Norfolk County Council

Norfolk Health Overview and Scrutiny Committee

Date: **Thursday 26 November 2020**

Time: **10.00am**

Venue: **Virtual meeting**

Pursuant to The Local Authorities and Police and Crime Panels (Coronavirus) (Flexibility of Local Authority Police and Crime Panel Meetings) (England and Wales) Regulations 2020, the 26 November 2020 meeting of Norfolk Health Overview and Scrutiny Committee (NHOSC) will be held using video conferencing.

Please click here to view the live meeting online: https://youtu.be/iujzhH2rwsw

Committee Members and other participants: DO NOT follow this link, you will be sent a separate link to join the meeting.

Members of the public or interested parties may, at the discretion of the Chair, speak for up to five minutes on a matter relating to the following agenda. A speaker will need to give written notice of their wish to speak to Committee Officer, Hollie Adams (contact details below) by **no later than 5.00pm on Monday 23 November 2020**. Speaking will be for the purpose of providing the committee with additional information or a different perspective on an item on the agenda, not for the purposes of seeking information from NHS or other organisations that should more properly be pursued through other channels. Relevant NHS or other organisations represented at the meeting will be given an opportunity to respond but will be under no obligation to do so.

Membership

MAIN MEMBER	SUBSTITUTE MEMBER	REPRESENTING
Cllr Penny Carpenter	Cllr Roy Brame / Cllr Ian Mackie / Cllr Graham Middleton / Cllr Haydn Thirtle / Cllr Alison Thomas	Norfolk County Council
Cllr Michael Chenery of Horsbrugh	Cllr Roy Brame / Cllr Ian Mackie / Cllr Graham Middleton / Cllr Haydn Thirtle / Cllr Alison Thomas	Norfolk County Council
Cllr Fabian Eagle	Cllr Roy Brame / Cllr Ian Mackie / Cllr Graham Middleton / Cllr Haydn Thirtle / Cllr Alison Thomas	Norfolk County Council

Cllr Emma Flaxman-Taylor	*Vacancy*	Great Yarmouth Borough Council
Cllr David Harrison	Cllr Tim Adams	Norfolk County Council
Cllr Brenda Jones	Cllr Julie Brociek-Coulton / Cllr Emma Corlett	Norfolk County Council
Cllr Chris Jones	Cllr Julie Brociek-Coulton / Cllr Emma Corlett	Norfolk County Council
Cllr Alexandra Kemp	Cllr Anthony Bubb	Borough Council of King's Lynn and West Norfolk
Cllr Robert Kybird	Cllr Helen Crane	Breckland District Council
Cllr Nigel Legg	Cllr David Bills	South Norfolk District Council
Cllr Laura McCartney-Gray	Cllr Cate Oliver	Norwich City Council
Cllr Richard Price	Cllr Roy Brame / Cllr Ian Mackie / Cllr Graham Middleton / Cllr Haydn Thirtle / Cllr Alison Thomas	Norfolk County Council
Cllr Sue Prutton	Cllr Peter Bulman	Broadland District Council
Cllr Emma Spagnola	Cllr Wendy Fredericks	North Norfolk District Council
Cllr Sheila Young	Cllr Roy Brame / Cllr Ian Mackie / Cllr Graham Middleton / Cllr Haydn Thirtle / Cllr Alison Thomas	Norfolk County Council
CO-OPTED MEMBER (non voting)	**CO-OPTED SUBSTITUTE MEMBER** (non voting)	**REPRESENTING**
Cllr Keith Robinson	Cllr Stephen Burroughes / Cllr Helen Armitage	Suffolk Health Scrutiny Committee
Cllr Judy Cloke	Cllr Stephen Burroughes / Cllr Helen Armitage	Suffolk Health Scrutiny Committee

For further details and general enquiries about this Agenda please contact the Committee Officer:
Hollie Adams on 01603 223029
or email committees@norfolk.gov.uk

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A g e n d a

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

2. Minutes

To confirm the minutes of the meeting of the Norfolk Health Overview and Scrutiny Committee held on 8 October 2020. (Page **5**)

3. Members to declare any Interests

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

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

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

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

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

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

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

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

5. Chair's announcements

6.	**10:05 – 11:05**	**Access to local NHS services for patients with sensory impairments**	(Page **15**)
7.	**11:05 – 11:55**	**Suicide prevention**	(Page **47**)
	11:55 - 12:05	**Break**	
8.	**12:05 – 12:55**	**St James' Medical Practice, King's Lynn – consultation on proposed relocation**	(Page **65**)
9.	**12:55 – 13:00**	**Forward work programme**	(Page **129**)
		Glossary of Terms and Abbreviations	(Page **132**)

Tom McCabe
Head of Paid Service

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Date Agenda Published: 18 November 2020

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Norfolk County Council

NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE
Minutes of the meeting held on Microsoft Teams (virtual meeting)
at 10am on 8 October 2020

Members Present:

Cllr Penny Carpenter (Chairman)	Norfolk County Council
Cllr Nigel Legg (Vice-Chairman)	South Norfolk District Council
Cllr Michael Chenery of Horsbrugh	Norfolk County Council
Cllr Emma Corlett	Norfolk County Council
Cllr Helen Crane	Breckland District Council
Cllr Fabian Eagle	Norfolk County Council
Cllr Emma Flaxman-Taylor	Great Yarmouth Borough Council
Cllr David Harrison	Norfolk County Council
Cllr Chris Jones	Norfolk County Council
Cllr Alexandra Kemp	Borough Council of King's Lynn and West Norfolk
Cllr Laura McCartney-Gray	Norwich City Council
Cllr Richard Price	Norfolk County Council
Cllr Sue Prutton	Broadland District Council
Cllr Emma Spagnola	North Norfolk District Council
Cllr Sheila Young	Norfolk County Council

Co-opted Members Present

Cllr Judy Cloke	Suffolk Health Scrutiny Committee
Cllr Keith Robinson	Suffolk Health Scrutiny Committee

Also Present:

Hollie Adams	Committee Officer, Norfolk County Council
Marcus Bailey	Chief Operating Officer, East of England Ambulance Service NHS Trust
Nancy Campen	School Immunisation Team Leader, Cambridgeshire Community Services NHS Trust
Ross Collett	Associate Director of Urgent and Emergency Care, Norfolk & Waveney CCG (Clinical Commissioning Group)
Dr Sarah Flindall	Clinical Advisor to Children Young People and Maternity, Norfolk & Waveney CCG, and GP partner at East Norfolk Medical Practice
Dr Clare Hambling	GP, Bridge Street Surgery, and Governing Body member, NHS Norfolk and Waveney CCG
Dr Gavin Hancock	Representing consultants in the Emergency Department, Norfolk & Norwich University Hospitals NHS Foundation Trust
Terry Hicks	Head of Operations, Norfolk & Waveney East of England Ambulance Service NHS Trust
Dr Linda Hunter	Clinical Director, East of England Cancer Alliance North and Associate Medical Director, Norfolk and Norwich University Hospital NHS Trust
Dr Caroline Kavanagh	Associate Medical Director for Emergency and Urgent Care, Norfolk & Norwich University Hospitals NHS Foundation Trust
Dr Mark Lim	Associate Director of Planned Care and Cancer, Norfolk & Waveney CCG
Sarah Miller	Lead for Intelligence and Informatics, East of England Cancer Workstream & Head of Information Intelligence, East of England South Cancer Alliance NHS England & Improvement
Maureen Orr	Democratic Support and Scrutiny Team Manager, Norfolk County Council
Marie Rogerson	Public Health System Transformation Lead, NHS England and NHS Improvement, East of England

David Russell	Member of Cromer Town Council
Mike Saunders	Sustainable Operational Performance Programme Lead, East of England North/South Cancer Alliance
Dr Jamie Scott	Interim Screening and Immunisation Manager (covering Cancer and Adult Screening Programmes in East Anglia), NHS England and NHS Improvement, East of England
Denise Smith	Chief Operating Officer, Queen Elizabeth Hospital NHS Foundation Trust
Dr Shylaja Thomas	Lead for Screening and Immunisation, East Anglia NHS England and Improvement, East of England/ Public Health England East of England
John Webster	Director of Strategic Commissioning, Norfolk & Waveney CCG
Emily Woodhouse	Business Development Director, Healthwatch Norfolk

1. Apologies for Absence

1.1 Apologies were received from Cllr Brenda Jones (Cllr Emma Corlett substituting) and Cllr Robert Kybird (Cllr Helen Crane substituting).

2. Minutes

2.1 The minutes of the meeting on 3 September 2020 were agreed as an accurate record.

3. Declarations of Interest

3.1 The following interests were declared:

- Cllr Keith Robinson declared a non-pecuniary interest as he had a sister receiving cancer treatment at the James Paget University Hospital
- The Chairman declared a non-pecuniary interest as a cancer patient at James Paget University Hospital.
- Cllr David Harrison declared a non-pecuniary interest as his daughter was a paramedic.
- Cllr Sheila Young declared a non-pecuniary interest as a carer.

4. Urgent Business

4.1 There were no items of urgent business.

5. Chairman's Announcements

5.1 The Chairman updated the Committee that she had recently attended the James Paget Hospital Annual General Meeting (AGM).

6. Cancer Services

6.1 The Committee received the report examining the situation regarding provision of cancer services in Norfolk and Waveney in light of Covid-19, including cancer screening, diagnostic and treatment services.

6.2 Healthwatch Norfolk had carried out research on people's experience of cancer services in Norfolk and Waveney and gave a short verbal presentation on their findings.

- Targeted engagement was carried out to gather the patient voice on experiences of

bowel, breast and cervical screening services, to find out why patients were not accessing screening, and ideas of how services could be more accessible.

- A survey was carried out which received 285 responses including 198 full responses; the results were shared with acute providers, the cancer board and voluntary sector partners
- A difference in experiences was reported across the three types of screening:
  - mobile breast screening was praised for convenience, but privacy and disability access were highlighted as issues
  - bowel screening home testing kits were described as helpful, convenient and informative and there was good satisfaction around the wait for results;
  - cervical screening had shown a variance in result timelines, and the main issues raised were discomfort and the impact of staff attitudes
- Staff attitudes were key to the screening process as this could impact on privacy, help reduce anxiety and impact on the likelihood of attending future screenings.
- GP surgeries were preferred to hospitals as they were more familiar and less intimidating
- There was more desire for out of hours appointments for those working full time
- Some people did not know what screenings they were entitled to and when the screenings stopped and why
- It was highlighted as important to reduce stigma and highlight the positive impacts of screening
- The full data can be found at the following links:
  - Experiences of Cancer Screening Services in Norfolk and Waveney: https://healthwatchnorfolk.co.uk/report/experiences-of-cancer-screening-services-in-norfolk-and-waveney/
  - Experiences of Early Cancer Pathways and Diagnosis: https://healthwatchnorfolk.co.uk/report/experience-of-early-cancer-pathways-and-diagnosis/

6.3 The following points were discussed and noted

- Cllr Robinson shared his sister's experience of being diagnosed with lymphatic cancer which had been delayed by a 6-month check-up being cancelled due to Covid-19 restrictions. He felt that people's outcomes could be affected by circumstances like this. The Associate Director of Planned Care and Cancer, Norfolk & Waveney CCG, **agreed** to discuss this further with Cllr Robinson after the meeting and **agreed** that the pathways involved would need to be looked at to ensure the pathways from outpatients into the cancer pathway were robust.
- A home testing FIT (faecal immunochemical test) kit was sent to people from the age of 60 to 75 every 2 years. If a positive test result was received a referral would be made for a screening colonoscopy. Over the next 5 years, bowel screening from age 55 would be phased out and replaced with the home testing FIT kit for people from the age of 50.
- The Vice-Chairman asked what was being done locally to prevent the 25% of colorectal cancers which presented in Accident and Emergency nationally. Cancer services and NHS representatives replied that work was being carried out with primary care clinicians on introduction of the FIT test in primary care, including for patients not eligible for a home testing kit. Primary care clinicians were asked to review clinical notes of late stage colorectal cancers which identified a number of reasons why patients were being diagnosed late such as patients being considered too young or symptoms being put down to other diseases.
- Cancer services and NHS representatives reported that throughout the pandemic cancer surgeries had been prioritised over other elective surgeries and there was evidence of them continuing within the appropriate timeframes. The 90% baseline

discussed in the report was for all elective surgeries and it was hoped that this would be reached by November 2020.

- Norfolk and Waveney Sustainability and Transformation Partnership (STP) had been successful in their bid for funding for computer endoscopy capsules as part of the pilot of a national study on use of computer tomography.
- At the start of the pandemic endoscopy services were restricted which impacted on diagnostics and caused a backlog; CT enemas were used to mitigate this, and results of FIT tests used to prioritise patients. The Norfolk and Norwich University Hospital was now at 75% of pre-pandemic levels for endoscopies. Use of St James surgery supported the Queen Elizabeth University Hospital with additional capacity.
- The Associate Director of Planned Care and Cancer, Norfolk & Waveney CCG, **agreed** to share figures for endoscopy recovery towards pre-pandemic levels for the three acute hospitals in Norfolk and Waveney.
- It was queried whether hospitals would be able to reach the 90% elective surgery target with the rising cases of Covid-19; representatives recognised that it would be challenging to meet this nationally set target but processes were being put in place to support hospitals for example looking into use of independent sector capacity.
- The impact of Covid-19 restriction on increased cancer morbidity due to delayed diagnosis was queried; representatives were unable to quantify this but there were concerns around patients with lung symptoms as Covid-19 could generate similar symptoms. Guidance had gone to primary care to advise that patients with a persistent cough should be investigated for cancer.
- The Lead for Intelligence and Informatics, East of England Cancer Workstream & Head of Information Intelligence, East of England South Cancer Alliance NHS England & Improvement, discussed the impact on cancer referrals and treatments during the pandemic. Cancer services and NHS representatives explained there had been work to support escalation of potential cancer cases by prioritising patients on a clinical basis and in terms of how long they had been waiting.
- Cancer services and NHS representatives reported that 93% of cancer patients were seen within 2-weeks of GP referral and all three acute hospitals in Norfolk and Waveney were looking to hit national targets, however in some areas there were backlogs but there were regular system meetings to discuss how these were being addressed. Some long waits could be impacted by patient choice and complicated patient treatment pathways.
- A report was due which set out what the UK was doing differently to other European countries where cancer outcomes were better. It was already known that diagnostics needed increasing so people were treated at an earlier stage, and the need for work on tobacco control, and the links between obesity and alcohol intake on certain cancers and cancer morbidity were noted.
- A Member asked what could be done to reach people with English as an additional language and people with poor access to medical services. Cancer services and NHS representatives replied that regular campaigns were run promoting screening and they worked with charities, Public Health teams and CCGs to help GPs identify patients being called for screening who needed further communication, including identifying any language barriers. To support this, leaflets were available in a range of languages and in simple language versions. People with physical and mental disabilities were offered additional support to attend screenings.
- More information was **requested** on the impact of different approaches to encourage and support different groups of people to attend screenings.
- Recruitment and retention of staff was queried; Cancer services and NHS representatives explained that from March to June 2020, some staff were redeployed to help with the Covid-19 response which impacted on screening work and diagnostics. There was a national shortage of breast cancer screening staff

and work was ongoing to address this and look at how the workforce could be used in a better way or how artificial intelligence could be used to support.

- In 2019, breast cancer screening at the James Paget Hospital had to close for 2 months due to staff shortages; a piece of work was now being carried out to look at how Acute Hospitals could work more closely to support each other; for example, with good IT links, images could be read remotely by a consultant radiologist.

6.4 The Norfolk and Waveney Overview and Scrutiny Committee (NHOSC):

- **ASKED** Norfolk and Waveney CCG to provide data on the level to which cancer diagnostic services (e.g. gastroscopy, endoscopy & flexible sigmoidoscopy), at each of the acute hospitals in Norfolk & Waveney are operating compared to pre-Covid levels (i.e. expressed as a percentage of the full operating level).
- **AGREED** that the NHOSC would receive an update at a meeting in 9 months' time focusing on:
  i. The impact of Covid 19 on backlogs and waiting times within screening, diagnosis and treatment services
  ii. The impact on cancer patient outcomes in Norfolk and Waveney
  iii. Measures to encourage people to come forward for screening, particularly those who are vulnerable and need support
  iv. Effectiveness of the measures to encourage people to come forward for screening.
- **ASKED** for an update on cancer workforce, to be included in the workforce update in Spring 2021.

7. Childhood Immunisations

7.1 The Committee received the report examining how the local NHS was managing provision of childhood immunisations in Norfolk and Waveney in a Covid-safe manner and what could be done to improve the take-up rate for childhood immunisations.

7.2 The following points were discussed and noted

- There was a difference in take-up at different age brackets due to a different cohort of children being included in the data caused by people moving home and by some of the boosters being deferred by parents giving the appearance of a lower take up at both ages. On starting school, the status of all children was checked, and those without the MMR or boosters were offered them in reception or year one.
- It was noted that there was a strong anti-vaccination group spreading false information, so teams were working hard to ensure the correct information was given to parents
- Childhood immunisations carried on throughout the pandemic with only a slight reduction in attendance in March to early April 2020. Guidance had been issued to school age providers on how to catch up with missed school vaccinations. Most of these had now been given with the remainder to be given over the next few months.
- There was evidence that primary care immunisation clinics were going to schedule; GPs were contacting women in the first 8 weeks as a priority and had been contacting them in the first 3 weeks to discuss the importance of vaccinations.
- When school vaccination clinics re-started, use of full PPE and the need to wipe down between each child greatly reduced their capacity; since September, community-based clinics had been set up in High Schools to provide vaccinations. The NHS was working in partnership with Carrow Road to provide a vaccination centre and links were in place with St Johns Ambulance to identify other possible venues if any schools were to go into lockdown.
- There was a discussion about the circulation of false information on social media

and the need for NHS England and CCGs to work jointly to circulate correct information to parents and carers so they could make informed choices

- As health services had moved more online, work was ongoing to see how parents could be supported ante and postnatally.
- It was noted that West Norfolk had a lower rate of immunisation take up than other districts in Norfolk. NHS representatives discussed work of West Norfolk and Great Yarmouth's Children and Young People Teams, Health Visitors and School Nurses to support increase in vaccination uptake and provision of correct information. Work was ongoing to ensure communication between the Child Health Immunisation team and GPs was transmitted in a timely manner so that when immunisation reminder letters were sent, GP practices could follow up with families.
- Support for parents and carers with English as an additional language was queried; representatives explained that the immunisation invitation letter was in simple language and GPs could provide support to parents and carers to understand the importance of immunisations. Support from Childrens Services to promote immunisation uptake was received from outreach services now that some of the Children's Centres had closed.
- An app was in development for parents to have an electronic child health record instead of the current red book; this would allow parents to receive alerts for appointments and immunisations via their phone
- Representatives explained that health prevention programmes never achieved 100% uptake, but 95% uptake of immunisation would give herd immunity.
- Vaccines for Covid-19 were being developed and the Joint Committee of Immunisation and Vaccination had published its guidance on this; it was proposed that the programme of vaccination against Covid-19 would begin with people in care homes and the elderly, followed by people over 80, reducing in 5 year age groups.

7.3 The Norfolk Health Overview and Scrutiny Committee:

- **REQUESTED** an annual update on childhood immunisation take-up rates in the NHOSC Briefing.

8. Ambulance response and turnaround times

8.1 The Committee received the report examining action to improve ambulance response and turnaround times since September 2019 and preparations for winter 2020-21 in light of Covid-19.

8.2.1 The Chairman gave a statement to the Committee about the recent CQC (Care Quality Commission) inspection of the East of England Ambulance Service NHS Trust (EEAST) in June 2020:

- The CQC found issues raised in its July 2019 report, when EEAST was rated 'Inadequate' in the 'Well led' domain, had not been fully addressed and was critical of the style of executive leadership; the CQC had issued urgent notices for EEAST to take action and recommended it be put in Special Measures.
- The Chairman noted that the performance of the ambulance service and the safety and wellbeing of Norfolk residents was linked to how effectively staff were led, supported and managed in the locality.
- She also pointed out that the CQC report did not say where the concerns raised came from, or where specific allegations of sexual abuse, bullying and harassment originated.

8.2.2 The Chief Operating Officer, EEAST, discussed that the CQC report had been distressing and difficult for the trust, but the Board accepted the findings of the report.

The newly formed board and Chair, formed in November 2019, were committed to looking at the pace and change required. and were focused on supporting and safeguarding patients and staff.

8.3 David Russell, Member of Cromer Town Council, spoke to the Committee:

- Cromer Town Council had read the CQC report and had been pleased to learn that "caring" had been reported as outstanding.
- Cllr Russell noted that transport to the Norfolk and Norwich University Hospital Accident and Emergency Department had dropped to 943 due to Covid-19
- Cllr Russell asked for a response on the email from Cromer Town Council sent to EEAST on action to improve the emergency response for patients with mental health needs. The Director of Strategic Commissioning, Norfolk & Waveney CCG, **agreed** to follow up on this after the meeting with Mr Russell and Cromer Town Council.

8.4 The following points were discussed and noted

- Targets and commissioning were focussed on improvement at the most local level. The new patient access standards allowed the Trust to focus on mean response times; this would mean that not all postcode levels would have the same level of response however there would be a focus on continuing local level improvement.
- A Member noted that response times did not seem to have improved for a few years. The Chief Operating Officer, EEAST, clarified that there had been improvements over the past few years due to a more stable workforce however 2020 had been more challenging due to the pandemic.
- A Member shared an anecdotal account of staff working long hours and not having time for a lunch break. The Chief Operating Officer, EEAST, reported on plans to focus on reducing the amount of staff ending later than their planned shifts; work was ongoing to ensuring staff not miss their breaks. There was a break point halfway through each 12-hour shift with 1.5 hours either side; if a staff member had not had a break after this time period the ambulance would automatically be stood down, unless they were with a patient.
- It was noted that measures put in place at the Queen Elizabeth hospital to increase ambulance turnaround had been successful in early 2020 however turnaround had reduced again. The Chief Operating Officer, Queen Elizabeth Hospital NHS Foundation Trust, explained that before Covid-19, changes were made to the Queen Elizabeth Hospital A&E department and work carried out with EEAST to revise processes which helped increase ambulance turnover. When the Covid-19 pandemic hit, it was necessary to separate the A&E department into areas for people with suspected Covid-19 and those without. Due to restrictions on size of the department it was relocated to the day services department but had now been moved back to its original location. This work impacted on turnaround times.
- The availability of early intervention vehicles in West Norfolk was queried; there was limited staff availability to provide early intervention vehicles in West Norfolk, however alternative pathways were in place to try and avoid hospital admissions
- West Norfolk had residual vacancies which were being recruited to. Vacancies in all other parts of Norfolk and Waveney had been recruited to. A 2-year programme was being developed to train emergency medical technicians (EMTs) and paramedics to support them, followed by training the EMTs into paramedics
- The STP had secured Aging Well funding to develop a 2-hour community response from wider community partners, which would provide some support in West Norfolk.
- The level of enforcement taken by the CQC to ensure staff and patient safety was noted as concerning by a member of the Committee, and that the concerns were raised by 7 whistleblowers.
- It was also noted that the CQC report flagged up a difference between processes in

place for staff to report concerns and staff confidence to use them; the Chief Operating Officer, EEAST, agreed that there was a need to support a culture to help staff to feel confident to speak up. He suggested bringing back more information on this area of work at a later date.

- Discussion was held about the system meeting urgent mental health needs; the Chief Operating Officer, EEAST, reported that there were now 2 advanced mental health practitioners in the control room to give advice to paramedics; there was an aim to have a further 6 practitioners to provide advice and signpost patients to the support they needed. The NSFT had set up an advice line for paramedics to contact mental health professionals for support and advice and to access patient records which helped avoid inappropriate admissions to emergency departments.
- The Chairman asked about VETS, the local volunteer emergency system which EEAST did not use in Norfolk and Waveney. EEAST instead used the GoodSAM app, which had over 1000 volunteers registered on it to provide support in communities. Representatives **agreed** to provide more detail on the decision behind this.
- A Member **asked** for information on lessons learned from past concerns.
- It was noted by a Member that when there were more staff available the response times were better. Representatives replied that during the pandemic support was put in place to support staff such as more availability of overtime. Staff availability could be affected by time taken to train new employees and seasonal variation in staff taking annual leave. A new rota profile had been implemented in 2020 which better met the needs of Norfolk and Waveney.
- It was queried what was being done to address bullying and intimidation of staff; the Chief Operating Officer, EEAST, replied that officers would listen to staff concerns and those raised in the CQC report with a focus on ensuring staff felt comfortable to speak up. A piece of work would be carried out on culture and behaviour to ensure leaders were as good as they could be, and staff felt valued.
- Cllr Helen Crane left the meeting at 13.03
- The Chairman was concerned that ambulance turnaround times could be affected by a need to keep beds available for a possible upsurge in Covid-19 cases. The Associate Medical Director for Emergency and Urgent Care, Norfolk & Norwich University Hospitals NHS Foundation Trust, replied that a large increase in cases had not yet been seen and empty beds were not yet being kept aside for Covid-19 cases. The Queen Elizabeth University Hospital was experiencing increasing cases with around 12 ambulance a day with suspected Covid-19 cases and 2 wards with Covid-19 or suspected Covid-19 patients.
- The Chairman asked whether the ambulance response times in Norfolk and Waveney would meet national standards. The Chief Operating Officer, EEAST, replied that there was a drive to meet the ARMP standards. A new policy was in place to reduce handover delays; work between the NNUH and EEAST meant that most patients arriving by ambulance were handed over in 35 to 15 minutes at this hospital.
- An internal team at EEAST could arrange same or next day Covid-19 testing for staff, with up to 5 days wait at the most.
- A discussion was held about gathering information from Covid-19 patients at hospital to support with picking up potential workplace outbreaks.
- Cllr Judy Cloke left the meeting at 13.21
- A Member suggested that EEAST, the CCG and NNUH work to develop work streams to support care leavers into the public service workforce, similar to the workstreams developed at the Queen Elizabeth Hospital.

8.5 The Norfolk Health Overview and Scrutiny Committee:

- **ASKED** EEAST to provide additional information on the reasons they use the GoodSAM app but do not use the local volunteer emergency system (VETS)
- **ASKED** EEAST and the CCG to return to NHOSC in 6 months' time with:
  i. An update on what has been done to address the CQC concerns about EEAST (i.e. in the September 2020 CQC report, including safeguarding of patients and staff). To include an explanation of the concerns in relation to Norfolk and Waveney, why the concerns persisted for so long, what EEAST has learned from the situation and its changes to policies and practices.
  ii. A progress report on the measures being put in place to improve the emergency response to patients with mental health requirements, including data on the effect of those measures and an explanation of why the past concerns about the service for patients with mental health emergencies have persisted for so long and what has been learned.
- **ASKED** the CCG, EEAST and NNUH representatives present at the meeting to develop workstreams to support care leavers into the public service workforce (the QEH has already done work on this).

9. Forward work programme

9.1 The Norfolk Health Overview and Scrutiny Committee received and reviewed the forward work programme.

9.2 Norfolk and Waveney CCG were no longer proposing changes to the out of hours GP service and so were not bringing a consultation on this. Therefore, there was no need to call a meeting of Norfolk and Waveney Joint Health Scrutiny Committee.

9.3 The Norfolk Health Overview and Scrutiny Committee **AGREED** the forward work programme with the following additions and amendments:

- **26 Nov 2020 agenda**
  - St James' Practice, King's Lynn – proposed relocation – consultation by the Practice and Norfolk & Waveney CCG
- **18 Mar 2021 agenda**
  - Queen Elizabeth Hospital NHS Foundation Trust – progress report (postponed from 26 Nov 2020 meeting)
  - Local actions to address health and care workforce shortages –progress update since July 2019
- **Added to agenda in around 6 months' time**
  - Ambulance service (see paragraph 8.4 above)
- **Added to agenda in around 9 months' time**
  - Cancer services (see paragraph 6.4 above)
- **Information to be received in the NHOSC Briefing**
  - Data on the level to which cancer diagnostic services at each of the three acute hospitals in Norfolk & Waveney are operating compared to pre-Covid levels (i.e. expressed as a percentage of the full operating level).
  - An annual update on childhood immunisation take-up rates – next one required around October 2021
  - Information from EEAST on the reasons they use the GoodSAM app but do not use the local volunteer emergency system (VETS)

Chairman

The meeting ended at 13:31

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Access to local NHS services for patients with sensory impairments

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

The committee will examine the experiences of people with hearing impairments and sight impairments when accessing local NHS services and receive NHS England and NHS Improvement East of England's plans for engagement with BSL users and others in advance of re-procurement of interpreting services for primary care in 2021.

1.0 Purpose of today's meeting

1.1 Today's meeting is for the committee to :-

(a) Hear about the experiences of people with sensory impairments when accessing services.
(b) Examine the current British Sign Language (BSL) interpreting service to enable Deaf[1] people to communicate with healthcare professionals in primary care services.
(c) Examine NHS England and NHS Improvement, East of England's (NHSE&I) plans for engagement with BSL users and others in advance of re-procurement of interpreting services in 2021.

1.2 In relation to (a) – **experiences**

Hearing impairment – BSL users

In July 2019 Healthwatch Norfolk (HWN) published a report on 'Service User Feedback on DA Languages', which is attached at **Appendix A**. HWN

[1] Deaf - A person who identifies as being Deaf with an uppercase D is indicating that they are culturally Deaf and belong to the Deaf community. Most Deaf people are sign language users who have been deaf all of their lives. For most Deaf people, English is a second language and as such they may have a limited ability to read, write or speak English. A person who identifies as being deaf with a lowercase d is indicating that they have a significant hearing impairment. Many deaf people have lost their hearing later in life and as such may be able to speak and / or read English to the same extent as a hearing person.

informed the commissioner, NHSE&I, about significant issues with the service at the time.

HWN has also provided comments received since March 2020 in a report at **Appendix B**. Some people Deaf people have provided information to HWN in video form. The video clips will be played at the meeting.

Sight impairment[2]

The RNIB has provided the briefing 'Implementing the NHS Accessible Information Standard (AIS) in Norfolk' November 2020' at **Appendix C**, which includes examples of local cases that illustrate problems experienced by sight impaired people, and a representative will speak to NHOSC at the meeting.

1.3 In relation to (b) – **current BSL interpreting service for primary care**:-

The interpreting service for primary care (GP services) and dentistry in Norfolk and Waveney is commissioned by NHS England and NHS Improvement East of England (NHSE&I). It has been provided by DA Languages since April 2019. Prior to that it was provided by Deaf Connexions.

NHSE&I has provided the paper at **Appendix D** which explains the history to the interpreting service, the reasons for difficulties encountered when DA Languages began their contract in April 2019, what has been done to address the issues, and plans for engagement with Deaf people prior to re-procurement of the service in 2021.

Representatives from NHSE&I will attend the meeting to answer Members' questions.

1.4 In relation to (c) – **engagement in advance of re-procurement of interpreting services**

NHSE&I intends to re-procure the interpreting and translation service for primary care (GP & dental) next year and it is understood that it may be extended to include community pharmacy and optometry. It is also understood that the current contract will continue until September 2021. In Appendix D NHSE&I has set out details of its engagement process in advance of the re-procurement.

Representatives from NHSE&I will answer Members' questions on this process.

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[2] Sight impairment – depending on the severity of vision loss a person may be registered as sight impaired (previously "partially sighted") or severely sight impaired (previously "blind"). The category of registration depends on measurements of visual acuity (ability to see detail at a distance) and field of vision (how much can be seen from the side of the eye when looking straight ahead).

2.0 Background information

2.1 NHOSC put the subject of access for people with sensory disabilities on its forward work programme in February 2020 following concerns raised by Members.

2.2 **NHOSC concerns about access for patients with hearing impairments**

2.2.1 The issues raised in February 2020 centred on the experiences of BSL users, particularly regarding access to psychological therapies, but Healthwatch Norfolk's 2019 findings on access to primary care were also a concern.

2.2.2 Today's report focuses on access to primary care for Deaf people, which could potentially affect all BSL users. The issues are set out in Appendix A and B and the commissioners' comments and plans for the future are included in Appendix D.

2.2.3 The other issue raised in February 2020 was about BSL user access to psychological therapies. The concern was that a specific need for BSL-fluent psychological therapists may not have been recognised or fully understood by the commissioners (the Clinical Commissioning Group). This potentially affects only a very small number of vulnerable people whose first language is BSL. It is perhaps just 2 or 3 individuals per year, but the effect on those people and their families / friends / carers could be very significant. The issue was initially identified by the Norfolk County Council Sensory Support Team.

The current pathway for BSL users who require psychological therapies is referral to Norfolk and Suffolk NHS Foundation Trust (NSFT). Psychological therapy is provided by non BSL-fluent therapists via BSL interpreters but the concern is that it is unlikely to work for the more vulnerable Deaf patients.

The issue is that the non BSL-fluent therapist will almost certainly not fully understand the pressures on a Deaf person living in a hearing environment, nor are they likely to pick up on Deaf cultural meanings, emotions and certain psychological behaviours that are Deaf specific. For some vulnerable BSL patients there is a risk that such therapy could make their anxiety and coping levels worse as it does not fit their understanding of daily living.

There is a national BSL charity running an Improving Access to Psychological Therapies (IAPT) service which could provide BSL-fluent therapists but the mental health service pathways in Norfolk & Waveney do not include using that service for Deaf patients. The issue was raised with NSFT representatives in advance of their attendance at NHOSC on 3 September 2020. In their report to NHOSC they stated that:-

"To our knowledge we have not previously explored using an external agency to provide BSL accredited therapists. This is a potential area for development, which would require a strategic approach with commissioners and input from expert agencies. Any details that HOSC has regarding concerns about the current provision would be welcomed and we can explore the options

available in addressing this, potentially in collaboration with Norfolk County Council's Sensory Support Unit."

Norfolk and Waveney CCG has been asked to contact the Norfolk County Council Sensory Support Team and to involve NSFT in discussing options for improving the service for the small number of vulnerable BSL users who require this service. NHOSC may wish to return to this subject in future depending on the progress made.

2.3 **NHOSC concerns about access for patients with sight impairments**

2.3.1 Concerns were raised following communication in December 2019 between a Member and people working with the Royal National Institute of Blind People (RNIB).

One of the issues was that important letters were going out to patients in ordinary format even though the patients had repeatedly made known their need to receive communications in a different format. This led to issues of confidentiality as patients had to turn to others to get private and confidential letters read out to them.

There were examples of this happening across many health service provider organisations, including in screening services, mental health services, community health services, acute services and others. It suggested that the Accessible Information Standard 2016 (AIS) was not being consistently implemented in Norfolk and Waveney.

2.3.2 As it is not possible to bring multiple NHS providers to the meeting, the initial plan was to discuss the issues with Norfolk and Waveney CCG. The AIS guidance to commissioners suggests they should:-

- Explicitly include the requirement to comply with the Standard as part of procurement / tender documents, service specifications and contracts with providers;
- Clearly indicate expectations around the receipt of evidence in this regard, which should be documented.
- Include explicit statements with regards to the Standard as part of their Annual Operating Plans, Business Plans, Commissioning Intentions, Equality and Diversity Objectives / Strategy and / or as part of Annual Reports.
- Consider their role in supporting locality or regionwide initiatives which support cost-effective, efficient and added value approaches to implementation of the Standard across the local health and care system.

2.3.3 The NHS in England returned to level 4 alert status at midnight on 4 November 2020, which coincided with the start of the second lockdown in

England due to the Covid 19 pandemic. This means that NHS England & NHS Improvement can take command of all NHS resources across England.

Due to pressures of preparing for the oncoming winter plus the escalating response to Covid 19 it is likely that staff within Norfolk and Waveney CCG will shortly be redeployed to other high priority work. The CCG managers have been unable to properly prepare for this NHOSC agenda item and will not be able to discuss it with the committee at the meeting.

The committee may therefore wish to use the opportunity to gather information from the RNIB, discuss the issues with them and consider whether to make comments to the CCG or specific local NHS providers. The RNIB has suggested some possible recommendations in its paper at Appendix C.

2.4 **Accessible Information Standard (AIS) 2016 and Implementation Guidance 2017**

The full AIS and Implementation Guidance is available on NHS England's website:-

https://www.england.nhs.uk/ourwork/accessibleinfo/

The Standard applies to service providers across the NHS and adult social care system, and it specifically aims to improve the quality and safety of care received by individuals with information and communication needs, and their ability to be involved in autonomous decision-making about their health, care and wellbeing.

There are five basic steps in the AIS:-

1. **Ask**: identify / find out if an individual has any communication / information needs relating to a disability or sensory loss and if so what they are.
2. **Record**: record those needs in a clear, unambiguous and standardised way in electronic and / or paper based record / administrative systems / documents.
3. **Alert / flag / highlight**: ensure that recorded needs are 'highly visible' whenever the individual's record is accessed, and prompt for action.
4. **Share**: include information about individuals' information / communication needs as part of existing data sharing processes (and in line with existing information governance frameworks).
5. **Act**: take steps to ensure that individuals receive information which they can access and understand, and receive communication support if they need it.

3.0 Suggested approach

3.1 Members may wish to explore the following areas regarding access for BSL users with the NHSE&I representatives:-

(a) Many Deaf people have BSL as their first language and have limited ability to read, write or speak English. In light of the necessary social distancing requirements due to Covid 19, how exactly does NHSE&I intend to engage with the Deaf community in advance of re-procurement of primary care interpreting services to avoid unforeseen consequences such as resulted from the 2019 procurement?

(b) It is understood that the current contract will run for almost another year. What assurance can NHSE&I and DA Languages give that Deaf people have a route by which they can raise any problems with the service for very rapid resolution?

(c) Prior to April 2019 Deaf people in Norfolk were able to ask the interpreting service to make the healthcare appointment for them. Under the current service they must make the appointment with the doctor / dentist / other healthcare professional themselves. As many Deaf people cannot speak, read or write English how can they do this without giving private information to a friend / family member / carer?

(d) Does NHSE&I and DA Languages have full oversight of the numbers of occasions on which interpreters were not available for Deaf patient's appointments, or did not attend as arranged?

(e) Healthwatch Norfolk's work with the West Norfolk Deaf Association noted some examples of Deaf people who found it difficult to understand BSL interpreters from other regions because of regional variations in signing. To what extent is this acknowledged to be a problem?

(f) In April 2020 DA Languages made virtual online interpreting services available to all GP practices in Norfolk and Waveney for both non-speaking patients and non-English speaking patients. The service is available to pre-book or on demand. There has been limited uptake in Norfolk. Have members of the Deaf community been informed of the existence of this service? Can the CCG or NHSE&I do more to encourage practices to make use of it?

(g) Is it possible for Deaf people to access primary care out of hours?

(h) How are interpreting services currently provided for Deaf patients attending community pharmacies or opticians for NHS funded services? How will they be provided under the new contract in 2021?

3.2 NHOSC may wish to discuss the following with the representative from the RNIB and raise comments or suggestions with the CCG or specific local NHS provider organisations at a later date:-

(a) What appear to be the main barriers that prevent effective implementation of the Accessible Information Standard (AIS)?

(b) What more could be done to encourage consistent implementation of the (AIS) across local health service providers?

4.0 Action

4.1 The committee is asked to consider:-

(a) Whether to make comments or recommendations as a result of today's discussions.

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

healthwatch Norfolk

Service User Feedback on DA Languages

July 2019

1 Background

In July 2019, the Healthwatch Norfolk Engagement Team ran a focus group with the West Norfolk Deaf Association, to discuss the service they receive from DA Languages, and the barriers they face.

1.1 About Healthwatch Norfolk

Healthwatch Norfolk (HWN) is the consumer champion for health and social care in the county. We are an independent organisation but we have statutory powers. The people who make decisions about health and social care in Norfolk have to listen to you through us. Healthwatch Norfolk use the things you tell us about local care to influence future services in Norfolk. Our remit is to represent your views and your experiences to help inform and improve the services that are commissioned and provided in Norfolk.

1.2 Interpretation provider requirements

NHS England guidance states that interpretation and translation should be provided free at the point of delivery for patients and be of a high quality, accessible and responsive to a patient's linguistic and cultural identity. Patients must not be asked to pay for interpreting services[1*].

The Accessible Information Standard (2016) aims to ensure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand with support, so they can communicate effectively with services. Examples of the types of support that might be required include large print, braille or using a British Sign Language (BSL) interpreter.

1.3 About DA Languages

DA Languages is a limited company which provides interpretation and translation services, including British Sign Language, for both private and public sector clients. On 1st April 2019, DA Languages secured the contract for GP and dentistry BSL interpreting services across the East Anglia, commissioned by NHSE East of England. Whilst Some issues have been raised with Healthwatch Norfolk around the quality of services delivered by DA Languages.

1.4 About This Report

This report details the feedback received by Healthwatch Norfolk over the last 6 months pertaining to services delivered by DA Languages. Predominantly, this report presents comments made by the deaf community at a focus group facilitated by HWN officers on 23/07/2019, but also makes reference to previous evidence gathered by HWN.

1* https://www.england.nhs.uk/primary-care/primary-care-commissioning/interpreting/

1.5 Transcription Methods

Public feedback cited in this report was communicated in British Sign Language (BSL) through an interpreter. The interpreter's words were transcribed by Healthwatch Norfolk's Engagement Team. Due to the grammatical and syntactical differences between BSL and Spoken English, the transcriptions had to be edited into continuous prose, but the meaning of contributions made remains the same.

1.6 Sign Language versus Spoken Language

According to the British Deaf Association: "British Sign Language (BSL) is the preferred language of over 87,000 Deaf people in the UK for whom English may be a second or third language. Sign languages are fully functional and expressive languages; at the same time they differ profoundly from spoken languages […] BSL is a visual-gestural language with a distinctive grammar using handshapes, facial expressions, gestures and body language to convey meaning"[1]

2) Previous evidence

The issue of interpreter services in primary care was first raised by attendees at the NHS Long Term Plan focus groups held in April 2019. Interpreters and availability of interpreters were raised as key concerns for the community, especially when interpreters don't turn up. Many had specific examples of experiences they have had trying to access health and social care services. Linked to this, DA Languages were mentioned frequently, having newly taken over the contract. Generally, people were unhappy that services were no longer locally based, which had reportedly worked well in the past.

The below excerpt is taken from our final report, which was published in July.

"I can't even mention DA Languages it really does make me sick to even think about it… Also what's the level of their interpreters are they level 1, 2, 4? I also will say that all these people here may be feeling vulnerable it's very difficult for them. So Cambridgeshire have a service called 'clarion' and they have some good people that work there you know level 6 and things like that. Why couldn't a service like clarion have it instead because they are closer than DA Languages who are much further away?"

On a separate occasion, a deaf service user who approached us at a health fair gave a review about the change of service provider, and the adverse impact this has been having on members of the deaf community in Norfolk:

[1] British Deaf Association [Website], www.bda.org/uk/help-resources (accessed 05 August 2019)

"For providers of BSL interpreters in Norfolk, the primary organisation has always been Deaf Connexions. They know the deaf community inside out and provide loads of interpreters to high standard. If I'm not happy with the service they are providing, they are very transparent and it's easy for me to make a complaint.

As of the 1st of April, the contract was taken over by DA Languages, who no one knows. They're based in Manchester and the quality isn't there; their standards aren't high enough and they're not being monitored properly. Many people in Norfolk aren't having their needs met and doctor's appointment are being cancelled because interpreters aren't turning up. It's the same with opticians."

We have rights to access services equally with hearing people, but DA are laughing at us and the NHS aren't monitoring them properly. This sort of thing was happening in the 1970s, why are we going back and making the same mistakes? They're not saving money, they're wasting it - these people need to be able to access services to prevent them becoming ill."

3) Focus group feedback

The focus group took place with 12 members of the West Norfolk Deaf Association, a support worker and an interpreter. Below are extracts of the feedback received from the consultation participants, specific to the service quality of DA Languages.

Issues Raised

Issues raised, in no particular order, were: lack of interpreter availability, having to cancel/ change appointments due to lack of interpreter availability, being unable to receive services due to lack of interpreter availability, poor standard of interpretation, difficulty communicating with the interpreter in certain medical settings, no guarantee of confidentiality, interpreter of service user's preferred sex being unavailable, lack of essential communication regarding bookings, lack of information about who the interpreter is, lack of Yellow Badge, different style of communication through BSL to what the service user is accustomed to.

Feedback Received

"We don't use spoken language, we just use BSL."

"The services before were perfect - now it's changed and it's awful."

"I faxed my doctors for an appointment, they booked the appointment for me and the interpreter from DA who didn't come. I asked who else could help me so my support worker had to phone Deaf Connexions. Again, I had to go back to the doctors with a letter. They then said they'd book the interpreter, and I had to explain how important it is to have an interpreter."

"I felt stressed and angry. I only use sign language - it's how I communicate. What happens if they give me the wrong info and I take the wrong meds? I had to look after myself and calm down. I want to know who the interpreter is first and if I don't know who it is, it makes a difference to how I feel. The process gets very frustrating."

"Once an interpreter sent by DA Languages was sent for a doctor's appointment. I didn't think her quality was very good. She couldn't spell things properly. She tried to look at the computer screen during my consultation with the doctor, so she could spell the things the doctor was saying, and I wasn't happy with her looking at my information on the screen. The whole thing felt wrong and I felt the quality wasn't there."

"My support worker called my doctor to ask for an interpreter, but no one was there. Having waited ten minutes or so, the doctor came to get me and told me to come in anyway. It was stressful to work out what he was saying. I was upset and stressed because there was no interpreter so explained I didn't want to go in".

"I wrote a letter to the boss of my GP and got a response from them. I didn't read it but my support worker helped me and I got an apology from them. I booked another appointment and there was an interpreter this time. They helped me explain to the doctor why I was there and I felt a bit better, but I was stressed before. On another occasion I went with my husband to the opticians but again, there was no interpreter. I got a letter saying 'sorry, the interpreter wasn't there'. My husband said he'd go without an interpreter but I said no don't because I wouldn't have done, so he shouldn't have to. I will complain about the interpreter not being there on the phone with my support worker."

"I went to the doctor with my husband. The check in screen told me to go to reception and the woman knows me there. She said DA Languages won't bring an interpreter out as they were not available. The second time I went, I had no interpreter. They asked me if I wanted another appointment, but I said no because they were wasting my time. The third time I went, they asked if I wanted to come through anyway, but I said no because she wouldn't understand me for my physio session. Another time I went in anyway even thought there was no interpreter, but the session 'failed' because she couldn't understand. My support worker wrote a letter. The reception was going to look at it for me, but had to ask for it to be given to practice manager. I did get a letter back."

"I don't feel the interpreter I had was good. I think they used a different style of sign language to me, [and] I don't like it as much. It wasn't clear, I didn't understand. The interpreter was hard to understand. I used to be a sign language tutor. Regional signing is different and there's a lot of adjustment needed. Like with voices, you get accents in sign language. At times, I've gone to reception and asked for an appointment, and they said they couldn't get an interpreter quickly. A lot of the time it's easier just not to go."

"I've used DA Languages for three things: the dentist, opticians and doctor. We've had problems with the dentist and opticians. When they have the mask on at the dentist and are trying to talk to the interpreter it makes it really hard to understand what's being said. When you have the glasses on and are in a darkened room at the opticians, you can't lip read. The whole experience makes it hard for us. We don't agree with DA Languages."

"Deaf Connexions are very good, and always confidential. How do we know it's confidential with DA languages? I'm concerned a man might come. I don't want a man to come. It's best to know who's coming to interpret for you and DA Languages don't let me know. And knowing where to meet beforehand is important."

"We're confident in Deaf Connexions's qualifications and the ones I have had all have the yellow badges. An interpreter from DA Languages didn't have a badge."

"Deaf connexions are very good. If someone is ill they will fax to let you know but DA won't even let you know who's booked so you don't even have that information."

"Someone out of county may not understand my sign just like I might not understand their sign."

"I am very confident of Deaf Connexions, but I am not confident of DA Languages. I've used the former for a long time and I know the people there."

"Just like any interpreter everywhere, I need one with a yellow badge. They need to be there at the right time on the right day. I also need to know the name of the interpreter, and communicate about any changes that might happen beyond their control."

"DVDs with information with subtitles are useful. Some surgeries do have the screens but they tend to be slide shows, and not spoken words, so that works okay. Doctors often come and call your name so there's nothing for you to see and then we don't know it's our time to go in."

"Because I don't need to have an interpreter I have to have more time to make sure the GP can understand me and I can explain myself. My GP is good but this isn't always the case with everyone. I still always have to ask for longer appointments first. This can feel quite rushed otherwise."

2 Feedback Pertaining to Accessibility Issues Faced by the Deaf Community More Generally

During the consultation, the feedback received by the participants also uncovered more general issues faced by the deaf community.

Issues Raised

Issues raised, in no particular order, were: primary care services failing to facilitate an interpreter, poor facilitation of interpreters, GPs no longer willing to use fax as a means of communication, not being allowed to use a family member/friend as an interpreter, lack of privacy as a result of family members/friends having to interpret, lack of interpreter availability.

Feedback Received

"At a hospital visit for my eyes, there was no interpreter, and I had to wait for a long time for one to arrive. They sent someone from Wisbech to Ipswich, but I couldn't understand why they'd come so far. I did understand her through. I was just surprised about the distance because I'm in the Cambridgeshire area. I'm not so happy with the interpreters in my area."

"I received a letter from the GP to say that faxes are stopping. How will I contact my doctor? I don't know how to email, and I've got to ask my daughter to help me now. She's got her own life. For 20 years I've been faxing my doctor. I am really stressed about it changing."

(With regards to what the patient detailed above, Healthwatch Norfolk asked: "Have you spoken to your doctor? Have they tried to resolve this?")

"I have not been to doctors for a long time but the letter came to me and I'm worried about the changes… A lot of people will only fax so it's very difficult when it's taken away. I'm in Cambridgeshire and I always have to go with my daughter. I don't want her to come, I want it to be private."

"You're not allowed to have a friend or relative interpret for you. I wouldn't ask family to, as it's not professional, even though my daughter is an interpreter. I would like frontline staff to learn signing and to have a better understanding of the deaf community. I go to the hospital every month and ask for an interpreter – and they do that fine. I am very happy with the hospital, but I'm not happy with DA Languages staff at my surgery."

"There's not many interpreters, and they come privately. They also come through the free ads."

3 The next steps

Healthwatch Norfolk intends to act upon this intelligence in the following ways:

1) Make the relevant commissioning stakeholders at NHS England aware of the experiences and concerns of the deaf community in Norfolk.

2) We will be tabling the issue of interpretation and translation services for deaf and hard of hearing patients at the next regional Quality Surveillance Group, making specific reference to this report.

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Feedback on interpretation services

In the below table is the feedback we have received from service users and carers about interpretation services since March 2020. This feedback has been received through our website, our signposting service, and through our COVID-19 survey.

Members of the public are consistently telling us that they have struggled to access a British Sign Language interpreter for their health appointments.

ID	Service	Title	Review	Date
9791	James Paget Hospital	Deaf ignored	After a fall a deaf man stayed for two nights in hospital. The staff would not call for a British Sign Language Interpreter. He was unable to understand what was going on and became utterly frustrated with people standing round his bed talking about him. One call to INTRAN would have summoned a BSL interpreter and then the staff could have had clear communication with him. This was two weeks ago, and he is still furious and frustrated. Accessible information staff standards state a patient's needs and preferences must be flagged up on their records. WHY didn't this happen? The same man had a fall and hip replacement a couple of years ago and again the Paget didn't call for a BSL Interpreter. He had no idea what was going on and was very distressed.	23/09/2020
9513	James Paget Hospital	No Deaf access	Deaf patient on ward and staff did not call a British Sign Language Interpreter in. Patient had no communication at all. What about the Accessible Information Standards? Staff don't even know about this requirement	11/03/2020
9668	Norwich Practices Health Centre and Walk-In Centre	Deaf refused	Walk in can't get BSL Interpreter so Deaf patients can't use it at all	09/08/2020
9807	The Woottons Surgery	Deaf despair	Still big problem seeing GP they won't get BSL Interpreters in for Deaf patients. Been awful since April 2019. Really serious health issues very upsetting but they won't get Interpreters. Not equal access. What can we do? In tears	02/10/2020

9669	The Woottons Surgery	Deaf ignored	Surgery can't get BSL interpreter been going on since April 2019. Not fair. Deaf should be treated equally. Deaf can't see doctor	09/08/2020
9667	Watton Medical Practice	No access for Deaf patients	Need BSL Interpreter surgery can't get one so I can't see doctor.	09/08/2020

Email	Comment in email	Date
1	Deaf people still can't get Interpreters for Doctor, dentist or eye test. Been going on since April 2019. In last two weeks DA have cancelled 3 Deaf appointments, this is not fair	11/09/2020
2	I want to ask you about how Deaf people can get healthcare? Many GPs are now only doing phone calls so we are stuck. We have to ask Deaf Connexions for help but nhs gave Interpreting contract to DA Languages and they are rubbish. Nearly all my Deaf friends just can't see a doctor, we keep asking but doctor wants to phone. Deaf Connexions can do video Interpreter which is better than nothing, but now Doctor has to use DA. So we are stuck with no access to healthcare. Is Norfolk Healthwatch interested, we have struggled for a year since contract went to DA but it is more worse now in lockdown. The face masks mean we can't even see someone's face or their expression, it is impossible. Will you ask all GPs in Norfolk how Deaf can access them? Many Deaf do not use internet or mobile phone, we stuck. I have hearing P.A. who helps me, not everyone has a PA	27/05/2020

COVID-19 survey ID	Comment	Date
141748310	Deaf can't see Doctor, no way for us to have BSL Interpreter or ask for appointment. Not fair	22/05/2020
141748566	Why Deaf can't see doctor? They only talk on phone. It not fair. Had to ask neighbour to help fill this 8n [*sic*].. it not Deaf friendly	22/05/2020

West Norfolk GP surgery practice manager response to BSL translator complaint

Healthwatch Norfolk have obtained consent to share the following response from a GP practice manager to a patient complaint about translator availability in August 2020:

"Thank you for leaving your feedback, I am very sorry that you have experienced ongoing issues.

DA Languages which provides interpretation and translation services, including British Sign Language, secured the contract for GP interpreting services across East Anglia in April 2019, commissioned by NHS England.

Unfortunately, we have experienced ongoing issues with their ability to provide a BSL Interpreter despite requesting that they contact Deaf Connexions to check availability. We have reported this to NHS England and will do so again to try and resolve these issues."

RNIB

See differently

Implementing the NHS Accessible Information Standard in Norfolk Health Overview and Scrutiny Committee (NHOSC)

November 2020

> "I have had a chronic pain condition for 17 years and I was discharged from the pain clinic because I missed two appointments due to them sending me letters I can't read. I have also had my pain medication withheld by the pharmacists as they have been told by the doctor that I missed a medication review." Norfolk Patient

Background

There are an estimated 37,600 people living with sight loss in Norfolk, this is higher than the national average. Blind an partially sighted people living in Norfolk have told RNIB that they are often not receiving vital health information in a format that they can read.

The Accessible Information Standard (AIS) came into force in July 2016. It establishes a framework and sets a clear direction so that patients who have information or communication needs relating to a disability can access services appropriately and independently and make decisions about their health, wellbeing, care and treatment. Publicly funded health and social care providers have a legal duty to follow the AIS.

NHS England's own guidelines have identified the following benefits of the AIS:

- Improved health and wellbeing amongst patients due to increased take-up of early intervention and prevention opportunities, ability to participate in decision-making and improved compliance with treatment / medical advice.
- Improved patient safety due to ability to understand and follow information regarding care and treatment, including medicines management and pre- and post-operative advice.

- More appropriate use of services, including increased use of primary care services and reduction in urgent and emergency care usage.
- Improvement in the effectiveness of clinical care due to addressing barriers to communication.
- Improvement in patient experience and satisfaction, and reduction in complaints and litigation associated with failure to provide accessible information and communication support.

What's happening now

Three years on from the introduction of the AIS, blind and partially sighted people living in Norfolk are not routinely receiving their health information in a format that they can read. A quarter of all calls to the RNIB campaigns hotline are about inaccessible health information.

Problems include:

Trusts not sending communications in people's preferred formats even where they have recorded people's needs.

> "Despite 'deafblind' being on my record, and my constant reminders. No alternative method, such as email, has been given.". **Norfolk Patient**

Patient communication needs are not being shared with other health or social care providers, even within the same hospital.

> "It is clear that my preferred format information has not been passed onto other health or social care providers. It is a continuous battle and trial of having to explain to every clinic or service I attend that I need everything sent to me via email." **Norfolk Patient**

Lack of awareness of the AIS amongst NHS front line staff.

> "I asked someone at my GP surgery to email me my information from now on so that I could read it, she said that my partner could just read the normal letter to me. When I told them about the NHS Information Standard they didn't know what I was talking about." **Norfolk Patient**

Patient confidentiality is being breached due to individuals relying on carers, relatives or friends to read appointment letters on their behalf.

> “Following the procedure, I was given the report by hand, including a very graphic picture of the inside of me and a carer, who I had never met before, had to come and read it to me. It was such a sensitive situation, it could have been really bad news” **Norfolk Patient**

Blind and partially sighted people are often told they cannot have their health information in their preferred format as to do so would be too resource intensive and / or would breach data protection.

> “At the eye clinic I was told they didn’t have time to do it and I was encouraged to make a complaint.” **Norfolk Patient**

People with sight loss are missing appointments due to not receiving appointment letters in accessible formats.

> “I turned up here expecting to be seen at the eye clinic this afternoon as per arranged only to discover that they have change my appointment.” **Norfolk Patient**

Blind and partially sighted people are being sent home from appointments or procedures because they have not prepared appropriately for them due to receiving instructions in inaccessible formats.

> “After a hearty breakfast I went to the NNUH for a liver function test but was sent home because it turns out I shouldn’t have eaten for twelve hours before. I hadn’t been able to read the appointment letter which said I should have fasted.” **Norfolk Patient**

People recently diagnosed with sight loss are returning to the eye clinic unnecessarily due to not being given information on managing their condition.

> “People often come to our ‘Confidence Building’ course not knowing the name of their eye condition, if they are registered as sight impaired or about the basic actions they can take to manage their condition.” **RNIB in Norfolk**

Blind and partially sighted people are not being able to access information to take medication safely independently.

> "Being able to read my own prescriptions would seriously improve my ability to manage my health conditions more effectively and safely." **Norfolk Patient**

Coronavirus

As the UK Government, local authorities and health care providers continue to grapple with the spread of coronavirus, the outbreak highlights the importance of effective and accessible health information so everyone knows how to keep themselves and their community safe.

One in five people aged 75 and over have sight loss and many blind and partially sighted people have comorbidities. It is therefore essential that all information about changes to health care providers policy, procedures and advice is accessible. This will give this vital information the best chance of reaching those at high risk from the virus.

Blind and partially sighted people have been unable to attend appointments independently due to not being given coronavirus guidance in a accessible formats.

> "I am often expected to instantly remember the appointment details, the directions to get to the clinic and the specific details of the procedure. This year these instructions have also contained Covid-19 specific guidelines which I've been unable to follow." **Norfolk Patient**

Blind and partially sighted and deafblind people are unable to attend virtual appointments independently.

> "In person consultation is a must because then i'm physically in front of a person and can understand them better, as opposed to virtual appointments when I'm not." **Norfolk Patient**

The committee is asked to consider

- To ask NHS England & NHS Improvement East of England, and the CCG (the commissioners), to monitor the extent to which healthcare providers are consistently implementing the AIS in Norfolk.
- Asking the commissioners to ensure all front line staff receive training in the requirements and implementation of the stand. Training to be mandatory and regularly refreshed.
- To ask NHS England & NHS Improvement East of England, and the CCG (the commissioners), to share their experience of implementing the standard as part of this years review of the AIS by NHS England

Case Studies

Case Study 1

My Doctors Surgery

Following the launch of the Accessible Health Information Standard on the 1 August 2016, I researched what I had to do to make sure I got my health and social care documents in an accessible format. I wrote to my doctors surgery in Norwich explaining that I needed to have **all** of my health information provided via email and that I give my permission for this information to be shared with other providers. Despite this, I had to remind the practice manager that I'd sent this directive. I was somewhat surprised that I also had to explain what the Accessible Information Standard was. Nobody has ever asked me how they could meet my communications needs best. I have had to request for my correspondence via email from my surgery every time.

I do not know how they record my communication needs or if it appears on my notes. On repeated occasions, I have been given information by the GP in print and then been told that I should get someone else to read it to me. There seems to be no understanding of how this leaves me feeling or the disempowerment and indignity of it. I am still getting screening appointment letters and referral documents in print from my GP surgery too. Occasionally, if I keep asking, I get the odd email response, but this is not consistent. It is clear that my preferred format information has not been passed onto other health or social care providers. It is a continuous battle and trial of having to explain to every clinic or service I attend that I need everything sent to me via email. This wouldn't be happening if the Accessible Health Information Standard was being adhered to.

Recently, I was called for a smear test, the letter came in print only. I feel that being able to read and process my own private correspondence independently and confidentially is essential to me retaining my dignity. The fact that I have nobody at home who can read information to me should not matter. Anyone receiving personal mail has the basic human right to read it themselves independently. I have a person from an agency who comes in to help me read post and fill in forms. Every week this could be someone different and almost always someone I don't know well or have built a personal bond with.

Because all of the screening letters come in print only, on the occasion of my smear test, the letter was read to me by a young man, who I'd

never met before and who struggled to read because of his dyslexia. In the same batch of post, I had another letter from the hospital detailing the results of a colonoscopy examination, including some very graphic images of the inside of my intestines. He was deeply embarrassed given the situation that he had had what could have been a very upsetting task of giving me the results of this test, plus having to go into detail about my smear test which needs no explanation as to how personal it is!. I was extremely upset about it and humiliated. I felt that all my dignity and the right to my own privacy had been stripped from me.

In practical terms, I am often expected to instantly remember the appointment details, the directions to get to the clinic and the specific details of the procedure. This year these instructions have also contained Covid-19 specific guidelines which I've been unable to follow. Not being able to assimilate the information in my own time means that such tests seem very frightening and the temptation is to ignore the letter.

The impact of not receiving health information in a form I can read causes intense anxiety and stress. This has a marked impact on my general mental health, reduces yet more my ability to live independently, making me more reliant on statutory services and likely to return to receive further medical care.

If my health information was sent to me in my preferred format I would be able to take better control of my own health and any matters related to it. It would empower me to make better decisions about my treatment and how to manage my condition independently. I would not feel the learned helplessness which is forced on me when health care professionals automatically assume that someone else is available to do things for me, and that my own dignity doesn't matter.

Case Study 2

My Pharmacy

I have no vision at all, I use assistive technology to read printed material so my preferred format is always electronic.

A couple of years ago I found out that I had H.pylori and was given a course of 3 different antibiotics. These were very strong medicines and the instructions had to be followed carefully to ensure they were effective. My GP did not explain to me what the doses were, I was feeling so unwell, I did not think to ask.

I went to the pharmacy to collect the medication, which she handed to me without any explanation of the dose or time it should be taken. I asked her about it and she said that they had carefully colour coded the medicine so I could tell which one was which and handed me a sheet which apparently had large print details on it. Whilst this would have been helpful for people with some residual vision, I could not read it. No effort was made to ask me what my communication requirements were and how they could meet them.

The pharmacist rattled through the instructions for all the medicines in one go. Some you had to take with food, some you shouldn't drink with and some were 2 tablets at a time. I couldn't remember the details by the end. There was nobody at home who could read this information to me. Luckily I have some knowledge of braille, so once I peeled back the printed labels covering them, I was at least able to read the name of the medicine. I took a guess at which ones should be taken when.

The medicine made me feel dreadful, but I persisted as I knew how important it was not to stop antibiotics half way through a course. When I neared the end of the two week intensive treatment I noticed that for one medicine there were still quite a few tablets left. I realised that I'd only been taking one tablet when it should have been two each time. I called the GP who said that I'd have to start the whole course of medication from scratch. This meant that I was on a huge dose of antibiotics for a month which was very stressful. This kind of thing has happened on many occasions.

The potential consequences of getting doses and precautions wrong fills me with dread, as it could endanger my life. I am a very independent person and I have the right to remain so for as long as I possibly can. Being able to read my own prescriptions would seriously improve my ability to manage my health conditions more effectively and safely. This would reduce the load on my doctors surgery, who have had to pick up the pieces when I haven't been able to take the medicine as prescribed.

Case Study

My Hospital

As a deafblind person I need my health information in an accessible format. I'm sight impaired and partly deaf and not to get things in my preferred format means I can't access my own healthcare independently. Currently all correspondence are done by phone which I find very difficult to hear and understand. This is still being

done despite deafblind being on my record, and my constant reminders. No alternative method, such as email, has been given. This means I can not interact with individual consultants confidently or privately. I have to ask my parents to talk on my behalf. In person consultation is a must because then i'm physically in front of a person and can understand them better, as opposed to virtual appointments when I'm not.

For more information on the briefing please contact Michael Wordingham, Policy and Campaigns Officer, RNIB – Michael.wordingham@rnib.org.uk

About the RNIB
The Royal National Institute of Blind People (RNIB) is one of the UK's leading sight loss charities and the largest community of blind and partially sighted people. We provide a wealth of services including practical and emotional support through our RNIB Connect community and our Sight Loss Advice Service, guide business and public services on accessibility, campaign for change, and have a library of over 60,000 accessible reading materials, including daily newspapers.

Every day 250 people begin to lose their sight. We want society, communities and individuals to see differently about sight loss. In our 150th year RNIB renewed our focus on creating a world where there are no barriers to people with sight loss.

Briefing for	**Norfolk Health Overview and Scrutiny Committee**
Subject:	**Interpreting Services**
On behalf of:	**Rachel Webb, Regional Director of Primary Care and Public Health – NHS England and NHS Improvement, East of England**
Author:	**Fiona Theadom, Senior Contract Manager and Jessamy Kinghorn, Head of Partnerships and Engagement**
Date:	26 November 2020

Background

This scope of this paper is to focus on access to primary care services for patients with a hearing impairment and actions being taken to address any concerns.

According to Action for Hearing Loss, in their Hearing Matters report published in May 2020, there are approximately 11m people with hearing loss in the UK. By 2025, it is estimated the total will rise to 15.6m. 250,000 people have both hearing and sight loss. Approximately 900,000 have profound hearing loss of which 24,000 are estimated to use British Sign Language (BSL).

The latest data published in 2010 showed that 3,530 people were registered deaf or hard of hearing in Norfolk.

In 2013, at its inception, NHS England and NHS Improvement (NHSE&I) inherited a variety of historic arrangements relating to the former East Anglia Area Local Area Team (Norfolk, Suffolk and Cambridgeshire & Peterborough) for the provision of interpreting services which Primary Care Trusts or Clinical Commissioning Groups (CCGs) had previously commissioned. In 2018, a new contract for GP and dental services for this geographical area was commissioned via the Crown Commercial Services Framework.

Whilst the CCGs hold the budget under delegated commissioning for both services, the NHSE&I team undertook to manage the procurement of these services on behalf of the CCGs.

The outcome of the procurement was that DA Languages was awarded the new contract and commenced service provision on 1 April 2019.

Following the completion of the procurement and contract award, it came to light, via patient feedback, that the new service did not include some additional services which had historically been provided for patients specifically in Norfolk by a local British Sign Language (BSL) provider, Deaf Connexions, such as arranging appointments for patients in addition to attending the clinical appointment with the patient.

An Equality Impact Assessment (EIA) was completed in 2018. As the procurement was undertaken on a “like for like” basis the issue of Deaf Connexions did not come to light throughout the engagement process and therefore the EIA would not

specifically have addressed this issue. We recognise that the deaf community in Norfolk have therefore seen a change in the services they receive.

Engagement prior to contract award

The procurement, tender, and post award process included engagement with Healthwatch in each geographical area, with an initial briefing in June 2018. Emails and newsletters were sent out to patient forums and face to face meetings were offered across the area.

All GP, dental practices, Local Dental Committees, Local Professional Networks and Local Medical Committees in the area were kept informed throughout the process.

Following the concerns raised by patients, in September 2019 the CCGs in East Anglia and the three Healthwatch organisations were contacted for feedback by NHSE&I and no additional concerns were raised about services.

Contract Monitoring and Management

There are regular service review meetings with the provider and whilst there were teething problems, particularly around the availability of BSL interpreters at short notice, the new contract is generally performing well in relation to the key performance indicators. The supplier is required to deliver a minimum fill rate of 95% for BSL services and it is acknowledged this has not always been met in Norfolk.

Between April 2019 – March 2020, 890 non-spoken appointments were delivered in the East Anglia region, 49% of these in Norfolk; 27 complaints were received from 14 practices, West Norfolk Deaf Association and Deaf Connexions. The majority of these related to the availability of interpreters at short notice and to the change in way services are provided.

From April - end Sept 2020, 230 appointments were delivered in the East Anglia region, of these 65% were delivered in Norfolk. A total of 10 complaints were received in relation to BSL services in Norfolk to end Oct. All complaints are fully investigated and where possible, resolved. Investigation of concerns of those received since April 2020 have found that issues relate to:

- the availability of BSL interpreters at short notice on two occasions;
- two instances when a BSL interpreter could not be sourced for a specific appointment time;
- two occasions when an interpreter failed to turn up for an appointment; appropriate action was taken by DA Languages; and
- four occasions when the GP or dentist failed to follow either NHSE/I policy and guidance, their obligations under the Accessible Information Standard or supplier booking instructions.

An audit of feedback for July and September 2020 in Norfolk showed that 92% (33/36) of practices rated BSL interpreter performance as Very Good and a further 2/36 rated performance as Good.

Since the specific concerns relating to BSL provision in Norfolk were raised last year, frequent discussions have been held with DA Languages to identify any shortfalls in their delivery of the contract, and to address the issues that have been confirmed as falling short of the required standards. The majority of concerns raised with NHSE/I

are provided by third parties and therefore more difficult to investigate although we are able to highlight particular themes that might be emerging such as the availability of interpreters at short notice.

West Norfolk Deaf Association have referred on a number of compliments from patients to NHSE&I. Compliments have also been received from users of both BSL and non-BSL interpreting services across the wider geography.

In April 2020, DA Languages made available virtual online interpreting services to all GP and dental practices in East Anglia for both non-speaking patients and non-English speaking patients. These are in addition to normal interpreting services available via telephone or face to face. The virtual online services are available to pre-book or on demand. DA Languages informed all practices about the availability of these services and NHSE/I sent out a reminder in June. There has been very limited uptake in Norfolk, only one practice has used it for BSL services on one occasion, although it has been used for non-English speaking languages.

Online virtual services for non-speaking patients attending the Norwich Walk-in Centre were planned to start in March however there was a delay due to Covid; they will be fully operational during November once all the technical issues are resolved and staff training completed. We recognise that not all patients wish to use virtual online services and face to face services continue to be available.

During the period April to end Sept, 230 BSL appointments were delivered either face to face or online in the East Anglia region; in Norfolk 14% of face to face appointments for interpreting services were cancelled, 54% of these by the GP or dental practice and 46% by the patient (including 3 when the patient did not attend). This compares to 9% in a three month period pre-Covid.

In recent weeks, there has been a 45% increase in the use of interpreting activity for BSL as practices start to restore services.

Key learning

As a result of the feedback relating to the loss of the Deaf Connexions services in the Norfolk area, the team have reflected on the process and identified some key learning from this procurement.

We have recognised that the approach taken in 2018 had its limitations and may not have been accessible directly to patients with specific health or literacy needs.

The patient engagement exercise relating to the procurement of a new contract during 2021 is taking a different approach to identifying and managing health inequalities following on from completion of an Equality Impact Assessment.

With expert support from one of the local deaf associations in the region, an online survey has been prepared and circulated to the deaf community via the patient associations and also to Healthwatch and CCG Engagement leads across the region; this survey is accompanied by a video translation of the questions and enables feedback by video. Patients have been given up to six weeks to respond and this timeframe may be extended if needed. NHSE&I is also investigating the feasibility of running a small number of independently facilitated virtual focus groups across the East of England region, including one in Norfolk, to understand from

patients what the impact of having a hearing impairment has on access to primary care services.

Actions taken to date

- Regular service review meetings with DA Languages, initially monthly are now quarterly due to improvement in performance.
- Daily contact with DA Languages as and when required to address individual concerns from practices, patients and other stakeholders.
- Monthly monitoring of activity and performance, including British Sign Language services to identify and manage any issues of concern. A detailed breakdown of BSL interpreting services usage in East Anglia is analysed and appropriate action taken.
- Contractual intervention asking DA Languages to address patient concerns about access at short notice in Norfolk in particular, with the result that DA Languages can request Deaf Connexions to provide interpreting support as and when appropriate, for example if they are unable to source an interpreter at short notice.
- DA Languages continue to try and increase the recruitment of interpreters. It should be noted that the British Deaf Association acknowledge that demand for interpreter services outstrips the number of qualified interpreters and other communication support workers but hopes to see an improving situation with increasing numbers wishing to learn BSL.

We note that one of concerns raised is that a patient cannot contact DA Languages directly. The services have been set up so that appointments are made by the GP or dental practice in consultation with the patient according to their clinical need and how individual practice triage and appointment systems are managed. It is the practice's responsibility to ensure appropriate reasonable adjustments are in place when communicating with individual patients. We acknowledge that not all practices fully understand their responsibilities despite recent communications from commissioners however appropriate action is always taken with the practice when investigation into a complaint finds this to be the reason.

In addition to the actions already being taken, NHSE/I and the CCG are seeking to implement the following actions:

Short term actions

Ensure the work being undertaken by GP practices and Primary Care Networks to identify health inequalities and patient cohorts who may not be accessing services includes patients from the deaf community to ensure that all patients have equitable access to services;

Commissioners will be reminding GP and dental practices about their obligations and to raise awareness about the availability of using interpreting services and training that is available; and

Norfolk and Waveney CCG's Training Hub plans to review its training programme for administrative and reception staff within GP practices to include awareness about the importance of equitable access for all patients, the value of BSL interpreting services and to communicate with patients.

Medium and long term actions (2020/2021)

Consider how GP and dental practices can be actively encouraged to implement the pledges in the BSL Charter published by the British Deaf Association;

Put in place training about access to online virtual services to complement the way in which GP services are now being provided;

Analyse the outcome of the current engagement process (a separate paper at this meeting refers) to determine how that will inform the development of local service delivery models;

Design and implement a training, awareness and communications programme for primary care services and patients with the new supplier when appointed; and

Investigate how GP practice telephony systems can be upgraded if and when they are replaced to make access to practices easier for patients.

NHS/I is committed to ensuring that all patients have equitable access to primary care services and that appropriate action is taken where failings are identified.

Norfolk Health Overview and Scrutiny Committee
26 November 2020
Item no 7

Suicide prevention

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

Examination of the work to prevent suicides in Norfolk and Waveney, focusing on the action delivered by NHS partners and particularly Norfolk and Suffolk NHS Foundation Trust.

1.0 Purpose of today's meeting

1.1 The focus of the meeting is:-

- To examine progress by NHS partners with their part of the delivery of the Norfolk Suicide Prevention Strategy 2016–2021, and in particular;

- To examine Norfolk and Suffolk NHS Foundation Trust's delivery of its Suicide Prevention Strategy 2017-2022.

1.2 Norfolk and Suffolk NHS Foundation Trust (NSFT) has provided the paper attached at **Appendix A** which sets out progress against their Suicide Prevention Strategy 2017-2022.

Representatives from NSFT will attend to answer Members' questions and a representatives from Norfolk County Council Public Health, who lead the local multi-agency Norfolk Suicide Prevention Implementation Group will attend to answer any questions about the wider context to the NHS partners' work.

2.0 Background information

2.1 National and local strategies

2.1 The national Preventing Suicide in England (2012) strategy highlighted that suicide was a major issue for society and a leading cause of years of life lost. It also noted that no one organisation is directly able to influence all the factors that may lead to someone taking their own life. Suicide is often the end point of a complex history of risk factors and distressing events and efforts to prevent suicide have to address this complexity.

2.1.2 The Norfolk Suicide Prevention Strategy 2016- 2021 is a local multi-agency commitment and action plan aiming to reduce the number of deaths by suicide in Norfolk. The Norfolk strategy starts with the premise that suicide is not inevitable and preventing it is everyone's responsibility and commits

longer term to reducing the number of suicides in the county to as close to zero as possible.

The Strategy and action plan are available via the County Council website:- https://www.norfolk.gov.uk/care-support-and-health/health-and-wellbeing/adults-health/suicide/learning-and-resources

2.1.3 The Norfolk action plan sets out specific actions for local organisations within the 6 priority areas identified in the national strategy:-

1. Tailor approaches to improve mental health in specific groups
2. Provide better information and support to those bereaved or affected by suicide
3. Reduce the risk of suicide in key high-risk groups
4. Reduce access to the means of suicide
5. Support research, data collection and monitoring
6. Support the media in delivering sensitive approaches to suicide and suicidal behaviour

Actions were assigned to a large range of organisations including:-

- Norfolk County Council
- Suffolk County Council
- District councils
- Norfolk and Suffolk NHS Foundation Trust
- Clinical Commissioning Groups (now merged into Norfolk & Waveney CCG)
- NHS acute trusts (i.e. the 3 acute hospitals in Norfolk & Waveney)
- NHS Commissioning Support Unit prescribing advisors
- Norfolk Constabulary
- The Office of the Police and Crime Commissioner (in coordination with the prison service and probation service)
- Public Protection Forum
- Armed Services Covenant
- Norfolk Coroner's Office
- Healthwatch
- Voluntary sector organisations – MIND; Samaritans
- Norfolk Safeguarding Children's Board partners
- Norfolk Recovery Partnership
- Adult Learning and Improvement Policy sub group (reporting to Adult Safeguarding Board)
- County Community Cohesion Network
- British Transport Police

The National Farmers Union is also involved.

2.2 NSFT's strategy

2.2.1 NSFT's Suicide Prevention Strategy 2017-2022 is available on its website. The strategy includes action in the following areas, aiming for the following stated outcomes :-

- **Clinical Pathways**
  - Increase the availability of male specific interventions across the community;
  - Develop the pathway of care for people experiencing affective disorders (depression, anxiety);
  - Develop the pathways of care for people experiencing crisis;
  - Integrate the recovery principles into our practice of care;
  - Seek to understand local needs in respect of differing population groups in respect of suicide risk;
  - Ensure the right clinical support is available at the time it is needed;
  - Continue to ensure safety is critical in our decisions about the medication people need;
  - Examine and develop the safety for service users at the time of discharge from services;
  - Continue to examine and evaluate our understanding of suicide in the local area transferring learning into clinical practice

  Outcome statement:- The strategy will influence the provision of clinical pathways with safety at its core. This will be measured through the effects of improvement methods influencing design of pathways of care.

- **Working with family and carers**
  - Make every contact count with families and carers through listening and responding to the information they provide;
  - Provide families and carers with increased information on the aspect of safety and suicide risk;
  - Ensure families and carers are supported in their role;
  - Ensure we are open and provide as much information as possible to support their role, with respect to the boundaries of confidentiality;
  - Continued implementation of the service user and carers strategy to ensure that they are at the centre of their care;
  - Encourage family and carer education through the Recovery college.

  Outcome statement:- The strategy will develop and enhance the way the Trust works with family and carers who support people at risk of suicide, using a range of measures to capture their experience.

- **Supporting staff with the most up to date skills and knowledge**
  - Review our risk assessment and suicide prevention training involving service users, families and carers;

- Provide staff with the skills and knowledge to support those with a chronic risk of suicide;
- Support staff in their knowledge and confidence of situations where it is appropriate to discuss an individual's risks with families and carers without their explicit consent;
- Support staff knowledge and skills in developing safety plans that meet the needs of the individual.

Outcome statement:- The strategy commits the Trust to support staff with the most up to date skills and knowledge through a range of learning methods. The outcome measure will be the breadth of learning opportunities available.

- **Innovations**
  - Make follow up contact with people who have experienced acute distressing events which have had a single or brief contact with Trust services e.g. acute liaison services;
  - Establish a working group to explore the principles and implications of Open Dialogue within clinical practice;
  - Explore how the Trust, in combination with partners, may introduce community spaces where people in acute mental distress may seek support;
  - Development of safety cards which involve stay safe planning;
  - Explore how the Trust could introduce the 'letter of hope' within clinical practice.

Outcome statement:- The strategy supports the Trust to apply innovations in order to develop the ways in which the Trust supports people at risk of suicide. The outcome measure will be the number of innovations applied and assessment of their impact.

- **Working with partners to deliver countywide actions**

Outcome statement:- The strategy supports the Trust to be an active partner in taking action to reduce suicide in our community, with the measures defined within the county suicide prevention groups.

2.2 General information and data on suicides in Norfolk

2.2.1 Norfolk County Council Public Health has provided the background report **Appendix B**, which includes latest information on local suicide rates and details of the wider prevention agenda within which NSFT's work sits.

2.2.2 Information aimed at suicide prevention is provided on Norfolk County Council's website:- https://www.norfolk.gov.uk/care-support-and-health/health-and-wellbeing/adults-health/suicide

This includes links to relevant organisations' websites, information / advice for friends and family, suicide prevention toolkits for employers and the wider

public health workforce including voluntary sector, emergency services, prison staff and all staff in health and social care.

2.3 **Previous reports on suicide prevention to other County Council committees and briefings to NHOSC**

2.3.1 **Norfolk Health and Wellbeing Board** received reports on:-

Suicide Prevention in Norfolk on 26 April 2017 (agenda item 10). The Board:-

- Endorsed the Norfolk Suicide Prevention Strategy and action plan
- Noted the Suicide Prevention Strategy developed and agreed by the NSFT
- Discussed the data analysis supporting the county-wide plan and possibilities for further developing that analysis to support further preventative action, particularly around children and young people.

Suicide Prevention Conference on 12 July 2017 (agenda item 12). The Board:-

- Supported the development and delivery of this learning event on 12 September 2017 as part of adult safeguarding week and agreed to encourage participation and subsequent engagement. The event was aimed at equipping those working with vulnerable adults and children in Norfolk with the skills, knowledge and confidence to support those affected by suicide, with a focus on prevention.

2.3.2 The **Communities Committee** also received the Suicide Prevention Plan on 7 March 2018 (item 10) when it noted progress to date and endorsed actions by the Suicide Prevention Implementation Group for 2018-19 including to:-

1. Work with Norfolk & Waveney (Sustainability Transformation Partnership – now known as the Norfolk & Waveney Health and Care

Partnership STP with the ambition to develop implementation projects with the NHS.

2. Consider potential action on the new priority on reducing self-harm, recently added to the National Suicide Prevention Strategy.
3. Establish a new multi-agency task and finish group with a focus on self harm and suicide data to:
    a) improve data collection, monitoring and reporting;
    b) respond to emerging trends;
    c) improve information sharing and referral pathways and d) share good practice.
4. Hold a second Suicide Prevention Learning Event, close to World Suicide Prevention Day in September. Potential areas of focus include:
    a) Bereavement by suicide
    b) Self-harm and emotional wellbeing
    c) Suicide in children and young people
    d) Suicide in prisons
    e) Suicide in Black, Asian and Minority Ethnic groups
    f) Suicide prevention training e.g. guided e-learning session
5. Develop action plans specific to each partner organisation/service detailing actions to be taken at different levels within the organisation/service i.e. organisation or service level, management level, staff level, customer/service user level, across other partnerships and networks.
6. Monitor the progress of the action plan, revising and creating new actions where required.
7. Continue providing communications, advice and support for
    a) people considering suicide, their families and friends, and professionals and
    b) people bereaved by suicide.

2.3.3 **NHOSC** put 'suicide prevention' on its forward work programme in October 2017 following information in the May and July 2017 NHOSC Briefings about a nationwide review of suicide prevention by the Parliamentary Health Select Committee. The Select Committee's review and the Government's response are available via the following links:-

Health Select Committee suicide prevention report - March 2017

Government response - July 2017

After a further Briefing in April 2018 NHOSC decided not to pursue the subject as an agenda item at that stage because both the Communities Committee and the Health and Wellbeing Board were monitoring progress.

3.0 Suggested approach

3.1 Members may wish to explore the following areas with the NSFT and Public Health representatives:-

(a) In the 2014-16 three year rolling period Norfolk had 12.6 suicides per 100,000 population, which was the 5th highest rate nationally. This has reduced to 11.1 in the 2017-19 period, which is near the English average. Although there have been annual fluctuations the overall downward trend has been sustained from 2014-16. Do NSFT and Public Health see this as evidence of success of their strategies, or is it too soon to be sure?

(b) Implementation of NSFT's strategy might be expected to lead to a reduction in the number of unexpected deaths of NSFT patients reported as a serious incident. Has this been the case?

(c) It has been predicted that the Covid 19 pandemic will have a detrimental impact on social, emotional and economic wellbeing. How will the innovations that NSFT has introduced under its Suicide Prevention Strategy help to mitigate the effects?

(d) When a person who has suicidal thoughts or has actively begun to plan for suicide contacts NSFT what do staff do to immediately help that person?

(e) What steps are taken to protect the mental health of those bereaved by suicide?

(f) Are the NHS partners satisfied that all partners involved in the Norfolk Suicide Prevention Strategy 2016-2021 are playing their part to reduce the rate of suicides?

4.0 Action

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

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Norfolk and Suffolk NHS Foundation Trust

Report to:	Health and Overview Committee
Meeting date:	26th November 2020
Title of report:	Norfolk & Suffolk NHS Foundation Trust Suicide Prevention
Action sought:	For information
Author:	Liz Howlett, suicide prevention lead at NSFT

1.0 Purpose

1.1 To update members on the Norfolk and Suffolk NHS Suicide Prevention Strategy 2017-2022. This strategy works alongside the system-wide Zero Suicide Alliance. The alliance holds the ambition that one day we will live in a world where suicide does not exist.

2.0 Background

2.1 During 2018/19 some 107 people living in Norfolk and Suffolk who were receiving care from the mental health trust sadly died. Coroners have reached a conclusion of suicide in 32 people's cases. Nineteen were male. Investigations have been held into these and two of these identified problems with the care the person received.

2.2 In 2019/20 there were 82 deaths of which 22 (18 male) were recorded as suicide. Of the Serious Incident Investigations conducted in one case there were problems with the care received. We remain committed to the Zero Suicide ambition and continue to implement best practice.

2.3 This report covers what we have done. Most recently we have employed an Advisor in Suicide Prevention who has lived experience following the death of her son who took his own life. She joins our Suicide Prevention Lead to influence future strategy. We have held five events to share information and learning with staff, led by these two and other partners.

2.4 What follows is an update on each of the five key priorities in the Trust's strategy.

1. Clinical Pathways, which are a guide of how we work with service users to plan care from admission to discharge
2. Working with family and carers

3. Supporting staff with the most up to date skills and knowledge
4. Innovations
5. Working with partners to deliver countywide actions

3.0 Current position

3.1 Clinical Pathways

3.1.1 To make a difference to people's lives, we need to ensure that people get the right care at the right time. Unfortunately, as a nation we know that males are increasingly more likely to take their own life than females. A Men's Mental Health Lead was employed to deliver male specific training to teams to increase awareness. This lead liaises with the local services aimed at men to ensure our teams had strong community links to organisations such as MensCraft. We also hosted a Men's Mental Health Awareness Day attended by over 500 people from across Suffolk and Norfolk including NSFT staff, service users and partnership organisations.

3.1.2 People in crisis and their loved ones need support as soon as possible. In April 2020, we introduced the First Response line (0808 196 3494**)**. This is a 24/7 helpline for people of any age offering immediate advice, support and signposting for people experiencing mental health problems. Those who need help are directed to the right service at the right time. We have had 25,000 calls in the first seven months.

3.1.3 While people may be well enough to leave an inpatient unit, it can increase the risk of suicide. People who leave wards have always received a face to face contact within a week. However, national evidence showed it is more supportive to carry out this contact within 72 hrs of the person leaving. This has been put in place. It means we can check on welfare and whether there is a need to give the person any more advice and support to continue their recovery.

3.1.4 We also recognise that people who have received acute mental health care can relapse once support reduces. We have created a policy earlier this year to the enable people who have been discharged from acute care within three months to refer themselves back to the team should there be a concern that their mental health is getting worse. Their loved ones and carers can also get in touch.

3.1.5 Understanding the needs to the population of Norfolk is vital. The Real Time Surveillance system has been developed that means deaths from suspected suicide are recorded in real time. It means we can put in place additional support where the prevalence of suicide is high or rising.

3.2 Working with family and carers

3.2.1 The Suicide Prevention Strategy 2017-2022 highlights evidence of the importance of involving the family in care. To understand the barriers, a

Consultant Psychologist conducted an independent study. It led to the development of the “Stepping Back Safely” pilot project which looks at safety planning and involving carers. This training will be shared across all Trust teams to enhance skills at giving families and carers more information on safety and suicide risk.

3.2.2 Two Making Families Count conferences have been held for clinicians across Norfolk and Suffolk. This looked at the importance of involving families in their loved one’s care when a life changing event has happened. A Family Liaison Officer has been employed to help meaningfully engage families in the Serious Incident process and ensuring the information that they want us to know is represented in the report. Some families have helped teach the teams in sessions. These have been extremely effective and welcomed by staff.

3.2.3 These initiatives support the Trust’s wider aim for improved carer involvement. This includes dedicated carers leads, People Participation Leads, Have Your Say groups and regular carers meetings ensuring we capture their experiences and support people better in their role.

3.3 Supporting staff with the most up to date skills and knowledge

3.3.1 We have reviewed all our suicide and risk assessment training. Our new training will be delivered on three levels 1) for all staff 2) practitioner and 3) full two-day training.

3.3.2 Norfolk Public Health, under its Suicide Prevention Strategy, commissioned a local voluntary organisation to deliver “Question, Persuade, Refer” suicide prevention training. Due to positive feedback, we will be commissioning this course for staff from December 2020.

3.3.3 The practitioner training will be for Care Co-ordinators. The full two-day training will support the Care Groups, identifying areas covering specific risks in different groups. It will include learning from Serious Incidents and sharing of information. Service users and those bereaved by suicide will be co-producing the course and our aim is that they will be supported to co-deliver this as well.

3.3.4 Since 2018, 97% of our employees have completed the Zero Suicide Ambition online courses. This training has been received positively by the teams, particularly non-clinical staff who report this to be the first time they have received Suicide Prevention Training.

3.3.5 The Recovery College also has co-produced Suicide Prevention Training. This will be delivered with those bereaved by suicide to service users, carers and staff next spring. The Recovery College aspire to make this the first course delivered externally.

3.3.6 To promote World Suicide Prevention Day this year, the Trust held a series of live events online for NSFT staff to discuss factors which can influence suicide and invited staff to ask questions throughout. The panel consisted of the

Suicide Prevention Lead, Chief Nurse, People Participation Lead, member of the Suffolk Service User Forum and a mother who was bereaved by suicide. Other experts were also invited. The first event focused on the importance of language and was watched by over 500 people. A bereaved mother gave a powerful talk about her son, the care he received from the Trust and how his suicide has affected her and the community. The final two covered dual diagnosis and personality disorders. These events were so popular we are holding them twice a month from December onwards. The next planned topics are veterans, children and young people, carers needs and men and suicide. We have been asked to develop sessions for our partnership organisations, service users and carers, which we are planning to do from spring 2021.

3.4 Innovations

3.4.1 Public Health England funded a pilot study called RUSH for NSFT. This provides a psychosocial assessment and follow up support for those young people who attend Emergency Departments with self-harm or thoughts of self-harming. This is an initial small, year-long pilot in the Norfolk and Norwich University Hospital and East Suffolk and North East Essex Partnership Trust at the Ipswich site. If it is successful, this will be extended to other hospitals in Norfolk and Suffolk.

3.4.2 The Trust has invested in Kooth for the young people of Norfolk and Waveney. Kooth provides online counselling and support to any young person and was commissioned following positive feedback from Suffolk services where this was initially trialled.

3.4.3 Service users from Norfolk who have had a single or brief contact with acute liaison teams now have face to face visits and/ or access to a helpline from a local charity to give additional support.

3.4.4 Families who have been suddenly bereaved have been contributing to investigations to help us learn important lessons. A Family Liaison Officer engages with and supports the families to help identify areas of learning for the Trust. Since July 2019, 56 families have been offered support from the Family Liaison Officer and 27 have accepted. The Family Liaison Officer works closely with third sector organisations offering family bereavement support.

3.4.5 The Trust uses “Formulation” which takes a holistic, collaborative and systematic approach to support service users, careers and staff members to work together to gain a shared understanding of the service user’s story and mental health difficulties. It helps make sense of their experiences and enables a better understanding of what might be preventing service users from moving forward towards their goals. This project has been co-produced with service users, careers and staff. It was trialed in an Integrated Delivery Team in Suffolk and we are working towards making this Trust-wide.

3.4.6 Safety Plans help people understand how to care for themselves. Three inpatient units across Norfolk are delivering suicide prevention training so that all service users leave the inpatient unit with a personalized safety plan. Peer Support Workers will work with teams to continue learning about safety planning and help teams develop helpful safety planning language.

3.5 Working with partners to deliver countywide actions

3.5.1 The Trust has been an active partner in both the Norfolk and Suffolk Suicide Prevention Strategies hosted by Public Health.

3.5.2 The Suicide Prevention Funding was released to Norfolk and Suffolk Suicide Prevention which enabled us to fund the “Stepping Back Safety Project” and the “Safety Planning / Peer Support on Inpatient Units”.

3.5.3 The Trust is a member of the Zero Suicide Alliance and National Suicide Prevention Alliance and has benefitted from the support and education through conferences and webinars to ensure our strategies reflect National learning.

3.5.4 The Trust has also received the support of Public Health England which has brought together NHS Trusts across the East of England to learn from each other’s practice with Suicide Prevention.

4.0 Conclusion

4.1 Only by everyone working together can our Zero Suicide Alliance make an impact. As part of that, the Trust’s strategy is supporting this ambition.

4.2 Members are asked to note the report.

Information provided by Norfolk County Council Public Health

Norfolk Suicide Prevention:

November 2020

Context

Nationally, the Department of Health and Social Care (DHSC) estimates that each suicide costs society £1.7 million and affects 6-60 people. Suicide is the leading cause of death in men aged under 45. The highest suicide rate in the UK was for men aged 40–44. Men from the lowest social class and living in the most deprived areas are up to 10 times more likely to die by suicide than others in the highest social class from the most affluent areas. Male rates remain consistently around three times higher than female suicide rates

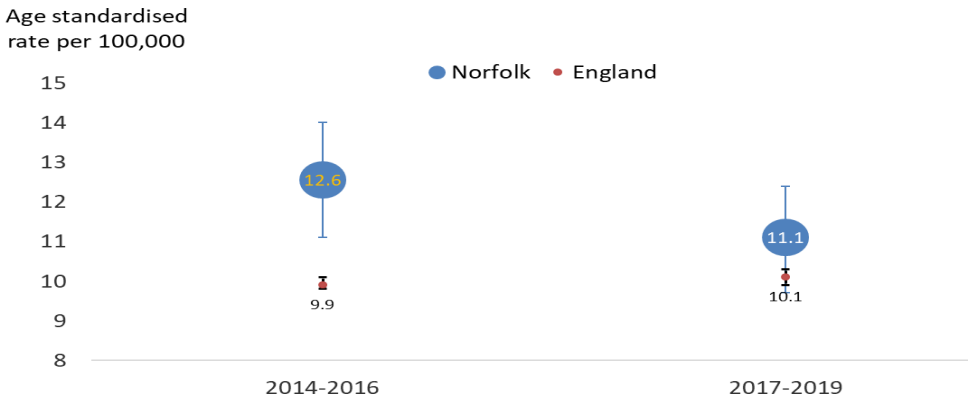
Locally, in 2017 Norfolk developed the county wide Suicide Prevention Strategy 2016-2021, in direct response to the counties high suicide rate, which led us to have the 5th highest rate nationally. The strategy set an ambition of reducing the number of deaths in Norfolk by 10% by 2020/21, which is in line with the National Suicide Prevention Strategy 2012.

Norfolk County Council, Public health continue to lead the coordination of the strategy, taking a local multi-agency approach. The Suicide Prevention Implementation Group (SPIG) is a key group helping to drive delivery forward. Membership has multiple partners from the statutory and VCSE sectors, including, Coroner's Office, Constabulary, Fire and Rescue, Norfolk & Suffolk Foundation Trust, mental health commissioners, Mind, Samaritans, DWP, HM Prison Service.

The suicide prevention workstream is an integral part of Norfolk's Community Mental Health transformation work which will establish a new model of primary and secondary mental health care organised around the new Primary Care Networks.

Prevalence:

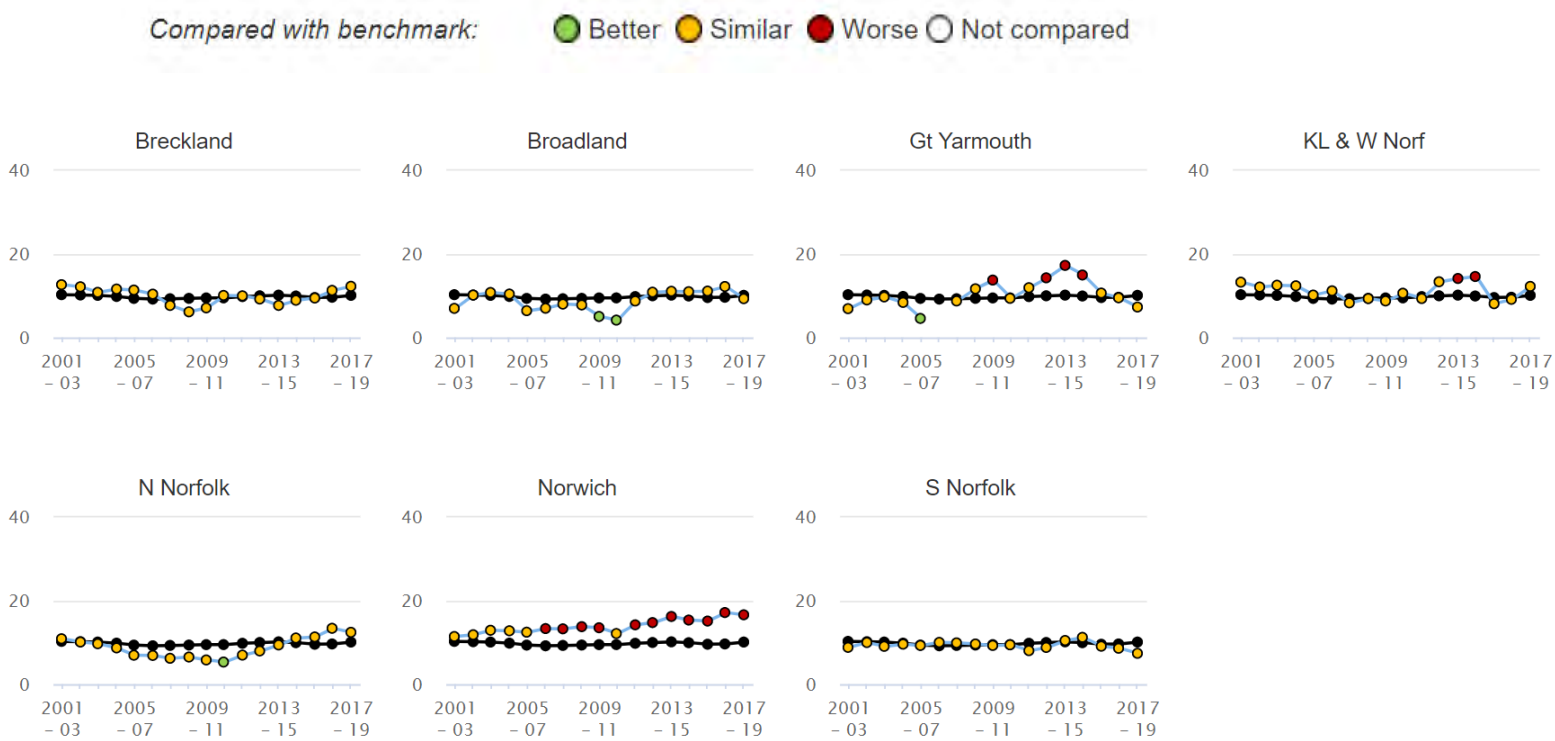
The latest Office for National Statistics (ONS) age standardised suicide rates for Norfolk residents for 2017-2019 is 11.1 per 100,000 people. This is almost 12% lower than 12.6 per 100,000 people from the last consecutive period 2014-2016. Running 3 yearly rates do fluctuate[1], but the overall trend has been downward since 2014-2016.



[1] In addition to any change in underlying suicide risk in Norfolk, random fluctuation and variations in registration delay contribute to the overall variation in suicide registration statistics. For these reasons the Office for National Statistics (ONS) publish suicide rates by combining 3 years of registrations.

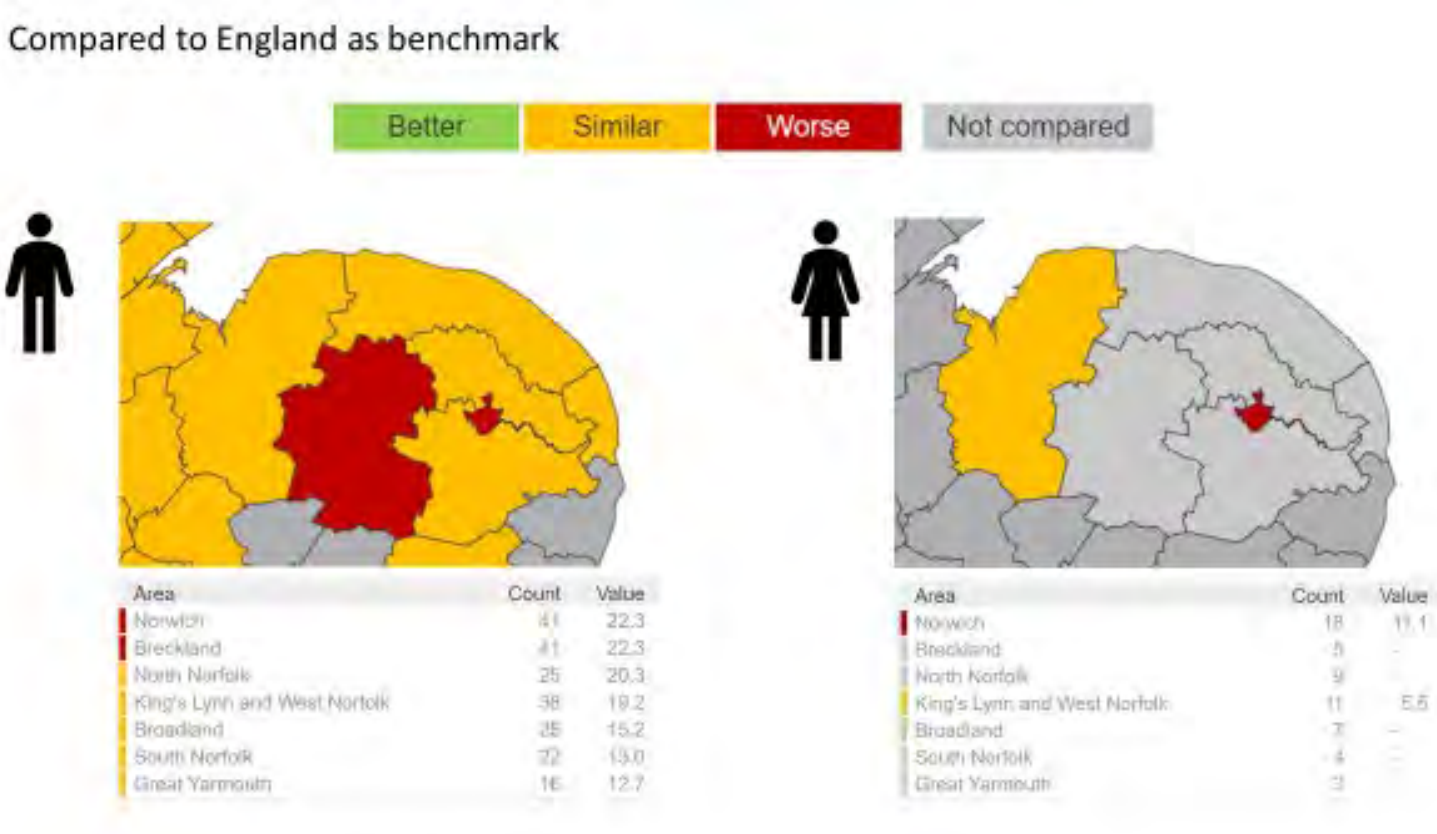
Fig 1 ONS suicide rates for Norfolk residents. These are standardised to a rate per 100,000 people using a common age structure. This allows fair comparisons over time with different geographic areas including the National average rate per 100,000. Unlike recent periods the overlap between the current rate and England average benchmark rate means these 2017-19 rates are now similar. Vertical lines show the 95% credible margin for the rates.

Fig 2 District trends: 3-year age standardised suicide rates (persons) per 100,000 compared with England average benchmark (black dotted line) **for each period.** Only Norwich shows a worse suicide registrations rate than the England average benchmark for the 2017-2019 period.



Public Health England. Public Health Profiles 02/11/2020. https://fingertips.phe.org.uk © Crown copyright 2020

Fig 3 Norfolk districts residents suicide registrations: 3-year age standardised rates by sex 2017-2019 compared to England. The only districts that had worse suicide rates in 2017-2019 compared to the England average was Breckland (male rate) and Norwich (both male and female rates). In 2016-18, North Norfolk and Norwich districts' male and female suicide rates were worse than the England average rate for that period. Grey areas indicate that the number of suicides is too few to calculate a statistically reliable rate.



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Though suicide risk may result from long term complex health and social risk factors that predate current interventions and prevention initiatives, the recent downward trend is supportive evidence that the recent significant investment into Norfolk, nationally and locally to support the delivery of the strategy is making a difference. Since 2017/18 Norfolk Public health has received over £1.5m to develop new services, projects and interventions to reduce suicide rates further.

<u>Menscraft – PPA – Prevention and Positive Activities Coordinators</u>

- 1:1 support for men and women in Norfolk & Waveney referred to NSFT and waiting for their first appointment.
- 1:1 support for men due for release from HMP Norwich.
- Develop sustainable PPA delivery model aligned with PCN mental health teams.

<u>The Outsiders</u>

- MHFA training for barbers, pubs, cycling groups etc.
- Develop micro-communities to support ongoing learning, social events and campaigns

<u>NCAN (Norfolk Community Advice Network)</u>

- NCAN referral system allows internal referrals to local charities providing welfare rights information, advice and guidance.

<u>Youth Loneliness & Isolation Campaign</u>

- Targeted CYP comms campaign aimed at reducing loneliness and isolation during the pandemic

NNUH – Self-harm pilot

- Deliberate self-harm and attempted suicide data obtained in Emergency Departments (ED) to be shared with the real-time suicide surveillance system (RTSSS).

Norfolk & Waveney Mind

- Increase complex bereavement service provision across Norfolk and Waveney.
- Training and recruitment of GP champion and deputy within each PCN.

Real Time Suicide Surveillance System

A Real Time Suicide Surveillance system (RTSSS), is a system that enables information about a suspected suicide to be identified quickly and often in advance of the Coroner's conclusion. This information provides us opportunities to offer timely support to people who have been bereaved or affected by a suspected suicide; the coroner's officers seek consent to refer to our commissioned bereavement service. RTSSS also enables us to respond quickly to emerging patterns that could indicate clusters, increasing trends and/or changing methods of death.

One of great achievements for this year has been the ability to collect self-harm data from the Norfolk acute hospitals. Self-harm is one of the biggest risk factors for suicide and so this data will provide a much clearer picture of what is happening and how and where we should focus resources efforts.

Work is also underway with East of England Ambulance Service and Royal National Lifeboat Institution to capture local data around attempted suicide and self-harm to help us continue to build the picture across the system.

COVID-19 Response – enhanced suicide prevention offer

We have extended our existing suicide bereavement service to include deaths from Covid-19, with the provision of immediate intensive support after a death along with a time-limited support group at six months.

i. There are also two Suicide Prevention Champion roles working with communities to build community capacity and engagement and lead on co-production. These posts are currently deployed to work in those areas that have. seen increases in suspected suicides. Without the RTSSS early intervention would not have been possible.
ii. The Training and Workforce programme continues to develop and is seeking ways to deliver in line with current social distancing guidance as well as online. The offer includes

    - Development of suicide bereavement training
    - Suicide awareness and intervention skills
    - Mental Health First Aid training
    - Professional development learning events across Norfolk - https://www.norfolkandwaveneymind.org.uk/training-and-courses

- Suicide and self-harm training for schools and CYPF services

iii. Additional capacity in the voluntary sector to provide information, advice and guidance around debt, housing, immigration and other social issues through the Norfolk Community Action Network NCAN), which is referral system is one-stop referral for information, advice and guidance – clients give their details once and are contacted directly by the relevant charities.
The NCAN referral system has been rolled out across hospital liaison teams and Primary Care Networks and piloting the system with DWP.

iv. The successful 12th Man project providing Mental Health First Aid training, social events and engagement campaigns to encourage men to talk about mental health to middle aged men has been expanded.

v. Menscraft has been asked to expand their prevention and positive activities support offer to men across the county, including safety planning, support around mental health and social issues as well as enriching social activities to help build emotional resilience. Consideration is being given to expanding the offer to women.

Communications:

Significant investment in communications and campaigns over the last three years. Our most recent supplement in the EDP to support activity around World Mental Health Day was published on October 22nd, 2020 and was a timely reminder to all that preventing mental ill-health is more important than ever in these challenging times.

https://edition.pagesuite-professional.co.uk/html5/reader/production/default.aspx?pubname=&edid=586a5881-46b4-43bb-9b4b-1b53bbe960cb

Case Study:

Before David* (66) retired, he had to take time off work with stress and poor mental health. He has dyslexia and left school without any qualifications, affecting his confidence and self-esteem.

David signed up for a Pitt Stop Active history course. “I’d never done anything like this before, but it’s nice to do something a bit more intellectual,” he said. “Studying has taken me into areas I’ve struggled with all my life, but it is helping me to overcome my disability – dyslexia can be very restricting.” David is also a regular on the Heritage Health Walks. “I didn’t know anyone else when I joined, but it has helped with my low moods and my general mental wellbeing. It’s too easy for me to just withdraw into my shell, so mixing with other people does help a lot.”

*Not his real name

Next steps

The current strategy is due for review in 2021 and we intend to continue to use the national strategy as a framework, key aims include:

- Reducing the risk of suicide in high risk groups;
- Tailoring approaches to improve mental health in specific groups;

- Reducing access to means of suicide;
- Providing better information and support to those bereaved or affected by suicide;
- Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour;
- Supporting research, data collection and monitoring
- Reducing rates of self-harm as a key indicator of suicide risk.

Locally, there will be the development of a system wide strategy which will require senior leadership and commitment to guarantee success.

Continue to expand the RTSSS. One of the key outcomes will be to find a mechanism by which the system can review unexpected deaths to enable us to respond as a system to emerging trends and themes

St James' Medical Practice, King's Lynn – proposed relocation

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

The committee will receive consultation from St James' Medical Practice regarding a proposal for relocation to a new site in King's Lynn.

1.0 Purpose of today's meeting

1.1 Representatives from **St James' Medical Practice**, King's Lynn, (the Practice) will present a proposal for relocation of the practice from its current town centre location on County Court Road to a new building sited in North Lynn, on land owned by Norfolk County Council on Edward Benefer Way near South Wootton Junior School. This is a move of approximately 2 miles to the north from its current location.

The practice currently has approximately 20,000 patients, with the greater number living in the north of the town.

The proposed new location is marked as **'Site 2 – Land off Edward Benefer Way'** in Appendix A, Annexe 1 – Long list of potential sites.

A reserve site has also been proposed, which is 'Site 9 – Land at Nar Ouse Way' in Appendix A, Annexe 1. It is to the south of the current location.

1.2 The Practice and CCG are consulting Norfolk Health Overview and Scrutiny Committee (NHOSC) today because Members considered the proposed relocation was a substantial change and that consultation with the committee was required.

At today's meeting NHOSC will have the opportunity to examine the proposal with representatives from the Practice and Norfolk and Waveney Clinical Commissioning Group (CCG) and to make comments and / or recommendations for consideration before final decisions are made about the proposed relocation by the CCG and ultimately by NHS England and NHS Improvement (NHSE&I).

1.3 The former West Norfolk CCG had already supported an Outline Business Case (OBC) for St James' Medical Practice to relocate, which was approved by NHS England (NHSE) in May 2019. The OBC set out a number of options for sites for a new practice build. NHSE's approval at OBC stage enabled the Practice to move towards producing a Full Business Case (FBC), which would

include a specific proposed location. The CCG will ask the STP Estates Oversight Group to support the FBC, which if supported will be signed off by the CCG Chief Finance officer for submission to NHS England and NHS Improvement (NHSE/I) for approval. None of these meetings are held in public.

2.0 The proposal

2.1 The Practice has provided details of the proposed relocation, the reasons for it and the results of engagement with patients and other stakeholders in the document at **Appendix A.**

The long list of the potential sites considered is attached at Appendix A, Annex 1.

2.2 The CCG has commissioned a west Norfolk primary care demand and capacity review from Norlife Ltd which is due to report in December 2020. The full review is therefore not yet available but some slides with preliminary information are attached at **Appendix B**.

It is clear that additional capacity is needed across King's Lynn, north, south and central. St James' proposed new site would help with capacity in the north of the town.

2.3 The CCG has also provided the following information about financing of new primary care buildings and the potential for primary care development in King's Lynn in addition to the St James' proposal:-

> Primary care providers are able to work with third party developers who can provide private capital to fund new primary care buildings (as is the case with the St James proposed move). They are also able to apply to the NHS for improvement grants for estates related work.
>
> The CCG was notified in 2019 of national "Wave 4b" funding to support primary care developments and £5m of the £25m allocated to Norfolk and Waveney has been specified for West Norfolk. The preliminary outputs of the above-mentioned demand and capacity review would indicate a strong case for the Wave 4b funding to be allocated to support King's Lynn. The CCG has committed that Project Initiation Documents for Wave 4b projects will be submitted to NHS England by May 2021.
>
> St James was also successful in applying for the national Estates Technology and Transformation Fund (ETTF) to support the professional fees associated with their project. There is a risk that the loss of the ETTF funding (£250k) may result in the privately financed capital being lost to the King's Lynn area. The NHS reimburses GPs for the cost of leasing their premises: i.e. the NHS reimburses the rent the GPs pay. Making a capital contribution to the development of the scheme enables the NHS to "abate" the rental payment for a period of time (in this case for at least 10 years) thereby reclaiming in part the cost of the initial investment.

Losing the ETTF funding would risk this ability and could result in more expensive rental payments for the NHS.

3.0 Background information

3.1 NHOSC's role in the consultation process

3.1.1 The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 require local commissioners and providers of health services to offer consultation with health scrutiny regarding proposals for substantial changes to local services (Regulation 23).

3.1.2 Usual practice is for the health scrutiny committee to receive the consultation document during the public consultation period (if public consultation is being held) to discuss the proposals with the consulting body and, if the committee wishes, make comments to be considered alongside public and patient comments at the end of the consultation period.

3.1.3 If the health scrutiny committee has concerns based on the evidence it has examined, its comments to the consulting body may include recommendations for action.

3.1.4 If the committee does not make recommendations the process may end at this stage.

3.1.5 Where a recommendation has been made and the consulting body disagrees with that recommendation, it must notify the health scrutiny committee. Both must then seek to reach an agreement in relation to the subject of the recommendation.

3.1.6 Ultimately, if the NHS bodies intend to proceed with the proposed change without having reached agreement with health scrutiny regarding its recommendation(s) the committee may choose to make a report to the Secretary of State for Health if:-

(a) It is not satisfied that consultation with the committee has been adequate in relation to content or time allowed;
(b) It considers that the proposal would not be in the interests of the local health service.

It is worth noting that:-

i. Any report to the Secretary of State regarding (b) must include a summary of evidence considered by the committee regarding the effect of the proposal on the sustainability or otherwise of the health service. This includes financial sustainability.

ii. Norfolk County Council must be notified before any such referral is made.

iii. If a referral is made, the NHS bodies must not proceed with the proposed changes until the health scrutiny committee has received a response from the Secretary of State. This could take some months.

3.2 **The NHS decision-making timeline**

The information provided by the Practice in Appendix A and by the CCG in paragraph 1.3 above indicates the following timetable around the proposed relocation of St James' Medical Practice:-

March 2021	Full business case submitted to the CCG for approval (the CCG will ask the STP Estates Oversight Group to support the FBC, which if supported will be signed off by the CCG Chief Finance officer for submission to NHS England and NHS Improvement (NHSE/I))
By May 2021	Planning permission to have been secured
May 2021 or later	Full business case submitted to NHS England & NHS Improvement for approval (subject to completion of the steps above)
Estimated August 2022	Opening of the new surgery

3.0 Suggested approach

3.1 After the Practice and the CCG have given a brief introduction to their papers (Appendix A & B) Members may wish to examine the following areas with them:-

The case for relocation of the practice

(a) Is it clear that the Practice needs new premises to enable it to provide high standard modern primary care to its patients?

(b) Is it clear that suitable premises could not be provided at or near the current site?

The case for the proposed site at North Lynn (Edward Benefer Way, near South Wootton Junior School)

(c) Does it make sense for the decision about St James' relocation to North Lynn to be taken in advance of the decisions about how the CCG's Wave b funding for primary care development will be spent in King's Lynn and West Norfolk? (See paragraph 2.3. above)

(d) The information from the CCG at Appendix B and paragraph 2.3 above makes it clear that King's Lynn needs more GP primary care capacity

across the town; north, south and central. Does it make sense for the first development to take place in the north of the town?

Mitigation / re-provision for vulnerable patients of St James' Medical Practice for whom travel to north Lynn would be particularly difficult

(e) Appendix A says that the 400 – 500 patients who are in this category would have the option to register with another practice, or arrange for home visits where there is a clinical need, or to make the journey to the new St James' location while waiting for another new facility to be provided in South Lynn (and more work would be done on transport options, e.g. with community transport providers). Is there assurance from the Practice and the CCG that vulnerable patients would be identified and actively helped to make suitable alternative arrangements?

(f) Southgates Medical Centre, the nearest GP surgery to St James' current site, can take on new patients at present. How many current patients of St James' would be likely to want to register at Southgates? Would there be capacity for them to do so?

(g) To what extent does increased use of technology for GP / allied professionals' consultations with patients, which has been established for patient safety during the Covid 19 pandemic, reduce the importance of the location of the practice?

4.0 Action

NHOSC is asked to consider whether to make comments or recommendations to St James' Medical Practice and / or the CCG in response to the consultation.

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

Note: The current facility

SJMP
Caring for our community

GP premises

- **St James Medical Practice**
  - The practice operates from premises which are too small and not fit for purpose
  - There is urgent need to move to a new site to enable continued provision for the registered list
  - In new premises, the medical team will provide improved access to a wider range of health and social care services within one space
  - The practice's current weighted list size is currently 18,763 and rising rapidly. In 2010 it was 14,916.
  - New Primary Care Network workers such as pharmacists, physician associates, physiotherapists and para-medical staff are requiring significant amounts of additional space
  - Nationwide recruitment of GPs and other clinical staff is extremely difficult. There is clear evidence that good premises are essential for retaining existing staff and attracting additional staff
  - The following slide summarises the main issues at the current premises

Note: KKey themes for the Executive Summary of the Full Business Case

Challenges in the current building

Significantly too small to support registered list or future growth

Appointment availability constrained by number of clinical rooms

No on-site patient parking. Two disabled spaces on the road outside

Does not support equality of access. Steps and narrow corridors throughout

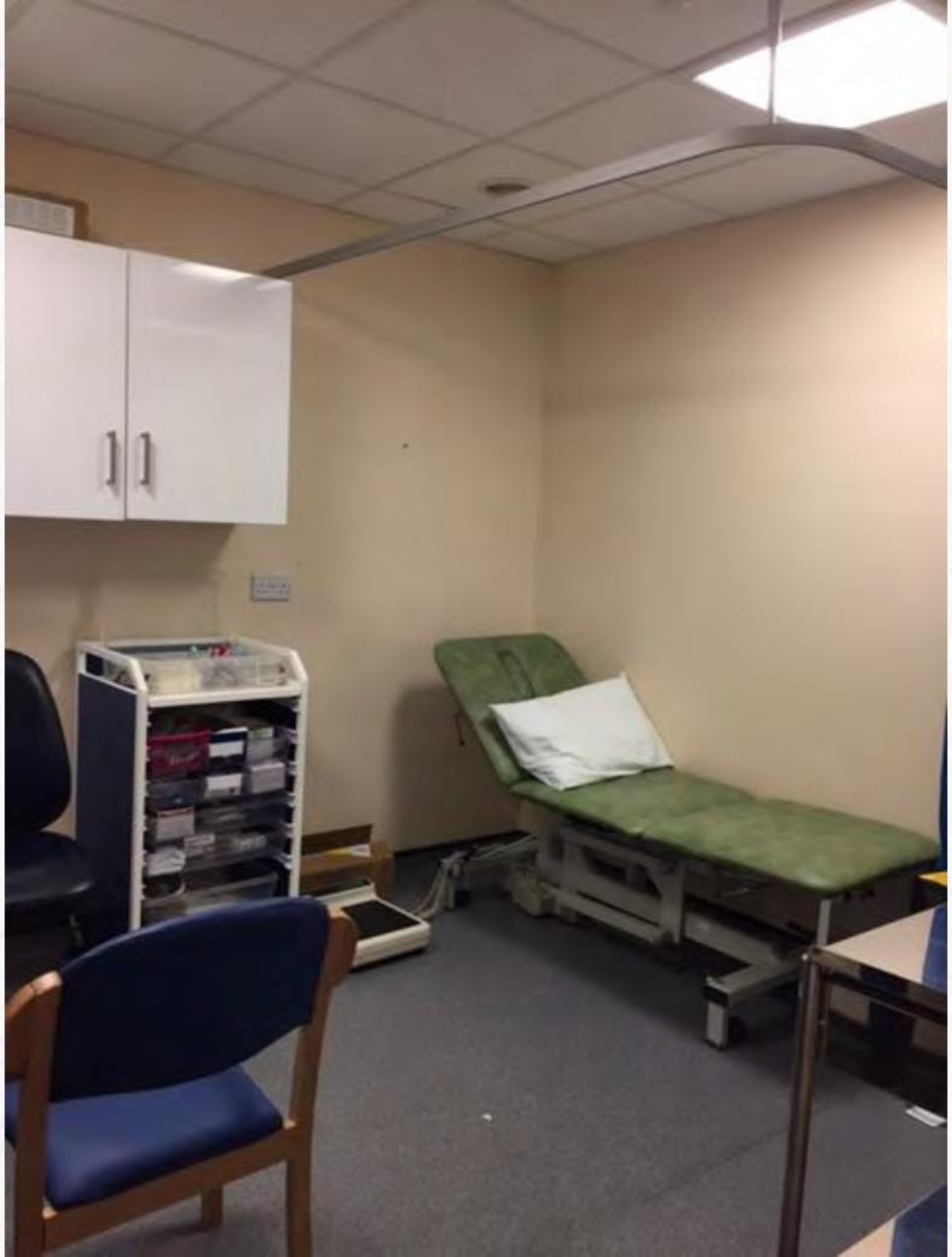
Does not support social distancing

Non-compliance with infection control standards

Challenges in compliance with fire safety standards

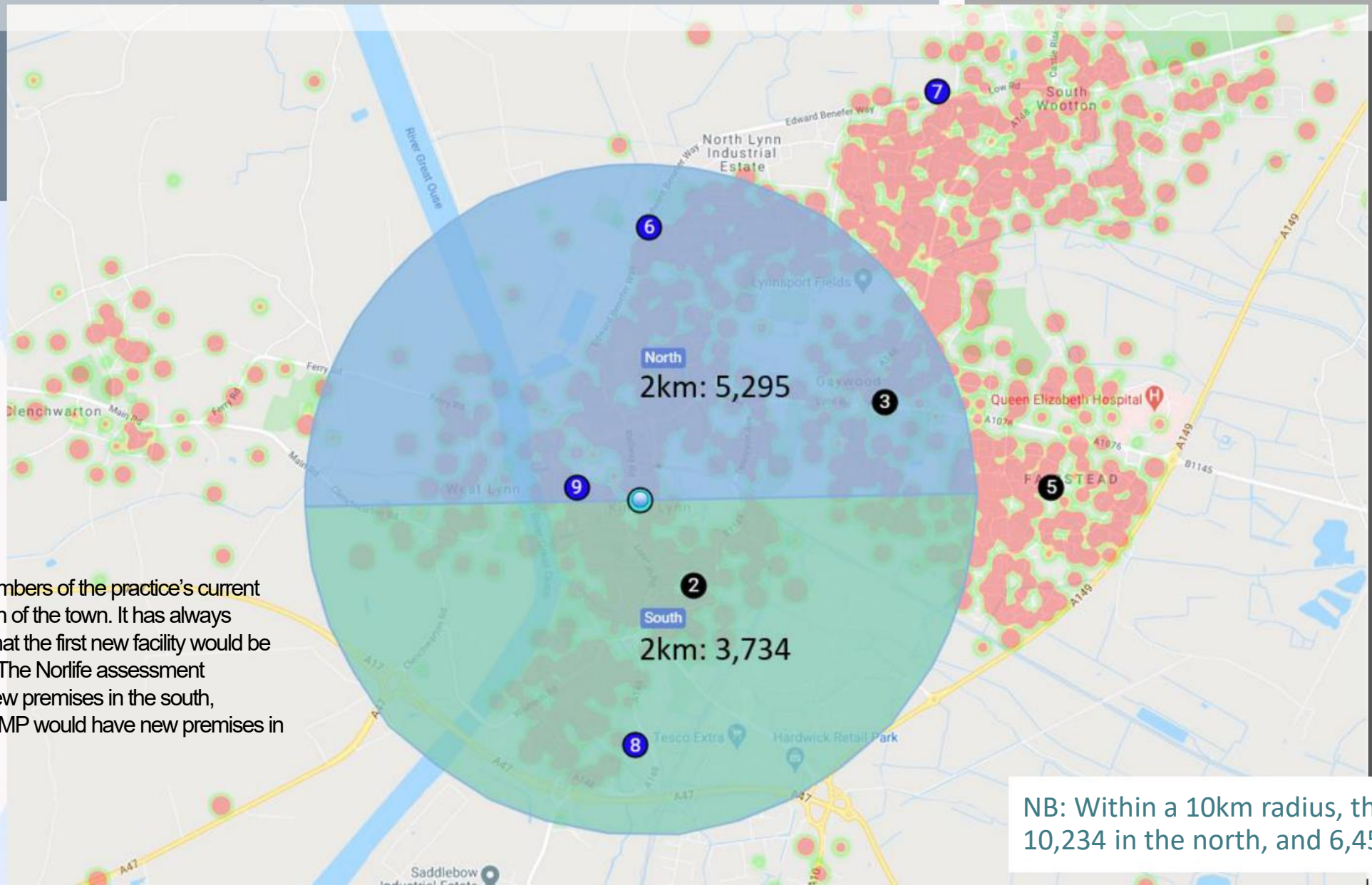
Does not support multi-disciplinary working or expansion of services closer to home

Note: Care closer to home is vital to ensure the sustainability of the NHS. The current premises have few redeeming features.



Note:
Corridors are too narrow for mobility scooters, consultation rooms do not reach minimum CQC requirements

Registered patients within a 2 km radius of SJMP



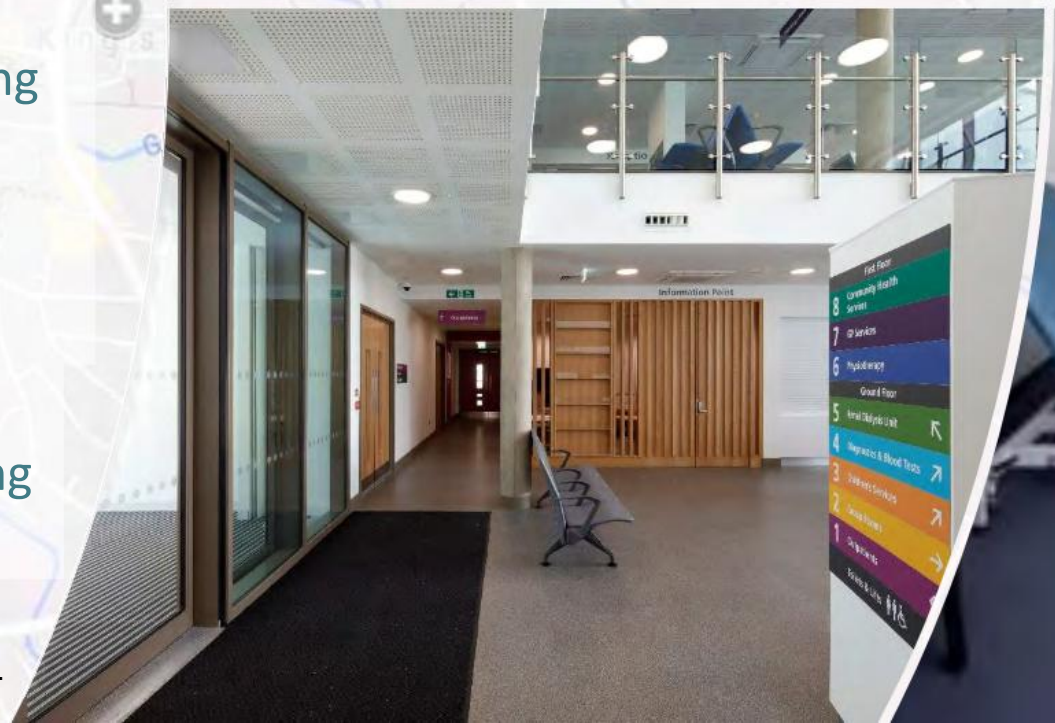
Note: Greater numbers of the practice's current list live in the north of the town. It has always been assumed that the first new facility would be built in the north. The Norlife assessment of the need for new premises in the south, assumed that SJMP would have new premises in the north.

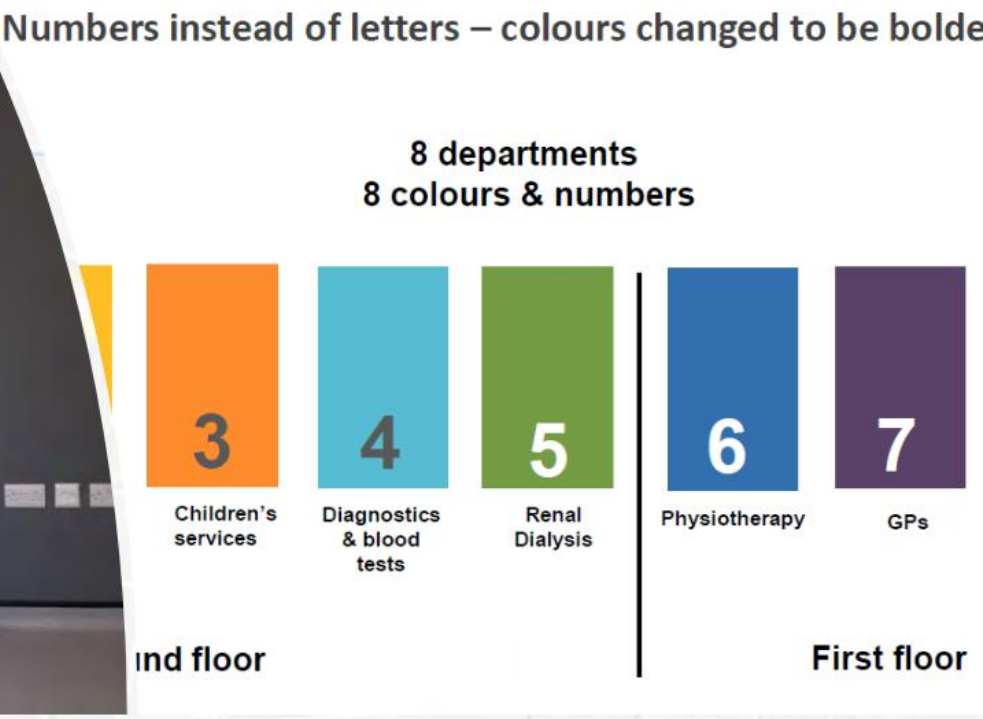
NB: Within a 10km radius, the numbers are 10,234 in the north, and 6,455 in the south

Facilities for the 21st Century

- Light and airy
- Integrated i.e. diagnostics, physio, general practice and children's services
- Safe – for access and infection control (including COVID-19)
- Flexible for the future
- Attractive to work in

Funding has been secured for a 1,676 sq metre building with 93 parking spaces

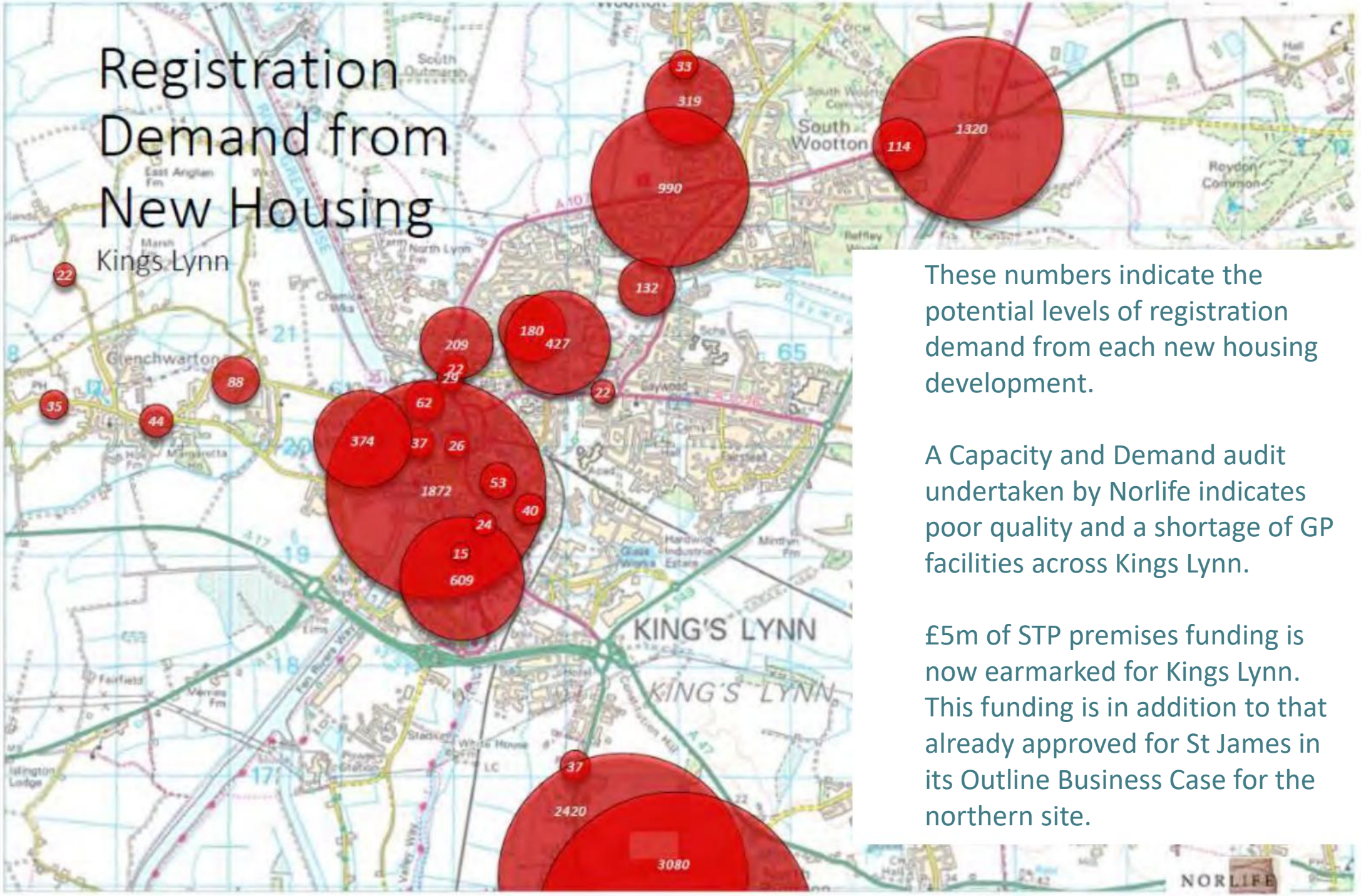




Note: The modern surgery is a completely different facility from that which exists today.

Registration Demand from New Housing

Kings Lynn



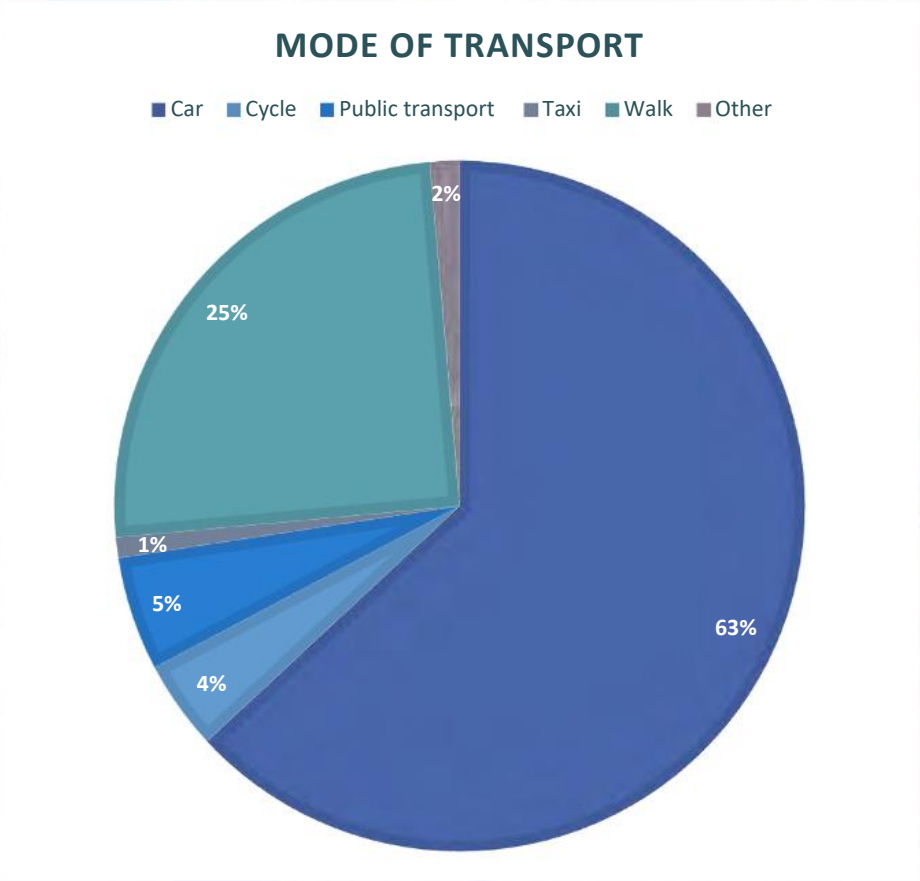
These numbers indicate the potential levels of registration demand from each new housing development.

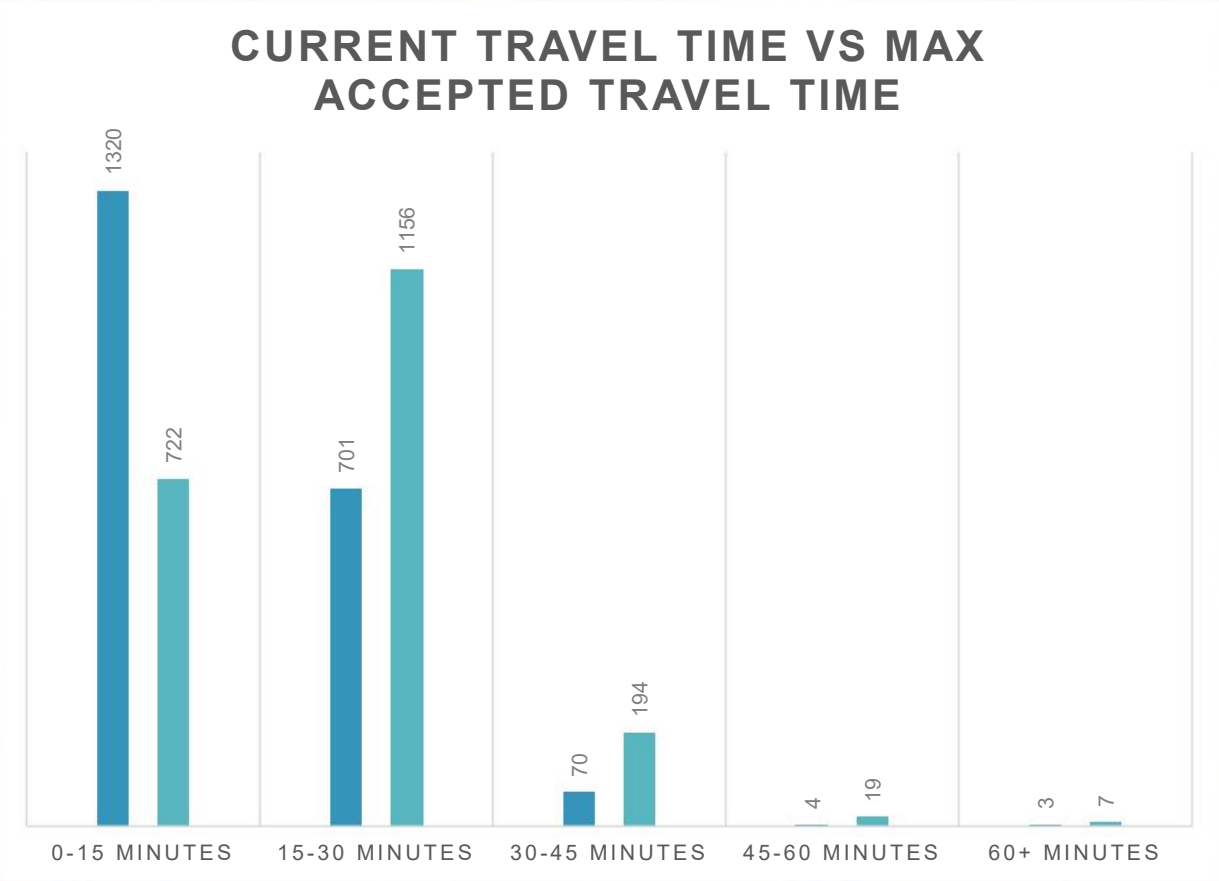
A Capacity and Demand audit undertaken by Norlife indicates poor quality and a shortage of GP facilities across Kings Lynn.

£5m of STP premises funding is now earmarked for Kings Lynn. This funding is in addition to that already approved for St James in its Outline Business Case for the northern site.

Note: The town is growing in several areas to the north and south.

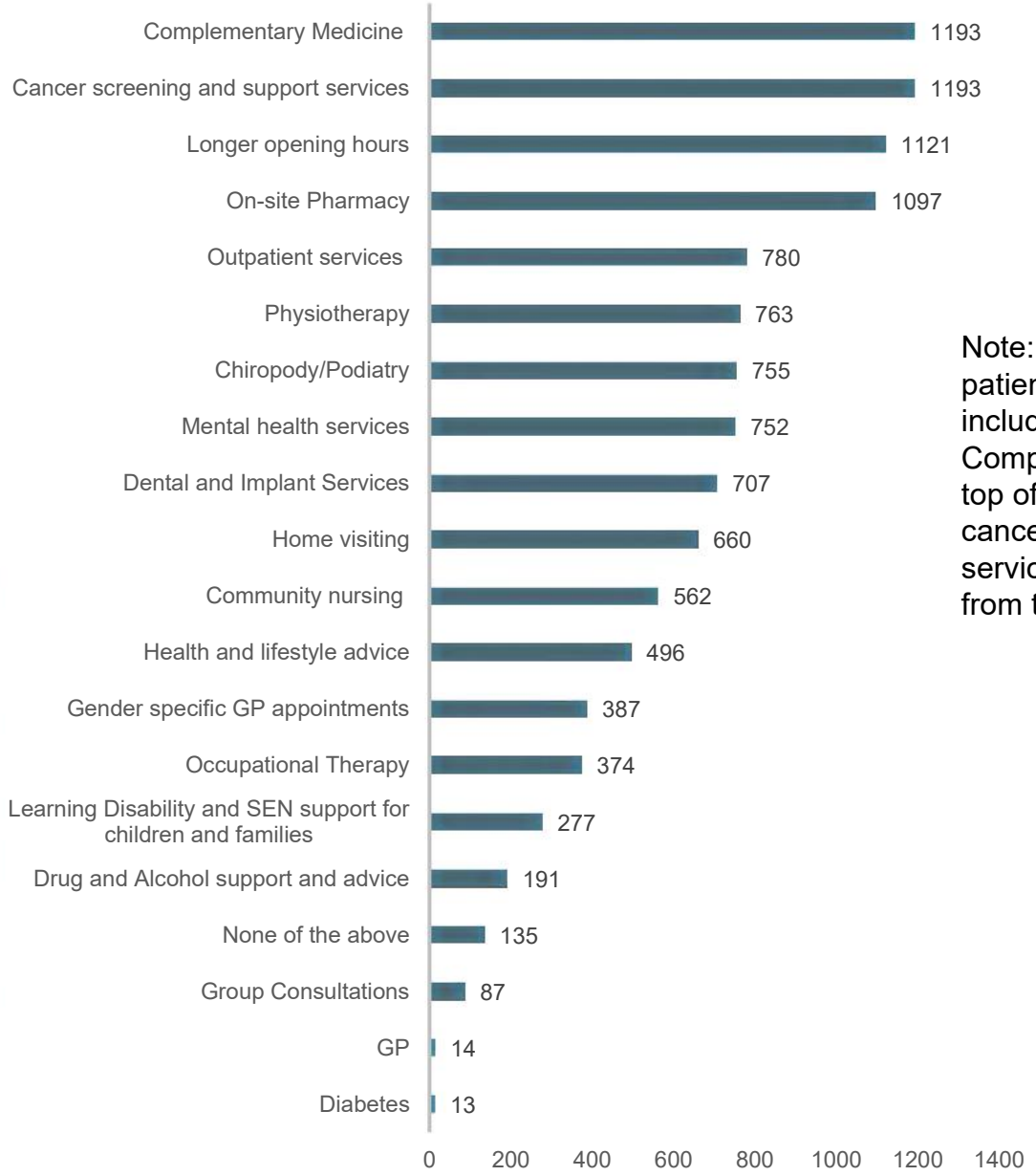
Patient Views - from 2,098 responses - Travel





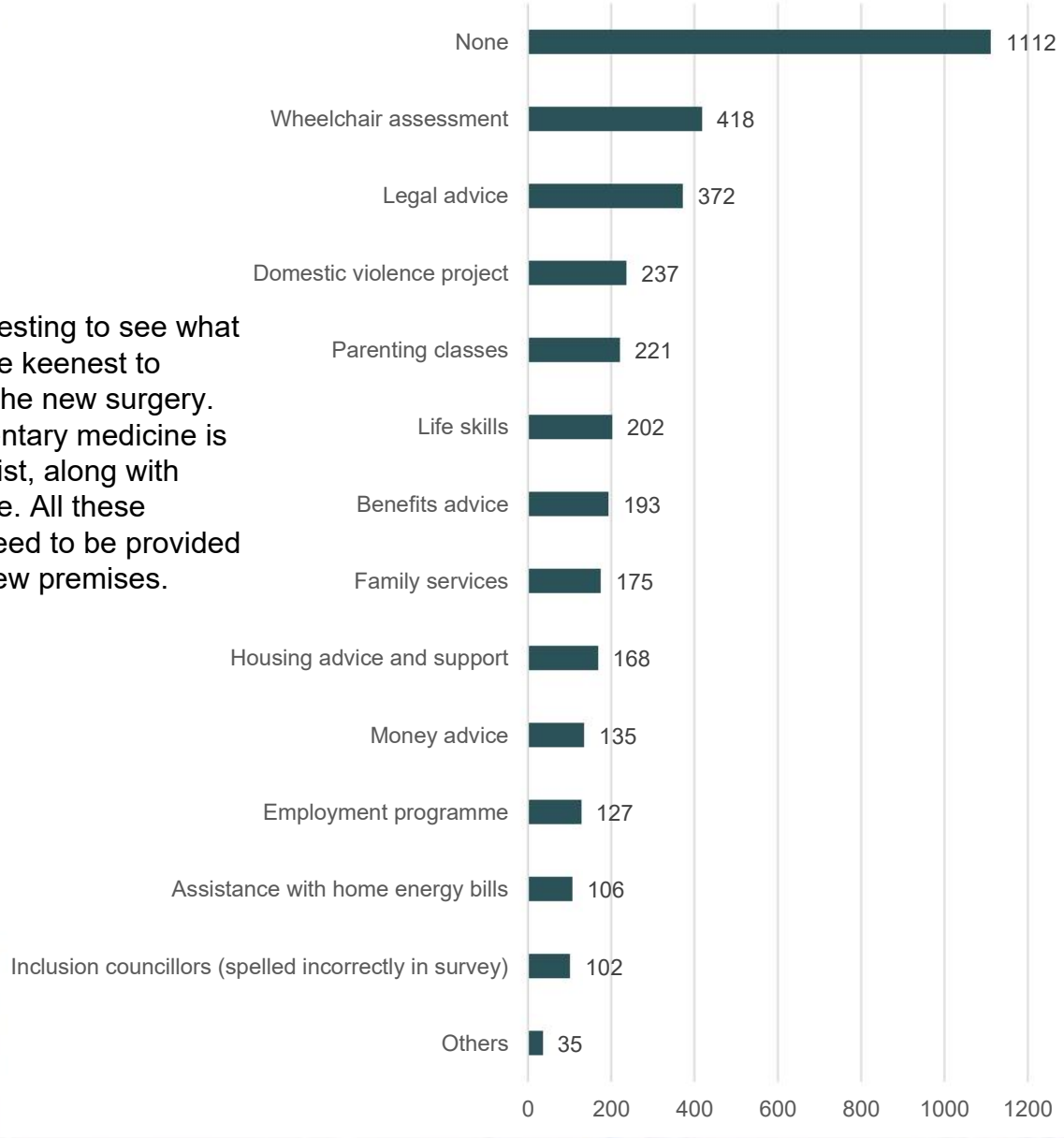
Note: Feedback from patients is that although the preferred jjourney time to their surgery would be less than 15 minutes, most are also happy to travel for between 15 and 30 minutes.

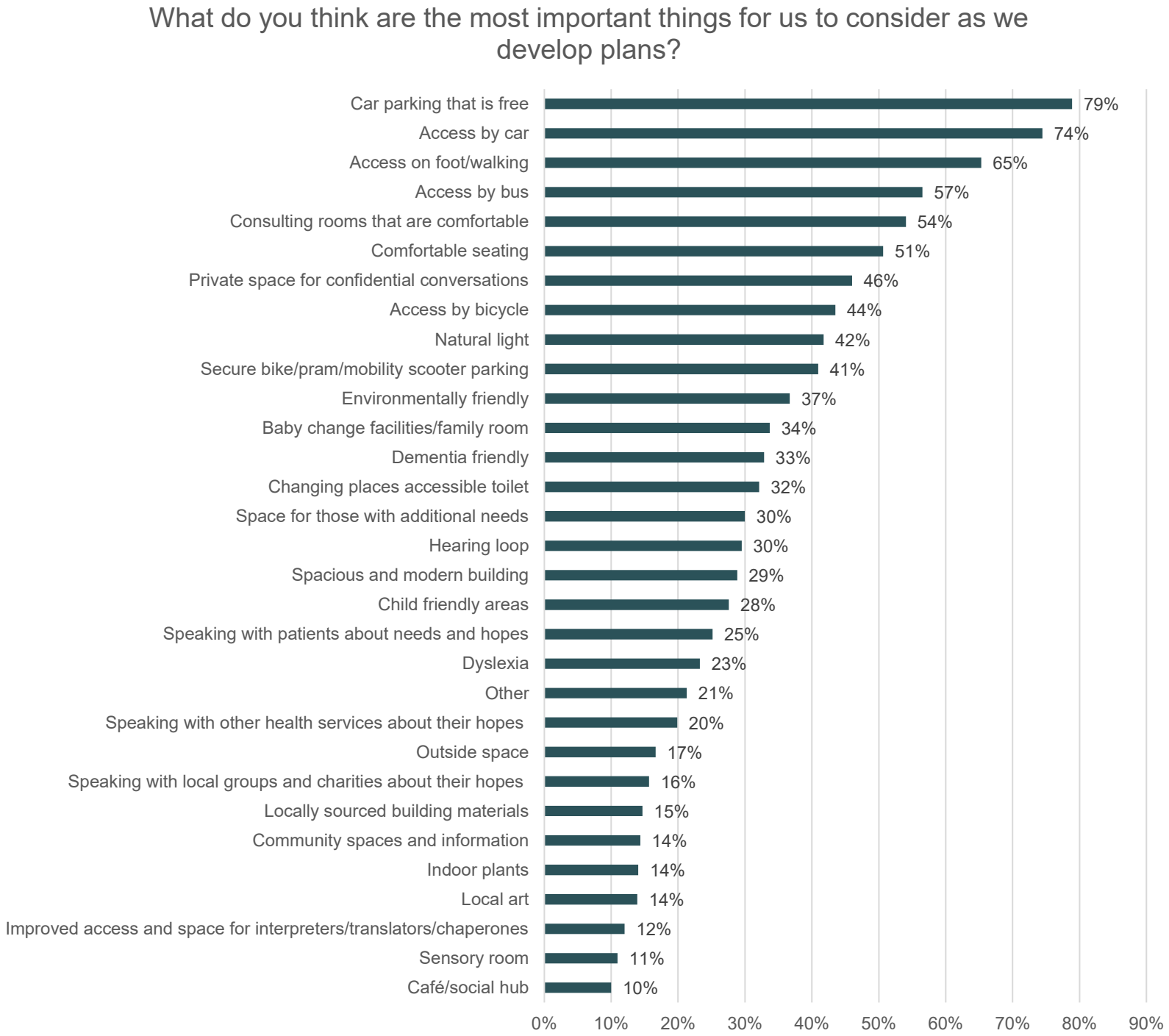
Which of the following health services would be important to you in the proposed new facility?



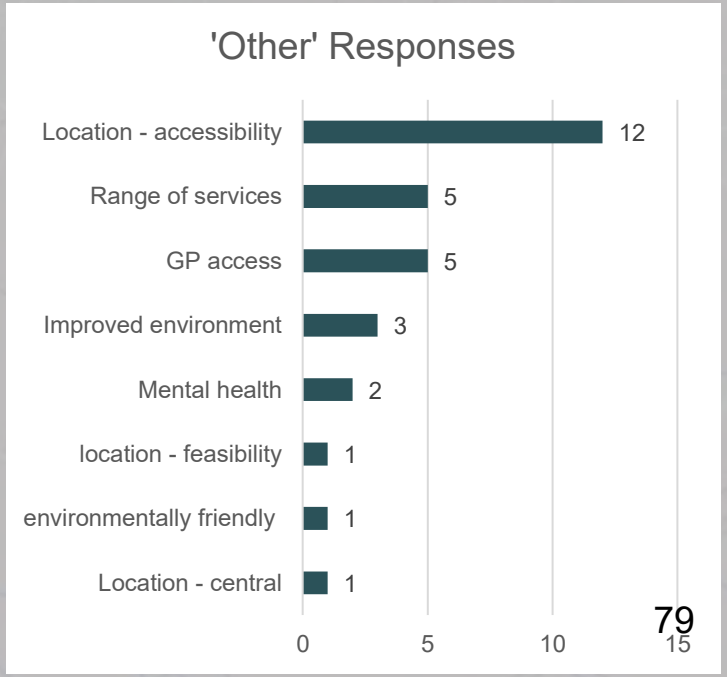
Note: Interesting to see what patients are keenest to include in the new surgery. Complementary medicine is top of the list, along with cancer care. All these services need to be provided from the new premises.

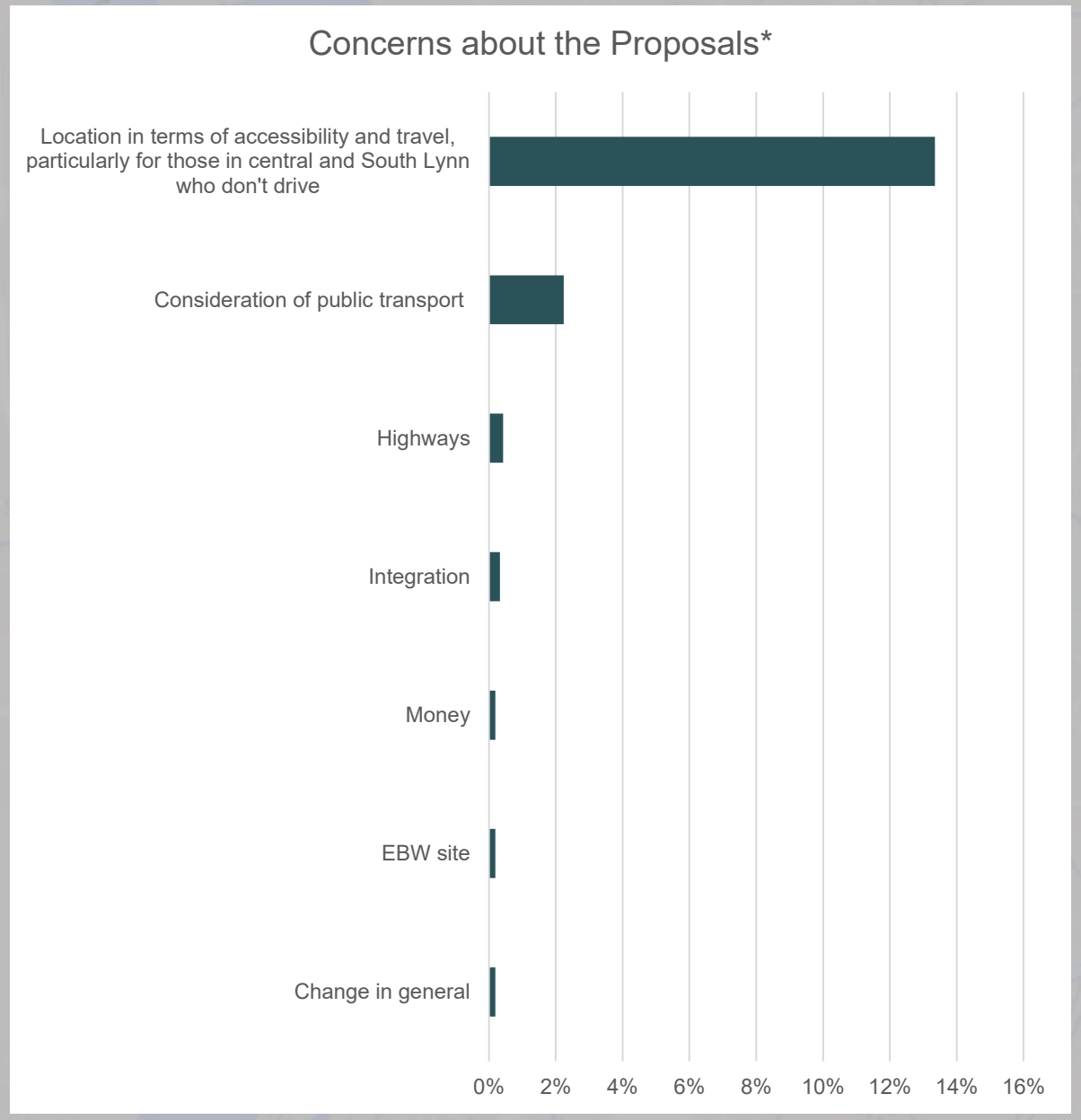
Which of the following social and wellbeing services would be important to you in the proposed new facility?

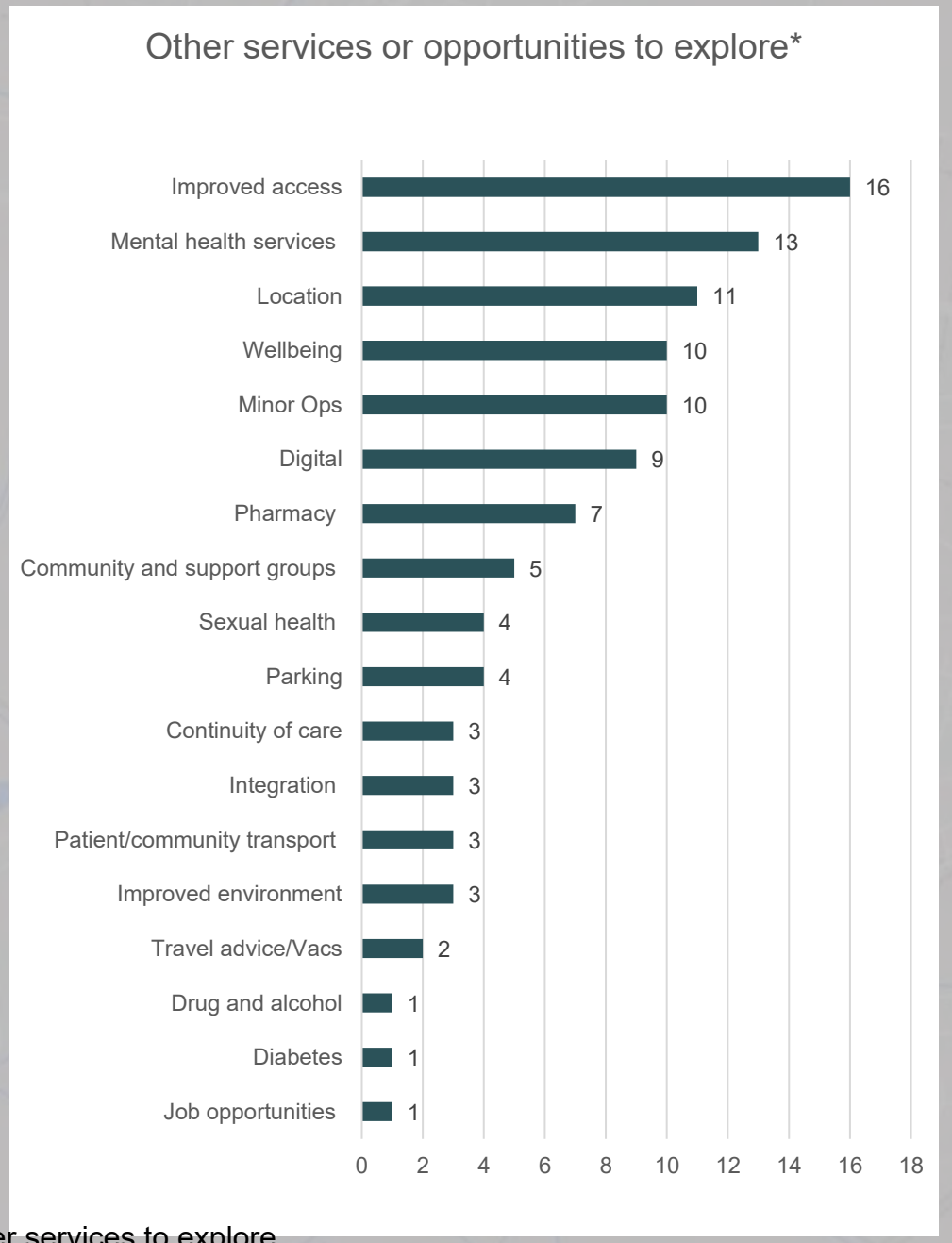




Note: Car parking tops the list of important things to consider when developing the plans. Other access – buses and walking also important.



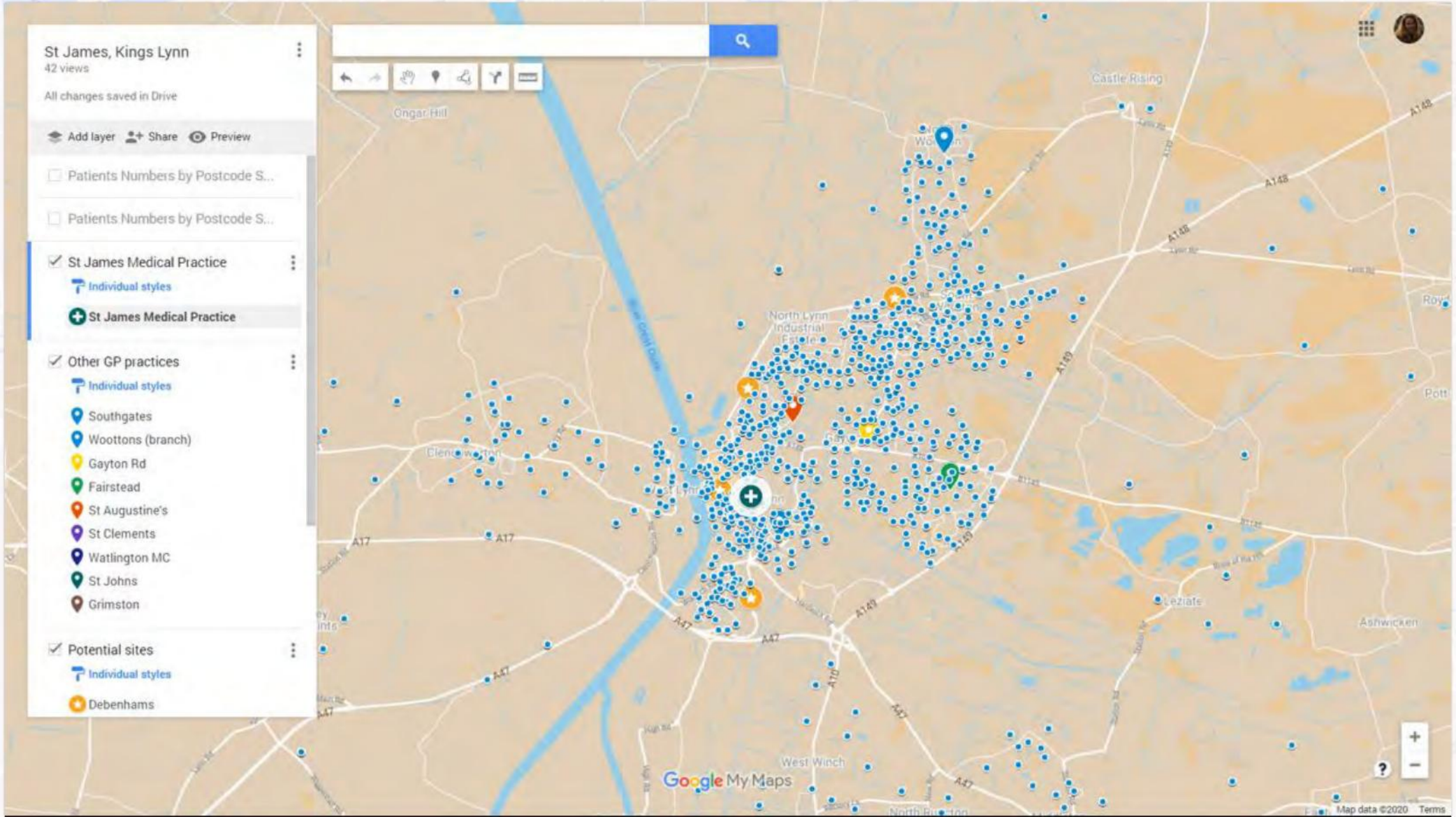




Note: There are concerns about the planned move to the north. Also, there are plenty of other services to explore.

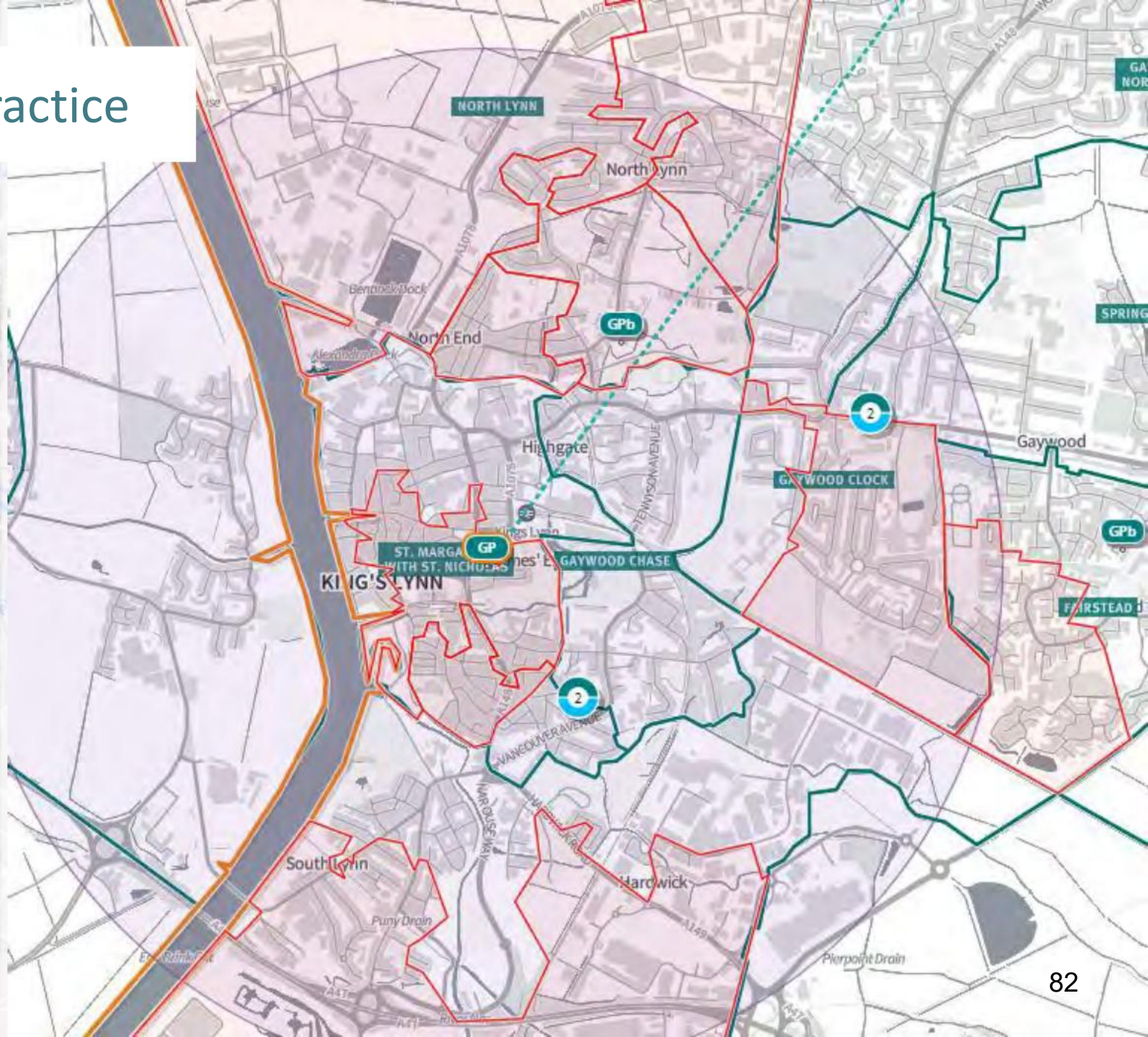
* Free text responses categorised by PCP

Where the survey responses came from

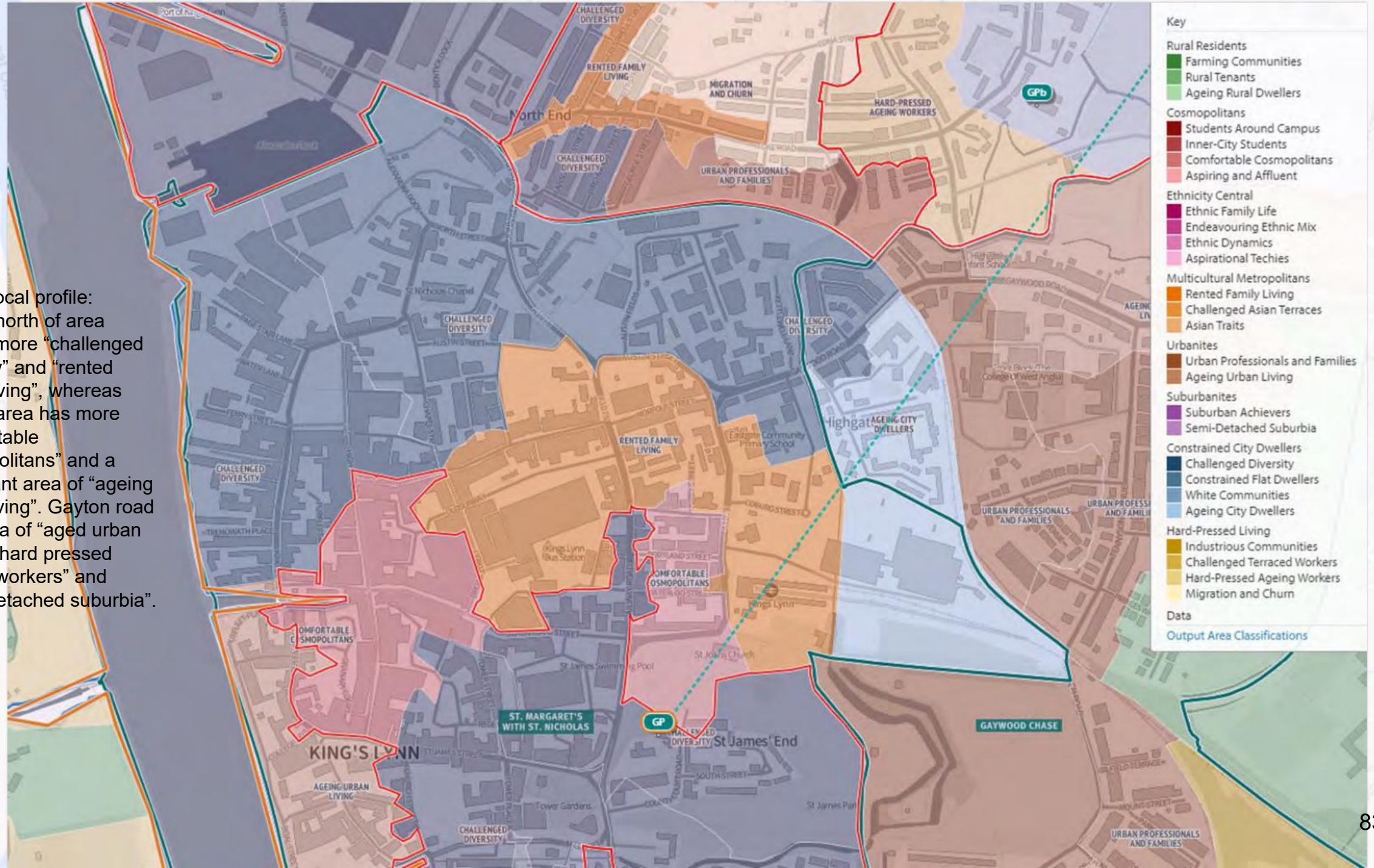


2 km radius of the current practice

- Wards highlighted with red boundaries have higher levels of deprivation
- Existing practices are not ideally located – a greater spread would be better
- New premises are needed in both north and south
- The recent Norlife Capacity and Demand Review always assumed that SJMP would move to the north



Note: Highest levels of deprivation are in the centre and the north



Note: Local profile: Shows north of area having more “challenged diversity” and “rented family living”, whereas central area has more “comfortable cosmopolitans” and a significant area of “ageing urban living”. Gayton road is in area of “aged urban living”, “hard pressed ageing workers” and “semi-detached suburbia”.

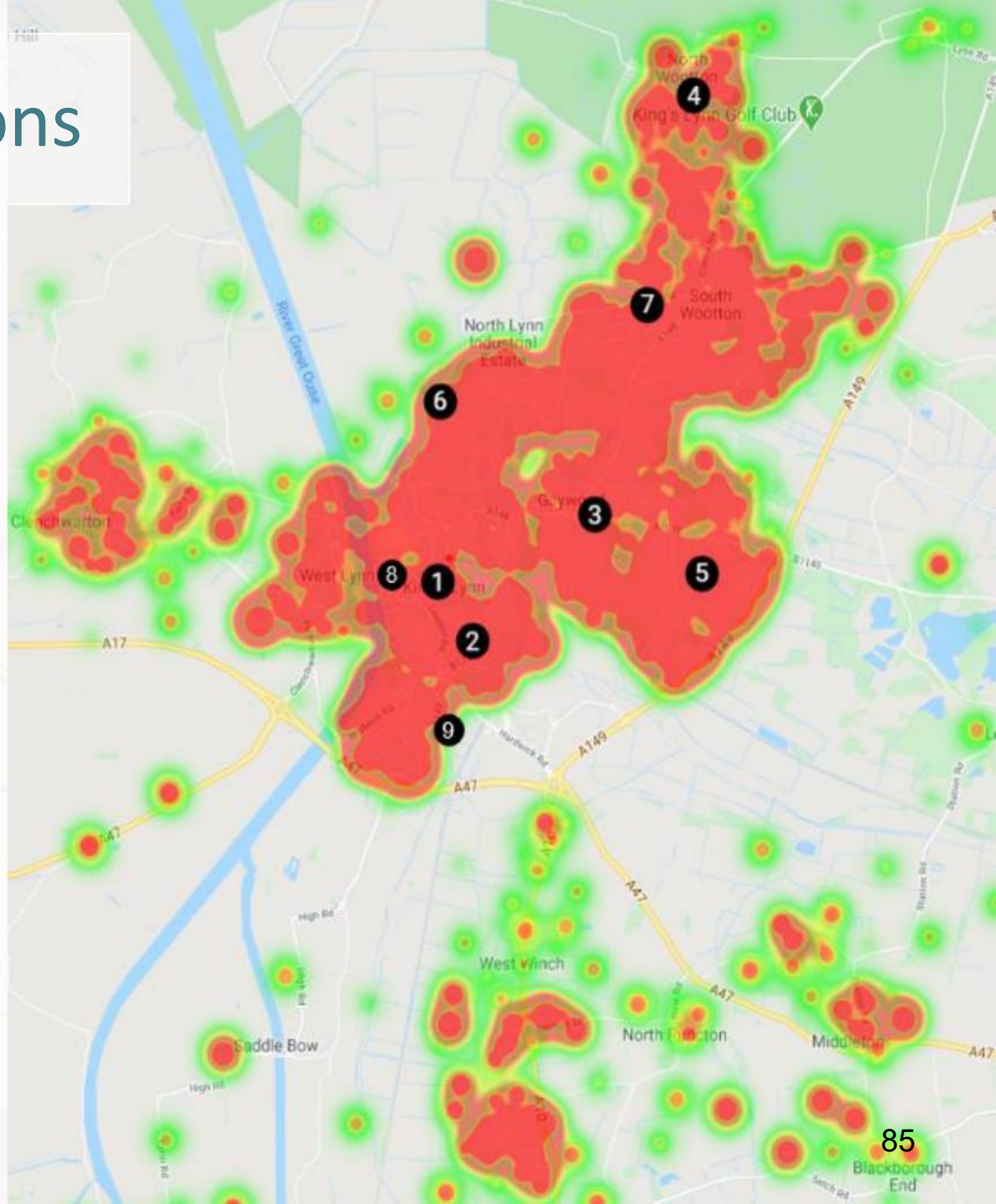
Options appraisal

- A process of information gathering and checking
- An NHS requirement when seeking funding
- A collaborative exercise to involve patients, NHS staff and the private sector
- Driven by local needs and gaps in the provision of local services
- Carried out with 18 people from the PPG, practice, CCG and Health in September
- Split into two groups to independently reach a recommendation

Note: Background information about the options appraisal held in September 2020.

Options appraisal | Agreed options

- Do nothing (1)
- Do minimal - Redecoration and minor reconfiguration
- Expansion of current surgery
- Move to a new surgery:
  - District Council Site (6)
  - County Council site (7)
  - Debenhams (8)
  - Nar Ouse Way (9)
- No further options were identified by the group



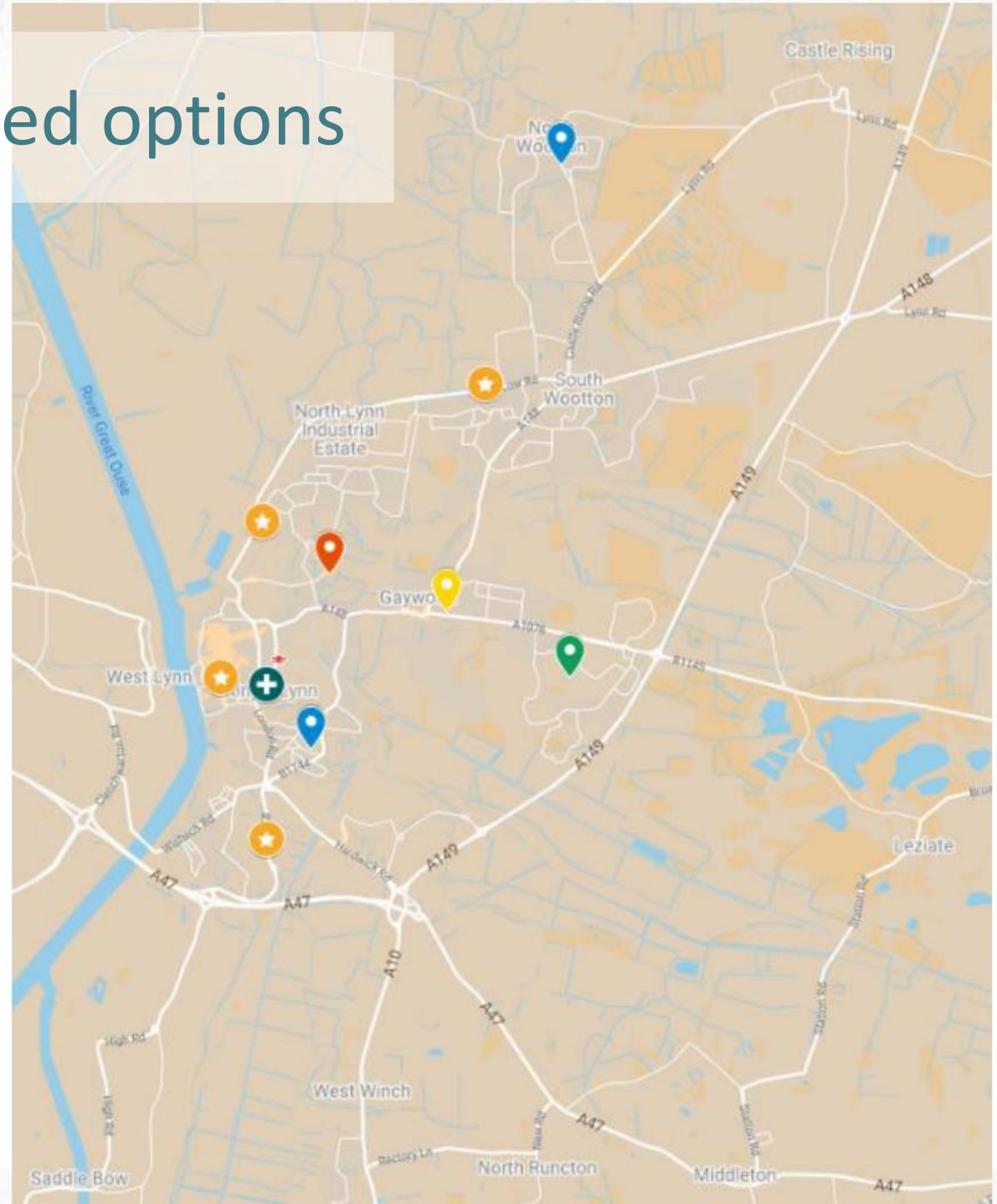
Note: Heat map to show where population of SJMP is located along with current and proposed locations – next slide shows streets.

Options appraisal | Agreed options

St James Medical Practice

Southgates
Woottons (branch)
Gayton Rd
Fairstead
St Augustine's

Debenhams
DC site
CC site
Nar Ouse Way



Note: Map to show geography more clearly.

Options appraisal | Weighted scores

Group 1:

Note: Group 1 results – County council site is the winner.

	Weighted Score	Weighting	Improving the range and quality of services offered in primary care	Improving the building environment for patients and staff including safety and security	Providing greater integration of health, social care and voluntary/community sector services	Increasing recruitment and training opportunities for healthcare staff	Create flexibility for the future	Be acceptable, deliverable, available and value for money	Improving access, particular for those with greatest need	Social prescribing and facilities for non-medical intervention	Total
			18	17	11	13	14	3	16	8	
Option 1	Do nothing		0	0	0	0	0	0	0	0	0
Option 2	Do minimal		18	34	0	13	0	0	48	0	113
Option 3	Expansion of current surgery		36	51	11	26	14	0	48	8	194
Option 4	District Council Site EBW		180	119	110	91	140	30	128	80	878
Option 5	County Council Site EBW		180	170	110	130	140	30	128	80	968
Option 6	Debenhams		144	34	88	78	140	12	64	80	640
Option 7	Nar Ouse Way		180	136	110	104	140	24	80	80	854

Options appraisal | Weighted scores

Group 2:

Note: Independently evaluated - Group 2 results – Again County council site is the winner.

	Weighted Score	Improving the range and quality of services offered in primary care	Improving the building environment for patients and staff including safety and security	Providing greater integration of health, social care and voluntary/community sector services	Increasing recruitment and training opportunities for healthcare staff	Create flexibility for the future	Be acceptable, deliverable, available and value for money	Improving access, particular for those with greatest need	Social prescribing and facilities for non-medical intervention	Total
Weighting		18	17	11	13	14	3	16	8	
Option 1	Do nothing	0	0	0	0	0	9	0	0	9
Option 2	Do minimal	0	0	0	0	0	9	0	0	9
Option 3	Expansion of current surgery	0	0	0	0	0	0	0	0	0
Option 4	District Council Site EBW	180	136	110	104	140	21	112	64	867
Option 5	County Council Site EBW	180	170	110	130	140	27	112	64	933
Option 6	Debenhams	180	102	110	91	98	15	144	80	820
Option 7	Nar Ouse Way	180	153	88	117	140	18	128	80	904

Options appraisal | Discussion

Note: These are the themes that the full group discussed.

Option 1: Do nothing

- Does not address any of agreed criteria

Option 2: Do minimal

- Would improve feel of current environment
- Some improvement in equality of access may be achieved
- Does not address any other agreed criteria
- Would be disruptive to current services

Option 3: Extend current

- Scope would be minimal due to constraints of site
- Staff parking would be lost
- Would improve feel of current environment
- Small amount of additional space and some improvement in equality of access may be achieved
- Does not address any other agreed criteria
- Would be disruptive to current services

Options appraisal | Discussion

Note: More themes.

Option 4: D C Site EBW

- New build = Huge improvement in space and built environment to support list growth, access, service provision and training
- Good parking and car access
- Average public transport links
- Not walkable for many who walk to the current site
- Will improve access for patients in North Lynn, but harder for those in South
  (The practice has more patients registered North of the town centre)
- Immediate industrial setting not attractive

Option 5: C C Site EBW

- New build = Huge improvement in space and built environment to support list growth, access, service provision and training
- Good parking and car access
- Average public transport links
- Not walkable for many who walk to the current site
- Will improve access for patients in North Lynn, but harder for those in South
  (The practice has more patients registered North of the town centre)

Option 6: Debenhams

- Central location would be preferred by many but may be difficult to access for those residing away from the centre
- Limited/no free parking
- Working within existing building would lead to compromise in terms of natural light and future flexibility
- Value for money to the NHS in question due to site ownership

Options appraisal | Discussion

Note: Conclusion – County Council Site is the preferred option. Nar Ouse a close second, and so should be included in business case as a reserve option. Agreed that risks of delays with Nar Ouse site were significant.

Option 7: Nar Ouse Way

- New build = Huge improvement in space and built environment to support list growth, access, service provision and training
- Average public transport links
- Pedestrian access may be difficult
- Road access is good, but traffic can get very heavy
- Free parking could be provided
- Would improve access for areas of need in the South
- Area likely to be developed in near future
- Site investigation will be needed to ascertain cost of removing concrete structures

Evaluation

- Scores agreed by group 1 and group 2 were very similar
- There was some discussion about the need to score inclusive design, but it was agreed that this would be inherent in a new build
- Adding the scores from group 1 and 2 results in ranking:
  1. Count Council site EBW (1,901)
  2. Nar Ouse Way (1,758)
  3. District Council site EBW (1,745)
- Helpful to consider options in a structured way
- Agreement that outcome was as reflective of discussion

Interviews – The key themes

- Space at SJMP
- Holistic Care
- Loneliness and Isolation
- Support and Advice
- Travel (and Parking)
- Healthy Living and Wellbeing
  - Health, diet and exercise
  - Mental Health

Note: Structured interviews with key stakeholders in local community.

Stakeholder Interviews - Summary

- *"The key is the people and the building"*.
- The move to a more modern practice may be a cause for "*worry that it would lose the intimacy of a smaller practice"*.
- Space: "*We ought to be future-proofing our buildings".*
- A new facility should have space for staff to deliver the services that they need and want to deliver, and also break and social spaces for staff to utilise.
- The correct space, with the right dimensions and design for modern practice could aid in the recruitment of staff.
- Different sized rooms, that can be utilised by group meetings by the practice and other organisations is important.
- Space to allow confidential conversations to happen in private is essential.

Stakeholder Interviews - Summary

Holistic Care: *"You need spaces [where] you can address various issues"*.

- There is a desire from all stakeholders that healthcare and wellbeing be treated holistically. Services should be integrated, to allow ease of access.
- GPs often signpost patients to other services. Financial support and benefits advice was identified as an important service.
- *"Finance is often at the bottom of 'wellbeing' issues"*.
- *"[People] might want to do the right thing, but they can't afford it".*

Loneliness and Isolation

- There was a common suggestion that St James' Medical Practice could help combat the loneliness and isolation experienced by many.
- By providing space within its new building for groups and clubs to meet and help people socialise, you could help people feel less isolated, and part of a community.

Stakeholder Interviews - Summary

Support and Advice: Carers are one demographic that *"often forego their own health needs because they are looking after others"*.

- A common suggestion was to provide space for those being cared, to receive professional advice, and socialise with others. This would give the carer respite, and time to attend GP appointments, get support and advice, or use their free time how they wished.

Travel (and Parking)

- The practice should be easily accessible by all forms of transport: car, bicycle, walking, public transport. There should also be adequate free parking for all those who drive to the practice

Health and Wellbeing

- Health issues relating to diet and exercise (e.g. obesity, chronic lung conditions, cardiac disease and diabetes) are some of the greatest health needs of the Kings Lynn population.
- Better links to other mental health services, or access to these Mental Health services at St James' practice should be made more easily accessible.

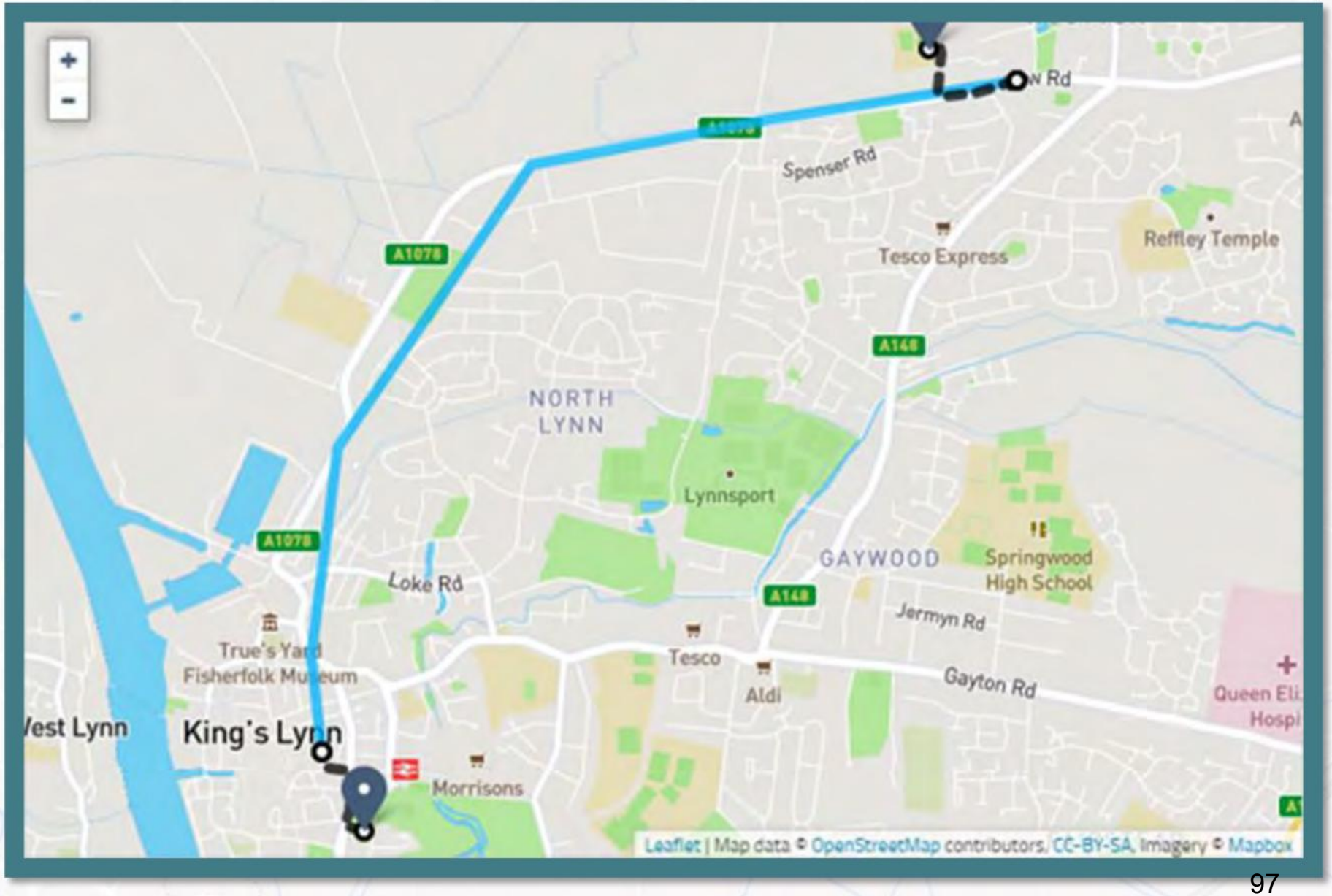
Meeting the needs of those who will disadvantaged

- The Ward with most deprivation is St Margaret's with St Nicholas, but others will be affected.
- Key will be helping those who cannot walk, cycle, take or afford a bus, drive or have access to a car
- It is estimated that these will number 400 to 500 from a list size of 20,000
- Their options will be to change practice, ask for a home visit if there is a clinical need for this, or to await the development of a second facility
- The patient list at Southgates Medical Centre is currently open
- A second new surgery in the south may well be completed within the same timescale as St James as this will be smaller and easier to build
- Patient parking will be provided for 93 cars, compared with none at present
- More work will be needed on this issue as the business case progresses. For example discussions with community transport providers.

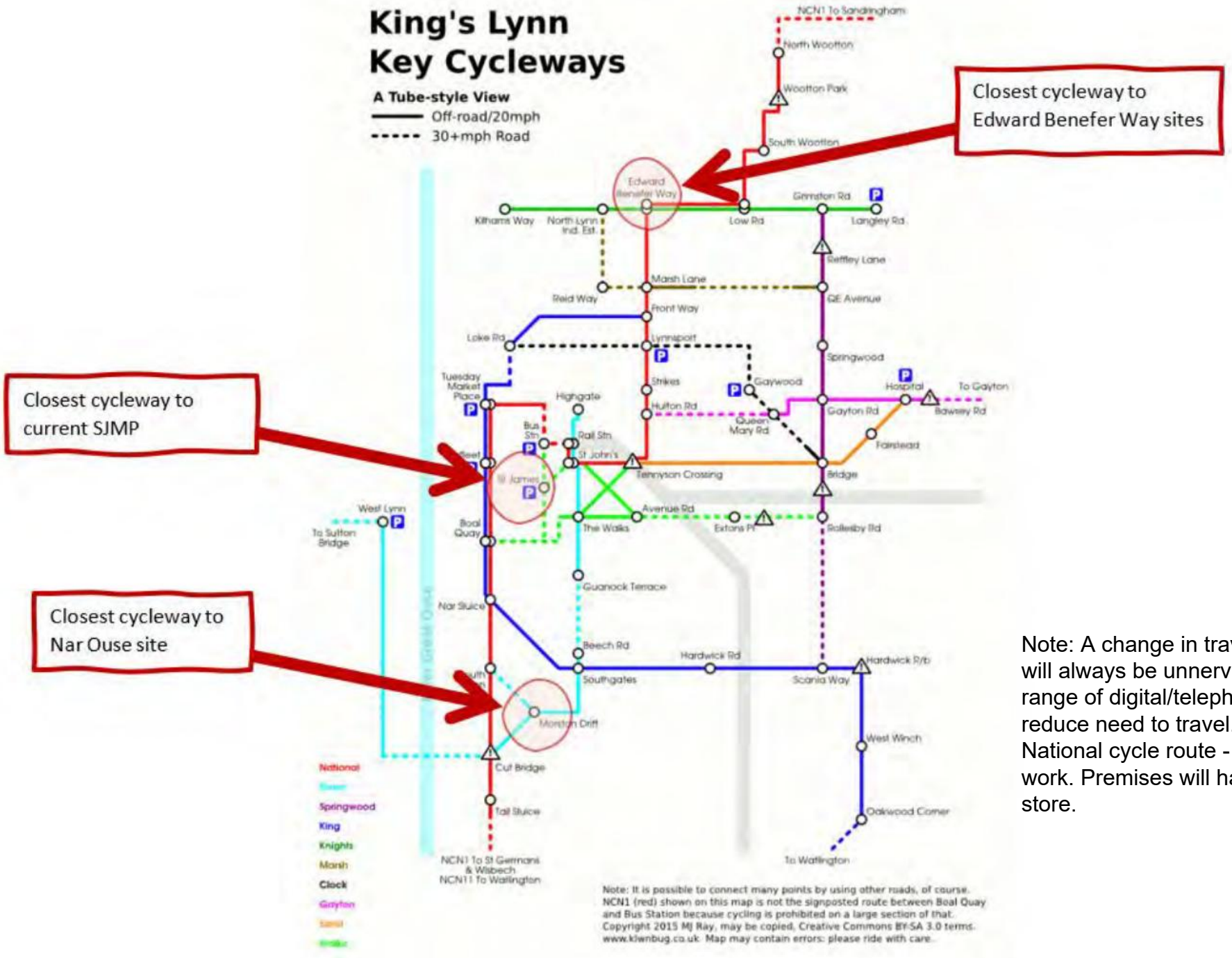
Note: Maureen Orr specifically asked for the practice's thoughts on this. More work will be needed as the business case progresses. For example, discussions can be help with community transport providers.

Buses

- Lynx buses 35 & 36 take 6 - 10 minutes and are at 30-minute intervals during the day. £2 single, £3 return, day ticket £3.50
- West Norfolk Community Transport buses 3 take 12 - 18 minutes, go every 30 minutes during the day – fare single is £2, or £1 before 9 am, day ticket is £3.20



Note: Costs of transport and the fact that parts of the walk from town are not particularly attractive, need to be considered.



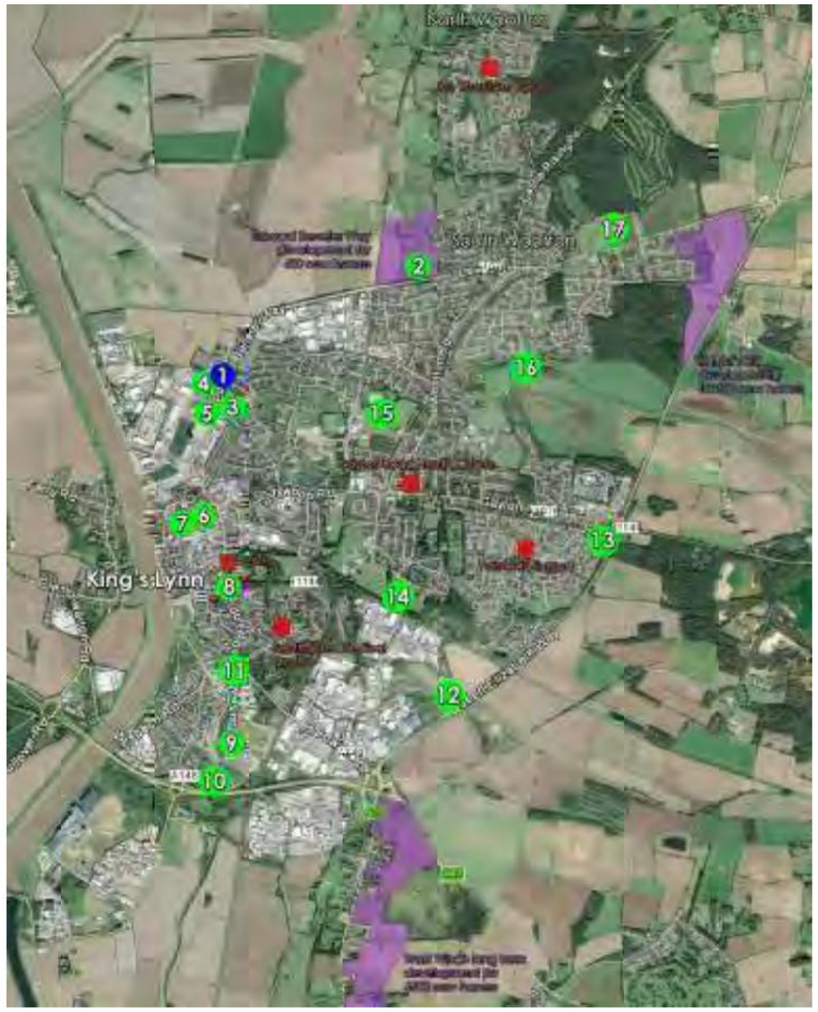
Note: A change in travel arrangements will always be unnerving. Increasing range of digital/telephone options to reduce need to travel. Green agenda – National cycle route - promoting cycle to work. Premises will have covered cycle store.

Key dates

- **Stage 1** of the consultation process for preparation of the business case is now complete
- **Stage 2** will involve the Patient Consultation Group and staff of the practice reviewing the detailed plans, and all normal processes involved for a formal planning application
- **Site surveying** is scheduled to start in the first week of December
- **Full Business Case** will submitted for approval to the CCG in March 2021, and to NHSI once planning permission has been secured which is expected by May 2021
- The estimated **completion date** (opening of the new surgery) is August 2022

Conclusions

- The best sites identified through the option and site appraisals are the County Council site, as well as the Nar Ouse Way and District Council sites
- Therefore the Full Business Case which is currently being prepared, will be recommending the progression of County Council Site in the first instance, with the Nar Ouse Way site as a reserve option
  - The County Council's surveyor has advised that the site on Edward Benefer Way has been declared surplus to educational requirements. This relates to a proviso that the site is used for healthcare and extra care purposes
  - The District Council's Estates Surveyor has indicated that land at Nar Ouse Way can be provisionally allocated for healthcare use. In principle, this secures land in that location if, for any reason, it is needed for the main development, or for the second surgery.
- Holding up the St James development through referring the consultation to date to the Secretary of State would cause distress to the practice, and possibly derail the whole project as ETTF project funding will be lost (£412,000)
- We need to actively address the concerns of those who will be disadvantaged by the move, and further work on this is needed as the planning application and business case progresses
- Kings Lynn has fallen behind most other similarly sized towns in the quality of its health care estate. The recent Capacity Planning work by Norlife identified that Kings Lynn has the greatest need for new premises in West Norfolk
- We have an opportunity, which could easily be missed, to address this, and to help improve the health of thousands of people



Site 1 *Land at Edward Benefer Way* 1:2000 @ A3

For:

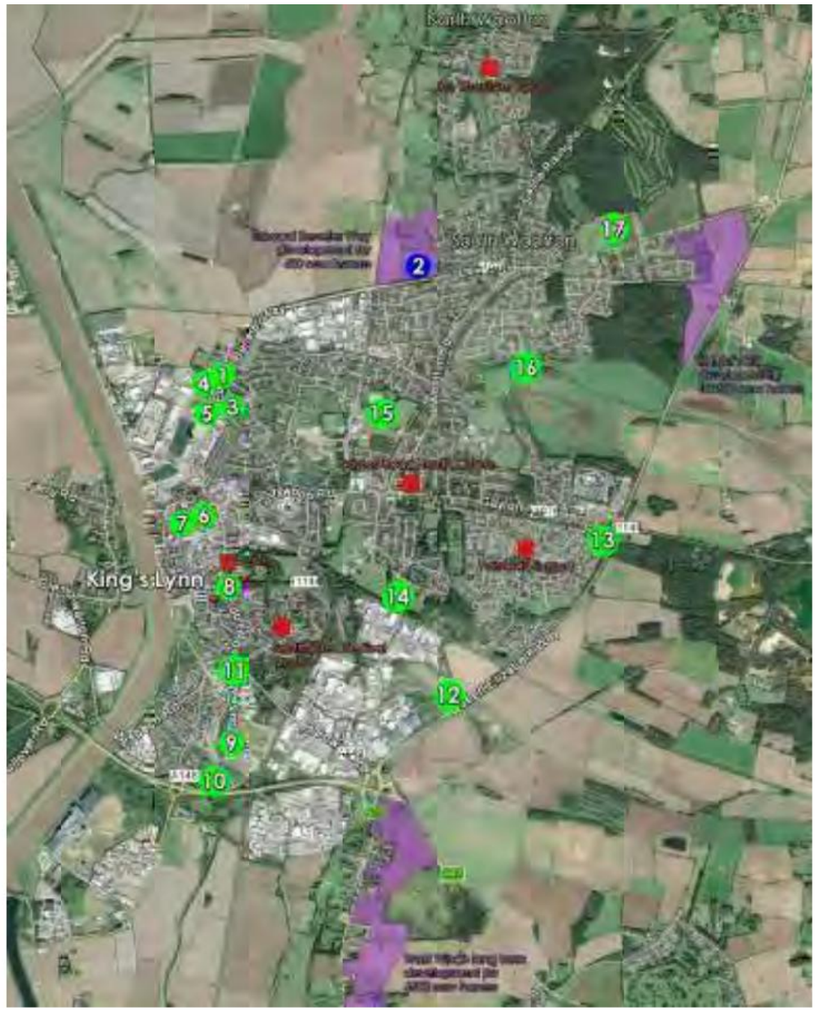
- Site is available within the time frame
- Has positive pre-application for medical centre use
- Large enough to accommodate building and future expansion
- Accessible by car, public transport, cycles and pedestrian
- Good public transport links
- Site has co-operative owner

Against:

- Site is within the flood risk area
- Requires costly Section 278 works to provide adequate vehicular junction access.

SJMP Diagnostic & Surgical
Caring for our community

St James Medical Practice
Caring for our community



Site 2 *Land at Edward Benefer Way* 1:2000 @ A3

For:

- Site is available within the time frame
- Large enough to accommodate building and future expansion
- Accessible by car, public transport, cycles and pedestrians
- Good Public Transport links
- Outside the flood risk area
- Site has co-operative owner

Against:

- Requires costly Section 278 works to provide adequate vehicular junction access.

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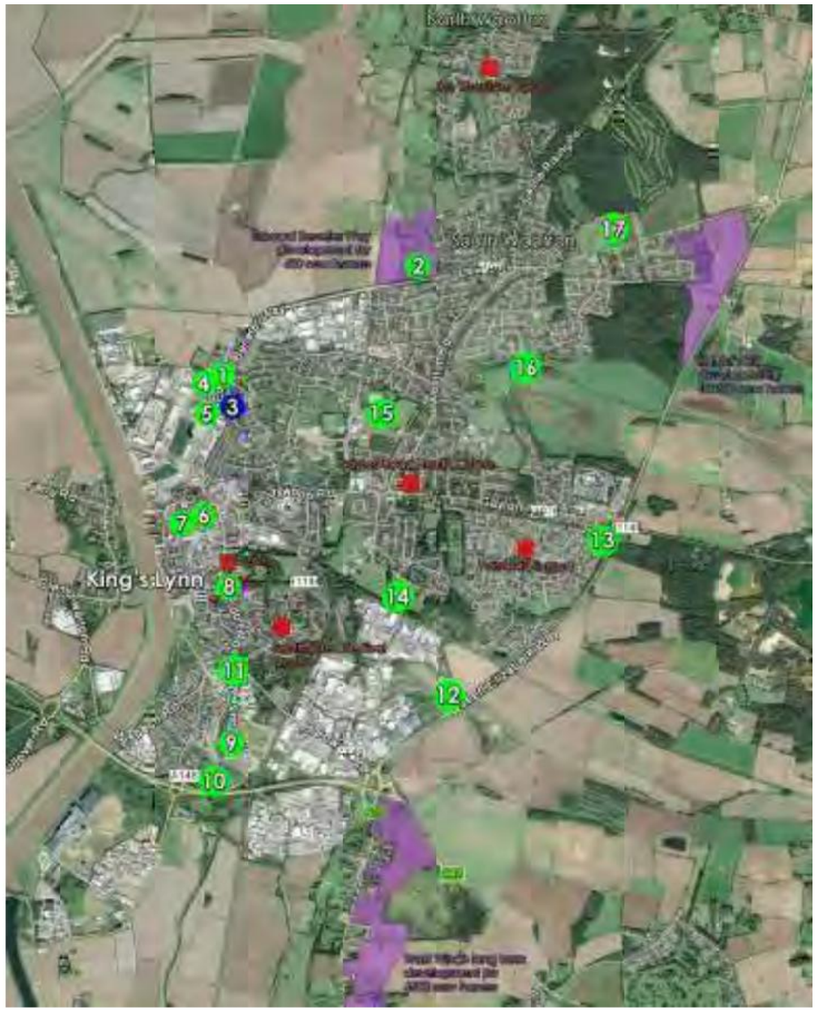
Caring for our community



Site 3 *Land at Edward Benefer Way* 1:2000 @ A3

For:

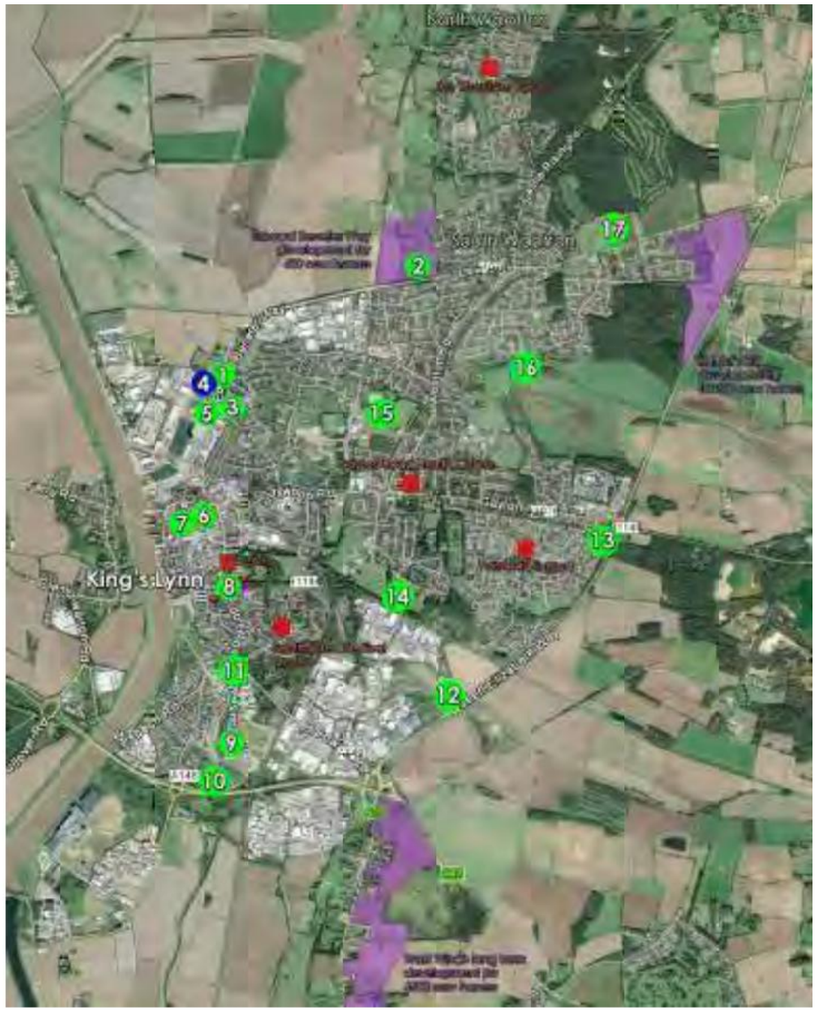
- Large enough to accommodate building and future expansion
- Accessible by car, public transport, cycles and pedestrians
- Good Public Transport links

Against:

- Site is within the flood risk area
- Site is subject to costly remediation due to contamination
- Site is being sold by auction
- More appropriate site available within the same general location

SJMP Diagnostic & Surgical
Caring for our community

St James Medical Practice
Caring for our community



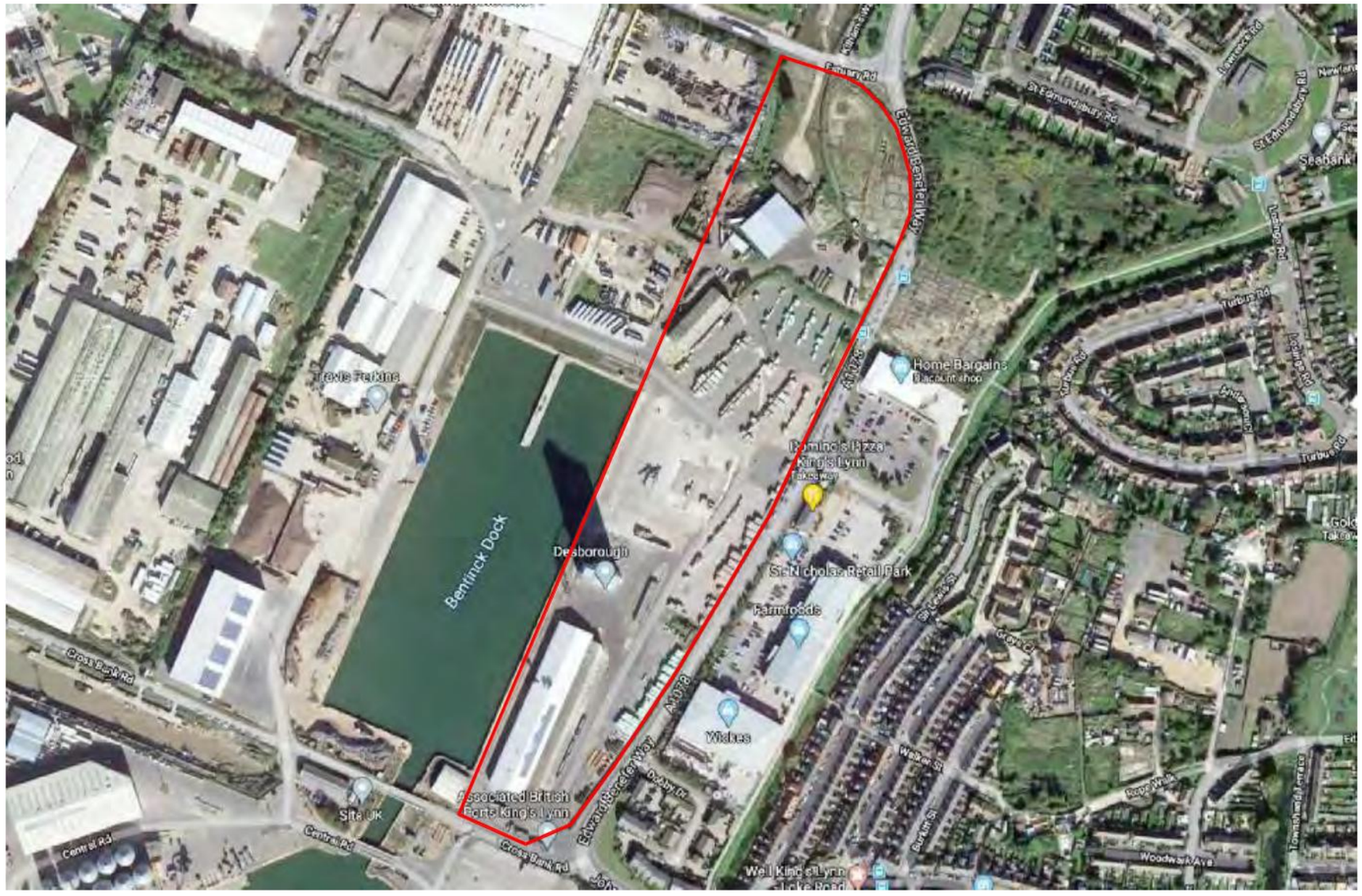
Site 4 *Land at Edward Benefer Way* 1:2000 @ A3

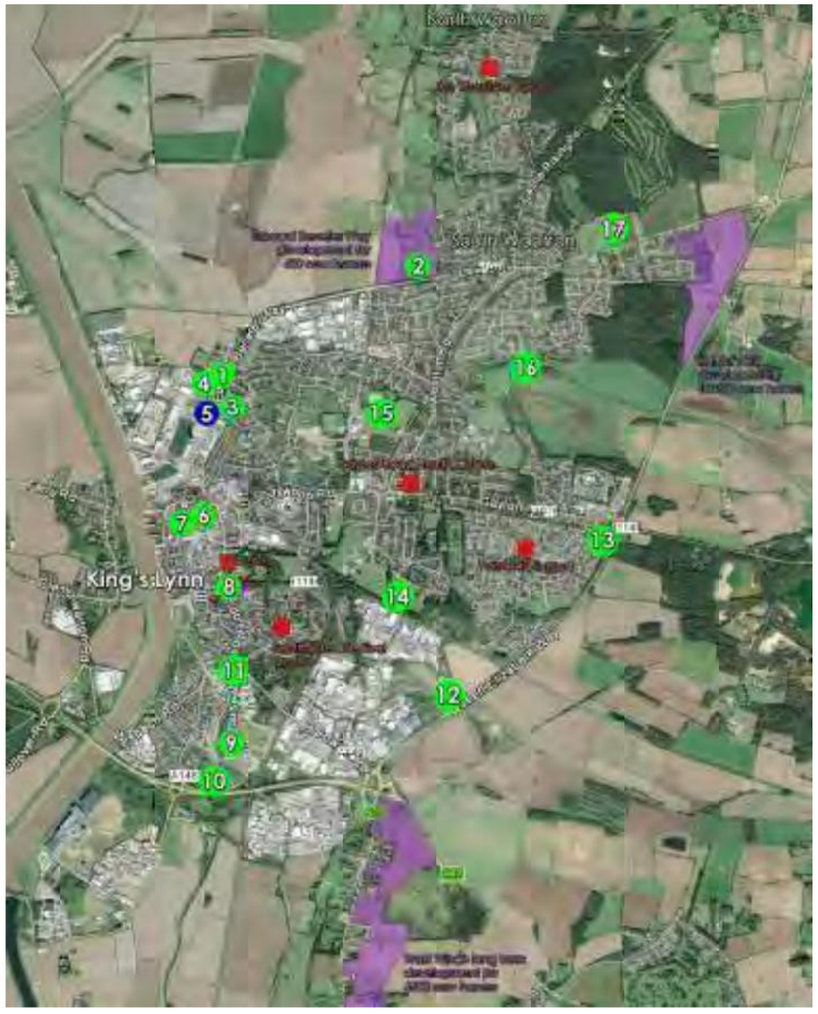
For:

- Large enough to accommodate building and future expansion
- Accessible by car, public transport, cycles and pedestrians
- Good Public Transport links

Against:

- Site and building security could be an issue
- Site is within the flood risk area
- Site is subject to costly remediation due to contamination
- More appropriate site available within the same general location
- Site has industrial uses in the immediate vicinity





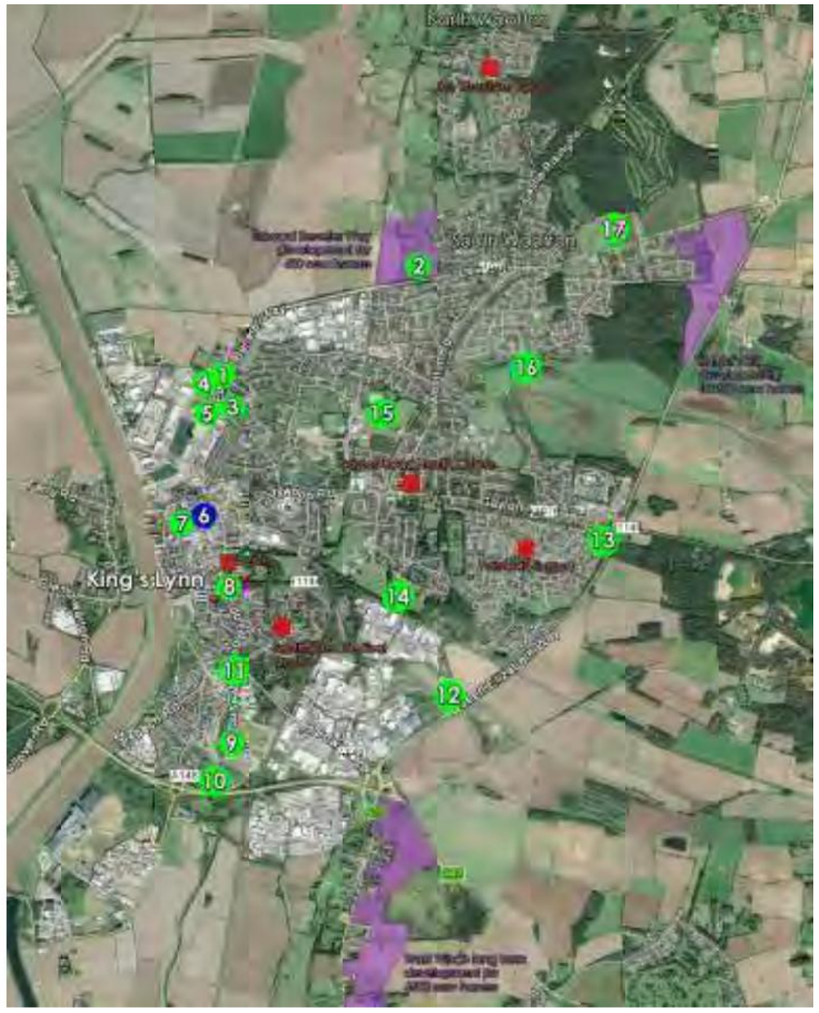
Site 5 *Land at Edward Benefer Way* 1:4000 @ A3

For:

- Large enough to accommodate building and future expansion
- Accessible by car, public transport, cycles and pedestrians
- Good Public Transport links

Against:

- Site and building security could be an issue
- Site is within the flood risk area
- Site is subject to costly remediation due to contamination
- More appropriate site available within the same general location
- Site is unlikely to be available within a sensible time frame



Site 6A *Town Centre Car Park* 1:2000 @ A3

For:

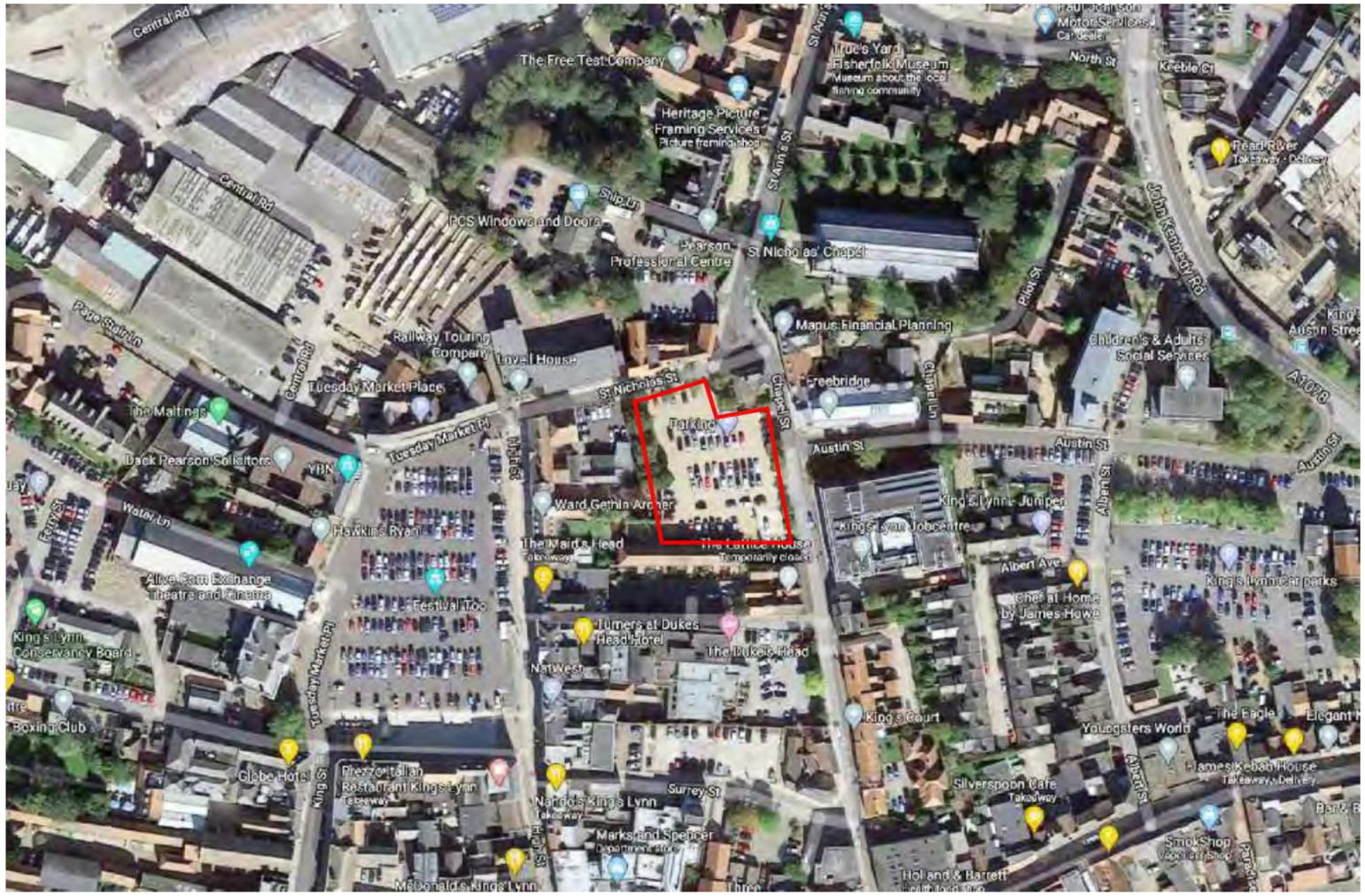
- Large enough to accommodate building and future expansion
- Accessible by public transport, cycles and pedestrians

Against:

- Site is within the flood risk area
- Site is currently a heavily used public car park, and is unlikely to be available for development
- Access to rear of surrounding properties needs to be maintained, adding to site constraints.
- Site may have below ground services resulting in added constraints.
- Practice concerned the town centre location makes accessibility by car or emergency services problematic at peak times.
- Defensible space between clinical rooms and the public domain maybe difficult to provide, adversely affecting patient confidentiality.

SJMP Diagnostic & Surgical
Caring for our community

St James Medical Practice
Caring for our community



Site 6B *Town Centre Car Park* 1:2000 @ A3

For:

- Accessible by public transport, cycles and pedestrians

Against:

- Not large enough to accommodate the Medical Centre and car parking requirement
- Site is within the flood risk area
- Site is currently a well used public car park, generally at capacity
- Site may have below ground services resulting in added constraints.
- Practice concerned the town centre location makes accessibility by car or emergency services problematic at peak times.
- Defensible space between clinical rooms and the public domain maybe difficult to provide, adversely affecting patient confidentiality.

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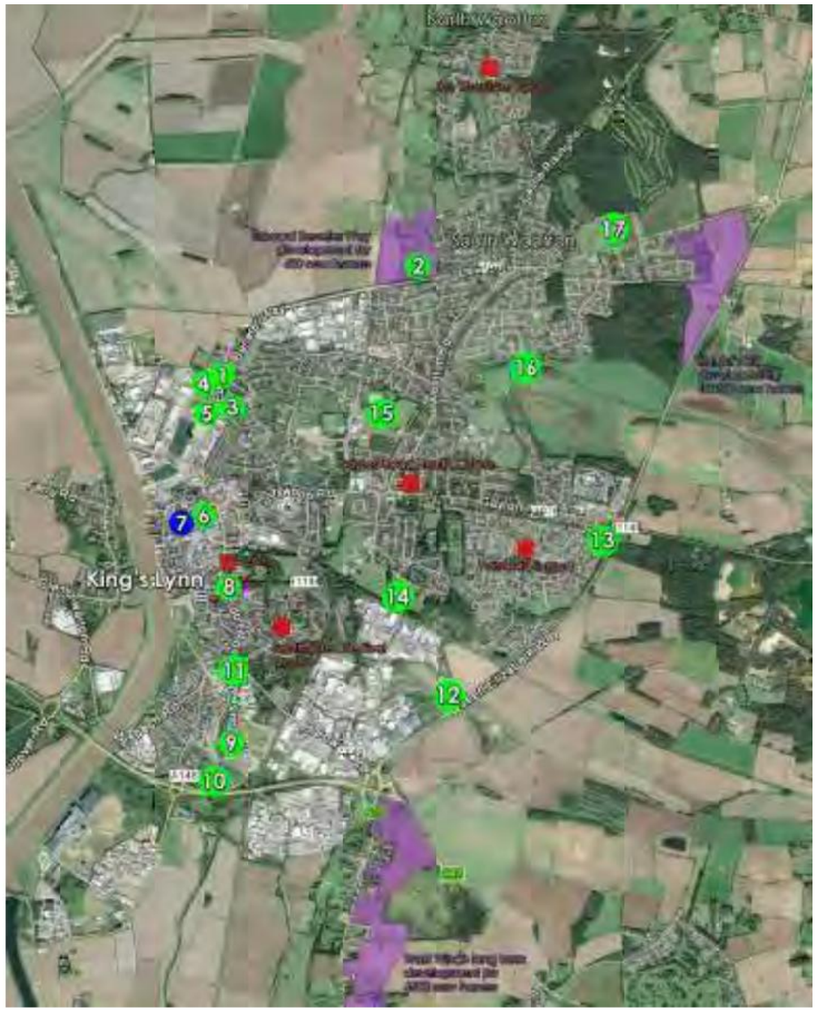

Site 7A *Town Centre Conversion* 1:2000 @ A3

For:

- Large enough to accommodate medical centre
- Accessible by public transport, cycles and pedestrians

Against:

- Site is within the flood risk area
- Existing building is too large as a whole and would require additional use for development
- Site is currently undergoing a planning application for residential use.
- Site is unlikely to be economically viable
- Existing building constraints make conversion into medical centre difficult, complicated and costly.
- Practice concerned the town centre location makes accessibility by car or emergency services problematic at peak times.
- No defensible space between clinical rooms and the public domain , adversely affecting patient confidentiality.
- Site cannot accommodate car parking.
- Existing building constraints are inefficient and difficult to alter in order to achieve an efficient medical centre use

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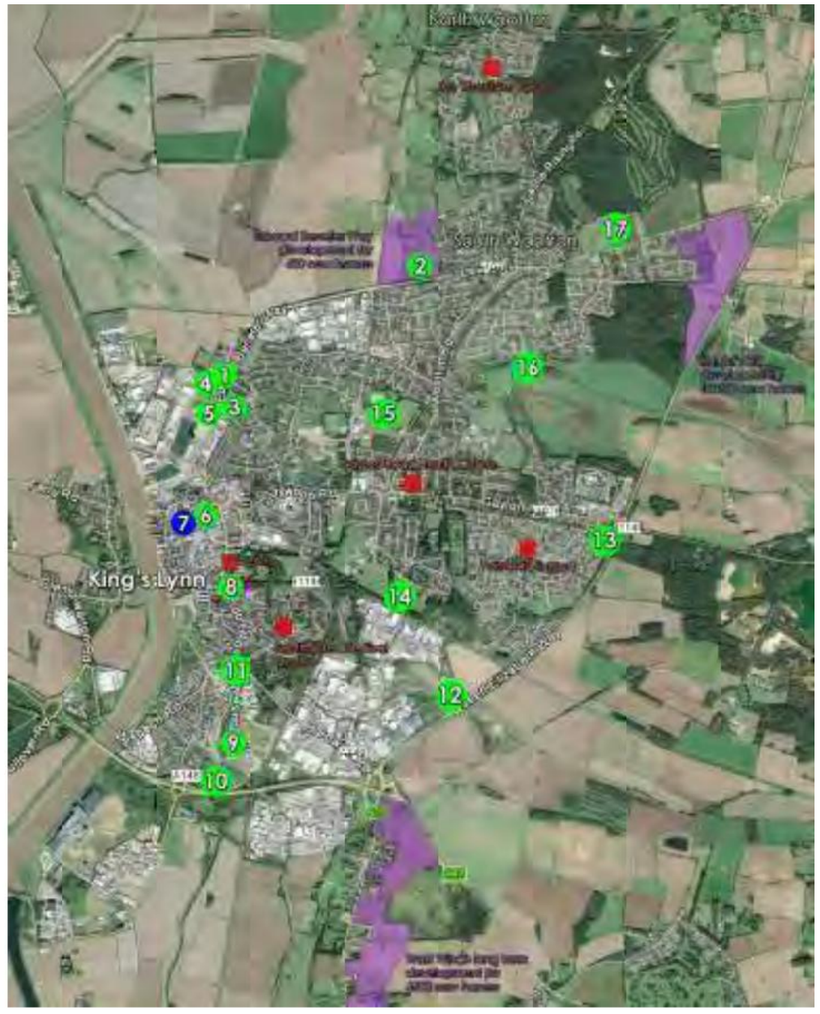
Caring for our community



Site 7B *Town Centre Conversion*

1:2000 @ A3

For:

- Large enough to accommodate medical centre
- Accessible by public transport, cycles and pedestrians

Against:

- Site is within the flood risk area
- Existing building is too large as whole to would require additional use for development
- Site is unlikely to be economically viable
- Existing building constraints and services make conversion into medical centre difficult, complicated and costly.
- Practice concerned the town centre location makes accessibility by car or emergency services problematic at peak times.
- No defensible space between clinical rooms and the public domain, adversely affecting patient confidentiality.
- Site cannot accommodate car parking and unlikely to accommodate future expansion.
- Structural, thermal and acoustic performance would require substantial upgrade.
- Difficult to meet required HTM and HBN standards with existing building envelope.
- DDA compliance problematic
- Existing building constraints are inefficient and difficult to alter in order to achieve an efficient medical centre use
- Property currently taken off the market with planning application submitted for a change of use to residential.

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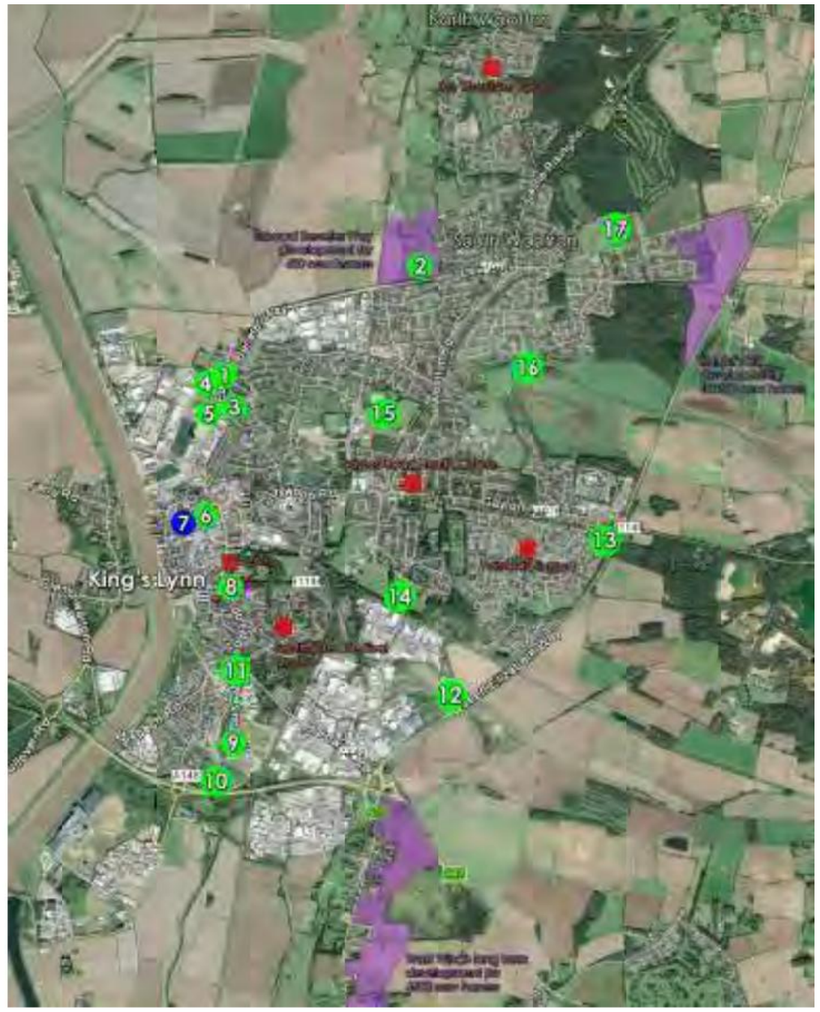

Site 7C *Town Centre Conversion*

1:2000 @ A3

For:

- Large enough to accommodate medical centre
- Accessible by public transport, cycles and pedestrians

Against:

- Site is within the flood risk area
- Building significantly oversized for medical centre use and demolition would be cost prohibitive
- Current owners are seeking retail use / tenant
- Site is unlikely to be economically viable
- Existing building constraints and services make conversion into medical centre difficult, complicated and costly.
- Practice concerned the town centre location makes accessibility by car or emergency services problematic at peak times.
- Deep plan makes natural daylight and views out to all clinical, patient waiting areas and office areas extremely difficult to achieve.
- No defensible space between clinical rooms and the public domain, adversely affecting patient confidentiality.Site cannot accommodate car parking and unlikely to accommodate future expansion.
- Structural, thermal and acoustic performance would require substantial upgrade.
- Difficult to meet required HTM and HBN standards with existing building envelope.
- DDA compliance problematic
- Existing building constraints are inefficient and difficult to alter in order to achieve an efficient

- medical centre use
- Car Parking and issue

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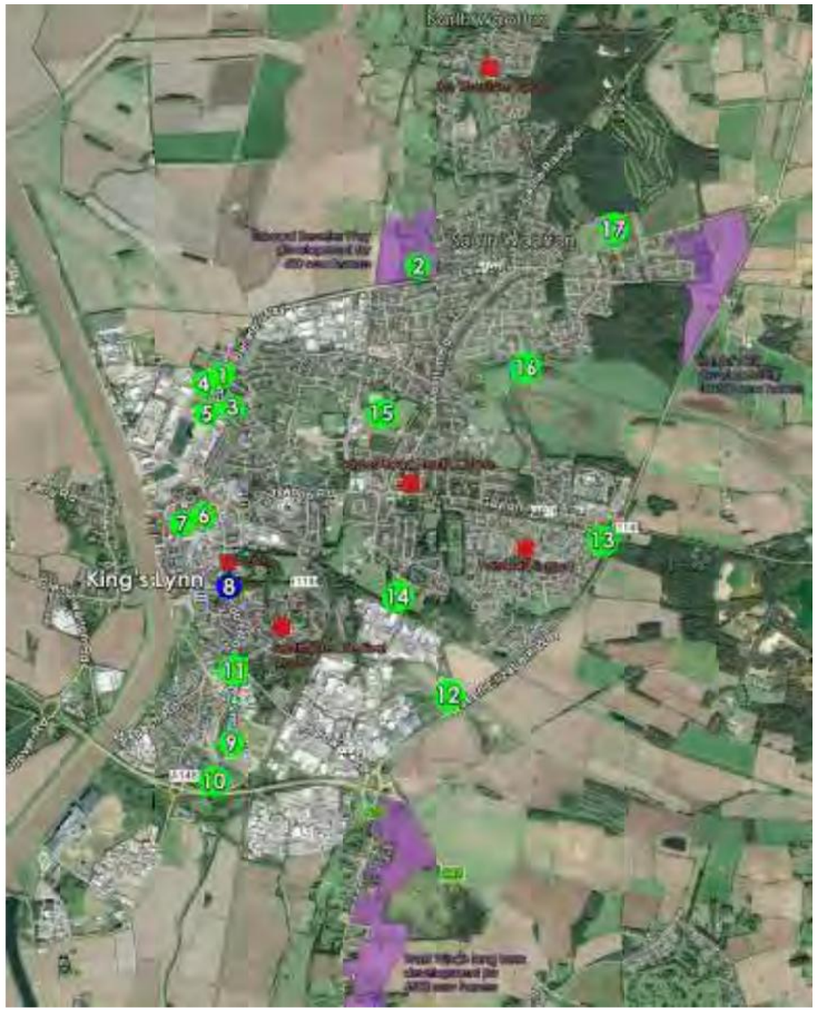

Site 8 *Vancouver House*

1:2000 @ A3

For:

- Large enough to accommodate medical centre
- Accessible by public transport, cycles and pedestrians

Against:

- Site is within the flood risk area
- There is insufficient vacant space available within this building to accommodate the requirements of the new Medical Centre
- Site unlikely to be available within the timeframe
- Site is unlikely to be economically viable
- Existing building constraints and services make conversion into medical centre difficult, complicated and costly.
- Practice concerned the town centre location makes accessibility by car or emergency services problematic at peak times.
- No defensible space between clinical rooms and the public domain adversely affecting patient confidentiality.
- Site cannot accommodate car parking and unlikely to accommodate future expansion.
- Structural, thermal and acoustic performance would require substantial upgrade.
- Difficult to meet required HTM and HBN standards with existing building envelope.
- DDA compliance problematic
- Existing building constraints are inefficient and difficult to alter in order to achieve an efficient medical centre use

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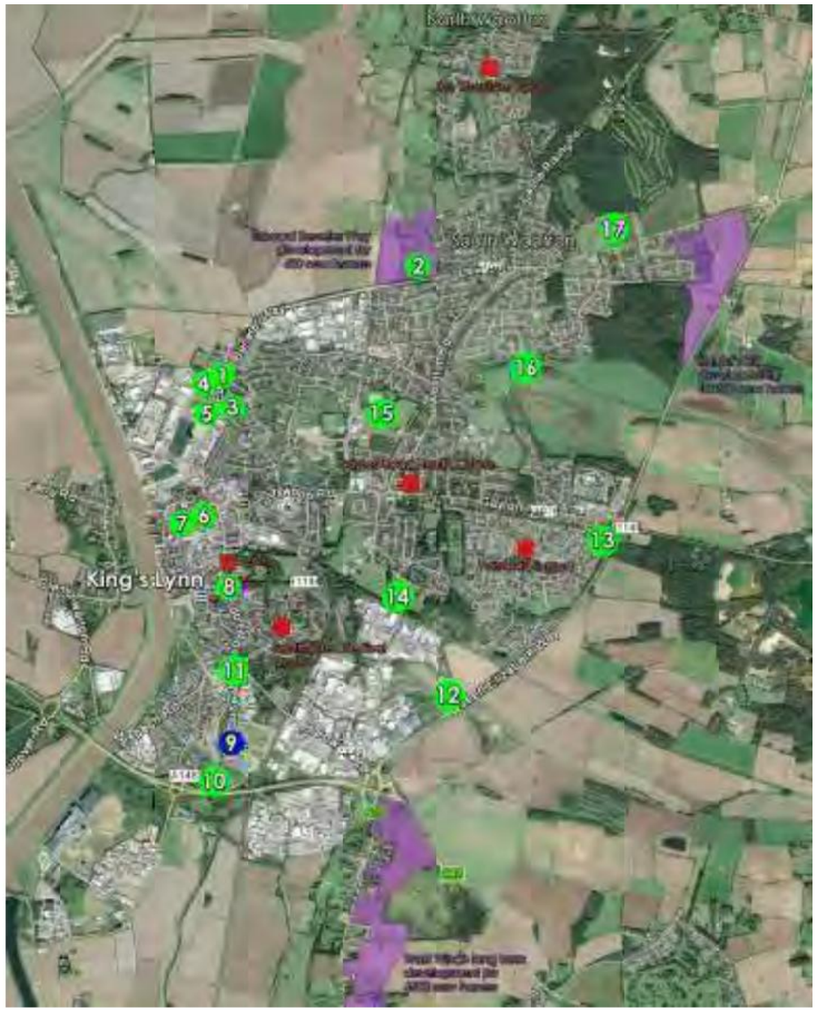


Site 9 *Land at Nar Ouse Way* 1:2000 @ A3

For:

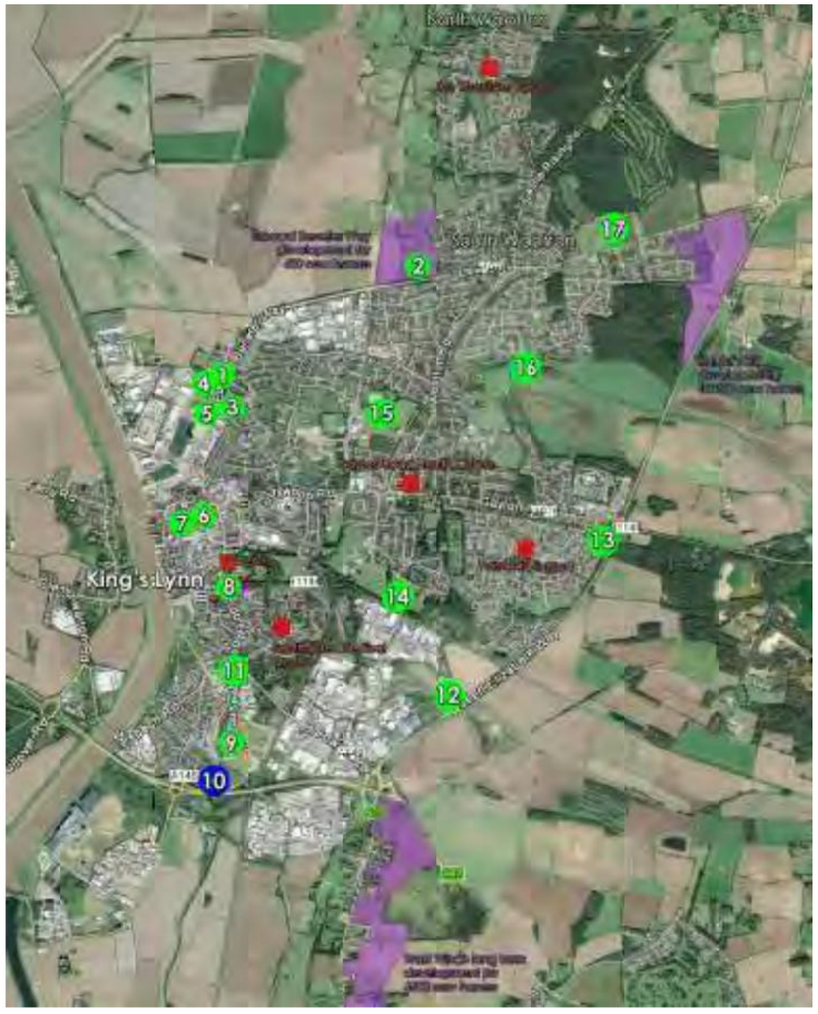
- Site may be available within the time frame*
- Large enough to accommodate building and future expansion
- Accessible by car, public transport, cycles and pedestrians
- Good Public Transport links
- Site has co-operative owner

Against:

- Site outside of flood risk area but in the event of a flood would inaccessible especially for emergency services
- Site contamination and remediation cost may be an issue
- Existing ground conditions an issue, with existing structures to be removed and pile foundations likely to be required
- Site is low lying and may need to be elevated

NOTE

If this site is chosen as the development site and the issues relating to ground conditions (clean up of contamination and removal of significant concrete structure from within the site) prove insurmountable, the landowner has confirmed thart it may be possible to consider an alternative site on the other side of the road (plots A3 and A4 or an area within the land allocated to the 'D' plots as shown on the Nar Ouse Way Enterprise Zone Masterplan).



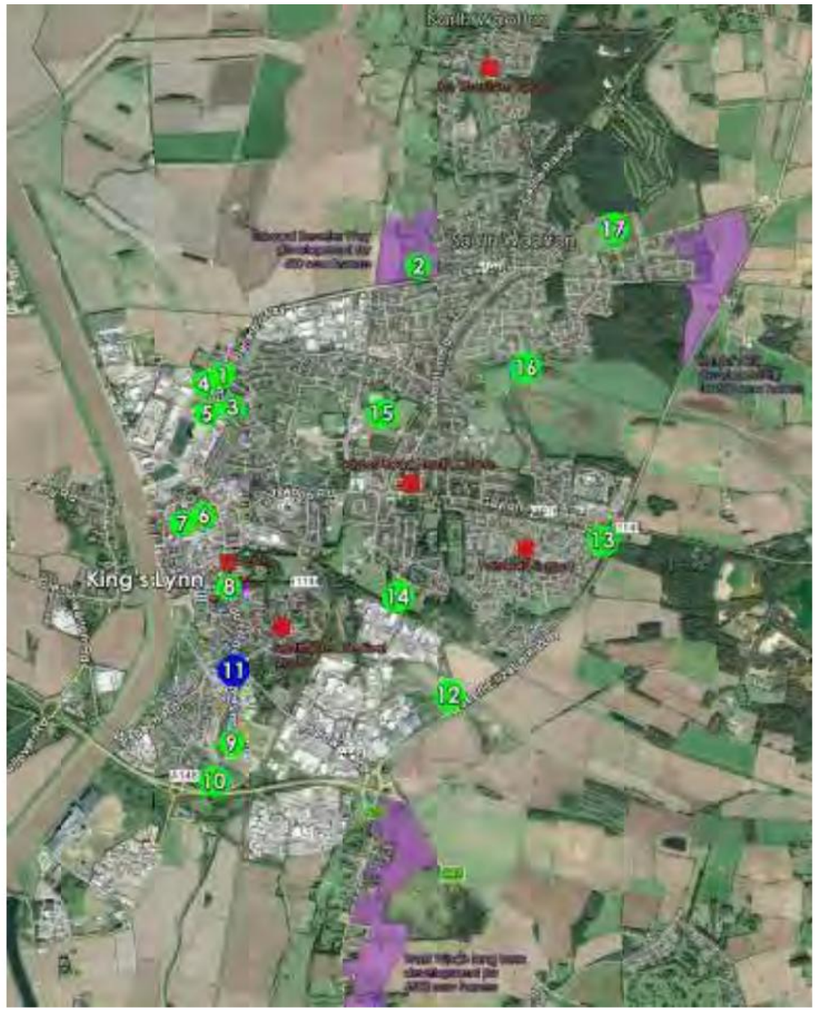
Site 10 *Land at Morston Drift* 1:2000 @ A3

For:

- Large enough (but of a poor, linear shape) to accommodate the new development and future expansion. Accessible by car, public transport, cycles and pedestrians

Against:

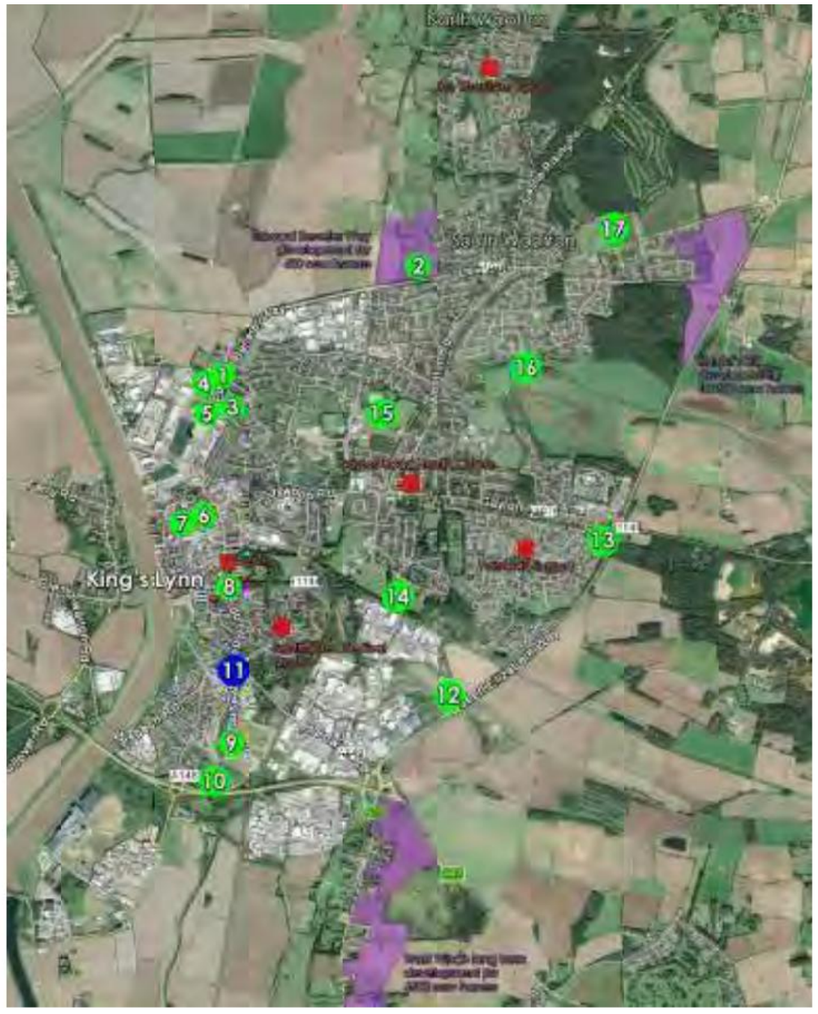
- Site within flood risk area
- Site contamination and remediation cost may be an issue
- Site is extremely narrow and would be problematic in accommodating the building efficiently, requiring a long linear building, inappropriate for acceptable internal travel distances.



Site 11A *Land at Kellard Place* 1:2000 @ A3

For:
- Accessible by car, public transport, cycles and pedestrians
- Accessible by Public Transport

Against:
- Site within flood risk area
- Site area insufficient to accommodate building, expansion and required car parking provision.



Site 11B *Land at Kellard Place* 1:2000 @ A3

For:

- Accessible by car, public transport, cycles and pedestrians
- Accessible by Public Transport
- Site area is large enough

Against:

- Site within flood risk area
- Site area insufficient to accommodate building, expansion and required car parking provision.
- Building and development compromised having regard to proximity of industrial / commercial processes adjacent and having regards to the potential need locate car parking away from the building, possibly across the road on site 11A

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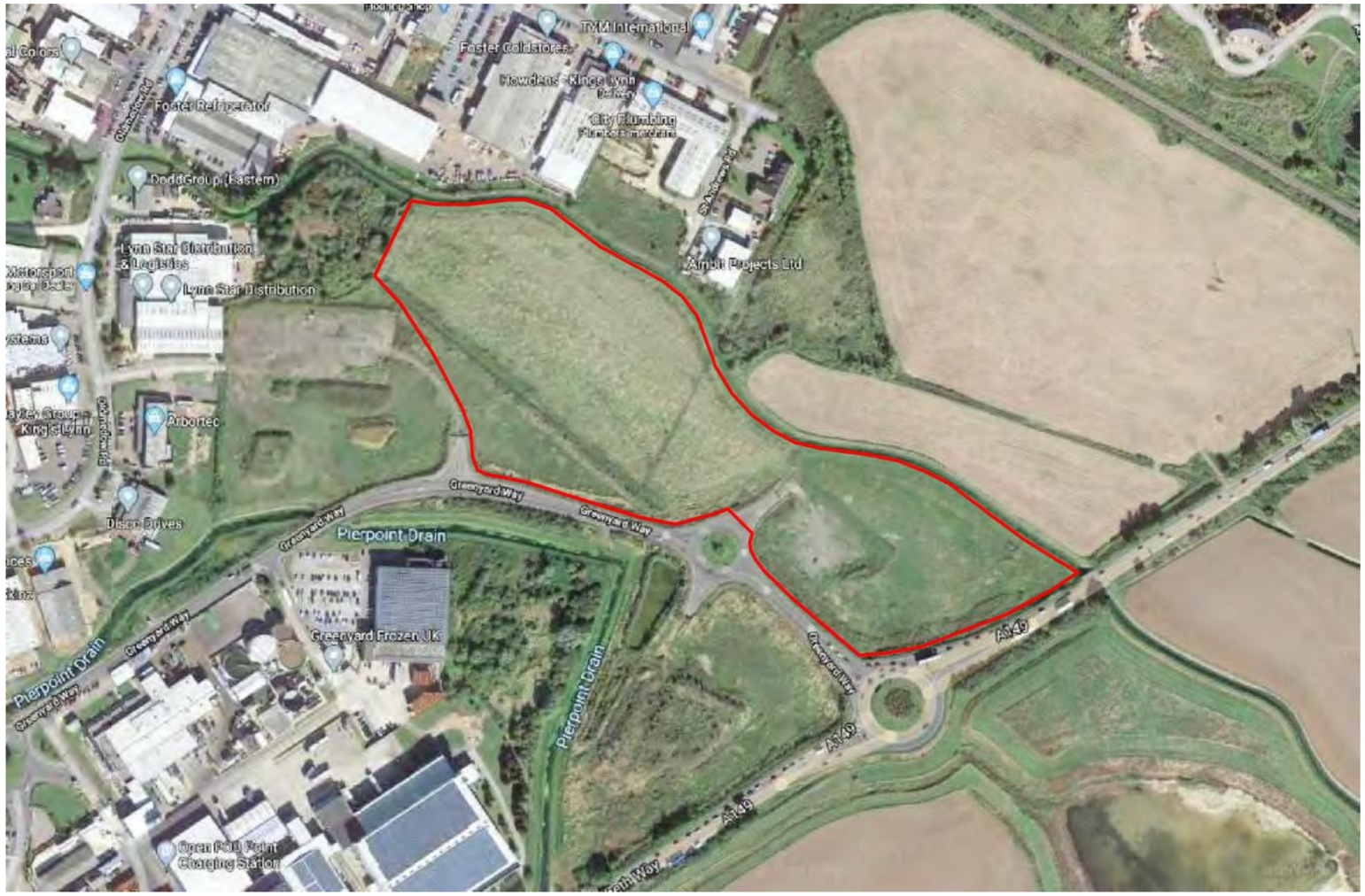
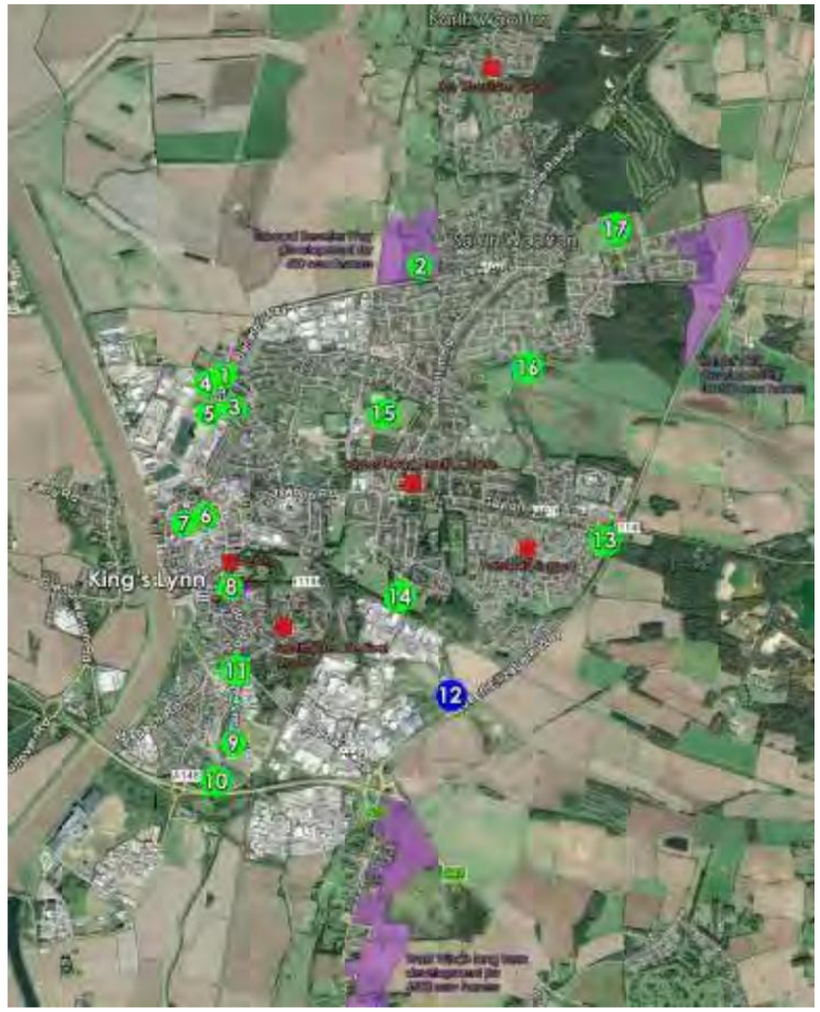




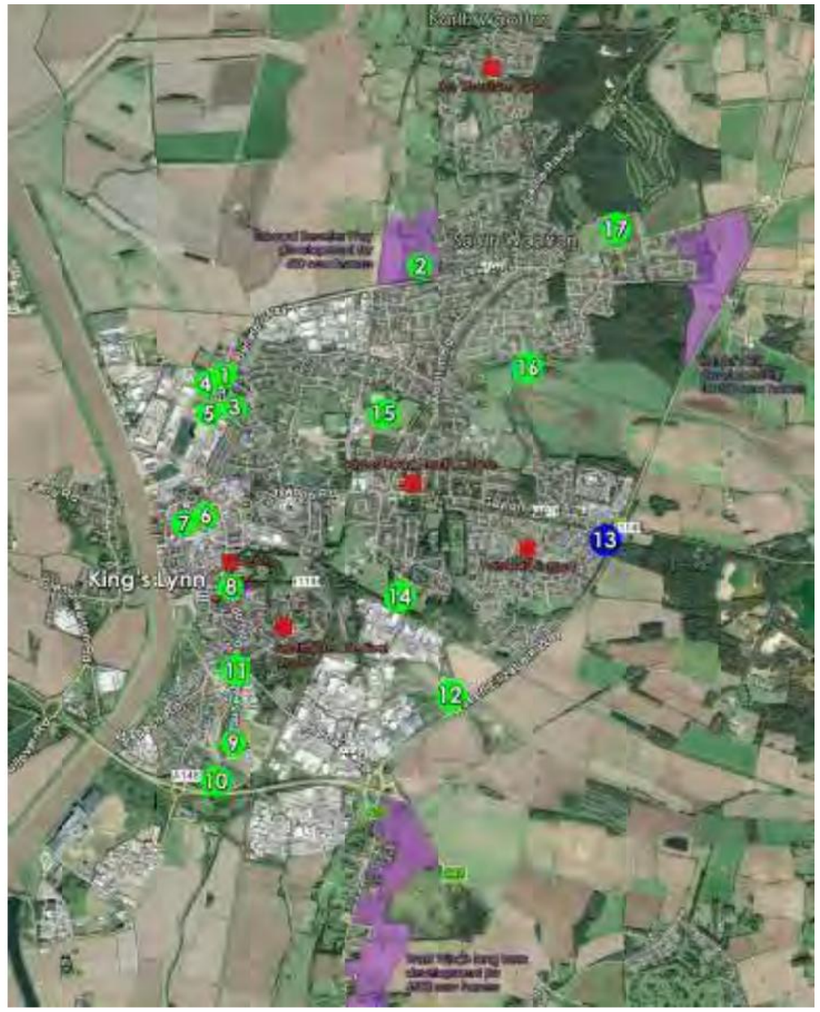
Site 12 *Land at Greenyard Way* 1:4000 @ A3

For:

- Site is available within the time frame
- Large enough to accommodate building and future expansion
- Accessible by car, public transport, cycles and pedestrians
- Good Public Transport links

Against:

- Site is on the very edge of the defined town boundary and security may be an issue
- Site is within the flood risk area
- Site is within an industrial area



Site 13 *Land Opposite Queen Elizabeth Hospital* 1:2000 @ A3

For:

- Large enough to accommodate building and future expansion

Against:

- Access into the site extremely problematic with no existing access available
- Site whilst not seemingly allocated, currently used as public open space.

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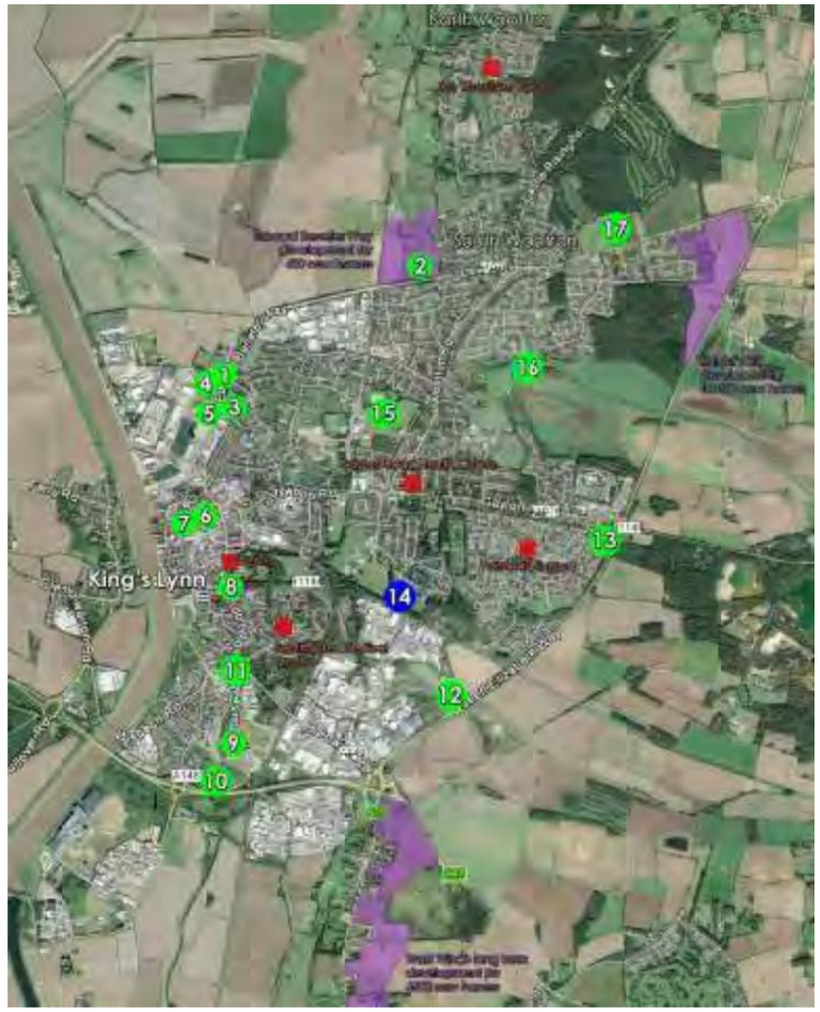


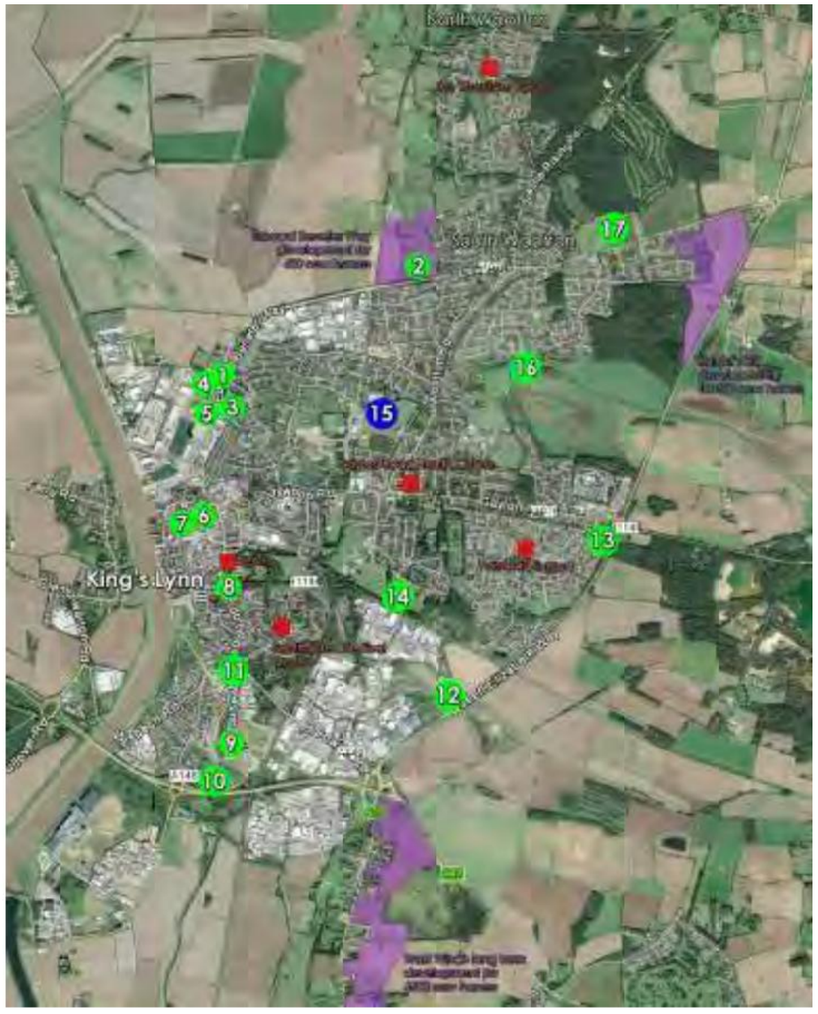
Site 14 *Land at Parkway* 1:4000 @ A3

For:

- Large enough to accommodate building and future expansion

Against:

- No main road connection with access only available through a residential area
- Currently benefits from planning consent for residential development.



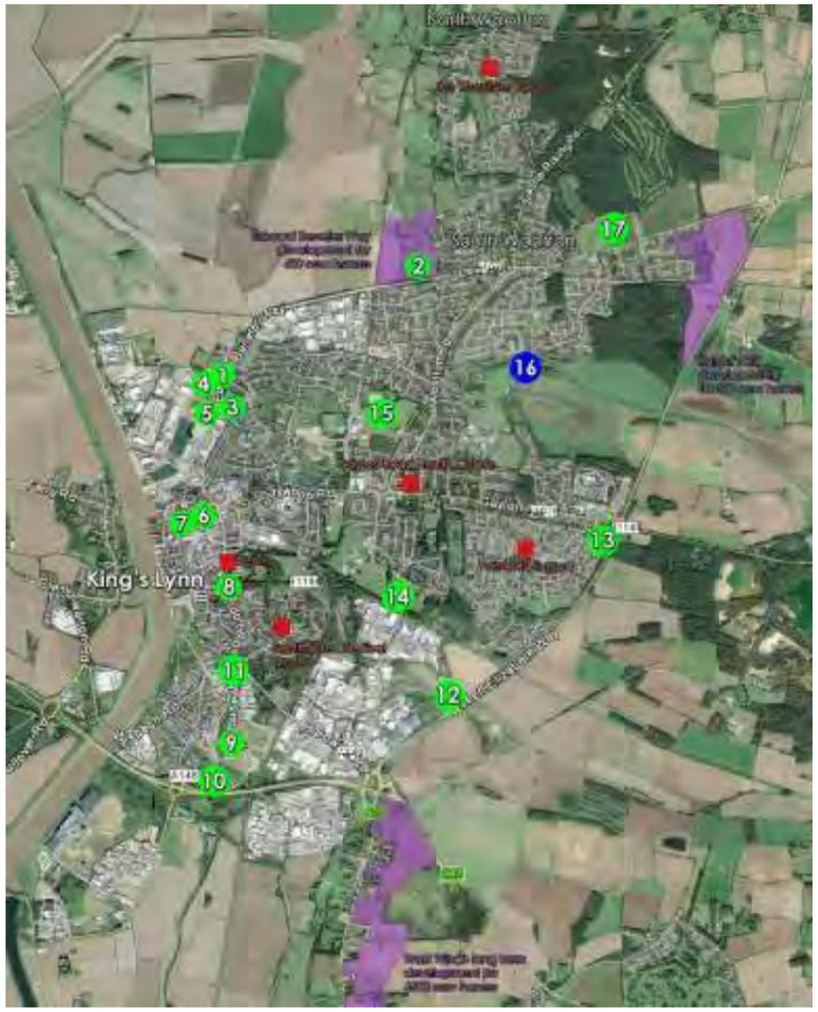
Site 15 *Land at Lynnsports* 1:4000 @ A3

For:

- Large enough to accommodate building and future expansion

Against:

- Only access into the site is through an existing car park.
- Currently used as public open space
- Ecology and habitat restrictions.



Site 16 *Land off Russett Close* 1:4000 @ A3

For:

- Large enough to accommodate building and future expansion

Against:

- No main road connection with only access only available through a residential area.
- Currently benefits from planning consent for residential development.

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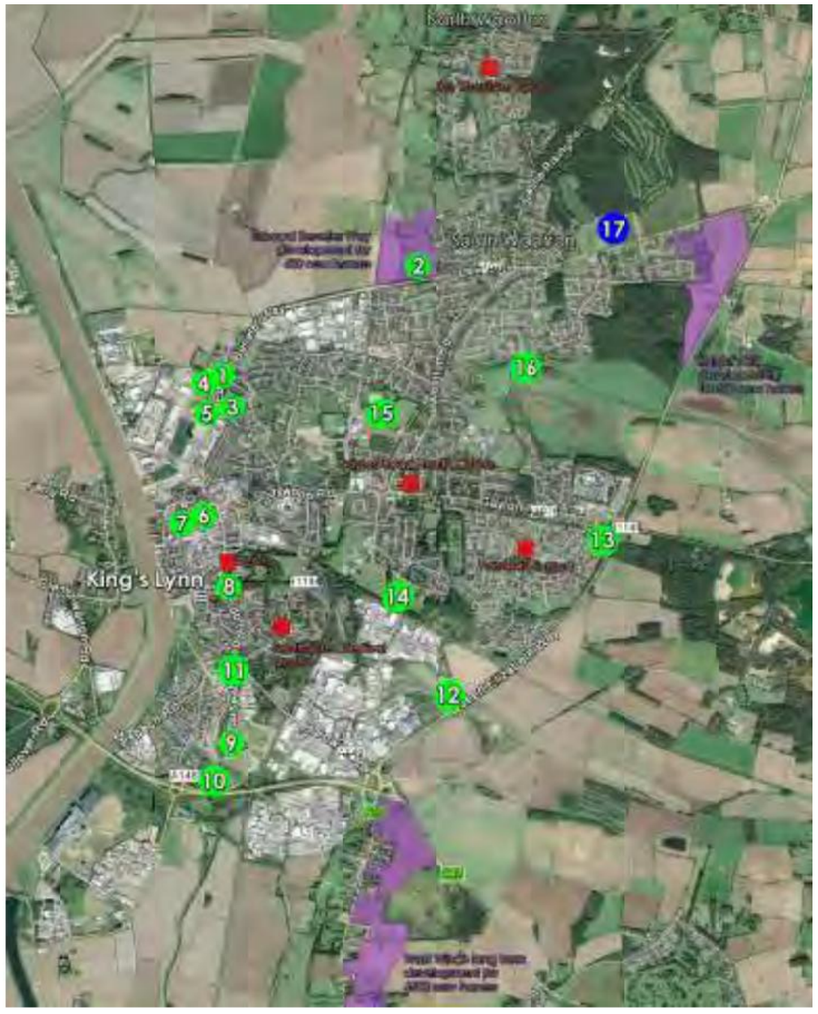

Site 17 *Land off Grimston Road* 1:4000 @ A3

For:

- Site is potentially available within the time frame
- Large enough to accommodate building and future expansion
- Accessible by car, public transport, cycles and pedestrians
- Good Public Transport links
- Outside the flood risk area

Against:

- Requires costly Section 278 works to provide adequate vehicular junction access.
- Site is outside the defined town boundary

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Capacity Planning

West Norfolk

1

Background

- Norlife are a partnership between the private sector and the NHS in Norfolk and Waveney. They have worked with commissioners in the planning and provision of health facilities across the area.
- Together with the CCG they are currently assisting NHS England in a national exercise to review the Primary Care estate.
- Plans are being discussed to undertake a comprehensive study of the condition of all GP owned and leased premises in the area
- The CCG commissioned Norlife to independently review current registration capacity and demand from new housing in West Norfolk.

2

Demand and Capacity

- Registration Demand

  Arises from a number of sources
  - New housing (Estimated 2.2 registrations per dwelling)
  - The demographics of the population
  - Overcrowding in current premises.
- Premises capacity
  - GPs own or lease their own premises
  - The NHS reimburses them for the space required to deliver the commissioned services.
  - Modern fully compliant facilities should support at least 16 patients per m^2

3

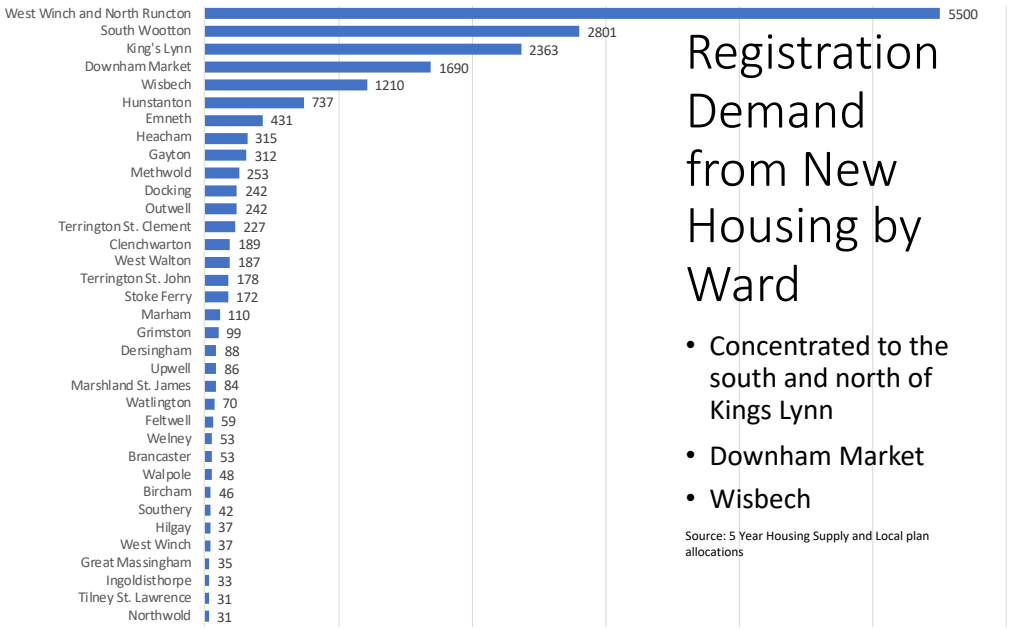
Methodology

- **Demand** is the planned housing times 2.2
- **Current Utilisation** the practice list divided by the reimbursed floor area to show 'Patients per $m^{2'}$
- **Capacity** the additional registrations before reaching 16 patients per m^2
- **Constraint** the number of patients that would need to be de-registered to get back to 16 per m^2.

Caveats

- *Older GP surgeries may have been built to less demanding standards and can function adequately with more patients per metre*
- *Extended opening hours can create additional capacity*
- *The increase in on-line and phone consultations may see a reduction in the physical space required.*

4

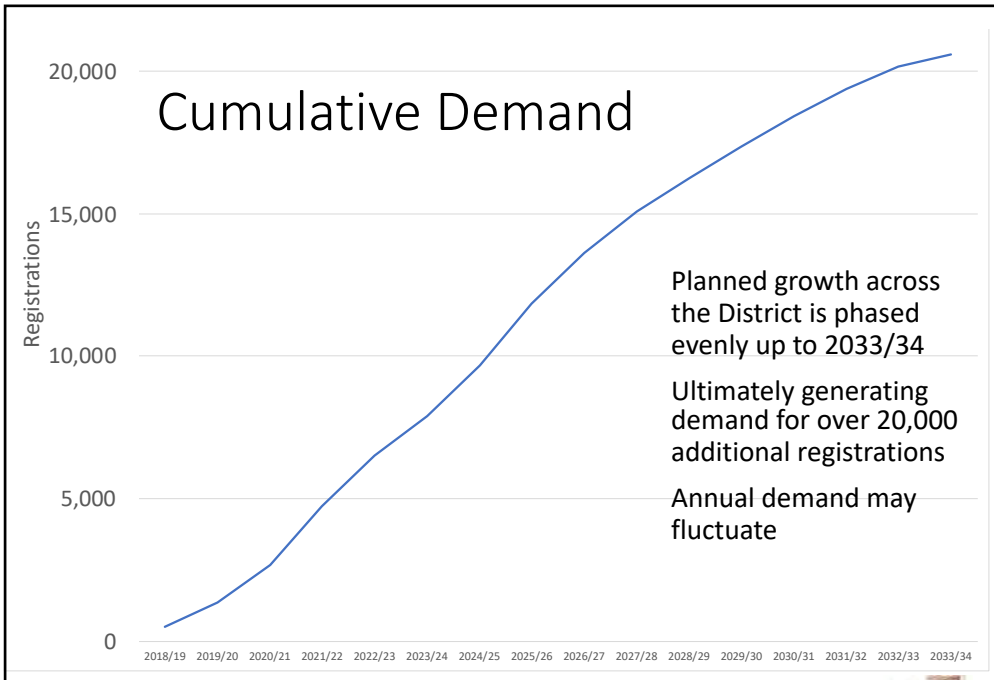


Registration Demand from New Housing by Ward

- Concentrated to the south and north of Kings Lynn
- Downham Market
- Wisbech

Source: 5 Year Housing Supply and Local plan allocations

5



Cumulative Demand

Planned growth across the District is phased evenly up to 2033/34

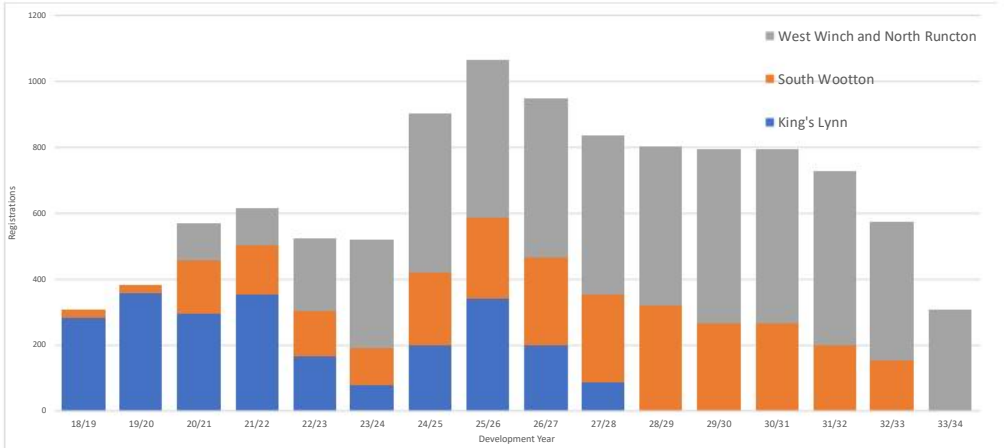
Ultimately generating demand for over 20,000 additional registrations

Annual demand may fluctuate

6

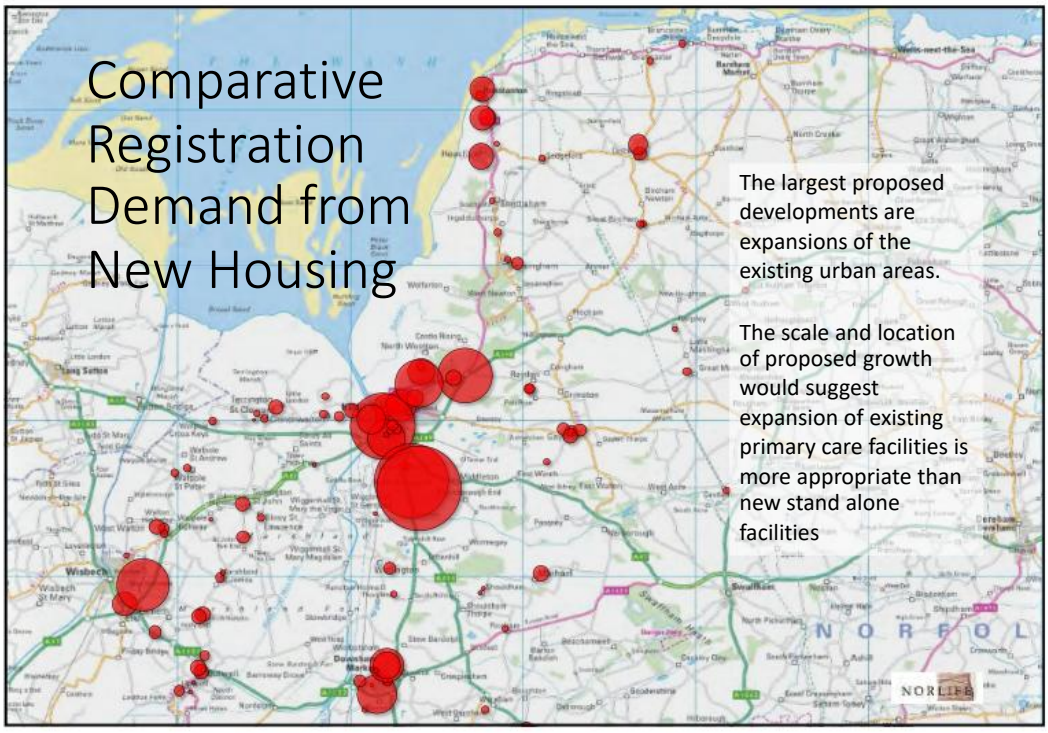
Annual Registration Demand

Strategic Sites Kings Lynn



7

Comparative Registration Demand from New Housing



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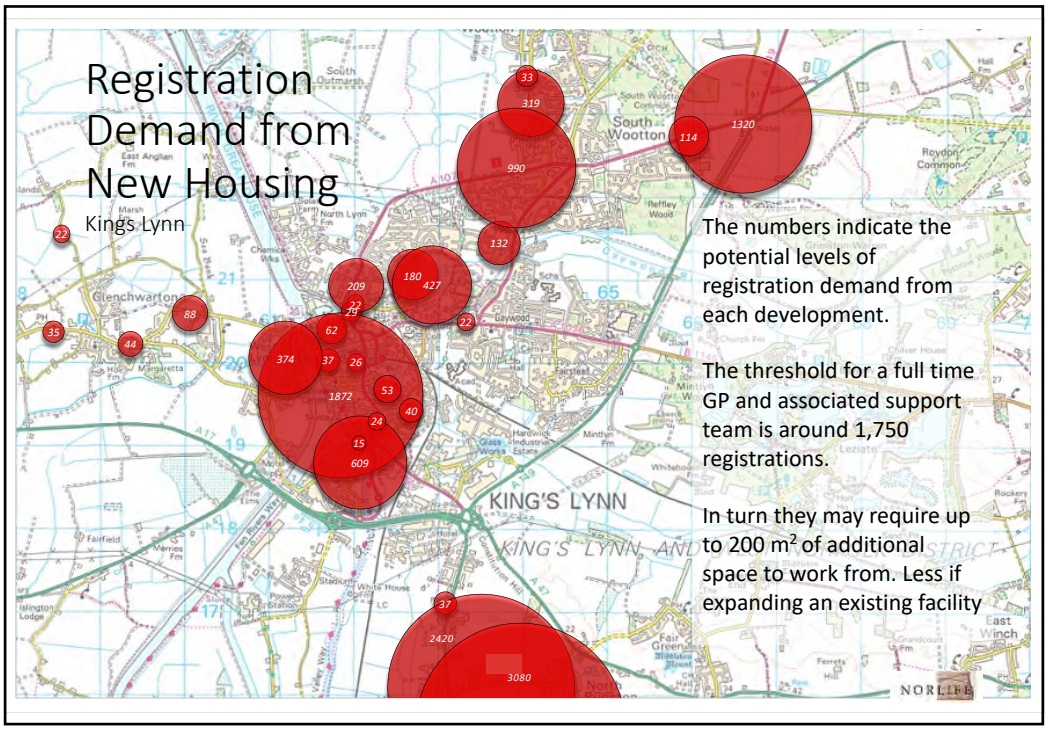
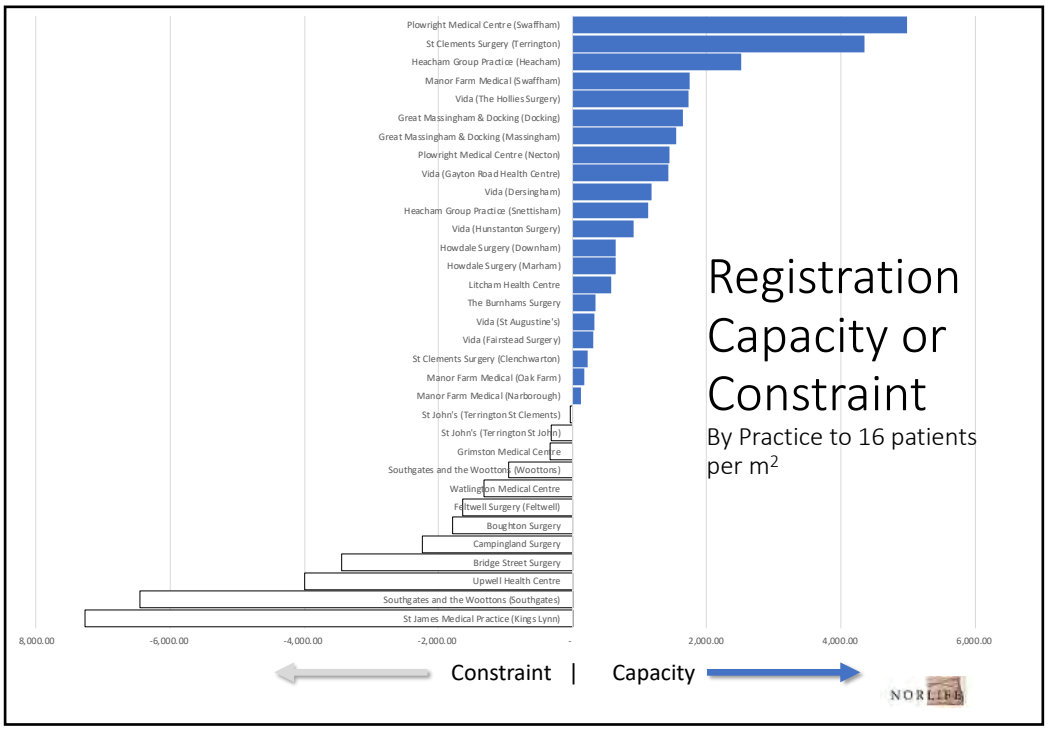
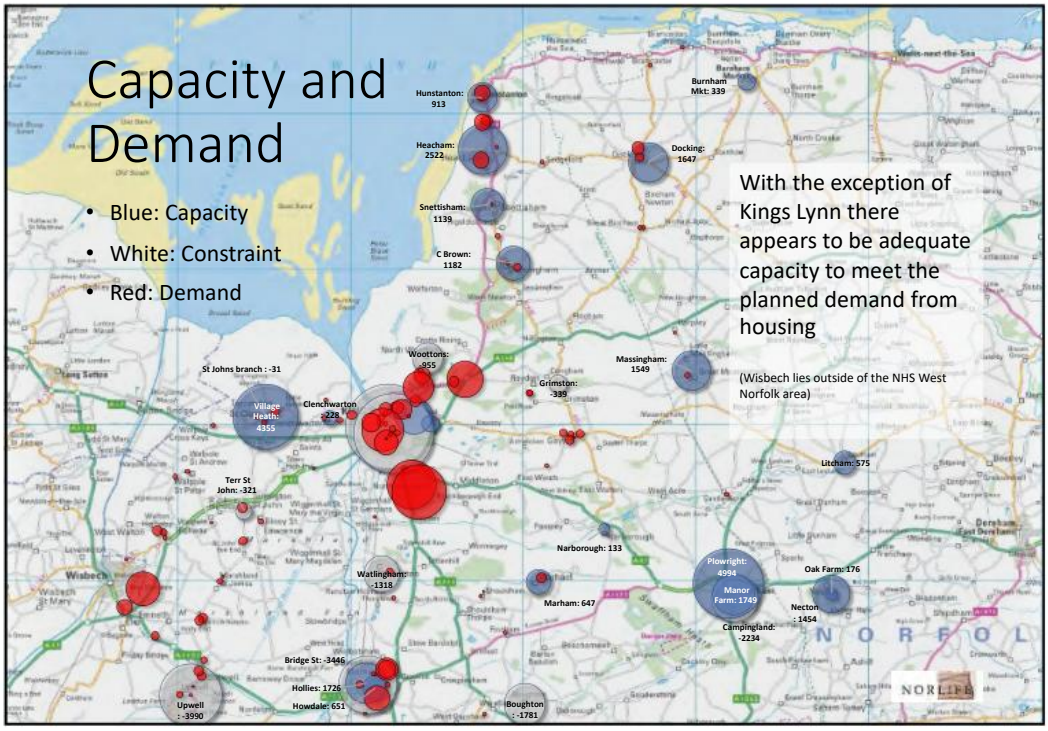

Registration Demand from New Housing
Kings Lynn
The numbers indicate the potential levels of registration demand from each development.
The threshold for a full time GP and associated support team is around 1,750 registrations.
In turn they may require up to 200 m² of additional space to work from. Less if expanding an existing facility
KING'S LYNN
33
319
990
1320
114
132
180
427
209
22
88
35
44
62
374
37
26
1872
53
40
24
15
609
37
2420
3080
NORLIFE

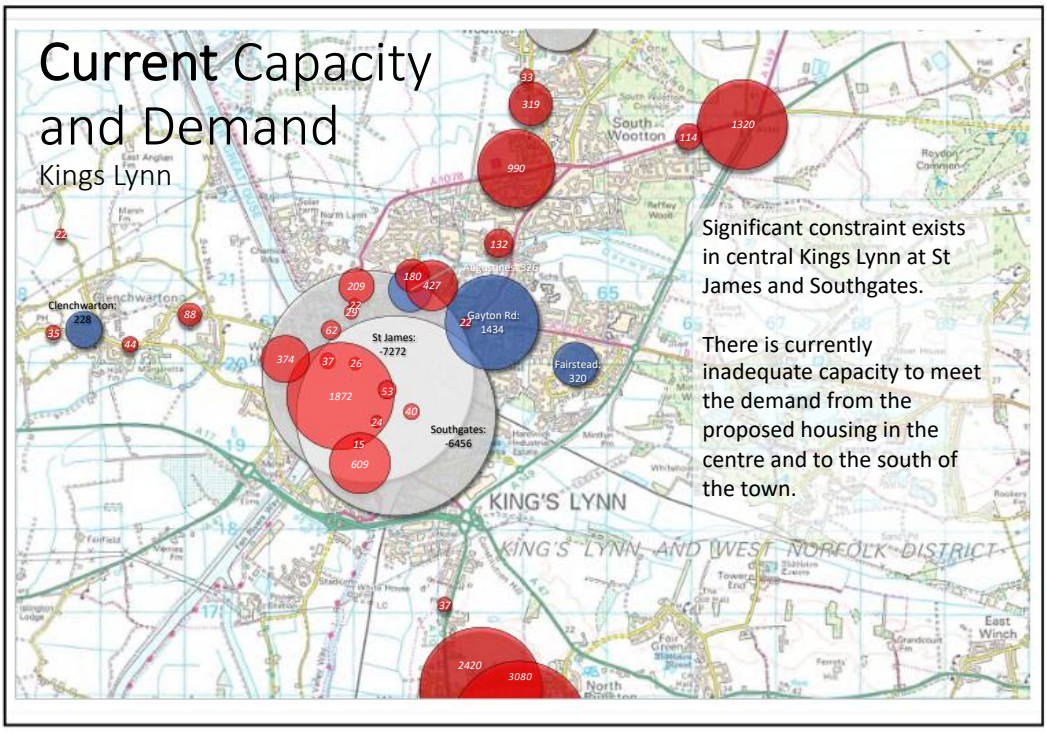
9


Plowright Medical Centre (Swaffham)
St Clements Surgery (Terrington)
Heacham Group Practice (Heacham)
Manor Farm Medical (Swaffham)
Vida (The Hollies Surgery)
Great Massingham & Docking (Docking)
Great Massingham & Docking (Massingham)
Plowright Medical Centre (Necton)
Vida (Gayton Road Health Centre)
Vida (Dersingham)
Heacham Group Practice (Snettisham)
Vida (Hunstanton Surgery)
Howdale Surgery (Downham)
Howdale Surgery (Marham)
Litcham Health Centre
The Burnhams Surgery
Vida (St Augustine's)
Vida (Fairstead Surgery)
St Clements Surgery (Clenchwarton)
Manor Farm Medical (Oak Farm)
Manor Farm Medical (Narborough)
St John's (Terrington St Clements)
St John's (Terrington St John)
Grimston Medical Centre
Southgates and the Woottons (Woottons)
Watlington Medical Centre
Feltwell Surgery (Feltwell)
Boughton Surgery
Campingland Surgery
Bridge Street Surgery
Upwell Health Centre
Southgates and the Woottons (Southgates)
St James Medical Practice (Kings Lynn)
8,000.00
-6,000.00
-4,000.00
-2,000.00
-
2,000.00
4,000.00
6,000.00
Registration Capacity or Constraint
By Practice to 16 patients per m²
Constraint | Capacity
NORLIFE

10


Capacity and Demand
• Blue: Capacity
• White: Constraint
• Red: Demand
With the exception of Kings Lynn there appears to be adequate capacity to meet the planned demand from housing
(Wisbech lies outside of the NHS West Norfolk area)
Hunstanton: 913
Heacham: 2522
Snettisham: 1139
C Brown: 1182
Burnham Mkt: 339
Docking: 1647
Massingham: 1549
Grimston: -339
Woottons: -955
St Johns branch : -31
Village Heath: 4355
Clenchwarton: -228
Terr St John: -321
Litcham: 575
Narborough: 133
Watlingham: -1318
Marham: 647
Plowright: 4994
Manor Farm: 1749
Oak Farm: 176
Necton: -1454
Campingland: -2234
Bridge St: -3446
Hollies: 1726
Howdale: 651
Upwell: -3990
Boughton: -1781
NORFOL

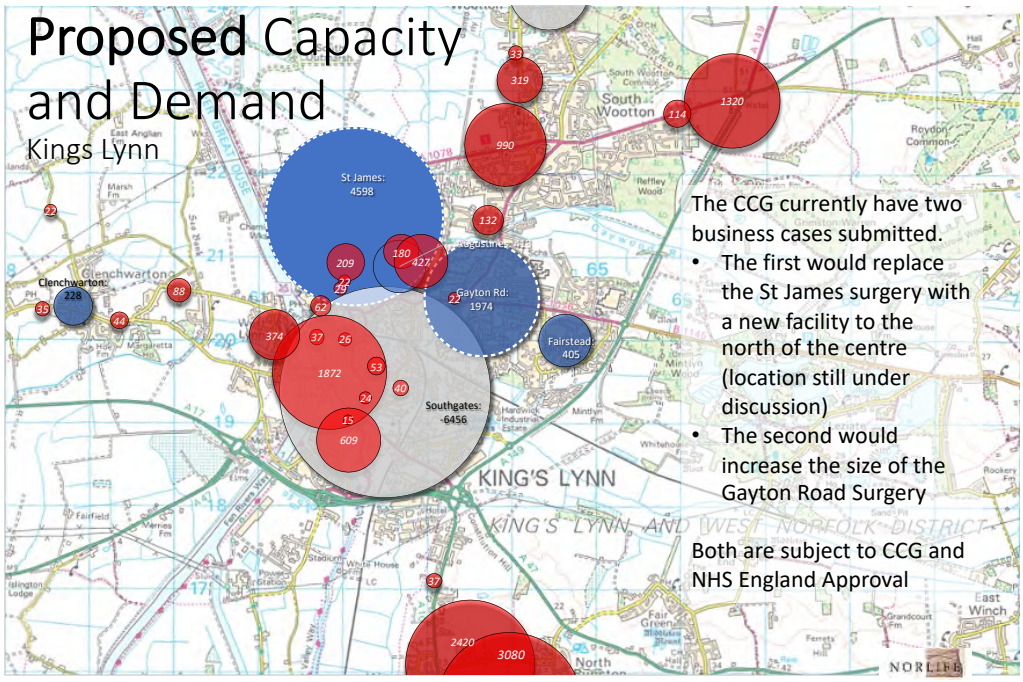
11


Current Capacity and Demand
Kings Lynn
Significant constraint exists in central Kings Lynn at St James and Southgates.
There is currently inadequate capacity to meet the demand from the proposed housing in the centre and to the south of the town.
South Wootton
Clenchwarton: 228
St James: -7272
Gayton Rd: 1434
Fairstead: 320
Southgates: -6456
KING'S LYNN
KING'S LYNN AND WEST NORFOLK DISTRICT
East Winch
North

12

Proposed Capacity and Demand

Kings Lynn



The CCG currently have two business cases submitted.

- The first would replace the St James surgery with a new facility to the north of the centre (location still under discussion)
- The second would increase the size of the Gayton Road Surgery

Both are subject to CCG and NHS England Approval

13

Conclusions

- The average level of utilisation in West Norfolk is just under the NHS England target of 16 for new facilities at 15.58 patients per m^2.
- Whilst it is significantly lower than other areas (Bedfordshire 23.36, Luton 22.38, Milton Keynes 20.01). There are very constrained practices in central Kings Lynn.
- Proposed investments at St James and Gayton Road could alleviate capacity shortfalls to the north of Kings Lynn
- Significant unmet demand will continue to exist in the central area and to the south of Kings Lynn This will be exacerbated by constraint at the Southgates practice (even if the St James Project goes ahead)
- We understand no developer contributions are associated with the major sites at West Winch and North Runcton. Further discussions with the local planning authority may identify other opportunities to address the expected shortfall.

NORLIB

14

Norfolk Health Overview and Scrutiny Committee

ACTION REQUIRED

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

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

Proposed Forward Work Programme 2020-21

Meeting dates	*Main agenda items*	*Administrative business*
4 Feb 2021	Vulnerable adults primary care service Norwich (replacing City Reach) – progress report Children's neurodevelopmental disorders (i.e. autism and other conditions) – waiting times for diagnosis Prison healthcare - examination of prisoners' access to physical & mental healthcare services	
18 Mar 2021	The Queen Elizabeth Hospital NHS Foundation Trust – progress report Local actions to address health and care workforce shortages – progress update since July 2019	

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

NOTE: Norfolk County Council election will be held on 6 May 2021

Provisional dates for later reports to the Committee 2021 (main agenda items) (dates post May 2021 dependent on the programme of meetings agreed at Norfolk County Council AGM)

First NHOSC date after the NCC AGM - Ambulance Service (follow-up to NHOSC 8/10/20)

i. An update on what has been done to address the CQC concerns about EEAST (i.e. in the September 2020 CQC report, including safeguarding of patients and staff). To include an explanation of the concerns in relation to Norfolk and Waveney, why the concerns persisted for so long, what

EEAST has learned from the situation and its changes to policies and practices.

ii. A progress report on the measures being put in place to improve the emergency response to patients with mental health requirements, including data on the effect of those measures and an explanation of why the past concerns about the service for patients with mental health emergencies have persisted for so long and what has been learned.

Around July 2021 - Cancer Services (follow-up to NHOSC 8/10/20)

i. The impact of Covid 19 on backlogs and waiting times within screening, diagnosis and treatment services
ii. The impact on cancer patient outcomes in Norfolk and Waveney
iii. Measures to encourage people to come forward for screening, particularly those who are vulnerable and need support
iv. Effectiveness of the measures to encourage people to come forward for screening.

Provisional dates for items in the NHOSC Briefing 2020-21

February 2021 - *Depending on publication of new NICE Guidance, which was expected in December 2020 but is likely to be later (consultation on draft guidance closes on 22 Dec)*

ME / CFS service – steps taken by the CCG and service provider to comply with new NICE Guidance

March 2021 - Update on progress with delivery of annual physical health checks for people with learning disabilities (age 14 and over)

Summer 2021 - Merger of Norfolk and Waveney CCGs – progress briefing

- How the new CCG has maintained local focus one year on from merger
- Extent to which various healthcare statistics etc are still available on a district or locality basis to enable understanding of local issues.

Around October 2021 - Annual update on childhood immunisation take-up rates (follow-up from NHOSC 8/10/20 meeting)

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

Norfolk and Waveney CCG	-	Chairman of NHOSC – Penny Carpenter (substitute Vice Chairman of NHOSC – Dr Nigel Legg)
Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust	-	Sheila Young (substitute Michael Chenery of Horsbrugh)
Norfolk and Suffolk NHS Foundation Trust (mental health trust)	-	David Harrison (substitute Michael Chenery of Horsbrugh)
Norfolk and Norwich University Hospitals NHS Foundation Trust	-	Dr Nigel Legg (substitute David Harrison)
James Paget University Hospitals NHS Foundation Trust	-	Emma Flaxman-Taylor
Norfolk Community Health and Care NHS Trust	-	Emma Spagnola

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

Glossary of Terms and Abbreviations

AGM	Annual general meeting
AIS	Accessible Information Standard
BSL	British Sign Language - BSL is a visual-gestural language that is the first or preferred language of many d/Deaf people and some deafblind people; it has its own grammar and principles, which differ from English.
CC	County Council
CCG	Clinical Commissioning Group
CYP	Children and young people
CYPF	Children, young people and families
DC	District Council
DDA	Disability Discrimination Act 1995
d/Deaf	A person who identifies as being deaf with a lowercase d is indicating that they have a significant hearing impairment. Many deaf people have lost their hearing later in life and as such may be able to speak and / or read English to the same extent as a hearing person. A person who identifies as being Deaf with an uppercase D is indicating that they are culturally Deaf and belong to the Deaf community. Most Deaf people are sign language users who have been deaf all of their lives. For most Deaf people, English is a second language and as such they may have a limited ability to read, write or speak English
Deafblind	The Policy guidance Care and Support for Deafblind Children and Adults (Department of Health, 2014) states that, “The generally accepted definition of Deafblindness is that persons are regarded as Deafblind “if their combined sight and hearing impairment causes difficulties with communication, access to information and mobility. This includes people with a progressive sight and hearing loss” (Think Dual Sensory, Department of Health, 1995)."
DHSC	Department of Health and Social Care
DWP	Department for Work and Pensions
EBW	Edward Benefer Way, King’s Lynn
ED	Emergency Department
EEAST	East of England Ambulance Service NHS Trust
EIA	Equality Impact Assessment
ETTF	Estates Technology and Transformation Fund
FBC	Full business case
Field of vision	How much you can see from the side of your eye while looking straight ahead.

HWN	Healthwatch Norfolk
IAPT	Improving Access To Psychological Therapies
INTRAN	A non-profit-making partnership that commissions and manages interpreting and translation services on behalf of public-facing organisations throughout the East of England.
ME/CFS	Myalgic encephalomyelitis / chronic fatigue syndrome
MHFA	Mental health first aid
NCAN	Norfolk Community Advice Network
NCC	Norfolk County Council
NHOSC	Norfolk Health Overview and Scrutiny Committee
NHSE&I EoE	NHS England and NHS Improvement, East of England. One of the regional teams that support the commissioning services and directly commission some primary care services and specialised services in England. Formerly two separate organisations, NHS E and NHS I merged in April 2019 with the NHS England Chief Executive taking the helm for both organisations. NHS Improvement, which itself was created in 2015 by the merger of two former organisations, Monitor and the Trust Development Authority, was formerly the regulator of NHS Foundation Trust, other NHS Trusts and independent providers that provided NHS funded care.
NICE	National Institute of Health and Care Excellence
NNUH	Norfolk and Norwich University Hospitals NHS Foundation Trust
NORLIFE	A company that delivers its services through companies that are joint ventures with public sector partners (it has both NHS and Local Government partners) and focusses on delivering joined up services to the public.
NSFT	Norfolk and Suffolk NHS Foundation Trust (the mental health trust)
OBC	Outline Business Case
ONS	Office of National Statistics
OSC	Overview and Scrutiny Committee
PA	Personal Assistant
PCN	Primary Care Network
PCP	Primary Care Partnership – a primary care consultancy company based in York
PPA	Prevention and positive activities
PPG	Patient Participation Group
RNIB	Royal National Institute of Blind People
RTSSS	Real time suicide surveillance system
RUSH	Rapid Response Pathway United to Reduce Self-Harm

SEN	Special educational needs
SPIG	Suicide Prevention Implementation Group
STP	Sustainability Transformation Partnership (known as Health and Care Partnership for Norfolk and Waveney)
SJMP	St James' Medical Practice, King's Lynn
VCSE	Voluntary, community and social enterprise
Visual acuity	Ability to see detail at a distance