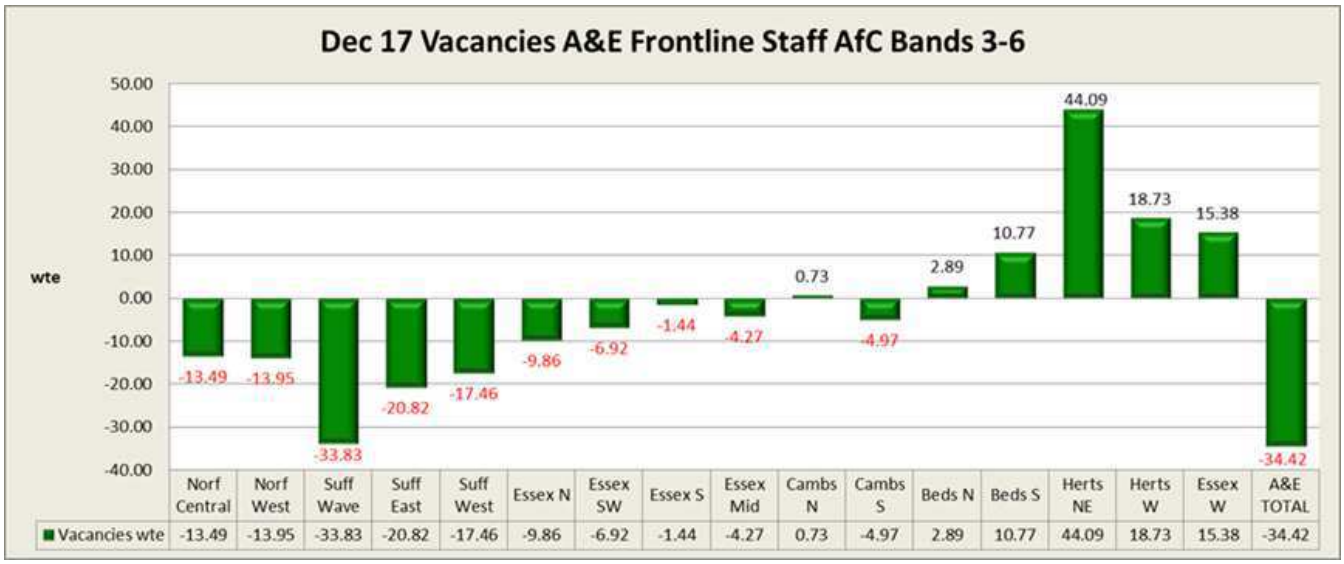
Staff Recruitment Plan

Since 2014/2015 EEAST's recruitment plan has delivered an increase of over 700 'frontline' staff. In order to mitigate both internal and external staff turnover the Trust has had to recruit and train over 1500 people to achieve these increases in whole time establishment.

In addition to the sustained delivery of this significant recruitment and training plan the Trust has worked to reduce staff turnover through a range of HR and organisational development processes and strong leadership and engagement. This has seen the Trust reduce frontline staff turnover from the 4th highest of all 11 Ambulance Trusts in July 2015 (11.8%) to the 2nd lowest in October 2017 (7.54%). Across Norfolk & Waveney, attrition was only 4.24% (28 staff) across the entire FY2017/18.

The Trust is currently 'over established' against its budget (see below). However, these figures mask the fact that the Trust has significantly more staff in some areas, including Norfolk, which have more staff than budgeted for and high levels of vacancies in other areas such as Hertfordshire.

In Norfolk and Waveney we have 686 staff against a budget of 618, which means this area is over established by 68 staff. There is a waiting list for recruits to come into Norfolk and staff in other areas are currently able to transfer in.



**Please note minus figures in red denote over establishment.*

Funding has been agreed with the Consortium of 19 CCGs which buy the ambulance services for the region which will enable a further 330 staff in three years. It will see the Trust recruit and train a further 1300 plus people. The Trust recognises that it remains challenging and is delivering a range of activities to address this challenge including:

- Recruitment and retention incentives in hard to fill areas
- School, College and University targeted engagement and recruitment events
- Focussed graduate recruitment campaigns and incentive packages
- Engaging with armed forces service leavers to look at EEAST as an alternative career option
- New marketing materials and recruitment campaigns to raise awareness of careers in the Trust and benefits of working for EEAST
- Targeted recruitment campaigns utilising, Bus stops, Bus backs and radio advertising
- Social media recruitment strategy
- Trained over 100 community ambassadors to promote the trust in hard to reach communities
- Taster days and engagement sessions
- Use of on-line job boards in addition to NHS jobs
- Building capacity in recruitment team
- Recruitment improvement project and safer and resilient recruitment initiatives
- Outsourcing of some volume recruitment
- Purchase of private training provision to frontload 3-year workforce plan
- Working with HEE to agree funding to support 3-year workforce plan including liaison with Higher Education Institutes
- Investment in the Trusts training and education infrastructure
- Developing apprenticeships for transition to new clinical career pathway
- Developing advanced and specialist routes to improve recruitment and retention

The Trust is also pleased that sickness has recorded a downward trend in 2017/18, although work continues to deliver a holistic wellbeing strategy to support staff and reduce absence levels further.

Mental Health Pathways

EEAST continue to work with commissioners and provider partners to seek the safest and most appropriate and efficient transport option for mental health patients. EEAST has also engaged with senior partners within Norfolk County Council, Norfolk Constabulary, NSFT to review and identify gaps in the transport pathway for mental health patients.

EEAST will follow up the positive Mental Health strategy day in March 2017 – which involved service users - with further workshops. We have planned ‘pop-up’ focus groups in line with the Trust’s Dementia Strategy.

Developments during winter 2017-18
Like all ambulance trusts and the NHS in general, the Christmas and New Year period was exceptionally busy. Following winter, all Ambulance Trusts participated in some form of “risk summit”. What follows is a timeline to help build the picture of what happened and what actions taken.

- Between 17 December and 16 January, the three control rooms received in excess of 96,000 calls. A small proportion of patients waited significantly longer for an ambulance response than was acceptable. Every day over this period, a Gold Commander worked with the executive management team to prioritise our most critically ill and injured patients. The Trust also remained in close contact with our NHS partners about pressures they were experiencing to ensure any emerging trends were addressed.
- There was a sharp rise in demand just after Christmas and this resulted in a significant increase in handover delays at hospitals. This means it takes longer for ambulance crews to respond to the next patient.
- On 27 December EEAST highlighted the rising demand and handover delays through the system-wide winter room which includes clinical commissioning groups, hospitals, NHS Improvement and NHS England. EEAST formally wrote to regulators that same day about the impact of handover delays.
- Daily reviews continued and on 31 December the forecasted activity predicted extreme pressure. Consequently, the decision was taken to enact the Resource Escalation Action Plan (REAP), a national escalation plan which helps ensure we prioritise the most critically ill patients in periods of high demand. During that 24-hour period alone we received 4,800 calls - the first time this level of demand had occurred over winter period.

Risk Summit

Issues experienced by the wider NHS system across the east of England over the winter period were raised in the House of Commons on 17 January. This led to a risk summit on Tuesday 30 January 2018.

Co-hosted by NHS Improvement and NHS England, it was attended by representatives from EEAST, its lead commissioner, Ipswich and East Suffolk Clinical Commissioning Group, the Care Quality Commission (CQC), Healthwatch Suffolk, Norfolk and Norwich University Hospitals NHS Foundation Trust, Mid Essex Hospital Services NHS Trust, Queen Elizabeth NHS Foundation Trust and Health Education England.

The Risk Summit saw a series of actions agreed. This is a brief update on those actions.

EEAST deploy additional staff and vehicles to manage the end of winter. This included securing additional vehicles from independent providers, and prepare plans for next winter

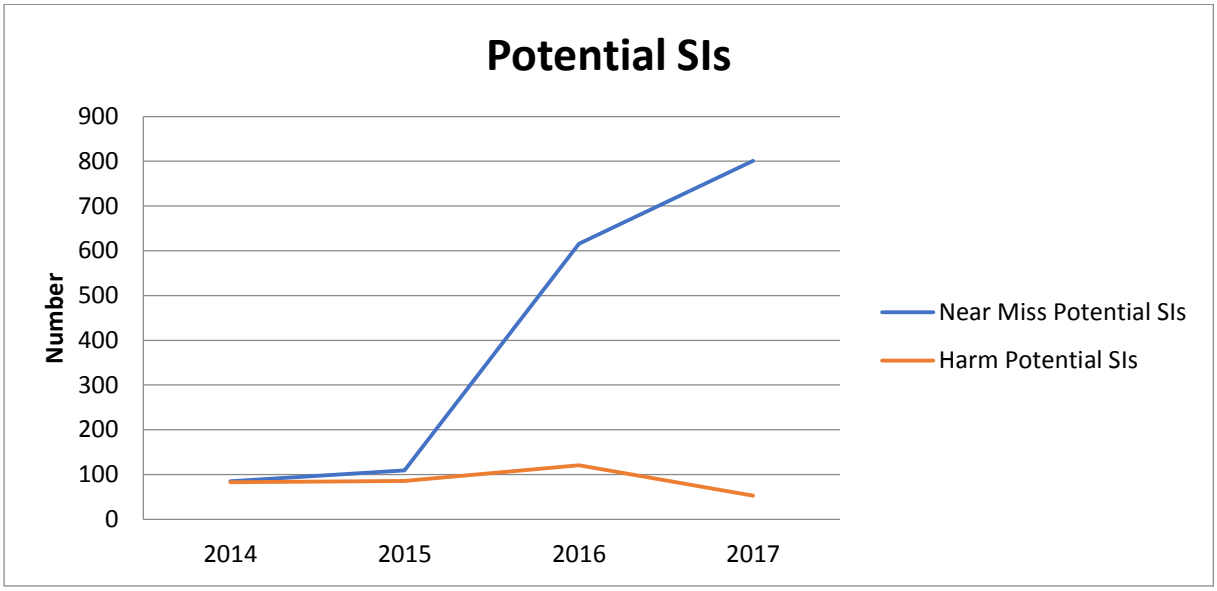
EEAST is looking to improve staff health to make sure there are enough staff available in busy periods, including increasing take up of flu vaccinations.

Local hospitals and ambulance services have worked together to make sure there is a prompt handover of patients from ambulance crews in order to release the crews for other calls. A standard operating procedure introduced in February has already seen crews waiting at hospitals for an average 29 minutes in January to 20 minutes in recent weeks across the region.

CCGs and other providers of NHS care across the region are working to implement measures to moderate the use of ambulance services, using safe alternatives wherever possible.

Serious Incidents

Since 2014, the Trust's patient safety team has reviewed almost 2,300 incidents in greater detail, with the trend as follows:



The Trust is committed not only to focus on reviewing incidents which have caused harm, but also those which did not cause harm but had the potential to. This helps mitigate the risk of reoccurrence prior to the same incident causing harm. The graph shows a sharp rise in near miss incidents being reviewed to proactively improve services and prevent harm. At the same time, a reduction in harm incidents has been reported.

During 17 December and 16 January, there were 47 cases which were potential issues. Of those, 22 were deemed to be serious incidents. The Trust has made it a key priority to thoroughly analyse each of these patients' cases. An independent analysis will be completed and published during May 2018.

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 - 24 MAY 2018

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

For: Norfolk Health Overview and Scrutiny Committee - 24 May 2018

The NNUH have been asked to update the committee on ambulance handover delays at the Hospital during the winter period and be prepared to answer four specific questions. The questions and response are shown at end of this paper.

Background

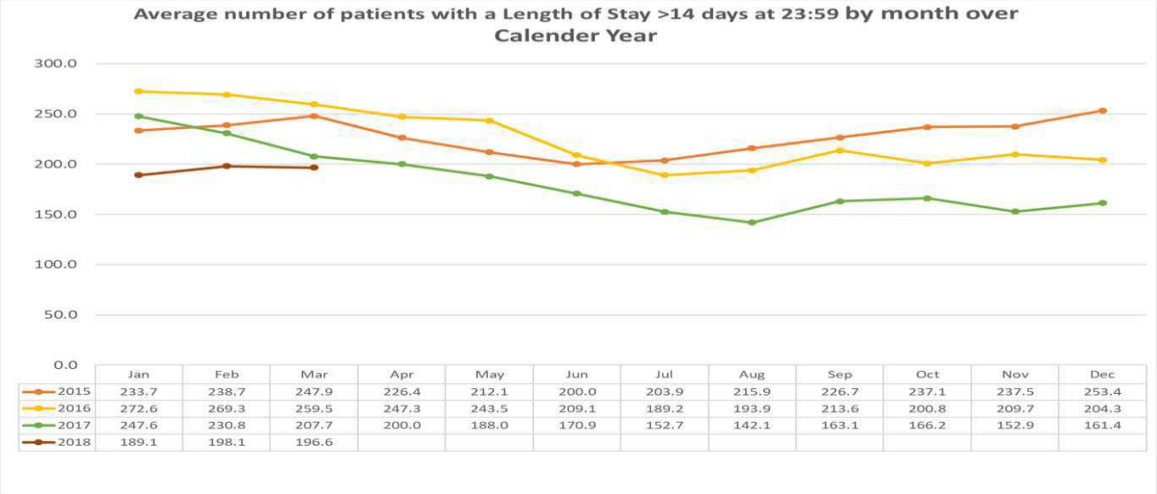
As recognised at section 1.2 of the NHOSC briefing paper when ambulance handover delays occur at the NNUH it is usually symptomatic of pressures across the local health and social care system

Winter 2017/18 was a particularly challenging period for the NHS, Central Norfolk system and the NNUH. Pre winter a significant amount of planning was undertaken in the summer/autumn of 17/18 to identify key schemes to address 4 themes and objectives as follows:

1. Managing and avoiding congestion through consistent and improved discharge practices (including weekends and holiday periods).
2. Increasing capacity – specifically in OPM.
3. Optimising schemes to avoid admission i.e. Ambulatory unless proven otherwise.
4. Learning from previous risks and issues i.e. Clinical ownership and opening of an escalation ward.

1. Managing & Avoiding congestion - Improved Discharge

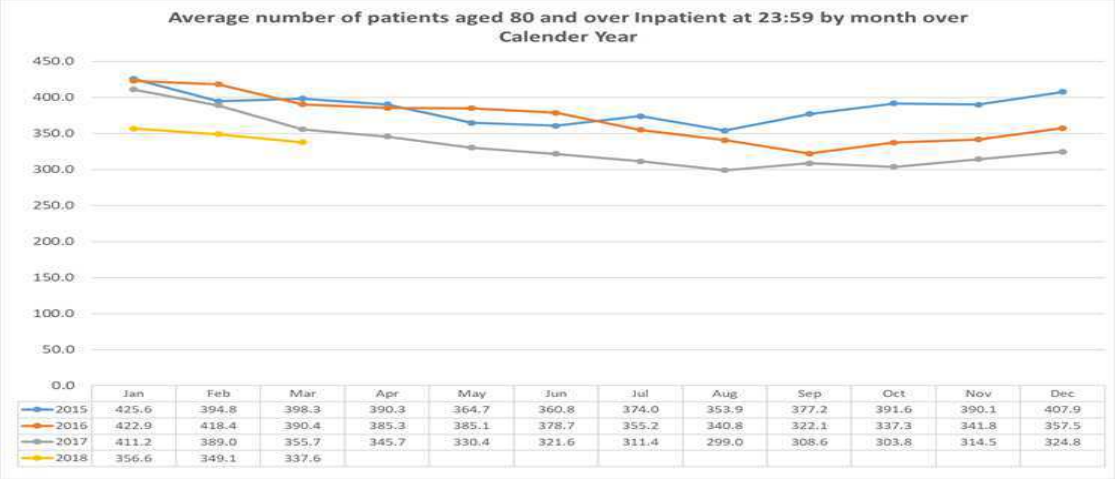
Using the '14-day-stranded' metric as a proxy for discharge performance, the suite of schemes in this area performed well.



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2015	233.7	238.7	247.9	226.4	212.1	200.0	203.9	215.9	226.7	237.1	237.5	253.4
2016	272.6	269.3	259.5	247.3	243.5	209.1	189.2	193.9	213.6	200.8	209.7	204.3
2017	247.6	230.8	207.7	200.0	188.0	170.9	152.7	142.1	163.1	166.2	152.9	161.4
2018	189.1	198.1	196.6									

2. Increased OPM capacity

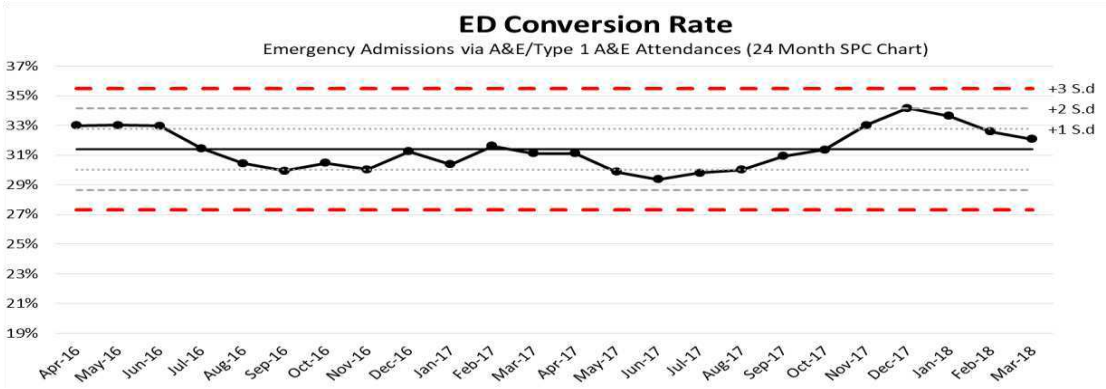
Schemes to actively reduce the numbers of Older People being admitted to hospital worked well with the lowest number of in-patients over 80yrs of age in the last 3 winters.



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2015	425.6	394.8	398.3	390.3	364.7	360.8	374.0	353.9	377.2	391.6	390.1	407.9
2016	422.9	418.4	390.4	385.3	385.1	378.7	355.2	340.8	322.1	337.3	341.8	357.5
2017	411.2	389.0	355.7	345.7	330.4	321.6	311.4	299.0	308.6	303.8	314.5	324.8
2018	356.6	349.1	337.6									

3. Admission Avoidance

Schemes to optimise admission avoidance were not as effective as was anticipated The conversion rate of ED attendances to admission was significantly higher in the late Autumn and early Winter period.



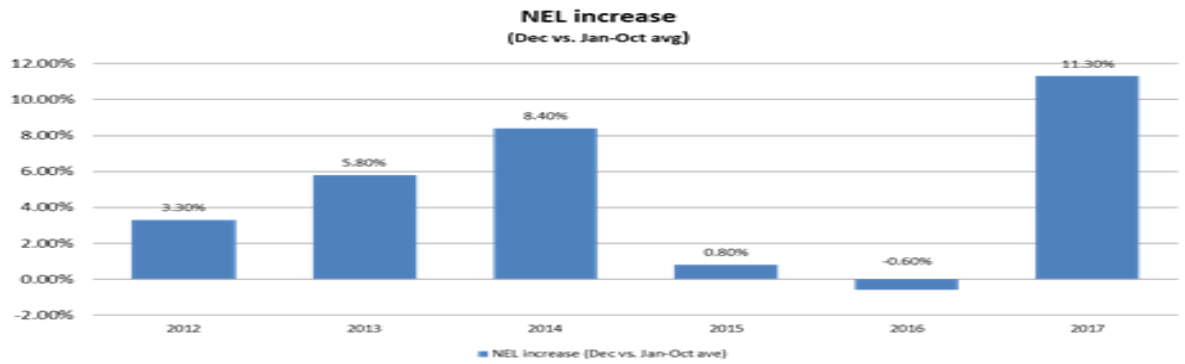
4. Lessons Learnt

Whilst the lessons-learnt from the previous winter in relation to the use of the refurbishment decant ward for temporary escalation seemed to work well, the ability to protect the DPU from in-patient use failed; DPU was used for in-patient escalation in the period 1 January until 11 April.

A sustained (16-month) period of effective NEL reduction was significantly reversed in Quarter 3.

The unexpected rise in Non Elective admissions during November, December & January was driven by a 24% rise in 70-79yrs patients (typically 1-6 day length of stay) – not representative of previous years profile (demand or demographic).
The most common presenting condition was 'Respiratory Illness'.

Non Elective Admission trends 2012 -2017

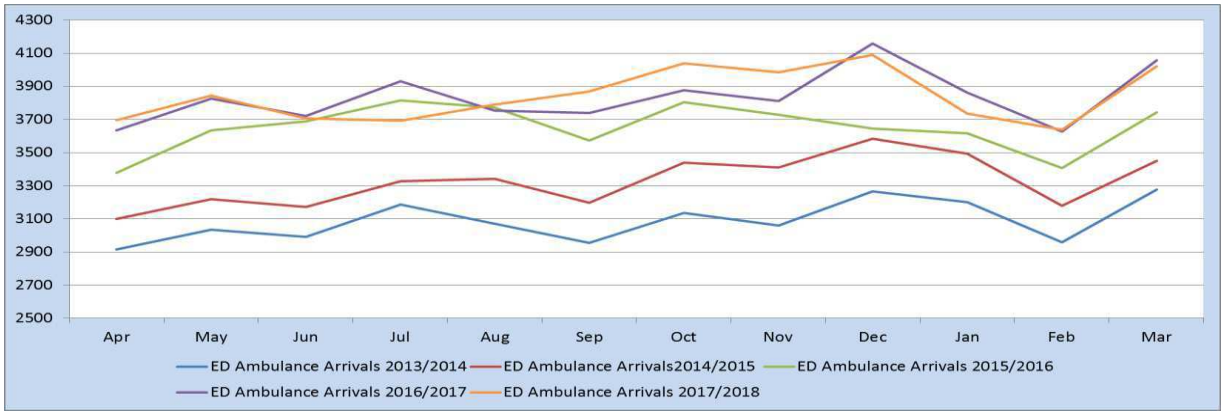


The winter plan was affected by the unexpected increases in emergency admissions and the relative failure of the Ambulatory Emergency Care service to identify sufficient patients suitable for rapid treatment avoiding the need for an inpatient bed. The pressure within the Central Norfolk system manifested at the hospital and resulted in congestion and ambulance handover delays

Ambulance Activity

In 2017/18 Ambulance arrivals at the NNUH represent 45.1% of the total attendances at the A&E department, compared to 45.5% in 2016/17.

Table 1. Ambulance arrivals at ED Apr 2013 – Mar 2018



Ambulance Conveyance rates – Norfolk Acute Trusts

	Average Daily conveyance	Range	Conveyance %*
JPH	69	55~86	47%
NNUH	144	105~182	61%
QEH	64	41~80	46%

The rate of conveyance by ambulance to the NNUH is higher than our near neighbours predominantly due to the specialist nature and size of the NNUH.

During the period 1 April 2017 – 31 March 2018, the rate of admission of ambulance arrivals at A&E has decreased from an average of 56% in 2016/17 to 51% in 2017/18. The vast majority of those patients admitted have been seen in either the Majors or Resus areas of the A&E department.

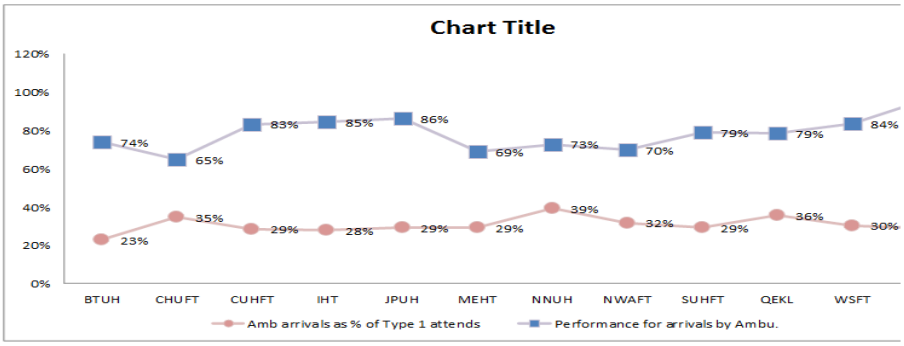
Patients requiring Type 1 resus or majors are the patient group with the highest acuity and immediate/urgent care requirements. There has been an 8.5**%** increase in combined majors/resus attendances 1 April 2017 – 31 March 2018 versus the same period of 2016/17.

This represents an additional 6243 resus/majors patient attendances compared with the same period in 2016/17. That is an average of 17 additional resus/majors patients per day. Assuming that, on average, 180 minutes are required for resus and majors patients, 17 additional patients per day represents 51 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.

A disproportionate amount of Type 1 (Resus/Majors) ED activity arrives by ambulance at NNUH

Ambulance arrivals as a % of type 1 attendances – Eastern region

	April - Oct 2017										
	BTUH	CHUFT	CUHFT	IHT	JPUH	MEHT	NNUH	NWAFT	SUHFT	QEKL	WSFT
Amb arrivals as % of Type 1 attends	23%	35%	29%	28%	29%	29%	39%	32%	29%	36%	30%
Performance for arrivals by Ambu.	74%	65%	83%	85%	86%	69%	73%	70%	79%	79%	84%



Source: NATIONAL A&E MONITORING TOOL

The NNUH fully supports the EEAST quick release protocol but, despite that commitment, the infrastructure to manage more than 8 ambulances per hour has not allowed full compliance in this area. Internal policies and protocols have been re-written to support the achievement of consistently earlier ambulance handover but the space available requires further expansion and modification to ensure sustained improvements in performance.

Ambulance Hnadover <15 Minutes – Eastern Region

A to H %<15 m in A&E of those recorded	2016/1	2017/18									
Hospital ED	March	April	May	June	July	August	September	December	January	February	March
Addenbrookes Hospital	50.8%	48.9%	47.1%	43.1%	46.3%	44.2%	43.8%	55.5%	59.5%	55.3%	53.8%
Basildon & Thurrock Hospital	41.7%	43.1%	38.7%	40.6%	39.9%	46.0%	40.6%	31.7%	30.7%	28.0%	28.5%
Bedford Hospital South Wing	62.0%	63.8%	66.5%	72.3%	65.1%	72.0%	63.6%	57.2%	61.5%	59.2%	64.9%
Broomfield Hospital	45.1%	46.4%	45.6%	36.6%	41.7%	42.6%	40.3%	17.9%	18.5%	19.6%	27.4%
Colchester General Hospital	30.1%	21.6%	19.4%	15.9%	15.3%	16.9%	18.6%	14.5%	18.2%	23.0%	32.1%
Hinchingbrooke Hospital	25.7%	22.2%	24.9%	23.8%	30.8%	52.9%	44.5%	23.3%	20.3%	18.2%	23.2%
Ipswich Hospital	34.9%	36.8%	39.3%	38.9%	39.8%	37.2%	32.9%	24.9%	32.7%	35.7%	44.1%
James Paget Hospital	48.5%	50.6%	53.3%	48.1%	50.8%	51.2%	48.4%	55.1%	50.8%	49.9%	43.6%
Lister Hospital	43.9%	80.4%	65.7%	75.4%	69.5%	62.3%	52.8%	41.0%	41.2%	39.6%	42.8%
Luton And Dunstable Hospital	43.8%	45.7%	52.2%	46.9%	50.6%	44.1%	45.4%	47.7%	41.2%	31.6%	35.2%
Norfolk & Norwich University Hospital	57.3%	58.7%	66.5%	62.2%	63.7%	56.6%	44.5%	20.9%	18.4%	26.7%	24.5%
Peterborough City Hospital	34.4%	34.8%	33.3%	41.8%	40.5%	36.6%	30.6%	22.0%	24.6%	23.9%	30.6%
Princess Alexandra Hospital	34.3%	31.6%	30.8%	28.3%	31.1%	31.4%	29.8%	22.5%	18.5%	17.8%	18.3%
Queen Elizabeth Hospital	19.6%	21.7%	22.0%	18.0%	17.2%	16.1%	18.6%	16.5%	14.4%	11.8%	15.4%
Southend University Hospital	50.0%	57.8%	44.5%	41.5%	44.1%	38.8%	37.8%	33.5%	42.8%	46.2%	50.0%
Watford General Hospital	24.0%	20.5%	26.1%	31.6%	25.2%	19.5%	25.0%	17.5%	12.3%	22.4%	27.7%
West Suffolk Hospital	32.1%	35.1%	31.6%	34.5%	31.2%	26.5%	27.8%	22.1%	28.3%	29.7%	28.8%

The Winter period was challenging for most trusts in the Eastern Region with even the highest performing only achieving 64%. Improvements in March and April are beginning to take effect however periods of peak activity continue to represent a challenge and ambulance handover will remain a key area of focus until further action on improving the handover environment and the supporting processes is completed in late 2018.

It should be noted that the higher dispatch to conveyance rate at NNUH - 61% vs circa 46-47% in other parts of Norfolk may represent an opportunity, with the right early assessment infrastructure, to further redirect a proportion of ambulance patients away from ED majors in future'

Major Actions Implemented to improve ambulance handover

Overall ambulance offload infrastructure and arrangements were severely tested in trying to support the ambulance Trust to respond to whole-system pressures in winter 17/18. The current physical ED infrastructure is too small to deal with volumes and variability of arrivals to enable offloading within 15-minutes.

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. The trust has also agreed an improvement trajectory with NHSE. A summary of the actions that will assist with ambulance handover is shown below:

1. A project to significantly increase the size and staffing within the ED was launched in April 17.

2. Construction work has been completed on the following:

    - Relocation of the Acute Medical Units
    - Relocation of Older Peoples Medicine short stay ward
    - Creation of new AEC
    - New Children's ED with expansion from 4 – 15 assessment spaces
    - Creation of Older Peoples Emergency Department
    - New Front Entrance with enhanced Triage area
    - Isolation/Mental Health suite
    - Additional Urgent Care Centre treatment room

3. Further Construction is planned in 18/19 to create:

    - New Clinical Decision Unit
    - 8 Rapid Assessment Treatment Service (RATS) Cubicles
    - Dedicated Children's entrance

ED Assessment/Treatment space	2014	2015	2016	2017	2018
Resus	6	6	6	6	6
Majors	16	19	19	16	16
Minors	3	4	6	6	6
Children's ED	3	4	4	9	15
Older Peoples ED	0	0	0	6	18
Urgent Care Centre	0	4	4	5	6
RATS	0	0	0	0	8
Clinical Decisions Unit	0	0	12	12	14
Dedicated ED Mental Health facility	0	0	0	0	3
Total ED Assessment/Treatment space	**22**	**31**	**45**	**54**	**84 (92)**

4. The five agreed Improvement 'Themes' with associated SMART actions are:

- Improve the breach performance of patients arriving by ambulance
- Improve and eliminate Minors and UCC breaches
- Maximise the AEC opportunity to reduce overall admission volumes
- Realign staffing to match demand
- Oversight of performance

5. Introduction of internal ambulance handover process to support the EEAST quick release protocol.

6. Introduction of a revised internal escalation policy to support flow within the NNUH.

7. Appointment of 10 ED mid-grade doctors in July/August 2018.

8. Establishment of additional senior nursing staff to provide ED Floor Co-ordinator 24/7

9. Extended operating hours of OPED.

10. Additional short stay bed capacity (12 beds) from October 18.

11. Provision of a dedicated winter ward facility (32 beds) following relocation of renal dialysis facility.

12. The system wide Urgent Care Recovery Plan is currently being revised to ensure focus on the 5 new national "mandated actions".

Norfolk and Norwich University Hospitals NHS Foundation Trust

(a) 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?

Yes. The Central Norfolk Health and Social Care system partners work together closely on all urgent and emergency care demand pressures. Regular weekly and monthly meetings are scheduled to keep all stakeholder abreast of issues and opportunities.

(b) Given that the 'Delayed Arrival to Handover (Keeping Patients in the Community Safe) Protocol' introduced in February 2018 has relied on an extremely high and potentially unsustainable level of escalation by EEAST leaders to ensure the necessary action occurs to release their crews, what can be done to enable the necessary decision making further down the management line?

The NNUH has introduced a revised internal policy and a specific protocol to improve flow into the hospital from ED in order to facilitate earlier ambulance handover. Longer term the development of an additional 8 Rapid Assessment Treatment Service (RATS) cubicles will provide a much improved environment to manage the volume of ambulances that are expected at the NNUH.

(c) It is clear from the ambulance turnaround figures that winter 2017-18 has been difficult. To what extend does the NNUH think that the opening of the Older People's Emergency Department) in December 2017 contributed to or alleviated ambulance turnaround delays at the hospital?

The Older Peoples Emergency Department was established to assess and treat patients 80 years of age and older. The patients that presented the most significant demand pressure on the Hospital in December 2017 was the 70-79 age group. OPED had a positive impact on bed occupancy and patient experience in the >80 year olds but was not a significant factor in ambulance delays at that time.

(d) In February 2018 there were local media reports of a discrepancy between EEAST's figures for ambulance delays at the NNUH and figures reported by the hospital for the period between 26 December 2017 and 21 January 2018. The NNUH subsequently corrected its data but said that the original hospital data had shown zero delays because a change in how the ambulance service measures its response times meant the data could not be verified or integrated into the hospital's systems. Can the NNUH explain how this difficulty arose and give assurance that it now has confidence in both the EEAST data and its own?

Handover data is submitted by NNUH on a daily basis. This information is provided by EEAST. EEAST updated their process for recording ambulance data including the arrival and handover time stamps in mid-October. At this point the NNUH was made aware that EEAST would not be able to provide accurate data until technical work had been completed. The NNUH did not receive confirmation that the data being supplied was correct until the 21st January and so no data was submitted over this period. The information was sent as a ***null*** *return rather than a zero return*.

Summary of EAST DCO Ambulance Handover Event Newmarket 23 March 2018

NHS England

The Ambulance Trust deals with 40% of callouts via "Hear & Treat" and "See & Treat" (i.e. only 60% of patients are conveyed). Over 3000hrs were lost to delayed handover in December 2018. At peak, the Ambulance service was holding over 300 calls. This is the single biggest patient safety risk in the UEC pathways and our ability to manage this risk depends on full engagement of all partners within the system, and not only with Hospitals or Ambulance Trust. Further, with every delay in ambulance arrival, frail elderly patients become de-conditioned and more likely to be admitted. Releasing ambulances early will help improve patient safety and ease pressure on beds. It's clear that organisations are deploying different strategies – some of which are highlighted below;

1. **Staff engagement** was reported as key; patients' stories are a powerful tool for engaging with staff
2. Emphasis on the importance of **clear and simple handover processes** that are well understood by staff within the trust and by ambulance crews
3. **Adopt improvement tools to understand what data is telling you**. Lister Hospital used Lean Six Sigma to map and truly understand where delays in the ambulance handover pathway are and as a result reduced the time lost to delays from 192hrs a week to 16hrs over a period of one week.
4. The new **Ambulance Handover SOP widely** rolled out but now needs review to reflect learning since implementation - Task and finish group will be formed shortly to progress.
5. Strong encouragement to systems to have **HALOs in place where this is not currently funded**. HALO relationship pivotal in helping flow and crews. 24/7 HALO service provided by a paramedic appears to be preferred model.
6. **Fit2Sit** – strong advice about constantly reviewing patient's need for trollies - acknowledging importance of clinical risk management. Fit2Sit posters are available on the NHSI website. Continuous review of hospital conveyances to challenge appropriateness. Create a mechanism for feedback to system to ensure learning.
8. **Limitations in Physical Capacity in EDs** can have a negative impact on flow- use the available space innovatively – visit others to learn. Small changes have big impact – computers on wheels, moving crew's printer to complete handover, easy access to trollies.
9. Put in place **early triggers and action cards** to respond to anticipated increases in demand. Work with Ambulance Trust to improve visibility of pressures on system.
10. Systems for **identification of frail patients prior to arrival** at hospital e.g. "Silver phone" - will help reduce unnecessary admissions
11. **Strong and visible leadership** was identified as a critical enabler at all levels; ED, Hospital and System.

Summary of EAST DCO GP Streaming Event Newmarket 23 March 18

An effective GP streaming service will result in a less crowded ED with positive impact on safety and patient and staff experience.

- Strong governance processes are necessary with protocols in place to help streaming nurses – co-designed with ED and primary care clinicians is critical factor for safe and effective GP Streaming service.
- Effectiveness of GP streaming is highly dependent on level of competency, consistency of clinical staff providing the GP streaming service and knowledge of and access to primary care services in place. At L&D streaming is done by a Band 7 Nurse however others view that this may be done as well by lower banded staff but there must be a clearly defined training programme to ensure staff are trained, competent and confident to stream.
- Streaming process must be simple and clear and must well understood by all staff in ED. A number of **misconceptions** may get in the way and may be worth challenging e.g:

1. A large number of patients are being streamed "inappropriately" and therefore ending up back in ED – **Question meaning of "inappropriate" must only refer to where protocol has not been followed. A patients may have been streamed appropriately but end up needing to go back to ED.**
2. We are being mandated to implement a model which does not work for us – **GP streaming model is nationally mandated, however, NHSE has allowed flexibility in the exceptional cases where the system has demonstrated that they have an alternative service which delivers the same or better outcomes.**
3. Will GP streaming lead to increase in demand? - **Yes, it's likely that successfully roll out will attract new patients – plan for this growth**
4. We have no patients suitable for streaming – **Very unlikely. Review your protocols, consider employing a physiological triage rather than pathological (if they can walk & talk - they can see the GP, with exceptions).**
5. Luton & Dunstable (L&D) stream up to 50% of their A&E attendances - **No, L&D stream about 30% of attendances to GP. GP service only accepts patients from ED.**
6. Are we asking staff to take too much personal risk with regards to the own registration – **No, but it's important staff are well trained, competent and confident and comply strictly to defined/written protocols that have gone through a robust governance process.**
7. This model is costing us more money that the system does not have - **The L&D GP streaming model was in part inspired in part by a need to reduce costs and that objective was delivered, the system report that it actually made savings by implementing GP streaming.**

Norfolk Health Overview and Scrutiny Committee appointments

Report by Maureen Orr, Democratic Support and Scrutiny Team Manager

The Committee is asked to appoint Members to Great Yarmouth and Waveney Joint Health Scrutiny Committee and link members with local Clinical Commissioning bodies and NHS provider trusts.

1. Appointments

1.1 The following lists show the roles to which NHOSC makes appointments, the names of members who currently serve in these roles and the vacancies that currently exist. NHOSC is asked to make appointments to vacant roles and re-appoint or change current appointees.

1.2 **Great Yarmouth and Waveney Joint Health Scrutiny Committee**

Meets quarterly; next scheduled meeting 13 July 2018. The joint committee is composed of six members, three from Suffolk Health Scrutiny Committee and three from NHOSC. The three nominations are not required to be in line with the political balance of Norfolk County Council. One must be the Great Yarmouth and Waveney Borough Council member of NHOSC. The other two may be appointed from the Great Yarmouth area or adjoining districts where a proportion of their residents look in the first instance to the James Paget University Hospital NHS Foundation Trust for acute services. Other members of NHOSC can substitute for the joint committee members as and when required.

Current NHOSC appointees (3)
Mrs M Fairhead *(the Great Yarmouth Borough Council member of NHOSC)*
Dr N Legg
Mr R Price

1.3 **Clinical Commissioning links** (1 for each CCG and 1 for the Joint Strategic Commissioning Committee)

Link members are nominated to attend CCG meetings held in public in the same way as a member of the public might attend. Their role is to observe the CCG meetings, keep abreast of developments in the CCG's area and alert NHOSC to any issues that may require the committee's attention.

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

The named members below are those who are currently appointed to these roles.

North Norfolk CCG (meets every other month in Aylsham, next scheduled meeting Tuesday 24 July 2018, 9.00 – 11.00am)
NHOSC link
M Chenery of Horsbrugh
(Substitute – Mr D Harrison)

South Norfolk CCG (meets every other month; venues to be confirmed; next scheduled meeting Tuesday 24 July 2018, 1.30 – 4.30pm)
NHOSC link
Dr N Legg
(Substitute – Mr P Wilkinson)

Great Yarmouth and Waveney CCG (meets every other month in Beccles; meetings start at 1.30pm; next scheduled meeting Thursday 19 July 2018, 1.30 – 5.00pm)
NHOSC link
Mrs M Fairhead
(Substitute – ***VACANCY***)

West Norfolk CCG (meets every other month in King's Lynn; next scheduled meeting Wednesday 4 July 2018, 9.30am (but the meetings are usually held on Thursdays))
NHOSC link
M Chenery of Horsbrugh
(Substitute – Mrs S Young)

Norwich CCG (meets every other month in City Hall, Norwich; meetings usually start at 2.00pm; next scheduled meeting Tuesday 24 July 2018)
NHOSC link
Ms E Corlett
(Substitute – Ms B Jones)

Norfolk and Waveney Joint Strategic Commissioning Committee (first meeting in public will be held on Tuesday 19 June 2018, 2.00 – 4.00pm; scheduled to meet every other month; venues to be confirmed)
NHOSC link
M Chenery of Horsbrugh – for meetings held in the west of the county
Dr N Legg – for meetings held in the east of the county

1.4 **NHS Provider Trust links** (1 for each local NHS provider organisation)

Link members are nominated to attend local NHS provider organisation meetings held in public in the same way as a member of the public might attend. Their role is to observe the meetings, keep abreast of developments in provider organisations and alert NHOSC to any issues that may require the committee's attention.

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

The named members below are those who are currently appointed to these roles.

The Queen Elizabeth Hospital NHS Foundation Trust (meets every other month at the hospital; next scheduled meeting Tuesday 31 July 2018, 11.30am)
NHOSC link
M Chenery of Horsbrugh
(Substitute – Mrs S Young)

Norfolk and Suffolk NHS Foundation Trust (meets most months in Norwich or Ipswich; next scheduled meeting Thursday 28 June 2018, 12.30 – 3.30pm)
NHOSC link
Michael Chenery of Horsbrugh
(Substitute – Ms B Jones)

Norfolk and Norwich University Hospitals NHS Foundation Trust (meets every other month at the hospital; next scheduled meetings Friday 25 May and Friday 27 July 2018, 9.00am)
NHOSC link
Dr N Legg
(Substitute – Mr D Harrison)

James Paget University Hospitals NHS Foundation Trust (meets every other month at the hospital; next scheduled meetings Friday 25 May and Friday 27 July 2018, 9.30am)
NHOSC link
Mrs M Fairhead
(Substitute – Mr M Smith-Clare)

Norfolk Community Health and Care NHS Trust (meets monthly, usually at Norwich Community Hospital; next scheduled meetings Wednesday 30 May and Wednesday 27 June 2018, 9.30 – 1.30pm)
NHOSC link
Mr G Middleton
(Substitute – Mrs L Hempsall)

2. Action

2.1 The Committee is asked confirm current appointments or make new appointments to:-

(a) **Great Yarmouth and Waveney Joint Health Scrutiny Committee** (see paragraph 1.2)

- Three members.
  - One must be the Great Yarmouth Borough Council representative on NHOSC
  - The other two must represent areas where a proportion of the population looks to the James Paget University Hospitals NHS Trust for acute services.

(b) **Clinical commissioning link roles** (see paragraph 1.3)

- Great Yarmouth and Waveney CCG - -appoint a new substitute link member
- Confirm the other named clinical commissioning link members in their roles or appoint different link members and substitutes

(c) **NHS Provider Trust links** (see paragraph 1.4)

- Confirm the named provider trust link members and substitute link members in their roles or appoint different link members and substitutes.

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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 2018

Meeting dates	*Briefings/Main scrutiny topic/initial review of topics/follow-ups*	*Administrative business*
12 July 2018	Maternity services – delivery of maternity reforms by the Local Maternity System Children's speech and language services – progress update since 7 September 2017	
6 Sept 2018	Physical health checks for adults with learning disabilities – an update on progress since 22 Feb 2018	
18 Oct 2018		
6 Dec 2018	Continuing healthcare – update on progress since 22 February 2018	

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

Other activities

To be arranged - Follow-up visit to the Older People's Emergency Department (OPED), Norfolk and Norwich hospital

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

Norfolk and Waveney Joint Strategic Commissioning Committee

For meetings held in west Norfolk	-	M Chenery of Horsbrugh
For meetings held in east Norfolk	-	Dr N Legg

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 M Fairhead (substitute Mr M Smith-Clare)
Norfolk Community Health and Care NHS Trust	-	Mr G Middleton (substitute Mrs L Hempsall)

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

Norfolk Health Overview and Scrutiny Committee 24 May 2018

Glossary of Terms and Abbreviations

A&E	Accident and emergency
AEC	Ambulatory emergency care
AfC	Agenda for change (NHS pay strucuture)
A to H	Arrival to handover
ARP	Ambulance Response Programme
BTUH	Basildon and Thurrock Hospital NHS Foundation Trust
C1 & C2	Categories of calls under the Ambulance Response Programme:- C1 – life threatening C2 – other emergencies
CCG	Clinical Commissioning Group
ChED	Children's Emergency Department
CQC	Care Quality Commission
CT	Computerised Tomography Scan – Uses X Rays And A Computer To Make Images Of The Inside Of The Body
CUHFT	Cambridge University Hospitals NHS Foundation Trust
DCO	Director of Clinical Operations
DPU	Day procedure unit
DSA	Double staffed ambulance
DPU	Day Procedure Unit
ED	Emergency Department
EEAST	East Of England Ambulance Service NHS Trust
EIV	Early intervention vehicle
EU/EEA	European Union / European Economic Area
FAST	Face Arm Speech Time (to call 999) – test for diagnosis of stroke
FY	Financial year
GDS	General dental services
GYW	Great Yarmouth and Waveney
HALO	Hospital Ambulance Liaison Officer
HEE	Health Education England
HOSC	Health Overview and Scrutiny Committee
HR	Human resources
HSCIC	Health and Social Care Information Centre (also known as NHS Digital)
IHT	Ipswich Hospital NHS Trust
Ipsos Mori	A multi-research company
JPH / JPUH	James Paget University Hospitals NHS Foundation Trust
LDC	Local Dental Committee
L&D	Luton and Dunstable Hospital

LDN	Local Dental Network
MAC	Military Aid to the Civil Authorities – protocol by which the armed forces can be brought in to deal with a range of situations
MEHT	Mid Essex Hospital Services NHS Trust
NEL	Non Elective (operation)
NHOSC	Norfolk Health Overview and Scrutiny Committee
NHSE	NHS England
NHS E M&E(E)	NHS England Midlands & East (East)
NNUH (N&N, NNUHFT)	Norfolk and Norwich University Hospitals NHS Foundation Trust
NSFT	Norfolk and Suffolk NHS Foundation Trust
OHNA	Oral Health Needs Assessment
OPAC	Older people's ambulatory care
OPAS	Older people's assessment service
OPED	Older People's Emergency Department
ORH	Operational Research in Health (ORH) Consultants
OPM	Older People's Medicine
PALS	Patient Advisory Liaison Service
PCT	Primary Care Trust (replaced by Clinical Commissioning Groups)
PDS	Primary dental services
QEH / QEKL	Queen Elizabeth Hospitals NHS Foundation Trust, King's Lynn
RATS	Rapid Assessment Treatment Service
REAP	Resource Escalation Action Plan (2015) – used by ambulance services Reap 1 (green) – steady state Reap 2 (amber) – moderate pressure Reap 3 (red) – severe pressure Reap 4 (black)– extreme pressure
SHA	Strategic Health Authority (abolished by the Health and Social Care Act 2012)
SI	Serious incident
SMART	Specific, measurable, achievable, realistic, time-bound (or timely)
SOP	Standard operating procedure
SPC	Statistical process control – charts designed for understanding variations in performance
SUHFT	Southend University Hospital NHS Foundation Trust
UCC	Urgent Care Centre
UDA	Unit of dental activity
UEC	Urgent and emergency care
UOA	Unit of orthodontic activity

WE	Week ending
WSFT	West Suffolk NHS Foundation Trust
YTD	Year to date