Norfolk County Council

NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE
MINUTES OF THE MEETING HELD AT COUNTY HALL, NORWICH
On 23 February 2017

Present:

Mr R Bearman	Norfolk County Council
Mr M Carttiss (Chairman)	Norfolk County Council
Mrs J Chamberlin	Norfolk County Council
Michael Chenery of Horsbrugh	Norfolk County Council
Mrs A Claussen-Reynolds	North Norfolk District Council
Mrs E Corlett	Norfolk County Council
Mr D Harrison	Norfolk County Council
Mrs L Hempsall	Broadland District Council
Dr N Legg	South Norfolk District Council
Dr K Maguire	Norwich City Council
Mrs S Weymouth	Great Yarmouth Borough Council
Mrs S Young	King's Lynn and West Norfolk Borough Council

Also Present:

Alex Stewart	Chief Executive, Healthwatch Norfolk
Rachael Peacock	Head of Continuing Care, Norwich CCG
Nikki Cocks	Director of Operations and Delivery, Norwich CCG
Jeanette Patterson	Continuing Healthcare Lead, Norfolk County Council
Rob Jakeman	Integrated Commissioning Manager, West Norfolk CCG and Norfolk County Council, Adult Social Care
Caroline Fairless-Price	Service User
Mark Harrison	Equal Lives
Maureen Orr	Democratic Support and Scrutiny Team Manager
Chris Walton	Head of Democratic Services
Tim Shaw	Committee Officer

1 Apologies for Absence

Apologies for absence were received from Mr P Gilmour, Mrs M Stone and Mr P Wilkinson. There were no substitute members present at the meeting.

2. Minutes

The minutes of the previous meeting held on 12 January 2017 were confirmed by the Committee and signed by the Chairman.

3. **Declarations of Interest**

3.1 There were no declarations of interest from members of the Committee.

4. **Urgent Business**

There were no items of urgent business.

5. Chairman's Announcements

5.1 The Chairman pointed out that Mr P Gilmour had filled the County Council vacancy on the Committee that arose from the death of Mr C Aldred and that North Norfolk District Council had re-appointed Mrs A Claussen-Reynolds to the Committee.

6 **Continuing Healthcare**

6.1 The Committee received a suggested approach by Maureen Orr, Democratic Support and Scrutiny Team Manager, to a report that provided an update on the effects of the new policy and guidance introduced by Norwich, North Norfolk, South Norfolk and West Norfolk Clinical Commissioning Groups in 2016 regarding the provision of NHS Continuing Healthcare.

6.2 The Committee received evidence from Alex Stewart, Chief Executive, Healthwatch Norfolk, Rachael Peacock, Head of Continuing Care, Norwich CCG, Nikki Cocks, Director of Operations and Delivery, Norwich CCG, Jeanette Patterson, Continuing Healthcare Lead, Norfolk County Council, Rob Jakeman, Integrated Commissioning Manager, West Norfolk CCG and Norfolk County Council, Adult Social Care. The Committee also heard from Caroline Fairless-Price, Service User and Mark Harrison, Equal Lives.

6.3 The following key points were noted:

- The speakers said that the four CCGs aimed to ensure fairness and equity in provision of NHS Continuing Healthcare (CHC) for patients who were assessed as eligible under the National Framework and to prevent delays in assessment or decision making. However, each CCG remained individually responsible for making their own arrangements for decision making for those patients they were responsible for.
- It was pointed out that NHS Great Yarmouth and Waveney CCG (GY&W CCG) had not adopted the same NHS CHC policy and guidance as the other four CCGs in Norfolk.
- The speakers said that no NHS Continuing Healthcare patients had been asked to change nursing homes as a result of the new policy. Also, no patients had declined a Continuing Healthcare Assessment on the grounds that they were resident in a nursing home that was not in contract with the CCGs and might be at risk of being asked to move.
- The speakers said that the four CCGs aimed to ensure a consistency of decision-making and service delivery across the four Complex Case Review Panels (CCRPs).
- The speakers explained the domains used in CCRP decision making that could be found at page 89 of the agenda.
- It was noted that in planning for the implementation of the new NHS CHC policy, the four CCGs had decided not to implement the following reference to a 5% difference rule in the options for care: "A CCRP (Complex Case Review

Panel) will ensure all domains are considered at the point where there is a more than 5% difference in the options for care being considered." In response to questions the CCG representative confirmed that the reference to this rule in the policy (page 32 of the agenda) was obsolete and would be removed from the policy.

- In reply to a question from the Chairman on behalf of Mrs Stone (who had given her apologies for the meeting) the speakers outlined the practical difficulties with instigating a single joint CCRP for the four CCG areas which they said it was not possible to introduce at this time. They added that it might be possible to move in stages towards a single panel as the CCGs developed plans for joint working through a single business unit.
- The speakers acknowledged that there was a large disparity in average waiting times between NHS CHC referral and assessment between the three central CCGs and West Norfolk CCG where referral to assessment waiting times remained much longer. The average waiting time in West Norfolk was said to be 70 days and one individual was known to have waited longer than 6 months. This compared with the Department of Health standard of 28 days.
- The numbers of complaints in West Norfolk had changed little since the introduction of the new policy (a slight increase from five complaints in 2015/16 to seven complaints so far in 2016/17). The lessons learnt from complaints were continuing to be shared between the CCGs.
- The four CCGs were looking to characterise complaints into a number of sub headings. In doing so they hoped to get a better understanding of the issues that led to complaints.
- Alex Stewart said that Healthwatch Norfolk (HWN) had undertaken an evaluation of complaints and feedback from patients since the adoption of the new arrangements. This internet based survey had identified no specific areas of complaint about the CHC policy. The survey had, however, identified an underlying concern about the format and tone of written communication with patients about the NHS continuing healthcare referral and assessment process i.e. what to expect, eligibility and what each decision meant. There was a need for more clear and accurate verbal and written communication of information about the different stages of the NHS CHC process, the outcome of each stage and particularly about the notification of decisions, including funding decisions with reasons why and in written requests for payment for NHS continuing healthcare. While issues to do with the communication of information had been found to be of some concern, most people giving feedback on current NHS continuing care packages were satisfied with the quality of the care being received.
- Heathwatch Norfolk was willing to follow up on some of the key issues that were identified in their report. Healthwatch was willing to do this though a more sophisticated method than the earlier on-line internet based survey.
- In reply to questions about the length of time patients had to wait for a NHS CHC assessment, the speakers said that the four CCGs continued to have efficient arrangements in place with social care as well as with hospitals and nursing homes for patient discharge. Getting the assessment process right was important in order to avoid delayed transfers of care. As the assessment was about planning for long term care it was important that it was undertaken at the right time to reflect long term needs.
- The speakers said that the NHS CHC not only acted as a vehicle for the delivery of long term care, but also provided an interface to a number of care pathways across health and social care.
- NHS CCG provision might take the form of a care home placement, or a package of care in the individual's own home, or elsewhere.

- Services were purchased from private providers in Nursing and Residential Care settings, by Domiciliary Care agencies and more recently via carers directly employed by an individual under a Personal Health Budget arrangement.
- Some of the wide range of measures that were taken to maintain NHS CHC standards in nursing homes and for home visits by NHS and social services staff and for visits by carers, were explained to Members. The speakers said that the quality standards within the service contracts helped to ensure that the CCGs were able to hold providers to account for the quality of care they provided.
- The speakers said that in order to receive positive feedback from patients, the training plans that the CCGs prepared for NHS and County Council staff and for CCRP members took account of equality, disability and human rights legislation and the Harwood Care and Support Charter.
- It was pointed out that very few patients were placed out of county and only where specific clinical needs could not be met locally.
- It was noted that details about the numbers of NHS CHC patients and the average cost per patient per week for each of the four CCGs could be found in table 7 on page 104 of the agenda. There was no significant geographical variations within Norfolk in the costs of providing NHS CHC.

6.4 Caroline Fairless-Price, Service User, spoke about the issues that are mentioned in Appendix A to these minutes.

6.5 Mark Harrison, Equal Lives, said that he was concerned that patients' needs and the outcomes patients wished to obtain from their CHC assessment could be lost if there continued to be a low take up in Norfolk of carers directly employed by individuals under Personal Health Budget arrangements. He said PHBs provided individuals with greater flexibility than contracts through care agencies. The maintenance of quality standards within service contracts were essential in ensuring that the CCGs were able to hold providers to account for the quality of care they provided. Due to Government austerity measures, for many vulnerable individuals in society who were not financially self-sufficient there remained little medical provision outside of a hospital setting other than through a CHC package and yet continuing health care was becoming increasingly difficult to obtain.

6.6 The Committee **agreed** to ask Norwich CCG (on behalf of the four CCGS) to provide a full written response to the questions that can be found at Appendix A to these minutes from Caroline Fairless-Price (a service user). The Committee also asked the Norwich CCG to comment on the points made by Mark Harrison (Equal Lives) and for both responses to be circulated to Members.

6.7 The Committee **noted** the information contained in the report and that provided by the speakers during the meeting. In so doing it was **noted** that Healthwatch Norfolk had agreed to liaise with the four CCGs about how they could help to obtain more patient feedback on the CHC service in the future.

6.8 The Committee **agreed** that:

- Recommendations to the NHS CHC Commissioners would be drafted, based on Members' discussions at today's meeting.
- The draft recommendations would be circulated to Members for comment.
- The final recommendations would be approved by the Chairman and Vice Chairman for despatch to the Commissioners.

7 **NHOSC Appointments**

7.1 The Committee received a report that asked Members to appointment a Member to Great Yarmouth and Waveney Joint Health Scrutiny Committee and a link member for the James Paget University Hospitals NHS Foundation Trust.

7.2 The Committee **agreed** to appoint Margaret Stone to Great Yarmouth and Waveney Joint Health Scrutiny Committee.

7.3 The Committee **agreed** to appoint Lana Hempsall as NHOSC link with the James Paget University Hospitals NHS Foundation Trust.

8. Forward Work Programme

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

8.2 The agenda items for 6 April 2017 were **agreed** as the following:-

- Children's mental health services in Norfolk
- IC24's NHS 111 and GP Out of Hours Service in central & west Norfolk.

8.3 The following subjects were suggested for the forward work programme:

- Availability of acute mental health beds – concerns about prolonged detentions in police cells / out of area placements.
- Speech and language therapy – concerns about long waiting times for children.
- Children's autism and sensory processing assessment / therapy – concerns about availability of services and waiting times.
- Sustainability Transformation Plan – progress in Norfolk and Waveney.

8.4 It was **agreed** that the Chairman and Vice Chairman should draw up an order of priority for these subjects for NHOSC to consider at its next meeting in April 2017.

Chairman

The meeting concluded at 13:15 pm

If you need these minutes in large print, audio, Braille, alternative format or in a different language please contact Tim Shaw on 0344 8008020 or 0344 8008011 (text phone) and we will do our best to help.

APPENDIX A
Comment by Caroline Fairless-Price, Service User

My first point is that I object to any policy that proposes a review of a domiciliary care package when it is over the cost of a residential placement by more than 5%. To me it is outrageous to suggest that someone who could be looked after safely at home might be forced into an institution. CCGs have said that the policy won't be used in

this way, but I and others see it as a constant background threat. It's only a matter of time before a CCG sees it as a public duty to minimise care costs by "warehousing" disabled people in institutions.

Will the CCGs ensure that this is removed from all their documentation once and for all?

Secondly, the processes do not ensure that people are protected when they are at their most vulnerable.
There is a duty under the Care Act to ensure that needs are met. Currently needs are assessed, budgets and training of staff are assessed but no-one actually performs a review that checks you are getting what you need.

Can I ask the CCGs to effectively review and record whether identified needs are being met, as a process separate from assessment?

Third, contingency planning is a problem for personal budget holders. This was confirmed by NHS managers in correspondence and discussions. We can't expect staff who are experienced and capable of dealing with our complex needs to be solely available for any occasional unplanned needs that may arise. We need a shared, umbrella organisation that can respond and allow us to become familiar with each other. If Swifts or Night Owls were to come to me during an unplanned episode we would really struggle. It is becoming increasingly obvious that there needs to be an ability to project-manage the service for people with chronic and fluctuating conditions.

Will the CCGs and NCC work together to create a 24/7 response service for people who cannot be re-abled but still need to continue coping with long-term conditions at home?

Finally, both NCC and the CCGs are signatories of the Care Charter, I would like to bring to their attention that commissioning from services that are also signatories of the Charter will encourage formation of contingency plans as far as is possible. It will also make sure that if there are problems people can report back when they are in need.

Are the CCGs and NCC going to develop commissioning, recording and safety-netting using the Harwood Care and Support Charter?