Norfolk County Council

Norfolk Health Overview and Scrutiny Committee

Date: **Thursday 15 October 2015**

Time: **10.00am**

Venue: **Edwards Room, County Hall, Norwich**

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

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

Membership

MAIN MEMBER	SUBSTITUTE MEMBER	REPRESENTING
Mr C Aldred	Mr P Gilmour	Norfolk County Council
Mr R Bearman	Mr A Dearnley	Norfolk County Council
Mr B Bremner	Mrs M Wilkinson	Norfolk County Council
Ms S Bogelein	Ms L Grahame	Norwich City Council
Mr M Carttiss	Mr N Dixon / Mrs S Gurney/ Mrs A Thomas/ Miss J Virgo	Norfolk County Council
Mrs J Chamberlin	Mr N Dixon / Mrs S Gurney/ Mrs A Thomas/ Miss J Virgo	Norfolk County Council
Michael Chenery of Horsbrugh	Mr N Dixon / Mrs S Gurney/ Mrs A Thomas/ Miss J Virgo	Norfolk County Council
Mrs A Claussen-Reynolds	Mr N Smith	North Norfolk District Council
Mr D Harrison	Mr B Hannah	Norfolk County Council
Mrs L Hempsall	Mr J Emsell	Broadland District Council
Dr N Legg	Mr C Foulger	South Norfolk District Council
Mrs S Matthews	Mr R Richmond	Breckland District Council
Mrs M Stone	Mr N Dixon / Mrs S Gurney/ Mrs A Thomas/ Miss J Virgo	Norfolk County Council
Mrs S Weymouth	Mrs M Fairhead	Great Yarmouth Borough Council

Mrs S Young	Vacancy	King's Lynn and West Norfolk Borough Council

For further details and general enquiries about this Agenda please contact the Committee Administrator:
Tim Shaw on 01603 222948
or email timothy.shaw@norfolk.gov.uk

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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 2015. **(Page 5)**

3. Members to declare any Interests

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

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

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

If you do not have a Disclosable Pecuniary Interest you may nevertheless have an **Other Interest** in a matter to be discussed if it affects:

- your well being or financial position
- that of your family or close friends
- that of a club or society in which you have a management role

- that of another public body of which you are a member to a greater extent than others in your ward.

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

4.		**To receive any items of business which the Chairman decides should be considered as a matter of urgency**	
5.		**Chairman's announcements**	
6.	**10.10 – 11.00**	**Ambulance Response Times and Turnaround Times in Norfolk** An update from the East of England Ambulance Service NHS Trust, Norfolk and Norwich University Hospitals NHS Foundation Trust and North Norfolk Clinical Commissioning Group	**(Page 11)**
7.	**11.00 – 11.50**	**NHS Workforce Planning in Norfolk** To receive responses to the recommendations agreed by the committee on 16 July 2015	**(Page 36)**
8.	**11.50 – 12.00**	**Forward work programme**	**(Page 56)**
Glossary of Terms and Abbreviations			**(Page 58)**

Chris Walton
Head of Democratic Services

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Date Agenda Published: 7 October 2015

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Norfolk County Council

NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE
MINUTES OF THE MEETING HELD AT COUNTY HALL, NORWICH
On 3 September 2015

Present:

Mr C Aldred	Norfolk County Council
Ms S Bogelein	Norwich City Council
Mr B Bremner	Norfolk County Council
Mr M Carttiss (Chairman)	Norfolk County Council
Mrs J Chamberlin	Norfolk County Council
Michael Chenery of Horsbrugh	Norfolk County Council
Mr D Harrison	Norfolk County Council
Mrs L Hempsall	Broadland District Council
Mrs S Matthews	Breckland District Council
Mrs S Young	Borough Council of King's Lynn and West Norfolk

Substitute Member Present:

Mrs J Virgo for Mrs M Somerville Norfolk County Council
Mr N Smith for Mrs A Claussen-Reynolds North Norfolk District Council

Also Present:

Professor Mike Sampson	Joint Chairman of the Central Norfolk Integrated Diabetes Management Group and Consultant Diabetologist at the N&N
Dr Nigel Thomson	Joint Chairman of Central Norfolk Integrated Diabetes Management Group, Chairman of the Diabetes Facilitator Management Board (and a GP)
Candy Jeffries	Cardiovascular Strategic Clinical Network Manager, NHS England Midlands and East (East)
Dr Nick Morrish	Consultant Diabetologist and Strategic Clinical Network Diabetes Lead, NHS England Midlands and East (East)
Dr James Hickling	Deputy Medical Director and Caldicott Guardian, NHS England Midlands and East (East). (Note-*a Caldicott Guardian was a senior person responsible for protecting the confidentiality of patient information).*
Sarah Johnson	Commissioner for Diabetes, West Norfolk CCG
Julie Widdowson	Diabetes Educator, Service Lead, Norfolk Community Health and Care
Maureen Orr	Democratic Support and Scrutiny Team Manager
Tim Shaw	Committee Officer

1. Apologies for Absence

Apologies for absence were received from Mr R Bearman, Mrs A Claussen-Reynolds, Dr N Legg, Mrs M Somerville and Mrs S Weymouth. An apology for absence was also received from Mr C Walton (Head of Democratic Services, Norfolk County Council).

2. Minutes

The minutes of the previous meeting held on 16 July 2015 were confirmed by the Committee and signed by the Chairman.

3. Declarations of Interest

3.1 There were no declarations of interest.

4. Urgent Business

4.1 There were no items of urgent business.

5. Chairman's Announcements.

5.1 T**he new day case theatre complex at the James Paget Hospital**

The Chairman said that on 7 August 2015 he was very pleased to have taken up an invitation from the James Paget University Hospitals NHS Foundation Trust to visit the new day case theatre complex at the James Paget Hospital. The trust was justifiably proud of this new state-of-the-art facility. The building was a vertical extension, which added a third floor to part of the hospital. It had increased the total number of theatres at the hospital from 7 to 8, providing increased capacity for day case procedures and emergency operations.

5.2 The Chairman added that this new £8 million complex included three day care theatres, a new day case ward and associated areas. The facilities were very modern and the new theatres provided an ultra-sterile operating environment created by a hi-tech air flow system. Energy costs would be reduced with power supplied from the site's own solar panels. The new complex would bring numerous benefits to both patients and staff at the James Paget Hospital for years to come. Not least they would help to reduce demand on beds and patients' length of stay in hospital.

5.3 **Mrs Lana Hempsall**

The Chairman welcomed Mrs Lana Hempsall from Broadland District Council to her first meeting of the Committee.

6. Diabetes Care within Primary Care Services in Norfolk

6.1 The Committee received a suggested approach from the Democratic Support and Scrutiny Team Manager to reports on the delivery of diabetes care within Primary Care Services in Norfolk from NHS England Midlands and East (East), West Norfolk Clinical Commissioning Group and a presentation from the Central Norfolk Integrated Diabetes Management Group.

6.2 The Committee received evidence from Professor Mike Sampson, Joint Chairman of the Central Norfolk Integrated Diabetes Management Group and Consultant Diabetologist at the N&N, Dr Nigel Thomson, Joint Chairman of Central Norfolk Integrated Diabetes Management Group, Chairman of the Diabetes Facilitator Management Board (and a GP), Candy Jeffries, Cardiovascular Strategic Clinical Network Manager, NHS England Midlands and East (East), Dr Nick Morrish, Consultant Diabetologist and Strategic Clinical Network Diabetes Lead, NHS England Midlands and East (East), Dr James Hickling, Deputy Medical Director and Caldicott Guardian, NHS England Midlands and East (East), Sarah Johnson, Commissioner for Diabetes, West Norfolk CCG and Julie Widdowson, Diabetes Educator, Service Lead, Norfolk Community Health and Care.

6.3 The Committee received a detailed presentation from Professor Mike Sampson which can be found on the Committee's website.

6.4 In the course of discussion the following key points were made:

- There were an estimated 3.2 million people in England with diabetes of whom 2.8 million had been diagnosed. A further 5 million people in England were at risk of Type 2 diabetes, and by 2030 more than 4 million people in England would have the disease.
- 90% of people with diabetes had Type 2, and the majority of these cases could be prevented or delayed.
- Many more people had blood sugar levels above the normal range but not high enough to be diagnosed as having diabetes, a condition which was known as pre-diabetes.
- North Norfolk CCG and West Norfolk CCG had some of the highest levels of people with diabetes in the UK. To a large extent this was due to the older age profile of the population in these areas of Norfolk.
- The health and financial burdens of this disease were high and would continue to grow unless more was done to prevent it.
- The witnesses stressed the importance of health checks which assisted in the detection of any early signs of diabetes so that they could be caught and treated successfully. They said that GPs were able to provide support with lifestyle choice such as how to enjoy healthy foods, how to adjust the diet and how to keep active.
- The witnesses also said that not enough was being done in society generally to tackle high levels of diabetes which had reached epidemic proportions.
- It was suggested by Members that a high visibility advertising campaign, better food labelling and more appropriate display of food items in supermarkets would go some way to raise public awareness of the issue. More work needed to be done at a government level to tackle the issue.
- A successful high visibility media campaign, similar to that which had led to reduced salt levels in food, and the wide range of measures that were continuing to be taken in society to reduce smoking, was needed if high levels of diabetes were to decrease.
- There was a danger that children born to women with gestational diabetes were more likely to go on to develop type 2 diabetes themselves.
- As obesity rates in children continued to soar, type 2 diabetes, a disease that was seen primarily in adults over age 45, was becoming more common in young people.

- The diagnosis of diabetes in a child or young person also affected the child's parents, teachers, friends and other carers. It was, therefore, vital that children and young people, and their families, received support that met their needs from diagnosis to transfer to adult services, including support in school settings such as Sure Start Centres.
- Following Public Health England, NHS England and Diabetes UK call for expressions of interest from local partnerships in becoming first wave sites for the NHS Diabetes Prevention programme several nationally recognised pilot diabetes prevention sites had been identified. Unfortunately none of these sites, which would be tasked with implementing and evaluating evidence based approaches to Type 2 diabetes prevention, were situated in Norfolk. However, a similar regional initiative that involved the Norfolk CCGs and their partners working together to deliver behavioural change interventions to prevent Type 2 diabetes in this area, had been given the go ahead. This initiative was welcomed by the Committee.
- The Committee noted that no significant progress had been made with the national system linking diabetic eye screening programmes with GP systems (GPDRS). The witnesses said that this project had been in a state of development for over a decade and was unlikely to progress in the immediate future.
- The Committee also noted the information supplied in the report on increasing prevalence of diabetes and Quality Outcomes Framework (QOF) 2013-14 data showing better delivery of care for people with diabetes in primary care that appeared in the National Diabetes Audit 2012-13.

6.5 It was noted that any additional questions from Members about Norfolk Diabetes QOF 2013-14 could be addressed to Dr James Hickling via Maureen Orr. Further information and advice on type 2 diabetes was available on-line at :-
www.nnuh.nhs.uk/videos/adultdiabetes
www.nnuh.nhs.uk/podcasts/adultdiabetes

7. Forward work programme

7.1 The forward programme was approved with the following changes:-

Policing and Mental Health Services – moved from 15 October 2015 to February 25 February 2016.

Children's and Young People's Mental Health – terms of reference approved and item scheduled for 3 December 2015.

The 14 January 2016 meeting of the Committee was cancelled.

Members who had items which they wished to have considered for inclusion in the forward work programme were asked to contact Maureen Orr, Democratic Support and Scrutiny Team Manager in the first instance.

7.2 The Committee agreed to make the following appointments:-

Great Yarmouth and Waveney CCG substitute link member – Mrs Marlene Fairhead

South Norfolk CCG substitute link member – Mrs Margaret Somerville

Chairman

The meeting concluded at 12.05 pm

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Ambulance response times and turnaround times in Norfolk

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

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

1. Background

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

1.2 NHOSC returned to the subject of ambulance services in February 2015 because it was aware that response times in Norfolk were still below locally agreed standards in some areas. At this stage NHOSC widened its focus to look at county-wide ambulance response times and the turnaround performance at the Queen Elizabeth (QEH) and James Paget (JPH) hospitals as well as the N&N.

1.3 For ambulance turnaround at hospitals, the standards are:-

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

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

1.4 For ambulance response to patients, the national standards, to be met at a region-wide level are:-

<u>Red calls</u> (2 categories)

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

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

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

Red 2 – all other life threatening emergencies.

Green calls (four categories)

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

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

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

Green – non life threatening emergencies

Both the Red categories are national requirements but the four Green categories are recommended standards.

1.5 NHOSC scrutinised stroke services in 2013-14. In relation to stroke EEAST's service standards are:-

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

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

1.6 It should be noted that EEAST is funded to meet the national response time standards on a regional level and not on a county or locality level. There have, however, been local agreements between EEAST and Clinical Commissioning Groups (CCGs) for 'recovery targets' in some areas (notably the North Norfolk area). These recognised that current local performance is well below national standards and set interim targets that were challenging but considered achievable in the locality, taking into account rurality and local geography.

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

1.7 There have been discussions at national level about the possibility of changing ambulance response time targets (specifically Red 2 targets) so that they are more realistic to achieve. NHOSC should note that one of the recommendations of a Healthwatch Norfolk report published in October 2014 following a survey of ambulance service users was:-

'If commissioners of the service review existing emergency response times (and tolerances within the service specification) and propose changes, they should do so following a *full public consultation* so that the public has the opportunity to influence any decisions taken.'

2. Purpose of today's meeting

2.1 EEAST's latest published statistics **at regional level** (up to July 2015) show a dip in response time performance in recent months:-

Red 1 – performance declining since June 2015 and target not achieved in July 2015. Target only achieved in 4 of the past 12 months.
Red 2 - performance declining since May 2015 and below target in all of the past 12 months.
Red 19 - performance declining since May 2015 and target achieved in only 1 of the past 12 months.

Average hospital turnaround times (both arrival to patient handover, and handover to ambulance clear) did not achieved the 15 minute standards in any of the 12 months to July 2015.

2.2 Historically, ambulance response times in Norfolk as a whole have been below the national standard and the regional average. As noted in paragraph 1.6 above, this is to be expected to some extent because of the challenges posed by the geography and realistic local targets have been agreed. EEAST has been asked to report today on performance trends in Norfolk since February 2015, specifically in relation to:-

i. Response standards achieved and how these compare with national targets and locally agreed targets.
ii. 'Tail breaches', i.e. the longest waits that patients experienced for the 2 red call categories.
iii. Stroke 60 transport times.
iv. Turnaround times (both arrival to hand over and hand over to ambulance clear) at all three acute hospitals.

EEAST's report is attached at Appendix A

2.3 Although ambulance turnaround figures for all three acute hospitals are included in EEAST's report, the N&N has been invited to report and to attend today's meeting as the largest hospital in Norfolk and consequently the one where potentially the most hours can be lost in ambulance delays. The N&N has been asked to update the committee on the success of measures put in place to improve turnaround performance.

The N&N's report is attached at Appendix B.

2.4 North Norfolk CCG has also been invited to today's meeting as the lead commissioner of the N&N. The Chief Officer of North Norfolk CCG also has a leading role for Norfolk in commissioning the ambulance service in conjunction with other commissioners in the region. The CCG can answer the committee's questions on the success of the measures included in Project Domino (in the central Norfolk area) together with other commissioning actions to encourage better ambulance response times and turnaround performance. Project Domino was initiated in 2012 with the aim of identifying and solving the causes of delay in all aspects of the urgent and emergency care system from the moment a patient calls for help to when they are discharged from care.

3. Suggested approach

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

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

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

(b) Paramedics are on the current UK Shortage Occupation List. Has EEAST been successful in recruiting and retaining the numbers of qualified and experienced paramedics that it needs?

(c) Does EEAST consider that the recruitment drive of recent years and the rising number of Student Ambulance Paramedics in its workforce is connected to the rising rate of patients being conveyed to hospital by ambulance (i.e. because new staff are more risk averse)? If so, what is being done to address the issue?

(d) The Red call standards are reported on a simple pass / fail basis that does not reflect the length of time that a 'failed' response actually took. At the time of the last report EEAST was making progress in eliminating the longest waits for responses to Red calls. Has there been further progress in this respect?

(e) At the time of the last report EEAST was not meeting the target of getting 56% of eligible stroke patients to a hyperacute unit with 60 minutes from the time of the 999 call. What is the current situation with regard to stroke patients?

(f) In the past EEAST and local CCGs have agreed local trajectory targets to improve response time performance in parts of Norfolk. Are local trajectory targets still used and if so, how is EEAST currently performing against them?

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

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

(h) Given all of the measures you have already taken, are there any other steps you can take to manage the flow of patients through the hospital?

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

(i) Hospital Ambulance Liaison Officers at the N&N appear to have been very successful in reducing turnaround times. Is funding for these posts guaranteed beyond 2015-16?

(j) How much have the ambulance service and hospital commissioners received in financial penalties levied against EEAST and the N&N for contract breaches in relation to response times and turnaround times and what proportion of this money has been reinvested in improving these aspects of service?

(k) Demand for ambulances is higher than the activity levels commissioned by the CCGs. Can the CCGs assist EEAST with the extra costs in these circumstances?

(l) Great Yarmouth and Waveney CCG is the only area in Norfolk with a reduction in ambulance activity this year compared to last year. What are the likely reasons for this?

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APPENDIX A

East of England Ambulance Service NHS
NHS Trust

Since the 1st April 2013, ambulance turnaround standards were introduced to all Ambulance Trusts and Acute Trusts with an Emergency Department (ED) for Ambulance handover standards at the ED.

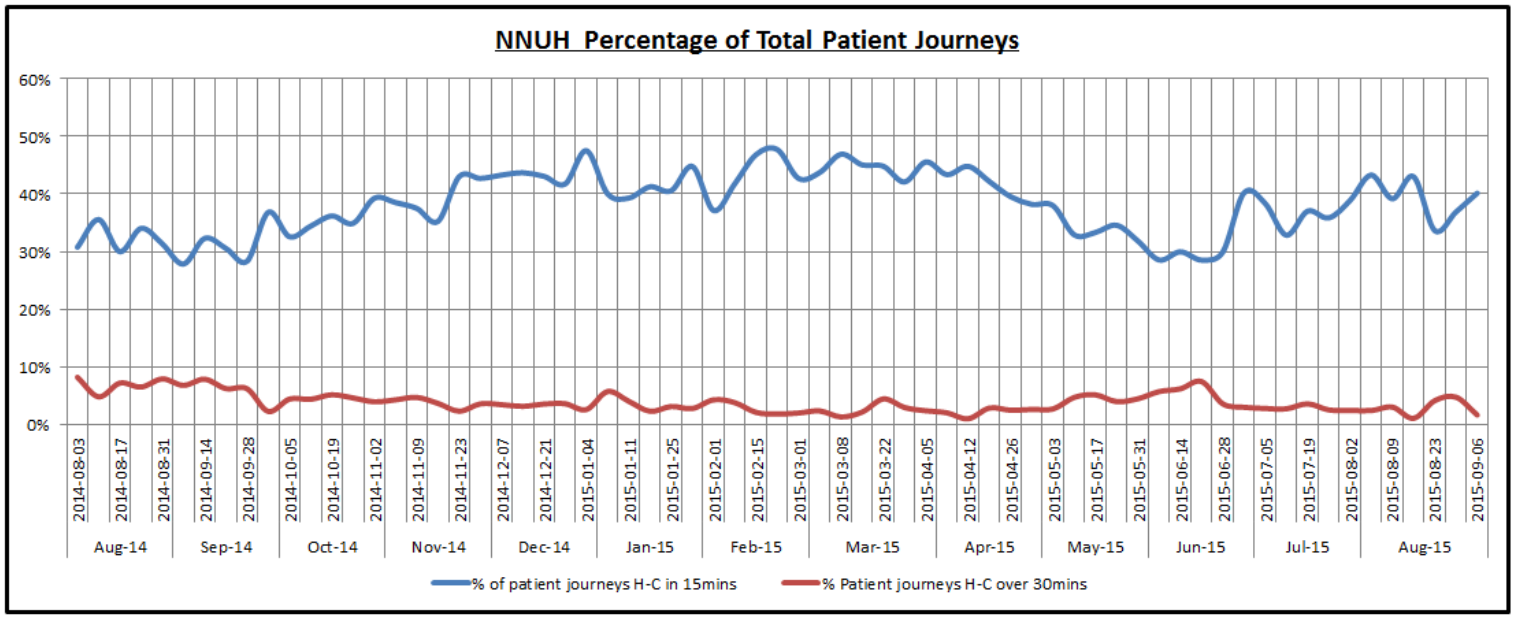
(a) 15 minutes - Arrival to handover; the time from ambulance arrival on the hospital site to the clinical handover of the patient (also known as 'trolley clear')

(b) 15 minutes - Handover to clear; the time from clinical handover of the patient to the ambulance leaving the site (also known as 'ambulance clear')

The Norfolk and Norwich Hospital is the busiest ED in the region, and one of the busiest in the country. Ambulance arrivals at the hospital are circa 900 per week. Breach times of 30 minutes and 60 minutes were also introduced alongside the standard in which trigger fines payable back to ambulance commissioners were included.

Handover to Clear Performance (EEAST)

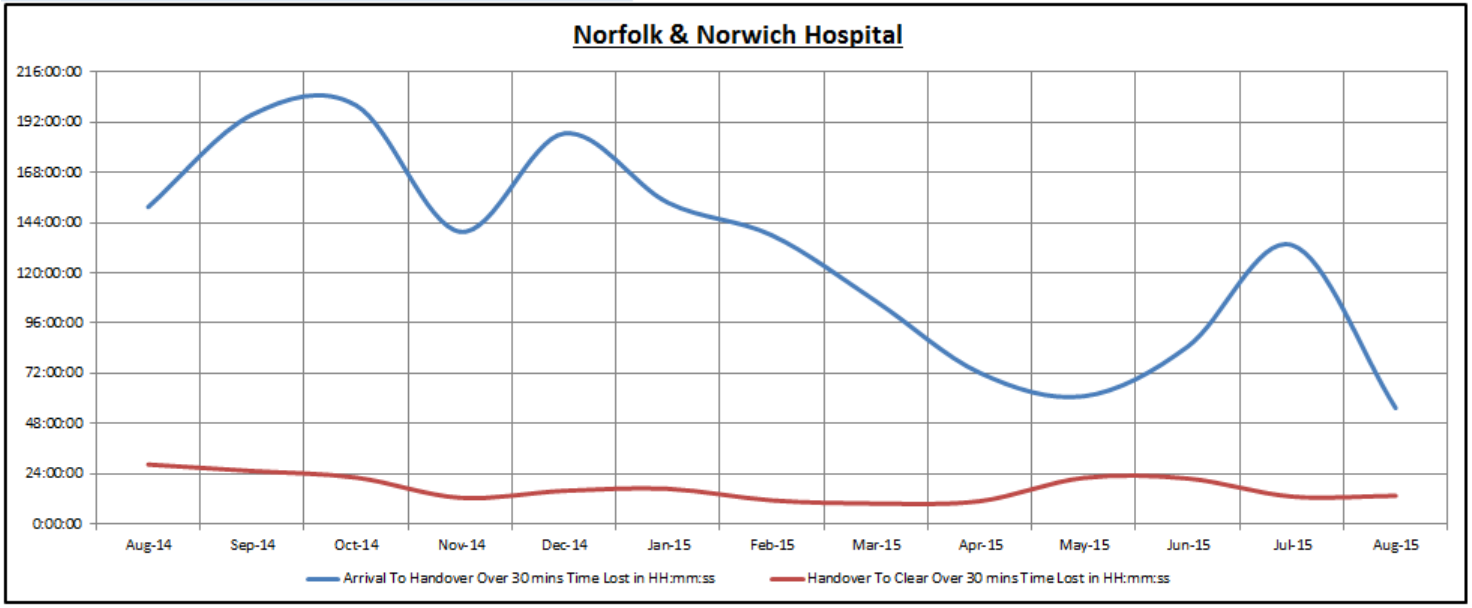
The handover to clear performance by EEAST crews at the Norfolk & Norwich University Hospital (NNUH) and the Queen Elizabeth Hospital (QE) continue to demonstrate stability. The average performance for the green in 15 times is now consistently around 40%. This is when a crew have completed the handover of a patient and are available for the next emergency call or standby. On average less than 5% of crews are delayed over 30 mins from completing their patient handover. There are a number of options being considered where greater accuracy of the trolley clear submit button press (that ends the arrival to handover time and starts the handover to clear time) can be achieved, and EEAST is looking to address these. Any early button press to start the handover to clear time impacts negatively upon EEAST's handover to clear performance. We do have to reset the handover times when crews report the trolley clear button being pressed by ED staff. Handover has occurred when both a verbal and physical transfer of the patient has occurred only. The graph below represents the percentage of crews available in 15 minutes, and 30 minutes at NNUH.



There are a number of reasons that still exist to which an Ambulance crew maybe delayed over 30 mins and are simply unavoidable, for instance staff welfare issues. Instances such as highly emotive and traumatic calls may result in a crew being delayed so they can receive support or a student/mentor debrief. At present there is not an agreed out of service code that can be applied in such cases.

Handover to Clear Performance V Arrival to Handover Performance

The charts below highlight both handover to clear and arrival to handover at the three main hospitals, in the last year, over 30 minutes, and the corresponding number of double staffed ambulance hours lost. At both NNUH and QEH, hours lost over 30mins are always higher in Arrival to Handover than they are in Handover to Clear, but improvements at NNUH are clearly evident. Delays at JPH vary in Arrival to Handover month to month, but are generally low. The handover to clear performance by ambulance crews has remained consistently good.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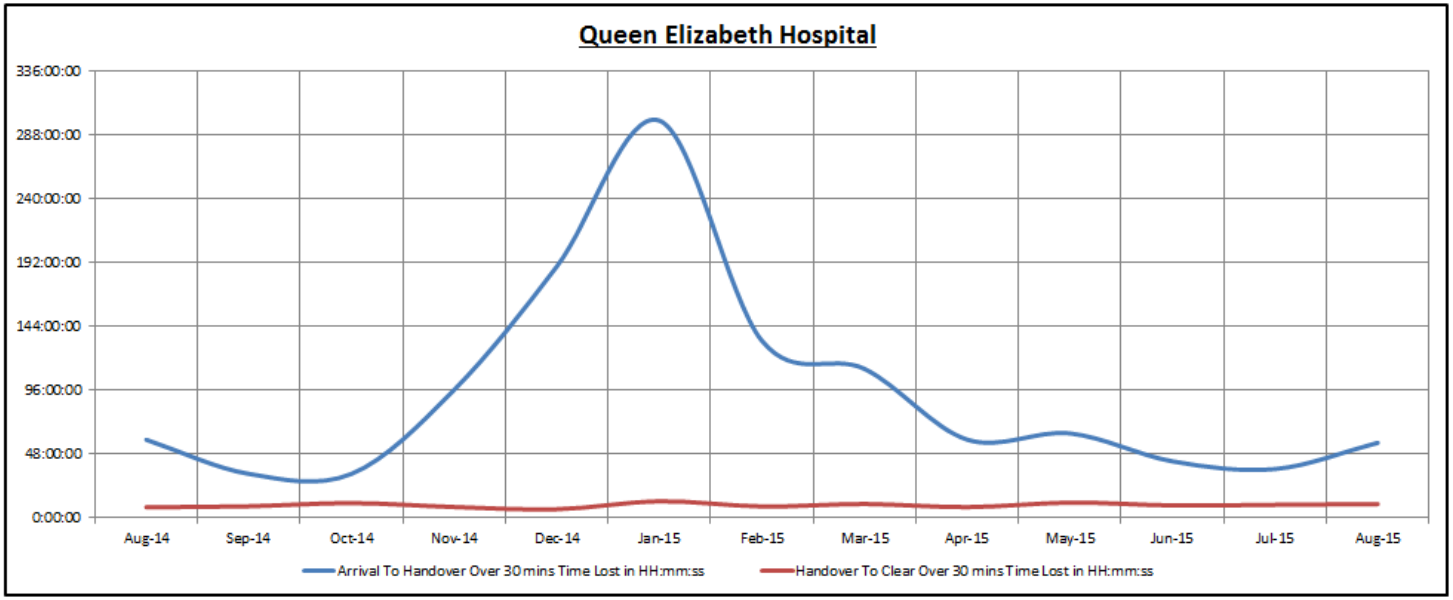
Arrival To Handover Over 30 mins Time Lost in HH:mm:ss
Handover To Clear Over 30 mins Time Lost in HH:mm:ss


Queen Elizabeth Hospital
336:00:00
288:00:00
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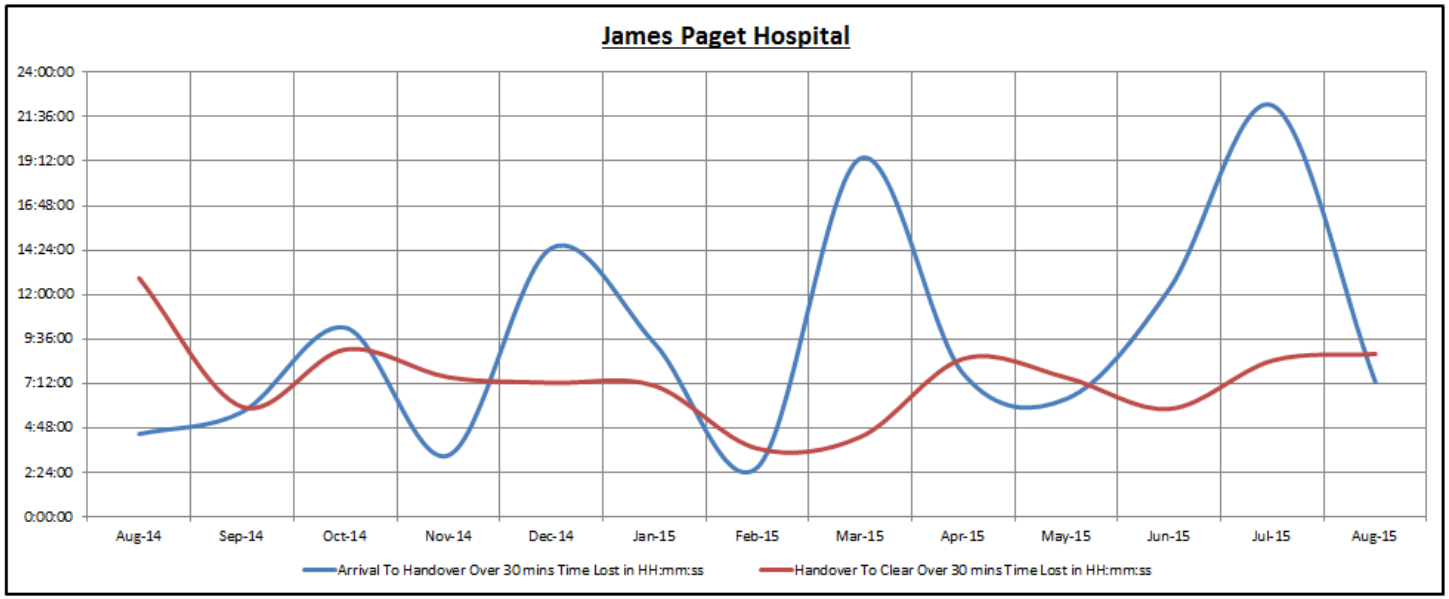
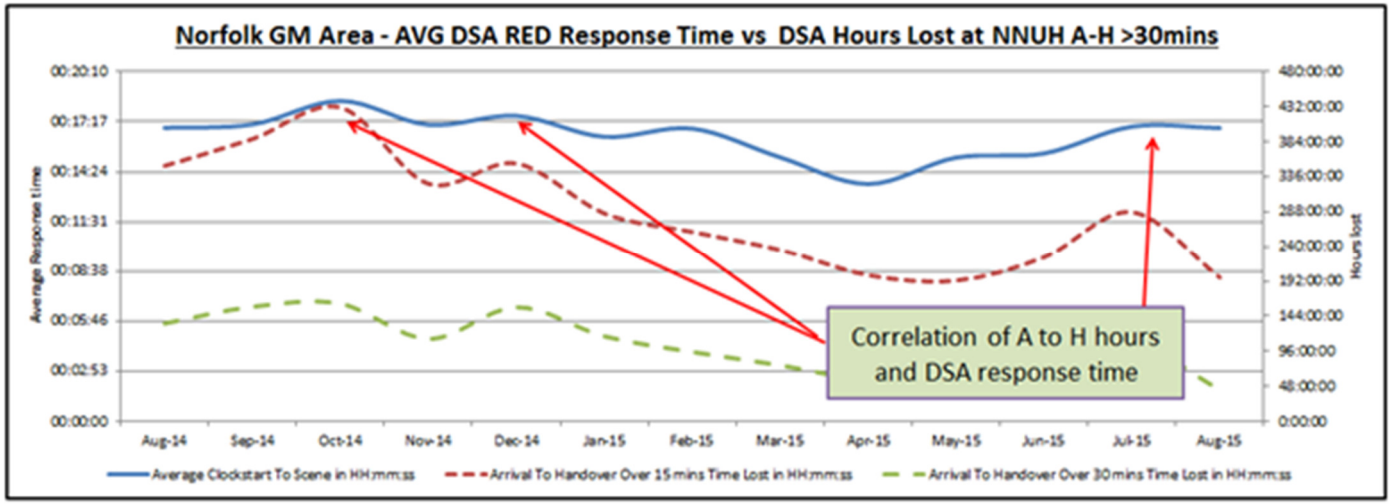
Arrival To Handover Over 30 mins Time Lost in HH:mm:ss
Handover To Clear Over 30 mins Time Lost in HH:mm:ss



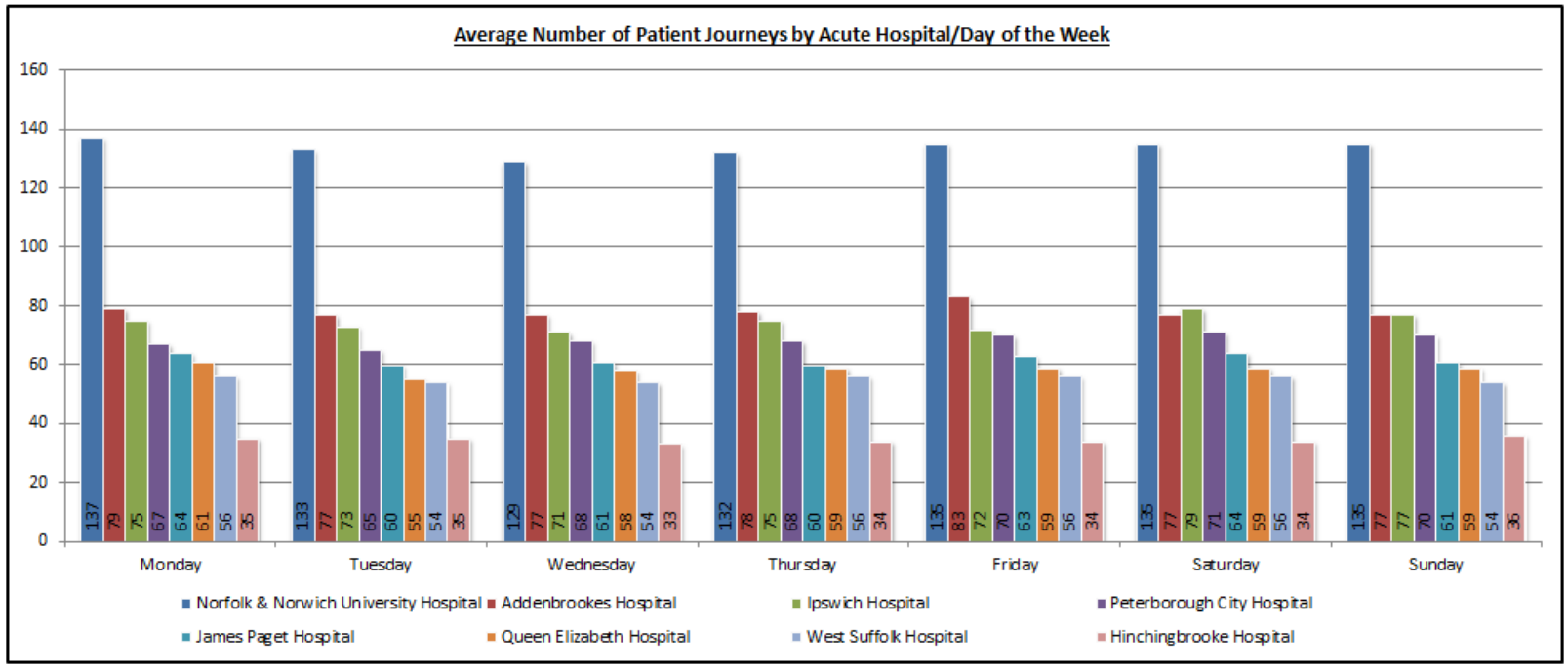
Hospital Ambulance liaison Officer (HALO)

EEAST introduced a team of staff known as Hospital Ambulance Liaison Officers (HALO) to support both EEAST and the NNUH in the turnaround of crews as quickly, efficiently and as safely as possible. Starting in October, 2013 the HALO's have been instrumental in supporting both crews and the NNUH with ambulance turnaround, in particular handover to clear times. EEAST were successful in securing winter funding to extend the HALOs presence at most of our acutes for winter 2015, and in particular increase the availability at NNUH, such that they are now 24/7 for the remainder of the winter period. The NNUH are entirely supportive of the HALO role, and we both recognise that they are funded by winter funding monies only. We have worked in close conjunction with the NNUH ED team and senior trust management to ensure the role develops and becomes an integrated role for both organisations. The HALO has worked with the ED staff to highlight peaks in demand and aids capacity planning and awareness. The HALO has been a success and has supported both EEAST and NNUH.

The impact of hours lost at the N&N on EEAST's wider performance



There appears to be a direct correlation between lost hours and handover performance at the ED. During peaks, the level of delays seen in ambulance handover had an effect of losing valuable emergency resources and a negative impact on ambulance response times in Norfolk. This chart demonstrates how handover delays at the NNUH from August 2014 to the end of August 2015 have had an effect on the average response times in Norfolk, and that the peaks in delays that result in an increase in lost hours, can be mapped against the increase in average response times. NNUH will likely be most reflective of this due to the volume of ambulance resource attending the ED on a daily basis (see chart below)



It is therefore vital that delays are kept to the absolute minimum. The dramatic improvements in the NNUH handover performance has been sustained since April 2013 and all providers work very closely in managing ambulance delays. EEAST participate at the weekly Capacity Planning Group meeting in central Norfolk and all delays are discussed and accounted for.

Norfolk Ambulance Response Times

Set out below are the performance figures for Norfolk financial year to date, to end August 2015. Whilst it is clear that there is much work to do, we are still in a period of developing all our student paramedics, and managing increased activity/demand and hospital delays regionally.

CCG	Red 1 (8 Mins)				Red 2 (8 Mins)				Red 1/Red 2 (19 Mins)			
	Activity	Compliant Responses	Performance	Over 30 min	Activity	Compliant Responses	Performance	Over 40 min	Transporting Activity*	Compliant Responses	Performance	R60T
NHS Great Yarmouth and Waveney	360	279	77.50%	-	5,845	4228	72.34%	6	6,176	5819	94.22%	144
NHS North Norfolk	182	94	51.65%	-	3,748	1711	45.65%	19	3,913	3230	82.55%	141
NHS Norwich	345	297	86.09%	1	5,066	4045	79.85%	2	5,338	5245	98.26%	86
NHS South Norfolk	261	158	60.54%	1	4,705	2347	49.88%	7	4,946	4336	87.67%	126
NHS West Norfolk	224	159	70.98%	1	4,323	2690	62.23%	1	4,528	4135	91.32%	59
TOTAL	1,372	987	71.94%	3	23,687	15021	63.41%	35	24,901	22,765	91.42%	556

With regard to comparison on last year the chart below highlights the increase in demand in the high acuity calls, and despite that increase, the actual improvements in performance in the same period with more patients being seen within the target times.

	2014 (June/July/August)			2015 (June/July/August)		
	Responses	Reached Within Target Time	% Reached within Target Time	Responses	Reached Within Target Time	% Reached within Target Time
Red1&2	12457	6974	55.98%	13450	8261	61.42%
Red19	12351	10630	86.07%	13338	11947	89.57%
Green 2	9321	7392	79.30%	10654	8452	79.33%

	Variance 2015 Vs. 2014		
	Variance in Responses	Variance in Demand	Variance in Performance
Red1&2	993	7.97%	5.44%
Red19	987	7.99%	3.51%
Green 2	1333	14.30%	0.03%

Norfolk Ambulance Activity

Ambulance activity is commissioned by each individual CCG. The current arrangement is that a consortium of CCG's collectively commission ambulance activity in the East of England. Each CCG can purchase more or less activity. Discussions take place with commissioners to set activity levels, which form the commissioned levels of activity for the new financial year. This also allows for planning of the year ahead with activity levels forming the basis for planning resourcing levels for the ambulance service.

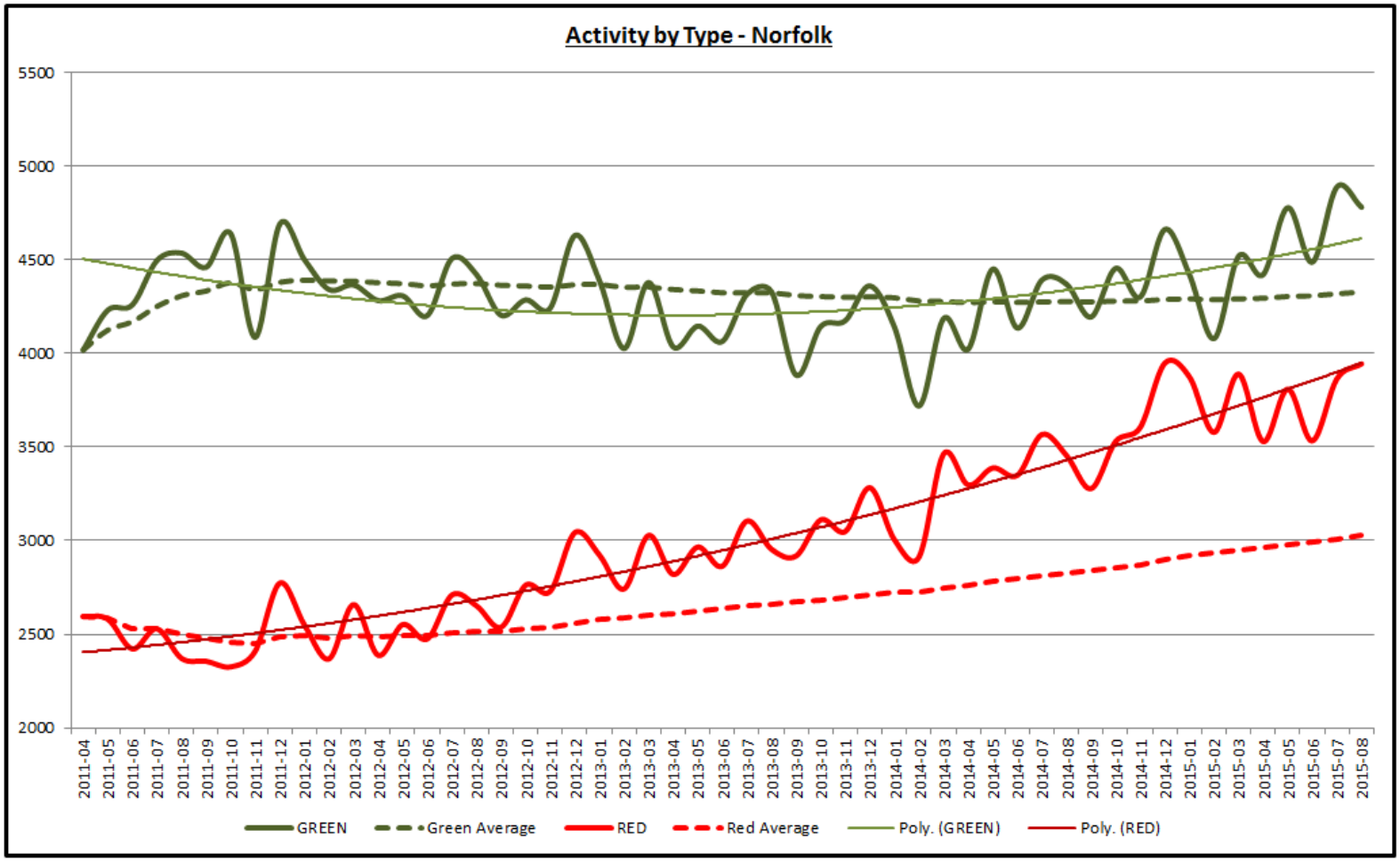
In general the activity commissioned for this year was underestimated. The increases by CCG are shown below, actual, contract and variance. Suffice to say that the increase of demand on EEAST has again been significant, and these totals of actual incident increase are highlighted below. NHS Norwich suffers from the highest over-activity from last year (for the whole region) and has a pull on all Norfolk resources in an effort to cope. Equally, the activity by type graph demonstrates how in Norfolk we are seeing increases in acuity of 999 calls, not just volume, such that green calls have remained largely static and that red call volume (8 minute response time target) has significantly increased, which is where the bulk of the extra activity sits. This has the effect of a greater pull of resources, as we continue to need to send a complex range of resources and clinical expertise thus stretching our capacity and people further.

A&E CONTRACT ACTIVITY SCHEDULE

East of England Ambulance Service NHS
NHS Trust

Aug-15

CCG	14-15 Activity	Purchased Growth	Contracted Activity	15-16 Actual Activity	14-15 Variance	14-15 Variance %	Contract Variance	Contract Variance %
Great Yarmouth & Waveney CCG	16,318	328	16,646	16,110	-208	-1.27%	-536	-3.22%
North Norfolk CCG	10,116	356	10,472	10,435	319	3.15%	-37	-0.35%
Norwich CCG	11,992	334	12,326	13,663	1,671	13.93%	1,337	10.85%
South Norfolk CCG	12,074	362	12,436	12,745	671	5.56%	309	2.48%
West Norfolk CCG	10,614	317	10,931	11,410	796	7.50%	479	4.38%
	61,114	**1,697**	**62,811**	**64,363**	**3,249**	**5.32%**	**1,552**	**2.47%**


Activity by Type - Norfolk
5500
5000
4500
4000
3500
3000
2500
2000
2011-04
2011-05
2011-06
2011-07
2011-08
2011-09
2011-10
2011-11
2011-12
2012-01
2012-02
2012-03
2012-04
2012-05
2012-06
2012-07
2012-08
2012-09
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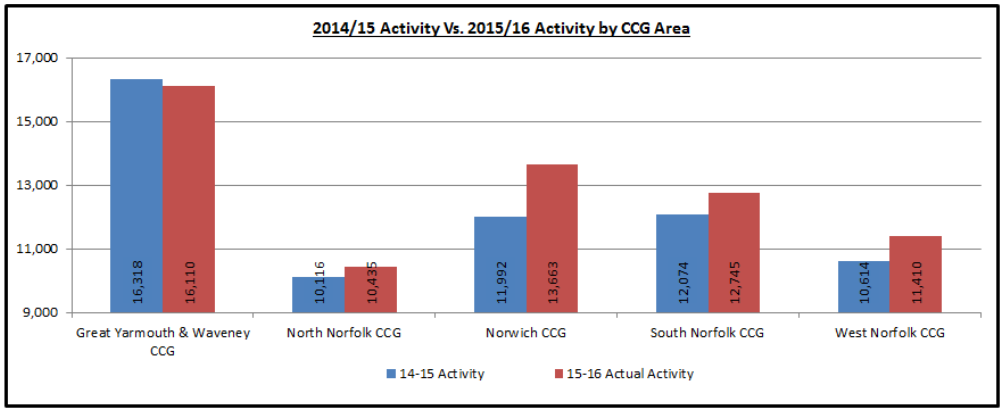
2014-07
2014-08
2014-09
2014-10
2014-11
2014-12
2015-01
2015-02
2015-03
2015-04
2015-05
2015-06
2015-07
2015-08
GREEN
Green Average
RED
Red Average
Poly. (GREEN)
Poly. (RED)

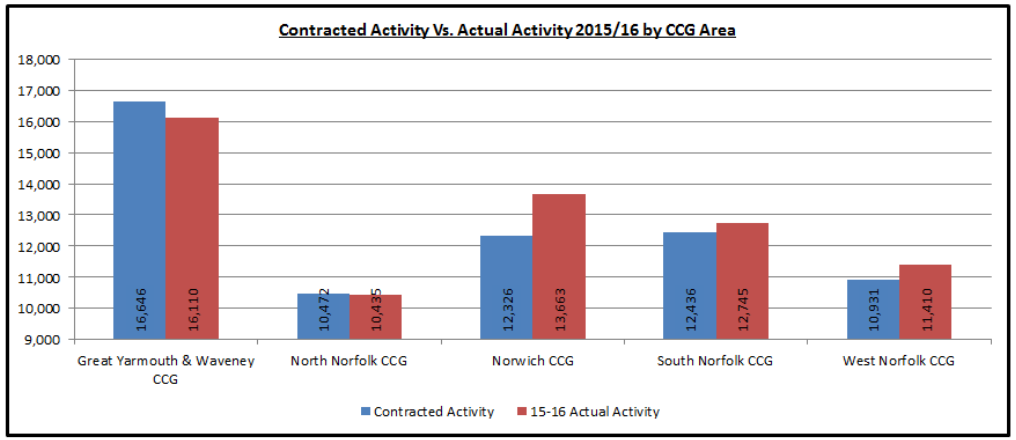
CCG	14-15 Activity	15-16 Actual Activity
Great Yarmouth & Waveney CCG	16,318	16,110
North Norfolk CCG	10,116	10,435
Norwich CCG	11,992	13,663
South Norfolk CCG	12,074	12,745
West Norfolk CCG	10,614	11,410

This graph shows the variance in activity from 2014/15 to 2015/16. With the exception on Great Yarmouth & Waveney CCG, all CCG areas show an increase in activity.



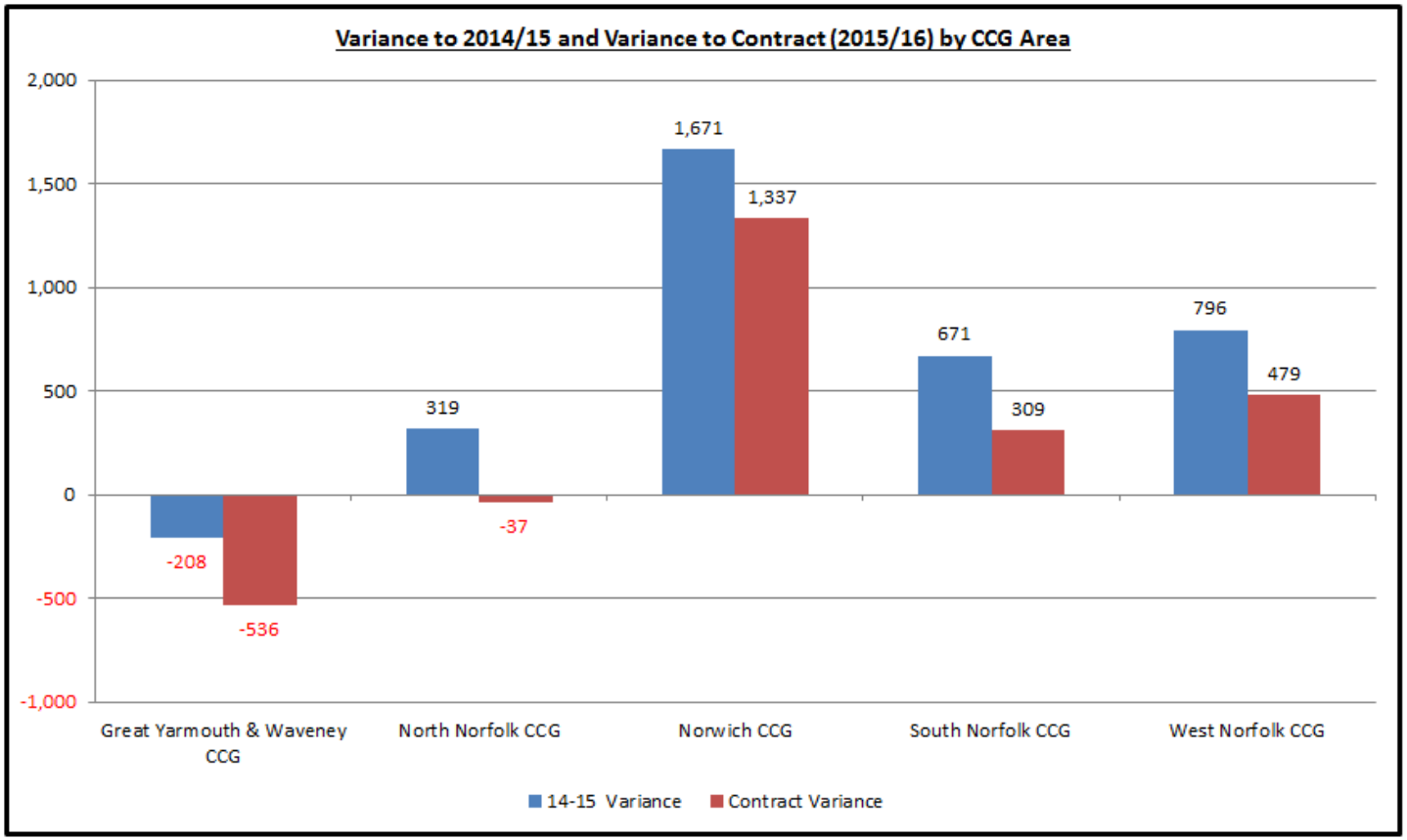
CCG	Contracted Activity	15-16 Actual Activity
Great Yarmouth & Waveney CCG	16,646	16,110
North Norfolk CCG	10,472	10,435
Norwich CCG	12,326	13,663
South Norfolk CCG	12,436	12,745
West Norfolk CCG	10,931	11,410

This graph shows the contracted activity for 2015/16 vs. The contracted activity. Great Yarmouth & Waveney is below contracted activity, North Norfolk is slightly below activity and the other three CCG areas are all above contracted activity, especially Norwich CCG.



CCG	14-15 Variance	Contract Variance
Great Yarmouth & Waveney CCG	-208	-536
North Norfolk CCG	319	-37
Norwich CCG	1,671	1,337
South Norfolk CCG	671	309
West Norfolk CCG	796	479

This graph shows the variance in activity from 2014/15 to 2015/16 and the variance in contract for 2015/16. Great Yarmouth & Waveney is the only area with a decrease in activity compared to last year, Norwich CCG area has seen a significant increase in demand compared to last year and is also well above contracted activity.



Norfolk's Resourcing

In the Norfolk, Suffolk and Cambridgeshire (NSC) Locality, resourcing focus remains on ambulances especially at weekends and nights. Rapid Response Vehicle (RRV) resourcing has been challenged but with the emphasis on the core delivery of ambulances there is a continued focus on ambulance coverage protecting the rural community and key RRV's supporting the urban areas. The need to continue to recruit student paramedics against the on-going rise in demand means that risks do exist about staffing all our RRVs if it means enough paramedics aren't available to support students on ambulances, and this sits on our risk register.

The service has a massive training and development programme in place for new student paramedics and existing staff wanting to progress to Emergency Medical Technician or Paramedic level. There is an ongoing challenge to balance the training and development programme (which is absolutely essential to increasing our frontline staffing numbers and skill sets) against maintaining operational cover. This will be a challenge for a number of months as we continue with the re-training programme and before our first student paramedics register as paramedics.

Equally, we are ensuring that we continue to support core delivery of professional update training for staff and this is taking place throughout the year.

For the year to date we have continued to put out at least budgeted ambulance levels, and often much more in order to keep up with rising demand. RRV resourcing is challenged to maintain ambulance levels and skill mix.

New rota hours are being implemented to support increased recruitment against increased demand. This has led to another 91 full time positions being created across NSC and will be complete in October 2015.

Norfolk's Recruitment and Current Actions

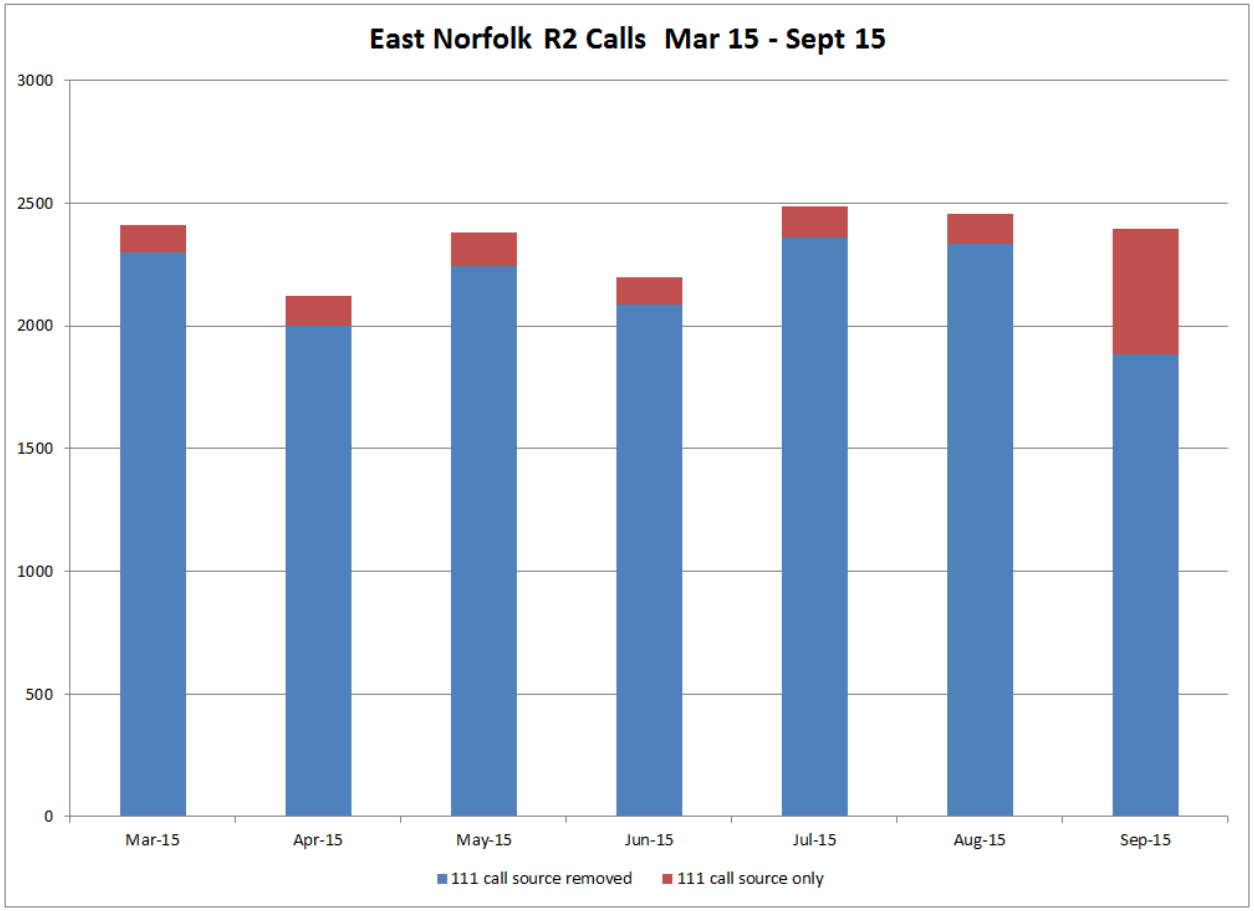
Actual vacancies amount to very few in Norfolk now, with just a handful in West Norfolk. However, the issue is the skill mix resulting from the temporary position of having many student paramedics requiring mentoring and training abstraction, versus the actual number of qualified paramedics. There are 169 students currently in Norfolk against a total staffing of 635. As students progress on their development pathway, this will improve the skill mix of our staff.

It is worth noting that over the past few years, EEAST has worked closely with commissioners to understand what level of resourcing is needed at individual CCG levels to meet mandated national targets. Given the rural nature of Norfolk, the gap between current resources and what would be needed to deliver the national standards is significant.

Given the current challenges within the Norfolk system, a Pre Hospital Improvement Board has been set up, led by NNCCG Accountable Officer Mark Taylor and attended by all the acute and primary care leads. As the pre hospital aspect covers more than the 999 part of health care, this task and finish group are deep diving into key areas of health activity and linking closely with Operation Domino.

Norfolk's 111 Contract

Although there were some initial teething problems with the IC24 takeover of 111 and out of hours services within Central Norfolk, EEAST and IC24 now liaise regularly to discuss any barriers that require addressing both at operational and management levels. The chart below highlights the effect on first month of operation, with balance of R2 call source, 111 v 999.


East Norfolk R2 Calls Mar 15 - Sept 15
3000
2500
2000
1500
1000
500
0
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
111 call source removed
111 call source only

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

Norfolk and Norwich University Hospitals NHS
NHS Foundation Trust

AMBULANCE HANDOVER AT NNUH - REPORT TO NHOSC 14 OCTOBER 2015

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

For: Norfolk Health Overview and Scrutiny Committee 14 October 2015.

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

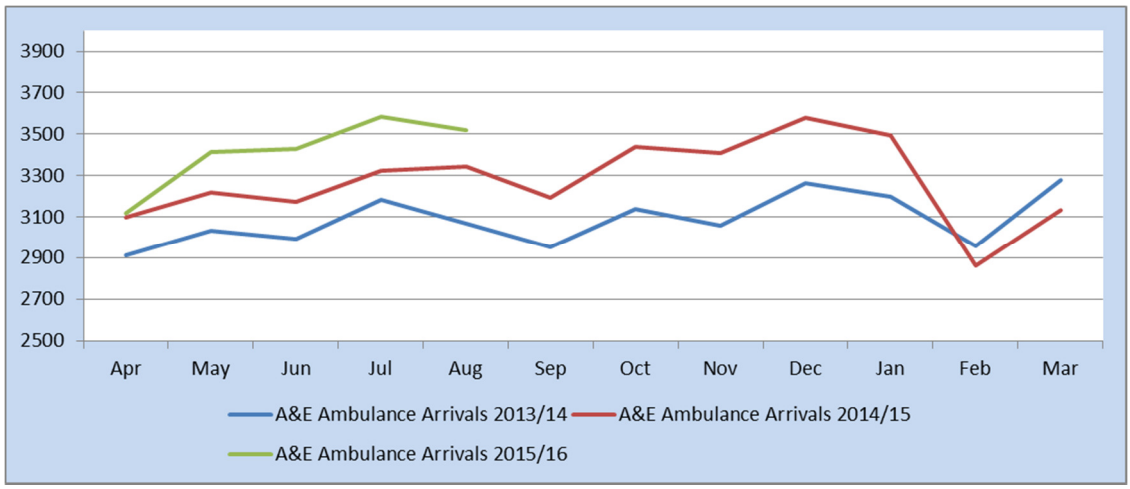
Background

When ambulance handover delays occur at the NNUH it is usually as a consequence of reduced flow throughout the Hospital and/or a significantly higher than expected demand on the emergency admission areas.

Activity

There has been a **14%** increase in ambulance arrivals in 2015/16. This represents on average **17** additional ambulances per day. Since 20 Jun the variation has increased to **16%** on 2014/15 or **20** additional ambulances per day.

Table 1. Ambulance arrivals at A&E April 2013 – August 2015



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
A&E Ambulance Arrivals 2013/14	2915	3035	2991	3185	3069	2955	3137	3059	3264	3201	2957	3278	30811
A&E Ambulance Arrivals 2014/15	3099	3218	3173	3325	3343	3195	3440	3411	3582	3494	2861	3134	39275
A&E Ambulance Arrivals 2015/16	3118	3413	3429	3584	3520								17064

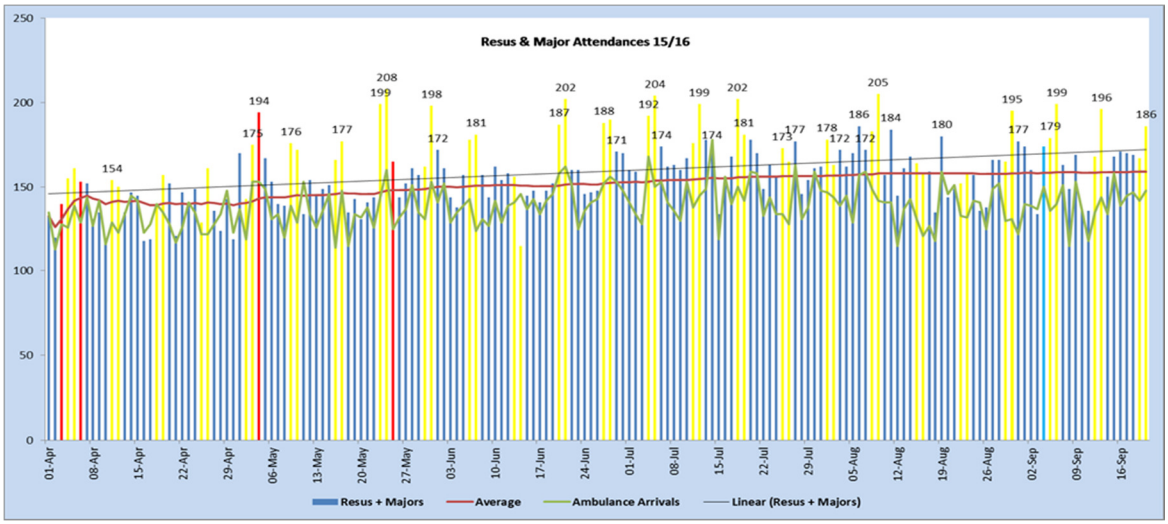
There has been a **22%** increase in combined majors/resus attendances 1 April – 20 September 2015 versus the same period of 2014.

There were early signs of a significant increase in May but activity returned to predicted levels in early June. However, there has been a sustained step change since approximately 20 June 15. Since that time, an additional **3339** resus/majors

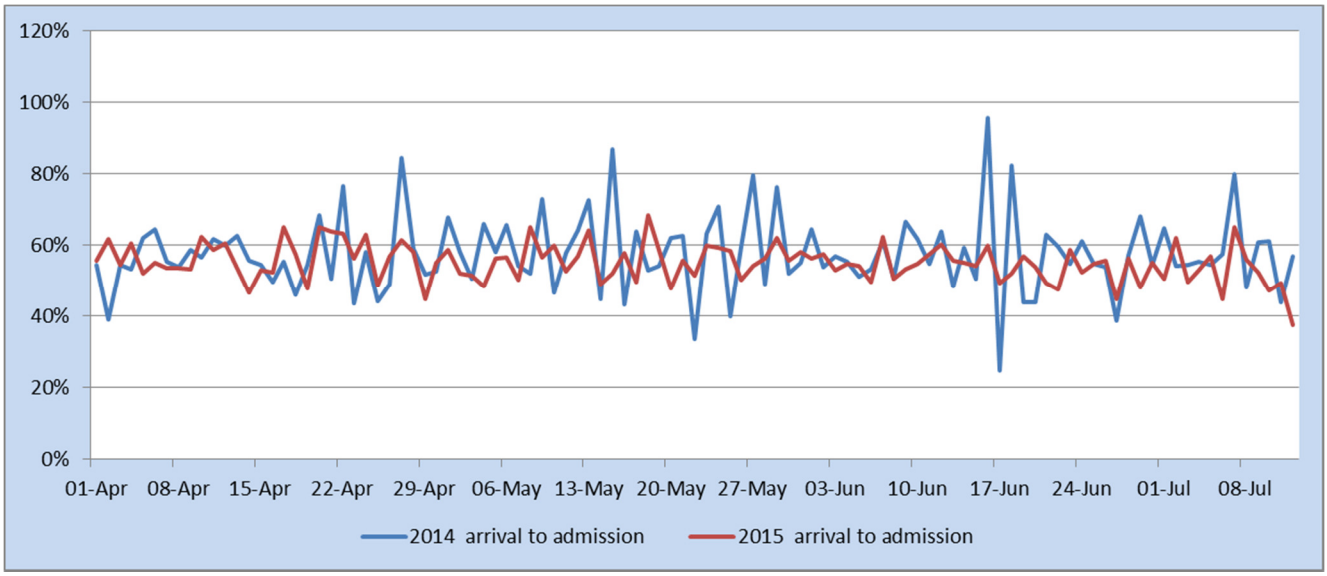
patients have attended compared with the same period in 2014. That represents **36** additional resus/majors patients per day and is applied relatively consistently. This is a **27%** increase on 2014.

Assuming that, on average, 180 minutes are required for resus and majors patients, 36 additional patients per day represents **6480** additional hours of clinical time in the ED every day: this represents approximately 9 additional nursing shifts. If there is not a consistent uninterrupted outlet to the emergency admission areas it is likely that this level of demand will result in a congested ED and 4 hour standard breaches and ambulance handover delays.

Table 2. Major A&E attendances April – September 2015



Ambulance arrival at ED to admission



During the period 1 Apr – 12 Jul, the rate of admission of ambulance arrivals at ED has decreased from an average of 60% in 2014 to 57% in 2015. There has been no significant variation between weekends and weekdays.

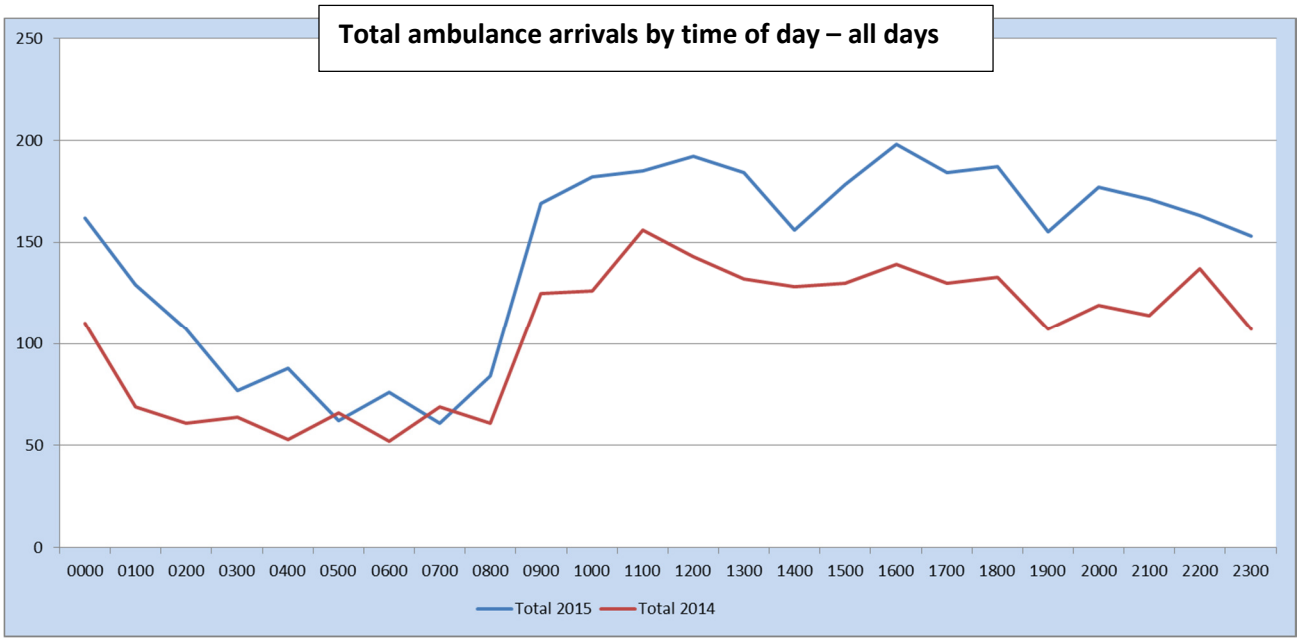
Ambulance Handover Performance February to September 2015

Table 3. Validated A&E only ambulance handover performance Feb – Sep 15

NNUH Validated ambulance Handover - A&E only			
Month	A&E ambulance arrivals	<15 Min Handover	> 60 min handover
February	2861	75.61%	27
March	3134	80.70%	41
April	3118	82.17%	8
May	3413	81.91%	17
June	3429	80.99%	30
July	3584	79.70%	47
August	3520	82.91%	4

August 2015 was one of the most challenging in terms of volume and complexity of attendance at the NNUH. Despite this, using EEAST's unvalidated data, the NNUH performance against the <15 minute handover requirement compared favourably with other hospitals in our region. The NNUH completed more successful <15 minute handovers in January than those Trusts highlighted in yellow handled in total.

Ambulance arrivals by time of day 20 Jun – 20 Sep 14 vrs 20 Jun – 20 Sep 15



During the period 20 Jun – 20 Sep the increase in ambulance arrivals has seen the peak shift to 16:00 and increased volumes late at night have created additional pressure when staffing levels are reduced.

However, if only Saturday and Sunday activity is measured, ambulance activity has peaked at 1300 and again at 1800

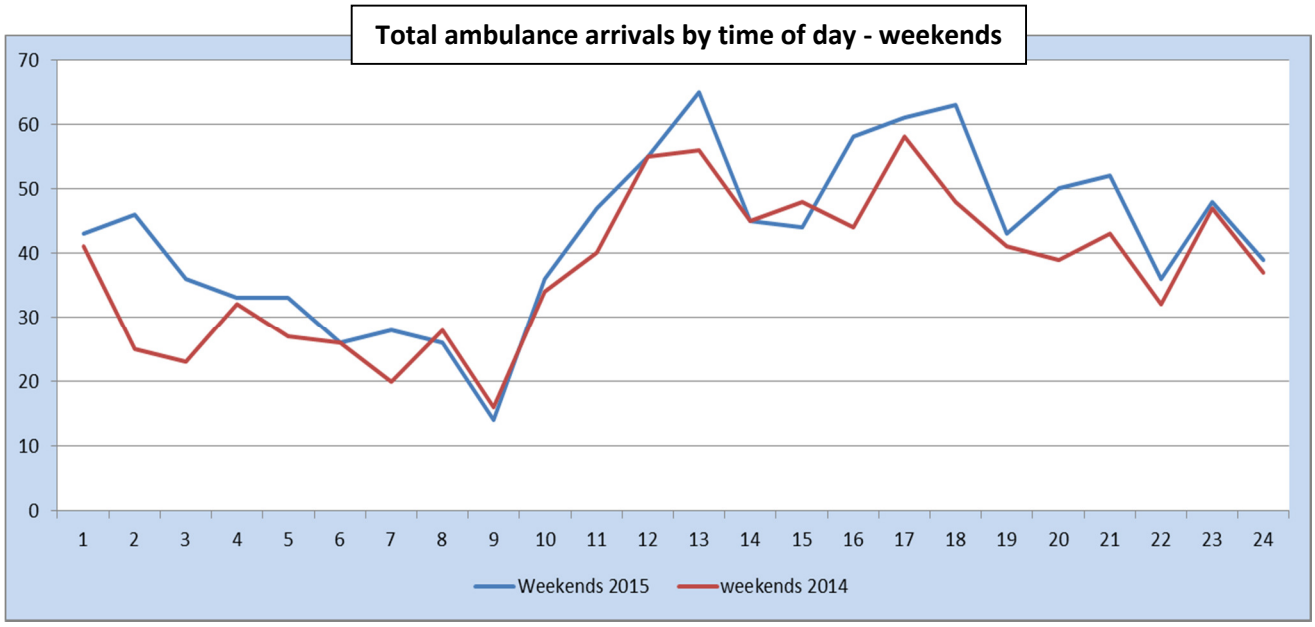


Table 3. East of England Region – un-validated ambulance Handover (all entrances) <15 minutes

Hospital	Total Handovers	Number <15 mins	% <15 mins
Bedford Hospital South Wing	1459	1218	83.50%
Hinchingbrooke Hospital	832	507	60.90%
James Paget Hospital	1822	1058	58.10%
Norfolk & Norwich University Hospital	4169	2380	57.10%
Barnet General Hospital	446	252	56.50%
Queen Elizabeth Hospital	1776	974	54.80%
Addenbrookes Hospital	2437	1312	53.80%
Peterborough City Hospital	2001	1032	51.60%
Luton And Dunstable Hospital	2264	1168	51.60%
Ipswich Hospital	2279	1168	51.30%
Queens Hospital	2	1	50%
Southend University Hospital	2318	1133	48.90%
Princess Alexandra Hospital	1869	781	41.80%
Watford General Hospital	2321	915	39.40%
Basildon & Thurrock Hospital	1774	660	37.20%
Broomfield Hospital	2249	751	33.40%
West Suffolk Hospital	1612	513	31.80%
Colchester General Hospital	2436	529	21.70%
Lister Hospital	2534	537	21.2%

Major Actions Implemented to improve ambulance handover

1. **Clear focus on a patient's 'next step' and 'expected date of discharge' to help reduce length of stay and reduce 'downstream' bed congestion**

2. **Building patient awareness of their own next steps, expected date of discharge and what they can do to help get home so patients can help drive their own timely care (in support of action 1)**

3. **WardView system rolled out to all appropriate medical wards to routinely capture next steps and improve visibility of discharge opportunities and available beds across the hospital**

4. **'Breaking the Cycle' exercise 30 Sept – 06 October to embed new systems and increase focus on patient flow, with rapid escalation across the health and social care partners to unblock obstacles to patients going home.**

5. **Emergency Dept (ED) 'command & control' system enhanced and external senior clinical support engaged**

6. **Breach analysis process developed to identify root cause of delays in ED**

7. **Additional Senior Medical and Nursing Staff posts created in the Emergency Department to manage additional demand (with locum staffing until permanent staff are recruited)**

NHS Workforce Planning in Norfolk

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

The committee will receive responses from all the organisations to which it made recommendations on 16 July 2015. Representatives from the three NHS System Resilience Groups in Norfolk, Norfolk County Council Public Health, and Health Education East of England will attend to discuss the responses to the recommendations and current action to secure the supply of NHS workforce for the future.

The committee will also discuss the planning underway to ensure that services are adequately staffed during the forthcoming winter.

1. Introduction

1.1 On 16 July 2015 Norfolk Health Overview and Scrutiny Committee (NHOSC) received the report of its scrutiny task and finish group on NHS Workforce Planning in Norfolk, which included eight recommendations. NHOSC approved seven of the recommendations to be sent to the relevant organisations but withheld one recommendation which the task and finish group had proposed for Norfolk MPs.

1.2 The other seven recommendations in the report were forwarded to the relevant organisations and individuals in July 2015 and they were asked to provide written responses in time for today's meeting.

2. Response from the Parliamentary Under Secretary of State for Care Quality

2.1 The recommendation which the task & finish group proposed for Norfolk MPs was 'To raise the issue of Service Increment Funding for Teaching (SIFT) with the Department of Health, with a view to speeding up progress towards a fair share for Norwich Medical School'. NHOSC decided not to send this recommendation to the Norfolk MPs immediately but to send the report to Lord Prior, Parliamentary Under Secretary for Health for comments before deciding whether to make the recommendation to MPs.

2.2 A response was received from Ben Gummer MP, Parliamentary Under Secretary of State for Care Quality who is the Minister responsible for Workforce at the Department of Health. Mr Gummer's letter is attached at Appendix A. It provides information about how the national tariff is set for

secondary care, covering non-medical, undergraduate and post-graduate clinical placement training, and about new work to develop tariffs for training in primary care. The work on primary care tariffs is at a very early stage. Mr Gummer acknowledges that the current secondary care transitional tariffs, which aim to gradually bring all areas their fair share of SIFT, can take up to 20 years to reach the goal. The letter does not say whether the introduction of primary care tariffs will play any part in bringing Norwich Medical School towards a fairer share of funding or whether anything can be done with secondary care transitional tariffs to speed up the process.

3. Purpose of today's meeting

3.1 Responses to NHOSC's recommendations are attached at Appendix B. Representatives from Health Education East of England, Norfolk County Council Public Health, the three System Resilience Groups (SRGs) in Norfolk have been invited to attend. The committee will have the opportunity to discuss:-

1. Progress on the recommendations for local actions that could help to improve workforce availability in the medium to long term. These were the recommendations made to Health Education East of England and Norfolk County Council Public Health.

2. Progress on local action and contingency planning to address workforce issues during the forthcoming winter. These issues can be discussed with the System Resilience Group representatives.

3.2 NHS England Midlands and East (East) has provided the paper at Appendix C, which includes options for commissioning of additional primary care capacity.

NHS England Midlands and East (East) commissions primary care in-hours (with involvement from CCGs to a greater or lesser extent in each CCG area). Primary care out-of-hours is commissioned by the CCGs and provided across Norfolk by IC24.

3.3 Norfolk and Waveney Local Medical Committee has also been invited to the meeting to provide their perspective on the challenges currently facing the GP workforce and the initiatives underway to tackle them.

4. Suggested approach

4.1 The Committee may wish to discuss the following areas with the representatives of present at today's meeting:-

Public Health

(a) Public Health, Norfolk County Council, is taking a lead to co-ordinate liaison between local planning authorities and the local

NHS. What is the time-table for roll out of the 'Public Health in Planning Task & Finish Group's' work on a county-wide protocol?

Health Education East of England

(a) What are the latest developments in the work by HEEoE and others in relation to local education and training of a workforce for the Queen Elizabeth Hospital and other NHS employers in west Norfolk?

(b) What is the progress with HEEoE and its partners' initiatives on new educational and training models to bridge NHS workforce gaps in future?

System Resilience Groups

(c) The Department of Health has placed a cap on agency nursing expenditure within the NHS in an attempt to hold down costs. Given the implications of this measure for local hospitals, are the System Resilience Groups assured that safe staffing levels for nursing can be maintained during the winter period?

(d) What are the contingency plans to ensure a supply of GPs to provide the out-of-hours service during the forthcoming winter period.

(e) Are the commissioners fully assured that the contingency plans are adequate?

APPENDIX A

From Ben Gummer MP
Parliamentary Under Secretary of State for Care Quality

Department of Health

Richmond House
79 Whitehall
London
SW1A 2NS

Tel: 020 7210 4850

POC5 950309

Michael Carttiss
Chairman of Norfolk Health Overview and Scrutiny Committee
Norfolk County Council
County Hall
Martineau Lane
Norwich
NR1 2DH

07 SEP 2015

RE: NHS Workforce Planning in Norfolk (Resources for GP Training in Norfolk)

Thank you for your letter of 20th July to Lord Prior about the recent report by the '*NHS Workforce Planning in Norfolk Scrutiny Task and Finish Group*' and for bringing it to our attention. I am responding as the Minister with responsibility for Workforce at the Department of Health.

One of the recommendations within the report was to ask the Department to consider speeding up the process with regards a 'fair share' for Norwich Medical Schools in respect of Service Increment Funding for Teaching (SIFT), paragraphs 6.3.1 and 6.3.2.

I recognise the importance of robust workforce planning and the important role medical schools play in this process and I agree that the report provides evidence of the current situation in Norfolk. Getting staffing levels right and ensuring the workforce is affordable is critical if we are to deliver safe quality care whenever and wherever patients need that care.

You may be aware that the Department already conducts an annual national exercise to collect costs from providers to develop a tariff for secondary care, the collection for 2014-15 has just completed. The data collected as part of this exercise informs the national tariff for secondary care covering non-medical, undergraduate and post-graduate clinical placement training.

A similar costing methodology has been developed to establish the actual costs incurred by GP practices in delivering education and training, and requests costs to be provided for the specified cost area, the end aim being to replace local payments with

national tariffs for primary care. At present work on this is still at the development stage and we are currently in the process of collecting data from a small number of practices as part of a pilot exercise. A 'working group' is also established, chaired by the Department and Health Education England which brings together key stakeholders to inform the development of tariffs for primary care.

To clarify, an introduction of primary care tariffs would not be based on the secondary care transitional tariffs, these transitional tariffs can take up to 20 years to fully implement and these are what I believe you make reference to within the report stating 17 years.

The proposed costing methodology (for primary care) seeks to recognise the benefits as well as costs to a GP practice from having trainees, this is so that the development of tariffs can take account of the true cost of non-medical, undergraduate medical and post-graduate medical clinical placement training and provide a fair playing field across the country.

Until the costing exercise has been completed, we will not know the level at which tariffs need to be set, and with what structure, in order to fairly recompense GP practices for their training work.

I hope that this goes some way to provide clarification of how the Department of Health and Health Education England are working together to understand the costs of primary care placement training.

BEN GUMMER

Norfolk Health Overview and Scrutiny Committee – NHS Workforce Planning in Norfolk – Responses to recommendations

Recommendations		**To**	**Response**
1.	That Public Health, Norfolk County Council, takes the lead to co-ordinate liaison between local planning authorities (LPAs) and the local NHS to i) Create a county wide protocol to ensure that the LPAs consult effectively with the NHS ii) Ensure that the NHS has the necessary information to be able to respond, based on evidence of growing needs modelled on the LPA geographic area. (paragraph 6.1.6.)	Interim Director of Public Health	**Recommendation accepted**. A 'Public Health in Planning' Task and Finish Group has been formed with membership drawn from Public Health and Infrastructure & Economic Growth Team, NCC and the districts' Planning Policy teams. Both of these recommendations are included in its intended output. A comprehensive document is in the final stages of development and will be presented at the West Norfolk CCG Governing Board on 29 October 2015, and rolled across the county thereafter accordingly.
2.	That Health Education East of England and the College of West Anglia work together with all the necessary partners with a view to receiving accreditation and providing health care degree courses in King's Lynn as soon as is practicable. (paragraph 6.2.5)	Health Education East of England	**RECOMMENDATION ACCEPTED** HEEoE has agreed to work with local partners to include College of West Anglia to address local workforce supply issues and opportunities for local residents. The focus, however, will remain on the 'right' solution for QEHKL that also provides opportunities for local residents and this may not be a nursing degree programme at CoWA. The Head of the Workforce Partnership met with the Principal of the College of West Anglia (CoWA) & local Councillor

Recommendations		To	Response
			Alexandra Kemp on 13 July 2015 to discuss the opportunity to develop a degree course at CoWA. The meeting concluded that HEEoE would consider commissioning a local cohort but a number of things would need to be in place before this could be taken forward: 1) Anglia Ruskin University (ARU) accredits the HE provision on the CoWA site and so would need to be supportive of setting up local provision in Kings Lynn; 2) The local hospital (QEHKL) would need to support local provision as it would be required to provide suitable placements for the nursing students accessing any local provision. Currently they take UEA students who rotate through QEHKL and the Norfolk & Norwich Hospital; 3) If ARU support the setting up of local nursing provision on the site of CoWA the Nursing and Midwifery Council would need to approve any new courses before these could be commissioned by HEEoE; 4) Before any contractual changes could be undertaken by HEEoE and commissions moved from other HEI provision any QEHKL would need to identify the need for a change in provision as part of the planning & commissioning cycle to which HEEoE would respond. The meeting concluded with the Principal agreeing to raise the issue of a local cohort with ARU and to seek the Trust

Recommendations		To	Response
			Boards views on the development of a local cohort. At present HEEoE has not been formally approached by QEHKL to review its current provision and develop a local nursing programme. The Head of the Workforce Partnership made contact with the QEHKL Director of Nursing prior to meeting with CoWA to advise her of the meeting and fed back the outcome of the meeting so as to ensure all parties were appraised of discussion that took place. Prior to this local meeting the Head of the Workforce Partnership also had a discussion with the Head of Commissioning from HEEoE to advise of the local interest from CoWA. The Head of Commissioning confirmed that HEEoE would **consider** changes to current commissioning arrangements if QEHKL were to formally raise this with HEEoE as part of the commissioning cycle.
		College of West Anglia	**Recommendation accepted.** CWA Principal and Head of Faculty for health care programmes met with Ross Collett, Health Education East of England on 13 July to explore planning framework and potential opportunities. Next steps to meet with the Chief Executive and director of Nursing at Queen Elizabeth Hospital NHS Foundation Trust.
3.	That Health Education East of England, UEA School of Health Sciences, the Queen Elizabeth Hospital NHS Foundation Trust,	Health Education East of England	**RECOMMENDATION ACCEPTED** This local placement provision is already in place.

Recommendations		To	Response
	Norfolk Community Health and Care NHS Trust and Norfolk and Suffolk NHS Foundation Trust urgently reach agreement and make arrangements for UEA nursing students to be offered placements in west Norfolk (paragraph 6.2.7)		As stated by QEHKL, the Trust already has local placement provision from the UEA and they have increased commissions to satisfy demand. In addition they have been working with the local workforce partnership and developed an apprenticeship model to take locally recruited or existing members of staff through an apprenticeship framework and then onto a work based nursing degree programme which is being offered through University Campus Suffolk. This provision will be delivered locally and supports the Trusts "grow your own" workforce strategy.
		UEA School of Health Sciences	**For clarification**: UEA students are already offered practice experience opportunities / placements in West Norfolk.
		Queen Elizabeth Hospital NHS Foundation Trust	The QEH already accepts students on placement from the UEA. We have increased capacity this year to 70 students from the UEA.
		Norfolk Community Health and Care NHS Trust	NCH&C are working closely with HEE and UEA in increasing the number of students on placement with us. We are piloting a new method of supporting students in the community teams (CLiP pilots) to increase number of placements. We are also committed to offering newly qualified staff more community jobs on qualifying. (Nursing students from UEA are already on placement with NCH&C in west Norfolk).

Recommendations		To	Response
		Norfolk and Suffolk NHS Foundation Trust	The Trust will continue to discuss the need for a greater presence by the educational provider in West Norfolk as this continues to be very Norwich-centric. The Trust already has student placements in West Norfolk but would like to increase the numbers. This is being discussed with the educational provider. To support this, the Trust is reviewing its mentoring capacity within West Norfolk to ensure it is able to support higher student placement numbers in this area.
4.	That the Local Enterprise Partnerships in Norfolk and Cambridgeshire work with local NHS organisations and Higher Education Institutes to consider innovative ways to support recruitment of healthcare students and workers to Norfolk (paragraph 6.4.3)	New Anglia Local Enterprise Partnership (Norfolk)	**Not accepted:** We recognise the importance of healthcare to the population of Norfolk. Our work raising the profile of Norfolk and Suffolk as a place to work and live will assist with the recruitment of workers from the health sector as well as a wide range of other sectors. However we do not have the capacity to support a specific campaign focused on recruiting healthcare workers and students to Norfolk.
		Greater Cambridgeshire, Greater Peterborough Local Enterprise Partnership	**Not accepted** We have limited capacity and deploy this to stimulate private sector growth, as per Government's request of LEPs. GCGP only covers Kings Lynn West Norfolk within NCC's area and would envisage other solutions are pertinent to NHS Workforce Planning.
5.	That Norfolk County Council Children's Services explores ways in which co-operation between schools, including primary schools, and local NHS organisations, higher education institutes and Health Education East of England can be encouraged to	Interim Director of Children's Services	**Recommendation accepted in part** New Anglia Local Enterprise Partnership (NALEP) and Norfolk and Suffolk County Councils have recently been awarded funding for a 2 year project which forms part of the Enterprise Adviser programme funded by the national Careers & Enterprise Company. The project will focus on the delivery of an Enterprise Adviser brokerage service across each county,

Recommendations		To	Response
	promote early awareness of healthcare roles and career opportunities in the local healthcare system, to achieve 100% coverage of Norfolk's secondary schools and sixth form colleges. (paragraph 6.5.4)		that strengthens links between secondary schools, colleges and businesses in order to provide opportunities for young people to understand the world of work and job opportunities. This employer-led brokerage arrangement will enable employers and associated intermediary organisations to talk directly to pupils about the opportunities available across a range of sectors and ensure they are able to consider all the options as they move through school and college. The coverage for this project is stated as 95% of secondary schools and colleges. The project will also be promoting wider careers and enterprise education through Developing Norfolk's Future Workforce, a county wide initiative to improve the knowledge and understanding of young people about the range of career opportunities in Norfolk. Health and Social Care is one of the nine key sectors identified within the initiative as requiring increased focus and sustained support in order to showcase and promote healthcare roles and opportunities within the local healthcare system.
6.	That NHS England Midland and East (East) and Norfolk's Clinical Commissioning Groups consider how the public will be engaged and informed as changes to the skill mix and delivery of primary care are introduced (paragraph 6.6.3)	NHS England Midlands & East (East)	**Accepted** NHS England will engage with the public and stakeholders through national engagement and through joint commissioning arrangements with CCGs in Norfolk which are expected to be in place by April 2016 across the County
		North Norfolk CCG	**Accepted** CCG regularly discusses skill mix changes in Primary Care and other sections at its various Patient and Public Involvement (PPI) events, such as its Community Engagement Panel.

Recommendations		To	Response
		South Norfolk CCG	**Accepted** South Norfolk CCG is in the initial stages of applying for Joint Committee status. It is the intention that public will be engaged and informed through Governing Body public meetings along with key updates via the CCG website. Should the changes become material and/or when the CCG moves to full delegation in due course the CCG may consider running a public event to answer any questions, seek public views and provide assurance.
		Great Yarmouth & Waveney CCG	**Accepted** The CCG will ensure active patient participation and engagement through our PPG Forum and additional targeted patient focus groups will also be arranged to ensure patients are made fully aware of the proposed changes to primary care workforce and the opportunities /benefits these present. Communication and Engagement with all our stakeholders including patients is a key work stream in Great Yarmouth and Waveney's CCG's Primary Care action plan.
		West Norfolk CCG	**Accepted** NHS West Norfolk CCG accepts the recommendation, proposed by the Norfolk Health Overview & Scrutiny Committee Task & Finish Group, in their report on the NHS Workforce Planning in Norfolk, that NHS England Midland and East (East) and Norfolk's Clinical Commissioning Groups consider how the public will be engaged and informed as changes to the skill mix and delivery of primary care are introduced (paragraph 6.6.3)
		Norwich CCG	**Accepted** NHS Norwich CCG will ensure that patient and public are engaged and informed on workforce and skill-mix as a part of its YourNorwich programme and through its

Recommendations		To	Response
			Primary care development programme in conjunction with NHSE as a “co-commissioner”. The CCG has carried out a review of its patient engagement process following 18 months of engagement and co-design activities to look at strengthening the patient voice across all commissioning processes and services. A new Community Involvement Panel and Patient Advisory Group are currently being implemented to ensure that this is delivered.
7.	That HEEoE checks with the community providers, and other providers if necessary, on the issues of funded services versus probable requirements and the forecast number of front-line staff retirements and involves CCGs in the discussions if necessary. (paragraph 6.7.4)	Health Education East of England	**RECOMMENDATION ACCEPTED** HEEoE, through the Workforce Partnership, has a well established process that delivers a set of workforce and commissioning plans from all local NHS Providers. Part of this process seeks assurance that Trust Boards have engaged CCGs to input to their workforce plans. In addition the Accountable Officers from the CCGs across Norfolk and Suffolk attend the Workforce Partnership Board where we share the various iterations of the plans as they are built during the planning cycle. This provides an opportunity for CCGs at a senior level to challenge plans and commissions. As part of our planning and commissioning process next year, in line with other Workforce Partnerships in HEEoE I will seek invitations to the various system resilience groups that are established in the patch in order to get their input and critical challenge as plans are built.

NHS England

PRIMARY CARE PLANNING FOR XMAS/NEW YEAR BRIEFING PAPER

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1 PURPOSE

1.1 The purpose of this paper is to update the HOSC, System Resilience Groups (SRGs), and key stakeholders of the position for primary care providers in relation to providing services over the Christmas/New Year period and sets out a number of potential options that SRGs will be considering in developing their system resilience winter plans

2 PRIMARY MEDICAL SERVICE CONTRACTUAL RESPONSIBILITY

2.1 GP contracts require essential core services to be provided Mondays to Fridays from 8.00 am – 6.30 pm excluding weekends and Public/Bank Holidays. This year Monday 28 December 2015 has been designated a Bank Holiday and this means that GP practices will not be open for the 4 day period from Friday 25 December – Tuesday 29 December

2.2 In addition, although Christmas and New Year's Eve are designated as normal working days, in reality in recent years many GP practices implement alternative cover arrangements in the afternoons with local Out of Hours providers or neighbouring GP practices for emergency urgent care only.

2.3 In order to support SRGs with planning NHS England is preparing letters for General Practices reminding them of their contractual responsibilities to provide services during core hours which will be sent out in the near future.

2.4 It is important that practices recognise the need to provide services during core hours on normal working days over the Christmas and New Year holiday period particularly on Thursday 24th December 2015 and Thursday 31st December 2015. The letters to practices are expected to include a request to GP practices to provide details of when they are open to patients during the two week festive period to ensure all practices are open as normal. Practices will be encouraged to review their usual appointment systems to schedule enough free appointments on the days not only immediately before and after the bank holidays but in the weeks leading up to this period.

3 ACCESS TO URGENT GP SERVICES OUTSIDE CORE HOURS

3.1 CCGs are responsible for commissioning GP Out of Hours services to meet the need for access to urgent primary medical services at evenings, weekends and on Bank and Public Holidays.

3.2 In addition there are Walk In centres located in Norwich, and Great Yarmouth which will be open as a minimum from 8 am to 8 pm throughout the holiday period.

3.3 There are also a number of extended hours schemes commissioned either by NHS England through a Directed Enhanced service often in the evenings or at weekends.

4 OPTIONS FOR COMMISSIONING OTHER MODELS FOR PRIMARY MEDICAL CARE

4.1 There would appear to be 4 potential options that the SRGS will consider

- Commissioning additional capacity from existing GP practices outside core hours
- Commissioning additional capacity from identified GP networks, i.e. GP federations/PMCF
- Commissioning additional capacity from existing OOH providers
- Commissioning additional capacity from existing Walk In centres

4.1.1 Commissioning additional capacity from existing GP practices outside core hours

This model was implemented in some areas, as a locally commissioned enhanced service, in response to national demand to mitigate and reduce demand on urgent care services particularly A&E in 2014 and at Easter 2015.

The NHS England national primary care team has acknowledged that this option is not recommended unless in exceptional circumstances for particularly rural or remote areas following national evaluation of these schemes.

National evaluation has shown that this option had little impact on reducing demand on urgent care services and was very poor value for money, as individual practices were commissioned to open for a limited number of hours on either New Year's Day or Easter Sunday on a voluntary basis, for their own patients only. The level of take-up was limited and variable.

The financial incentive paid for GPs was often higher than that offered by OOH providers, which had an adverse impact on filling OOH shifts in some areas. There is also a very limited pool of GPs willing to work outside core hours.

Clearly for any such schemes, consideration would need to be given to the learning from last year, to ensure these services were optimised i.e. GPs having to advertise opening, GPs covering patients from elsewhere if covering a patch; ensuring this didn't deplete capacity from elsewhere in the system.

It should be noted that NHS England is responsible for commissioning services during core hours only and therefore additional non-core capacity would need to be funded by the SRG, rather than solely through NHS England.

4.1.2 Commissioning additional capacity from identified GP networks, ie GP federations/Prime Ministers Challenge Fund

It may be worth considering commissioning emerging GP federations to deliver additional primary care capacity within a locality, rather than commissioning individual GP providers. Careful consideration would be required in relation to the cost of commissioning care under this model which could be prohibitive. In addition, GP federations will be seeking additional funding to cover indemnity costs. PMCF and GP federation work is also not usually eligible for NHS Pension payments.

4.1.3 Commission additional capacity from existing OOH providers

Although OOH providers will be planning to deliver additional capacity during this period, there may be scope to consider commissioning additional services to reduce the need to commission services from individual GP providers. Commissioners and OOH providers should also consider commissioning services from pharmacists, as part of the clinical OOH team.

4.1.4 Commission additional capacity from existing Walk In Centres

Discussions need to take place with local CCGs/SRGs to consider commissioning any extensions/additional capacity (for example Colchester has recently extended to 11pm) to provide additional capacity over the holiday period.

5 PHARMACY CONTRACT REQUIREMENTS

5.1 Pharmacists are required to provide a minimum of 40 hours a week (core hours) but many also provide additional supplementary hours. Pharmacies are not required to open for core or supplementary hours on a Public/Bank Holiday.

5.2 Changes to core hours require NHS England consent but pharmacists only need to notify NHSE with three months' notice of changes to supplementary hours.

5.3 There are a number of pharmacies who are open for 100 hours a week. These are core hours and they are also not required to open on a Public/Bank Holiday and require consent from NHS England to vary any of their hours.

5.4 Pharmacists are aware that Saturday 26 December is a normal working day and that NHS England will not approve any requests from pharmacists to close on this day where Saturdays are part of core hours.

5.5 Many pharmacies will choose to open as normal even on Public and Bank Holidays. Requests to vary opening hours over the holiday period must have been made to regional teams by 25 September. Requests to change core hours are not routinely approved. Changes to supplementary hours cannot be refused if submitted by 25 September but this information will be needed to determine the availability of pharmacy services and determine whether a local enhanced service is required in order to ensure adequate access to pharmaceutical services throughout the holiday period.

5.6 The final picture of provision over the Christmas period and analysis of potential gaps across the region is unlikely to be known until the end of October, as many requests to change hours are not submitted until the 25 September deadline and the volume of requests which need to be collated, reviewed and agreed by Pharmaceutical Services Sub Committees.

6.7 System Resilience Groups (SRG) may wish to review how their OOH providers integrate local commissioning of services from community pharmacies into their overall OOH GP service

5.8 SRGs can also encourage their CCGs to commission local services from community pharmacies that enable patients to receive care directly from their community pharmacy reducing their reliance on 111, GP OOH and A+ E services. Such local services include NHS funded emergency supply of prescription only Medicines, triage and assessment services to support 111 and OOH services, support for self care including NHS Minor Ailments schemes, palliative care services and enhanced signposting arrangements.

5.9 To support the need to keep people well, the national Flu Vaccination programme is being rolled out across pharmacies, this will provide additional capacity within the system to target at risk patients.

5.10 The Community Pharmacy Seasonal Influenza Vaccination Advanced Service (flu vaccination service) will support NHS England, on behalf of Public Health England (PHE) in providing an effective vaccination programme in England and it aims:

- to sustain uptake of flu vaccine by building the capacity of community pharmacies as an alternative to general practice;

- to provide more opportunities and improve convenience for eligible patients to access flu vaccinations; and
- to reduce variation and provide consistent levels of population coverage of community pharmacy flu vaccination across England by providing a national framework.

5.11 Care home patients can be particularly vulnerable to the effects of flu and NHS England will look to the SRGs for assurance that arrangements are in place to safeguard this group of patients from this particular risk.

6 DENTAL CONTRACT REQUIREMENTS

6.1 Dental practices who wish to reduce their normal contracted opening hours over the holiday period are required to make alternative arrangements with a local NHS dental provider to provide emergency access to NHS dental services.

6.2 It is a breach of the Dental Contract to close the practice and redirect all patients to NHS 111 or Out of Hours service during core working hours. Regional teams are writing to all dental providers to request details of their opening arrangements over the holiday period (19 December to 2 January).

6.3 Dental Out of Hours services are commissioned by NHS England but access to these schemes for urgent dental problems is through NHS111/Out of Hours providers. It is recognised that many patients with dental pain contact their GP in the first instance rather than their dental practice. OOH providers will have dental triage arrangements in place to ensure that only clinically appropriate cases are referred on to the on call dentist, outside normal working hours.

7 Current NHS England Activity

7.1 NHS England commissioning responsibilities for medical, dental and pharmacy contractors are summarised in appendix A.

7.2 In addition to ensuring our commissioning responsibilities are discharged NHS England locally are focusing activity on engaging with stakeholders to identify the most pragmatic options for developing Primary care services to support overall NHS system resilience winter plans.

7.3 Meetings with the three SRGs in the locality have been arranged where these options can be explored and developed. At the same time the views of the Local Medical, Dental and Pharmaceutical Committees are being gathered so that an integrated, aligned approach can be developed where all these organisations are pulling in the same direction.

7.4 The SRGs will be asked to investigate which of the four options above, or a combination of these options, will deliver the significant additional access to routine primary care that may be required to ensure that winter pressures on OOH and A+E are manageable.

7.5 In addition SRGs will be asked to ensure that this additional primary care capacity is closely integrated with existing 111, OOH and A+E services; and that these additional services are clearly signed posted to the general public so that it is clear which service provider would be the most appropriate choice to support them in times of need.

7.6 The Primary Care Team are meeting with the Associate Medical director for IC24 (the new OOH service provider which took over from EEAST on 1st September) to discuss how Primary Care and OOH work together effectively to increase capacity when required without

duplication and unnecessary underutilised provision. How this would work within each of the options will be explored.

8. Summary

8.1 This paper to inform the HOSC and for discussion by SRGs on the potential options for primary care over the Christmas and New Year period and to inform development of SRG system resilience plans.

Author: **Ruth Derrett, Locality Director Cambridgeshire & Norfolk**

October 2015

Appendix A (to APPENDIX C of the report) NHS England Commissioning Responsibilities

NHS England commissioning responsibilities
GP Services
Ensure delivery of GP core contract hours 0800 – 1830
NHS E can issue breach notices to practices where there is failure to adhere to contract
NHS E locally will remind all practices of opening times. NHSE will send comprehensive letter to practices outlining responsibilities and suggested ways to manage LTC patients for example.
NHS E will issue national guidance to all practices re: opening times.
NHS E would encourage practices to have Business Continuity Plans in place but no contractual requirement to do so, however this is a CQC requirement.
NHS E will encourage practices to take up Enhanced Services e.g. Unplanned Admissions) but these are non- mandatory and so cannot force sign up.
NHS E cannot commission additional GP capacity outside core hours other than those directed in relevant Direct Enhanced Services but these are non-mandatory and NHS England cannot force sign up.
Liaise with PH to monitor flu uptake across CCG, & pharmacy initiative re flu
Pharmacy
NHS E will ensure pharmacies are open as contracted and changes to contract hours will be declined where access is diminished but looked upon with favour where access is improved.
Pharmacies are required to apply to NHSE to change Core hours (either 100hr or 40hr pharmacies) - NHSE can (and more often than not do) refuse these. Opening hours vary. Pharmacies are required to notify NHSE of any changes to Supplementary hours (any additional hours) giving 90 days' notice. NHSE is able to issue a remedial or breach notice if required. NHSE then has the power to remove a pharmacy from the pharmaceutical list if it fails to take the steps set out in the notice.
Pharmacies are legally able to provide an emergency supply of medication if this has previously been prescribed by a GP in the past for the patient.
Ensure pharmacies (esp. 100hrs) are open and providing all services required during their contracted hours
Write to all contractors to remind them of their contractual obligations in terms of opening hours (esp. over Christmas period) and that audits will be undertaken
NHS E will supply COMMs and Winter planning leads of opening times of all pharmacies –both contractual and bank holiday Rota
Dental
NHS England commissions primary dental services - There are no set/contracted hours in which services must be provided but there is an obligation for providers to

ensure patients are directed appropriately should treatment be required.
Dentists are required to provide access to urgent treatment for existing patients – if not complied with NHS E could issue breach notices.
NHS England commissions Emergency Dental Services and has recently re-procured this service.
NHS E will ensure that NHS 111 has up to date information regarding service provision and access.
NHS E can commission primary care dental provision should the need arise by increasing UDA activity in specific area

Norfolk Health Overview and Scrutiny Committee

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

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

Proposed Forward Work Programme 2015-16

Meeting dates	*Briefings/Main scrutiny topic/initial review of topics/follow-ups*	*Administrative business*
3 Dec 2015	Stroke Services in Norfolk - update (12 months after the responses to stroke recommendations, presented to NHOSC 27 November 2014) Children's Mental Health Services in Norfolk – to scrutinise the level of service provided and comment on Norfolk's Local Transformation Plan for children and young people's mental health.	
14 Jan 2016	MEETING CANCELLED	
25 Feb 2016	Policing and Mental Health Services - an update from the Police & Crime Commissioner for Norfolk, Norfolk and Suffolk NHS Foundation Trust and Norfolk Constabulary (further to the presentation given to NHOSC in October 2014).	
14 Apr 2016	Service in A&E following attempted suicide or self-harm episodes - an update to the report presented in April 2015 by Norfolk and Suffolk NHS Foundation Trust and the three acute hospitals.	

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

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

Clinical Commissioning Groups

North Norfolk	-	M Chenery of Horsbrugh (substitute Mr David Harrison)
South Norfolk	-	Dr N Legg (substitute Mrs M Stone)
Gt Yarmouth and Waveney	-	Mrs M Stone (substitute Mrs M Fairhead)
West Norfolk	-	M Chenery of Horsbrugh (substitute Mrs S Young)
Norwich	-	Mr Bert Bremner (substitute Mrs M Stone)

NHS Provider Trusts

Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust	-	M Chenery of Horsbrugh (substitute Mrs S Young)
Norfolk and Suffolk NHS Foundation Trust (mental health trust)	-	M Chenery of Horsbrugh (substitute Mrs S Bogelein)
Norfolk and Norwich University Hospitals NHS Foundation Trust	-	Dr N Legg (substitute Mrs M Stone)
James Paget University Hospitals NHS Foundation Trust	-	Mr C Aldred (substitute Mrs M Stone
Norfolk Community Health and Care NHS Trust	-	Mrs J Chamberlin (substitute Mrs M Stone)

Norfolk Health Overview and Scrutiny Committee 15 October 2015

Glossary of Terms and Abbreviations

A&E	Accident and emergency
ARU	Anglia Ruskin University
CCG	Clinical commissioning group
CLIP	Collaborative Learning In Practice
COWA / CWA	College of West Anglia (King's Lynn)
CQC	Care Quality Commission
CSU	Commissioning Support Unit
DSA	Double staffed ambulance
ED	Emergency Department
EEAST	East Of England Ambulance Service NHS Trust
GCGP	Greater Cambridgeshire Greater Peterborough
GP	General Practitioner
HEE	Health Education England
JPUH/JPH/JP	James Paget University Hospital
LEP	Local Enterprise Partnership
LPA	Local Planning Authority
LTC	Long term condition
NALEP	New Anglia Local Enterprise Partnership
NCC	Norfolk County Council
NCH&C (NCHC)	Norfolk Community Health and Care NHS Trust
NHOSC	Norfolk Health Overview and Scrutiny Committee
NHSE	NHS England
NNUH (N&N, NNUHFT)	Norfolk and Norwich University Hospitals NHS Foundation Trust
NSC	Norfolk Suffolk and Cambridgeshire
OOH	Out of hours
PH	Public Health
PHE	Public Health England
PMCF	Prime Minister's Challenge Fund
PPG	Patient Participation Group
PPI	Patient Public Involvement
QEH/QE	Queen Elizabeth Hospital, King's Lynn
RRV	Rapid response vehicle
SIFT	Service Increment for Training
SRG	System Resilience Group
UDA	Unit of dental activity
UEA	University of East Anglia
VOR	Vehicles off road