Norfolk County Council

Norfolk Health Overview and Scrutiny Committee

Date: **Thursday 8 October 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 8 October 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/2zdKRCQ81Bc

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 5 October 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

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

A g e n d a

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

2. Minutes

To confirm the minutes of the meeting of the Norfolk Health Overview and Scrutiny Committee held on 3 September 2020. (Page **6**)

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

Tom McCabe
Head of Paid Service

County Hall
Martineau Lane
Norwich
NR1 2DH

Date Agenda Published: 30 September 2020

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

Norfolk County Council

NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE
Minutes of the meeting held on Microsoft Teams (virtual meeting)
at 10am on 3 September 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 David Harrison	Norfolk County Council
Cllr Brenda Jones	Norfolk County Council
Cllr Chris Jones	Norfolk County Council
Cllr Alexandra Kemp	Borough Council of King's Lynn and West Norfolk
Cllr Robert Kybird	Breckland District Council
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 Alison Thomas	Norfolk County Council
Cllr Sheila Young	Norfolk County Council

Co-opted Members Present

Cllr Judy Cloke	Suffolk Health Scrutiny Committee
Cllr Stephen Burroughes	Suffolk Health Scrutiny Committee

Also Present:

Hollie Adams	Committee Officer, Norfolk County Council
David Barter	Head of Commissioning, NHS England and NHS Improvement, East of England
Dr Caroline Barry	Consultant in Palliative Care, Norfolk and Norwich University Hospitals NHS Foundation Trust and ReSPECT Lead
Jenny Beesley,	Chairman of East Coast Hospice
Dr Daniel Dalton	Medical Director, Norfolk and Suffolk NHS Foundation Trust (NSFT)
Pam Fenner	Clinical Lead Palliative and End of Life Care Programme
Rebecca Hulme	Associate Director - Children, Young People and Maternity, Norfolk and Waveney Clinical Commissioning Group (CCG)
Dr Ian Hume	Macmillan GP
Dr Sarah Maxwell	Clinical Director, Norfolk Children's and Young Peoples Services, NSFT
Tom Norfolk	General Dental Practitioner, Chair of East Anglia Local Dental Network and Lead Dental Practice Adviser of NHS England and NHS Improvement, East of England
Maureen Orr	Democratic Support and Scrutiny Team Manager, Norfolk County Council
Mark Payne	Senior Programme Manager for Mental Health
Gita Prasad	Head of Acute Transformation and Clinical Programmes, Norfolk and Waveney CCG
Dr Ardyn Ross	GP and Clinical Mental Health Lead, Norfolk and Waveney CCG
Dr Jeanine Smirl	Clinical Director of Norwich Primary Care Network & GP with special interest in palliative care
Nick Stolls	Secretary of Norfolk Local Dental Committee
John Webster	Director of Strategic Commissioning, Norfolk and Waveney CCG
Joanna Yellon	Associate Director of Mental Health, Norfolk and Waveney CCG

1 Apologies for Absence

Apologies were received from Cllr Eagle (Cllr Alison Thomas substituting), Cllr Emma Flaxman-Taylor and Cllr Keith Robinson (Cllr Stephen Burroughes substituting).

2. Minutes

2.1 The minutes of the meeting held on 30 July 2020 were agreed as an accurate record.

3. Declarations of Interest

3.1 The following interests were declared:

- Cllr Michael Chenery of Horsbrugh declared a non-pecuniary interest as a Member of the new dental surgery at Marham
- The Chairman declared a non-pecuniary interest as Vice-Chairman of the James Paget Hospital cancer survivors' group, and as having a personal knowledge of registered speaker Jenny Beesley
- Cllr Emma Spagnola declared a non-pecuniary interest as she had a child who was waiting for Point One children's mental health support, and as a carer
- 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 had no announcements.

6. Norfolk and Suffolk NHS Foundation Trust

6.1 The Committee received a report which was a follow up to previous scrutiny of Norfolk and Suffolk NHS Foundation Trust (NSFT) providing local NHS commissioners' responses to Care Quality Commission's (CQC) reports and examination of NSFT's current service in light of Covid-19 requirements.

6.2 The following points were discussed and noted

- The Thrive model for children's mental health was discussed; due to delays caused by the Covid-19 pandemic, arrangements around the contract had been extended. Despite this, work to achieve some aims of the model had been achieved, such as joint working, holding resources in one place, setting up advice lines and putting joint triage, assessments and outcome frameworks in place.
- As more services had moved online during the pandemic, NSFT were asked how the needs of people who did not have access to the internet or a telephone had been taken into account. The Medical Director, NSFT, replied that digital services had allowed 7500 people, instead of the usual 6500, to be seen per week. One in three contacts were face to face to accommodate those who required this type of service. Suffolk had supplied iPads to people in learning disability services to help them access online services; NSFT were looking at how to develop this in Norfolk
- The Medical Director, NSFT, confirmed that there were now around 200-300 bed

days of inappropriate out of area placements. At the peak of inappropriate out of area placements70-90 people were inappropriately placed in out of area beds. NSFT were committed to preventing people going out of area inappropriately but it was recognised that some people may need to do so for specialist treatment not available locally. A rehabilitation strategy was being developed so people needing acute rehabilitation could be cared for locally and new approaches to treatment such as the personality disorder pathway had reduced the need for people to be sent out of area for specialist treatment.

- The wait time for assessment was queried; NSFT representatives explained that the wait time for assessment for young people varied in different parts of the County due to differences in capacity and demand. Benchmarking had shown that NSFT received three times as many referrals to its children's and young people's services as other areas. The NSFT planned to work with other organisations to provide additional avenues of support. The adult ADHD service had a long waiting list as demand was higher than capacity to meet it at that time.
- The Chairman asked what support was available to young people on the waiting list; NSFT representatives gave information on measures in place such as tracking of young people on the waiting list, face to face review meetings and the Kooth online service which was publicised to all young people on the waiting list. Other interventions were being looked into.
- A 24h crisis line had been set up, also available for those who were not already receiving NSFT support, providing immediate access to services
- Work would be carried out to reduce waiting lists and provide support to people before referral; it was recognised that there were often missed opportunities to support people at an earlier stage
- The Medical Director, NSFT, responded to a query for information on the long-term staffing plan for the NSFT; total staffing levels would increase by a third including an increased psychology and psychotherapy workforce, an enhanced peer support network and increased resource outside of the NSFT. Funding bids had been successful for 4 mental health support teams and 17 trainee posts made up of 6 children's wellbeing practitioners and 11 practitioners under other modalities
- The NSFT had worked with education settings to put in resources for when young people returned to schools, such as information on the NSFT website and contact details for first response advice lines and Kooth.
- The Associate Director, Children, Young People and Maternity, Norfolk & Waveney CCG agreed to provide Cllr Alison Thomas with further information regarding funding of Health Passports.
- It was pointed out that not all people in Norfolk had access to technology or had good internet signal; the Medical Director, NSFT, assured the Committee that all people on the NSFT case list had been contacted to ask if they were able to access digital consultations or if they required face to face care. Older people's wellbeing services had been carrying out face to face services and webinars to provide immediate support.
- The NSFT was working towards a combined digital platform so everyone could see what support was available to them. It was important to ensure that a range of choice was available but also that Norfolk's infrastructure was developed so online services were more accessible to all.
- NSFT representatives were asked what progress they had made since the last CQC visit. The Medical Director, NSFT, felt that the response of NSFT staff to the Covid-19 pandemic had been extraordinary. He reported that the CQC had reported positively when carrying out assurance visits and had given feedback on areas for improvement. He recognised that issues related to children's services would take time to reform but felt that leadership had improved since the last inspection
- The NSFT were queried about the mistaken discharge of around 300 young people.

The Clinical Director, Norfolk Children's and Young Peoples Services, NSFT, reported that at the beginning of the pandemic, a 50% reduction in staffing due to illness and shielding was expected. As part of planning for this, young people were written to offering them a different service and giving a timescale in which to ring in or be discharged. This resulted in around 300 young people being discharged. This decision was later reversed.

- It was noted that restrictive interventions had increased during the pandemic and staff training was queried. The Medical Director, NSFT, was keen to drive down interventions but recognised that there had been an increase at the start of the Covid-19 pandemic. He thought this could be related to fewer people in hospital but those patients requiring a higher level of intervention
- Training in positive behaviour support and de-escalation was important and would continue to be offered to staff and it was believed that NSFT staff of all levels received this training. The Chairman **requested** a briefing for Committee members on NSFT staff training around use of restraints and how staff managed interventions, and on the impact of Covid-19 on young people and support available in schools.
- NSFT representatives reported that there were mental health champions in schools across the county and a mental health link worker for all schools.
- The NSFT planned to review services brought in during the pandemic to identify which to take forward and which to discontinue.

6.3 The Norfolk Health Overview and Scrutiny Committee **ASKED** NSFT and Norfolk and Waveney CCG to provide an update via the NHOSC Briefing including:

- The extent to which different categories of staff (e.g. registered / non registered) are equally trained in the techniques needed to avoid physical restraint or seclusion of patients (e.g. de-escalation training / positive behaviour support)
- The extent to which mental health support for schools provides the necessary capacity to support pupils needs on the return to school after the Covid 19 home-schooling period.
- Accessibility of mental health services in the new Covid 19 environment; particularly access for those who cannot use communication technology.
- The situation regarding waiting lists for assessment and for treatment; including the effects of expansion of support in community and primary care on the numbers being added to waiting lists.
- Date of next CQC inspection.

7. Access to NHS Dentistry

7.1 The Committee received the report providing information on progress regarding access to NHS dentistry across Norfolk & Waveney following NHOSC's last examination of this subject in April 2019.

7.2 The following points were discussed and noted

- The chairman thanked Healthwatch and Family Voice for information they provided for inclusion in the report
- A Member asked about dentist capacity in West Norfolk and how many practices were accepting new patients; the General Dental Practitioner, Chair of East Anglia Local Dental Network and Lead Dental Practice Adviser of NHS England and NHS Improvement, East of England, acknowledged that there had been recruitment and retention issues in West Norfolk. A new dentist surgery had recently been set up in Marham and increasing practices in Kings Lynn was being looked at as well as inequalities of access, access for patients with urgent problems, and dental therapists to provide some NHS services.

- The updated figures on number of NHS dentists per 100,000 of population in Norfolk and Waveney were still being awaited
- Funding had been received to start up more specialist dentistry services in Norfolk, and staff for this had been recruited.
- Dentistry sector representatives confirmed that it was the responsibility of NHS England and NHS Improvement to commission NHS and secondary care dentistry in Norfolk. NHS dental services had been paused from 25 March 2020 to 8 June 2020 due to the pandemic and since reopening, the way services were delivered had needed to change due to the need for PPE, social distancing and to allow surgeries to lay empty for 1 hour between patients, reducing patient throughput at all surgeries. Due these measures, dentists could see 5-7 patients per day, a reduction from the usual 30-40.
- It was clarified that NHS surgeries did not have a registered list and patients could attend any NHS surgery to receive treatment.
- A Member queried why Healthwatch had only been able to find one practice providing NHS treatment; the Head of Commissioning, NHS England and NHS Improvement, East of England, thought this may be because not all practices were providing all services at that time due to the constraints caused by the pandemic
- From the first wave of the pandemic, dentistry sector representatives shared that they had learned the importance of all areas working together; this had allowed them to set up urgent dental care centres and to triage to ensure all patients were responded to quickly or referred to the urgent care centres. Urgent care centres were still in pace in case of a second wave.
- Information in the report which highlighted that a third of parent carers waited over a year for specialist children's dental treatment was highlighted. Dentistry sector representatives replied that special care dentistry had now started up but faced social distancing restrictions, with patients triaged to prioritise those with the most acute needs. Special needs patients were ensured access to urgent care dentistry throughout the pandemic.
- Representatives were asked when the next full oral needs health assessment would be carried out. It was clarified that NHSE looked at the dental health needs of local populations on an ongoing basis and worked with the Local Dental Council and providers to commission services
- The lack of dentists taking on new NHS patients in Norfolk was discussed as a concern by the Committee.
- It was confirmed that if dentist providers handed back their contract to provide NHS services, it would be re-contracted with another dentist in the area. If this happened several times in one area, then new services would be commissioned
- The General Dental Practitioner, Chair of East Anglia Local Dental Network and Lead Dental Practice Adviser of NHS England and NHS Improvement, East of England, clarified that dental implants were excluded from primary care dentistry services however dentures and bridges were included
- It was noted that NHS dentistry was the only sector without an uplift of funding for the past 10 years
- NHSE was working with commissioners on the contract to develop something more fit for purpose.
- A concern was raised that there was not consistency of treatment across practices at the current time; dentistry sector representatives explained that consistency was difficult at that time due to practice-based restrictions caused by Covid-19. The urgent dental centres across Norfolk could accept referrals from all practices in Norfolk and many were open 7 days a week
- Dentistry sector representatives confirmed that the special care dental service were providing dentistry for care home residents; local dentists could refer patients to this service. In West Norfolk this was provided out of King's Lynn

- The Chairman noted the Committee's frustration at the lack of dentists to treat NHS patients, issues related to waiting times for children with special educational needs, and that some sections of the community were finding access to services difficult

7.3 The Norfolk Health Overview and Scrutiny Committee:

- **AGREED** to write to the Department of Health and Social Care regarding the national issues that appear to have hindered progress in providing sufficient NHS dentistry capacity in Norfolk and Waveney (e.g. the national dental contract). Draft letter to be circulated to committee members for comment before dispatch.
- **ASKED** NHS England & NHS Improvement to provide information on:
  - The number of dentists per 100,000 population (when available)
  - The current situation with regard to recruitment and retention of dentists in Norfolk and Waveney

The committee took a break from 12:08 until 12:15

8. Access to palliative and end of life care

8.1.1 The Committee received the report examining progress made by NHS commissioner and provider partners to improve palliative and end of life care services for adults in Norfolk and to respond to the effects of Covid 19.

8.1.2 The Chairman mentioned that points on this subject had been received from member of the public, Dr Patrick Thompson, and circulated to Members of the Committee and NHS representatives; Members could raise points made by Dr Thompson if they wished.

8.2.1 The Committee heard from registered speaker Jenny Beesley, Chairman of East Coast Hospice:

- Mrs Beesley raised three points about the report around choice, 24/7 outreach and what more the Collaboration Group could do to speed up provision of additional beds
- Mrs Beesley noted that when she visited Beccles hospital, she was told that the palliative care consultant worked 9-5 and nurses could phone Ipswich hospital or a local GP for advice. She did not believe that this was meeting the aim of providing specialist palliative care and asked what the NHS would do to fulfil their contract in this regard
- Mrs Beesley felt that the Collaboration Group could work better in partnership with hospices and organisations. East Cost Hospice had been told they did not meet criteria for funding despite the CCG setting the criteria and Mrs Beesley believed there were many other hospices that would struggle due to loss of funding. East Coast Hospice were willing to work in partnership with other hospices to save money
- She believed that NHS Great Yarmouth and Waveney Collaboration Group should look at having 24/7 specialist palliative care doctor leads

8.2.2 The Head of Acute Transformation and Clinical Programmes, Norfolk and Waveney CCG, replied to Mrs Beesley's statement by explaining that in Great Yarmouth and Waveney, specialist support and advice was available 24/7 through beds in Beccles Hospital, home visits and by specialist consultants; the model had been commissioned by the CCG to be a 24/7 service so she **agreed** to find out what hours the consultants were available at Beccles Hospital were and send this information to Mrs Beesley

8.3 The following points were discussed and noted

- The Clinical Director of Norwich Primary Care Network & GP with special interest in palliative care, reported on the shift in use of hospice and end of life care; due to the

increased training in end of life symptom control, highly skilled nurses and professionals were in place to help manage these symptoms. There was a deficit in hospice beds at that time but there were beds available elsewhere such as hospice at home and hospice-like beds in care homes

- The proportion of people dying in hospices or at home was queried; the Clinical Director of Norwich Primary Care Network & GP with special interest in palliative care, reported that there had been an increase in people dying at home through choice. This had increased further during the pandemic as people wanted to have their relatives around them
- The capacity in the community and hospice at home team to cope with this increase was queried. As the hospice at home team were triaged through the Norfolk Escalation Avoidance Team, community nurses could also be called on if needed
- Palliative care sector representatives confirmed that East Coast Hospice colleagues were engaging with the Collaborative Group. Officers were looking at all localities to see what models of support people in the communities wanted and to see how to support the professional workforce. It was noted as important to listen to the needs of patients and their preferred routes of care
- Extra beds were provided at Tapping House during the pandemic and the Norfolk Escalation Avoidance Team worked with the virtual team to provide more capacity to support discharges.
- A Member asked if ministers of religions were able to access people as part of their end of life care; the Consultant in Palliative Care, Norfolk and Norwich University Hospitals NHS Foundation Trust and ReSPECT Lead, reported that at the Norfolk and Norwich University Hospital, the chaplaincy provided multi-faith laminated prayers to all wards and all patients' spiritual needs were assessed
- Provision of syringe drivers was queried; at the beginning of the pandemic it was anticipated that there would be difficulty obtaining them but due to investment over a year ago a shortage was not experienced
- Palliative care sector representatives confirmed that clearer information in the discharge summary helped by the ReSPECT process, and work ongoing to improve conversations around death helped improved patient care outside of acute settings.
- Specialist palliative care for people with motor neurone disease had been put in place, and specialist care for other non-malignant conditions was being looked into
- Palliative care sector representatives were asked about recruitment; Norfolk Community Health and Care had recruited a new palliative care consultant, the Big C were providing knowledge and support to the workforce and end of life care facilitators had been recruited in the central area to work with care homes and other providers. There were work force issues and therefore services were working together across areas to support skill mix and capacity.
- The shortage of consultants was a national issue, and this was being mitigated locally by having GPs with special interests and other professionals providing support such as clinical pharmacists supporting with end of life and symptom control and social prescribers helping with non-medical needs. The Compassionate Community approach was being piloted in Halesworth. If successful this model would be rolled out more widely throughout Norfolk
- Electronic sharing of documents related to end of life care was queried; the Head of Acute Transformation and Clinical Programmes, Norfolk and Waveney CCG acknowledged that Embedding Palliative Approaches to Care (EPAC) was not as good as in other areas and a digital version of the ReSPECT system needed to be put in place. The importance of using the same template across organisations for gathering information was noted
- Cllr Laura McCartney-Gray left the meeting at 1pm
- The Chairman noted the deficit of number of specialist palliative inpatient beds in Norfolk; the Head of Acute Transformation and Clinical Programmes, Norfolk and

Waveney CCG explained that the model had changed to look at the model of care rather than just provision of beds. She agreed to check the number of beds and circulate to the Committee

- Awareness of the ReSPECT document was being rolled out in general practice and the ambulance trust. Work was ongoing around having open conversations around death and there was an ambition to have connected care records
- The Clinical Director of Norwich Primary Care Network & GP with special interest in palliative care **agreed** to forward detailed data to the Committee on the numbers of people who died at home and in other settings.

8.4 The Norfolk Health Overview and Scrutiny Committee **ASKED** Palliative & End of Life Care Collaborative representatives to provide information on:

- The hours of Consultant cover provided for the specialist palliative care beds (& other beds) in Beccles, both in person and by telephone.
- Data on the numbers of specialist palliative care beds that are now considered necessary to meet the needs of the population of N&W, in light of the developing model of care for end of life (i.e. updating the figures supplied in the Norfolk and Waveney STP Palliative and End of Life Care Strategy for Adults 2019 – 2024).
- The numbers of additional specialist palliative care beds that have been provided across Norfolk and Waveney
- Numbers of people who die in various settings across Norfolk and Waveney (i.e. at home, in hospital, in hospice, and other settings)

9. Forward work programme

9.1 The Committee received and discussed the forward work programme which had been updated in line with the discussion held at the last Committee meeting.

9.2 The CCG had been in touch regarding a proposed change to GP out of hours services which would affect Norfolk and Waveney and it was therefore proposed that the Norfolk and Waveney Joint Health Scrutiny Committee was established to receive the consultation, on the afternoon of 8 October 2020, following on from the NHOSC meeting in the morning, after a lunch break. The Chairman asked Members to confirm with Maureen Orr if they were available for this afternoon meeting.

9.3 The Norfolk Health and Overview Scrutiny Committee **AGREED** the forward work programme with the following additional information included:

- **NHOSC Briefing** - Information to be sought from Norfolk and Waveney CCG on whether there have been changes to the commissioned ERS hospital transport service and information on how car transport services are operating at present.
- **NHOSC agenda 8 October** - Childhood Immunisations item to include examination of record keeping into adulthood.

Also noted

- **Norfolk and Waveney Joint Health Scrutiny Committee** will meet on the afternoon of 8 October 2020 to receive consultation from N&W CCG on change to GP out of hours services.

The meeting ended at 13:08

Chairman

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

Norfolk Health Overview and Scrutiny Committee
8 October 2020
Item no 6

Cancer services

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

Examination of the situation regarding provision of cancer services in Norfolk and Waveney in light of Covid 19, including cancer screening, diagnostic and treatment services.

1.0 Purpose of today's meeting

1.1 The focus of the meeting is:-

- To examine how the local NHS is managing cancer diagnosis and treatment services in a Covid-safe manner.

- To examine how cancer screening services commissioned by NHS England and NHS Improvement (NHSE&I) are being restored in a Covid-safe manner.

1.2 The Norfolk and Waveney Clinical Commissioning Group (CCG) have been asked to provide a report on the situation with cancer diagnosis and treatment services across their area, which is attached at **Appendix A**. CCG representatives will attend to answer Members' questions.

NHS England and NHS Improvement (NHSE&I) have been asked to report on the situation with cancer screening services, including breast, cervical and bowel cancer screening. NHSE&I's report is attached at **Appendix B**. It consists of:-

(a) A briefing that was first provided for NHOSC Members in the NHOSC Briefing in February 2020 covering data from the cancer screening services for the years 2010/11 to 2018/19 and:
(b) An **addendum** with information on what has happened in screening services during the Covid 19 outbreak and other specific issues about the services raised in advance of today's meeting.

Representatives of NHSE&I will attend to answer Members' questions.

2.0 Background information previously received by NHOSC

2.1 Cancer diagnosis and treatment in Norfolk & Waveney

2.1.1 NHOSC Members received information on cancer diagnosis and survival rates from the Norfolk and Waveney STP[1] Cancer Programme Manager in the March 2020 NHOSC Briefing, which is attached at **Appendix C** for reference. It showed the percentage of cancers diagnosed early, i.e. at stage 1 or 2, on average (for those cancers for which stages are defined) in each of the five former CCG areas in Norfolk and Waveney for the years 2012 – 2017. It also provided cancer survival rates at one year post diagnosis for breast, colorectal and lung cancer for each of the former CCG areas in the years 2002 – 2017.

Points to note from the data included:-

- As in the rest of England, the average one-year survival rate across all cancers in Norfolk and Waveney had steadily improved since 2012.
- In 2016 Norfolk and Waveney fell slightly below the English average for one-year survival across all cancers
- In 2017 (latest available info) significantly fewer patients were diagnosed with cancer at stage 1 or 2 in Great Yarmouth and Waveney compared to the Norfolk and Waveney STP and English averages.
- One-year survival rates for breast and colorectal cancer in Norfolk and Waveney are below the English average; the survival rate for lung cancer is above the average.

2.1.2 In an earlier NHOSC Briefing, in February 2015, Members were advised that although Norfolk's one-year survival rates were close to the national average, England as a whole lagged behind the rest of Europe, so there was clearly room for improvement. Improving early diagnosis of cancer was seen as essential to improving people's chances of survival.
I
More information on survival rates for the various kinds of cancer is available on the Cancer Research UK website:-
http://www.cancerresearchuk.org/cancer-info/cancerstats/survival/

2.2 **Cancer screening in Norfolk and Waveney**

2.2.1 Cancer screening services are commissioned by NHSE&I.

NHOSC Members received information from NHSE&I on breast, cervical and bowel cancer screening services in the February 2020 NHOSC Briefing. The information is repeated in Appendix B to today's report, provided by NHSE&I.

2.2.2 Points to note from the data provided in February 2020 included:-

Breast screening

- Coverage was declining across England and across Norfolk & Waveney.

[1] STP = Sustainability Transformation Plan; now known as Norfolk and Waveney Health and Care Partnership

- Breast screening coverage in all areas of Norfolk & Waveney was higher than the English average
- Coverage in the Norwich CCG area was the lowest within Norfolk & Waveney had declined relatively sharply over the past 3 years.
- Coverage in the Great Yarmouth and Waveney CCG area fluctuated in 2015-16 and in 2019 because of difficulties in recruiting and retaining key radiological and radiographical staff and in covering staff sick leave at the James Paget Hospital (although currently the key programme standards were met). The Queen Elizabeth Hospital had historically experienced similar difficulties. There was a national shortage of these practitioners.

Cervical screening

- Since 2010 there had been a gradual decline in coverage in Norfolk & Waveney in both the age 25-49 years and 50-64 years brackets. This had reflected a decline across England as a whole.
- There was an upturn in the 25-49 age bracket in 2019 both in England and in Norfolk & Waveney, with a greater upturn in Norfolk & Waveney. This was believed to be a response to national and regional campaigns but one year's data could not be taken as evidence of an improving trend. Norfolk & Waveney also saw a very slight increase in coverage in the 50-64 age bracket in 2019, which was not seen across England as a whole.

Bowel screening

- The Norfolk and Waveney screening programme had one of the highest levels of coverage in the country. All five CCG areas performed better than the English average and all had increased their coverage in the past year.

2.3 **The effects of Covid 19**

2.3.1 On **30 July 2020** representatives from Norfolk & Waveney CCG and various NHS providers attended NHOSC to give an overview report on the effects of the Covid 19 outbreak on local NHS services. The report provided for the meeting by the CCG informed NHOSC of the following:-

Urgent and cancer care

Throughout the pandemic we have strived to maintain urgent care services and cancer care. In part we have done this by working with the independent sector to increase our capacity. As part of the national agreement with independent sector providers, we have been working with Spire Healthcare's Norwich hospital and BMI Sandringham. Each week on average they are providing:

- 25 cancer procedures
- 44 other high priority procedures

- 1,000 outpatient and chemotherapy treatments

Again, in line with other parts of the country, we have seen a reduction in people going to their GP and being referred on to the cancer pathway. There have been reduced numbers of two week wait cancer referrals during the pandemic. The referral numbers are now significantly increasing, but have not achieved pre- pandemic levels yet. This could be due to a number of factors, including patient shielding. We have been proactive in putting out local media messaging to patients to contact their GP if they have worrying symptoms. According to the latest data, cancer referrals have increased for all three of our acute trusts:

- JPUH has increased by 45% since early May
- NNUH has increased by 31% since early May
- QEH has more than doubled since early May

The three national cancer screening programmes for cervical, breast and bowel cancer were significantly affected by the pandemic. These are currently restarting but there will be a backlog of patients to be invited.

Some of the diagnostic tests that patients need to see if they have cancer or not, have been affected by the pandemic. This includes continuation, but severe restrictions on, endoscopy services due to COVID-19 infection risks, as stipulated by guidance from the British Society for Gastroenterology, and this is particular problem area as this procedure is not easily replicated by virtual technologies. A Norfolk and Waveney wide group has been established to co-ordinate efforts to increase capacity and prioritise patients, which includes an exploration of the use of CT (computerised tomography) scans of the bowel and a bid to be a pilot for video capsule endoscopy, where the patient swallows a camera and is able to capture internal images. The exact impact of these alternatives is uncertain at this stage, as patient with a polyp which needs removal will still need a physical endoscopy.

Overall, challenges for providing cancer care and treatments at the moment include reduced capacity due to infection prevention and control measures, staffing issues related to COVID-19 and patient concerns regarding proceeding with cancer tests and/or treatments in the hospital care setting.

In response, we have adapted clinical pathways to reduce risk, in line with national guidance. We have re-sited some services, for example acute oncology onto ‘green sites’ and we have maximised our use of the independent sector to continue as much cancer surgery as possible. We have developed a modelling tool to help us plan the demand and capacity needed for the restoration of cancer care to pre-COVID-19 levels, including diagnostic services.

We are reviewing how we use our cancer transformation funding to enable us to best care for people during the pandemic. We will be

working closely with local Primary Care Networks to support them in their new contract which looks to improve earlier cancer diagnosis rates and cancer screening uptake.

We continue to work closely with specialist commissioning colleagues from the regional NHSE/I team and are linking with the work of the East of England Cancer Workstream.

2.3.2 The CCG & providers slide presentation on 30 July 2020 also informed NHOSC that:-

- Cancer service providers were tracking patients, conducting harm reviews and communicating with patients to optimise capacity.
- At that stage it was very difficult to advise members of the Health Scrutiny Committee of an exact timetable for recovery and restarting services for the following reasons:
    - The possibility of a second peak (in Covid 19).
    - Requirement for external funding for part of the capacity for recovery.
    - They expected to receive detailed recovery plans for five specialities, which local systems will be expected to prioritise and execute under national direction and guidance. At the time of writing, only one of these specialties has been announced (gastroenterology)

3.0 Suggested approach

3.1 Members may wish to explore the following the NHSE&I and local NHS representatives:-

Capacity of services in light of Covid 19

(a) What is the reduction in capacity of local cancer screening, diagnostic and treatment services because of the necessary restrictions to minimise spread of Covid 19 compared to pre-Covid capacity?

(b) How much more capacity are the commissioners and providers aiming to provide and how far short of pre-Covid capacity should people expect cancer services to remain while spread of Covid 19 remains a serious risk?

(c) Due to the necessary restrictions for Covid 19 safety, what are now the average waiting times that people should expect to wait both from referral to diagnostic test and from referral to treatment?

(d) To what extent have local hospitals been able to use different technologies to investigate and provide diagnosis while reducing risk of spread of Covid 19 (e.g. CT scans and video capsule endoscopy)?

(e) To what extent are local hospitals now increasing their capacity for face-to-face diagnosis, treatment and monitoring of cancer patients?

Mitigation in place while diagnostic and treatment capacity is reduced

(f) How are 'harm reviews' of cancer patients carried out?

(g) To what extent are commissioners and providers confident that patients can be appropriately prioritised in this way?

Process of recovery / restoration of services

(h) Do the plans that Norfolk and Waveney Health and Care Partnership submitted to NHS England on 21 September 2020 for recovery / restoration of cancer diagnosis & treatment services allow for the full range of existing services to continue at or around each of the three acute hospitals in Norfolk?

(i) To what extent is additional funding required for recovery of cancer services (screening, diagnostic and treatment) and how much additional funding has been provided?

(j) Will it be possible for the restored services to operate at their planned capacity even if there a significant resurgence of Covid 19 in Norfolk and Waveney?

Communication with the public

(k) Given that cancer screening rates had been falling in advance of Covid 19, what can now be done to encourage take-up of screening, particularly in areas where it was already relatively low (e.g. breast screening in Great Yarmouth and Waveney and in Norwich where it has declined in recent years)?

(l) Who is responsible for following up with people who do not come forward for screening at the first invitation?

(m) What is done to ensure that people whose first language is not English understand that screening is available for them and are encouraged to take up the offer?

(n) What more can be done to make it easier for people with symptoms to present to their GP practice for onward referral and encourage them to do so?

4.0 Action

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

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.

Norfolk and Waveney
Clinical Commissioning Group

Appendix A - Update on Cancer Services in Norfolk and Waveney

Norfolk Health Overview and Scrutiny Committee

8th October 2020

1. Background and Purpose of Paper

Members received briefing and presentation in relation to health services, including cancer services, at the July meeting. An update has been requested, particularly in relation to:

- Mitigating potential harm for patients whose services may be disrupted
- Capacity
- Primary care engagement

2. Implementation of National Directions

As noted by members and officers of the Health Overview and Scrutiny Committee, at the previous meeting, further national instructions were expected in relation to recovery of NHS services. This was issued on 31st July 2020 and had a number of key deliverables in relation to cancer:

- Reduce unmet need and tackle health inequalities, work with GPs and the public locally to restore the number of people coming forward and appropriately being referred with suspected cancer to at least pre-pandemic levels.
- Manage the immediate growth in people requiring cancer diagnosis and/or treatment returning to the service by ensuring that sufficient diagnostic capacity is in place in Covid-19-secure environments
- Increase endoscopy capacity to normal levels
- Expand the capacity of surgical hubs to meet demand and ensuring other treatment modalities are also delivered in Covid-19-secure environments.
- Putting in place specific actions to support any groups of patients who might have unequal access to diagnostics and/or treatment.
- Thereby reducing the number of patients waiting for diagnostics and/or treatment longer than 62 days on an urgent pathway, or over 31 days on a treatment pathway, to pre-pandemic levels, with an immediate plan for managing those waiting longer than 104 days.

Norfolk and Waveney Health and Care Partnership has jointly agreed plans to address these directives, which was submitted to NHS England on 21st September 2020 and are thus, at the time of writing, still draft, but many of the actions directed have been taken or are already planned.

In keeping with the suggested areas of focus, further details are given in the following three sections on specific parts of the plan. Members are invited to ask health representatives for further detail on other aspects of the plan should they require further information.

3. **Mitigating potential harm for patients whose services may be disrupted**

The Norfolk and Waveney system has robust quality assurance processes in place for patients waiting more than 104 days. These processes ensure that all acute CEOs are aware of every person waiting more than 104 days for cancer diagnostics or treatment, that the reason for the wait is understood and that there is a clear individual plan for each patient. Weekly reports are in place and provided to Executive and operational teams for oversight of all patients waiting over 104 days. These reports are at individual patient level with reasons for delay and management / escalation plans used where necessary to expedite treatment.

There is system oversight via the monthly Cancer Programme Board (attended by patients, carers, providers, commissioners and Healthwatch), weekly cancer assurance meetings with the East of England Cancer Alliance and via Acute Trust Board Quality Committees.

We have significantly reduced the number of patients waiting more than 104 days for treatment from the levels at the peak of the pandemic. All Trusts are seeking to have no patients waiting over 104 days by December 2020 but we aware that despite all efforts by clinical teams there are a small number of patients still not accepting offers for diagnostics or treatment. There is regular and proactive patient contact by clinical nurse specialists, which is documented appropriately, with additional support from Consultants if needed to encourage patient attendance. Clinical harm reviews are undertaken and learning shared in line with local Trust clinical harm policies. The system is engaged with the regional Cancer Clinical Quality Harm Group which is establishing a shared principles approach to cancer clinical harm.

4. Capacity

Delivery of cancer services can be affected by capacity in a broader range of hospital functions, since the previous presentation, Norfolk and Waveney Healthcare Partnership has strengthened arrangements in relation to the recovery of capacity for outpatients, diagnostics, endoscopy and elective operations more generally, which are critical in maintaining services for cancer patients. Since August 12th a weekly Elective Care Recovery Cell meeting; its membership includes the Chief Operating Officers of each hospital, lead GPs from each of the hospital catchment areas, and the STP Planning and Transformation Team (including Programme Director, Finance and Business Intelligence).

NHS England has set up regional meetings consisting of leads from the six STPs in the East of England (Cancer, Outpatient Transformation, Endoscopy, Diagnostics, CT and MRI and Waiting Lists) and for each these areas there is an STP Clinical

Lead, who are also member of the Norfolk and Waveney Elective Care Recovery Cell.

Through these meetings have developed a series of high impact interventions, aimed at meeting the national requirements, known as 'Adopt and Adapt Programmes' for STP clinical leads, to implement in their own geographies. Local Norfolk and Waveney groups have been established to mirror the regional groups, undertake baseline assessments of current service provision against the interventions, working with the STP Cancer Programme Board and Elective Care Recovery Cell, including:

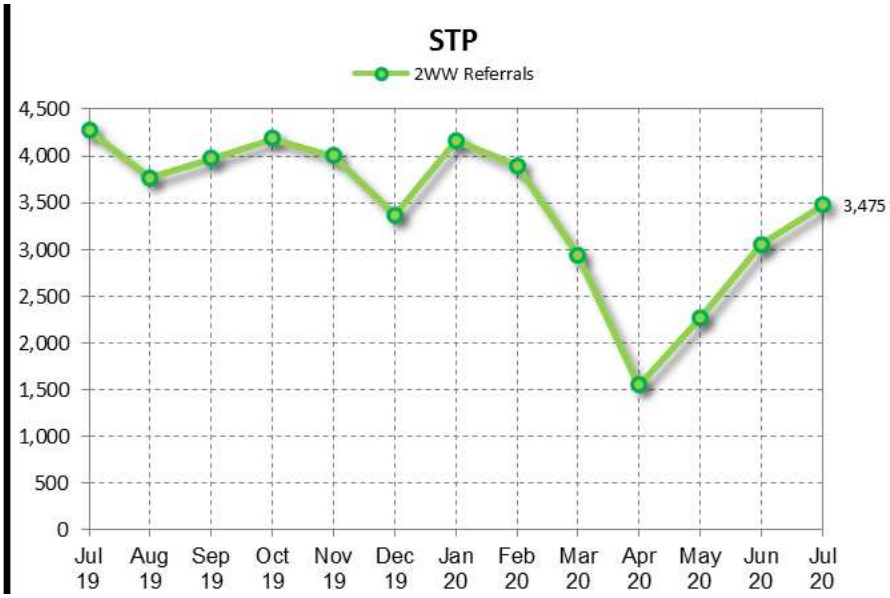
- Rapid diagnostic pathway for lung and colorectal cancer.
- Mutual aid between sites in place to support cancer diagnostics.
- Complete implementation of Covid-19 adapted lung, prostate, colorectal and upper GI pathways in line with national guidance.
- Expanding virtual consultations, nurse led triage, straight to test / one stop clinics, increase personalised follow up and to extend use of teledermatology to support skin cancer pathway.
- Agreement of regional pathway and infection control protocol for upper and lower gastrointestinal endoscopy. This also includes support of early senior decision making for triage of suspected cancer referrals and stricter clinical review of endoscopy referrals for non-cancer pathway requests with amended referral form for Primary care, appropriate use CT colonography.
- Increased hours of operation – fully utilising existing facilities.
- Improved ventilation in endoscopy suites to improve productivity.

Plans, as they currently stand, should see activity in elective surgery rise to above 90% of baseline levels by October 2020, and outpatients and diagnostics to above 90% by November 2020. At the time of writing we are in advanced planning for the increased use of independent sector capacity, where NHS clinicians and operational managers collectively agree this is appropriate.

5. Primary Care Engagement

The STP Cancer Team are providing continued educational sessions to primary care, working in partnership with Macmillan GP's and Cancer Research UK. They have also developed Primary Care Network cancer data packs and support with developing PCN cancer action plans. These include the appointment of a dedicated Primary Care Network Clinical Champion. 13 Primary Care Network virtual meetings out of a possible 17 have been delivered to date.

Additionally, there is enhanced support for patients from Clinical Nurse Specialists to give reassurance around attending for diagnostic appointments for patients who may be concerned about attending, virtual outpatient appointments provided where possible, and the introduction of rapid diagnostic pathway for patients with "vague" / serious non-specific symptoms.



As the previous committee noted and requested a further update on, 2-week wait referrals had begun to resume, at the time of writing the latest available data does not yet demonstrate complete recovery and we will be monitoring this closely especially with the pathway changes which have been described in the previous section.

The STP Cancer Team is also working closely with CCG population health management team and local authority to inform targeted approach to local screening initiatives for hard to reach groups. In the particular case of cervical screening, noted previously by the committee, we aim to stratify the risk of hidden cancer in potential patients using general practice data and targeting those with particular risk factors, such as history of non-attendance, previous abnormal smears, socio-economic status, smoking and ethnic background. We expect NHS England to publish a risk stratification framework in due course and anticipate to be able to adapt this into our plans; in any case we have had strong support from local practices and aim to start contacting patients in November commencing with practices with more deprived populations.

6. Emergency Presentations of Cancers

In response to the specific query in relation to cancers presenting as emergency presentations, this is provided by the National Cancer Registration and Analysis Service, and the last figure they have is 17.5% for the second quarter of 2019, compared to a national average of 17.4%.

Dr Mark Lim

Associate Director of Planned Care and Cancer, Norfolk and Waveney CCGs

Public Health England

Cancer Screening Report for the Norfolk HOSC

Public Health England

February 2020

This report is produced by Screening and Immunisation Team December 2019

NHS England and NHS Improvement

Contents

Authors: Jamie Scott, Peter Ruane, Angela Moss and Monica Sharma

1. Cancer Screening Summary

Cancer screening programmes are commissioned regionally by NHS England's Screening and Immunisation Teams (SIT's) as part of the section 7a agreement. The Screening services in Norfolk and Waveney are generally well run and achieve higher levels of coverage than the national mean. Despite this there are varying levels of coverage in certain areas within Norfolk and Waveney.

1.1 Breast Cancer Screening

Programme Overview

The NHS Breast Screening service offers breast screening to women between the ages of 50 and 70 years of age. It also offers screening at an earlier age to those women who are identified as having a higher risk of breast screening due to genetic reasons. Eligible women are identified through GP registration systems based on their year of birth. All women should be invited by their 53rd birthday and then recalled every 36 months after their last Normal Mammogram. Most units operate vans which will screen women at the nearest location to their home address using digital mammography.

Women whose mammograms are abnormal are recalled for further assessment. They are usually seen in a trusts breast screening unit where they may need further mammograms, ultrasound or a biopsy. The interval between abnormal mammography and further assessment should be no longer than three weeks. Women who are found to have breast cancer are referred to a specialist cancer team for treatment. Further information can be found on the NHS Breast screening services website https://www.gov.uk/topic/population-screening-programmes/breast.

Breast Screening Coverage and Uptake

Coverage is defined as the percentage of women in the population who are eligible for screening at a particular point in time, who have had a test with a recorded result within the last three years. Uptake refers to the proportion of women accepting invites. As seen in Chart 1 the coverage of breast screening has generally been higher than the England mean but replicates the pattern seen in England with regards to the fact that the uptake has decreased since 2010. This pattern is also repeated with the breast screening uptake within the five CCG populations in Norfolk and Waveney as can be seen in Chart 2. North Norfolk CCG has the highest uptake over the last five years from 2014/15 to 2018/19. NHS Norwich has had the lowest uptake on average when compared to the other CCG's. Even though the overall coverage is higher than the national average there is still a need to target hard to reach groups with a view of looking at access to the whole breast cancer pathway. NHS England and Improvement East of England is working with stakeholders such as the Local Authority, the STP, CCGs and Charities to look at improving access to hard to reach groups.

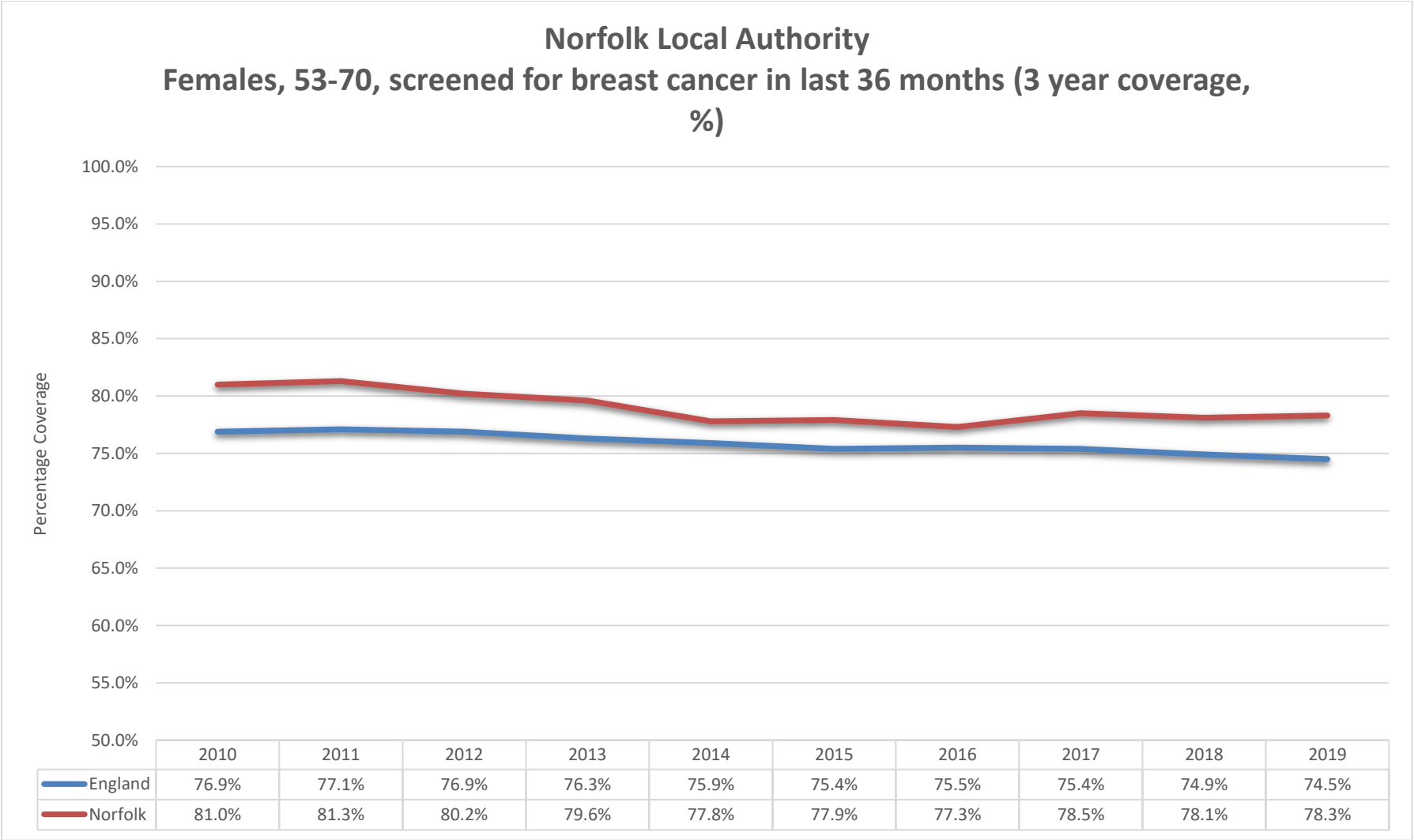
Norfolk and Waveney Breast Screening Services

There are three Breast Screening Programmes in Norfolk and Waveney - one based in each of the three acute hospitals of Norfolk and Norwich University Hospital (NNUH), James Paget University Hospital (JPUH), and Queen Elizabeth Hospital Kings Lynn (QEHKL).

National guidelines state that each Programme should service populations no less than 500,000 and up to about one million. NNUH has a population circa 605,354, but JPUH (223,456) and QEHKL (236,843) population numbers are considerably below recommendations. Smaller services have difficulty with recruiting and retaining staff and are vulnerable at times of annual leave, sick leave or retirement of senior staff.

Historically, JPUH and QEHKL have experienced difficulties recruiting and retaining key radiological and radiographical staff. There is a national shortage of these practitioners and these units are not unique nationally in having these issues. Due to unforeseen circumstances the JPUH breast screening service had to be suspended for a short period of time between July and September 2019, due to unforeseen sick leave. Screening was also suspended in JPUH for 3 months in 2015/16 following the retirement of a senior member of staff. On both occasions the key performance indicators were not met for few months in that year, including the 36-month round length which is the percentage of women screened within 36 months of their last screen. However, the service did recover and meet the standards soon after the incidents were closed, and key programme standards continue to be met.

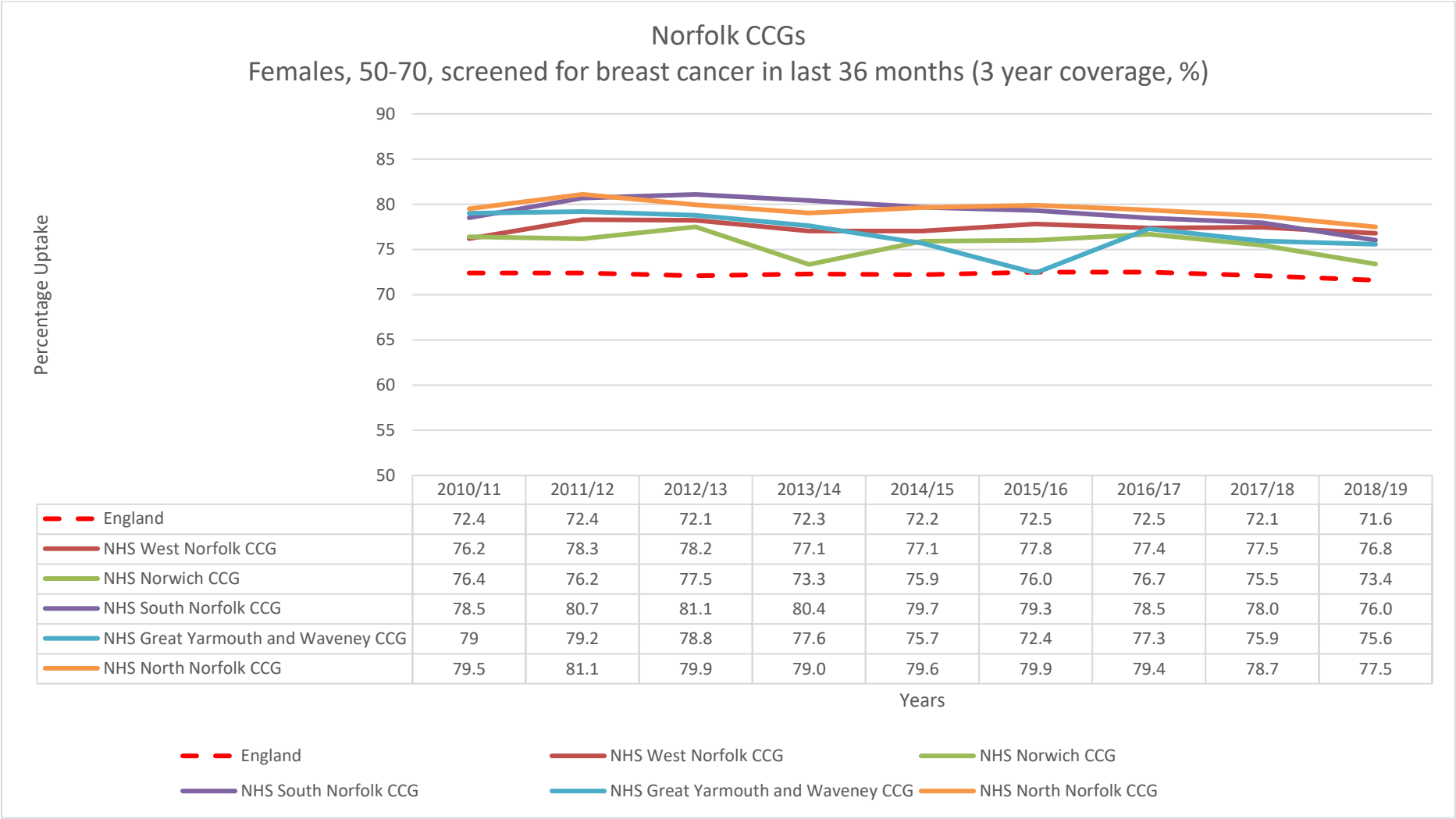
NHS England and Improvement East of England is looking at long term plans to improve staff resources in the Norfolk and Waveney area which will include working with providers and other stakeholders to find networking and training solutions to this problem.



	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
England	76.9%	77.1%	76.9%	76.3%	75.9%	75.4%	75.5%	75.4%	74.9%	74.5%
Norfolk	81.0%	81.3%	80.2%	79.6%	77.8%	77.9%	77.3%	78.5%	78.1%	78.3%

Chart 1. Annual 36 month Round length coverage for Women between 53 and 70 years of age in the Norfolk local authority region (Source: PHE Public Health profiles)

Authors: Jamie Scott, Peter Ruane, Angela Moss and Monica Sharma



	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
England	72.4	72.4	72.1	72.3	72.2	72.5	72.5	72.1	71.6
NHS West Norfolk CCG	76.2	78.3	78.2	77.1	77.1	77.8	77.4	77.5	76.8
NHS Norwich CCG	76.4	76.2	77.5	73.3	75.9	76.0	76.7	75.5	73.4
NHS South Norfolk CCG	78.5	80.7	81.1	80.4	79.7	79.3	78.5	78.0	76.0
NHS Great Yarmouth and Waveney CCG	79	79.2	78.8	77.6	75.7	72.4	77.3	75.9	75.6
NHS North Norfolk CCG	79.5	81.1	79.9	79.0	79.6	79.9	79.4	78.7	77.5

Chart 2. Annual Breast Screening 36-month round length coverage for women between 50 and 70 for each of the 5 Norfolk and Waveney CCG's (Source: PHE Public Health profiles)

Authors: Jamie Scott, Peter Ruane, Angela Moss and Monica Sharma

2. Cervical Screening

2.1 Cervical Screening Programme Overview

Cervical screening is offered to women aged 25 to 64 (every three years to women aged 25 to 49 and every five years from the ages of 50 to 64). A sample is taken using Liquid based cytology (LBC) and is tested for the presence of strains of HPV thought to be responsible for most cervical cancers. This is the first test used for women's samples and those women found to be negative for HPV require no further testing and are sent back to normal recall of 3 or 5 years. Those samples which are positive for HPV are sent for LBC processing and are sent to cytology to undergo a full cytological examination. A full flowchart of the cervical screening protocol can be found at the following link: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/773338/Appendix_1_cervical_screening_protocol.pdf

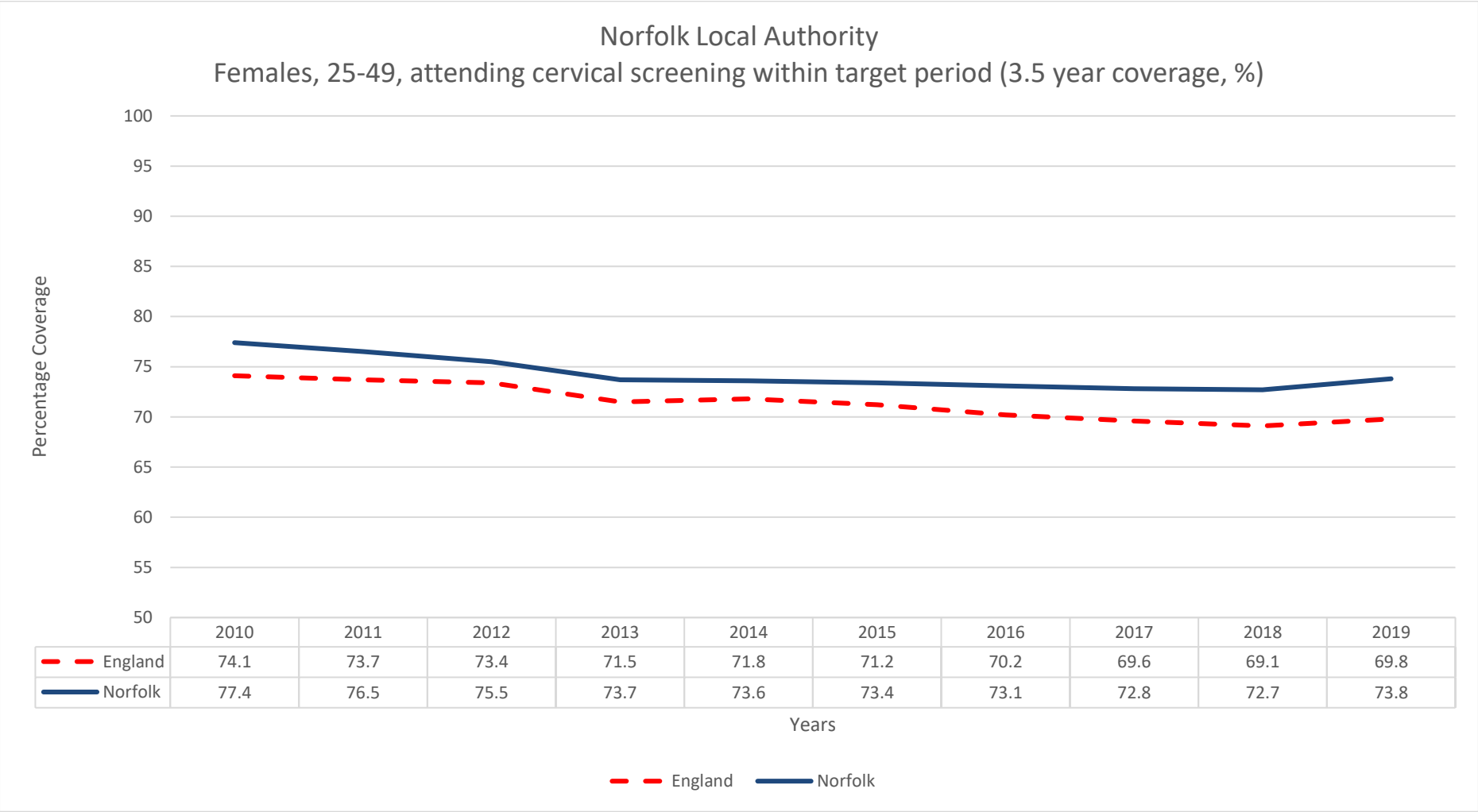
Those women found to be HPV positive and have an abnormal cytology result are referred to Colposcopy for further examination and further treatment if necessary.

Cervical Screening Coverage

As can be seen in Chart 3 the pattern of coverage for the younger cohort (Defined as the percentage of women eligible for screening at a given point in time who were screened adequately within a 3.5 years) is similar to Breast screening in the fact it is higher than the England mean but showing a slow decline. There was a slight increase in coverage in 2019 thought to be due to greater awareness due to national and regional campaigns. The coverage for older women as seen in chart 4 follows a similar pattern as the younger cohort but is nearer to the national mean figures overall and coverage is generally higher in this group. Cervical Screening Coverage is not available at CCG level in any of the Nationally validated data sets available. NHS England and Improvement East of England is working with stakeholders such as the Local Authority, the STP, CCGs and Charities to look at improving access to hard to reach groups.

Norfolk and Waveney Cervical Screening services

Screening samples are taken at primary care services (usually GP practices) and are sent to a lab for processing. The screening test in Norfolk and Waveney is the primary HPV test which is provided by the Pathology services at the Norfolk and Norwich Hospital. This lab is situated at the Cotman centre and has recently won a procurement bid to provide primary HPV services for the East of England as a whole. It has historically performed well and regularly meets the key performance standard for results being processed within 2 weeks of receipt (>98%). There are three Colposcopy units in Norfolk and Waveney which are situated in the three Hospital trusts. All three regularly meet their KPI targets and are well run but do sometimes struggle with staffing capacity.



	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
England	74.1	73.7	73.4	71.5	71.8	71.2	70.2	69.6	69.1	69.8
Norfolk	77.4	76.5	75.5	73.7	73.6	73.4	73.1	72.8	72.7	73.8

Chart 3. Annual Cervical Screening coverage for the younger Cohort of women (25-49)within the Norfolk Local Authority region who have been screened within the 3.5 year target period (Source: PHE Public Health profiles)

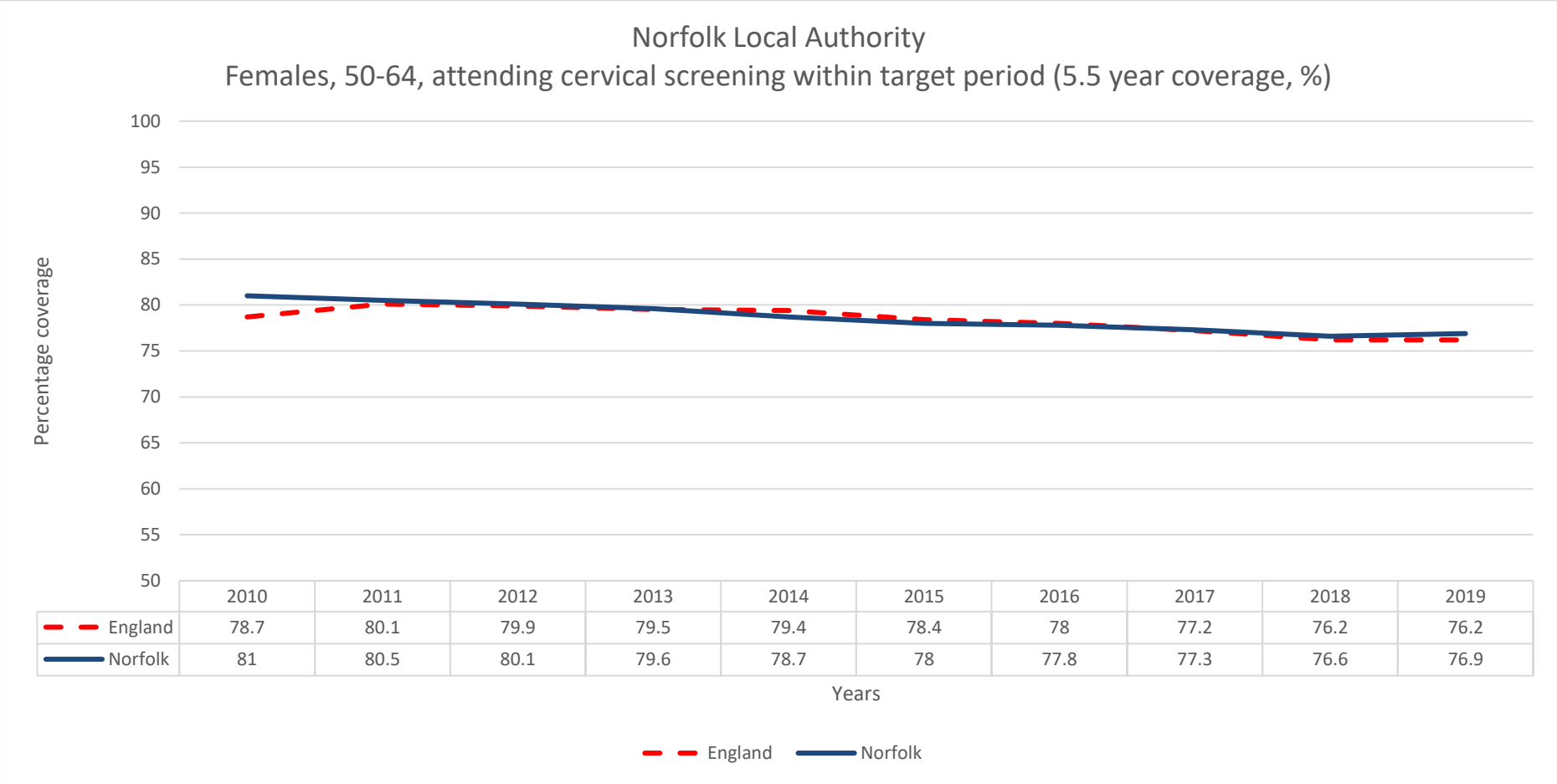


Chart 4. Annual Cervical Screening coverage for the older Cohort of women (50-64) within the Norfolk Local Authority region who have been screened within the 5.5 year target period (Source: PHE Public Health profiles)

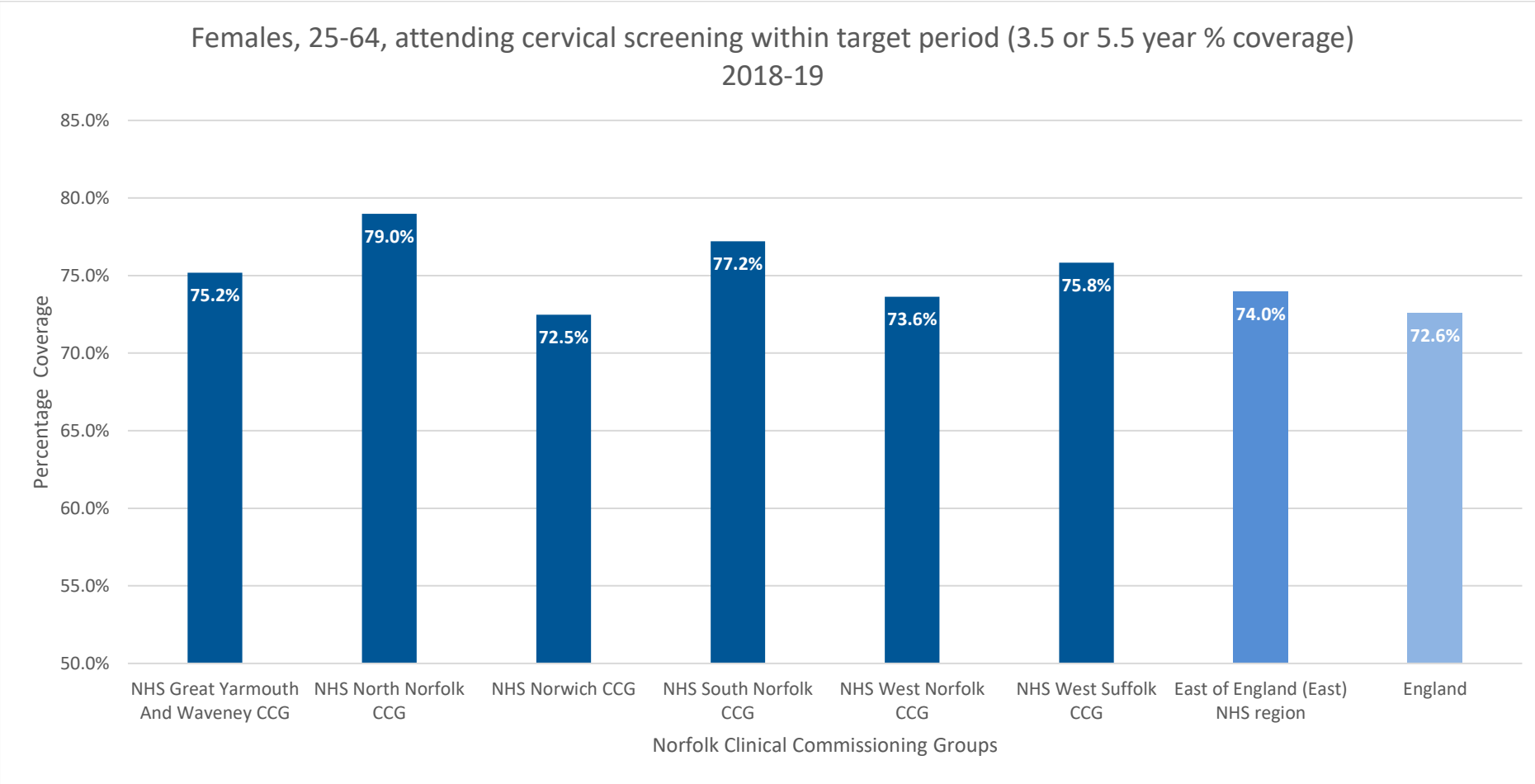


Chart 5. Annual Cervical Screening coverage for the Cohort of women (25-64) within the Norfolk CCG region who have been screened within the 3.5 or 5.5 year target period (Source: Fingertips/PHOF)

Women aged 25-49 are invited for routine screening every 3 years and women aged 50-64 are invited for routine screening every 5 years. This indicator gives a combined coverage for the full age range so that it counts women aged 25-49 screened within a period of 3.5 years and women aged 50-64 within a period of 5.5 years prior to the report date and combines the counts to give the final measure.

Authors: Jamie Scott, Peter Ruane, Angela Moss and Monica Sharma

3. Bowel Cancer Screening

3.1 Bowel Cancer Screening Overview

Currently the test used is the faecal immunochemical test (FIT), which is aimed at men and women aged 60 to 74. People aged 60-74 are sent an information leaflet and invitation letter from the Bowel screening Hub, followed one week later by a FIT kit. This test requires a single stool sample only (compared to the older FoBT test which required 4 samples) which is then returned by post to the hub. Samples are quantitatively analysed in the laboratory, with samples recorded as having 120 micrograms of haemoglobin per gram of stool being recorded as positive. Patients should receive their result (positive or negative) within two weeks of the laboratory receiving the kit. The test is repeated at two-yearly intervals. Around 2% of patients can be expected to have a positive result and these individuals are referred to the local Bowel Screening Centre where they are seen by a specialist screening practitioner who goes through varying options and offers the individual a colonoscopy if it is suitable. Those deemed unfit may be referred for CT colonography (a radiological examination). Colonoscopy allows an endoscopist to visualise the lining of the entire large bowel. Around 10% of patients undergoing screening colonoscopy can be expected to have a cancer and a larger number (around 30%) will have polyps detected. Polyps can generally be removed during the colonoscopy. If a cancer is detected, the patient is placed on the cancer referral pathway and may require surgery.

Bowel Screening Coverage

The Norfolk and Waveney screening programme has one of the highest levels of coverage in the country. Chart 5 shows that the levels of coverage have remained relatively stable over the last 4 years. Chart 6 shows the CCG level coverage which also shows a stable level of coverage since 2012 with NHS South Norfolk and NHS North Norfolk showing higher levels of coverage than the other three CCG's. NHS England and Improvement East of England is working with stakeholders such as the Local Authority, the STP, CCGs and Charities to look at improving access to hard to reach groups.

Norfolk and Waveney Bowel Screening services

The bowel screening Hub which covers the East of England area is located at the Queens Medical Centre in Nottingham. This is a well-run service which is commissioned by the Nottinghamshire Screening and Immunisation Team. The Bowel Screening Centre is located at the NNUH and is a very well run service. It regularly meets its key performance standards and takes part in efforts to increase uptake.

In addition to the bowel cancer screening programme bowel scope screening is offered to residents of Norfolk and Waveney as a one off screening at the age of 55 years.

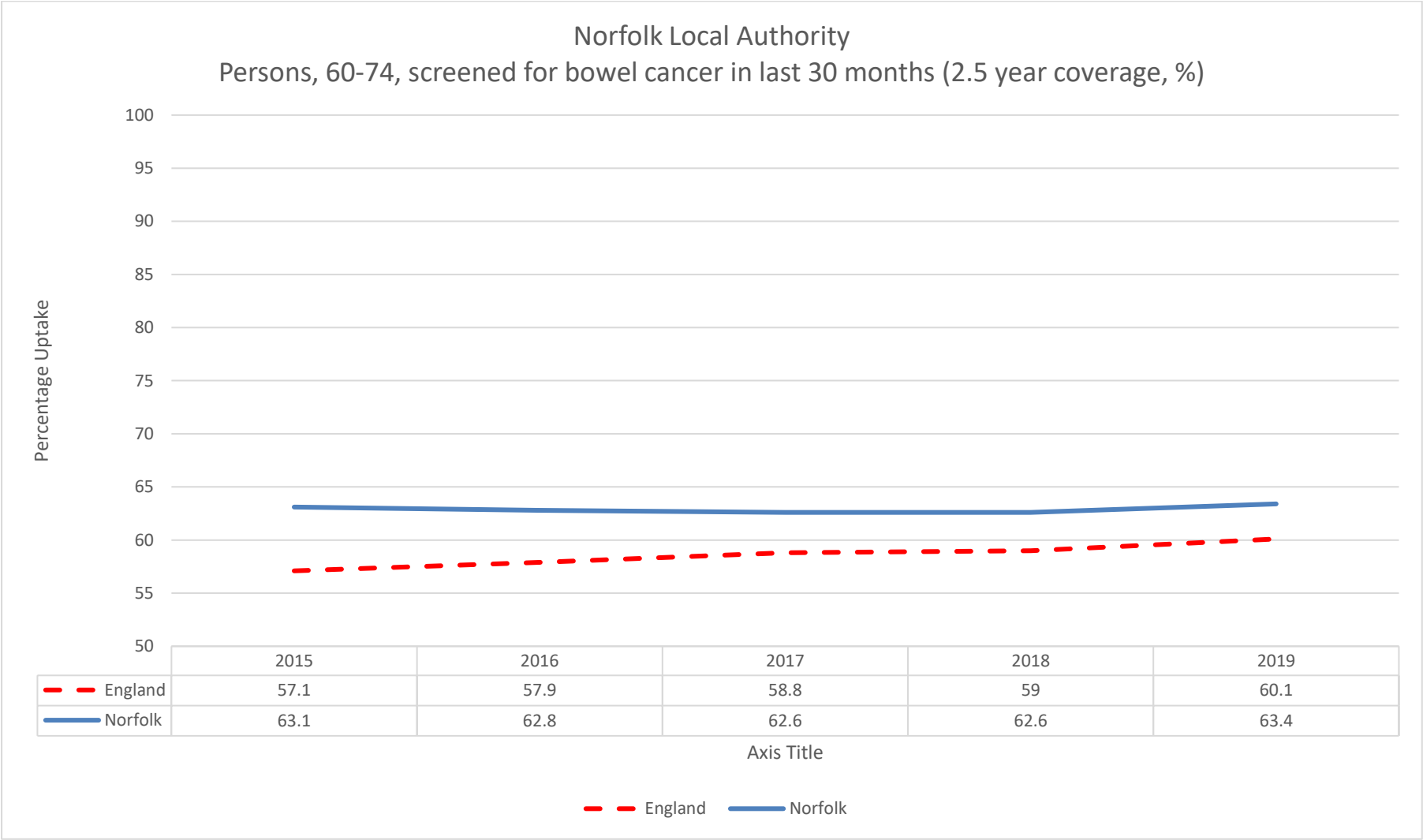
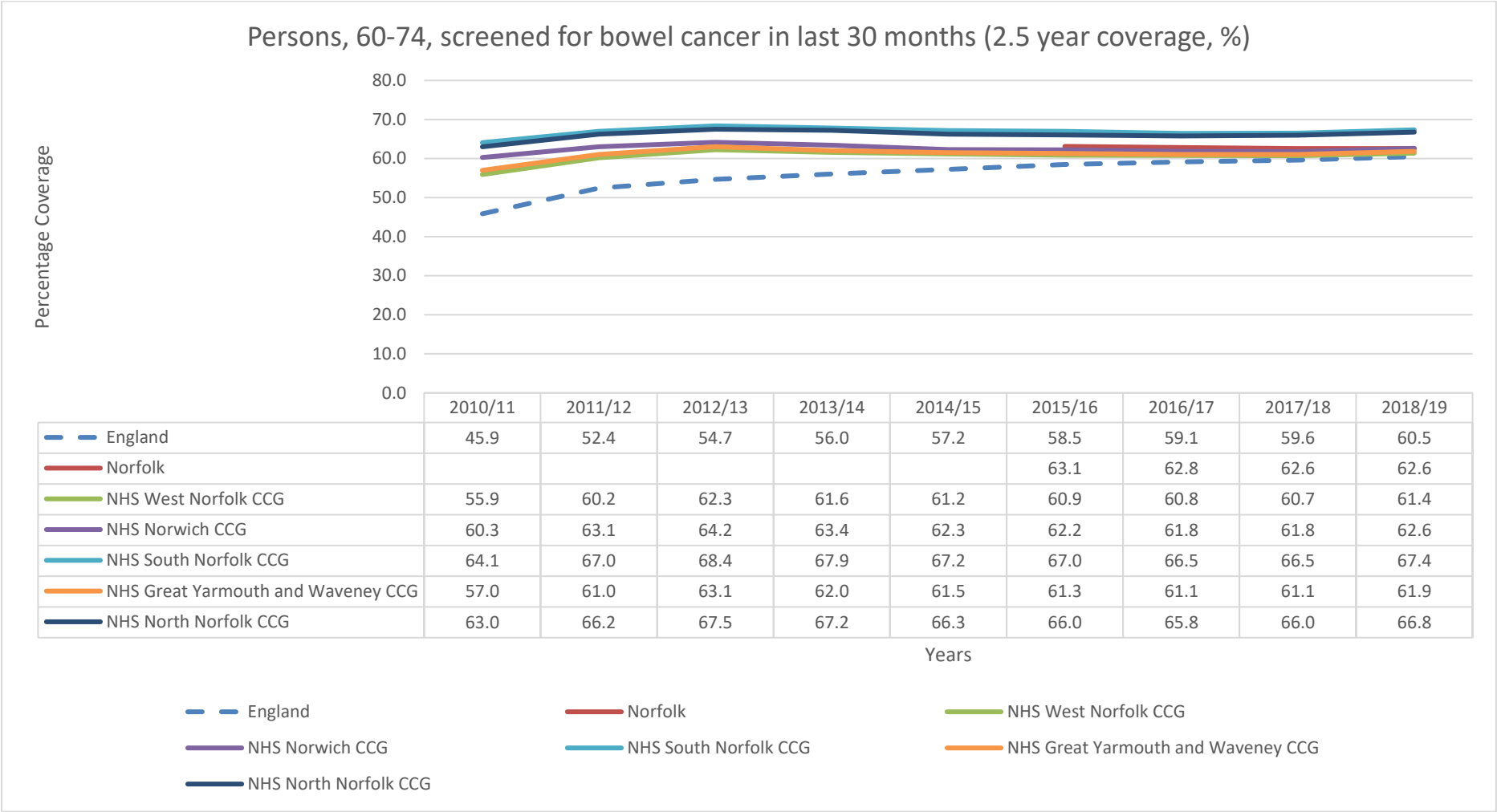


Chart 5. Annual Bowel screening coverage for the Norfolk Local Authority eligible population

Authors: Jamie Scott, Peter Ruane, Angela Moss and Monica Sharma



	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
England	45.9	52.4	54.7	56.0	57.2	58.5	59.1	59.6	60.5
Norfolk						63.1	62.8	62.6	62.6
NHS West Norfolk CCG	55.9	60.2	62.3	61.6	61.2	60.9	60.8	60.7	61.4
NHS Norwich CCG	60.3	63.1	64.2	63.4	62.3	62.2	61.8	61.8	62.6
NHS South Norfolk CCG	64.1	67.0	68.4	67.9	67.2	67.0	66.5	66.5	67.4
NHS Great Yarmouth and Waveney CCG	57.0	61.0	63.1	62.0	61.5	61.3	61.1	61.1	61.9
NHS North Norfolk CCG	63.0	66.2	67.5	67.2	66.3	66.0	65.8	66.0	66.8

Chart 6.Annual Bowel screening coverage for the Norfolk and Waveney CCG eligible population

HOSC Meeting with Councillors 8th October 2020

Addendum to original report

Details of what was done regarding cancer screening services following the onset of Covid 19

The Cancer screening services were affected by the onset of the pandemic from late March 2020, due to the lockdown in place, and the redeployment of Health care staff to support the COVID response and surge capacity in NHS acute trusts and community services and primary care. Some level of High risk screening services continued while routine screening invitations were rescheduled to start from June 2020 onwards. Technical guidance was issued to all the service providers by NHS England/ Improvement and PHE to safely manage the screening services during this time.

Details of restoration of services, or plans for future restoration / provision of screening services in a Covid-safe manner

The routine screening restarted from June/ July 2020, when Cervical, Bowel and Breast screening routine invitations recommenced. The screening services and provision were risk assessed and evidence presented to the NHS England and Improvement weekly Regional panel meetings in June prior to restart in a COVID safe manner. This involved risk assessing the patient waiting areas, screening equipment and venues, screening staff, and putting in enhanced Infection Prevention control measures in place.

Any action the commissioner is taking to:-
(i) Encourage increase in take-up rates, particularly for breast and cervical screening which have been declining over the longer term.
(ii) Investigate and address the relatively larger decline in breast screening coverage in the Norwich CCG area in recent years

A lot of national and local promotion of Cervical screening has happened over the past 2 years. NHS England and Improvement East of England is working with stakeholders such as the Local Authority, the STP, CCGs and Charities to look at improving access to hard to reach groups.

In the recent months improving uptake activities have reduced due to the impact of the pandemic and the lockdown in place to suppress the transmission of Corona virus.

The uptake in Norwich CCG is affected by the fact that it is mainly the city population which is younger and more mobile compared to rural areas. On a general level big cities and regions like London have lover levels of cancer screening uptake. All the initiatives to improve uptake is happening in Norwich, same as rest of Norfolk.

(iii) Support the breast screening service at the James Paget Hospital and ensure its future sustainability, given that it has been suspended twice in the last five years (before Covid 19).
(iv) Support the hospitals, particularly the Queen Elizabeth and James Paget, in recruitment of the necessary staff for the screening programmes or other measures taken to ensure availability of suitably qualified staff.

The commissioners and providers are working together to support the three breast screening services in Norfolk (James Paget Hospital, Queen Elizabeth hospital and Norfolk and Norwich hospital) to identify and put in place sustainable networking solutions to enable them to better support each other with the resources they have. In addition, the staffing issues within the breast screening services is a nationally identified risk within the breast screening programme. There is national work planned in partnership with Health education England (HEE) to look at recruiting and training of more staff in England and various other mitigations that could be put in place. The use of technology and Artificial intelligence is being explored in breast screening to tackle some of the workforce and COVID related constraints.

In the recent months all the 3 breast screening services in Norfolk (James Paget Hospital, Queen Elizabeth hospital and Norfolk and Norwich hospital) are functioning and performing well.

Information on the degree to which bowel screening coverage, for which Norfolk and Waveney has one of the highest take-up levels in the country, could be increased further (i.e. to make a greater contribution towards early diagnosis and survival rates).

The bowel cancer screening performance for Norfolk is one of the best in the region. With the change in screening test to FIT from June 2019, the uptake in the bowel cancer screening is increased even further. There are national plans to further expand the bowel cancer screening which will enable the identification of more early cancers in a larger population. The endoscopy workforce must be expanded to enable this to happen, and there are plans in place for this.

In relation to breast and bowel screening, information on the process of keeping patients' GPs informed when patients have been invited for screening and whether or not they attended for screening.

The breast screening service has a call recall of every 3 years between the age of 50 and 70 years, and bowel careening service has a call recall of every 2 years between the age of 60 and 75 years. The GPs are informed of patients who are invited and did not attend the screening appointment. With the funding given from Cancer alliance to the N&W STP in 2020-21, it is expected that GP practices will be provided with the support to ensure that those people who DNA screening appointments are encouraged to take up screening.

Extract from NHOSC Briefing, March 2020

Cancer – stage at diagnosis and survival rates in Norfolk & Waveney

At its meeting on 13 February 2020 NHOSC asked for information on cancer survival rates in Norfolk be included in the next NHOSC Briefing. The Norfolk and Waveney STP Cancer Programme Manager has provided the latest information on the percentage of cancers diagnosed early (stage 1 or 2) and the one-year survival rates across all cancers across Norfolk and Waveney (see below):-

Indicator	CCG	2012	2013	2014	2015	2016	2017
Stage at Diagnosis (% diagnosed at Stage 1 or 2)	North	56.3%	53.9%	54.8%	55.0%	53.3%	54.5%
	Norwich	55.3%	51.7%	53.6%	56.8%	53.6%	54.4%
	South	56.1%	55.8%	56.3%	57.1%	57.5%	54.6%
	West	57.6%	57.2%	59.8%	55.6%	54.3%	53.2%
	GY&W	55.1%	52.9%	52.8%	54.8%	51.7%	51.0%
	STP Total	**56.1%**	**54.3%**	**55.4%**	**55.8%**	**54.1%**	**53.5%**
	Eng Avg	**53.4%**	**54.1%**	**54.4%**	**54.0%**	**53.7%**	**53.7%**
One year survival rate (all cancers)	North	70.5%	71.3%	72.0%	72.5%	72.4%	
	Norwich	70.0%	70.5%	71.0%	71.3%	71.7%	
	South	71.5%	72.1%	72.6%	73.2%	73.8%	
	West	70.5%	71.2%	71.7%	72.4%	73.1%	
	GY&W	69.4%	70.0%	70.5%	71.1%	71.4%	
	STP Total	**70.5%**	**71.1%**	**71.6%**	**72.2%**	**72.6%**	
	Eng Avg	**70.2%**	**70.9%**	**71.5%**	**72.2%**	**72.8%**	

Notes:-

Stage at Diagnosis indicator – reported annually; excludes un-staged cancers

Stage 1 cancer – localised cancer that has spread to nearby tissues. It has not yet spread to lymph nodes or other areas.

Stage 2 cancer – cancer has spread to a regional area or into nearby tissues or lymph nodes.

CCG-level cancer survival rates for breast, colorectal and lung cancers in the years from 2002 to 2017 are provided overleaf. This data was extracted from the national dataset.

Points to note:-

- As in the rest of England, the average one-year survival rate across all cancers in Norfolk and Waveney has steadily improved since 2012.
- In 2016 Norfolk and Waveney fell slightly below the English average for one-year survival across all cancers
- In 2017 (latest available info) significantly fewer patients were diagnosed with cancer at stage 1 or 2 in Great Yarmouth and Waveney compared to the Norfolk and Waveney STP and English averages.
- One-year survival rates for breast and colorectal cancer in Norfolk and Waveney are below the English average; the survival rate for lung cancer is above the average.

2002-2017 Cancer survival data – Norfolk & Waveney

Cancer Survival																	
Table 1: Breast cancer survival (%) 1-year, by calendar year of diagnosis: all adults (aged 15 to 99 years), 2002 to 2017																	
Geograph	Geography name	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Country	England	93.5	93.8	94.1	94.4	94.7	95	95.2	95.4	95.7	95.9	96.1	96.3	96.5	96.6	96.8	97
CCG	NHS Great Yarmouth and Waveney CCG	93.1	93.5	93.7	93.5	93.8	94.2	94.3	94.4	94.4	94.6	94.7	94.8	94.7	94.8	95	95.3
CCG	NHS North Norfolk CCG	94.3	94.6	94.9	94.6	95.2	95.3	95.5	95.5	95.7	95.9	96.2	96	96.3	96.5	96.7	96.8
CCG	NHS West Norfolk CCG	92.5	93.1	93.6	94.3	94.7	95.2	95.7	96	96.3	96.7	97	97.3	97.4	97.6	97.9	98.1
CCG	NHS Norwich CCG	94.4	94.7	94.7	94.9	95.1	95.1	95.2	95.3	95.6	95.7	95.8	95.9	95.7	96.2	96.3	96.1
CCG	NHS South Norfolk CCG	95.8	95.6	95.8	95.7	95.7	95.2	95.8	95.5	95.5	95.6	95.3	95.5	95.5	95.3	95.7	94.9
STP	Norfolk and Waveney Health and Care Partnershi	94.5	94.7	94.8	94.8	95	95.1	95.3	95.3	95.4	95.6	95.7	95.7	95.8	95.8	96.1	96.1
Table 2: Colorectal cancer survival (%) 1-year, by calendar year of diagnosis: all adults (aged 15 to 99 years), 2002 to 2017																	
Geograph	Geography name	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Country	England	73.8	74.3	74.8	75.3	75.8	76.3	76.8	77.2	77.7	78.1	78.6	79	79.4	79.9	80.2	80.7
CCG	NHS Great Yarmouth and Waveney CCG	71.6	72.3	72.8	73.7	74.4	75.1	75.4	75.6	76.7	76.7	77.5	77.9	78.7	79.1	79.2	79.9
CCG	NHS North Norfolk CCG	75.2	75.8	76.5	77.1	77.2	77.1	77.3	77.8	78.1	78.2	78.2	78.5	78.5	79.1	78.6	79.2
CCG	NHS West Norfolk CCG	73.4	74.1	75	76.4	76.4	77.3	77.4	77.2	78.4	78.8	79.3	80.2	80.1	80.8	81.4	81.5
CCG	NHS Norwich CCG	79.3	79.8	79.2	79.6	78.7	78.6	79.1	78.6	78.1	78.5	77.8	77.3	77.2	77	76.4	77.2
CCG	NHS South Norfolk CCG	76.9	77.4	77.9	78.1	78.1	78.6	79	79.1	79.4	79.2	79.9	79.9	80.3	80.4	80.4	81.2
STP	Norfolk and Waveney Health and Care Partnershi	75.6	76	76.4	76.9	77	77.4	77.6	77.7	78.1	78.3	78.6	79	79.3	79.6	79.8	80.1
Table 3: Lung cancer survival (%) for 1-year, by calendar year of diagnosis: all adults (aged 15 to 99 years), 2002 to 2017																	
Geograph	Geography name	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Country	England	26.7	27.8	28.8	29.9	31	32	33.1	34.2	35.3	36.4	37.6	38.7	39.8	40.9	42	43.1
CCG	NHS Great Yarmouth and Waveney CCG	29.5	30.4	31.1	32.2	32.8	34.3	35	35.5	36.9	37.5	38.2	39.5	40.5	41.4	42.3	43.3
CCG	NHS North Norfolk CCG	29.4	31.3	31.6	33.6	34	35.4	36.8	38.3	39.5	41.3	42.2	44.6	45.2	47	47.3	49.1
CCG	NHS West Norfolk CCG	30.4	31	32.1	32.3	32.6	32.9	33.7	34.5	35	36	35.9	37.1	37.4	38.5	38.8	39.7
CCG	NHS Norwich CCG	32.3	32.7	33.5	34.3	34.7	35.3	36.1	37.1	38	39	39.4	40.4	41.1	41.9	42.8	43.1
CCG	NHS South Norfolk CCG	33	33.5	34.5	35.2	35.8	36.5	37.4	38.3	38.9	39.7	40.3	41.3	41.7	43.3	43.5	44.3
STP	Norfolk and Waveney Health and Care Partnershi	31.1	31.7	32.6	33.3	34	34.8	36	36.8	37.5	38.7	39.2	40.3	41	42.3	42.9	43.9
Source: Public Health England; Index of cancer survival for Clinical Commissioning Groups in England: adults diagnosed 2002 to 2017 and followed up to 2018; published Nov 2019																	

Childhood immunisations

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

Examination of the situation regarding provision of childhood immunisations in Norfolk and Waveney in light of Covid 19.

1.0 Purpose of today's meeting

1.1 The focus of the meeting is:-

- To examine how the local NHS is managing provision of childhood immunisations in a Covid-safe manner.

- To examine what can be done to improve the take-up rate for childhood immunisations.

1.2 The commissioners, NHS England and NHS Improvement (NHSE&I) have been asked to provide a report showing the trend in take-up rates of childhood immunisations:-

- Diptheria, tetanus, pertussis, polio and *Haemophilus influenzae* type b
- Pneumococcal disease
- Rotavirus
- Meningococcal group B
- Meningococcal group C
- Measles, mumps, rubella
- Children's flu vaccine

They have also been asked to provide information on:-

(a) What was done regarding childhood immunisation services following the onset of Covid 19

(b) Restoration of services, or plans for future restoration / provision of childhood immunisation services in a Covid-safe manner

(c) How children would be taken into account in any future Covid 19 vaccination programme (if possible to provide this information at this stage).

NHSE&I's report is attached at **Appendix A**. It consists of childhood immunisation coverage data for 2013/14 – 2018/19 that NHOSC Members first received in the February 2020 NHOSC Briefing and an **addendum** with data for 2019/20 and 2020/21 quarter1 together with information about the service during the Covid 19 outbreak.

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

1.3 Representatives from Norfolk and Waveney CCG will also be in attendance as they are the commissioners of GP primary care services through which many childhood immunisations are delivered.

There will also be a representative from Cambridgeshire Community Services NHS Trust, which delivers the School Age Programme across Norfolk and Waveney.

2.0 Background information

2.1 The European Region of the World Health Organisation (WHO) has recommended that on a national basis at least 95% of children are immunised against diseases that are preventable by immunisation and are targeted for elimination or control.

There have been national reports of declining take up of childhood immunisation programmes and in 2019 the UK lost its measles-free status.

2.2 NHOSC Members first received information from NHSE&I (Public Health England) on childhood immunisation coverage for the years 2013/14 – 2018/19 in the February 2020 NHOSC Briefing.

2.3 Points to note from the data provided in February 2020 and the updates in addendum section of Appendix A to today's report include:-

- 2020/21 quarter 1 data shows that Norfolk vaccination rates have improved across all childhood vaccinations during the Covid 19 pandemic outbreak. The 95% target is met in quarter 1 for the majority of vaccinations. The data for the year 2019/20 was also encouraging.

Looking back at trends for the years 2013/14 – 2018/19 (including England and the east of England region) and 2019/20 (Norfolk only):-

<u>For the 5-in-1 & 6-in-1 vaccine</u>
(diptheria, pertussis, tetanus, polio & disease caused by *Haemophilus influenzae* type B *(Hib)*; plus hepatitis B post August 2017. Coverage measured at ages 12 months, 24 months, 5 years)

- There was a trend of decreasing coverage across England, the region and Norfolk in the years to 2018/19.

- The rate of decline was less in Norfolk than across the region and across England.
- There was improved coverage in Norfolk in 2019-20

For the MMR vaccine
(measles, mumps, rubella – two doses (MMR1 & MMR2). Coverage measured at ages 24 months (MMR1) and 5 years (MMR1&2))

- There was a trend of decreasing coverage and England as a whole was well below target by 2018/19.
- In 2018/19 Norfolk exceeded the 95% target for MMR1 by age 5 with 95.9% coverage but coverage at 24 months was below target at 93.7%. At age 5 years MMR2 coverage in Norfolk was 90.2%, which was below target but higher than the regional and national levels
- Coverage at age 5 years improved in 2019/20 and was above 91% in all parts of Norfolk and Waveney, with marked improvements in the Great Yarmouth & Waveney and West Norfolk areas.

For rotavirus vaccine (earliest data available from 2016/17)
(rotavirus – common cause of diarrhoeal disease among infants and young children. Coverage measured at age 12 months)

- In quarter 4 2019/20 North Norfolk was the only part of Norfolk and Waveney that achieved the 95% target and West Norfolk was lowest at 90.6%

For pneumococcal conjugate vaccine (PCV)
(pneumococcal disease - (mild to severe) meningitis, blood poisoning, pneumonia, ear infection. Coverage measured at ages 12 months (primary course) and 24 months (booster))

- There was a trend of decreasing coverage with England well below target in 2018/19.
- In 2018/19 Norfolk was meeting the target at 12 months with 95.1% coverage but was below target at 24 months with 93.9% of children having received their second dose of vaccine.
- In 2019/20 Norfolk was still below target for children receiving their second dose but there was an improvement to 94.8% in the first quarter of 2020/21.

Hib/MenC vaccine
(a booster for the *Hib* vaccine offered in the first year of life; the primary dose for MenC – meningitis (meningococcal group C). Coverage measured at ages 24 months and 5 years)

- There was a trend of decreasing coverage in England and the region, with neither meeting the 95% target at 24 months or at 5 years in 2018/19/

- In 2018/19 Norfolk was also below target with 93.7% coverage at 24 months and 94% coverage at 5 years.
- In 2019/20 quarter 4 Norfolk coverage had improved to 94% at 24 months and 94.9% at 5 years.

MenB vaccine (earliest data available from 2017/18)
(meningococcal disease group b – can lead to meningitis and infections of the blood. Coverage measured at ages 12 months and 24 months)

- In 2018-19 the 95% target was not being met in England, the east of England region or in Norfolk. At 94.3% for age 12 months and 92.7% for age 24 months, coverage in Norfolk was significantly higher than in the region and in England as a whole.
- In 2019-20 Norfolk was still below the 95% target.
- In the first quarter of 2020-21 Norfolk has achieved the target for age 12 months and has improved to 94.1% coverage at age 24 months.

Although Norfolk & Waveney has achieved better coverage across all immunisation programmes than the regional and national averages it has not met the 95% target against any of the diseases at all of the measured points in a child's life.

3.0 Suggested approach

3.1 Members may wish to explore the following the NHSE&I and CCG representatives:-

Delivery of childhood immunisations in light of Covid 19

(a) To what extent have the restrictions necessary to reduce the spread of Covid 19 affected capacity to immunise children against other diseases?

(b) Does the extra work caused by the Covid 19 pandemic, including planning for any vaccination programme for the disease which may eventually be possible depending on the creation / availability of a vaccine, take away from resource to plan for and / or deliver routine childhood immunisations?

(c) What are the contingency plan for delivery of immunisations to school aged children in the event of future local or more widespread lockdowns?

Target level of coverage

(d) In the table of overall vaccination coverage in Appendix A addendum, 90% is mentioned as 'acceptable' and 95% as 'achievable'. The WHO

recommended 95% coverage. Is a 90% vaccination coverage level effective in controlling an infectious disease?

Communication with parents

(e) Given that childhood immunisation coverage was below the 95% target in Norfolk and Waveney before the pandemic, particularly for MMR, what can now be done to encourage parents to get children immunised and make it easy for them to do so?

(f) How much capacity is there within the Healthy Child Programme teams to follow up with parents who do not bring their children for vaccination?

Records of childhood immunisations

(g) GPs are informed of vaccinations and are responsible for updating patient records but is there a check on whether this is actually done?

(h) How easy is it for adults to get copy of the record of vaccinations they received as a child?

4.0 Action

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

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.

Public Health England

Immunisation Report for HOSC

Public Health England

December 2019

Authors:

Tina ten Hove Screening & Immunisation Manager

Screening & Immunisations Team (NHS Digital)

COVER Team (Public Health England)

Responsible Statistician:

Sally Harrison (NHS Digital)

Contents

1. Introduction and Programme Summary

This report has been prepared on childhood vaccination statistics for England in 2018-19, relating to the routine vaccinations offered to all children up to the age of five years, derived from the Cover of vaccination evaluated rapidly (COVER) programme and is based on the annual report produced by NHS Digital. The report compares national performance with regional performance and in addition the performance of the Norfolk local authority.

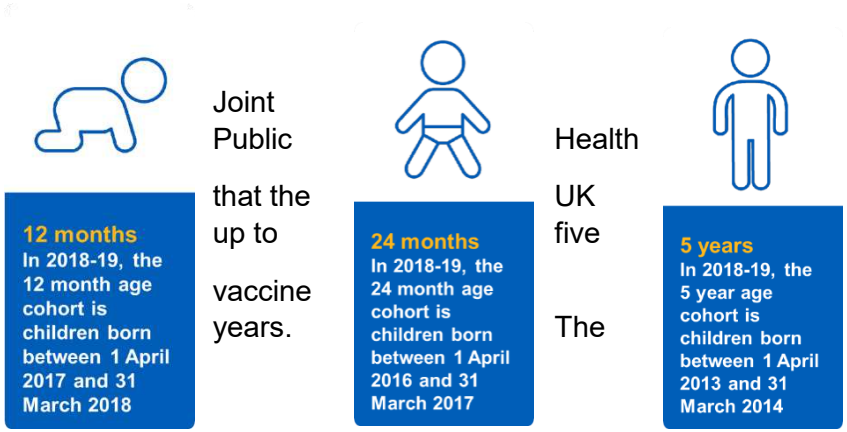
Vaccine coverage data for the routine childhood immunisation programme are extracted quarterly and annually at Local Authority level from local Child health information systems or CHISs by staff in Child Health Record Departments (CHRDs) and submitted to the PHE national COVER surveillance team. COVER collects information on the proportion of children aged 12 months, 24 months and 5 years who have completed courses of each routine childhood immunisations. This information is promptly fed back to the local level via the COVER report and associated tables, creating the opportunity to improve coverage and to detect changes in vaccine coverage quickly. Data is not published at CCG level.

The European Region of the World Health Organization (WHO) currently recommends that on a national basis at least 95% of children are immunised against diseases preventable by immunisation and targeted for elimination or control (specifically, diphtheria, neonatal tetanus, pertussis, polio, Haemophilus influenzae type b (Hib), Hepatitis B, measles, mumps and congenital rubella[1]).

The routine childhood immunisation programme for the UK includes these immunisations recommended by WHO as well as a number of others as advised by the Joint Committee on Vaccination & Immunisation (JCVI) and defined by Public Health England (PHE)[2].

There is an expectation that the UK coverage estimates for all routine childhood immunisations evaluated up to five years of age achieve 95%.

Seasonal influenza vaccine coverage is also presented in this report, for children aged 2 and 3 years. The 95% target does not apply to influenza vaccinations.



Key findings

Source:

Coverage declined in all routine vaccinations*†

Vaccinations measured at 12 months, 24 months or five years, in England in 2018-19, compared to the previous year.

The decreases ranged in size from 0.2 to 1.0 percentage points.

*NB. This excludes the MenB booster, which is reported for the first time this year.

DTaP/IPV/Hib coverage declined for all ages

Coverage at 12 months was 92.1%, its lowest since 2008-09.

Coverage at 24 months was 94.2%, the first time it has dropped below the 95% target since 2008-09.

MMR1 and MMR2 coverage at 5 years dropped

MMR1 coverage at 5 years is 94.5%, down from 94.9% in 2017-18 and below the 95% target.

MMR2 coverage at 5 years is 86.4% (down from 87.2% in 2017-18).

† This key fact has been updated post-publication for clarity. It previously stated 'Coverage declined in all 13 routine vaccinations'.
In 2018-19, coverage declined in all 13 measures of coverage for 9 routine childhood vaccinations, compared to the previous year. Changes in coverage c
measured for the 10th routine vaccination, MenB booster, as this is reported for the first time in 2018-19, therefore no comparison to 2017-18 data is availa
Coverage for some vaccines is assessed at multiple ages resulting in more measures of coverage than vaccinations.

http://www.euro.who.int/ data/assets/pdf_file/0010/98398/wa540ga199heeng.pdf

Source: https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book

2. Recent Changes to the Vaccine Programme

Introduction of the Hexavalent vaccine

From autumn 2017, all babies born on or after 1 August 2017 have been eligible for a hexavalent vaccine[3] which protects against six diseases (diphtheria, tetanus, pertussis, hepatitis B, poliomyelitis and disease caused by *Haemophilus influenzae* type b) for their primary immunisations.

This vaccine, called Infanrix hexa®, replaces the pentavalent infant vaccines Infanrix®-IPV+Hib and Pediacel®, which protected against five diseases.

Hepatitis B is the additional disease that is now also protected

against.

In 2018-19, children in the 12 month age cohort (those born between 1 April 2017 and 31 March 2018) are the first age cohort affected by this change. They will have received either the pentavalent or hexavalent vaccine, depending on the date they were vaccinated.

The 24 month and 5 year age cohorts will not be significantly impacted by this change.

Meningococcal B (MenB) vaccination

Coverage data for the MenB booster, evaluated at 24 months, is included in the report as a National Statistic for the first time in 2018-19.

3. Summary of routine vaccinations up to the age of five years old

Disease (Vaccine)	Age	Notes	Coverage * 12m	24m	5yr
Diphtheria, tetanus, pertussis, polio and *Haemophilus influenzae* type b (DTaP/IPV/Hib)**	1st dose: 8 weeks 2nd dose: 12 weeks 3rd dose: 16 weeks	Primary course	✓	✓	✓
Diphtheria, tetanus, pertussis and polio (DTaP/IPV)	3 years/4 months to 5 years	Booster: 3 years after completion of primary course			✓
Pneumococcal disease (PCV)	1st dose: 8 weeks 2nd dose: 16 weeks	Primary course	✓		
	One year	Booster		✓	
Rotavirus	1st dose: 8 weeks 2nd dose: 12 weeks	Primary course (has to be competed before 24 weeks of age)	✓		
Meningococcal group B (MenB) (from September 2015)	1st dose: 8 weeks 2nd dose: 16 weeks	Primary course	✓		
	One year	Booster		✓	
Haemophilus Influenzae type b and meningococcal group C (Hib/MenC)	One year	MenC primary Hib booster		✓	✓
Measles/mumps/rubella (MMR)	One year	First dose		✓	✓
	3 years/4 months to 5 years	Second dose			✓
			2yrs		3yrs
Children's flu vaccine (2018-19)	Aged 2 to 9 years on 31/08/2018	Annual vaccination	✓		✓

Coverage is assessed when children reach specific ages. The ages presented in this report are marked with a tick

** From autumn 2017, all babies born on or after 1 August 2017 are eligible for a hexavalent vaccine which includes hepatitis B (HepB) for their primary immunisations.

‘5-in-1’ or ‘6-in-1’ vaccine – National coverage

DTaP/IPV/Hib or DTaP/IPV/Hib/HepB

Vaccine protects against:
5-in-1: diphtheria, pertussis, tetanus, polio, disease caused by *Haemophilus influenzae* type b
6-in-1 (post-August 2017): additionally protects against hepatitis B

Primary course scheduled at ages:
8, 12 and 16 weeks

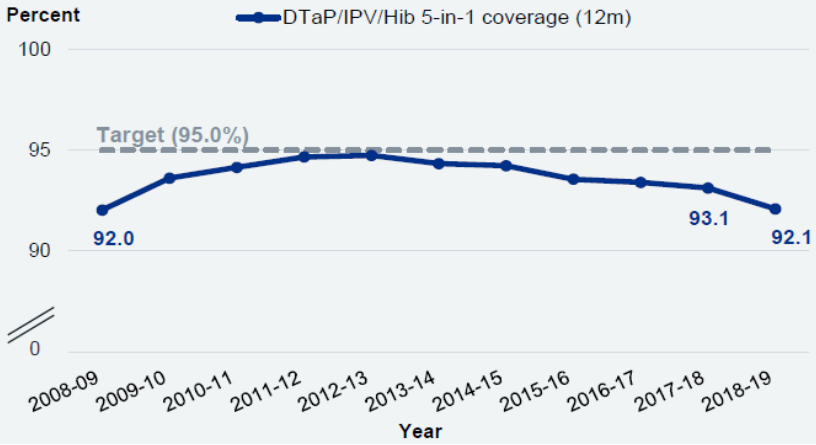
Coverage measured at ages:
12 months, 24 months, 5 years

Note: For all babies born on or after 1 August 2017, the pentavalent (5-in-1) vaccine was replaced with a hexavalent (6-in-1) vaccine, this additionally protects against hepatitis B[4].

In 2018-19, children in the 12 month cohort received either the 5-in-1 or the 6-in-1 vaccination, depending on when they were vaccinated. As all vaccinated children in this cohort received the DTaP/IPV/Hib component of the vaccine (but not all received the HepB component), coverage is referred to as 5-in-1.

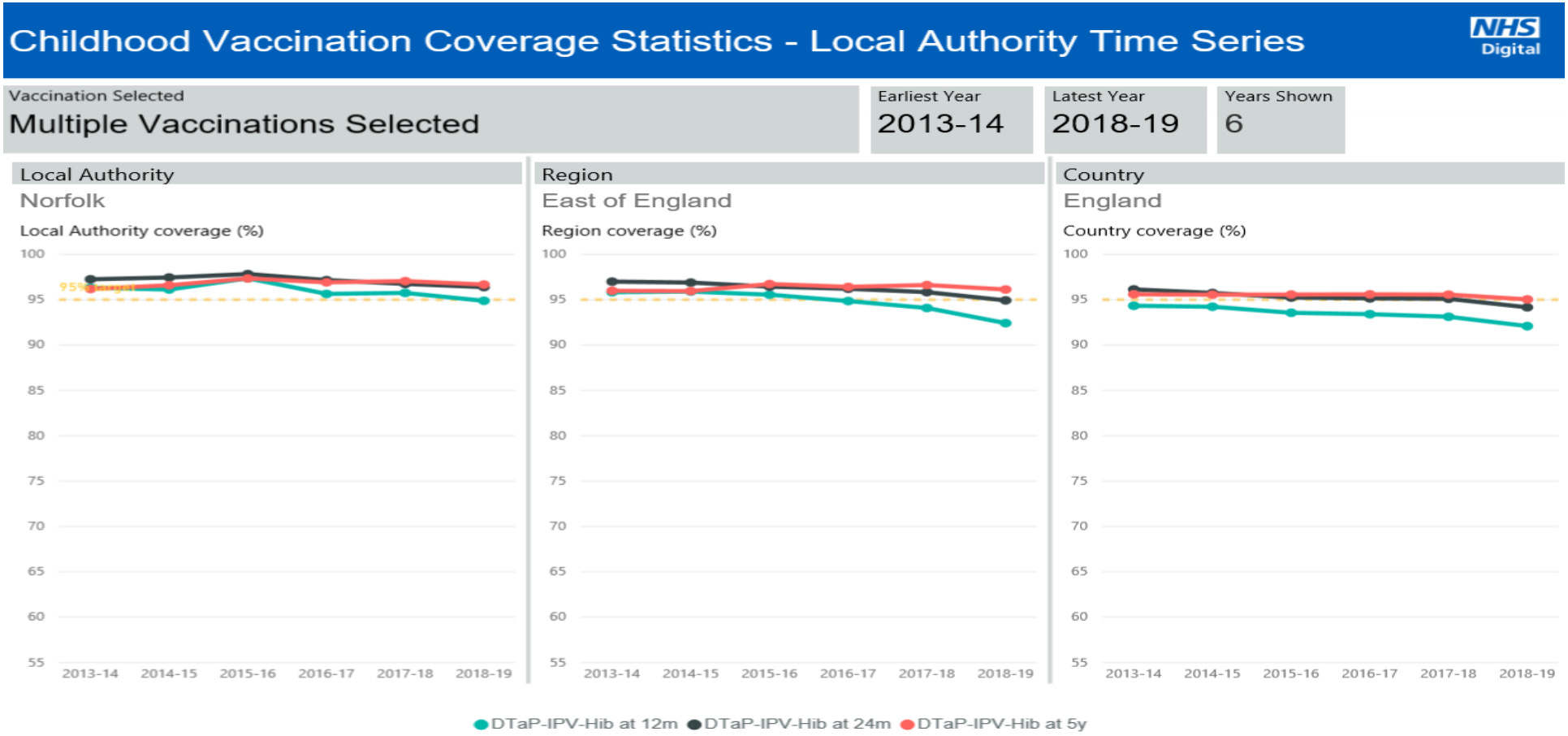
National coverage at 12 months

- In 2018-19, 92.1% of children were reported to have completed their primary course of three doses at 12 months. This compares with coverage of 93.1% in 2017-18.
- The chart shows 5-in-1 coverage at a national level has declined in each of the past six years, following a peak in 2012-13. The coverage decrease over six years is 2.6 percentage points.



5 in-1' or '6-in-1' vaccine – coverage – 12 months, 24month and 5 years

DTaP/IPV/Hib or DTaP/IPV/Hib/HepB presented by Norfolk Local Authority, East of England Region and England.



Coverage at 12 months

Nationally in 2018-19, 92.1% of children were reported to have completed their primary course of three doses at 12 months. This compares with coverage of 93.1% in 2017-18.

The chart shows 5-in-1 coverage at a national level has declined in each of the past six years. The coverage decrease over six years is 2.6 percentage points.

In 2018-19, eight of nine regions reached 90% coverage with only one region exceeding the national target of 95%.

East of England and Norfolk local authority replicated the national trend of seeing coverage go down, dropping by 1.7% points and by 0.8% points respectively compared to the previous. Norfolk overall dropped by 1.4% percentage points since 2013, this is again below the national rate of fall off.

Norfolk continues to perform above both the national and regional levels of achievement, missing the 95% target by just 0.1%.

Coverage at 24 months

In 2018-19, coverage for the 5-in-1 vaccine at 24 months was 94.2%, falling below the 95% national target for the first time since 2008-09.

However, Norfolk maintained uptake above 95% achieving 96.4%; 2.2% higher than the national level but mirrored the national and regional trend with a reduction of coverage but only of 0.9% percentage points since 2013/14.

Coverage at 5 years

Nationally in 2018-19, coverage for the 5-in-1 vaccine at 5 years was 95.0%, meeting the national target. However, this is a decrease from the 95.6% coverage reported in 2017-18.

This is the sixth consecutive year that coverage assessed at 5 years has met the 95% target.

In 2018-19, coverage was above 90% in all regions. Norfolk achieved 96.7% uptake exceeding the national target.

MMR vaccine – National coverage

Vaccine protects against:
Measles, mumps, rubella

Doses scheduled at ages:
Dose 1 (MMR1) 12 or 13 months
Dose 2 (MMR2) 3 years 4 months to 5 years

Coverage measured at ages:
24 months (for MMR1)
5 years (for MMR1 and MMR2)

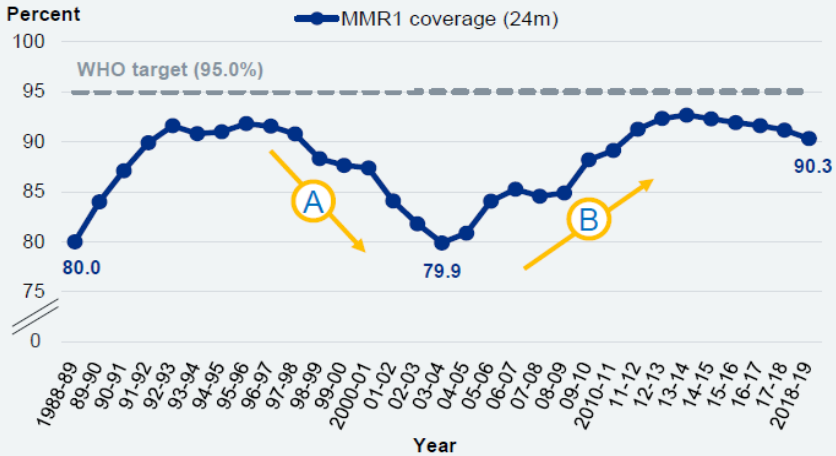
Chart interpretation notes

A → During the 1990s and early 2000s coverage was impacted by a since discredited potential link between the MMR vaccine and autism and Crohn's disease.

B → Subsequent recovery of coverage rates mean MMR1 coverage at 24 months remained above 90% for the past 8 years. This may be a result of national campaigns, a recommendation by the JCVI to offer the Hib/MenC and PCV booster vaccines and the first dose of MMR vaccine at the same visit, as well as local initiatives to improve coverage.

National coverage of MMR1 at 24 months

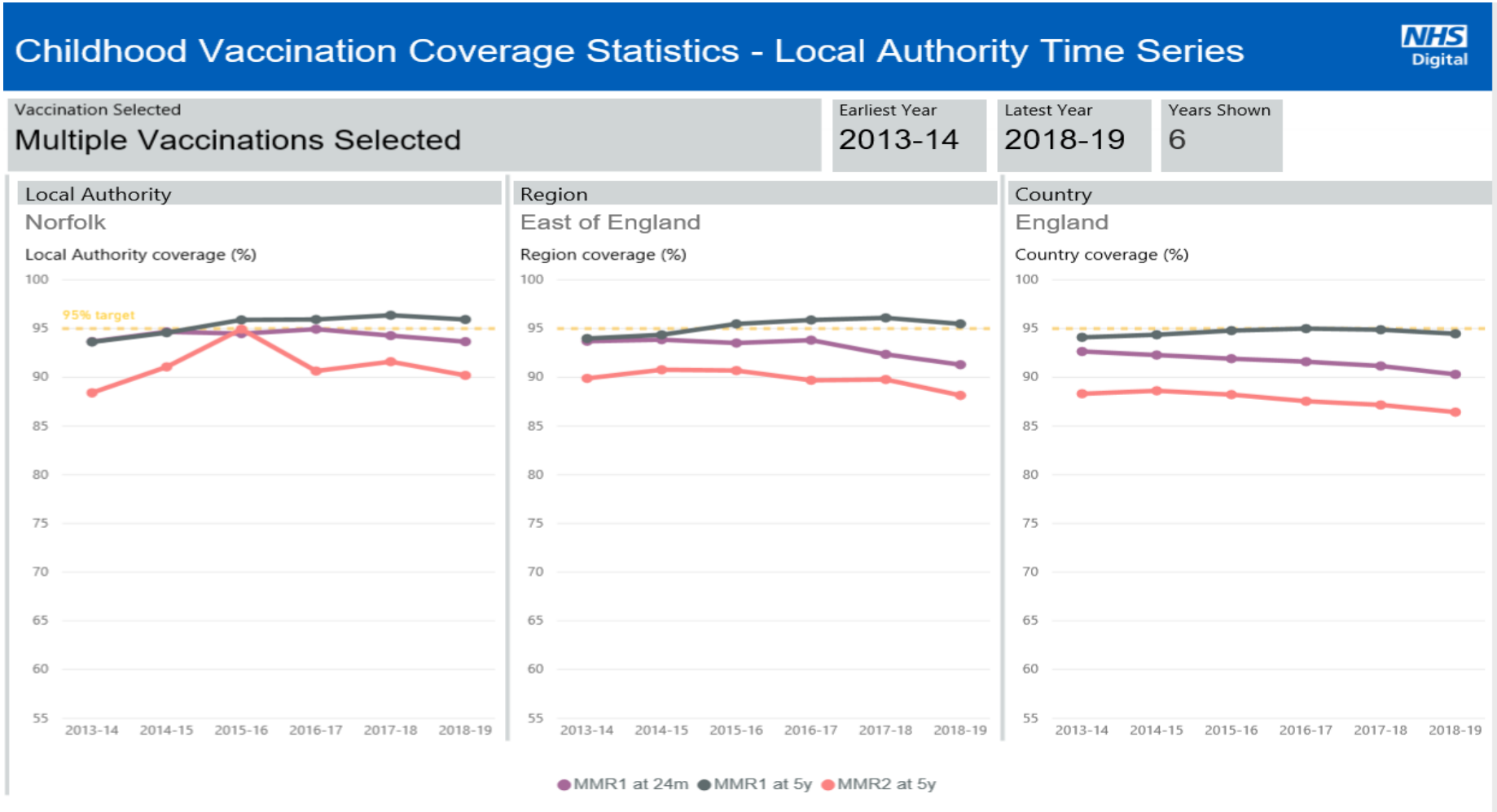
- In 2018-19, 90.3% of children completed their first dose of the MMR vaccine. This compares with 91.2% in 2017-18.
- Coverage at a national level has declined in each of the past five years following a peak of 92.7% in 2013-14.



Source: COVER – PHE, NHS Digital. See Data Tables 2 and 7.
NB. Due to variable data quality in recent years, some caution should be exercised when comparing figures over time, as apparent trends could reflect changes in the quality of data reported as well as real changes in vaccine coverage. See Appendix D for more details.

15

4. MMR Uptake Data MMR1 24 Months, MMR1 at 5 Years and MMR2 at 5 years by Country, East of England Region and Norfolk Local Authority



11

Nationally in 2018-19, 90.3% of children completed their first dose of the MMR vaccine. This compares with 91.2% in 2017-18. Coverage at a national level has declined in each of the past five years following a peak of 92.7% in 2013-14. Nationally in 2018-19, 86.4% of children received their second dose of MMR vaccine (MMR2) by their 5th birthday, a decrease from 87.2% in the previous year. Norfolk achieves 93.7% uptake for MMR1 at 2years rising to 95.9% at age 5, thus exceeding the vaccination target.

However, MMR2 uptake lags at 90.2% but still remains higher than both the national and regional levels of 88.4% and 88.1% respectively.

The UK lost its measles free status in 2019.

The measles elimination strategy explains the UK's strategy towards measles and rubella elimination:

https://www.gov.uk/government/publications/measles-and-rubella-elimination-uk-strategy

The strategy focuses on 4 core components required to maintain elimination of measles and rubella:

1.Achieve and sustain ≥ 95% coverage in the routine childhood programme.

2.Achieve ≥ 95% coverage with 2 doses of MMR vaccine in older age cohorts through opportunistic and targeted catch-up.

3.Strengthen measles and rubella surveillance.

4.Ensure easy access to high-quality, evidence-based information

In Norfolk, the Screening and Immunisation team are working in collaboration with the local authority, CCGs and Health child programme to improve vaccination uptake by:

Increasing vaccination opportunity with school immunisation teams offering catch up to Reception year children and children in Year 10.

By sending reminders for vaccination out with Local authority offer of school place letters.

By improving the data flow and collection between GP practices and child health departments.

By using the Just One Norfolk platform to promote vaccination and translate into several different languages.

Rotavirus vaccine – National and regional coverage

Vaccine protects against:
Rotavirus

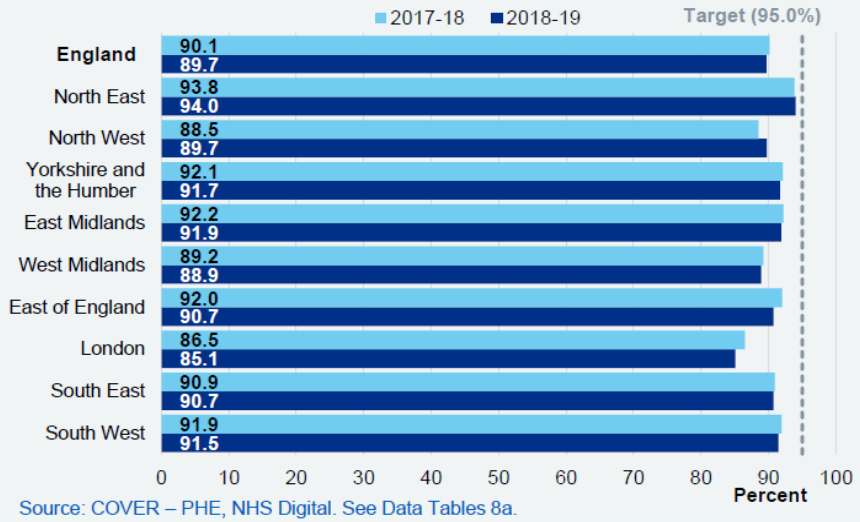
Vaccine scheduled at ages:
8 weeks and 12 weeks

Coverage measured at age:
12 months

Note: Unlike other vaccines offered in the primary schedule, opportunities for children to catch up missed doses are limited as it cannot be given beyond six months of age and so coverage at 12 months is likely to be lower than other vaccines offered at the same time.

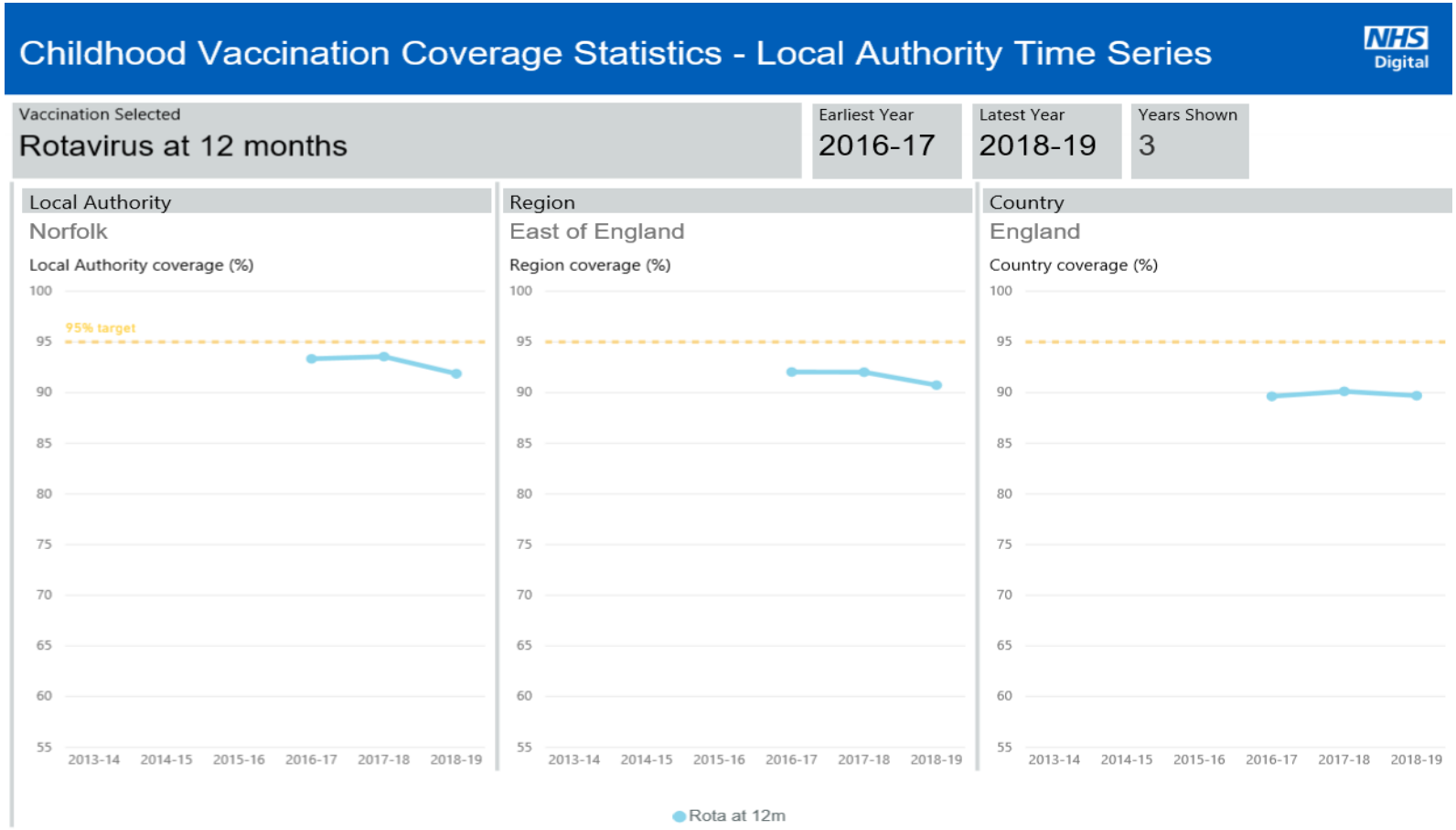
National and regional coverage at 12 months

- Third year Rotavirus coverage has been reported as a National Statistic.
- In 2018-19, 89.7% of children in England were reported to have received two doses of the rotavirus vaccine as measured at 12 months, a decrease from 90.1% in 2017-18. Similar to the 2016-17 coverage of 89.6%.
- Coverage in six regions was above 90%. None achieved 95% coverage.



Source: COVER – PHE, NHS Digital. See Data Tables 8a.
Data quality issues within the London region were reported in 2018-19. See Appendix D for more details.

5. Rotavirus Uptake data presented by National, Regional and Norfolk Local Authority



East Anglia achieved 90.7% and Norfolk 91.9%, again performing above the England rates.

Pneumococcal Conjugate Vaccine (PCV) – National coverage

Vaccine protects against:
Pneumococcal disease

Vaccine scheduled at ages:
Primary course (2 doses) 8 and 16 weeks
Booster dose 12 to 13 months

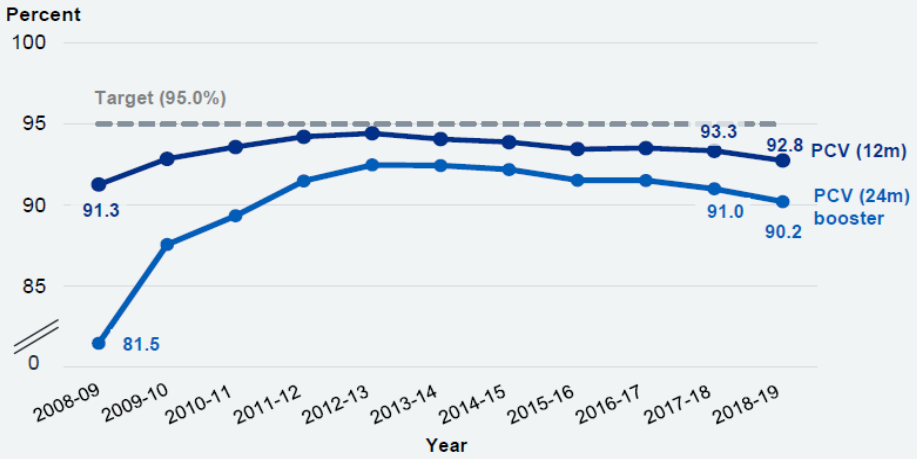
Coverage measured at ages:
12 months (primary course)
24 months (booster)

National coverage at 12 months (PCV first dose):

- In 2018-19, 92.8% of children had completed a primary immunisation course of PCV, a decrease from 93.3% the previous year.

National coverage at 24 months (PCV booster):

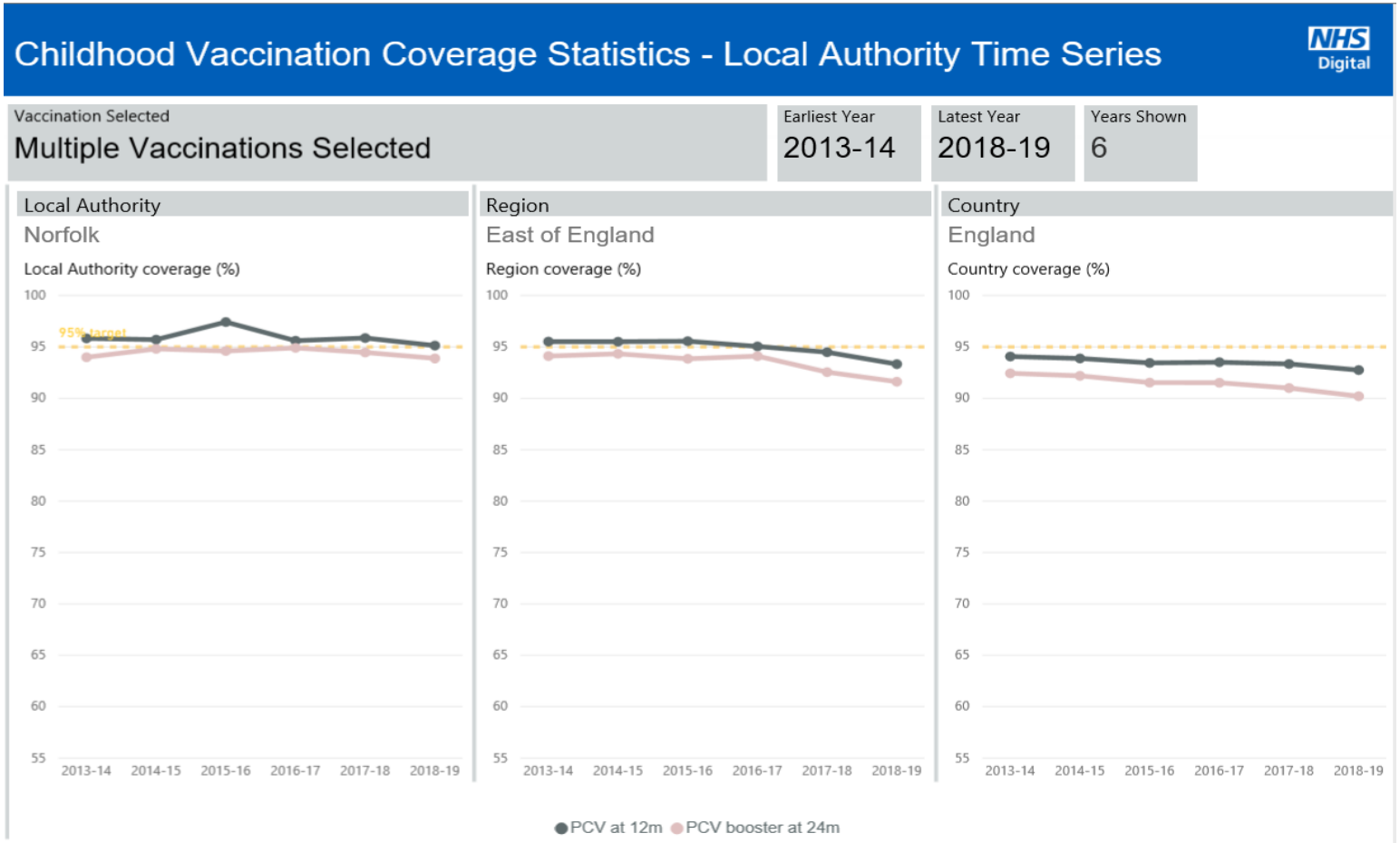
- In 2018-19, 90.2% of children received the PCV booster, a decrease from 91.0% the previous year.



Source: COVER – PHE, NHS Digital. See Data Tables 1 and 2.

21

PCV Uptake data at 12month and and 24 months by Norfolk Local authority, East of England region and England.



In East Anglia 93.2% of children were vaccinated with Norfolk performing at 95.1%, so meeting the national target at 12 months and at 24 months 93.9% of children in Norfolk have received their 2nd dose of vaccine.

Hib/MenC vaccine – National coverage

Vaccine protects against:
***Haemophilus influenzae* type b (Hib),**
meningococcal disease group C (MenC)

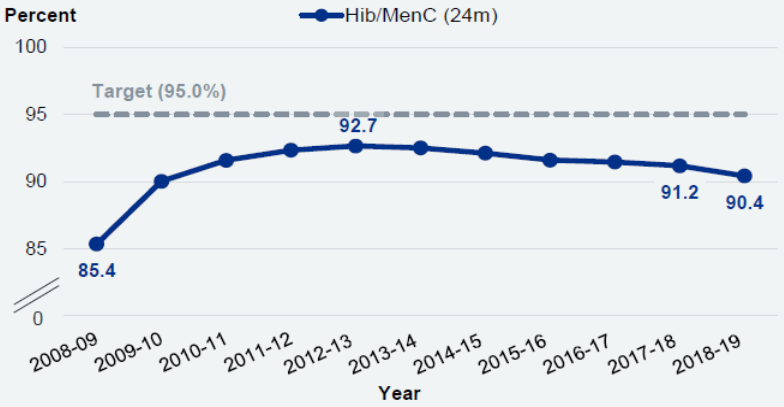
Combined vaccine scheduled at ages:
12 to 13 months

Coverage measured at ages:
24 month and five years

Note: The Hib/Men C is a combined vaccine. It is a booster for Hib *(also offered in the first year of life as part of the DTaP/IPV/Hib/HepB primary course)* and the primary dose for MenC.

National coverage at 24 months

- In 2018-19, 90.4% of children in England were reported to have received the combined Hib/MenC vaccine.
- This is the sixth consecutive year that coverage has decreased, down from 92.7% in 2012-13.

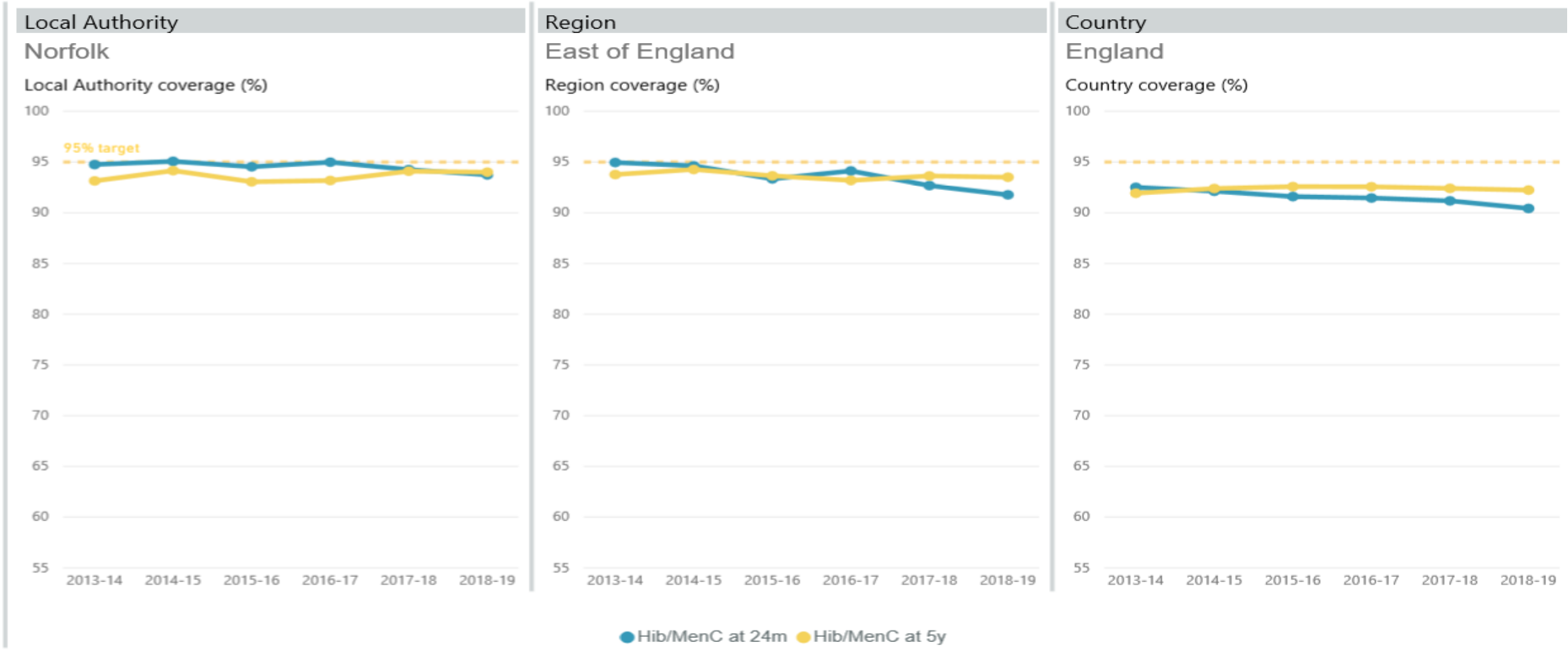


Source: COVER – PHE, NHS Digital. See Data Table 2.

Childhood Vaccination Coverage Statistics - Local Authority Time Series

NHS Digital

Vaccination Selected	Earliest Year	Latest Year	Years Shown
Multiple Vaccinations Selected	2013-14	2018-19	6



Coverage at 24 months

In 2018-19, 90.4% of children in England were reported to have received the combined Hib/MenC vaccine. This is the sixth consecutive year that coverage has decreased, down from 92.7% in 2012-13. In 2018-19, eight out of nine regions reached 90% coverage. No regions reached the national target of 95%. East of England achieves 91.8 and in Norfolk 93.7%, the same as 2013/14.

Coverage at 5 years

In 2018-19, eight out of nine regions reached 90% coverage. None reached 95%, but two regions (North East and South West*) achieved coverage above 94.9% Coverage in England was below the 95% target in 2018-19, at 92.2%. However, coverage is higher than when assessed at 24months 91.6% in 2015/16. East of England achieved vaccination rates of 93.5%, with Norfolk achieving 94%.

MenB vaccine – National and regional coverage

Vaccine protects against:
Meningococcal disease (group b)

Combined vaccine scheduled at ages:
Primary course 8 and 16 weeks
Booster 12 to 13 months

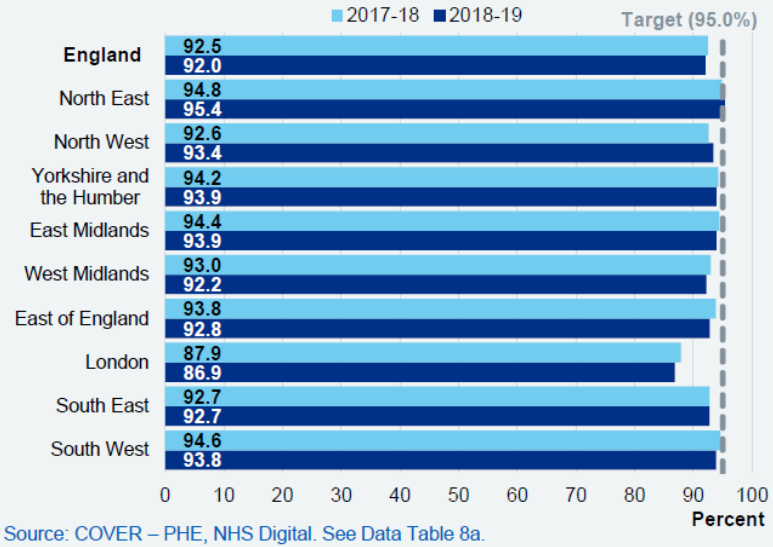
Coverage measured at ages:
12 months and 24 months

Note: Children are not eligible for the MenB booster after their second birthday.

The MenB vaccine was first introduced from 1 September 2015 alongside other routine vaccinations.
The primary course was first reported at 12 months as a National Statistic in the 2017-18 reporting year.
MenB booster data, evaluated at 24 months, is available in this report for the first time.

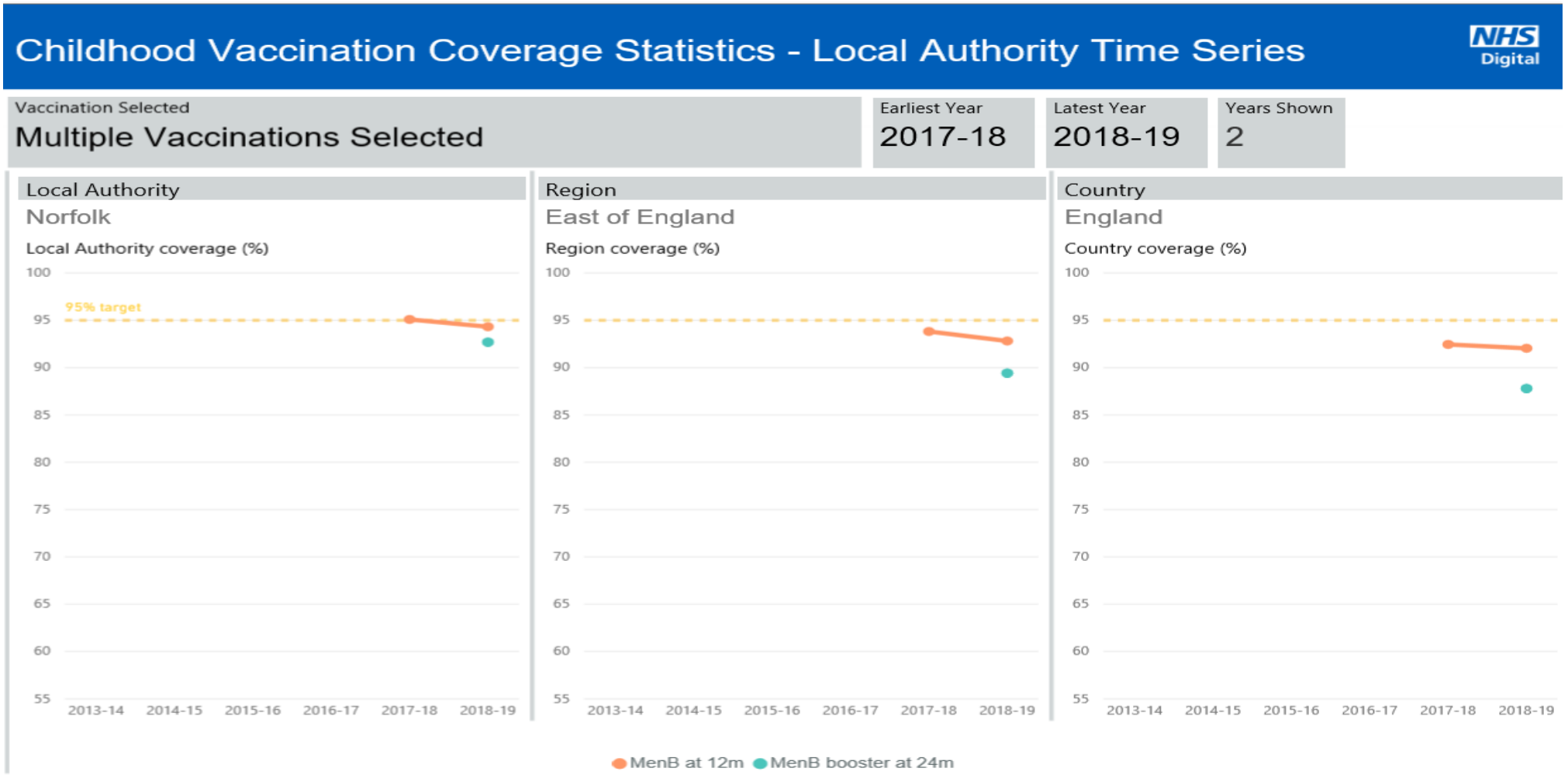
National and Regional coverage at 12 months

- In 2018-19, 92.0% of children in England received two doses of the Men B vaccine. A decrease from 92.5% in 2017-18.
- In 2018-19, eight of the nine regions reached 90% coverage, one region exceeded the 95% national target.



Source: COVER – PHE, NHS Digital. See Data Table 8a.
Data quality issues with the London region were reported in 2018-19. See Appendix D for details.

25



In East of England 92.8% and in Norfolk vaccination rates of 94.3% were achieved, 2.3% points higher than the national average. Second does is reported for the first year and Norfolk achieve 92.7%, 4.9% percentage points higher than the England average and 3.3% percentage points higher than the regional average.

Selective neonatal vaccination programmes

In addition to the routine vaccines listed in this report, there are two selective neonatal vaccination programmes

Vaccine	Age	Notes
Hepatitis B	Birth to 12 months	Given to 'at risk' infants*/4 doses
Bacillus Calmette–Guérin (BCG)**	Birth onwards	Given to 'at risk' infants***/1 dose

* 'At Risk' infants: born to mothers who are chronically infected with HBV or to mothers who have had acute hepatitis B during pregnancy

** Data for BCG collected through COVER were included for the first time in 2016-17

*** At risk infants:
1. All infants (aged 0 to 12 months) with a parent or grandparent who was born in a country where the annual incidence of TB is 40/100,000 or greater.
2. All infants (aged 0 to 12 months) living in areas of the UK where the annual incidence of TB is 40/100,000 or greater

Due to known data quality issues there are no regional or national data published for BCG or Hepatitis B within the data tables and both are designated as official statistics, rather than National Statistics.

Despite the data quality issues, it remains important to make the data available for the following reasons;

- They are acknowledged as the best that they can be given the issues involved.
- To maintain public awareness.
- Justification of respondent/collection burden.
- Identification of trends at local level within an active programme so that action can be taken to improve uptake where needed.

BCG data can be found in Table 11a of the accompanying data tables. Coverage and eligible population data are only published for LAs running a universal vaccination programme.

HepB data can be found in Tables 11b and 11c for children aged 12 months and 24 months old respectively.

More information on BCG can be found in the Tuberculosis report published by PHE:
https://www.gov.uk/government/publications/tuberculosis-in-england-annual-report

Appendix E of the accompanying Appendices document has more information.

Vaccine protects against:
Seasonal influenza

Vaccine scheduled at ages: Annual vaccination, given between 1 September 2018 and 31 March 2019

Coverage measured at ages: 2 years and 3 years

Influenza vaccine

During the 2018-19 winter season (1 September 2018 to 31 March 2019), all GP practices in England were asked to offer the influenza (seasonal flu) vaccine to all registered children aged two and three years. Primary school age children (aged 4 to 9 years) are also vaccinated, but this data is not presented in this report. Age is defined as age on 31 August 2018. Data is collected for the period 1 September 2018 to 28 February 2019.

Percentage of children vaccinated at two and three years.

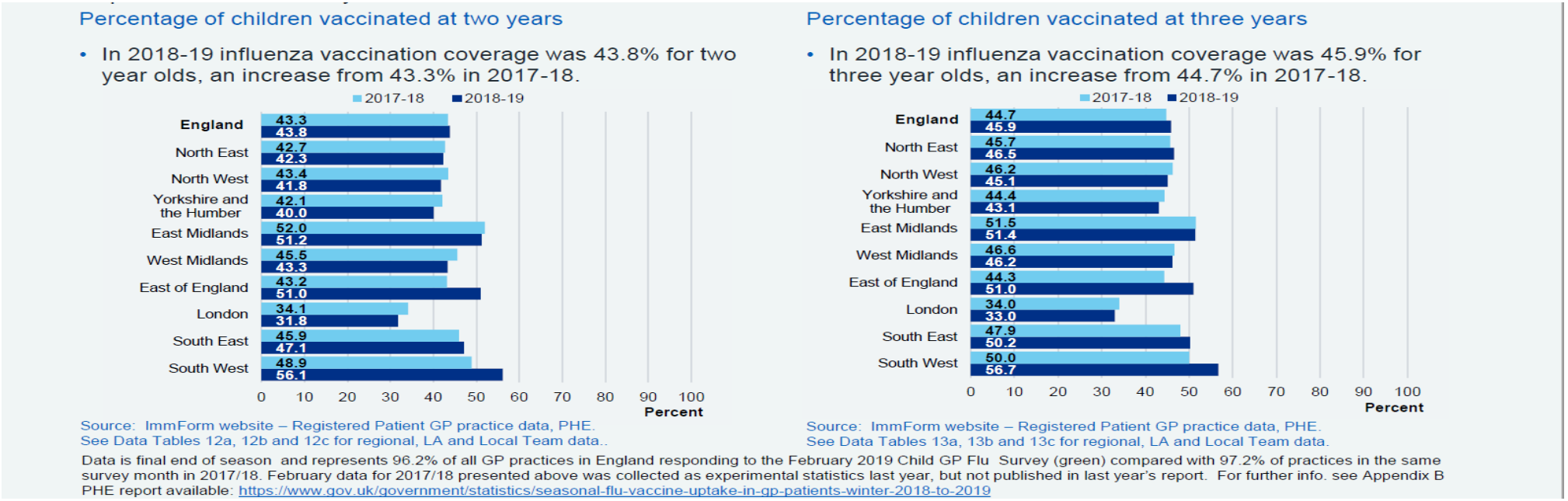
In 2018-19 national influenza vaccination coverage was 43.8% for two year olds, an increase from 43.3% in 2017-18 and 45.9% for three year olds, an increase from 44.7% in 2017-18

In East Anglia a fantastic 51% uptake was achieved for both groups. This was following an initiative led by the screening and immunisation team, to commission Child health services to send reminder letters to the parents of all 2 and 3 year old children inviting them for vaccination.

In Norfolk all areas achieved above the national level of coverage and in some areas increases of 11% percentage points were achieved.

In both 2 and 3 year old cohorts vaccination uptake for Norfolk local authority was 54.7% higher than both the national and regional levels and comfortably exceeded the vaccination ambition target of 48%.

Regional Influenza Uptake



Norfolk local authority generally performs well across all immunisation programmes, performing better against both the national and regional uptake figures. With the exception of influenza, Norfolk has experienced the same national trend seeing a decline in uptake across all programmes, following peaks in uptake mainly in 2016/17.

Norfolk however does achieve the 95% target across many of the programmes which should be commended and generally performs at levels of uptake in excess of 90%.

The influenza programme for 2 and 3 year olds saw an impressive rise in uptake following an active call and recall programme and this demonstrates the importance of invitation for vaccination and effective follow up. This initiative has been continued for the 2019/20 season.

References and Resources

https://files.digital.nhs.uk/4C/09214C/child-vacc-stat-eng-2018-19-report.pdf

https://app.powerbi.com/view?r=eyJrIjoiZTI3NWZhNzItMTIyZS00OWM2LTg0MzMtOGY5YTJjMGY0MjI1IiwidCI6IjUwZjYwNzFmLWJiZmUtNDAxYS04ODAzLTY3Mzc0OGU2MjllMiIsImMiOjh9

https://www.gov.uk/government/publications/hexavalent-combination-vaccine-programme-guidance

https://www.gov.uk/government/publications/measles-and-rubella-elimination-uk-strategy

http://www.euro.who.int/ data/assets/pdf_file/0010/98398/wa540ga199heeng.pdf

https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book

https://www.gov.uk/government/collections/vaccine- uptake#seasonal-flu-vaccine-uptake:-figures
https://www.who.int/influenza/vaccines/virus/recommendations

HOSC Meeting with Councillors October 2020

Addendum to original report

Details of what was done regarding childhood immunisation services following the onset of Covid 19
The impact of Covid19 on vaccination uptake was closely monitored; nationally MMR uptake fell in the 1st three weeks after physical distancing measures were announced but preliminary data from the Child Health Information Service regarding MMR uptake since the end of March 2020 was monitored and suggested that coverage for Norfolk had remained fairly consistent with no substantial drop off due to Covid19. Q1 data is due to be released and shows that Norfolk vaccination rates have in fact improved across all vaccinations. The 95% target is met for the majority of vaccinations and those falling below show consistent improvement every quarter.

Details of restoration of services, or plans for future restoration / provision of childhood immunisation services in a Covid-safe manner
Childhood Immunisations were seen as a priority and services continued to operate throughout the pandemic. Primary care services are following the Technical guidance issued from NHS England and NHS improvement including infection prevention and control measures for provision of childhood immunisation services in a Covid-safe manner.

If possible, an explanation of how children would be taken into account in any future Covid 19 vaccination programme
Early indications are that it is unlikely that any new COVID 19 vaccination would be licensed for those under the age of 18 years. If a licenced COVID vaccine becomes available in future, the most likely route of delivery will be through the school age immunisation services.

To include information on the vaccination rates in each of the childhood immunisation programmes at CCG level (i.e. the 5 CCGs in Norfolk and Waveney in the years up to 2019-20)
Quarterly collection reports on the immunisation coverage at CCG level is available on NHS Digital but only as management information. The term management information describes aggregate information collated and used in the normal course of business to inform operational delivery or the management of organisational performance. The information may be incomplete in places, is not quality assured to the same extent as official statistics and may not necessarily be fully representative.
Therefore, the source of official national statistics remains the **Public Health England COVER** (Cover of Vaccinations Evaluated Rapidly) data at a Local Authority.

Acceptable	Achievable	Q1 2019-20			Q2 2019-20			Q3 2019-20			Q4 2019-20			Q1 2020-21
90%	95%	Num	Den	%	Num	Den	%	Num	Den	%	Num	Den	%	
12 Month	DTaP/IPV/Hib/Hep B	2044	2138	95.6%	2086	2193	95.1%	1978	2079	95.1%	1891	2005	94.3%	95.70%
	PCV2	2050	2138	95.9%	2093	2193	95.4%	1991	2079	95.8%	1897	2005	94.6%	95.70%
	Rota	1956	2138	91.5%	2035	2193	92.8%	1924	2079	92.5%	1829	2005	91.2%	92.80%
	MenB	2040	2138	95.4%	2082	2193	94.9%	1981	2079	95.3%	1889	2005	94.2%	95.30%
24 Month	DTaP/IPV/Hib/Hep B	2162	2242	96.4%	2172	2237	97.1%	2038	2128	95.8%	2059	2131	96.6%	96.80%
	Hib/MenC Booster	2089	2242	93.2%	2108	2237	94.2%	1996	2128	93.8%	2003	2131	94.0%	95.20%
	PCV Booster	2090	2242	93.2%	2110	2237	94.3%	1991	2128	93.6%	2001	2131	93.9%	94.80%
	MMR1	2085	2242	93.0%	2105	2237	94.1%	1998	2128	93.9%	2003	2131	94.0%	95%
	MenB Booster	2056	2242	91.7%	2079	2237	92.9%	1982	2128	93.1%	1992	2131	93.5%	94.10%
5 Years	DTaP/IPV/Hib/Hep B	2319	2384	97.3%	2434	2513	96.9%	2356	2403	98.0%	2182	2247	97.1%	97.30%
	DTaP/IPV Booster	2151	2384	90.2%	2268	2513	90.3%	2200	2403	91.6%	2027	2247	90.2%	92.20%
	Hib/MenC Booster	2273	2384	95.3%	2372	2513	94.4%	2283	2403	95.0%	2132	2247	94.9%	94.30%
	MMR 1st Dose	2306	2384	96.7%	2420	2513	96.3%	2335	2403	97.2%	2168	2247	96.5%	97%
	MMR 2nd Dose	2191	2384	91.9%	2298	2513	91.4%	2230	2403	92.8%	2043	2247	90.9%	93.60%

Any actions the commissioner is taking to Increase take-up rates of all childhood immunisations and particularly of the MMR2 vaccine, which at 90.2% has the lowest take-up of any of the vaccinations given.
MMR2 has improved at 93.6% for Q1 the period during COVID.

In Q4 by CCG North Norfolk achieved 94.9% and all other CCGs achieved above 91%; marked improvements are noted in GYW and West Norfolk compared to last year.

2109-2020			GY & W CCG				North Norfolk CCG				Norwich CCG			
Age	Immunisations	Target	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
12 months	DTaP/IPV/Hib/ Hep B	95%	93.3	95.2	93.0	93.3	95.9	98.3	95.2	96.5	96.3	94.9	95.5	95.2
	PCV	95%	94.4	96.5	94.5	95.4	96.5	98.6	96.0	96.8	96.8	95.7	96.4	96.1
	Rotavirus	95%	92.3	93.7	92.8	94.1	92.1	95.2	94.3	95.1	93.0	94.5	93.4	94.8
	Meningitis B	95%	94.1	96.3	94.1	94.9	96.5	98.0	96.0	96.5	95.7	94.9	95.5	95.3
24 months	DTaP/IPV/Hib/ Hep B	95%	95.6	95.2	95.9	95.6	98.7	95.8	94.3	96.1	95.7	95.4	95.1	97.0
	HIB/Men C booster	95%	91.6	93.2	93.4	94.1	96.3	98.1	94.0	95.8	93.9	93.5	95.1	95.9
	PCV Booster	95%	91.8	93.0	94.0	94.3	96.3	97.8	94.0	96.5	92.9	94.8	94.6	96.1
	Men B Booster	95%	89.0	91.2	92.9	92.6	94.7	96.9	94.0	95.2	90.3	93.5	94.2	94.9
	MMR 1st dose	95%	90.8	92.5	93.3	94.1	95.0	97.8	94.0	95.8	93.6	94.1	95.6	95.9
5 years	DTaP/IPV/Hib	95%	96.9	85.8	96.6	96.5	98.1	92.4	99.5	98.1	89.2	89.4	97.0	96.5
	DTaP/IPV booster	95%	89.2	96.2	90.2	90.8	91.9	98.8	94.5	91.8	97.2	95.5	88.7	88.6
	HiB/Men C booster	95%	95.4	94.0	93.0	94.1	97.3	95.7	98.0	97.3	95.2	92.3	92.8	92.9
	MMR 1st dose	95%	96.4	96.3	96.1	96.0	96.8	97.4	98.5	98.1	96.9	95.8	96.3	96.4
	MMR 2nd dose	95%	89.8	87.2	91.0	91.7	93.5	94.5	95.5	94.9	92.0	91.0	92.4	91.0

2109-2020			South Norfolk CCG				West Norfolk CCG			
Age	**Immunisations**	**Target**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
12 months	DTaP/IPV/Hib/ Hep B	95%	95.9	95.4	95.6	97.4	93.3	91.3	92.9	95.7
	PCV	95%	96.4	95.9	96.2	97.6	93.6	92.1	95.0	96.5
	Rotavirus	95%	93.4	92.1	91.6	93.8	89.2	89.2	90.0	90.6
	Meningitis B	95%	96.2	95.7	96.0	97.4	93.8	91.6	94.5	95.7
24 months	DTaP/IPV/Hib/ Hep B	95%	96.9	96.8	95.0	96.8	94.5	95.1	94.1	94.5
	HIB/Men C booster	95%	95.1	94.5	93.5	95.3	90.3	92.2	92.0	95.1
	PCV Booster	95%	94.4	93.9	93.5	95.8	90.5	92.4	91.7	95.1
	Men B Booster	95%	92.5	92.4	92.9	94.7	88.8	91.0	91.2	93.7
	MMR 1st dose	95%	94.4	94.1	93.5	95.8	90.3	91.9	92.0	94.2
5 years	DTaP/IPV/Hib	95%	97.1	91.6	98.3	96.5	97.5	88.9	98.7	97.0
	DTaP/IPV booster	95%	90.9	97.2	92.1	92.5	91.6	95.7	92.2	91.5
	HiB/Men C booster	95%	96.3	96.5	95.7	94.7	96.1	93.6	96.0	93.5
	MMR 1st dose	95%	96.6	97.2	97.6	96.7	97.3	95.3	97.6	95.9
	MMR 2nd dose	95%	92.0	92.6	93.2	92.3	92.7	89.9	92.4	91.5

Reference
https://www.gov.uk/government/statistics/cover-of-vaccination-evaluated-rapidly-cover-programme-2019-to-2020-quarterly-data

Accessed 17.9.2020

Is any work done around helping parents who do not take up the offer of immunisations for their children to fully understand what the results of this can be?
The covid pandemic has limited the work that has been possible in this area. The Healthy Child Pogramme teams are very keen to work collaboratively and we plan to send lists from CHIS of children who do not attend for vaccination, so HCP teams can actively follow them up and have these conversations. The School immunisations teams will also be actively following up those children with an incomplete vaccination.

Who keeps the records of childhood immunisations and how do people access their immunisation record when they become adults?
Child health information systems keep comprehensive vaccination records for children up to 18 years, and all GPs are informed of vaccinations and are responsible for maintaining up to date patient records. The parent child health record (Red book) is given to every parent/ carer which contains information on the child's immunisation given to 5 years of age. The digital parent child health record (Red book) work continues with NHS Digital.

Future strategies and next steps

- Previously, accessing and interpreting data on MMR uptake has been subject to some difficulties. Data interpretation and analysis should be improved by the introduction of a new reporting style for NHSEI: statistical process control (SPC). This is an analytical technique which looks at data trends over time, taking into account variation to determine if changes are significant and important or not. This will improve analyses such as these by helping to avoid being distracted by random variation in figures and looking at long term trends. Regional data packs will be available which include monthly MMR vaccination data along with redevelopment of national dashboards.
- New service specification for the community school aged immunisations service includes checking vaccination records on school entry and offering vaccination catch up in Reception.
- Utilising GMS contractual changes to ensure increased opportunity and greater flexibility of appointments is achieved through NHSEI networks.
- It is important that genuine parental concerns about risk of COVID infection and difficulties accessing healthcare are taken into account in regard to children who did not attend vaccinations, and that vaccinations are promoted and reoffered to these groups. Collaborative working with the HCP team to follow up children who fail to attend for vaccination on two consecutive occasions is being developed.
- Continue sign up to Apollo for non SystmOne practices to automate process of adding vaccine data to the CHIS system to prevent manual errors in data entry.
- East of England Measles elimination strategy is in progress with multiple work-strands including:
    - Improving data
    - Expanding and improving access
    - Communications
    - Workforce

Ambulance response times and turnaround times in Norfolk & Waveney

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

Examination of action to improve ambulance response and turnaround times since September 2019 and preparations for winter 2020-21 in light of Covid 19.

1. Purpose of today's meeting

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

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

- EEAST and the wider health and care system's preparations for winter 2020-21 in the context Covid 19 and maintaining ambulance service performance.

1.2 EEAST, Norfolk and Waveney Clinical Commissioning Group (CCG) and the Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH) have been asked to provide the following information:-

- An update on ambulance response times across the Norfolk & Waveney (data on a post code basis) and turnaround times at all 3 acute hospitals in Norfolk, including trends for both sets of data.
- Effects of Covid 19 on the ambulance service and details of how it now operates to minimise risk of infection to patients and staff
- An update on the system-wide project to improve ambulance performance in Norfolk and Waveney
- Progress with pathways for mental health patients
- The current situation with regard to recruitment and retention of ambulance staff in the Norfolk and Waveney area
- Any other developments affecting ambulance response times & turnaround times that they think NHOSC should know about

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

1.3 Representatives from EEAST, the Clinical Commissioning Groups, the Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH)

and the Queen Elizabeth Hospital NHS Foundation Trust (QEH) have been asked to attend.

The James Paget University Hospital NHS Foundation Trust has not been asked to attend on this occasion because ambulance turnaround delays have historically been at a lower level there.

The NNUH is the busiest hospital in the region in terms of arrivals by ambulance and delays at the hospital therefore have the greatest potential to affect ambulance response times. As Members will see from the NHS partners' report at Appendix A, patient handover delays at the QEH are also a significant issue.

2. Background

2.1 National standards

2.1.1 Ambulance response time standards

The following response time standards for England were introduced in winter 2017 with the Ambulance Response Programme (ARP). The expectation was not for them to be delivered straightaway but for Ambulance Services and wider health system to work towards achieving them.

Call category	National Standard	How long does the ambulance service have to make a decision?	How is this measured?
C1 Calls about people with life-threatening injuries & illnesses	7 minutes mean response time 15 minutes 90th centile response time (i.e. these type of calls will be responded to at least 9 out of 10 times before 15 minutes)	The earliest of:- • The problem is identified • An ambulance response is dispatched • 30 seconds from the call being connected	The first ambulance service-dispatched emergency responder arrives at the scene of the incident There is an additional Category 1 transport standard to ensure that these patients also receive early ambulance transportation
C2 Emergency calls	18 minutes mean response time 40 minutes 90th centile response time (i.e. these type of calls will be responded to at least 9 out of 10 times before 40 minutes)	The earliest of:- • The problem being identified • An ambulance response is dispatched	If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle counts. If the patient does not need transport the first ambulance service-dispatched

		• 240 seconds from the call being connected	responder at the scene of the incident counts
C3 Urgent calls	120 minutes 90th centile response time (i.e. these type of calls will be responded to at least 9 out of 10 times before 120 minutes		
C4 Less urgent calls	180 minutes 90th centile response time (i.e. these calls will be responded to at least 9 out of 10 times before 180 minutes)		

The latest national Ambulance Quality Indicators data for August 2020 showed that the C1 7-minute standard was being achieved in the London, North East, South Central and West Midlands areas but not in the rest of England. The East of England region came close with a 7 minute & 8 seconds mean response time for C1 life threatening cases.

It is important to note that the ambulance services, and the wider health system within the areas in which they operate, are expected to work towards achieving the national response time standards on average across their areas as a whole. **They are not commissioned to achieve them in each and every locality**.

2.1.2 **Ambulance turnaround standards**

The national standards for ambulance turnaround times at hospitals are as follows (to be achieved at every hospital):-

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

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

2.2 **REAP levels**

2.2.1 There are 4 REAP (Resource Escalation Action Plan) levels reflecting pressure on the ambulance service:-

REAP level one (green) – steady state
REAP level two (amber) – moderate state
REAP level three (red) – severe

REAP level four (black) – extreme pressure

Patients with urgent and immediately life-threatening conditions are the priority and during periods of high demand those with less serious conditions may be advised that there could be a delayed response or, if it is safe to do so, they should seek alternative care.

2.3 Findings from the CQC's inspection of EEAST, June & July 2020

2.3.1 On 30 September 2020 the Care Quality Commission published the findings a focused inspection which took place in June and July 2020. This inspection focused on leadership within EEAST (which the CQC calls the 'well-led' domain in their inspection programme).

The CQC found that the Trust had not done enough to address previously identified concerns around safeguarding staff, organisational culture and processes, staff diversity; governance; management of risk, issues and performance and information management. Safeguarding was a key concern with more consistency needed in the approach to combatting sexual harassment, bullying and other inappropriate behaviour to protect staff and patients.

The CQC recommended that the Trust be placed in special measures and has issued two notices for it to take immediate action. This will include:-

- a staff survey on experiences of inappropriate behaviour will take place as soon as possible in October
- updated safeguarding policies
- using new procedures to record, manage and audit concerns
- support and mentoring for staff raising concerns and clearer routes for mental health support
- more robust complaints procedures to make sure we have effective investigations and lessons are learned systematically
- an awareness month starting in October to raise the visibility of Freedom to Speak Up Guardian encourage staff to speak up and new campaigns to encourage positive cultural change and behaviour.

EEAST is also in touch with the Equality and Human Rights Commission which may lead to the development and implementation of an action plan.

The report can be found on the CQC website (still pending at time of writing).

2.4 **Previous report to NHOSC**

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

The subject was last on NHOSC's agenda on 5 September 2019; the report and minutes of the meeting are available on the County Council website (agenda item 8).

The committee heard that:-

- There had been a positive improvement in performance against EEAST's response time 'trajectory' standards agreed with their commissioners (the CCGs in the east of England). These standards were lower than the national standards introduced by the Ambulance Response Programme but were seen as a stepping-stone towards achievement of the national standards. EEAST was not achieving all the trajectory standards but was moving closer towards that goal.

- In Norfolk like other rural areas it was a challenge for EEAST to meet response time standards consistently and this was compounded by the pressures from handover delays at the hospitals. However, significant progress has been made across the trusts and performance reflected that, with a downward trend in handover delays in the past 12 – 15 months.

2.4.2 During the meeting on 5 September 2020, NHOSC asked for additional information on waiting times at the NNUH A&E to be provided, including numbers of patients waiting up to 6 hours. The NNUH provided information for the October 2019 NHOSC Briefing based on the year from 30 Sept 2018 to 30 Sept 2019 (available from the Democratic & Scrutiny Support Team Manager maureen.orr@norfolk.gov.uk on request). In summary:-

- Average Total time in Emergency Department (ED):
  - Admitted = 439 minutes (7.3 hours)
  - Non-admitted = 203 minutes (3.38 hours)
- Time to triage = 15 to 21 minutes
- First assessment by a doctor = 19 to 38 minutes
- Average time to treatment = 170 minutes (2.8 hours)
- Wait for a bed (left department following a Decision to Admit (DTA) = 161 minutes (2.7 hours)
- Longest element of delay/wait is for a bed for admitted patients and treatment to discharge for non-admitted people

2.5 **Request from North Norfolk Overview and Scrutiny Committee**

2.5.1 In January 2020 North Norfolk District Council's Overview and Scrutiny Committee resolved:-

That a formal request is made for NHOSC to increase its ambulance response times monitoring to quarterly, and that the data is reviewed on a post code basis.

The North Norfolk Overview and Scrutiny Committee was particularly concerned about ambulance response times in the NR25 and NR23 post code areas.

NHOSC was informed of the request on 13 Feb 2020 and while it was considered unlikely that the committee could include quarterly reports from EEAST in its programme it was agreed that the next report, which was scheduled for September 2020, would be brought forward to April 2020 and that EEAST would be asked to include data at post code level in its report. The April NHOSC meeting was cancelled due to the Covid 19 outbreak.

3. Suggested approach

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

Ambulance response times

(a) What response times are EEAST and the commissioners aiming for in the North Norfolk area?

(b) Do the commissioners and EEAST expect that ambulance response times taken as an average across Norfolk and Waveney will eventually meet national ARP standards?

(c) Do the commissioners consider that response time performance is moving in the right direction quickly enough?

(d) Lack of capacity to meet emergency / urgent mental health need in Norfolk and Waveney has had a knock-on effect on the ambulance service in the past. Does EEAST consider that the situation is now significantly improved?

(e) What is the current REAP (Resource Escalation Action Plan) level at EEAST and how does this compare with early October in previous years?

Ambulance turnaround times at hospitals

(f) Ambulance turnaround times at the Queen Elizabeth Hospital, King's Lynn, appeared to reduce early in 2020 when the hospital reconfigured its emergency department but they have gone up again in recent months. Is there anything more that the QEH, the commissioners or EEAST can do before winter 2020 to improve the situation?

(g) To what extent are turnaround times at A&Es affected by the need to keep hospital beds available for any upsurge in Covid 19 cases?

(h) What more can be done to reduce waiting times at the Emergency Departments between 'decision to admit' and admission of the patient to a hospital bed?

(i) Early Intervention Vehicles operating in Great Yarmouth & Waveney and Central Norfolk appear to reduce the numbers of conveyances to hospital. Are the commissioners, EEAST and the community health service provider considering an EIV in West Norfolk to help relieve pressure on the QEH Emergency Department?

Effects of Covid 19 on the ambulance service and its workforce

(j) The measures required to restrict the spread of Covid 19 may have the effect of slowing down the rate at which hospital emergency departments can treat patients. What more can be done to mitigate the knock-on effect on ambulance turnaround times?

(k) How quickly can EEAST staff in Norfolk & Waveney access Covid 19 testing and how quickly do they receive results?

(l) To what extent is EEAST's workforce in Norfolk and Waveney affected by the need to self-isolate due to Covid 19 symptoms and how is the service managing this situation?

Staff and staffing

(m) Is the position with regard to staffing front-line services (call handlers and those who go out to patients) better or worse now than in previous years?

(n) Given the findings of the latest CQC inspection (see paragraph 2.3) what immediate actions are being taken to support staff and thereby support the service in Norfolk and Waveney?

4. Action

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

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

in good health

Norfolk & Waveney Ambulance Update: EEAST, NNUH and Central Norfolk System

September 2020

1. Executive Summary

1.1. The purpose of this paper is to provide a further update and overview of Ambulance Performance across the Norfolk and Waveney locality following the previous presentation in September 2019. The paper mainly focuses on the Central System and the Norfolk and Norwich University Hospital (NNUH). Progress against the following core areas is included:

- Ambulance response and turnaround times at the acute hospitals
- Performance trajectories and future ambitions
- Progress and update on plans to improve performance and flow
- Update on Mental health patient pathways and impact on response times
- Impact of Covid19 on response times and the Emergency Department
- Workforce plans – call handlers, front line EEAST staff and paramedic training

1.2. The ambulance response programme (ARP) standards were introduced in October 2017 as outlined in the September 2019 paper. The NHS Operational Planning and Contracting Guidance 2020/21 for urgent and emergency care includes the following in relation to ambulance performance:

a) For the 20% of patients who arrive in Emergency Departments by ambulance, we will continue to work with ambulance services and commissioners on **safely reducing avoidable conveyance to emergency departments**. Further work is needed to ensure ambulances are swiftly available to respond to other incidents and calls, therefore continued focus with acute trusts **on avoiding ambulance handover delays at hospital** is required, as well as to **eliminate 'corridor care'**.

b) Ambulance services should ensure they meet the ambulance response time constitutional standards.

As part of the national "phase 3" Covid response the NHS Chief Executive wrote to NHS Trust Chief Executives and CCG Accountable Officers on 31 July asking them to prepare for winter.

A key element of this preparation is focussed on having a range of new offers in place for patients with low acuity /low complexity urgent care needs. This has been brought together under expanding "111 First". The public will be encouraged to contact 111 if they have an urgent care need to allow them to be directed to the right service that can meet their needs quickly. The 111 service will have access to pre-bookable slots in emergency departments, a range of same day emergency care clinics and to a 2 hour urgent response from the community.

The infrastructure to allow these services to be pre-booked is planned to be in place by 30 November ahead of the peak of winter. By pre-booking a range of urgent care services within our hospitals and the community we would expect to see reduced congestion in our Emergency Departments that will free up resource to improve ambulance handover.

1.3. In Norfolk like other rural areas it remains a challenge for EEAST to meet these standards consistently; this continues to be compounded by the pressures from handover delays at the hospitals and the national state of emergency as a result of Covid19. We have seen some good progress, but we are still experiencing periods of poor performance and variation. EEAST, NNUH and the CCG are working together to overcome significant challenges.

1.4. For the ambulance service the factors at play across Norfolk, in relation to the NNUH are in four areas, these being: The coastal territory, the roads network, some unique population-characteristics and the efficiency of circulation in our systems. System-partners have a degree of control in the last of these four factors.

Ambulances mostly do not sit at base during shift, they are mostly mobile between locations, with patients, and at hospitals. Crews begin each shift from their Ambulance station and take up a set of data-engineered response positions. These enable us to shorten the distance and time we can expect to take, to reach the maximum proportion of the area population.

1.5. The interaction between ambulance circulation on the road and reducing hospital handover delays is crucial. EEAST and NNUH have been working together to implement processes to support re-circulation of ambulances under high pressures, which are usually transient, but can become extended. The current performance position is provided below along with the remedial actions and plans to address the challenges.

2. **Performance Overview:**

2.1. The performance headlines do identify an overall positive picture against previous years, but recognising that they are not delivering against national standards in all categories, however increases in activity and emerging hospital delays across the summer weeks contributed to a decline in performance, particularly in August.

Standard	National Standards	May	June	July	August
C1 Mean	07:00	06:51	07:19	07:28	08:20
C1 90th	15:00	12:40	13:34	14:30	15:43
C1T Mean	/	08:49	10:00	09:46	12:15
C1T 90th	/	16:34	18:45	18:38	21:33
C2 Mean	00:18:00	00:14:29	00:18:01	00:20:34	00:25:36
C2 90th	00:40:00	00:27:33	00:34:38	00:40:35	00:53:44
C3 90th	02:00:00	01:06:25	01:31:25	01:48:25	02:44:24
C4 90th	03:00:00	02:04:09	02:18:53	02:50:24	02:39:55

2.2. All three acute hospitals have seen an increase in the number of handover delays recently. This is multifactorial but stems from increased demand, higher acuity and challenges with flow out of the hospitals. The A&E Delivery Board has been revised following the learning from Covid19 and is now the Urgent and Emergency Care (UEC) System Transformation Steering Group. The focus is on targeted high impact changes to improve all areas of performance across UEC areas as listed below – the impact and future plans are included in section 3:

- Community Capacity Cell (timely discharge)
- Ageing Well (2 hour response time – admission avoidance and discharge)
- Think 111 First (alternative conveyancing, reduced ambulance delays)
- System Resilience (improved responsiveness and use of resource)

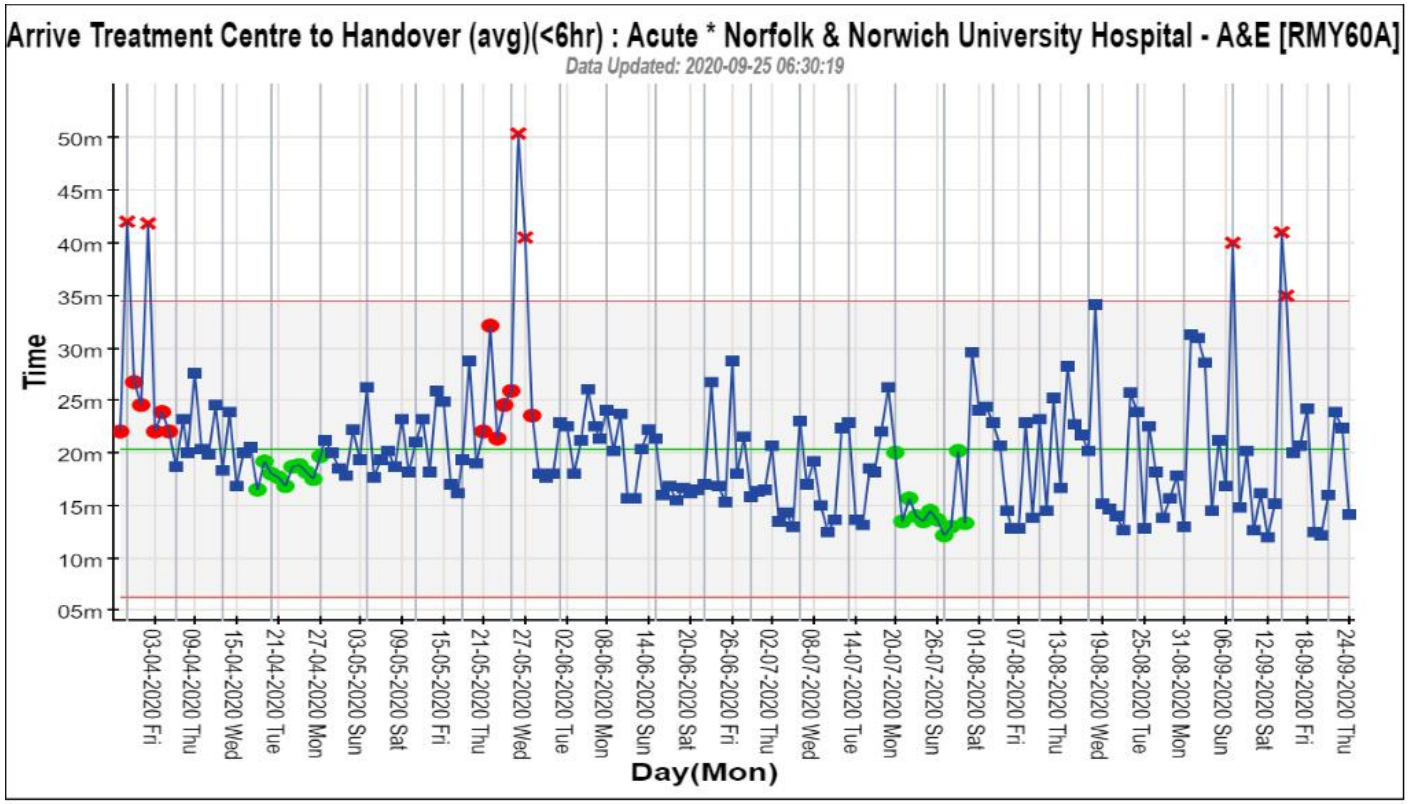
2.3. In Norfolk & Waveney the top 3 main challenges to EEAST performance are still:

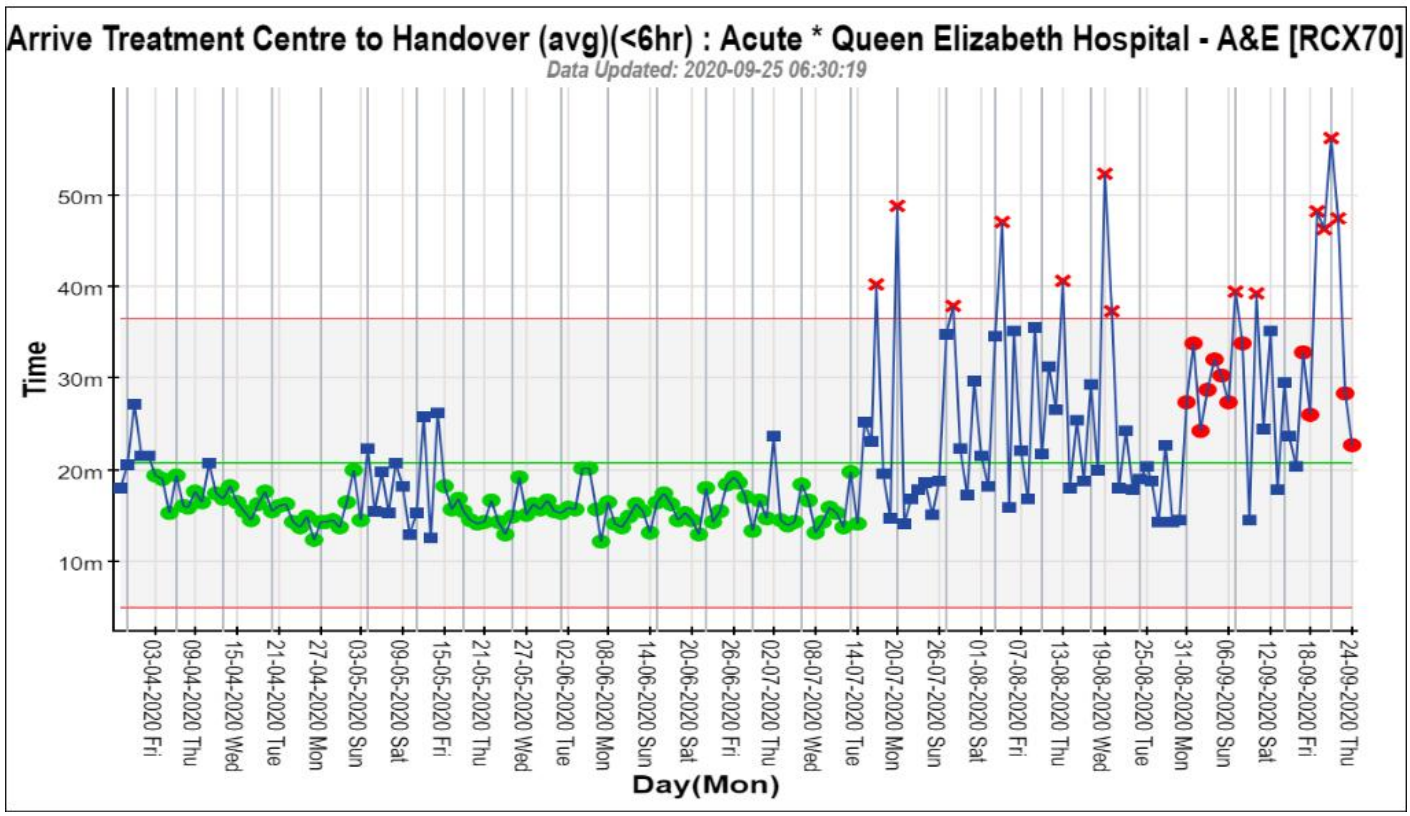
1. Delays at the front door of acutes, most notably NNUH and QEH (see below – although JPH has experienced handover delays throughout the summer weeks). This has the single biggest impact on our ability to deliver a safe service, through lost ambulance hours, ability to respond in the community and supporting staff wellbeing.

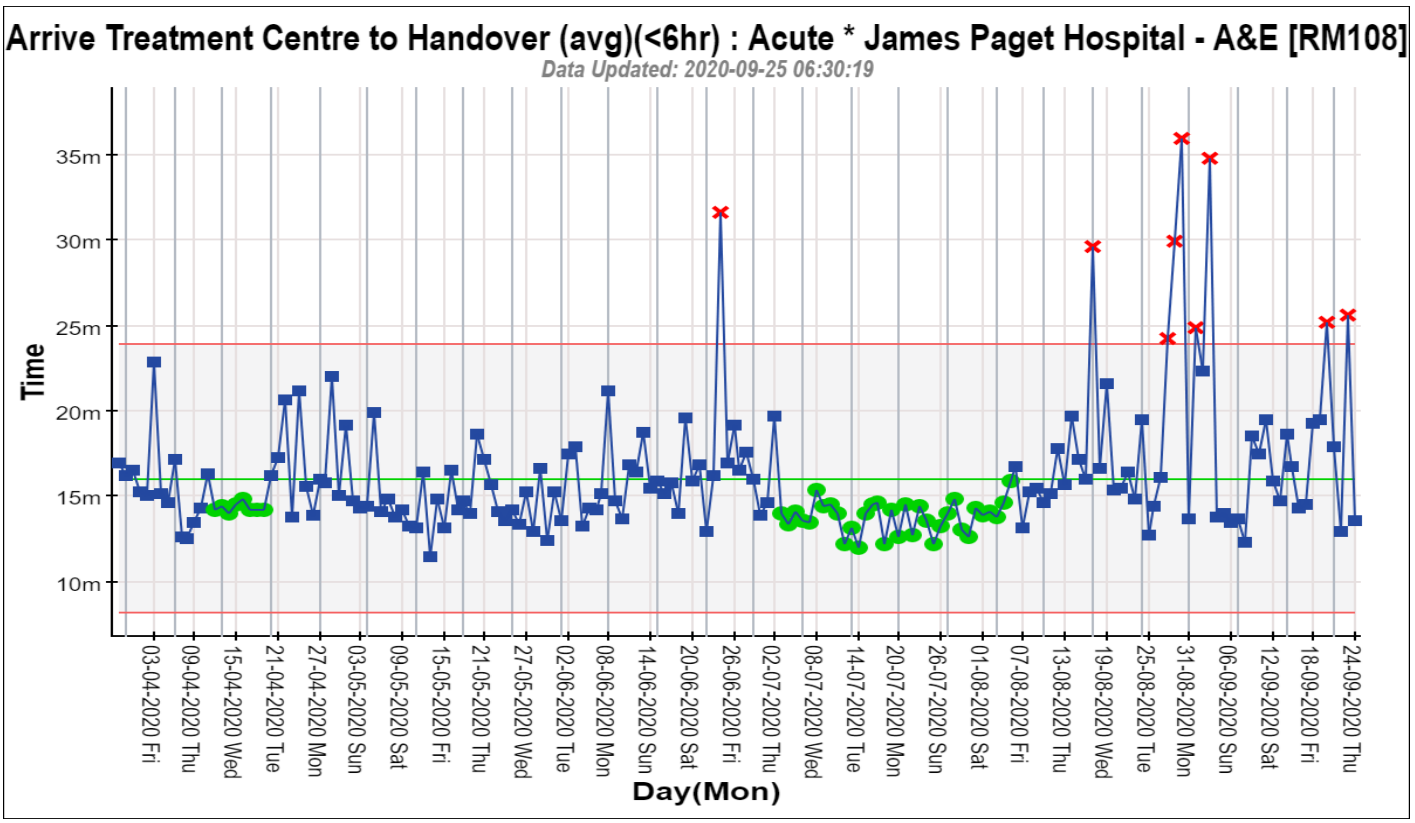
2. Year on year increase demand on the 999 service, including an increase in primary care conditions.

3. Coastal rurality and Road infrastructure.

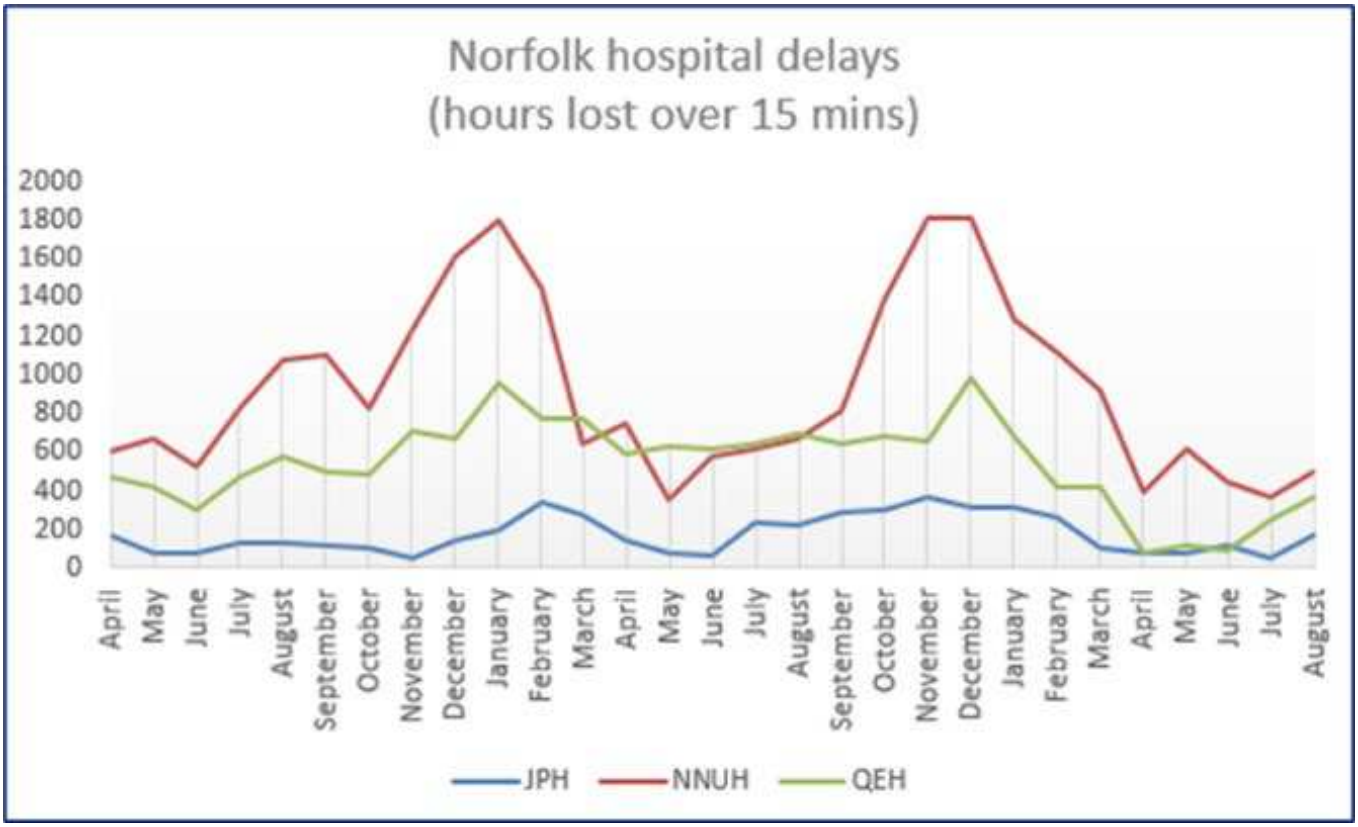
2.4. The charts below show the average handover time taken per patient to handover per acute.







2.5. The graph below (April 2018 to August 2020) shows periods of improvement, but these have not been sustainable and overall we are still experiencing significant lost hours:

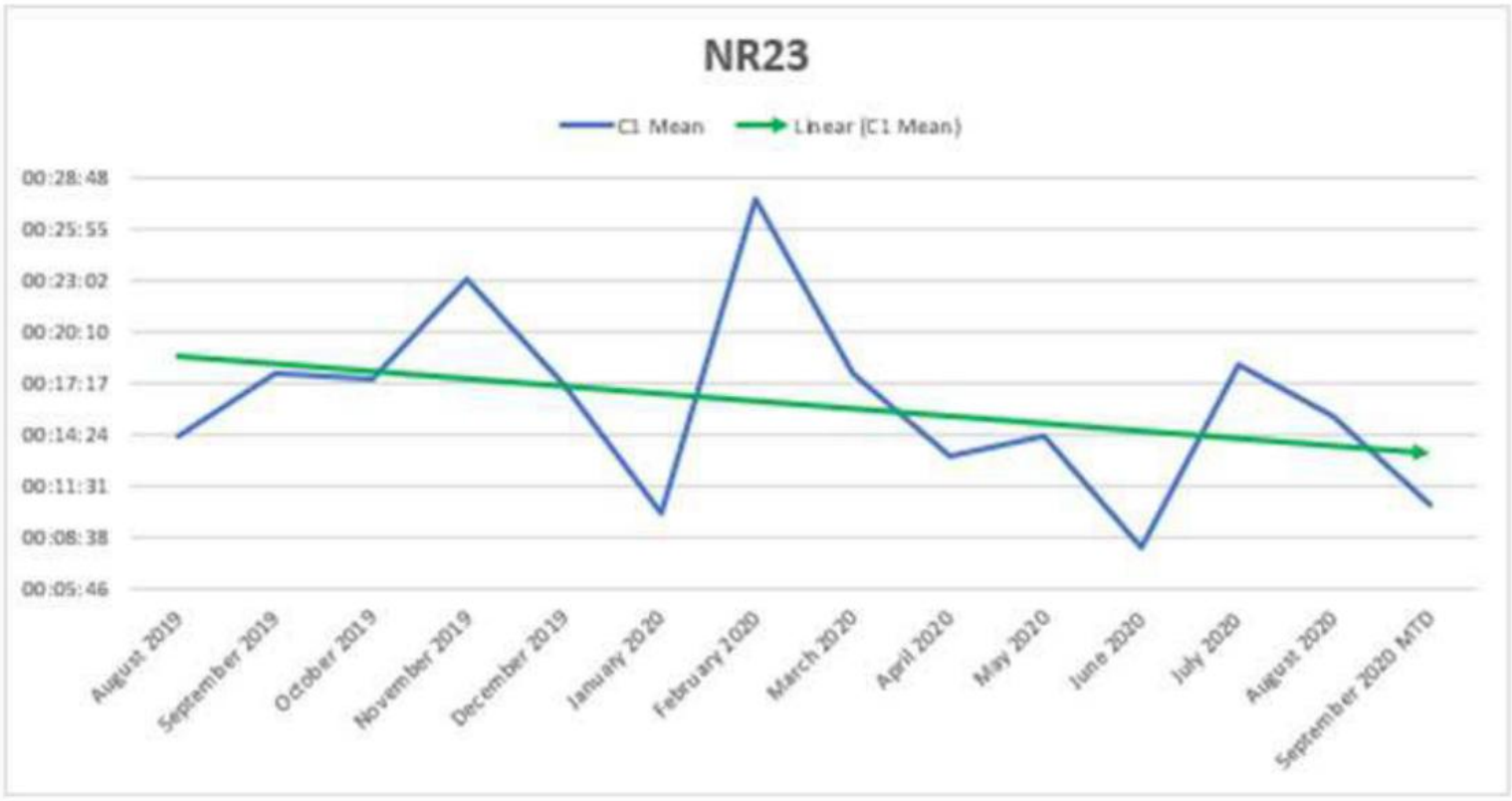


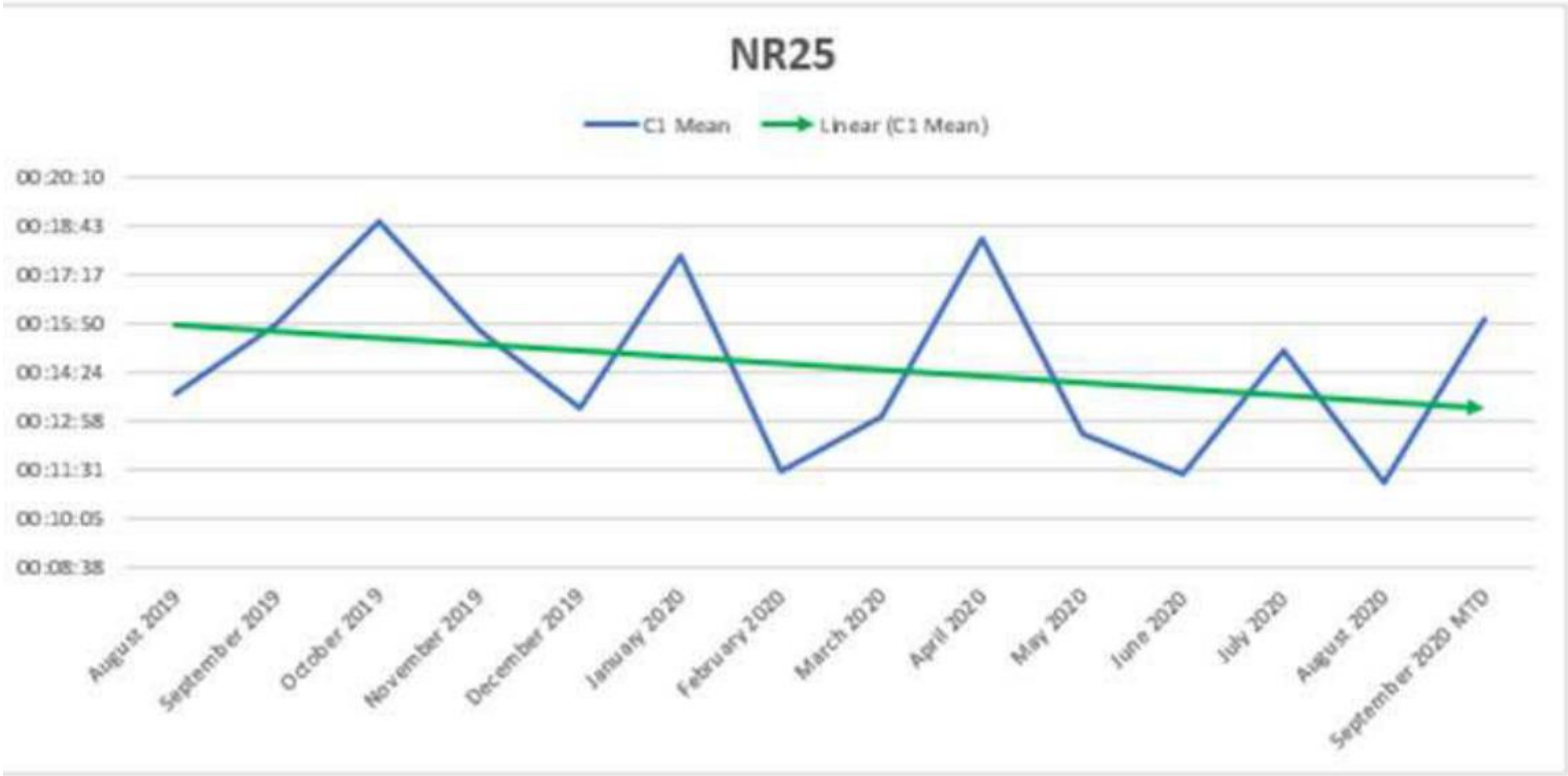
2.6. Hospital delays have the ability to significantly impact upon EEAST's ability to provide a sufficient response. As ambulances delay, more and more resource is lost and it is quite common that when this occurs we will be forced to hold patients in queue for allocation once an available resource becomes clear. These patients, as they wait, are constantly rearranged by order of clinical priority and those appropriate will be welfare called by clinicians deployed by EEAST in our 999 Control centres, who can escalate or de-escalate as required, making judgement-calls on patients whose condition may be worsening or stabilising.

2.7. Within EEAST we continue to work with CCG and acute colleagues at all levels to reduce the impact of these delays as much as possible, and to reduce the overall delay. Hospital Arrival Liaison Officers (HALOs) are deployed at each acute and these are 24/7 at NNUH and 12 hours per day/7 days at JPH/QEH. They help provide a smoother transition of flow for patients and support at times of delay and increased demand, and act as the conduit between the trusts to identify barriers to timely patient handovers.

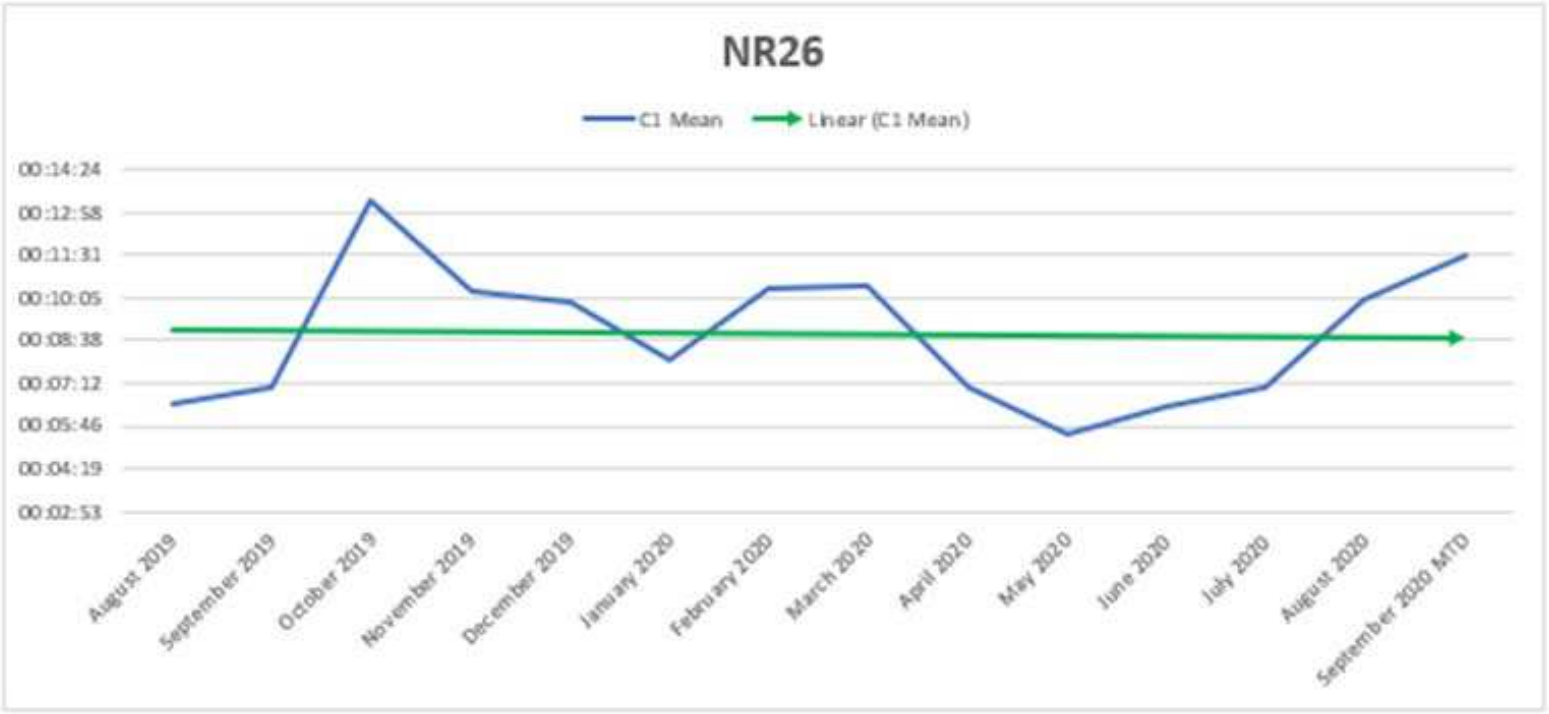
2.8. The EEAST Norfolk & Waveney management team meet (virtually) weekly to review performance and take action that may support areas where performance recovery is needed. Actions are also reviewed where specific planning is needed eg seasonal or event planning.

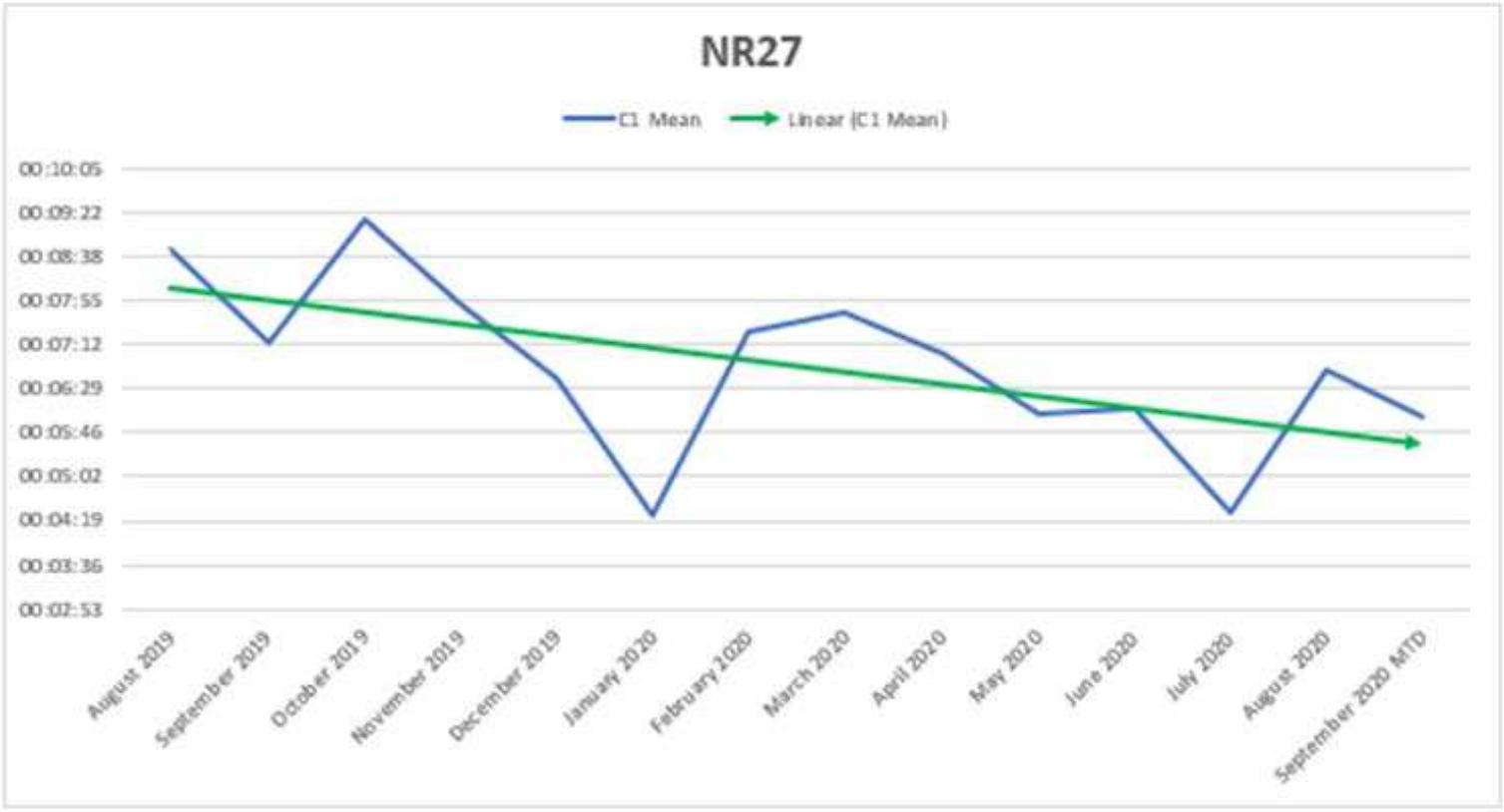
2.9. Postcodes where EEAST's C1 response remain a concern are illustrated here[1].





[1] NR23 – post town Holt; NR25 – post town Wells-Next-The-Sea
NR26 – post town Sheringham; NR27 – post town Cromer





In all four cases two things may be noted; firstly that the trend-line is showing a reduction in C1 response-time. Secondly it should be noted that the number of instances of C1 events is very small indeed, which tends to make the data very variable if influenced by unusual circumstances on a particular occasion.

2.10. Stations at Cromer, Fakenham and Diss are priority for primary cover so ambulances, once clear at scene or hospital, will be sent for cover in order of rural priority.

2.11. Community first response volunteers have been part of the response plan and supported with dedicated RRV response cars in Waveney and West Norfolk.

2.12. Norfolk Accident Response Service (NARS), is a charity-funded service to support EEAST with specialist and critical interventions. Primarily, they provide a car as part of the critical care cover, however they also provide a community first responder car. When not tasked to calls NARS have been designated to cover areas where cover may become depleted, eg coastal areas at busy weekends.

2.13. EEAST use “Power BI” data and “Informatics” to continually analyse and identify changing patterns of hotspots, differentiating between transient and persistent challenges. This can lead management to adjust response-point changes, sometimes weekly, according to operating conditions and behavioural changes, such as hot weather events and times when the coast is busy, or not. These are governed by consultation with/notification to the CCG and are reported retrospectively.

2.14. In summary, performance persists to be a challenge despite implementing the range of improvements and interventions outlined last time. As such, a more intensive urgent recovery programme is under development as summarised below.

3. **Projects and Progress (including Resilience Planning):**

3.1. In summary, the planned initiatives put in place over the past year have included:

- Access to alternative conveyance services in all hospitals e.g. Ambulatory Care
- Wider range of alternatives to conveyance e.g. via NEAT
- Introduced NEAT practitioners in the 999-control room
- Rotation of extended trained paramedics through the NCH&C speciality teams; These included palliative care, NEAT, community nursing, and acute & chronic respiratory care
- Additional ward capacity at NNUH and QEH
- NNUH Frailty OPED model and phone line for EEAST expanded into the weekend
- MADE and 'Perfect Week' events held at all acutes
- New fleet of ambulances and full recruitment
- Implementation of "GP Front Door Practice" models at the Emergency Departments

3.2. Partnership initiatives operated by EEAST in Norfolk & Waveney include:

- Advanced Paramedics in Urgent Care – from 1st April 2021, Primary Care Networks will have full funding, under the Additional Roles Retention Scheme (ARRS), for the recruitment of one community Paramedic. This could represent a significant loss of many of our most experienced staff across the region. To mitigate this, we are working toward collaboration with PCNs for the rotation of appropriately qualified staff into Primary Care. Currently, we have two Norfolk pilot sites which, initially addressed Covid 19 symptomatic patient visits but, in close collaboration with PCN Clinical Leads, has developed to include specific patient cohorts. We have been successful in embedding Advanced Paramedics into home-visiting elements of Primary Care and are able to offer the practices a reliable resource for the treatment of patients. Our Norfolk initiatives will inform our regional offer for a robust and efficient framework for rotational working and will contribute to moderating the number of staff directly recruited to PCNs. We are invested in our staff and in offering opportunities for development and diversification and the Primary Care setting offers our staff this opportunity of learning and progress within a new clinical setting.

- Great Yarmouth and Waveney and Central Norfolk Early Intervention Vehicles – an admission-avoidance response for patients following no-injurious falls. The Early Intervention Vehicle (EIV) is a close collaboration between EEAST and community nursing and therapy services across Norfolk & Waveney, allowing patients an immediate assessment by a Senior Emergency Medical Technician (SEMT) and Occupational Therapist. The EIV delivers care for patients within their own home, where an acute admission to hospital may otherwise have been necessary. The Occupational Therapist is able to provide a range of equipment to avoid further falls in the short term, gives prevention advice and has direct referral pathways to social care, falls and bone health services to assure longer term resilience. The EIV attains a consistent 75%+ "non conveyance" rate, demonstrating a valuable role in our system.

3.3. Measures that NNUH have instigated to reduce ambulance handover delays include:

a. A bigger RATS area- more computers on wheels
b. New handover policy -will occur in the cubicle with the nurse
c. Safety huddles- involves ED Opel Status framework and attended by HALO
d. Escalation process in place for ambulance delays >15 mins (change in culture from previous 60 mins aims in 2019 which was an improvement on 2018 when not achieving 60min handovers)
e. Ongoing work with 'fit to sit' arrivals
f. Streaming pathways allowing faster flow through ED
g. Safety nurse providing oversight of all patients in the department and providing a clinical view

3.4. Measures that NNUH have instigated to improve flow out of ED include:

a. Revised escalation policies and internal professional standards to facilitate early patient specialty reviews and decisions
b. Development of pathways for SDEC
c. Criteria Led Discharge work increasing across the Trust
d. New Matron leading Discharge with oversight and responsibility for discharge of complex patients.
e. Improved data accuracy of site operations to inform decision making and improve flow across the Trust

3.5. Outcomes of NNUH measures: (see slides in Appendix B) While 111 referrals and ambulance conveyances are higher than pre-Covid, NNUH has demonstrated sustained improvement in our ambulance handover, time to assessment and length of time in ED.

3.6. Other interventions to mitigate the pressures and risks of ambulance delays are:

- Having a local Tactical Cell (staffed by the senior management team) to deal specifically with Norfolk issues relating to demand and hospital delay escalation.

- Earlier escalation to Executives of delays and no plans to address them 24/7

- Pan-system cohorting agreements in place from January 2020 (dedicated location in the NNUH ED staffed by EEAST to enable crews to be released more quickly)

- Increased mutual aid support across the system to manage surges in demand

3.7. CCG-led workstreams include:

National requirement to deliver NHS111 First model by December 2020.

- Mobile patients will be advised to contact the Emergency Department prior to an attendance in at hospital.
- Patients contact 111 and if they need an Emergency Department attendance they will have the chance to be booked into a time slot in the Emergency Department.
- 111 services will also be able to book directly into Secondary Care “clinics”, such as Surgical admission areas or same day Emergency Care “hot” clinics.

The national expectation is that 20% of these mobile patients will be booked into a service rather than self-presenting to the Emergency Department, these services could be community services, as well as Primary Care services.

The reasons behind the move for patients to contact NHS111, are to try and stop any potential overcrowding in the Emergency Departments, prevent potential infection spread with Covid-19 and Flu - big concerns this winter.

Ageing Well

Alongside the NHS111 First and the core NHS111 services,

- Ageing well will be able to deploy a community service either health or social care depending on the needs and requirements of the patient,
- A 2-hour community response, as well as delivery of 2 day re-ablement for patients discharged from hospital.
- Will also work with the System Wide Clinical Assessment Service (CAS) to take patients that don’t need an Emergency attendance (either 999 or Emergency Department) and send a community response in line with the patient’s needs.
- Will also support discharging from the Emergency Department to help with hospital flow from the ED.

3.8. The ‘winter’ resilience plans, which also included a number of additional schemes funded by NHS England & Improvement (NHSEI) continue to be in place to assist with improved performance and patient experience:

	Winter Schemes
1	NHS111 - mental health nurses in control centre
2	Mental health nurses to support EEAST/police control centre
3	Extend "Care Home Selection" (CHS) placement service
4	Hospital @ Home - James Paget Hospital
5	NNUH increased operational support for the front door
6	NNUH additional Hospital Ambulance Liaison Officer (HALO) for winter
7	Mental Health Liaison Psychiatry service - addresses 25% shortfall due to scale of referrals for NNUH
8	Integrated Discharge Hub for NNUH
9	Expanded NNUH@Home at NNUH
10	Increased social services Norfolk First Support (NFS) "NNUH@Home" bridging service
11	Additional Clinical Site Manager shift - maintain patient flow out of hours at QEH
12	Enhanced Flu point of care testing at QEH and NNUH
13	Transfer team to reduce delays in internal handover process – QEH
14	Increase the opening hours of AEC at the and extend RATS cover at weekends for QEH
15	Increased Norfolk First Support (NFS) for QEH
16	Extend the QEH discharge lounge opening times to include weekends
17	Additional ward-based pharmacist on the medical assessment zone and short stay ward QEH
18	Create a weekend discharge team – QEH
19	Street Triage – mental health
20	MIND enhanced access service
21	Increased CAMHS liaison – mental health
22	JPUH liaison service for mental health
23	Mental Health support into NEAT/DIST
24	Increased Approved Mental Health Practitioners to expedite assessments across Norfolk

3.9. Collectively these schemes and actions prevented the situation being worse that it has been. As part of the new annual resilience planning (as opposed to ‘winter planning’) the learning will be taken forward to form the ongoing recovery plans.

4. Mental Health Pathways and EEAST Interactions

4.1. Overall there has been significant progress in terms of progressing joint working and improved communication with mental health, 111 and social care. The schemes listed above have been integral to this for example having social care, mental health and community therapy/nursing colleagues working within the control centres alongside EEAST.

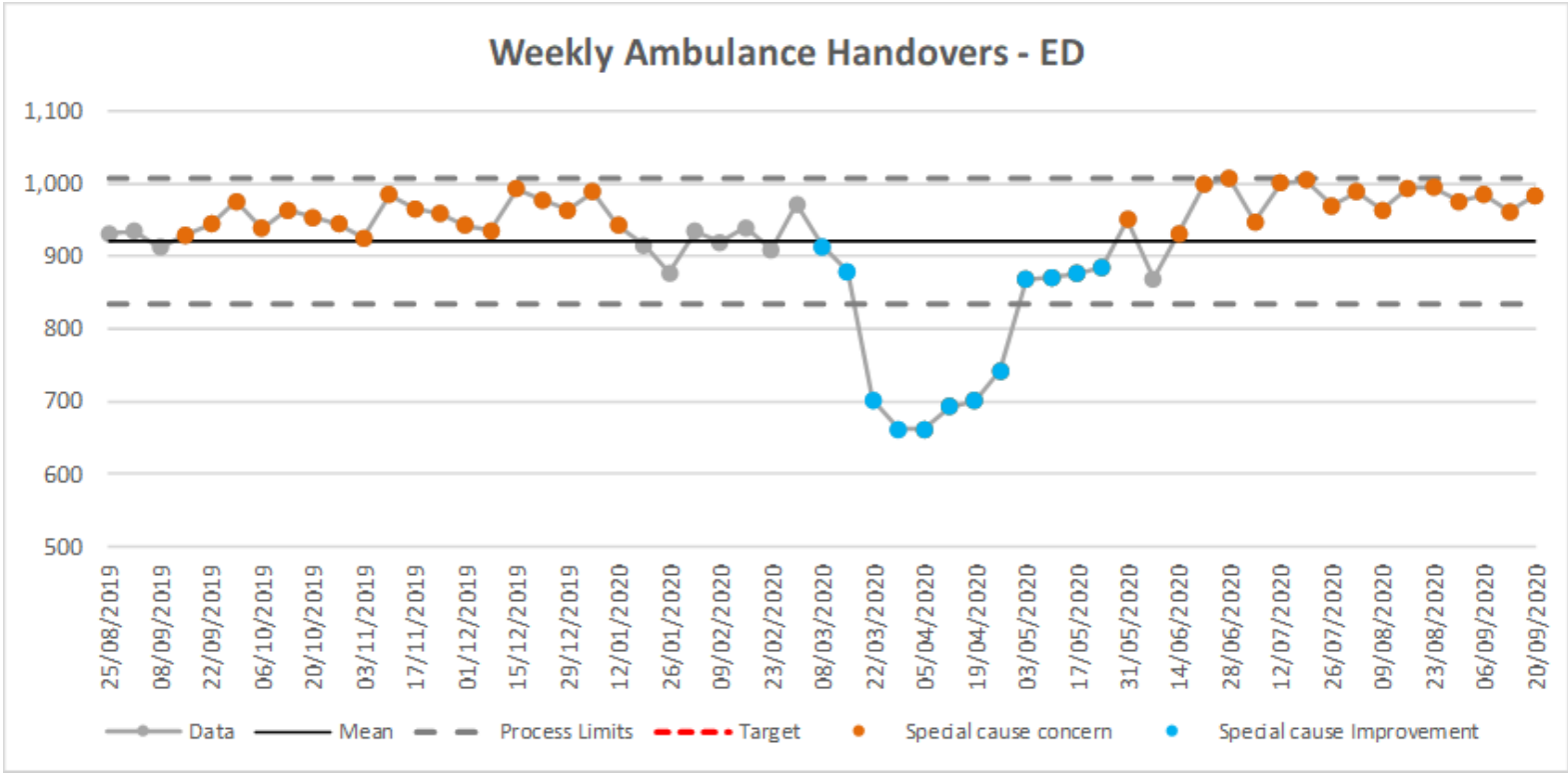
4.2. NSFT have also provided additional support helplines that are available to EEAST staff from the control room and operational teams to provide specialist advice and sign-posting to the most appropriate source of support where possible.

4.3. This is being facilitated by the system urgent and emergency care governance framework whereby the different teams are meeting regularly to agree new ways of joint working. This is now established and will continue moving forward.

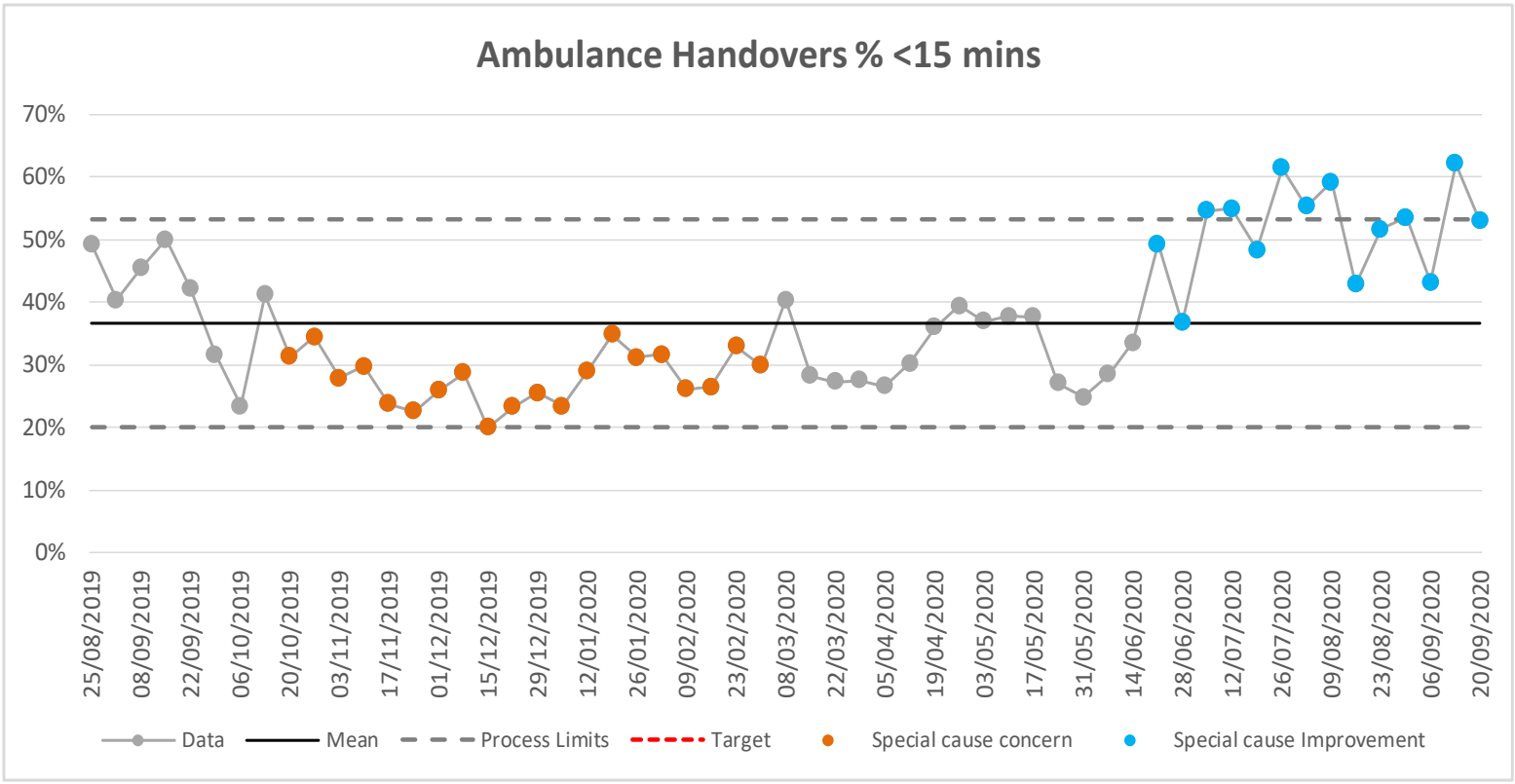
4.4. Covid has unfortunately driven an increase in primary and secondary mental health presentations, putting additional strain on an already limited range of available services provided by NSFT often meaning that EEAST staff continue to take these patients to ED.

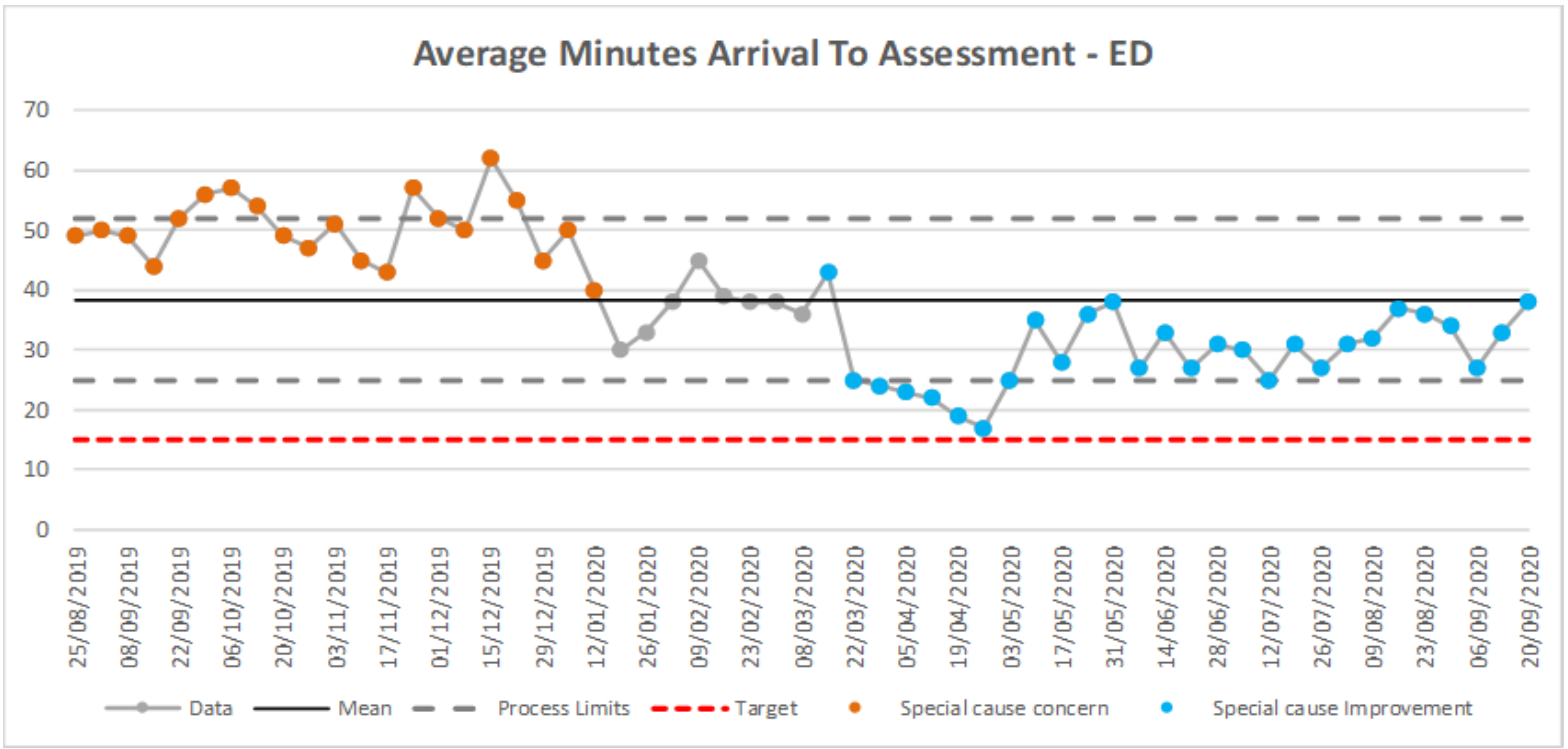
5. Impact of Covid19

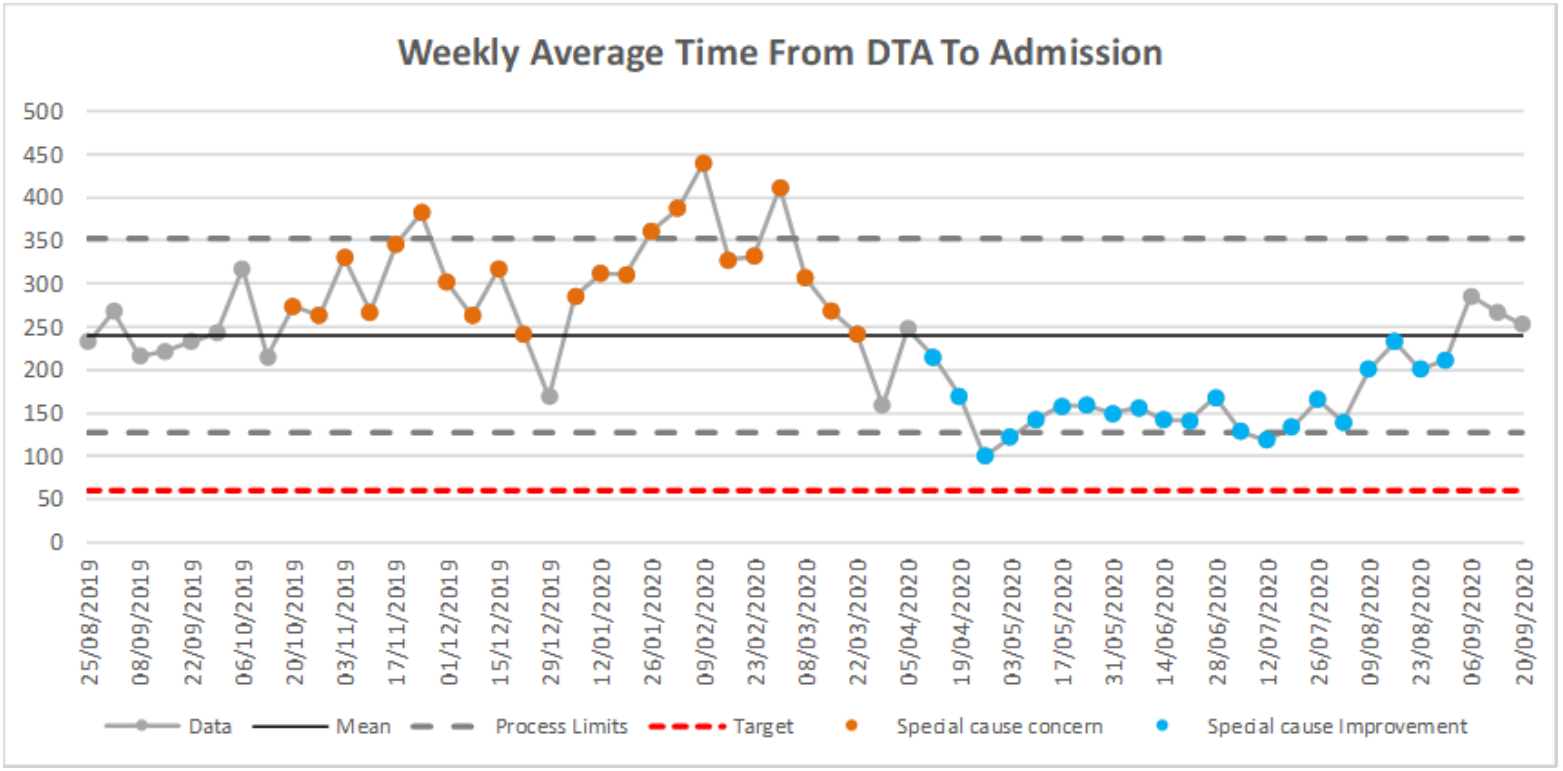
5.1. Overall attendances to EDs significantly reduced during the peak of the pandemic and bed occupancy dropped correspondingly but the number of patients arriving by ambulance only dipped for a short period of time as shown below; since June we have seen a rise slightly above pre-Covid levels:



5.2. However, despite fluctuations in demand the ongoing NNUH Emergency Urgent Care improvement programme is now starting to see the positive impact increased >15 minute handover performance, time to initial assessment in ED and transfer to a bed as shown in the 3 charts below:







5.3. The new ward block has opened this month allowing full pathway redesign and an additional 68 beds, which along with the dedicated isolation unit capacity will help mitigate the risk of a further Covid19 surge.

5.4. The system discharge work and transformation schemes will also radically improve flow and reduce admissions, which will in turn have a positive impact on performance and patient pathways.

6. How EEAST operates in the field, to minimise risk of Covid 19 infection to staff and patients.

6.1. The trust has comprehensive safe practice guidelines, IPC training, IPC policies and an audit schedule. Following the increased risk during the pandemic there are some key risk mitigation strategies that were implemented. The guidance we have shared with staff has evolved as the national guidance has developed.

6.2. Increased vehicle cleaning capacity of Make Ready teams to perform emergency decontamination and routine cleaning. During this time routine cleaning compliance was increased significantly in levels of compliance with standards.

6.3. Dissemination of information to all staff via multiple channels, including station posters, weekly ‘newsletter’ style updates sent out to stations during the initial phase; email, updated bulletins on the Trust website, various meeting groups and others.

6.4. Weekly managers webinars for information sharing and Q&A session in particular related to infection prevention and control and patient safety.

6.5. Daily monitoring of PPE availability and assurance that a consistent supply of the correct PPE was available in all areas, with central oversight.

6.6. Development and implementation of COVID working safely guidance for non-clinical areas including the implementation of COVID safety checkpoints on premises to defer symptomatic persons from entering the workplace and a Test and Trace process adopted to follow up for contacts to be stood down and test referrals made.

6.7. Station changes, incorporating risks assessments, including facilitating social distancing where possible e.g moving furniture and one way systems where possible and instructions to wear surgical masks where social distancing cannot be met. Installation of screens in buildings where multiple staffs occupy smaller spaces.

6.8. Development of a Trust Test & Trace procedure for monitoring symptomatic cases and contacts, working in conjunction with regional Health Protection Teams and NHS Test & Trace contact tracers.

6.9. Modifications to infection prevention audit process to include assessment of COVID Secure status incorporating station modifications and also staff PPE compliance and adequacy of vehicle decontamination at patient handover points.

6.10. Collaborative working with relevant national groups to ensure consistency and best practices are being adopted by the Trust.

6.11. Procurement of respirator hoods for staff for whom masks do not match their fit testing.

7. EEAST Workforce

7.1. EEAST has continued recruitment across the whole trust, with ongoing training courses regularly completing each month. Norfolk & Waveney are fully established against the budgeted position and are recruiting to maintain those levels against the rate of leavers and staff currently engaged with funded schemes (i.e. HALO, etc), ensuring that this remains positive when compared to previous years.

Control room staffing (in both Call handling and Clinical Roles) has increased as a direct result of Covid demand but has remained positive against previous years.

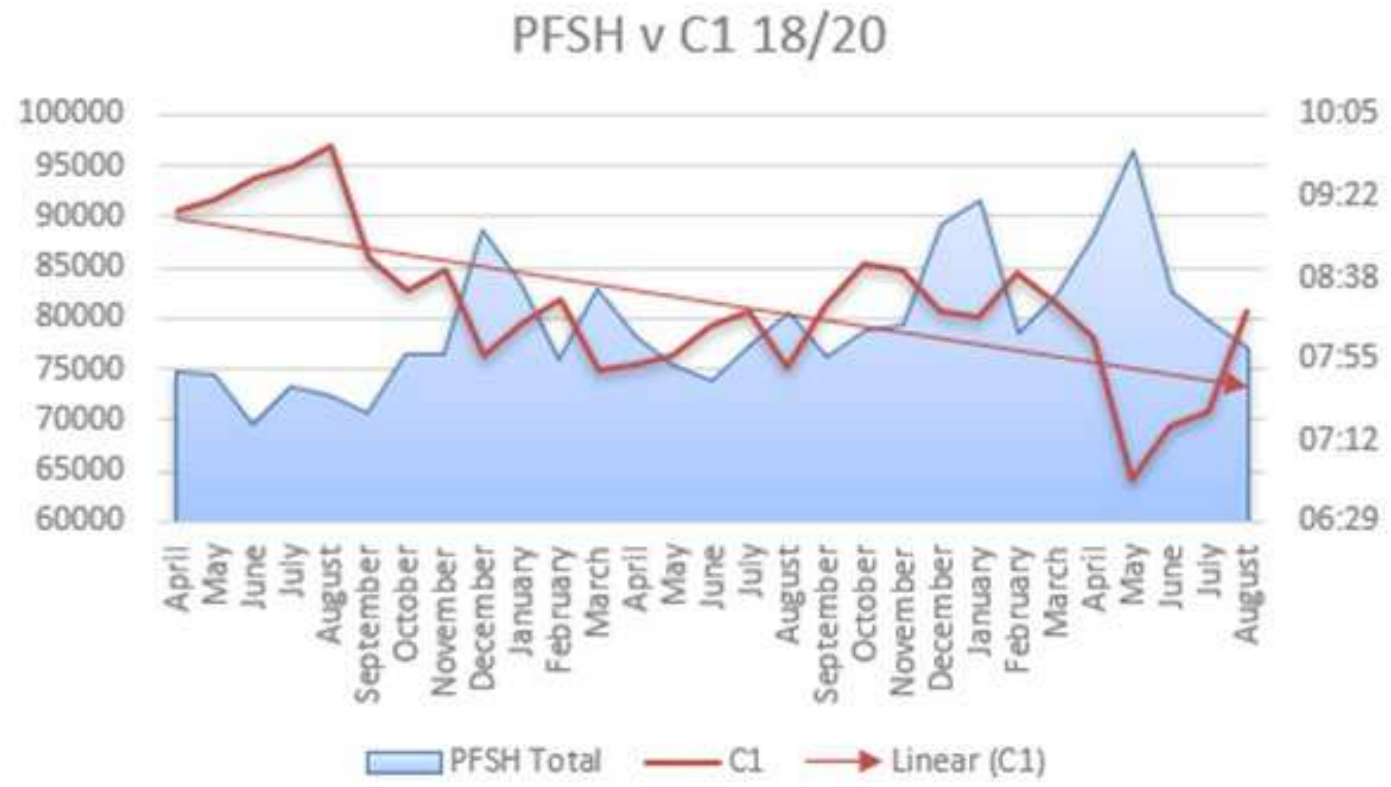
Contributors to a reduction in overall staffing levels have included;

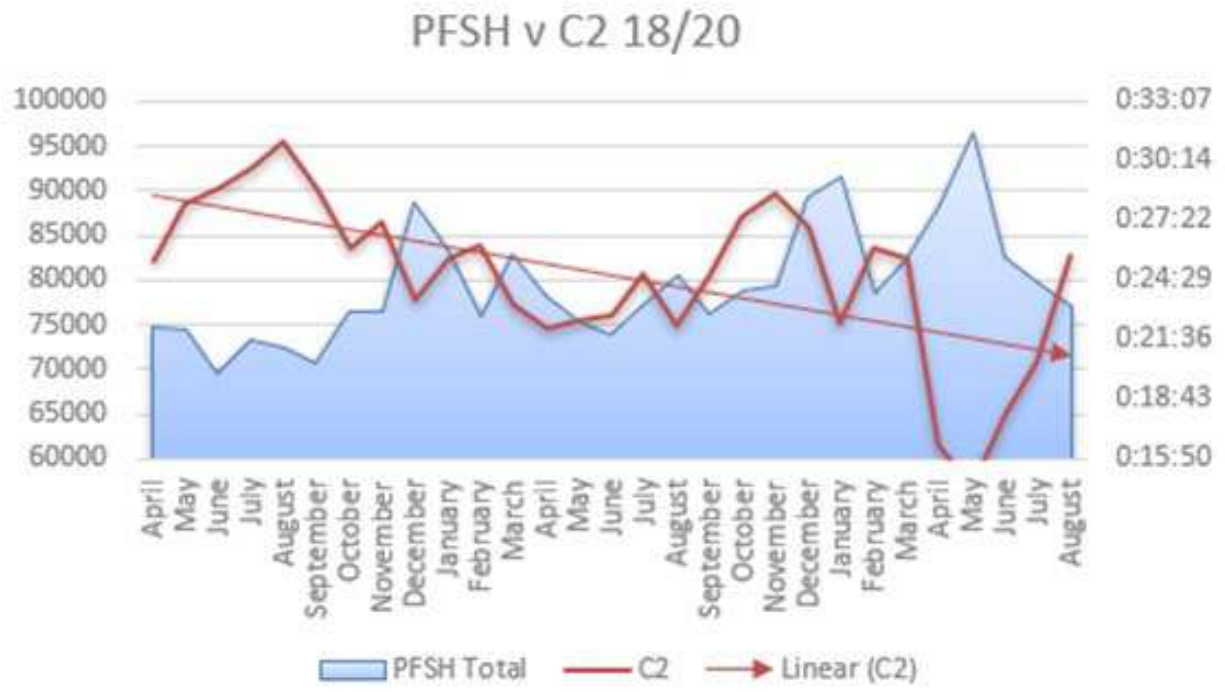
- numbers of shielding staff (@6% of frontline workforce in N&W)
- staff affected directly by Covid sickness
- those affected by test, track & isolate

It is anticipated that this may feature again across the next few months.

7.2. It takes approximately 5 years to train a fully qualified paramedic - 3 years to study to BSc level before applying to the HCPC to become a qualified Paramedic, followed by an 18 month-2 year period of preceptorship and consolidation.

7.3. We saw, through the lens of the unique Covid 19 “control scenario”, what can be achieved when the staff are available, whether that be due to reduced delays or the precautionary peak in patient-facing staff-hours shown here:



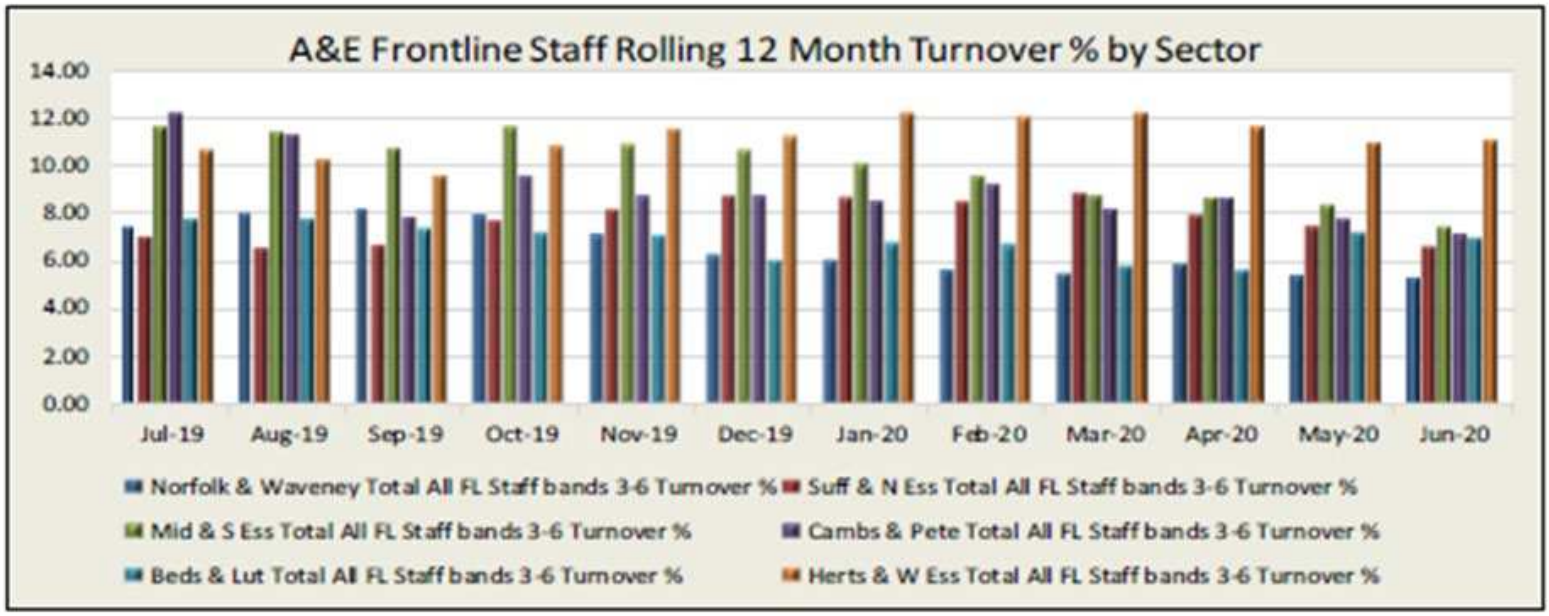


Charts are of C1 and C2 response over time, PFSH (patient-facing staff-hours) is sat behind showing an improving picture of better cover correlating with better C2 performance, and with a notable reduction in response-time since the Covid outbreak.

Notable increase in C2 response time since this cover has dropped during Covid – shielding our staff, and staff with symptoms going sick until tested and well to return but the overall trend is positive.

7.4. Following the successful support from Norfolk Fire & Rescue Service staff in our Covid response, we have offered many of those staff bank contracts as non-clinical emergency drivers, working with our clinically trained staff in delivering patient care thereby helping to alleviate the loss of staff through COVID track/trace and sickness.

7.5. Norfolk has the highest retention of staff in the trust - just 5% turnover.



7.6. NHS England have mandated that PCNs (Primary Care Networks) recruit one WTE advanced paramedic to support GP resources and increased caseload, due to the high numbers of GPs approaching and taking retirement. While not able to replace GPs, these paramedic staff are able to take on some of the time-consuming patient assessment duties, freeing GPs to do more of what only GPs can do, which is to prescribe a fuller range of drugs and other treatments and to make referrals to specialists. In order for EEAST to help retain our specialist Advanced Paramedics and not lose them to PCNs, where their paramedic skills will fade, we have begun trialling rotational models whereby we operate a 24/7 team of specialists and rotate them through PCNs in the hope that, if successful, PCNs forge alliances to buy into our teams, producing a win-win for our staff, our patients and our stakeholders. Norfolk is at “establishment” stage, meaning it is in place, and we are running schemes such as that highlighted above in a ‘proof of concept’ phase.

8. Summary and Next Steps

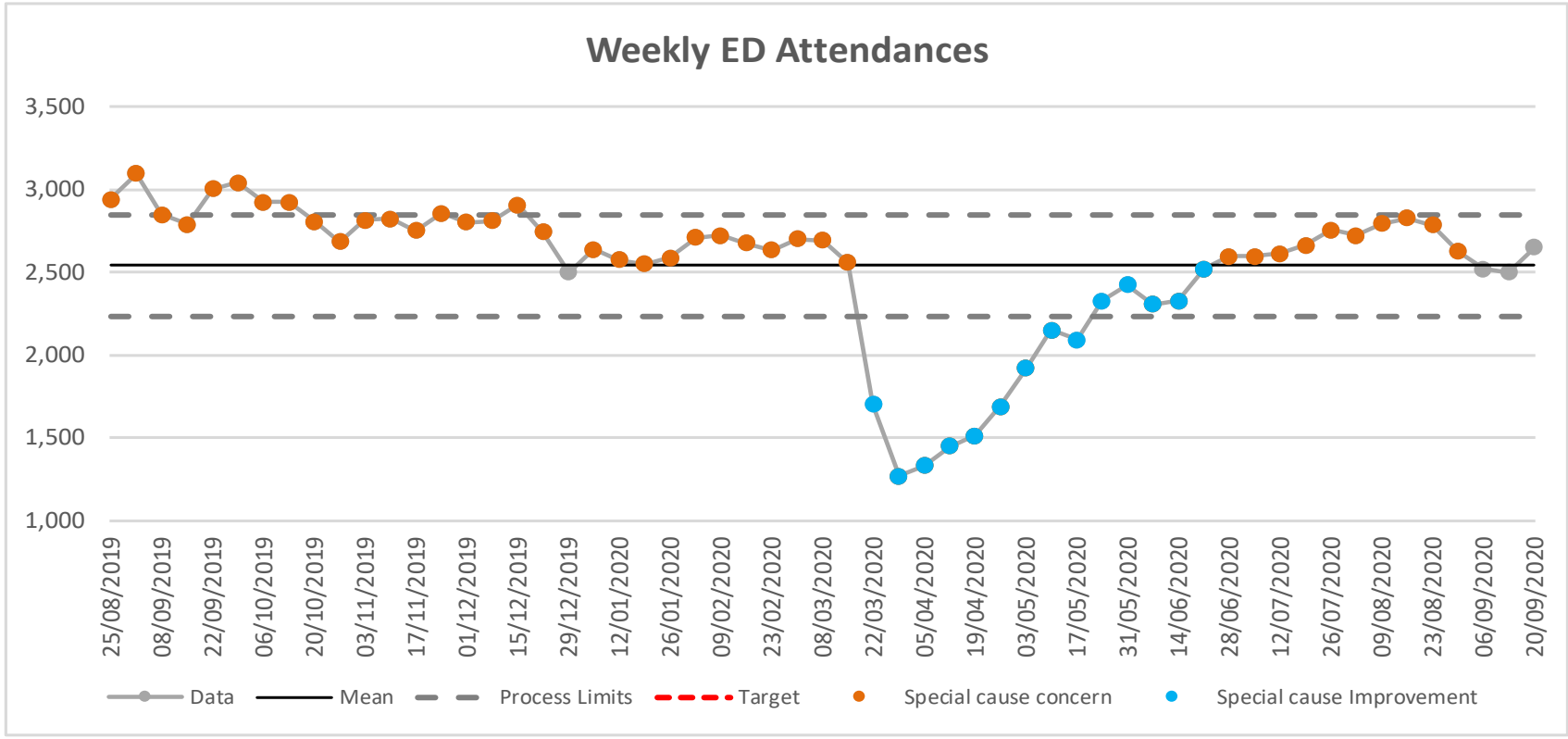
8.1. In conclusion, despite the large number of initiatives and changes implemented, we continue to experience challenges with ambulance performance. However, many areas have significantly improved and the Norfolk and Waveney System have adapted and modified processes and approaches in an attempt to ensure

that we do not return to the pre-Covid19 position and that we sustain the changes achieved to date.

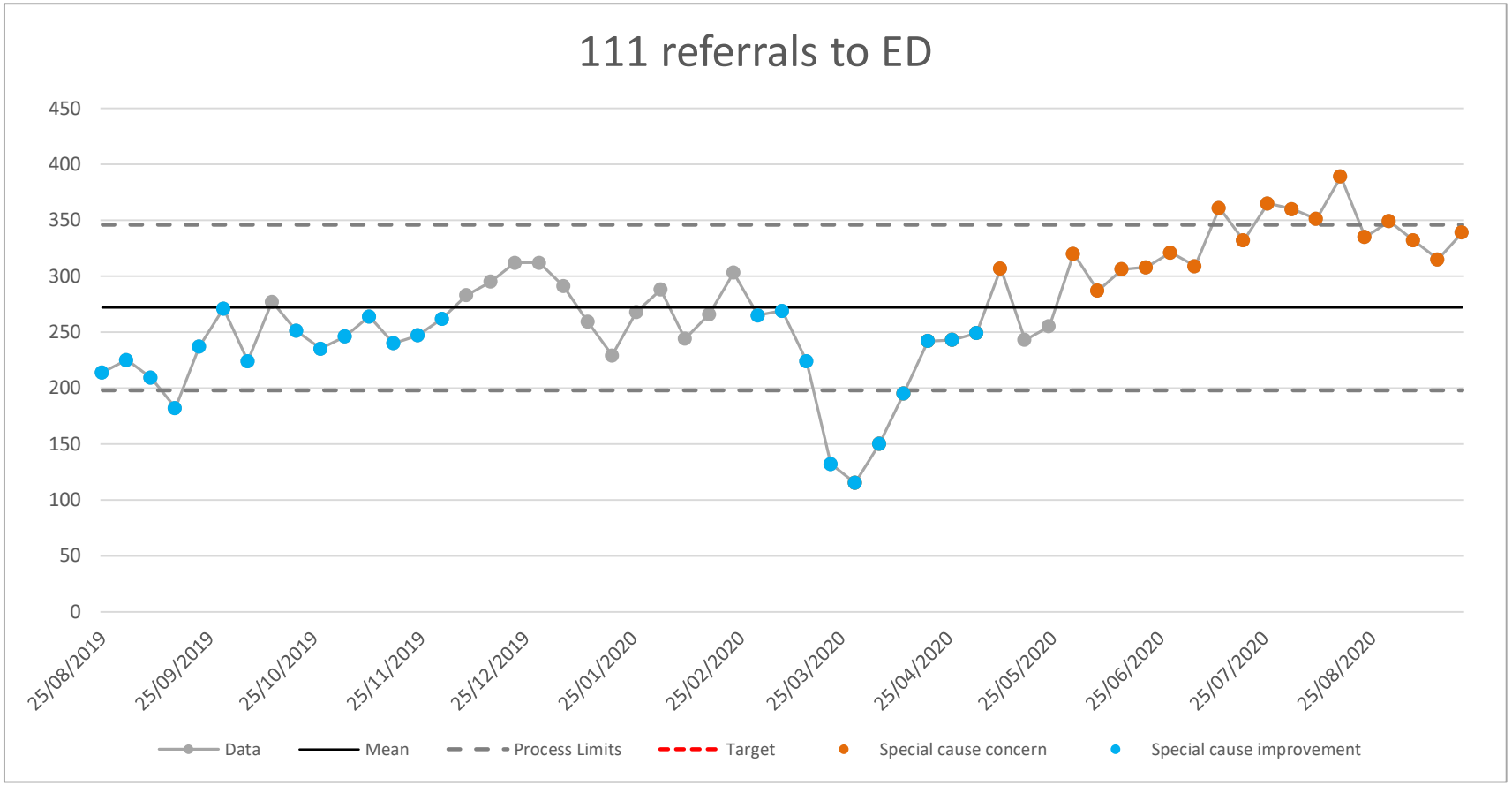
8.2. Moving forward we will take the learning from those areas that had the greatest impact in order to scale these up and the NNUH has worked with EEAST and Central Norfolk colleagues to develop a long term improvement plan, which we have not had before. This is in the process of being modified as a result of Covid19 but it will shape into a collaborative evidence based improvement programme.

in good health

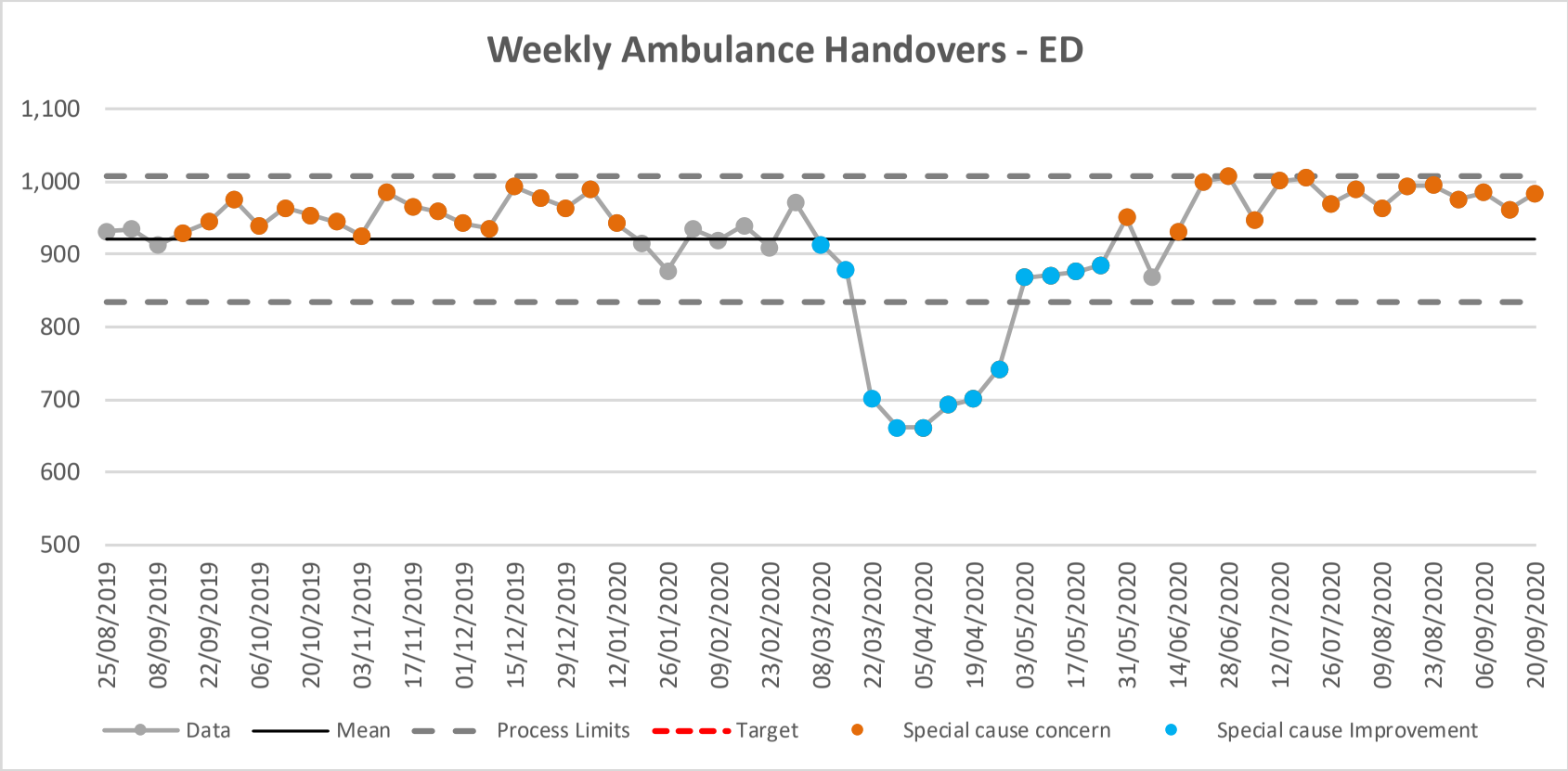
Norfolk and Norwich Hospital - illustrative slides



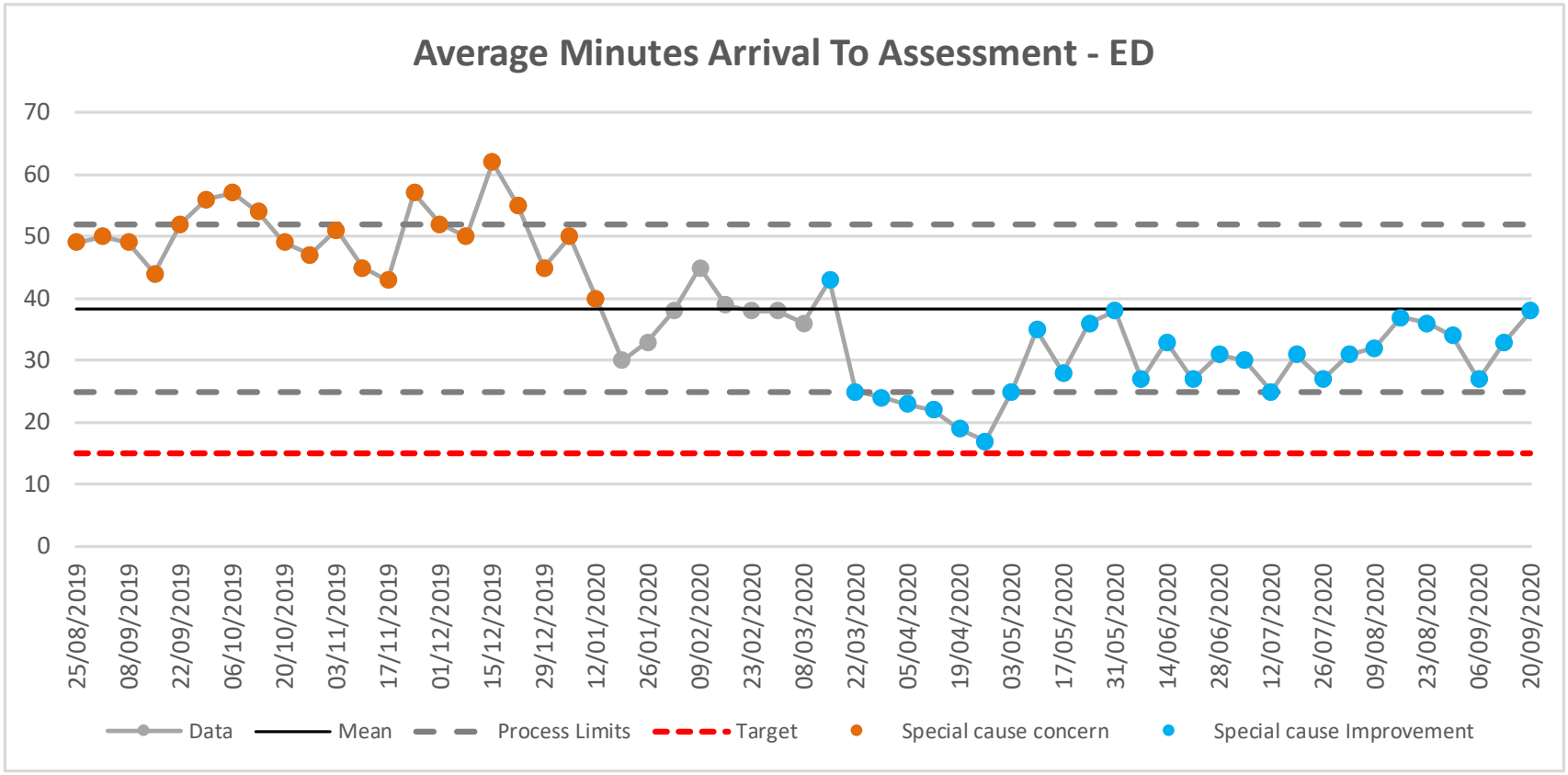
Overall weekly attendances to the Emergency Department are below the same period last year.



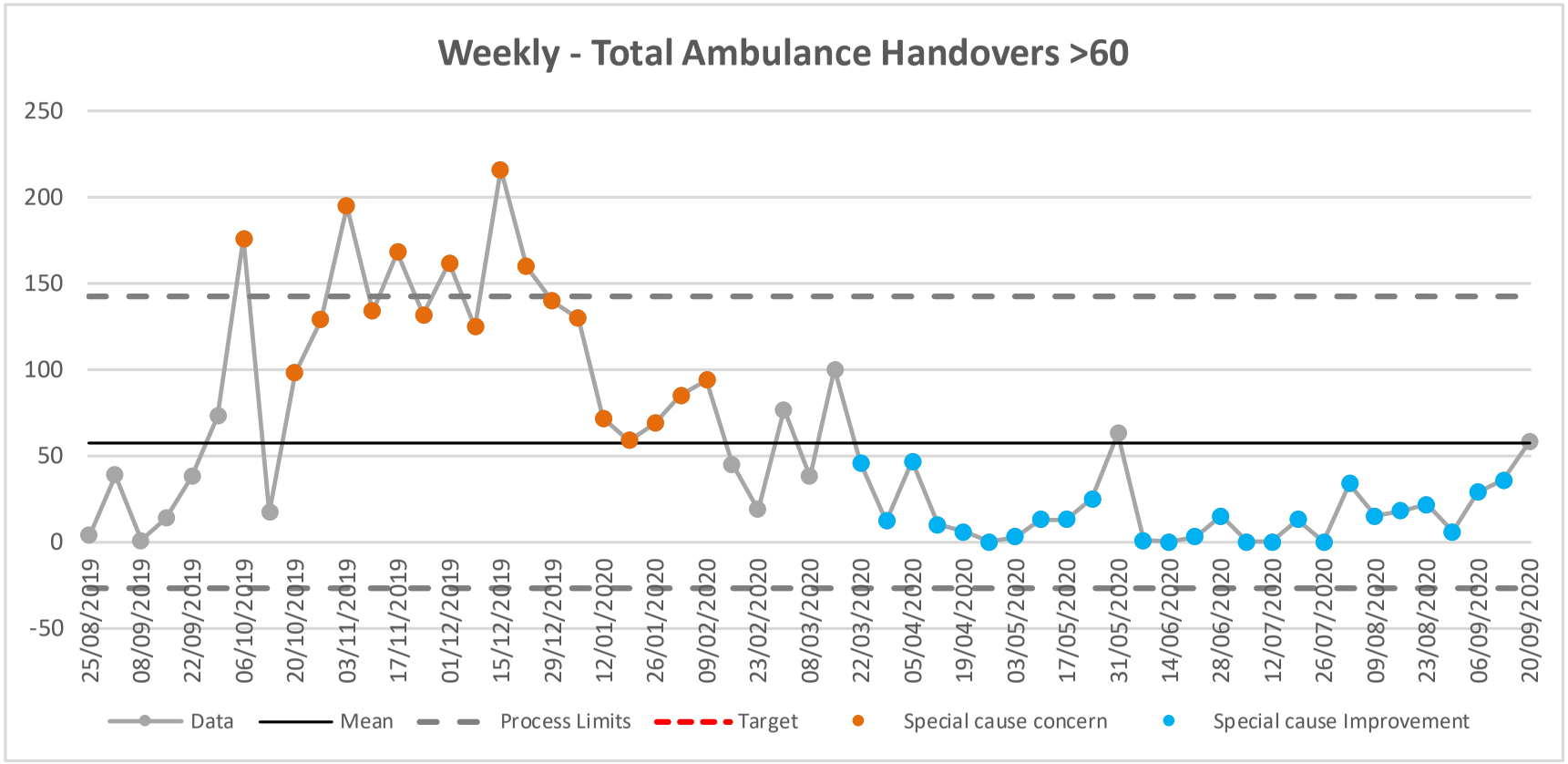
Referrals from 111 for attendance at ED have increased post phase 1 covid.



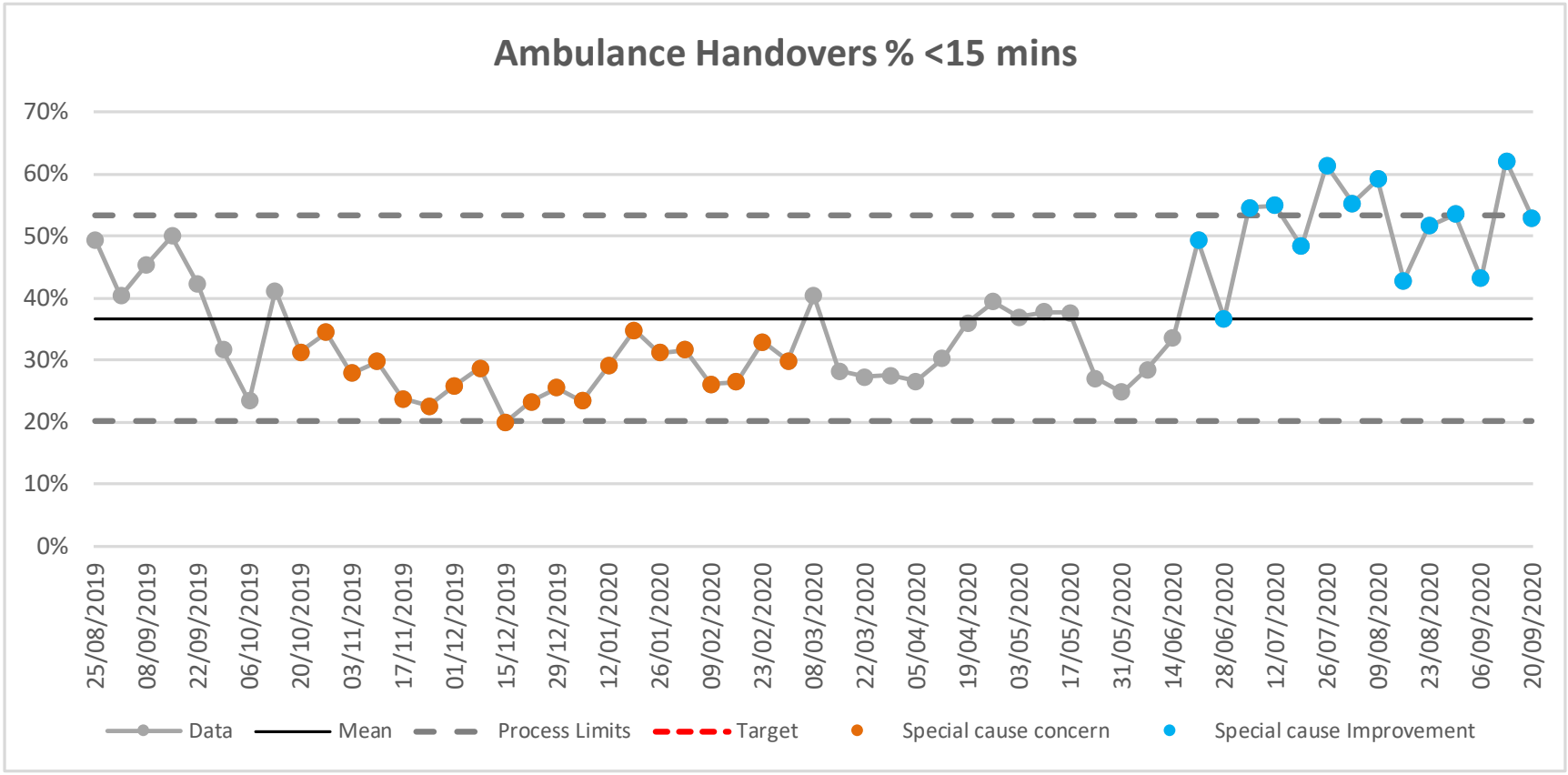
Ambulance conveyance to the Trust has increased above phase 1 covid levels



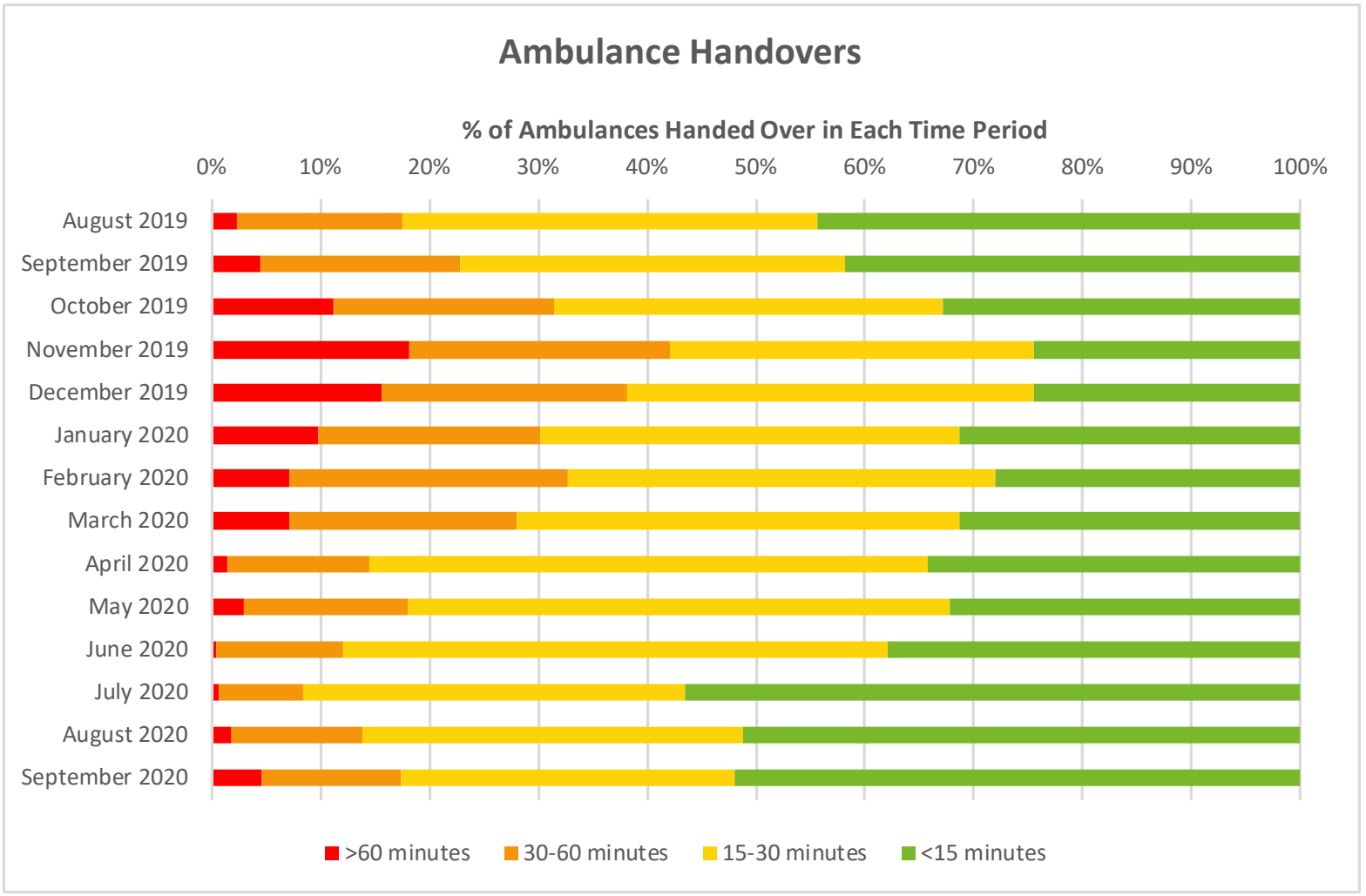
Focused work undertaken for time to Initial Assessment, to ensure we can identify the 'hidden sick' patients early and direct to the appropriate area of the department.



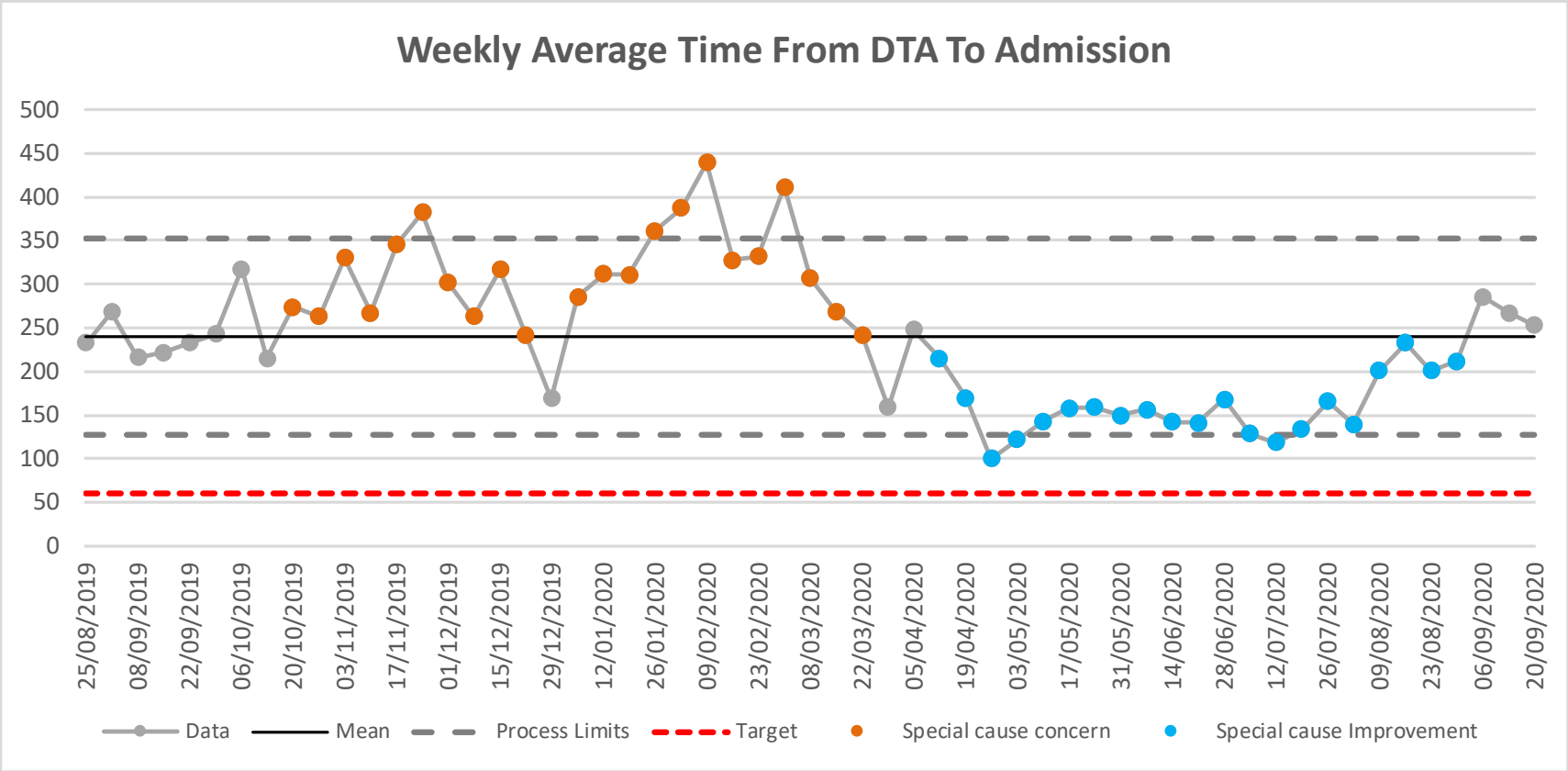
Significant reduction in Ambulance handover delays over 1Hr, with clear escalation criteria beginning with on-route crews that have no identified space.



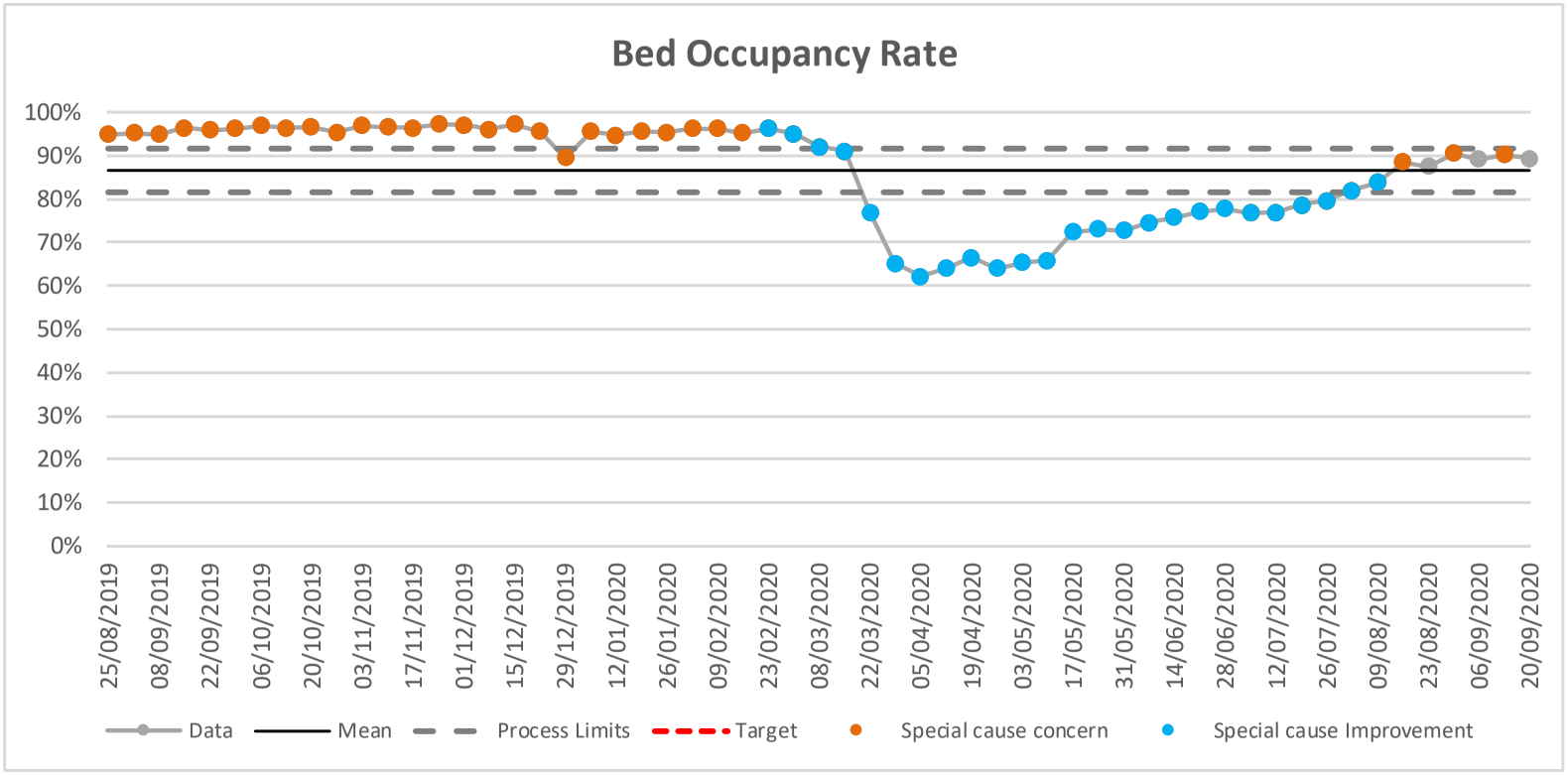
The significant improvement in Ambulance handover under 15 minutes continues, this improvement was delivered by moving the RATS location from an 8 trolleyed area to a 16 trolleyed area and encouraging the use of a fit to sit process.



September data is part month effect.



Recent weeks had seen an increase in the time patients were spending in ED after a decision to admit, this increase was lower than the pre covid position. The new assessment pathways are being implemented currently following the new ward block opening on the 21st September which will reduce that time


Bed Occupancy Rate
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
25/08/2019
08/09/2019
22/09/2019
06/10/2019
20/10/2019
03/11/2019
17/11/2019
01/12/2019
15/12/2019
29/12/2019
12/01/2020
26/01/2020
09/02/2020
23/02/2020
08/03/2020
22/03/2020
05/04/2020
19/04/2020
03/05/2020
17/05/2020
31/05/2020
14/06/2020
28/06/2020
12/07/2020
26/07/2020
09/08/2020
23/08/2020
06/09/2020
20/09/2020
Data
Mean
Process Limits
Target
Special cause concern
Special cause Improvement

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*
26 Nov 2020	Provision of accessible health services for disabled patients / service users (i.e. specifically visually impaired or hearing impaired people) – to examine practical issues of access and confidentiality Suicide prevention – to examine ongoing preventative work in light of concerns about increasing suicide rates St James' Practice, King's Lynn – proposed relocation – consultation by the Practice and Norfolk & Waveney CCG	*Item & date subject to NHOSC approval on 8 Oct 2020*
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	*Date subject to NHOSC approval on 8 Oct 2020 (postponed from 26 Nov)*

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

Provisional dates for later reports to the Committee 2020-21

Spring / summer 2021	-	Local actions to address health and care workforce shortages – progress update since July 2019

Provisional dates for items in the NHOSC Briefing 2020-21

February 2021	-	*Depending on publication of new NICE Guidance, which is expected in December 2020* 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.

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

Norfolk and Waveney CCG	-	Chairman of NHOSC – Cllr Penny Carpenter (substitute Vice Chairman of NHOSC – Cllr 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.

Norfolk Health Overview and Scrutiny Committee 8 October 2020

Glossary of Terms and Abbreviations

A&E	Accident and emergency
ARP	Ambulance Response Programme
ARRS	Additional roles retention scheme
BMI	BMI Healthcare - established in 1970, BMI Healthcare is an independent provider of private healthcare
CAMHS	Child and adolescent mental health services
CAS	Clinical Assessment Service
CCG	Clinical Commissioning Group
CEO	Chief Executive Officer
CFS	Chronic Fatigue Syndrome
CHIS	Child Health Information System
CHRD	Child health record department
CHS	Care home selection
COVER	Cover Of Vaccine Evaluated Rapidly - a vaccine coverage data collection that has been running since 1987
CT	Computerised Tomography Scan – Uses X Rays And A Computer To Make Images Of The Inside Of The Body
DIST	Dementia Intensive Support Team
DNA	Did not attend
DTA	Decision to admit (to hospital)
ED	Emergency Department
EEAST	East of England Ambulance Service NHS Trust
EIV	Early Intervention Vehicle
FIT	Faecal immunochemical test
GI	Gastro intestinal
GY&W	Great Yarmouth & Waveney
HALO	Hospital Arrival Liaison Officer
HCP	Healthy Child Programme
HCPC	Health and Care Professions Council
HEE	Health Education England
HPV	Human papillomavirus (associated with some cancers)
IPC	Infection prevention & control
JCVI	Joint Committee on Vaccination and Immunisations – advises UK health departments on immunisations
JPUH	James Paget University Hospital
KPI	Key performance indicator
LBC	Liquid based cytology
MADE	Multi Agency Discharge Event
ME	Myalgic Encephalomyelitis
MMR	Measles, mumps, rubella

MRI	Magnetic Resonance Imaging – a scan that produces multiple cross sectional pictures of parts of the body
NARS	Norfolk Accident Response Service
NCH&C	Norfolk Community Health and Care NHS Foundation Trust
NEAT	Norfolk Escalation Avoidance Team – manages urgent unplanned health and social care needs to support patients and carers in the community
NFS	Norfolk First Support
NHOSC	Norfolk Health Overview and Scrutiny Committee
NHSE&I EoE	NHS England and NHS Improvement, East of England. One of seven regional teams that support the commissioning services and directly commission some primary care services and specialised services. 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 for Health and Care Excellence
NNUH (N&N, NNUHFT)	Norfolk and Norwich University Hospitals NHS Foundation Trust
N&W STP	Norfolk and Waveney Sustainability & Transformation Plan / Partnership
OPED	Older People's Emergency Department
PCN	Primary Care Network
PFSH	Patient facing staff hours
PHE	Public Health England
PHOF	Public Health Outcomes Framework
PPE	Personal protective equipment
QEH / QEHKL	Queen Elizabeth Hospital, King's Lynn
RATS	Rapid Assessment and Treatment
RRV	Rapid response vehicle
SDEC	Same Day Emergency Care
SEMT	Senior Emergency Medical Technician
SIT	Screening and Immunisation Team
SPC	Statistical process control
STP	Sustainability & transformation plan / partnership (from 2019 known as the Health and Care Partnership for Norfolk and Waveney)
UEC	Urgent and emergency care

WHO	World Health Organisation