Norfolk County Council
at your service

Norfolk Health Overview and Scrutiny Committee

Date: **Thursday 4 September 2014**

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 J Bracey	Mr P Balcombe	Broadland District Council
Mrs C Woollard	Ms S Bogelein	Norwich City Council
Mr M Carttiss	Mr N Dixon / Miss J Virgo	Norfolk County Council
Mrs J Chamberlin	Mr N Dixon / Miss J Virgo	Norfolk County Council
Michael Chenery of Horsbrugh	Mr N Dixon / Miss J Virgo	Norfolk County Council
Mrs A Claussen-Reynolds	Mr B Jarvis	North Norfolk District Council
Ms D Gihawi	*Vacancy*	Norfolk County Council
Mr D Harrison	Mr T East	Norfolk County Council
Miss A Kemp	Mr R Bird	Norfolk County Council
Mr R Kybird	Mrs M Chapman-Allen	Breckland District Council
Dr N Legg	Mr T Blowfield	South Norfolk District Council
Mrs M Somerville	Mr N Dixon / Miss J Virgo	Norfolk County Council
Mrs S Weymouth	*Vacancy*	Great Yarmouth Borough Council
Mr A Wright	Mrs S Young	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 17 July 2014. (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 – 10.30**	**Policing and mental health**	(Page 11)
		A briefing by the Mental Health, Drugs & Alcohol Co-ordinator, Office of the Police and Crime Commissioner for Norfolk	
7.	**10.30 – 11.40**	**Changes to mental health services in central Norfolk and west Norfolk**	(Page 16)
		Appendix A – update on the central Norfolk area	(Page 21)
		Appendix B - update on the west Norfolk area	(Page 31)
	11.40 – 11.50	**Break at the Chairman's discretion**	
8.	**11.50 – 12.15**	**System-wide review of services in west Norfolk**	(Page 64)
		Appendix A - an update by West Norfolk CCG	(Page 66)
9.	**12.15 – 12.50**	**Proposed relocations of NHS community healthcare services**	(Page 71)
		Consultation by Norfolk Community Health and Care NHS Trust	(Page 73)
10.	**12.50 – 12.55**	**Working protocol with Healthwatch Norfolk**	(Page 91)
		Appendix A – revisions to the working protocol with Healthwatch Norfolk to reflect the new system of governance at Norfolk County Council.	(Page 92)
11.	**12.55 – 13.00**	**Forward Work Programme**	
		To consider and agree the forward work programme	(Page 97)
Glossary of Terms and Abbreviations			(Page 100)

Chris Walton
Head of Democratic Services

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Date Agenda Published: 27 August 2014

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Norfolk County Council
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NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE
MINUTES OF THE MEETING HELD AT COUNTY HALL, NORWICH
ON 17th July 2014

Present:

Mr C Aldred	Norfolk County Council
Mr J Bracey	Broadland District 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
Ms D Gihawi	Norfolk County Council
Ms A Kemp	Norfolk County Council
Dr N Legg	South Norfolk District Council
Mrs M Somerville	Norfolk County Council
Mrs S Weymouth	Great Yarmouth Borough Council
Mrs C Woollard	Norwich City Council

Substitute Members Present:

Mrs S Young for Mr A Wright – Kings Lynn and West Norfolk Borough Council

Also Present:

Ms Katie Norton	Director of Commissioning, East Anglia Area Team, NHS England
Ms Fiona Theadom	Contract Manager, East Anglia Area Team, NHS England
Chris Walton	Head of Democratic Services, Norfolk County Council
Maureen Orr	Democratic Support and Scrutiny Manager
Karen Haywood	Democratic Support and Scrutiny Manager

1. Apologies for Absence

Apologies for absence were received from Mr D Harrison, Mr R Kybird, Mrs M Chapman Allen and Mr A Wright.

2. Minutes

The minutes of the previous meeting held on 29th May 2014 were confirmed by the Committee and signed by the Chairman.

3. Declarations of Interest

There were no declarations of interest.

4. Urgent Business

There were no items of urgent business.

5. Chairman's Announcements

5.1 The Chairman welcomed Mrs Charmain Woollard who had joined the committee as the representative from Norwich City Council. He thanked Cllr David Bradford who had been an invaluable member of the Committee serving as the City Council's representative from June 2007 to May 2014.

5.2 The Chairman informed members that a 'Dementia Friends' session would be held following the meeting which they would be welcome to attend. He reminded the Committee that 'Dementia Friends' was an initiative to encourage 1 million people nationwide to use their knowledge about dementia in the community and at work.

6. Access to NHS Dentistry

6.1 The Committee received a suggested approach from the Democratic Support and Scrutiny Manager to the report from NHS England (East Anglia Area Team) updating members on the current position regarding access to NHS dentistry in Norfolk.

6.2 The Committee received evidence from Katie Norton, Director of Commissioning and Fiona Theadom, Contact Manager from East Anglia Area Team, NHS England.

6.3 In the course of discussion, the following key points were made:

- The Chairman informed the Committee that a written report had been submitted from Nick Stolls (Norfolk Local Dental Committee Secretary).

- The witnesses informed the Committee that oral health was still one of the key areas where health inequalities were apparent. There were many areas where the Committee could be assured that many of the core primary dental services were effective however there was still work to be undertaken with the Directors of Public Health to raise understanding of the importance of regular dental check-ups, particularly among vulnerable groups.

- With regard to the Oral Health Needs Assessment the witnesses said that it had taken longer than anticipated to be completed for effective commissioning due to the complexities experienced in East Anglia.

- The witnesses informed the Committee that the Orthodontic Needs Assessment was being reviewed by the Local Professional Dental network. The Assessment had highlighted those areas that weren't getting good access to orthodontic services.

- In response to an issue raised by the Committee as to why dental practices were discontinuing the practice of using general anaesthetic in surgeries the witnesses said that national guidance determined that general anaesthetic services should be consultant led. This was something that would be looked at in the whole patient pathway to work with patients

around anxiety management with general anaesthetic services being a last resort.

- The Chairman drew attention to the issue raised in Nick Stolls' report regarding the vacancy at the Norfolk and Norwich Hospital for a part time consultant in restorative dentistry. He recommended that the Committee support the suggestion from the Norfolk Local Dental Committee that the post would be more attractive to prospective candidates if two more sessions could be funded by the Area Team. This was agreed by the Committee.

- Witnesses said that they were not aware of any major problems across Norfolk regarding access to routine dental care. If patients were experiencing problems accessing dental services then NHS England would signpost them to a local dental practice. Access to specialist services was a challenge for East Anglia and there was a need to develop appropriate networks in order to allow such services to flourish.

- The issue of vulnerable groups, such as homeless people, not accessing services was raised. Concerns were also raised that those on lower incomes may be reluctant to access services due to the cost. In response witnesses said that there was a need to understand why people may not access dental care and where charging issues were being highlighted these could be raised when influencing national policies.

- The Committee highlighted the issue of access to dental services in Care Homes. It was recognised that there was a need to ensure that the services provided were fit for purpose for a growing elderly population many of whom had retained their own teeth. Witnesses said that a survey would be undertaken of care homes to understand if the provision in place had had a positive impact on those in care homes.

- It was noted that elected members could have an important role in spreading the message about oral health and prevention through local communities.

- Mr John Caley, a member of the public, spoke to the Committee expressing concerns that more work needed to be undertaken in care homes regarding oral hygiene and in improving the dental care services provided to vulnerable people. In response the witnesses said that they would be improving the proactive care that they provide in care homes and would build this into the care home packs.

- The need to educate parents in the importance of good oral hygiene and of children having regular check-ups was highlighted as was the need to promote the preventative message through healthy eating in schools.

- The Committee supported that suggestion from the witnesses that oral health should be given a priority within the public health agenda in Norfolk.

- The Committee agreed to receive a copy of the Oral Needs Assessment report when it was finalised and that NHS England and the Norfolk Local Dental Committee should be invited to attend a meeting in Spring 2015 if the Committee considered there were issues that still needed addressing,

6.4 The Committee agreed

- To support the suggestion from the Norfolk Local Dental Committee that to make the post of part time consultant in restorative dentistry more attractive to prospective candidates two more sessions could be funded by the Area Team.

- To receive a copy of the Oral Needs Assessment report when it was finalised and that NHS England and the Norfolk Local Dental Committee should be invited to attend a meeting in Spring 2015 if the Committee considered there were issues that still needed addressing,

7 Stroke Services in Norfolk

7.1 The Committee received the report from the scrutiny task and finish group on Stroke Services in Norfolk.

7.2 In introducing the report Margaret Somerville thanked the members of the working group, the witnesses who gave evidence and the Officers supporting the working group.

7.3 In the course of discussion, the following key points were made:

- The working group had recognised the shortage of stroke specialist staff and staff shortages in other disciplines

- The importance of a fast response by ambulances to patients who had had a stroke was emphasised as was the need to train paramedics to make a quick diagnosis.

- The Committee emphasised the importance of preventing stokes and making people aware and recognising the signs.

7.4 The NHOSC agreed to endorse the working group's report and the actions as outlined in the report.

8. Delayed Discharge from Hospitals in Norfolk

8.1 The Committee received the report from the scrutiny task and finish group on Delayed Discharge from Hospitals in Norfolk.

8.2 In introducing the report Margaret Somerville thanked those members who had contributed to the work of the working group.

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

- There were often many reasons why patients were being delayed in being discharged from hospital.

- Project Domino at the Norfolk and Norwich Hospital was one of the innovations in the County that had improved service improvements in urgent care and patient flow.

- Funding from the winter pressure fund had been used to fund some of the service improvements so that staff were more prepared to deal with

situations where delayed discharge problems may occur.

- Reference was made to the Better Care Fund and it was noted that while this may be used to reduce pressures it did not provide extra money for the service.

- An issue was raised regarding the number of late discharges at the James Paget Hospital in Great Yarmouth. This would have implications for care cover for elderly people being discharged.

8.4 The NHOSC agreed to endorse the working group's report and the actions as outlined in the report.

9 Norfolk Health Overview and Scrutiny Committee Appointments

9.1 The report from the Democratic Support and Scrutiny Manager was received.

9.2 The Committee agreed to appoint to the following vacancies:

- **Great Yarmouth and Waveney CCG – HOSC link**
  Shirley Weymouth

- **Norwich CCG – HOSC link**
  John Bracey

9.3 **RESOLVED:**

- To nominate link members for Great Yarmouth and Waveney and Norwich CCGs as outlined above.

- To confirm the continuation of the other CCG and provider trust link members in their roles

- Confirm that members of the former liver Re-section Services Joint Committee will attend a meeting regarding implementation of the liver re-section service, which will be their final duty in connection with the joint committee.

10 Forward Work Programme

10.1 The Democratic Support and Scrutiny Manager said that Norfolk Community Health and Care had indicated that they would like to consult with the Committee on an issue regarding the relocation of their services. If the Committee agreed to add this to their forward work programme for the meeting on 4th September then consideration of the 'Health and Well Being Strategy 2014-17' could be delayed.

10.2 The Democratic Support and Scrutiny Manager said that Mr Kybird had raised an issue with her regarding the closure of the medical practice in Watton. He said that this had highlighted the wider issue of GP provision in the County.

10.3 The Committee referred to fact that often the problem was wider than the issue of the GP workforce and suggested that the Committee could look at this wider issue at the meeting on 27th November.

10.4 The Chairman reminded the Committee that it was important to focus on those

areas where they could have influence however it was important not to be too narrow in what areas they looked at. He suggested that any future work could relate specifically to the NHS recruitment problems in Norfolk for instance in areas such as primary care, midwifery and stroke services.

(The meeting concluded at 11.56am)

Chairman

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Policing and Mental Health Services

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

A briefing on recent developments regarding policing and mental health services in the county.

1. Background

1.1 National

1.1.1 It is generally acknowledged that incidents involving people with mental health problems take up a significant amount of police time. People with mental health problems are more likely to be victims of crime than others[1] and up to 90 per cent of prisoners and two fifths of those on community sentences have mental health problems[2].

1.1.2 A Home Affairs Parliamentary Select Committee inquiry into policing and mental health is currently underway. When introducing the inquiry the Chairman highlighted the fact that nationally a third of people detained under section 136 of the Mental Health Act 1983 are taken to police cells and on average are detained there for 10 hours. He also pointed out that the 'place of safety' envisaged in the Mental Health Act should be a hospital or psychiatric facility not a police cell.

1.1.3 In February 2014 the Department of Health and the Home Office published a 'Mental Health Crisis Care Concordat'. Signatories included health, social care and policing bodies at national level. A number of voluntary organisations also agreed to be identified as supporters of the concordat.

The concordat is available on the government website:- https://www.gov.uk/government/publications/mental-health-crisis-care-agreement

There was no additional funding to achieve the aims of the concordat.

1.1.2 The concordat set out the standards that people who use the services should expect if they need help in a mental health crisis. The main

[1] Mind research report 2013 'At risk, yet dismissed: the criminal victimisation of people with mental health problems'

[2] Sainsbury Centre for Mental Health (2009). Briefing 39: 'Mental health care and the criminal justice system'.

points are summarised below (written from the point of view of a patient):-

- Access to support before crisis point
  - I know who to contact 24 hours a day, 7 days a week if I need urgent help
  - I get fast access to help when close to a crisis

- Urgent and emergency access to crisis care
  - I am treated with as much urgency and respect as if it were a physical health crisis
  - I am supported to travel safely in suitable transport to where the right help is available
  - I am seen quickly by a mental health professional
  - Staff check any relevant information that services have about me and as far as possible follow my wishes and any voluntary plan that I have agreed to
  - I feel safe and am treated kindly, with respect and in accordance with my legal rights
  - If I have to be physically restrained this is done by people who understand that I am ill and know what they are doing
  - Those closest to me are informed about my whereabouts

- Quality of treatment and care when in crisis
  - I am treated with respect and care at all times
  - I get support and treatment from people with the right skills
  - If I need longer term support this is arranged
  - I am able to have an advocate or support from family and friends if I so wish

- Recovery and staying well, preventing future crises
  - I am given information about and referrals to services that will support me
  - I, and people close to me, have an opportunity to reflect on the crisis, and to find better ways to manage my mental health in the future
  - I am offered an opportunity to feed back to services my views on my crisis experience, to help improve services

1.1.3 Local partnerships between the NHS, local authorities, and the criminal justice system are expected to deliver the aims of the concordat locally. Each area is expected to agree their own Mental Health Crisis Declaration to include:

- A jointly agreed local declaration across the key agencies that mirrors the key principles of the national Concordat - establishing a commitment for local agencies to work together to continuously improve the experience of people in mental health crisis in their locality
- Development of a shared action plan and a commitment to review,

monitor and track improvements

- A commitment to reduce the use of police stations as places of safety, by setting an ambition for a fast-track assessment process for individuals whenever a police cell is used; and
- Evidence of sound local governance arrangements.

1.2 Developments in Norfolk

1.2.1 There were reports in the local press earlier this year about people detained under the Mental Health Act in Norfolk waiting for up to eight hours for an ambulance to take them to hospital and that police cells had been used as the 'place of safety' on 40 occasions in the past year.

Members may also have read reports about new initiatives in the county to get ambulances more quickly to people who have been sectioned and to base mental health practitioners in the police command and control room. There have also been discussions about more staff to enable extended opening of the county's section 136 suites and the introduction of a 'street triage' service whereby a mental health practitioner would accompany police officers to assess whether individuals should be detained under the Mental Health Act.

The street triage initiative is being tried in Suffolk, i.e. mental health staff accompany the police in a triage car. In Suffolk the initiatives are being funded by the Clinical Commissioning Groups (CCGs) but in Norfolk they are partly funded by Norfolk and Suffolk NHS Foundation Trust.

1.2.2 Work is underway between the Police and Crime Commissioner's office, the Clinical Commissioning Groups and Norfolk County Council to develop a gap analysis for the mental health crisis services in Norfolk, as envisaged under the Mental Health Crisis Care Concordat. The intention is to take an interim report to the Health and Wellbeing Board in October 2014 and a final report in January 2015.

1.2.3 Members are also aware of the Norfolk and Suffolk NHS Foundation Trust Service Strategy 2012-16, which involves a radical redesign of mental health services. The Trust was faced with the challenge of saving 20% of its budget over four years. In September 2013 NHOSC heard that the Trust also expected to make a 20% reduction in staffing levels.

Changes to mental health services are ongoing across the county:-

Great Yarmouth and Waveney – the CCG is currently considering proposals for consolidation of acute mental health beds on one site rather than the current two, with a reduction of 20 beds for people with functional mental illness (i.e. conditions other than dementia). The proposed changes would also result in a reduction of section 136 suites in the area from two to one but more staff would be available for the one that remained. Twelve dementia assessment beds are also proposed to

close. More care would be provided in the community through an enhanced crisis resolution and home treatment team for people with functional mental illness and a dementia intensive support team for people with dementia. There would also be an information and resource centre for people with dementia and mental health problems and their families.

Central Norfolk and West Norfolk – full details of changes to mental health services in these areas are provided in the reports for the next item on today's agenda.

2. Purpose of today's meeting

2.1 Against the backdrop of the financial pressures on the NHS, social care and the police and in view of the new Mental Health Crisis Care Concordat, Emma Hutchinson, Mental Health, Drugs & Alcohol Co-ordinator from the Office of the Police and Crime Commissioner for Norfolk has been invited to today's meeting to give views about policing and mental health services in Norfolk.

2.2 A representative of Norfolk and Suffolk NHS Foundation Trust (NSFT) has also been invited to today's meeting to answer questions for the mental health service which may arise during the committee's discussions.

3. Suggested approach

3.1 When the committee has heard from Emma Hutchinson, Members may wish to explore the following areas with her and with the representative from NSFT:-

(a) What has been the impact of having mental health practitioners working in the police command and control centre?

(b) In Suffolk mental health staff accompany the police in a triage car. Is any such initiative planned for Norfolk?

(c) What specifically is being done to reduce the length of time that people are detained in police cells in Norfolk:-
(1) while waiting for a mental health assessment
(2) while waiting for a mental health bed following an assessment?

(d) Who is funding the initiatives on policing and mental health in Norfolk?

(e) What other practical options are there, in the Mental Health, Drugs & Alcohol Co-ordinator's view, for improving the situation regarding policing and mental health?

(f) What are the Mental Health, Drugs & Alcohol Co-ordinator's views about the ongoing changes to mental health services in Norfolk

under NSFT's Service Strategy 2012-16.

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Changes to mental health services in central Norfolk and west Norfolk

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

An update from the Clinical Commissioning Groups and Norfolk and Suffolk Foundation Trust regarding mental health services in central and west Norfolk.

1. Background

1.1 In June 2013 Norfolk Health Overview and Scrutiny Committee (NHOSC) received responses from Norfolk and Suffolk NHS Foundation Trust (NSFT) and the commissioners' responses to recommendations made by a Norfolk and Suffolk Joint Scrutiny Committee on Radical Redesign of Mental Health Services, which had published a report on NSFT's draft Trust Service Strategy (TSS) 2012-16 before the May 2013 elections.

1.2 One of the undertakings given to the Joint Committee, and confirmed to NHOSC on 20 June 2013 by the NSFT and Clinical Commissioning Group (CCG) representatives, was that they would consult NHOSC before making substantial changes 'on the ground' during implementation of the four year strategy.

1.3 **Central Norfolk** - It was considered that the TSS for the central area did not amount to substantial variation in service for which formal consultation with NHOSC would be required. Nevertheless, the CCGs were asked to keep NHOSC up-to-date with developments in central Norfolk in light of the potential effect of substantial changes, including bed closures, in the neighbouring CCG areas.

The last report to committee about central Norfolk area was on 16 January 2014 when both NSFT and the commissioners (then led by North Norfolk CCG) acknowledged that pressures on bed placements were leading to too many out of area placements. The thrust of the TSS was to deliver more services in the community so that pressure on beds would be reduced and the Chief Executive of the CCG expected bed capacity in central Norfolk to be 'about right' by April 2014. The pressure on adult acute beds has continued but the number of out of area placements has reduced in recent months from 22 in May to 7 in July 2014. Full details are provided in Appendix A.

1.4 **West Norfolk** – For west Norfolk it was considered that the TSS, which proposed closure of acute dementia beds in the area, was a substantial variation in service for which formal consultation with NHOSC would be

required. However, the approach in west Norfolk has been to stop using some of the beds on a trial basis while at the same time establishing a Dementia Intensive Support Team to provide much more extensive support in the community obviating the need for beds.

Full details of all the changes made in west Norfolk are given in Appendix B.

NHOSC was previously assured that all beds taken out of the system on a trial basis would remain available for use if needed and that the committee would be consulted before any decisions on permanent substantial changes to services were taken.

In May 2014 NSFT reported to West Norfolk CCG with an evaluation of the changes to the dementia and complexity in later life (DCLL) pathway. The report, which is included with Appendix B, concluded that the changes in West Norfolk had had a positive impact and greatly increased the availability of services in the community whilst still ensuring those with the most acute needs had access to specialist inpatient assessment when needed.

West Norfolk CCG decided to extend the DIST pilot period to allow more time for collection of information, including the response of GPs, service users and carers to the changed service design. The pilot is likely to continue until 31 March 2015. Beds in west Norfolk will remain out of use during this period.

This means that the pilot arrangements, which have already been in place for over a year, are continuing longer than originally envisaged. The CCG has repeated its assurance to NHOSC that it will come back to the committee in good time with any necessary consultation about substantial permanent changes to service in west Norfolk.

1.5 NHOSC should also be aware that there has been both public consultation and consultation with the Great Yarmouth and Waveney Joint Health Scrutiny Committee (Norfolk & Suffolk) regarding changes to mental health services in Great Yarmouth and Waveney. The proposals include a reduction of 20 functional (i.e. non dementia) acute mental health beds and a reduction of 8 dementia beds in the area. Aware that almost one third of the functional (i.e. non dementia) acute mental health beds in Great Yarmouth and Waveney were occupied by patients from the central Norfolk area, the Joint Health Scrutiny Committee commented that:-

1. Arrangements should be made so that other CCGs fund patients from their area who are placed in Great Yarmouth & Waveney mental health beds.

2. There should be a transition process to ensure that suitable and sufficient alternative provision is in place and working in the community before mental health bed closures are undertaken.

Great Yarmouth and Waveney CCG is due to decide on the proposals at its meeting on 24 September 2014.

2. Purpose of today's meeting

2.1 In light of the fact that Great Yarmouth and Waveney CCG's decisions could impact on mental health services in the rest of Norfolk, NSFT, the central Norfolk CCGs (represented by South Norfolk CCG) and West Norfolk CCG have been invited to today's meeting to update the committee on the current situation with mental health services in their areas.

2.2 NSFT and both the CCGs were asked to give the committee an overall situation report for their area. The report from South Norfolk CCG and NSFT for the central Norfolk area is attached at Appendix A and the report from West Norfolk CCG and NSFT is attached at Appendix B. The reports are informative but there are some specific pieces of information that were requested and have **not** been included:-

1. **Access -** numbers and trend over the past year with regard to:-
    - The length of time between referral and treatment for less urgent cases (i.e. those who should be seen within 28 days).
    - Unallocated cases (i.e. patients who have been referred and assessed but have not been allocated to a mental health practitioner).
    - Requirements for mental health beds, dementia and non dementia (figures have been provided for west Norfolk but not for central Norfolk).

2. **Placement of central Norfolk patients in out of area beds** - details of the numbers of patients from central Norfolk, showing patients with dementia separately from patients with functional mental illness, placed in out-of-area beds <u>not because a specialist bed was required but because a bed was not available in the central Norfolk area</u>, to include:-
    - The numbers of patients from central Norfolk who were placed in west Norfolk beds each month in the year before the beds closed on a pilot basis.
    - The numbers of patients from central Norfolk who were placed in Great Yarmouth and Waveney beds in the past year.
    - The numbers of patients from central Norfolk who were placed out-of-area beyond west Norfolk or Great Yarmouth and Waveney.
    -

(Appendix A gives the overall number of out of area placements placed outside the provider NSFT area, but it is not clear if the figures include just those who were sent out of area because of bed capacity issues in Norfolk or also include those who were sent out of area because they required a specialist bed. There is no information on the numbers of patients from central Norfolk placed in beds in Great Yarmouth and

Waveney, and in west Norfolk prior to the pilot closure of west Norfolk beds.)

3. Suggested approach

3.1 After the representatives from the CCGs and NSFT have presented their reports Members may wish to discuss the following areas with them:-

(a) Can the CCGs and NSFT provide the information requested in paragraph 2.2?

(b) Given that referrals to the service currently outstrip the capacity to take on new cases into the service (Appendix A paragraph 4.4.3), how long are non-urgent patients (i.e. those who should be assessed within 28 days) waiting to receive 1.assessment and 2.treatment?

(c) The report at Appendix A says 'Norfolk CCGs' view is that there should be no overall net reduction in current bed capacity' (paragraph 4.2.3.5) but Great Yarmouth and Waveney is proposing closure of 20 functional mental health beds and 8 dementia beds and West Norfolk CCG has been piloting closure of 12 dementia beds and 12 functional mental health beds. Can the representatives from West Norfolk CCG and the central Norfolk CCGs clarify their views on the proposals for reduction of mental health beds in the Great Yarmouth and Waveney area?

(d) For years there have been plans at national level to introduce a 'payment by results' (PbR) system of funding for NHS mental health services, whereby funding follows the patient (as it does for acute physical NHS health care). This would mean that local CCG funding would automatically follow a resident to whichever mental health service provides their treatment. However, national PbR for mental health has not yet been introduced and block contracts, which do not relate to the actual number of patients or where they come from, still prevail. Is it possible for a PbR system for mental health to be introduced locally?

(e) The reports show that demand for mental health care continues to rise but the NSFT Service Strategy 2012-16 made clear that the Trust could only treat the same number of patients each year as it had in 2012-13 within the planned funding envelope. The report (Appendix A paragraph 4.4.1) says that the planned caseload capacity for Norfolk was 5848 but the actual caseload has risen to 7,683. What are the commissioners doing to address this situation?

(f) NSFT staff vacancy rates are high, particularly in the community teams (Appendix A paragraph 4.3.2.4), and recruitment is difficult. NHOSC will be looking at NHS workforce planning for Norfolk at its November 2014 meeting. Are there any specific issues regarding mental health workforce that NSFT or the CCGs would

recommend the Committee to raise with NHS England, Health Education East of England or another agency?

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Norfolk and Suffolk NHS
NHS Foundation Trust

NHS
South Norfolk Clinical Commissioning Group

Joint response to the Norfolk Health Overview and Scrutiny Committee by

Norfolk and Suffolk Foundation Trust & NHS South Norfolk Clinical Commissioning Group on Changes to Mental Health Services in Central Norfolk

4th September 2014

1.0 Introduction

1.1 This response has been jointly prepared by Norfolk and Suffolk Foundation Trust (N&SFT) and NHS South Norfolk Clinical Commissioning Group (SNCCG) on behalf of NHS Norwich CCG and NHS North Norfolk CCG, following a request from HOSC to update the Committee on the current situation with mental health services covered by the three CCGs.

1.2 The Committee has agreed separate reporting arrangements with regard to the West Norfolk and Great Yarmouth and Waveney localities, and these are hence are out of the scope of this report. Where possible data have been presented that covers the three CCG areas, however due to the complexities of gathering this, some information is presented at different levels, Trust wide, Norfolk wide, Trust service delivery basis and CCG level basis. Throughout the paper clarity is given regarding the geographical or delivery area the data covers.

2.0 Background

2.1 The Committee is reminded of the context within which the Trust is working in relation to the changes that are needed to respond to the efficiency requirements driven by the national economic situation and its impact on NHS finances. Put simply, N&SFT and all NHS providers are, under national policy, required to find efficiency savings equivalent to about 20% over a 4 year period, between 2012/13- 2015/16. On top of this, Mental Health services receive no activity related payments. This means that whilst acute hospital services have grown their funding by up to 20 % over the last three years, NSFT has shrunk by 3%

2.2 When the Committee was updated in January 2014 the main themes reported were as follows:

- The consistency of delivery of the agreed assessment standards. Problems were identified relating to the accuracy of the Access and Assessment (A&A) service delivery reporting and the compliance with 4 hour and 72 hour assessment completions – this has now significantly improved
- The pressure on acute inpatient beds, including the numbers of Out of area (OoA) placements and Delayed Transfers of Care (DTOC). The number of OoA placements has now significantly decreased
- Quality and safety reporting, including the number and reporting of serious incidents. HOSC was provided with assurance relating to the numbers and monitoring of these. It was that NSFT has a low proportion of incidents resulting in severe harm or death. The Trust continues to be below average and actions are being taken to address any specific issues highlighted..
- Trust capacity to manage the number of referrals within a commitment to achieve efficiency savings between 2012-16.

- Service user and carer involvement. The development of Service User and Carer forums in all Localities in Norfolk was reported and the co-production of the Trust's recovery programme within Youth and Adult Services.

3.0 Service Developments Central Norfolk Locality

3.1 The three CCGs have been working with the Trust to monitor the continued implementation of the following community services:

- Access and Assessment (A&A) Service
- Children, Families and Youth Service
- Dementia and Complexity in Later Life Service, with the significant change being the rolling out of the Dementia Intensive Support Teams across the whole of central Norfolk (these had previously been successfully piloted in part of Central Norfolk).
- Adult Services – the transition of this is due to continue to March 2015.

3.2 There have been no changes to facilities or location of the inpatient services in central Norfolk.

3.3 A small number of Practices in South and North Norfolk CCG areas continue to receive their community based services from teams who operate out of the West Norfolk delivery locality, 'West Plus'. Whilst this remains not an ideal delivery model for these areas, continued dialogue with the provider and the GP Practices covered by this arrangement is in place. It is expected that this element of service delivery will need to be reviewed once the further development of each CCG's approach to integrated service delivery through the Better Care Fund begins to be further shaped and moved forward.

3.3 Mental health liaison at Norfolk and Norwich Hospital.

3.3.1 Funding for this has increased since January 2014. As part of the service's main contract with CCGs, NSFT provide mental health liaison services within the NNUHFT. However this has been limited in capacity and was recognised by Commissioners, who have made further recurrent investments into this element of provision. In addition to this the following have been funded from the Central Norfolk resilience plan:

- 1WTE Consultant Psychiatrist to work across adult and older people services between 09:00 and 17:00 Monday to Friday. This will be linked to the services Dementia Intensive Support Team, the NNUHFT Mental Health Liaison staff and Community Support workers (see below).
- 4 WTE Community Support Workers, who will work between 16:00 and 00:00 to facilitate supported discharge. All patients seen by these workers will be assessed by mental health practitioners from the NNUHFT liaison team or CRHT staff.
- 2.1 WTE Mental Health Practitioners to provide clinical advice/support to 111/ambulance control and out of hours GP's. 17:00 to 02:00 seven days per week.

3.3.2 Within the planned Urgent Care Unit, NSFT plans to put in place 3.64 wte band 6 nurses plus administration support to review patients.

3.3.'3 At this point in time, for those elements of service delivery within the NNUHFT that are not core block contract arrangements, no decisions have been made in relation to potential future long term funding.

3.4 Work with criminal justice system

3.4.1 In the Spring 2014 the Department of Health and the Home Office produced the Mental Health Crisis Care Concordat. Statutory and Independent Organisations across Norfolk including Norfolk CCGs, Norfolk County Council, NSFT and Third Sector providers have signed up to the aspirations outlined within the Concordat. The emphasis being to improve the provision and co-ordination of services for people suffering with mental health conditions who are in crisis. This also includes prevention and promoting recovery. There are no additional resources for this purpose with the focus being on improvement of co-ordination between organisations to provide more efficient and effective services.

3.4.2 In May 2014 North Norfolk, Norwich and South Norfolk and West Norfolk CCGs agreed to the funding of a specific staffing arrangement for the Section 136 Suites at Hellesdon and Fermoy hospitals. This will result in 11.16 wte staff across Norfolk being appointed to ensure that all individuals requiring assessments are able to receive swift access to clinical care, Police Officers are able to leave the Section 136 suite if the individual has been assessed as a low level risk and necessary arrangements are made for either discharging the individual following the assessment or admitting them to a hospital bed. This arrangement will be reviewed as it is anticipated that other projects will reduce the demand for usage of the Section 136 suites

3.4.3 Mental health practitioners have been located into the Police Control Centre to assist with the handling and advising Police Officers when dealing with mental health issues. The project is aimed at ensuring the police respond appropriately to people suffering from mental ill health and the Control Room provides an efficient and effective response to these calls. The team is able to gain immediate access to health records and supports the ability to make on the spot professional assessments and decisions. The funding has been approved by the Home Office Innovation Fund with the Police and Crime Commissioner contributing 40% of this.

The Control Room project is fully recruited to; two of the Band 6 nurses are in post with the final one starting on the 8th September 2014. The team is planned to be fully operational by the end of September 2014, providing a service seven days per week 8am to 10pm cover.

The effect of this has been a reduction in the use of Section 136 assessments, more efficient outcomes and more effective use of Police time.

Norfolk is now one of only 3 Counties nationally to have fully committed to the Concordat, Suffolk being one of the other two .

4.0 Update on Progress of changes in central Norfolk to September 2014.

CCGs are working intensively with NSFT to effectively manage the concerns identified to the Committee in January; an update on progress on this is outlined below.

4.1 Access and Assessment

4.1.1 A new reporting method is in place for the A&A services. The Trust has increased the staffing within Access and Assessment and is providing evening and weekend assessments for those patients that GP's refer on Fridays for an urgent 72 hour assessment. Commissioners have been working proactively with NSFT and performance has significantly improved in terms of 4 and 72 hour referrals. Within the 4 Norfolk CCG areas there were only 4 breaches between the 9th and 27 June 2014 out of a total of 262, 4 and 72 hour referrals.

4.1.2 However access and communication remain one of the top areas of concern raised by Primary Care. NSFT are actively working to improve communication to GP's. Communication with GPs is a CQUIN for 14/15 and includes reviewing template letters to ensure they provide the information GPs need. Other activities are taking place to improve GP communication and there is an access and assessment reference group which has GP attendance.

4.1.3 In response to issues raised relating to CAMHS referrals NSFT are piloting an adjusted pathway, whereby after triage, assessments of children (14 and under) are now taken forward by the CAMHS teams within the NSFT central delivery area. This has allowed the existing AAT staff to focus on assessments and clearing of the backlog of CAMHS referrals prior to 1st July 2014. The Trust's Children, Young People's and Families services are reporting waiting times as part of the weekly performance review (across the 4 Norfolk CCG areas) as of Wednesday 13th August there were 37 CAMHS Patients waiting from 0 to 8 weeks, average waiting time was 19.56 days.

This new arrangement appears to be working well with good systems in place and improved triage and signposting of referrals as appropriate at the multi-agency triage meetings which are attended by Point 1, Primary Infant Mental Health Services, community paediatrics and other services. If successful this pilot will be rolled out to those over 14 years of age and to the West Norfolk locality. CCG's are actively monitoring the pilot with NSFT.

4.1.4 The Trust and commissioners believe that is essential that all service users who require a 4 or 72 hour assessment are seen within this timescale. It is also important that non urgent cases are seen within the expected timescales.

4.1.5 National benchmarking with other Trusts confirms that the commissioned capacity and staffing levels for mental health services in Norfolk are comparable with other counties. Investigations have been taken forward to identify the reasons for the high number of referrals for mental health services reported to HOSC in January 2014. The Trust is working in partnership with GPs via the CCGs to address referral numbers. As part of this partnership working the Trust has increased the level of Consultant Psychiatrists within the A&A from one to two whole time posts and qualified and medical staff have been based at the NNUH over weekends at times of peak referral to meet patient need at the most appropriate time and place.

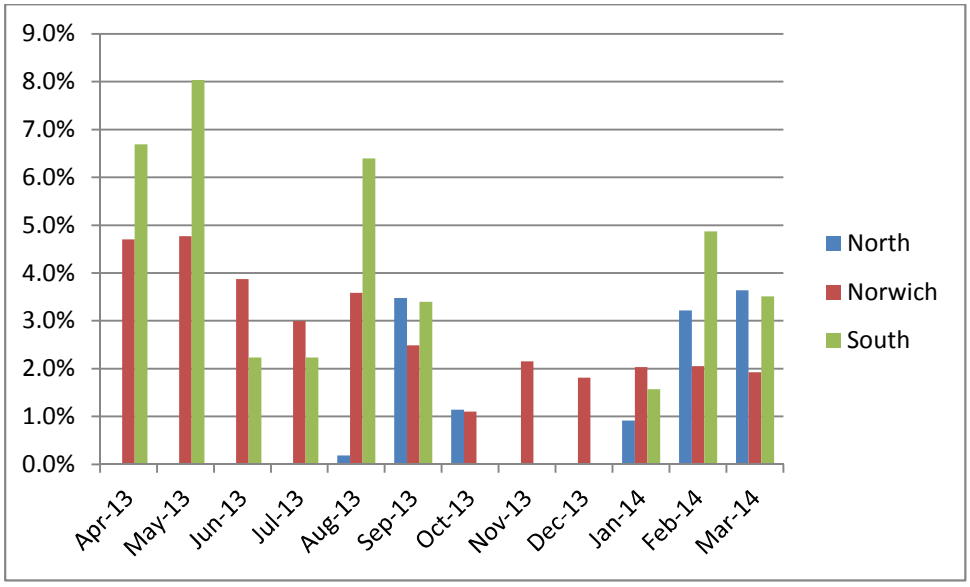
4.2 Pressure on inpatient beds

4.2.1 The aim of the Trust Service Strategy is to ensure that the service provides an efficient acute system and at the same time has enough beds for all service users who require one, when they require one.

4.2.2 Delayed Transfers of Care (DTOC)

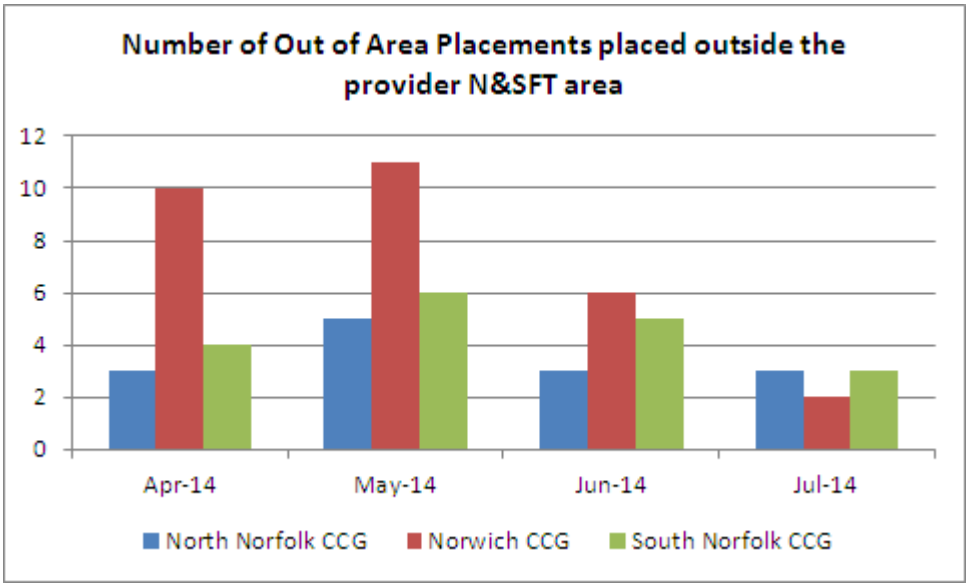
4.2.2.1 Delayed Transfers of Care have improved significantly in Norfolk since January. Weekly meetings take place to monitor DTOC and to support the active planning of appropriate discharges.

4.2.2.2 Over the year NSFT have consistently been within target[i] overall for DTOCs as outlined below for South, Norwich and North CCG's, however as it can be seen below in May 2013 for South Norfolk CCG the target of 7.5% was not met.



4.2.3 Out of Trust Placements

4.2.3.1 Details of the number of patients from the three CCG areas admitted to out of Trust providers due to a lack of available beds in NSFT are provided below. The rise during April and May in Norwich this was primarily as a result of the impact of the redesign of adult community services the numbers have been on a downward trajectory since then and continues to improve.



4.2.3.2 The Trust has put a number of actions in place to bring down the number of acute out of Trust placements as outlined below.

- A designated placement liaison practitioner is reviewing out of area patients and facilitating moves closer to the service user's home or enabling direct discharge to the Crisis Home Resolution Team (CRHT) where appropriate. This also ensures regular direct clinical input from NSFT into each patients care.
- NSFT has provided medical cover at the NNUHFT over each weekend to reduce the pressure on the CRHT (to enable effective CRHT treatment to manage patients at home where possible and clinically appropriate).
- Recruitment to CRHT is ongoing with agreed up-skilling of team by increasing numbers of qualified staff and assessors in the team.
- Extension to the hours worked by Bed Management Team once recruitment is complete. This will enable further improvements to managing Trust bed stock across weekends and late evenings.
- NSFT continues to hold weekly cross locality Director led meetings to examine and hold teams to account for performance in all inpatient areas and Crisis Teams.

4.2.3.3 The actions are focused on reducing the number of placements out of Trust area, which Commissioners would expect the provider to be able to manage within the Trust's existing bed capacity. It is important to note very clearly that a number of placements are made out of Norfolk because they are clinically appropriate for patients needing more specialised or tailored packages of care.

4.2.3.4 The above measures also aim to ensure that admissions only occur when clinically indicated and that stays in hospital are no longer than clinically needed.

4.2.3.5 The Trust has also committed to not closing any beds without public consultation and support from commissioners. N&SFT and CCG Commissioners are both committed to ensuring that all patients can be cared for within Norfolk unless it would be clinically inappropriate to do so. Norfolk CCGs' view is that there should be no overall net reduction in current bed capacity.

4.3 Quality and Safety

4.3.1 Serious Incidents (SI's)

4.3.1.1 Commissioners and the Trust monitor the number of SIs carefully throughout the year and we have not seen a year on year increase. The numbers in 2013/14 were comparable with previous years. The table below is Norfolk wide and shows the numbers of SI's for 2012/13, 2013/14 and the first quarter of 2014/15.

Year	Number of SIs reported
2012/13	96
2013/14	82
01/04/14 – 31/07/14	35

4.3.1.2 A number of steps have been taken to improve the process of investigations of SIs, and embedding the learning that comes from them. There is greater Board scrutiny of the Route Cause Analysis (RCA) process, with two Directors now overseeing the Level 2 and 3

Sis directly, and the Nursing and Medical Directors reviewing all Level 1 incidents, and feeding back themes directly to Lead Clinicians and Service managers. Recruitment of two dedicated RCA facilitators (one for each county) will improve the consistency of the investigations, and tighten up recommendations. Key themes arising from SIs are assigned a lead to take a Trustwide approach, with localities responsible for identifying and competing local actions, and these are closely monitored.

4.3.1.3 Dr Peter Jefferys report on the review of 20 unexpected deaths identified several ways in which services could be improved. These included strengthening access to clinical supervision, improving risk management skills, improving record keeping (whilst minimising the bureaucratic burden on practitioners), and improving communication with and support for families and carers.

4.3.1.4 Progress against the recommendations made by Dr Jeffrey's is monitored at the Trust's Service Governors' Committee. Each of these themes has an action plan with nominated leads. Some of the actions have been picked up by the team overseeing the implementation of the Trust's new data management system, including risk management and record keeping, although interim plans have been put in place to address immediate issues. A specific audit of risk assessment and management has been completed and will be presented at the October Trust Board with associated actions.

4.3.2 Staff Morale, Retention and Sickness

4.3.2.1 Staff morale and engagement within NSFT is an area of concern. Feedback obtained from the 2013 Staff Survey highlighted this as a key issue the service needs to address. NSFT are taking active steps to improve this situation. The delivery of improved staff engagement is a priority for the Chief Executive and the Executive team. A Staff Engagement plan has been developed and a working group has been set up. The working group will report through the Director of Workforce and Organisation Development into the Workforce and Organisational Development Committee, a Subcommittee of NSFT's Board. The focus of this group is to:

- build great management and leadership
- promote a safe and healthy working environment
- involve staff in decision-making
- develop skills and knowledge
- ensure every role counts.

4.3.2.2 A dedicated employee engagement communications post has been recruited to. A series of communications events in order to increase visibility of the Executive team and engage all staff groups in two way communications and events has been planned over the next 18 months.

4.3.2.3 In addition, each locality has its own locality-based staff engagement and wellbeing plans focused on more local issues. Local events have included such as "Have your say" days to engage staff in what they feel is working well or not so well within their areas and to share ideas on improvements.

4.3.2.4 Staff morale directly impacts on the ability of the service to retain staff and keep key skills and expertise within their workforce. The Trust vacancy rates since August 2013 are provided below. In Norfolk and Waveney, there is particular pressure within the Community teams each of which are running at between 15% and 24% vacancies, West Norfolk being worst affected.

:

	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14
4. Vacancy Rate as a % (WD08)	10.7	11.7	11.3	11.7	12.6	12.8	13.0	12.6	11.84	11.59	12.06	12.38

4.3.2.5 Between April – June 2014 the vacancy rate of staff for the South Norfolk, North Norfolk and Norwich CCGs was 9.6%, turnover was 15.8% and sickness absences >= 21 day was 11.1%.

4.3.2.6 A Recruitment Strategy is in place, reporting into a Flexible Workforce Programme Board. 275.79 whole time equivalent posts have been recruited since January 2014, including 71 external appointments to the South Norfolk, North Norfolk and Norwich CCG areas. Whilst the service is taking active steps to recruit to the vacancies that it has, it does, however, need to be acknowledged that recruitment is an issue across all health sectors in Norfolk and nationally. In particular, this is an issue for Band 5 and Band 6 Registered Mental Health Nurse positions.

4.3.2.7 In line with the national trend across Mental Health Trusts, partly due to increased activity, overall demand for temporary nursing provision through NHS Professionals within NSFT has increased by 12% (5.29% for the North Norfolk, South Norfolk and Norwich CCG areas) over the last quarter but demand related to vacancies is decreasing as anticipated in conjunction with recruitment activity. NSFT and NHS Professionals are working in partnership in regard to recruitment to meet substantive as well as temporary staffing demand.

4.3.2.8 Temporary staffing spend within Norfolk and Waveney over the last quarter to end June 2014 (excluding specialist and corporate services) is £946,893 bank, £602,188 agency and £434,678 medical locum. The figures specific to South Norfolk, North Norfolk and Norwich CCGs are £622,271 bank, £359,526 agency and £168,741 locum.

4.4 Referrals and number of service users – service capacity

4.4.1 N&SFT made a commitment that despite the need to achieve savings of 20%, it would provide a service to the same number of service users as received a service in 2011-12 (the year before the start of the Strategy). The Trust planned to have a caseload capacity for Norfolk of 5848 (based on caseload at end of 2011/12).). The actual caseload (Norfolk) has increased to 7,683 since the start of the Strategy.

Central Community Service Line Caseload = 5,584
West Community Service Line Caseload = 2,099
(Central and West Community Service Line Total) = 7,683

Central Locality Referrals/Discharges per month = 538/450
West Locality Referrals/Discharges per month = 213/248
Central and West Locality Referrals/Discharges per month Total = 751/698

Source: Community Service Line Status Reports Trust Locality Reporting

4.4.2 The Trust receives 1613 referrals a month for North Norfolk, Norwich, South Norfolk and West Norfolk CCGs, 1259 are for South, North and Norwich CCG patients.

4.4.3 Every case is triaged and where appropriate receives a face to face assessment within 4 hours, 72 hours or 28 days. An average of 567 North Norfolk, Norwich and South Norfolk CCG patients are accepted into service. For those not taken into service NSFT offer the person and referrer advice or sign post to other non NHS agency. Patients can be in the service for a few weeks to several years depending on the type of mental health problem and severity. The discharge rate for central locality 2014-15 has been 450/538 = 84% of referrals in 2014-15. This means that referrals currently outstrip the capacity to take on new cases into the service.

5 NSFT Cost Improvement Plan implementation

5.1 The Trust achieved 84% of its Cost Improvement Programme (target of £14.9m) in 2013/14, with the remainder met through various mitigations, including additional income to offset the need for the saving. However, £6.2m of the savings were found non-recurrently and has added to the CIP programme for 2014/15. This target stands at £14.7m and the Trust has thus far identified savings plans of £10m against this target.

5.2 Monitor, as the independent regulator, rates every Foundation Trust on a scale of 1 to 5 for their financial performance, where 5 is the highest and 1 indicates significant concern. This is undertaken every quarter year. N&SFT is rated at a 3 and has maintained this, along with a green governance rating over recent years.

6.0 Next Steps

6.1 Progress has been made with some positive improvements achieved since January. However there remains further work to be taken forward and some continued areas of concern to be addressed.

6.1 The North Norfolk, Norwich and South Norfolk CCGs have all included mental health provision within their vision for future integrated care within the Better Care Fund developments. What this looks like for each CCG will differ accordingly in response to local needs. Each of the CCGs has 4 localities/hubs around which integrated service delivery will be based. NSFT is working actively with CCG on their integrated care developments and future service delivery will need to be shaped in line with this. It's important to reflect that patients with mental health conditions physical health needs are focused on as part of this integrated approach alongside the mental health of physically ill patients. This is a key plank to ensuring a clear approach to parity of esteem within the Norfolk health and social care system.

6.2 The currency and activity structure nationally for mental health is not the same as for Acute providers. The system for the Acute provider market is payment by results meaning for each individual patient a payment is received whereas for mental health a block payment is received by NSFT. It is acknowledged that there is an in built disadvantage to the block payment system and as such nationally a Payment by Results system has been attempted for mental health over the past number of years without success. This is now called the Payment and Pricing system and Norfolk is one of the most advanced areas in moving to this structure. This is a complex process by which all patients have to be ascribed into 21 clusters and care pathways with agreed menus of interventions have to be and are being developed.

6.3 The scale and complexity of the changes being managed by the Trust are considerable, both in terms of the actual practical changes being made, but also the need to ensure timely communication to patients, staff and other stakeholders about them.

[i] The total number of DTOC days on all Norfolk inpatient wards (excluding secure wards) within the reporting month must be less than 7.5% of all occupied days on those same wards

Subject:	**Update regarding Mental Health Services in West Norfolk**
Presented by:	**Kathryn Ellis, Director of Operations and Strategic Planning**
Submitted to:	**Norfolk Health and Scrutiny Overview Committee (NHSOC), 4 September 2014**
Purpose of Paper:	**To report to NHSOC in relation to the changes in Dementia and Old Age Mental Health Services in West Norfolk and progress towards public consultation**

Introduction

This report has been jointly prepared by the West Norfolk Clinical Commissioning Group (WNCCG) in collaboration with Norfolk & Suffolk NHS Foundation Trust (NSFT) and should be read alongside the joint response from NSFT and the South Norfolk Clinical Commissioning Group on behalf of the Central Norfolk CCGs. NSFT has a standardised service delivery model in Central and West Norfolk and some services to West Norfolk, like Access and Assessment, are hosted within Central Norfolk.

This report will therefore provide an update specifically in regard the changes that have occurred to services for older people provided by NSFT in West Norfolk following implementation of the Trust's Service Strategy in 2013. These are services for people over 65, particularly those with complexity in later life (CLL) and dementia or suspected dementia.

Evaluating the changes to services for older people

'Living with Dementia – a National Dementia Strategy' (2009) identified the need to provide care and support at a time of crisis for people with dementia and their carers as a key objective; it is generally accepted that for people with dementia a change of environment, routine and carer can have a significant negative impact on their wellbeing and functioning. The introduction of a pilot of the Dementia Intensive Support Team (DIST) in West Norfolk, while Tennyson and Chase Wards were suspended, was designed to maintain people at home as long as possible with two local 'Alternative to Admission' (ATA) beds available when appropriate, and referral to specialist care at the Julian Hospital in Norwich for those with the most challenging conditions.

Information about the impact of these changes is contained in a report from NSFT (attached as Appendix 1) presented to Governing Body meeting of WNCCG on 29 May 2014. It was agreed that the pilot appeared to have been a success in terms of the number of WNCCG patients seen and the favourable views expressed about the new service from people with dementia and their carers but WNCCG wanted to set their decision on the pilot within a broader discussion about the Strategic Direction of Dementia Services in West Norfolk.

Following this at the WNCCG Governing Body Meeting (and Annual General Meeting) held on 31 July 2014 further consideration was given to the pilot in the context of WNCCG's 'Statement of Strategic Direction for improving service for people with dementia' (attached as Appendix 2). In adopting the Strategic Direction document it was agreed that before a WNCCG view is taken to proceed to final consultation on the service change, given complications with recruitment which delayed the start of the pilot and the higher than expected demand for community mental health services, WNCCG would extend the DIST pilot.

As well as providing more extensive information to inform service evaluation, the extended pilot period would enable further discussion with a greater number of users of the service and their carers, the opportunity to gain a fuller response of GPs to the changed service design and to consult more extensively before any formal public consultation takes place. The WNCCG decision to consult will be made once these actions have been completed and the Governing Body has received the results. It is likely therefore that the pilot will be extended until 31st March 2015. WNCCG will come back to NHOSC in good time providing information about any proposed consultation.

This report includes updated activity reports for referral and admission activity for residents of WNCCG accessing NSFT's Dementia Services. This shows consistency with the trends reported previously (see Appendix 1).

Detection of people with dementia in West Norfolk

West Norfolk CCG is eagerly awaiting the imminent release of the dementia detection rates for 2013/14, anticipating a marked increase in the 35.2% detection rate reported for WNCCG in 2012/13. If there is the expected improvement, this is likely a combination of a focus by WNCCG on improving identification of people with dementia in the region, but also due to the work done by the Dementia and Complexity in Later Life (DCLL) service that provides a dementia assessment and diagnosis service. As indicated in the information below, approximately 80% of all community referrals are for dementia assessment, equivalent to just under 100 referrals per month.

The extending of the DIST pilot will therefore enable the consultation, which will include NHOSC, and subsequent decisions to be informed by a more holistic and system-wide perspective.

Mental Health Liaison Service, The Queen Elizabeth Hospital (QEH), King's Lynn

The QEH has always had a rudimentary liaison service provided by the Fermoy Unit-based Crisis Resolution and Home Treatment Team. However, this team also provide emergency response to the community and also provides cover for Churchill Ward. The provision was inadequate to meet the high demand for mental health assessments in the QEH's emergency departments.

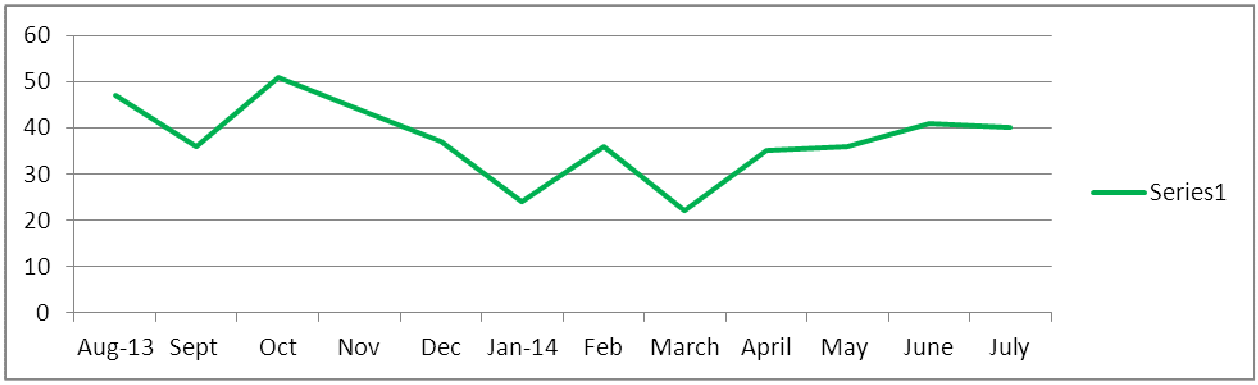
As a result of a successful liaison service pilot enabled through winter planning resources in 2013/14, a liaison service has now been contractually established and fully funded in 2014/15. This service is subject to regular review and although there may be changes to the skill mix and resource levels as a result of the evaluations, WNCCG, NSFT and West Norfolk Mind (a partner in the liaison service) are determined that a contracted liaison service will continue for the foreseeable future.

Conclusion

NHOSC is asked to take into consideration the steps already taken by WNCCG and NSFT.

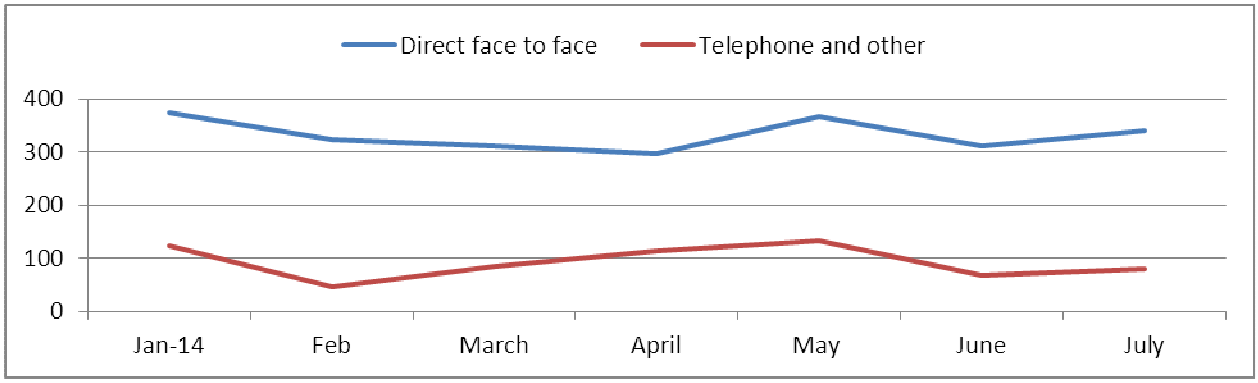
DCLL admission/referral activity

1) DIST Referrals



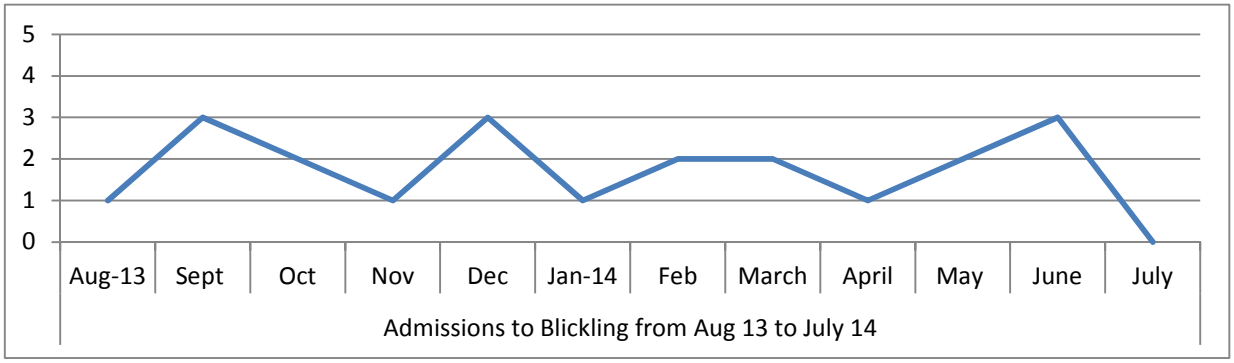
Averaging 37 per month

1a) DIST patient contact activity



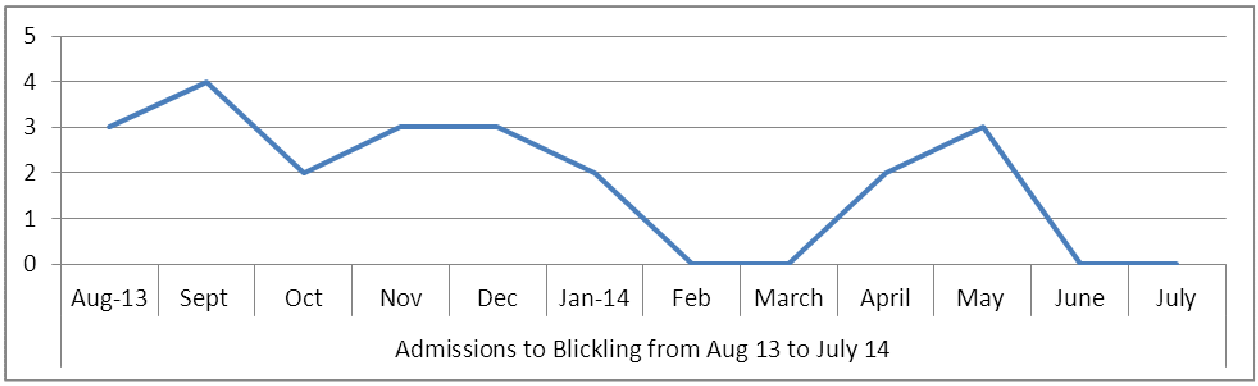
In the 7 months from January to July this year, the DIST team have undertaken a total of 2,972 contacts 78% of which are direct face to face contacts with the patients. This averages 14 individual contacts per day.

2) Paddocks ATA



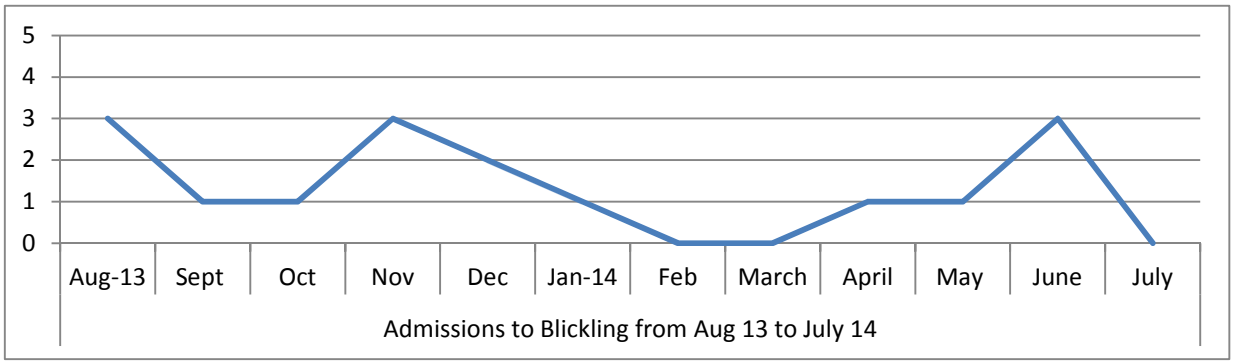
Averaging 1.75 admission per month

3) Blickling Ward (dementia)



Averaging 2 admissions per month

4) Sandringham Ward (CLL)



Averaging 1.3 admissions per month

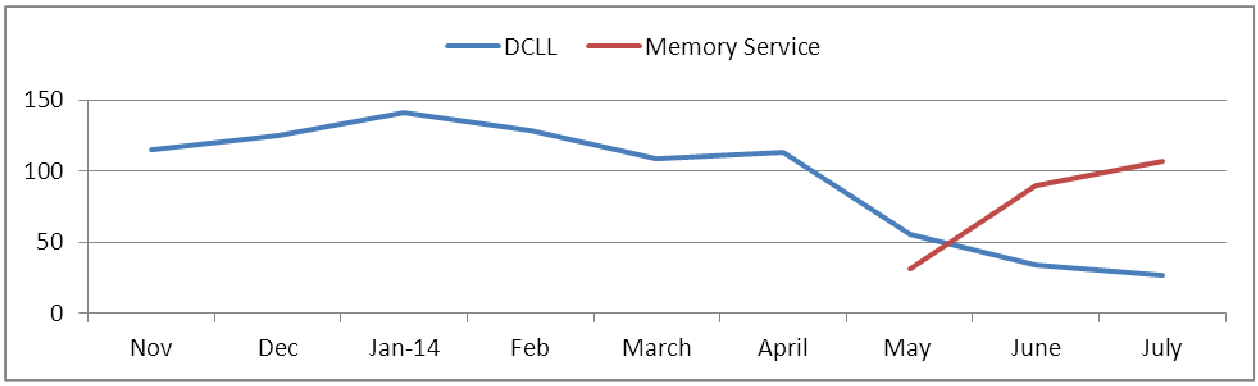
5) Churchill Ward (Non-CLL older people)

Three beds on Churchill Ward are designated for people over 65 years of age without complexity of later life who would previously have been admitted to Tennyson Ward at Chatterton House. The occupancy of these beds is reported as a % of total occupancy of the 3 beds per month. If all 3 beds were occupied by an older person for the entire month the % = 100%. If more than 3 beds are used for patients over 65 the % would be in excess of 100%. The following table provides the occupancy percentage for January to July this year:

Jan	Feb	March	April	May	June	July	Average
60%	96%	113%	77%	87%	90%	40%	80%

Ideal bed occupancy is 85% to 95%. Occupancy below 85% would therefore indicate underutilisation of these beds for people over 65.

6) Other DCLL community referral activity



Average from November 2013 to July 2014, 120 referrals per month.

Data from August to October not used as contains high number of duplicate referrals due to post-TSS transitions into new teams.

From May 2014 a separate team code is being used for Memory Assessment only referrals.

The proportion of memory service referrals in July (107) is 80% of all referrals received.

Based on an 80/20 memory assessment / DCLL referral split, in the 9 months shown here were approximately 862 referrals for memory assessment = 96 per month, 22 per week.

Norfolk and Suffolk NHS
NHS Foundation Trust

Report To:	West Norfolk Clinical Commissioning Group
Submission Date:	12 May 2014
Title of Report:	Evaluation of Dementia and Complexity in Later Life (DCLL) Pathway Changes in West Norfolk
Purpose of the Report:	Evaluate efficacy of pathway changes to inform next steps
Author:	Marcus Hayward, Locality Manager
Sponsor:	Kathy Chapman, Director of Operations

NHS Constitution principles

1. The NHS provides a comprehensive service, available to all;
2. Access to NHS services is based on clinical need, not on an individual's ability to pay;
3. The NHS aspires to the highest standards of excellence and Professionalism;
4. NHS services must reflect the needs and preferences of patients, their families and their carers;
5. The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population;
6. The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources
7. The NHS is accountable to the public, communities and patients that it serves.

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1.0 Introduction

1.1 This report describes the changes to the pathways for people in West Norfolk with dementia and those with functional mental health problems alongside complexities of later life. The new service line is named Dementia and Complexity in Later Life (DCLL)

1.2 The changes were part of the Trust Service Strategy (TSS) implemented from 2013 (see Appendix 1: *About the Trust Service Strategy*).

1.3 The TSS changes to services for people with dementia and complexity in later life are underpinned by a comprehensive evidence base (see Appendix 2: *DCLL: The Evidence Base*). The changes are also aligned with the out of hospital care and closer to home initiatives within the West Norfolk Alliance and Norfolk-wide Better Care Schemes.

1.4 Although the changes were partly necessitated by the requirement for NSFT to reduce its costs by 20% over 4 years, with the necessary re-investment it would be possible to return to the pre-TSS structure.

1.5 However, this report will provide evidence that the piloted changes have greatly increased the service efficacy and that many more people in need of NSFT's DCLL services in West Norfolk are able to receive the support they need.

1.6 No final decisions have been taken about permanently reorganising described services.

2.0 What changes have taken place to enable the new DCLL pathways?

2.1 12 dementia assessment beds on Chase Ward at Chatterton House have stopped being used and the staffing resource enabled the establishment of a Dementia Intensive Support Team (DIST) based at Chatterton House. The DIST provides intensive community support to people with dementia and their carers and those with functional (non-organic) mental health needs with comorbid complexity in later life (CLL).

2.2 An initial DIST pilot in Central Norfolk provided evidence that the demand for DCLL assessment beds would reduce and only those patients with very complex and acute needs would require an inpatient assessment. This indicated that 3 dementia assessment beds would be adequate for the needs of the West Norfolk population and consequently 3 specialist beds in Blickling Ward at the Julian Hospital in Norwich have been designated accordingly.

2.3 For those people with dementia in need of nursing care but who do not have the complexity of need requiring an acute assessment bed, 2 alternative to admission (ATA) beds have been made available at the Paddocks Care Home in Swaffham. The DIST support patients using these beds through in-reach, providing specialist support and treatment advice and prescribing to the Paddocks Care Home staff.

2.4 12 beds for people over 65 with functional (non-organic) mental health problems on Tennyson Ward at Chatterton House have also stopped being used. Many patients who had been admitted to these beds in the past had come from the existing adult service and transferred into the older people's service at age 65 despite no change in their needs on reaching this age.

2.5 People reaching and beyond the age of 65 will now remain with the adult community service to ensure continuity of care. If requiring admission, these patients are admitted to adult acute services and three beds on Churchill Ward at the Femory Unit are designated for people over 65.

2.6 For people with or who develop age related needs or complexities of later (CLL) along with acute functional mental health problems, 2 assessment beds on Sandringham Ward

at the Julian Hospital in Norwich have been designated for patients from West Norfolk.

2.7 Financial support for travel costs to Norwich is available for carers of West Norfolk patients admitted to Blickling and Sandringham Wards.

2.8 The DCLL Community Team based at Chatterton House is a continuation of the previously existing multi-disciplinary Community Mental Health Team for older people. This team receives referrals for people with complexities of later life and functional mental health problems and also for memory assessment and dementia treatment. Although there has been no major change to this service as a result of the Trust Service Strategy, the team are experiencing an increased number of referrals for memory assessment and dementia treatment and are included in this evaluation.

2.9 It is important to note that the beds on Chase and Tennyson Wards were for assessment only and not for longer stay Continuing Health Care (CHC). NSFT has never provided or been commissioned to provide CHC beds in West Norfolk. The Trust's CHC provision has always been provided either at Carlton Court in Lowestoft, or in Norwich which has now been consolidated at Hammerton Court, a new unit at the Julian Hospital. This has contributed to the Julian Hospital being the centre of the Trust's Dementia Academy and set to become a regional and national centre of excellence in the care of people with dementia and complexity of later life. Consolidating the DCLL inpatient assessment provision at the Julian Hospital ensures that the best care and treatment possible is available to all in Norfolk and Waveney.

3.0 Data Analysis Commentary

3.1 Appendix 3: *Data Analysis* provides the full data summarised below.

3.2 The inpatient data provided relates only to patients from the West Norfolk CCG area. When extracting the community activity data it was not currently possible to isolate WNCCG activity from the West+ Locality.

The Trust's informatics department are currently developing the ability to report community activity by CCG.

3.3 An analysis of activity by future CCG area was conducted in 2012 to inform the locality boundary changes implemented during the TSS in 2013. This predicted that WNCCG activity would constitute 72% of the workload for the West+ Locality with the other 28% coming from the practices within the mid-Norfolk region of the North and South CCGs.

As this report is specifically required to inform WNCCG, to provide a more accurate estimation of activity specific to this CCG area, 72% of the total community activity for West+ has been used in Appendix 3.

3.4 Prior to the establishment of the West Norfolk DIST in August 2013, there were two wards for older people, Chase and Tennyson, at Chatterton House with capacity for up to 18 beds, although this full capacity was never needed. Chase Ward provided dementia assessment beds and Tennyson Ward functional assessments beds for people over 65.

3.5 Inpatient services are the most expensive service provided by NSFT, but only used by a small number of patients. Prior to TSS changes that commenced in 2013, at any one time only about 2% of active service users occupied inpatient beds, yet the cost of the these facilities required in the region of 50% of the total spend.

3.6 <u>Inpatient benchmark activity (Appendix 3: 1)</u>

As a benchmark for comparison, activity on Chase and Tennyson Wards for the 6 months from August 2012 to January 2013, before implementation of the TSS, has been used. This shows a total of 38 admissions during this period with an average length of stay of 37 days per episode of care.

3.7 Transition from using the beds on Chase and Tennyson to the new pathways took place gradually between September 2012 to July 13 (see Appendix 3: 2).

3.8 DIST Activity (Appendix 3: 3)

The Dementia Intensive Support Team or DIST became fully operational on 1st August 2013 and provides intensive support to people with dementia and older people with functional (non-organic) mental health problems complicated by complexity in later life. In the 9 months to April 2014 the team have received 240 referrals, averaging 27 per month and maintaining an average active caseload of 33.

3.9 During the same 9 month period the team have undertaken 3,238 recorded contacts. Of these only 3.5% (114) where DNA or cancelled by patient and just under 1% (28) cancelled by practitioners. 96% (3,096) actual contacts have been recorded of which 73% (2250) were face to face with the patient with the remaining 846 mainly telephone contacts.

3.10 97% of attended contacts were for assessment or treatment, 2% for advice, information and education and 1% recorded for other purposes including complex case conferences and discharge planning.

3.11 Alternative to Admission beds (Appendix 3: 4)

A previous analysis of patients admitted to dementia assessment beds across the Trust showed that many did not require acute hospital admission, but were admitted due to lack of alternative options (e.g. increased community support as now provided by DIST or alternatives to hospital admission (ATA) beds).

3.12 A fundamental element of the change to the pathways is the provision of local ATA beds. 2 ATA beds have been established at the Paddocks Care Home in Swaffham. In the 9 months from August 2013, 16 patients have been admitted to these beds with an average length of stay (LoS) of only 18 days. Total occupancy has been below 85% with occasions when both beds are vacant.

3.13 A qualitative evaluation has taken place to inform this report which shows that service users and their carers are very positive about the use of the Paddocks as an alternative to hospital admission (see Appendix 4).

3.14 Blickling Ward, Julian Hospital, Norwich (Appendix 4: 5)

It has always been acknowledged that a small number of patients with dementia would still require admission to specialist dementia assessment inpatient facilities. For this reason 3 beds are designated for West Norfolk patients on Blickling Ward that provides specialist assessment and dedicated inpatient consultant psychiatrist time.

3.15 In the 9 months since August 2013, 18 patients from the WNCCG area have been admitted to Blickling Ward with an average LoS of 56 days. The trend in admissions and LoS is clearly reducing with far fewer admissions in the second half of the evaluation period. This is likely to be a consequence of the increasing confidence and efficacy of the DIST and confirms expectations.

3.16 Sandringham Ward, Julian Hospital, Norwich (Appendix 4: 6)

2 beds are designated for West Norfolk patients on Sandringham Ward that provides specialist assessment for people with functional mental health problems alongside complexities of later life.

3.17 In the 9 months since August 2013, 12 patients from the WNCCG area have been admitted to Sandringham Ward also with an average LoS of 56 days. The trend in admissions and LoS is also reducing with 9 patients admitted between August and November, but only 3 from December to April.

3.18 Churchill Ward, Fermoy Unit, Queen Elizabeth Hospital, Kings Lynn (Appendix 3: 7).

As referred to in 2.4 and 2.5 above, patients aged 65 and over who do not have age related needs (CLL) will continue to be supported by adult community services and if needing acute care will be admitted to an all age adult acute bed. 3 beds have been designated for people over 65 on the 20 bedded Churchill Ward.

3.19 In the 9 months since August 2013, 8 patients aged 65 and over have been admitted to Churchill Ward. These include patients with complex social care needs with one patient having a LoS of 245 days, increasing the average to 65 despite the majority of patients having considerably shorter inpatient episodes.

3.20 These patients continue to be supported by the adult community services and Crises Resolution and Home Treatment Teams and ATA provision for adults has yet to be established. Consequently the trend in admissions has not changed during the evaluation period.

3.21 Comparison of activity before and after pathway changes (Appendix 3: 8)

Although bed numbers on Tennyson and Chase Wards commenced gradual reduction from September 2012 the lack of demand for these beds had been an established factor prior to this.

3.22 As referred to in 3.6 above, during the 6 months from August 2012 to January 2013, there were 38 admissions to Tennyson and Chase Wards with an average LoS of 37 days per episode of care. This LoS is much less than in previous years as staff were being proactive in ensuring early safe discharge despite the unused bed capacity. There was no DIST during this period.

3.23 During the 6 months from August 2013 to January 2013 the total episodes of care provided was 233, which is a combination of referrals to DIST and inpatient admissions to the Paddocks Care Home, Churchill, Blickling and Sandringham Wards. Although the LoS for inpatient admissions increased to 48, the average LoS per episode of care is only 9. This shows considerably improved efficiency and cost per episode of care.

3.24 The length of stay of inpatients, initially high because of a small number of long stay patients with complex mental and social care needs, is greatly reducing as the Trust focuses on ensuring patients do not remain in an acute inpatient environment for any longer than necessary.

3.25 It is particularly notable that the average length of stay for patients admitted to the ATA beds at the Paddocks Care Home, supported by the DIST, is only 18 days.

3.26 Dementia and Complexity in Later Life (DCLL) Community Team (Appendix 3: 9)

The DCLL Services are seeing a much higher number of referrals than at any time previously. Referrals from November 2013 to April 2014 were 137% higher than the same period in 2012 to 13. The majority of new referrals are for memory assessment and dementia treatment.

3.27 Given the historically lower number of people with dementia identified in West Norfolk compared to expected incidence the increasing number now being referred for assessment is to be welcomed. However, the higher number of referrals compared to discharges is not sustainable and has already lead to seriously high caseload numbers and increasing waiting times.

3.28 The memory assessment function incorporated a shared care agreement with primary care first established in 2004. This facilitated transfer of prescribing for dementia treatment medication to primary care after 4 months and discharge after 10 months. The numbers now being referred, along with the dementia treatment medication becoming available generically, indicates this shared care arrangement is no longer fit for purpose.

3.29 Improving efficiency of the memory assessment and dementia treatment pathway to meet the growing demand evidenced by this data and n accord with demographic projections is a key priority for the West Locality in 2014/15.

4.0 Qualitative Evaluation and Feedback

4.1 Appendix 4: *Qualitative Evaluation Project for DCLL Service in West Norfolk* provides a condensed summary of feedback from randomly selected service users and their carers accessing the new pathways.

4.2 The feedback relates to DIST involvement in care, Sandringham Ward admission and admission to the alternative to admission beds at the Paddocks Care Home. Unfortunately it has not yet been possible to formally capture for this evaluation the feedback from a family member of patients admitted to Blickling Ward.

4.3 Overall the feedback has been positive, most notably in regard to the ATA beds.

4.4 The qualitative evaluation project summarised in Appendix 4 continues and will be informed by further service user and carer feedback over time.

5.0 Conclusion

5.1 This report shows that the DCLL changes NSFT introduced in West Norfolk in 2013 have had a positive impact, greatly increasing the availability of services in the community whilst ensuring that those with the most acute needs continue to have access to specialist inpatient assessment when needed.

5.2 The information in this evaluation now needs to inform the next steps to be taken by WNCCG in collaboration with NSFT. This is likely to include progressing to a public consultation to decide whether the changes described above can become permanent.

5.3 The Trust and the West Norfolk Locality senior management and clinical leadership team look forward to working closely with WNCCG and partner providers in taking forward the West Norfolk Alliance schemes to better meet the needs of the local population as cost effectively as possible.

Appendix 1

About the Trust Service Strategy

The nationally mandated changes to the NHS and more specifically the payment system for mental health, together with the economic pressures requiring a reduction in public spending along with the continued drive to improve outcomes has necessitated the Norfolk and Suffolk NHS Foundation Trust's (NSFT) strategic redesign programme known as the Trust Service Strategy (TSS).

The Service Strategy sets out how NSFT's services and support functions will operate in an environment where the key challenges are:

- The continual need to improve outcomes for service users and carers;
- The national economic situation and its impact on public finances, which will reduce NSFT's funding in real terms by 20% over four years;
- The need for NSFT to be able to respond quickly to change, in the light of the changing environment in the NHS;
- The introduction of competition to mainstream healthcare, leading to tendering exercises for services that were traditionally part of NSFT's remit;
- The shift of responsibility for commissioning to the Clinical Commissioning Groups (CCGs), making GPs the customer for most of NSFT's services.

In setting out the changes, the Strategy ultimately aims to give stability and certainty to staff, service users, and carers over the future direction and development of services.

The Trust has adopted an overarching strategic approach to service provision and quality whilst recognising that local and national commissioning arrangements mean that models within the strategy will differ between localities and counties. With the advent of more locally focussed CCGs we expect these differences to increase as clinicians work together with CCG clinical staff to develop more local models.[1]

The development of the new Service Lines and pathways within the TSS were clinically led and involved wide consultation with service users, stakeholders, commissioners and staff throughout 2012. This included an analysis of caseloads across Norfolk and Waveney in 2011/12 Q4 and culminated with the new structures being agreed in 2012/13 Q3. The implementation phase then commenced and progressed throughout 2013.

During TSS implementation, that inevitably required challenging workforce and service changes, concerns have been raised about the robustness of NSFT's approach to TSS communication as well as stakeholder and public engagement. This has been compounded by the major changes to commissioning structures in 2013 that increased the risk of lack of continuity in the engagement of commissioners and other partners and stakeholders. It is therefore essential that the collaborative approach to the TSS established in 2012 is further developed throughout 2014.

[1] Extract from *Norfolk and Suffolk NHS Foundation Trust: Service Strategy 2012-16.* NSFT product code: 13/085. Available from Hellesdon Hospital, Drayton High Road, Norwich, NR6 5BE. Or via Internet: http://www.nsft.nhs.uk/PageFiles/4479/TSS_FINAL.pdf

Appendix 2

Dementia and Complexity in Later Life: The Evidence Base

The evidence base for the DCLL service proposal is founded upon a wealth of national data, evidence and strategy and further supported by Operating Framework priorities and the Prime Minister's Dementia Challenges.

The clinical interventions are based upon NICE Guidelines.

Publications that have informed the service design include:

- Alabady et al NHS Norfolk (2010) Norfolk Dementia Needs Assessment : How dementia affects older people in Norfolk – Joint Strategic Needs Assessment
- Alzheimer's Society (2007) Home from Home. Quality of care for people with dementia living in care homes
- Alzheimer's Society (2009) Counting the Cost: Caring for people with dementia on hospital wards
- Alzheimer's Society (2012) Mapping the Dementia Gap: Progress on improving diagnosis of dementia 2010-2011
- Audit Commission (2000) Forget me not. Mental health services for older people
- Carers UK (2007)Carers UK & Leeds University. Stages and Transitions in the Experiences of Caring.
- Care Services Improvement Partnership / Royal College of Psychiatrists (2005) New Ways of Working for Psychiatrists
- Department of Health (2001) National Service Framework for Older People
- Department of Health (2005) Supporting people with long term conditions. An NHS and social care model to support innovation and integration
- Department of Health (2005) Securing better health for older adults
- Department of Health (2007) Continuing Care Framework
- Department of Health / CSIP (2006) Everybody's Business. Integrated mental health services for older adults: a service development guide
- Department of Health (2009) Living Well with Dementia: The National Dementia Strategy
- Department of Health (2010) "Nothing Ventured, Nothing Gained: Risk Guidance for people with dementia
- Department of Health (2009) The use of antipsychotic medication for people with dementia: Time for action
- Kitwood T (1997) Dementia reconsidered. The person comes first.
- Knapp M et al (2007) Dementia UK: Report to the Alzheimer's Society
- Knapp M et al (2007) Dementia: International comparisons. Report to the National Audit Office
- National Audit Office (2007) Improving services and support for people with dementia
- National Audit Office (2010) Improving dementia services in England
- National Institute for Health and Clinical Excellence (2006) Dementia. Supporting people with dementia and their carers in health and social care
- North West Public Health Office (2007) Indications of public health in the English regions 8: Alcohol
- Royal College of Psychiatrists (2005) Who cares wins. Improving the outcome for older people admitted to the general hospital

- Royal College of Psychiatrists (2006) Raising the standard: Specialist services for older people with mental illness
- Stewart R (2002) Vascular dementia: a diagnosis running out of time. British Journal of Psychiatry 180: 152-156
- The National Council for Palliative Care (2009) Out of the Shadows: *End of life care for people with dementia*

The National Dementia Strategy (NDS) was supported by a full economic impact assessment and it contains 17 objectives. Those objectives that are relevant to mental health services have formed the basis of the DCLL service proposal's objectives:

For people with dementia, the key objectives of the DCLL service proposal are:

- Maintenance of functioning, independence and quality of life of people with dementia (PwD) for as long as possible
- Prevention of admissions to acute and mental health care hospitals
- Prevention of or delaying admission of PwD to care homes
- The above will deliver huge financial savings to the local health and social care economy.

These key objectives will be met as a result of:

- Early identification of people who might have dementia (NDS objectives 1 and 2)
- Early assessment and diagnosis (NDS objective 2), leading to
- Early treatment (NDS objective 2) and
- Access to care, support, information and advice for people with dementia and their carers (NDS objectives 3, 4 and 5)
- Routine advanced care planning (NDS objectives 2 and 12)
- Routine proactive reviews of PwD and their carers (NDS objectives 2, 6 and 7)
- Timely and appropriate support for carers (NDS objective 7)
- Enhanced support for PwD and their carers who are in crisis, at risk of admission or who are already admitted to an acute hospital (NDS objectives 8 and 9).

The radical changes to the current services to deliver the above are:

- Greatly increased integrated working between DCLL practitioners and primary care and general acute services, social services and the third sector
- Roll out of Dementia Intensive Support Teams (DIST) to cover the whole of Norfolk and Waveney and provide in-reach services to acute hospitals to aid safe and early discharge
- Further enhancing the skills of DCLL practitioners in order to improve quality and productivity of the services.

In the area covered by NHS Norfolk and Waveney there are over 15,000 people with dementia but less than half of them are in receipt of a diagnosis. In other words more than half of the people with dementia locally have no diagnosis and therefore no access to treatment that can prolong their quality of life and independence, delay expensive institutionalisation, and help prevent expensive episodes of unplanned care.

<u>Dementia Intensive Support Teams (DIST)</u>

The Julian Hospital in Norwich (serving the North, City and South localities) had 36 acute dementia assessment beds until August of 2009 when they were reduced to 22. However there was a constant occupancy of 100% and many outliers such that occupied beds for the central Norfolk localities was averaging 30.

The pilot DIST became operational in June 2010, initially only taking referrals from the North and South community teams. By October/November of 2010 bed occupancy had reduced to between 13 and 16, and currently the bed occupancy is around 12.

From September of 2011 DIST began an in-reach service to NNUH predominantly to prevent admission to the in-patient wards and reduce length of stay. The evidence to date demonstrates that the DIST in-reach service does indeed achieve these goals, but only when DIST is working with people on the Medical Admissions Unit or very early in their admission. This can be replicated by a liaison service with practitioners able to incorporate DIST ways of working. There is very clear evidence that the DIST service has helped many people with dementia return to their own homes on discharge from the acute hospitals by providing intensive follow-up and prevented these people from being discharged to a residential home.

The DIST has also begun bed management for the dementia admission ward at the Julian Hospital to try to capture the patients that have been admitted without being known to DIST.

In the proposed service model, the central DIST team will deliver services to the whole of the new Central locality (ie including the city community that is not presently covered) and there will be new DIST teams set up in the West Locality and the GY & Waveney locality.

Primary Care Liaison and Integrated Working

Drawing on the experience of the Primary Care Dementia Practitioner (PCDP) pilot, the new DCLL teams will have the majority of the Band 6 practitioners aligned to specific surgeries. The PCDP pilot demonstrated that this way of working has not only facilitated integrated care but has also raised the dementia diagnosis rates in the surgeries they have been attached to. However there was not universal coverage in the pilot and many surgeries had no access to a PCDP. In the proposed model, every surgery will have a named Band 6 DCLL practitioner. Depending upon the size of the surgeries, they may be shared between two or more surgeries.

Older adults with functional illnesses

In the proposed service model older adults with functional illnesses will be taken on either by adult services or by DCLL services. The choice of service will be on the basis of need, not age, as is required by age discrimination legislation. Service users seen by the DCLL service will have complex age-related needs such as physical frailty, multi-system pathology, and very poor mobility. They will be able to access the same range of services that are available in the adult service but delivered by a team that is expert in managing the complexity of later life.

The evidence base for the interventions for older adults with functional illnesses is provided in the adult service evidence base.

Neil Ashford
DCLL Clinical Lead
Consultant in Old Age Psychiatry
January 2013

Appendix 3: Data Analysis

IMPORTANT NOTE

The inpatient information in this analysis specifically relates to West Norfolk CCG patients only. However, it was not possible in time for this report to identify only West Norfolk community activity from West+. The pre-TSS benchmark information estimated that WNCCG community activity would be 72% of the total for the West+ Locality. Therefore, as this report is specifically for the WNCCG, only 72% of the reported activity for West+ has been used. Due to the increasing trend in the number of referrals for people with dementia from the WNCCG these figures are likely to be a conservative estimate. Work continues to ensure accurate reporting of activity by CCG.

1. Benchmark Admission Data

August 2012 to January 2013 (26 weeks)

	Chase Ward	Tennyson Ward
Total Admissions:	**12**	**26**
Shortest LoS	**10**	**1**
Longest LoS	**145**	**183**
Average LoS	**86**	**40**
Total Bed Days (est.*)	**373**	**1040**
Total combined	**1413**	

* Total admissions x average LoS

This table shows the total number of episodes of care (admissions) to the two older persons 12 bedded wards at Chatterton House in Kings Lynn. At this time there was no Dementia Intensive Support Team.

2. Inpatient Bed Change Timeline

The following table details the transition of beds as follows:

Chase Ward (12 beds), transitioned to: 2 x Alternative to Admission (ATA) beds at the Paddocks Care Home, Swaffham + 3 x Dementia Assessment beds at Blickling Ward, Julian Hospital in Norwich.

Tennyson Ward (12 beds), transitioned to: 3 x non-complexity in later life beds on the all age acute admission Churchill Ward at the Fermoy Unit, Queen Elizabeth Hospital, Kings Lynn + 2 x complexity in Later Life beds at Sandringham Ward, Julian Hospital in Norwich.

Chase Ward (Dementia assessment for people over 65)					
No of Beds	18	12	8	6	3 (t ransferred + ATA) [1]
Date	Up to 12/09/12	From 13/09/12	From 13/12/12	From 15/01/13	Transferred from 30/06/13 – Ward closed
Tennyson Ward (Functional assessment for people over 65)					
No of Beds	18	12	8 [2]	6 [2]	4 (transferred) [2 3]
Date	Up to 21/09/12	From 22/09/12	From 19/10/12	From 03/06/13	From 30/06/13 – Ward closed
Churchill Ward (Acute assessment for 18-65 to all age, non-CLL)					
No of Beds	24	24+4 [2]	Gradual reduction from 24+4 to 17+3 [2]		
Date	Up to 19/10/12	From 19/10/12	From 24+4 March 13	To 17+3 Aug 13	

[1] 3 x Dementia Assessment beds provided at Blickling Ward, Julian Hospital;
2 x Alternative to Admission (ATA) dementia beds provided by Paddocks Care Home.

[2] Gradual transfer of beds from Tennyson to Churchill providing 3 beds for non-CLL older people (65+).

[3] 2 x Complexity in later life (CLL) beds provided by Sandringham Ward, Julian Hospital.

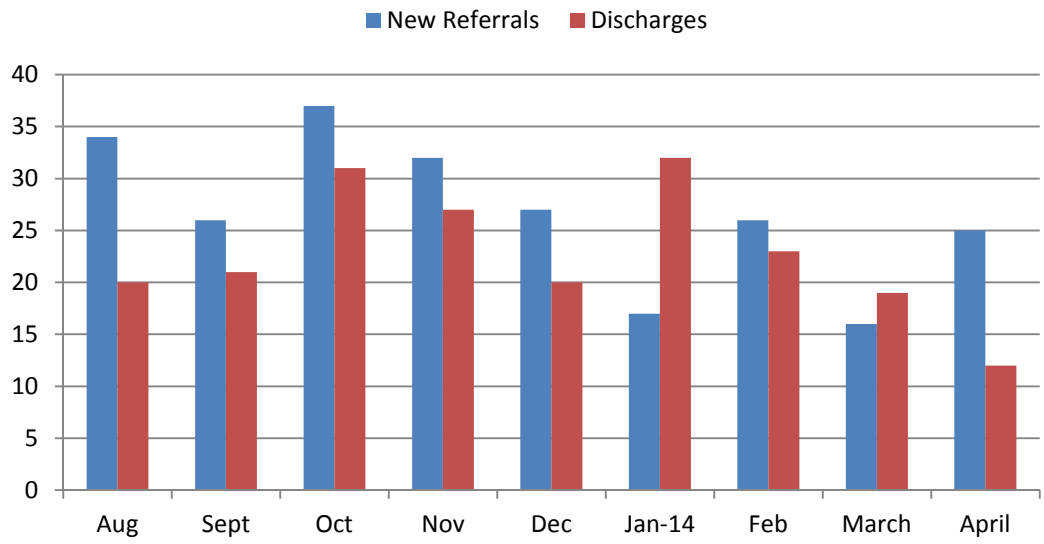
3. Dementia Intensive Support Team

Note: Totals for the West+ Locality have been reduced by 72% to provide a conservative estimate of actual West Norfolk CCG activity.

The Dementia Intensive Support Team (DIST) is a key component of the changes to the bed provision for the population of West Norfolk, enabling intensive community support to either prevent admission, access the alternative to admission beds at the Paddocks Care Home or when necessary support admission for the minimum period necessary to the dementia and CLL assessment beds at the Julian Hospital.

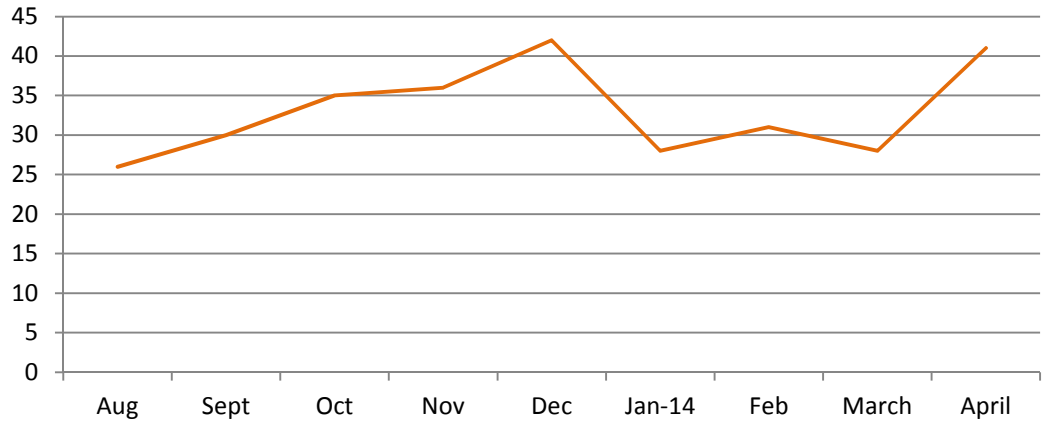
The DIST team provide support to people in their own homes, care homes and acute and community hospitals.

3 a) New referrals and Discharges by month (August 2013 to April 2014)



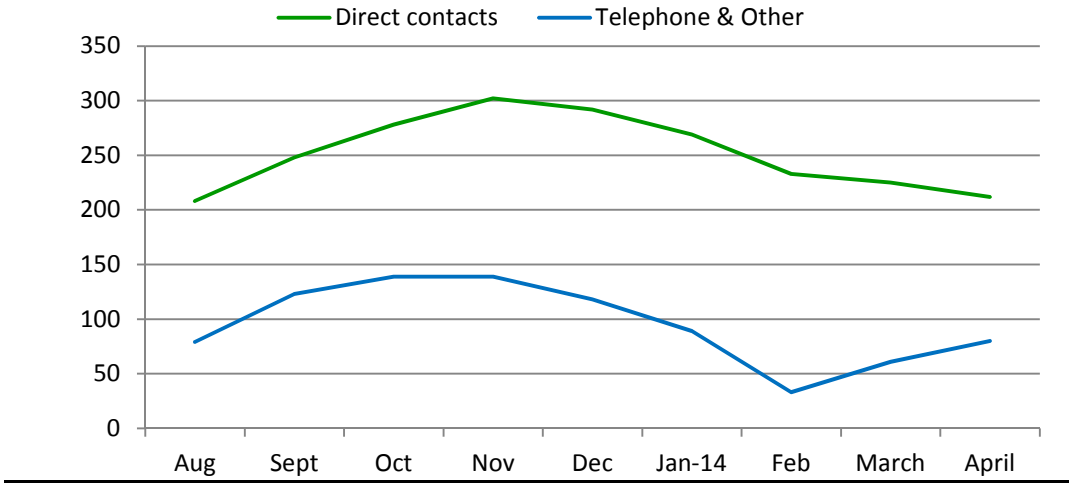
3 b) Caseload (open referrals) by month (August 2013 to April 2014)

The DIST team have a target caseload capacity in the region of 30 to 35 which gives capacity to deliver periods of intensive home or in reach support and treatment.



3 c) Clinical (patient) contacts by month (August 2013 to April 2014) = **3,096**

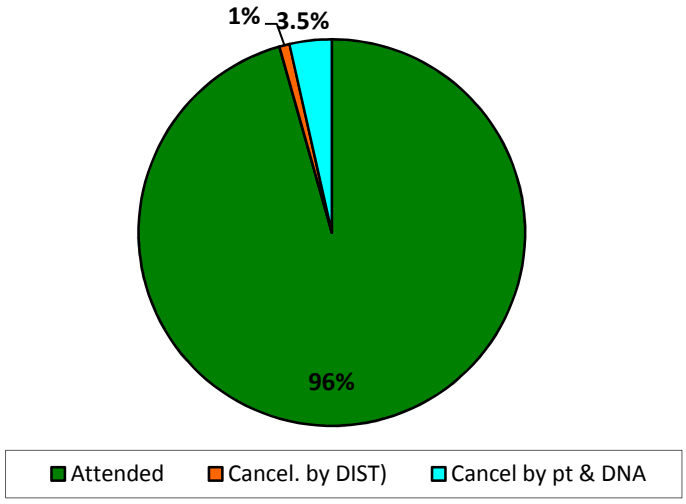
These figures only represent direct actual contacts with service users and those acting in a proxy role, but do not include the large number of DIST contacts with GPs and other health and social care professionals.



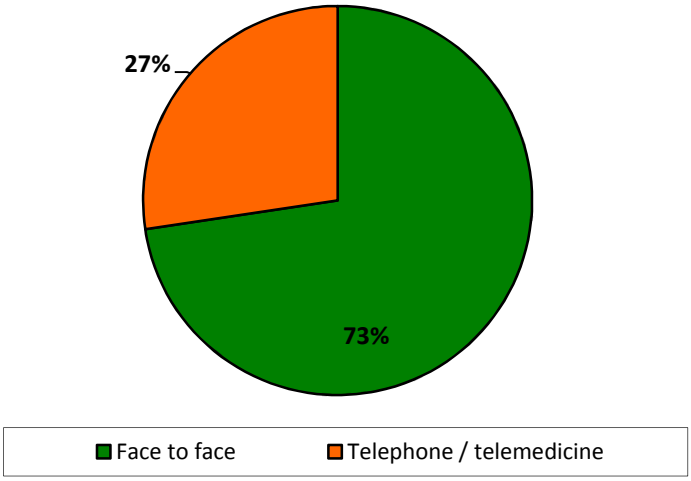
3 d) Contact Analysis (August 2013 to April 2014)

The analysis of contacts by the DIST shows remarkable effectiveness with a very low number of cancelled appointments and a high proportion of direct face to face contact with patients.

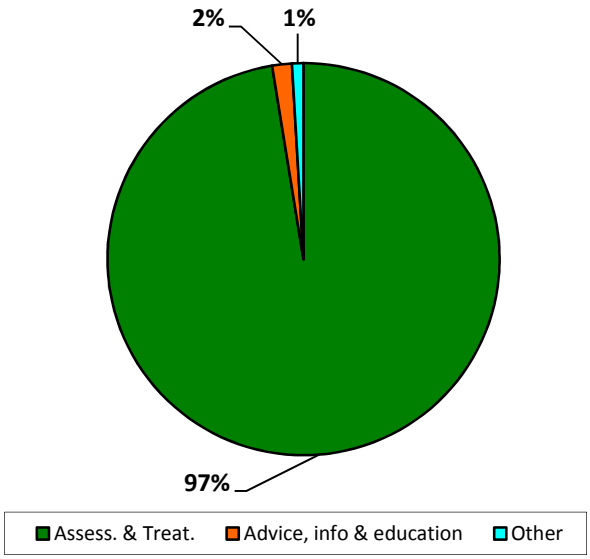
i) Attendance



ii) Attended contacts: Type

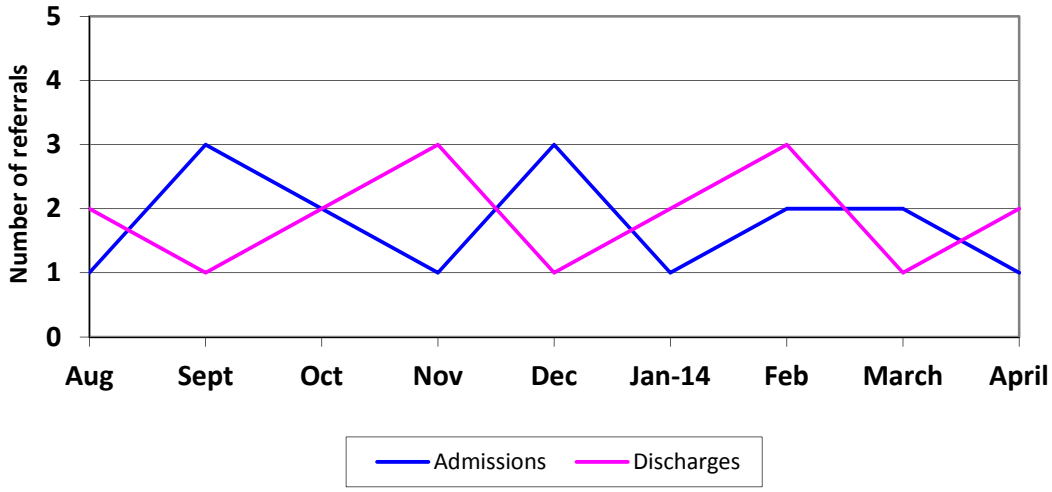


iii) Attended contacts: Purpose



4. Paddocks Care Home (Alternative to Admission) Bed Usage

Admissions & Discharges (August 13 to April 14)



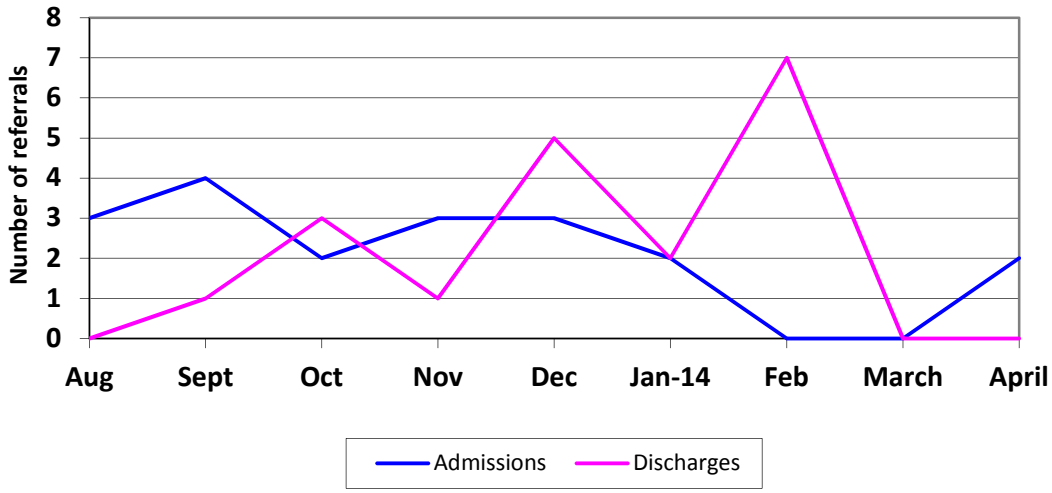
	Paddocks
Total Admissions:	**16**
Shortest LoS	**1**
Longest LoS	**63**
Average LoS	**18**
Total Bed Days (est.*)	**288**

* Total admissions x average LoS

5. Blickling Ward, Julian Hospital, Norwich (Dementia Assessment)

In August 2013 there were a number of patients transferred to Blickling Ward with protracted lengths of stay. These patients have been successfully discharged, subsequent admissions have required considerably less lengths of stays and the demand for beds has continued to reduce.

Admissions & Discharges (August 13 to April 14)



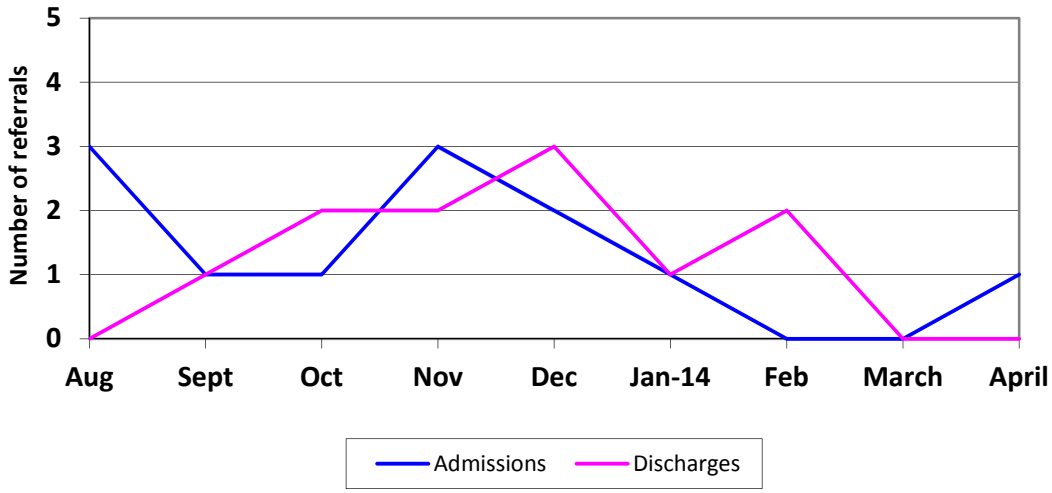
	Blickling
Total Admissions:	**18**
Shortest LoS	**5**
Longest LoS	**172**
Average LoS	**56**
Total Bed Days (est.*)	**1008**

* Total admissions x average LoS

6. Sandringham Ward, Julian Hospital, Norwich (CLL Assessment)

In August 2013 there were a number of patients transferred to Sandringham Ward with protracted lengths of stay. These patients have been successfully discharged and subsequent admissions require considerably lower lengths of stays and the demand for beds has continued to reduce.

Admissions & Discharges (August 13 to April 14)



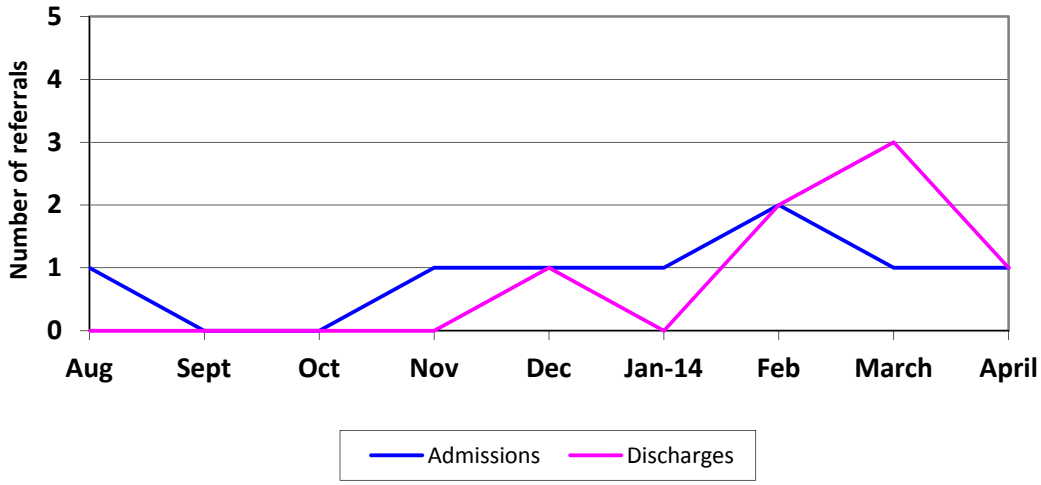
	Sandringham
Total Admissions:	**12**
Shortest LoS	**13**
Longest LoS	**160**
Average LoS	**56**
Total Bed Days (est.*)	**672**

* Total admissions x average LoS

7. Churchill Ward, Fermoy Unit, King's Lynn (non-DCLL older people)

There is one older patient on Churchill Ward who had an exceptionally long length of stay due to nature of their clinical presentation. If this patient is not included in the LoS figures the average reduces to 40 days.

Admissions & Discharges (August 13 to April 14)



	Churchill (65+)
Total Admissions:	**8**
Shortest LoS	**1**
Longest LoS	**245**
Average LoS	**65**
Total Bed Days (est.*)	**520**

* Total admissions x average LoS of discharged patients

8. Comparison Tables

8a) August 2012 to January 2013

	Chase	Tennyson	DIST	Church.	Paddocks	Blickling	Sand.
Admissions / referrals	**12**	**26**	**-**	**-**	**-**	**-**	**-**
Total Bed Days (est.)	**373**	**1040**	**-**	**-**	**-**	**-**	**-**
Combined bed days	**1413**		**-**				
Total episodes of care	**38**		**-**				
Bed days per episodes of care (average)	**37**		**-**				

8b) August 2013 to January 2014

	Chase	Tennyson	DIST	Church.	Paddocks	Blickling	Sand.
Admissions / referrals	-	-	**190**	**4**	**11**	**17**	**11**
Total Bed Days (est.)	-	-	-	**316**	**209**	**952**	**616**
Combined bed days	-	-	-	**2093**			
Total episodes of care	-		**233**				
Bed days per episodes of care (average)	-		**9**				

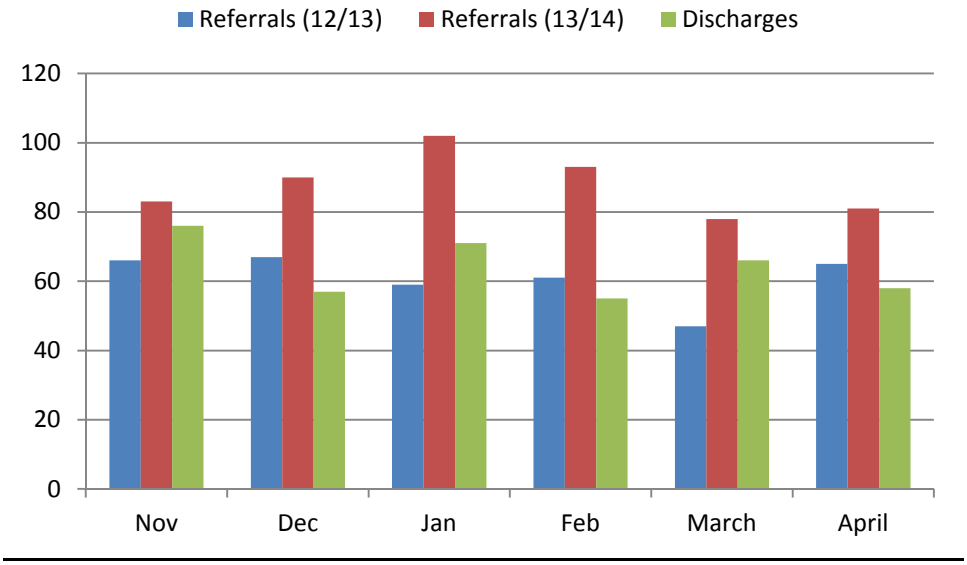
The length of stay figures continue to fall as community teams work closely with acute services to ensure inpatient episodes of care are no longer than necessary. For example, the LoS for people over 65 on Churchill Ward, averaging 79 in the above table, has more than halved to 36 for patients admitted since January 2014. In addition the demand for inpatient admissions is less than anticipated at this stage with very effective use being made of the Alternative to Admission beds at the Paddocks Care Home.

9. Dementia and Complexity in Later Life (DCLL) Community Team

Note: Totals for the West+ Locality have been reduced by 72% to provide a more accurate but conservative estimate of actual West Norfolk CCG activity.

The following information shows estimated WNCCG activity for the 6 months from November 2013 to April 2014. The referral activity from August to October contains greatly increased number of transition referrals from West+ (non-WNCCG) practices during the 3 months following commencement of the new Locality boundary and has therefore not been incorporated as would obscure West CCG area activity.

9a) New referrals and Discharges by month (November 2013 to January 2014, with referrals from November 2012 to January 2013 for comparison)

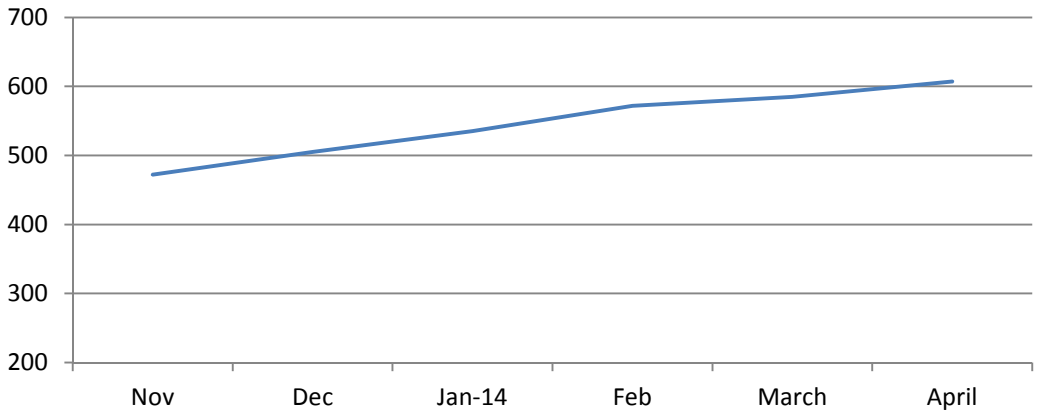


The13/14 referral figures have been adjusted to more closely reflect WNCCG activity. Those for the corresponding months in 12/13 were the old West Locality that was coterminous with the current WNCCG area.

The month on month higher rate of referrals compared to discharges is unsustainable and requires urgent remedial action currently being planned and implemented.

9b) Caseload (open referrals) by month (November 2013 to April 2014)

The upward trend in caseloads numbers directly corresponds to the differential between discharges and referrals in the above chart.



Appendix 4

Qualitative Evaluation Project for DCLL Service in West Norfolk

Introduction

In line with the NSFT recent service reconfiguration, a qualitative study has taken place to evaluate the service model so far. Service users and carers who have either been admitted to one of the wards at the Julian Hospital, or admitted to one of our alternative to admission beds at a local care home, or have been receiving a service from our dementia intensive support team (DIST) have been interviewed and notes taken on their experiences.

This is a work in progress and further data will become available as time progresses and more service users are seen. The collection of the following data has been somewhat problematic due to the complexities around the service users being part of a mental health service. Although the data has been collected at random, there have been some people who have not been able to be included, for example, if the service user has since passed away, if they are deemed to lack capacity to consent and there is no carer, or if their current mental health is in a state of crisis and it is felt that to be conducting the interview at this time would lack sensitivity.

All people interviewed have had the same set of questions asked of them, with the wording altered very slightly depending on which part of the service they have been part of. A typical interview spine is detailed in appendix 4A.

Data

To date 5 service users/carers who have received care from DIST have been interviewed. One carer of a service user who was admitted to Sandringham Ward has been interviewed.

Key themes

DIST involvement:

One person was unable to remember or comment on their experience.

One person was referred to the DIST by their community nurse – this person appeared to be confusing the DIST and community team during the interview.

Of the remaining 3, all apart were referred by their GP and then seen directly by the DIST. All reported positive experiences of the DIST team. This included comments regarding the staff being ‘very good’ and ‘on time’. All reported that the DIST staff explained their role, how the service operated and why they were involved with their care. All reported the team to be ‘helpful and useful’ in terms of having someone to talk to and someone who gave them strategies to help with care. All reported that the discharge process was explained to them and that they were aware of what they would need to do should they need to be seen again in the future. two reported this process took place via a telephone call, which one reported feeling ‘disappointed with’ and another reported feeling ‘happy’ about this.

The family and friends question was rated as ‘extremely likely’ by 3 people and ‘likely’ by one person. Comments made to explain this included people being ‘pleased with the service’, that’s staff were ‘helpful and caring’, and that ‘if you needed help now you would know what to do’.

In terms of any changes for the better, two people said ‘nothing they could think of’, another commented on advertising, in terms of people not being aware the team existed, and another said they waited a long while to be seen and that this could have been shorter.

Sandringham ward admission

One person was able to be interviewed regarding their family members admission to Sandringham ward. They reported a long contact with mental health services prior to this time, dating back a number of years. This current admission was as a result of physical health problems and an admission to the acute hospital, which had resulted in mental health medication being discontinued and a subsequent destabilisation of the presenting mental health problem. The family member reported a very positive experience of the liaison consultant who was said to be ‘amazing’ and who arranged the admission. The reason for the admission and the process itself was fully explained to them and they were happy with this. They reported the care on the ward to be good, the staff were

'brilliant' and the place was 'awesome'. They felt that the staff working on the ward were responsible for getting their family member better again. They described how they were flexible with visiting hours, to fit in with the travel from Kings Lynn. Prior to the discharge process, they were told it would be planned and were aware of the arrangements and were happy with how this was done.

The family and friends question was rated as 'extremely likely', and the comment made that they 'could not fault the place or the mental health team'.
In terms of anything changing for the better, they reported that they were initially worried when they were told it was going to be in Norwich, but actually found the ward environment good and the staff really helpful so felt happy about this. The travelling to and from the ward was their only gripe.

Blickling ward admission

Unfortunately it has not been possible so far to interview any family members whose loved ones have been admitted to this ward.

Alternative to admission beds

13 admissions to the ATA beds at the Paddocks Care Home are included within this project. Of these, so far, 4 carers/family members have been interviewed. Two feedback sessions have also been held, one with staff from the care home, the other with staff from the Dementia Intensive Support Team (DIST).

The key themes from the interviews with both sets of staff are as follows:

> The experiences of the project from both sides are generally positive. Both teams described initial anxiety, apprehension and concerns about the project, but these have now been resolved. Changes have been made to paperwork which has allowed for improvements to the project and the relationships between the two teams are building. Both teams describe feeling supported by each other. Both teams also report that sticking to the admission criteria for patients being admitted as part of the project, has helped with smoother running of the project. The monthly meetings are also reported to be helpful. There have been some issues with communication on both sides, some related to problems with paperwork, also telephone systems at the care home making it harder for DIST staff at times to keep in contact with the care home staff. The staff at the care home have been reported by the DIST team, to be friendly and helpful and welcoming to the project. The care home staff themselves report that the project has promoted the care home. DIST staff report that the care that the staff at the care home are providing appears to be good, and that there has been some positive benefits for patients admitted, but there have been some concerns regarding the environment not being ideal.

Of the 4 family members interviewed, the following themes have been found:

> The staff at the care home are consistently reported to be 'friendly', 'lovely' 'helpful' and 'fantastic'. It was reported that 'nothing is too much trouble' for the staff there. The manager was reported to be 'brilliant'. Families liked that they could visit when they liked and always felt welcomed.
>
> There was consistent praise for the fact that it is a care home and not a hospital, with families saying it was 'better than a hospital' environment and that they felt 'relief' when they found it wasn't a hospital. However there were also numerous comments that the environment seems 'dated', 'confined', 'drab' and 'dirty'.
>
> There were consistent comments around the care, with families describing that they 'could not fault the care' and that the care was 'good'.
>
> There was also consistent praise for staff from the DIST, as being good at keeping families informed of what was happening.
>
> In response to the families and friends question, of the 4 family members, two rated this question as' **extremely likely'**, both because it was a non-hospital environment, which was unpressurised for the patient and family. One rated it as '**likely'** again because it was a non-hospital environment, the reason they didn't rate it as extremely likely was due to the location. The final family member rated the question as '**unlikely'** due to the environment.

Appendix 4A

Patient and carer interviews

Interview spine:

- 1st contact with the service
- Experiences of their contact with the services up to the point of admission (or team contact)
- Explanation of the admission (or team) process
- Process of the admission (or team involvement)
- Experiences during the admission (or contact with team); care staff, environment, DIST involvement
- Process of discharge

Final questions to be asked at end:

In accordance with the Trust ethos of ensuring people remain close to home your recent care has been provided at the care home instead of in hospital. We would like you to think about your experience of this approach.

"How likely are you to recommend this approach to friends and family if they needed similar care or treatment?"

Response scale: 1 Extremely likely 2 Likely 3 Neither likely nor unlikely 4 Unlikely 5 Extremely unlikely 6 Don't know

"Please can you tell us the main reason for the score you have given?"

"Please can you tell us why you would/would not recommend this approach to your Friends and Family?"

Is there anything we could change for the better?

NHS
West Norfolk
Clinical Commissioning Group

"TOWARDS A DEMENTIA-FRIENDLY COMMUNITY IN WEST NORFOLK"

Statement of Strategic Direction for improving services for People with Dementia and their Carers in West Norfolk

July 2014

1. INTRODUCTION

Since its formal creation in 2013, West Norfolk Clinical Commissioning Group (WNCCG) has made services for people with dementia and those who care for them one of its top priorities. This Statement of Strategic Direction looks at progress made so far and the way ahead in terms of the objectives of the "Living Well with Dementia - a National Dementia Strategy" (2009) and taking into account the West Norfolk issues raised in workstream meetings involving clinicians and carers held during the summer of 2013.

This was part of the development of a West Norfolk Action Plan for Dementia which was subsequently approved by the Clinical Executive and the Executive Teams of WNCCG. The Plan was an iterative document subject to regular change as events have moved on rapidly and it is now superseded by this Statement of Strategic Direction.

The Vision being pursued strongly remains the same:

" West Norfolk Clinical Commissioning Group will make person centred care, and the integration of provision of services for people with dementia and those who care for them, central to its future commissioning intentions and its work with existing providers".

2. BACKGROUND

"Living Well with Dementia - a National Dementia Strategy" was issued in 2009 and set new standards for dementia care focusing on improved awareness, earlier diagnosis and intervention and a higher quality of care. It was followed in 2010 by Quality Outcomes for people with dementia building on the work of the National Dementia Strategy and the quality standard for dementia from the National Institute of Health and Care (NICE). The Strategy's ambitions were reinforced by the Prime Minister's launch of the "The Dementia Challenge: responding to a National Priority" in 2012 with a focus on speeding up the raising of diagnosis rates and improving the skills and awareness needed to support people with dementia and their carers. In 2013 NHS England published "Dementia: A state of the nation report on dementia care and support in England" highlighting the relative geographical performance in the identification and management of Dementia across England and promoting Dementia Friendly communities. WNCCG's position is set out in 3.2 below.

These intentions are reflected in the NHS Mandate 2014/15 – 2015/6 "Mandate 8 – Diagnosis, treatment and care for people with dementia: Make measurable progress by March 2015 towards being among the best in Europe at diagnosing, treating and caring for people with dementia. A national ambition for diagnosis rates will be built up from local plans".

Norfolk also has its own Dementia Strategy launched in 2009 which is in the process of being revisited with advice from the Strategic Partnership for Older People's Board in Norfolk. In West Norfolk, the workstreams identified inconsistency of health and social care services, the need for better communication, and greater integration of services by providers as the key themes of those healthcare professionals and carers who participated.

WNCCG is aware that progress on all these strategies has been made already and does not seek to duplicate the excellent documents already agreed but sets out in this document progress made since April 2013 and the steps needed to move further and faster to achieve the desired outcomes of the national and Norfolk-wide strategies in West Norfolk.

This may be subject to further development when the Norfolk Dementia Strategy has been reviewed and when there has been time to analyse fully "Living in Norfolk with Dementia: A Health and Wellbeing Needs Assessment; July 2014" which became available on 15 July 2014.

The progress made so far, and the further progress that needs to be made, are set out under the Objectives of "'Living well with Dementia" that are appropriate to Clinical Commissioning Groups.

3. LIVING WELL WITH DEMENTIA OBJECTIVES

3.1 Objective 1: Improving public and professional awareness and understanding of dementia

Action Taken:

- A Public Conference on Dementia was held on 24 April 2013 leading to the formation of workstreams for healthcare professionals and carers to help take forward understanding about dementia and to help develop the West Norfolk Dementia Action Plan.

- A Public Workshop was held on 17 September 2013 to help prepare the Action Plan developed from the workstreams.

- At the workshop a presentation was given by Penny Garner, Clinical Director of Contented Dementia and the SPECAL method which is focused on the analogy of the photograph album to help people to understand how normal memory works, the impact of ageing and the single dramatic change that occurs with the onset of dementia, and to understand the three golden rules: don't ask direct questions, listen to the expert – the person with dementia and don't contradict. This was seen as a useful and relatively straightforward approach to disseminate as part of helping to improve public understanding of dementia. Further training sessions were held on 5 December 2013 and further discussions were held with Penny Garner on 12 February 2014. On 9 May 2014 three West Norfolk Clinicians spent the day at Burford Hospital, the Contented Dementia centre, to see SPECAL in practice.

- At the public Mental Health conference held on 2 April 2014 there were further 'round table' discussions focused on dementia.

- WNCCG welcomes the training of Dementia Care Coaches who act as coach, mentor and role model across the span of the Dementia Pathway. The benefit of this is illustrated at the Winchley Care Home where there is a monthly Dementia Friends Club meeting where understanding of how to live well with dementia is promoted.

Way Forward:

- WNCCG is now developing its next steps in using SPECAL and supporting the encouragement of Dementia Care Coaches, Dementia Champions and other approaches to achieve this objective.

- WNCCG will work with Age UK Norfolk on strengthening the Dementia Friendly Swaffham initiative and seek to achieve a similar initiative in Downham Market as the fourth such Dementia Friendly Town in Norfolk.

3.2 Objective 2: Good-quality early diagnosis and intervention for all

- The importance of the role of GPs in referring people for diagnosis was not only identified in the National Strategy and the Dementia Challenge but also by the WNCCG's clinician and carer workstreams.
- The measure used to assess the level of diagnosis for dementia is the diagnosis rate calculated through NHS England's computer programme called the "Dementia Prevalence Calculator". The Calculator applies the figures for prevalence set out in the Dementia UK Report (2007) to a General Practice's registered patient population, by age and by gender and then aggregates them to CCG level. The published diagnosis rate in West Norfolk is 35% which is low when the usual figure is around 46%; the National Target by March 2015 is 67%. However, the figures for West Norfolk use the data from the 2012/13 Quality and Outcomes Framework (QOF) (the annual reward and incentive programme detailing GP practice achievement results) and do not yet reflect the work undertaken in West Norfolk by both WNCCG and NSFT during 2013/14. There is other evidence that suggests the diagnosis rate has significantly increased; however, there is no doubt that the number of referrals for diagnosis will have to improve further in order to meet the 67% target.
- QOF data for 2012/13 shows that in West Norfolk the number of people on GP registers with dementia with a recorded dementia review is the highest in Norfolk at 83.39%.
- Data for the 2013/14 QOF, from which a more up to date diagnostic rate can be calculated, will not be available until October 2014.
- At the West Norfolk workstreams it became apparent that one cause of reluctance to refer for diagnosis among GPs is because they see little point diagnosing dementia as they perceive that there are no services to support people with dementia and their carers after diagnosis. This was confirmed in the "GP Audit - Understanding the Dementia Diagnosis Gap in Norfolk and Suffolk" (October 2013) an Audit Survey Study by the University of East Anglia DEMSTART Dementia Hub for the Norfolk and Suffolk Dementia Alliance, which showed that 45% of GPs in West Norfolk who responded to the survey agreed with that view.

Action Taken:

- In order to enhance confidence and knowledge, information on dementia services provision was presented to the GP Clinical meeting held in January 2014 followed by a well-attended event for GPs held on 24 April 2014 illustrating through patient journey examples, the support that those with dementia can receive from the services provided by NSFT and the Alzheimer's Society. At the same time GPs and Consultants from NSFT and The Queen Elizabeth Hospital (QEH) presented an agreed pathway on identifying and referring people requiring a specialist diagnostic assessment for dementia and identified the relevant diagnostic tests to make the process more integrated. These have been distributed and made available on the WNCCG's website.

- WNCCG has also confirmed until 31 March 2015 the funding for the Dementia Adviser and Dementia Support Worker provided by the local Alzheimer's Society and will look at ways of sustaining and increasing investment.

Way Forward:

- Using information from the "Dementia Prevalence Calculator", although it is for 2012/13, WNCCG will confirm with practices whether the figures in their own QOF data suggest that the percentages shown in the "Dementia Prevalence Calculator" are still correct and will work with those practices where diagnosis rates remain low.

- "Living in Norfolk with Dementia: A Health and Wellbeing Needs Assessment; July 2014" estimates that West Norfolk needs five Dementia Advisers – at the moment there is one – to provide a comprehensive local service for the number of patients diagnosed in the community each year. WNCCG will consider its response to this recommendation.

3.3 Objective 3: Good-quality information for those with diagnosed dementia and their carers

- The Carers Workstream identified the value that carers place on the sessions held at Chatterton House for people newly diagnosed with dementia and those who care for them. During internal changes within NSFT these had been in abeyance but have now resumed. WNCCG remains convinced about the value of the sessions and the need to maintain them over the long term.

- At the Workstream, Carers also emphasised the importance that they attached to the booklet "Are you looking after someone: Norfolk Carers Handbook 2012-2013" produced by Norfolk County Council and the Carers Council for Norfolk. WNCCG welcomes the updated version for 2014/15 which is now available.

Way Forward:

- WNCCG will continue to encourage NSFT to maintain and expand their sessions for people newly diagnosed with Dementia and also for their Carers.

3.4 Objective 4: Enabling easy access to care, support and advice following diagnosis

- Research at the time of the Workstreams in 2013 drew attention to the 'Gnosall' model of a Primary Care Memory Clinic that has been operating since 2006 at Gnosall Health Centre in Staffordshire and adds the skills of a specialist old age psychiatrist to the extensive skills and knowledge available in primary care. Key to the organisation and function of the clinic is the eldercare facilitator, a new role situated in primary care and linking with the specialist and a wide range of other agencies and people. The data for the service suggests that it has the effect of reducing admissions into secondary acute and mental health inpatient beds and that 90% of patients can be managed within Primary Care given this sort of specialist involvement.

- On 15 July 2014 the evaluation of the Admiral Nurse pilot in mid-Norfolk will become available. In mid-Norfolk Dementia UK, the national charity responsible for promoting and developing the Admiral Nursing service, has been working in partnership with Age UK Norfolk to bring the first Admiral Nurse to the county; the pilot has been funded with money from the National Lottery. Admiral Nurses are mental health nurses specialising in dementia. Admiral Nurses work with family carers and people with dementia, in the community and other settings.

Working collaboratively with other professionals, Admiral Nurses seek to improve the quality of life for people with dementia and their carers. They use a range of interventions that help people live positively with the condition and develop skills to improve communication and maintain relationships.

Way Forward:

- Discussion about a Primary Care based memory service is under active discussion between WNCCG and NSFT.

- WNCCG will consider the Admiral Nurse pilot evaluation to determine whether an investment in Admiral Nurses offers an effective alternative service in improving the support that people with dementia and their carers receive.

3.5 Objective 8: Improved quality of care for people with dementia in general hospitals

- It is generally acknowledged that a stay in an acute hospital affects the functional ability of people with dementia given the change in environment, routine and carer that this involves. The work streams have identified that ward staff at the QEH had some lack of awareness in how to access specialist services and support for patients with dementia and their carers. It had been recommended that training should be initiated in order to improve dementia awareness across the organisation. The Trust began delivering mandatory training sessions in 2013 for medical and nursing staff and has increased the length of sessions on the Trust's induction programme for new staff.

Action Taken:

- A Commissioning for Quality and Innovation (CQUIN) scheme is in operation at Norfolk acute hospitals. This programme was introduced to highlight patients who come into hospital who may have memory concerns. The CQUIN pathway is indicated for those patients who are over 75 and are admitted to the acute trusts as an emergency. The CQUIN requirements are that the person is assessed, any investigations undertaken, and then where indicated referred to onward specialist service. WNCCG's contract with the QEH for 2014/15 includes this CQUIN. The aim of the CQUIN is to raise awareness among all clinical staff and ensure patients with memory concerns receive appropriate specialist input and services during and after admission. The Trust has reinforced its mandatory training programme by holding two events, one evening event for all, followed by a conference for all staff on the 21 May this year.

- Originally WNCCG used additional resources derived from "winter pressures" funding in 2013/14 to commission a "Mental Health Liaison Team" involving staff from NSFT, QEH, West Norfolk Mind and Alzheimer's society. This new team reinforced the existing mental health provision within the QEH; an established liaison team with two senior mental health nurses and dementia support workers. Much of the work undertaken by the new mental health liaison staff provided by the NSFT team focuses on ensuring that people with mental health problems attending the Accident and Emergency Department and other emergency areas at QEH are quickly assessed and, where appropriate, other services from outside the hospital are mobilised to support them rather that assessment and care at the hospital.

- The new team is working cohesively in the provision of care for patients with mental health needs including those with dementia. The team is further supported by a Consultant Psychiatrist who will assess patients, including those with dementia, undertakes ward rounds and is available to support care in the QEH three days each week. There is also a social worker working alongside the team assisting in the provision of care for people with dementia on discharge.

Way Forward:

- WNCCG will continue to work with the QEH, its major provider of acute care, to continue to enhance understanding of Dementia among the hospital staff, promote earliest possible appropriate discharge, and to increase the quality of care received by people with dementia while in hospital. WNCCG will monitor the performance of the Mental Health Liaison Service in meeting the needs of people with dementia.

3.6 Objective 9: Improved intermediate care for people with dementia

Action Taken:

- As part of the move to develop services in the community with the establishment of the Dementia Intensive Support Team (DIST) as set out in objective 3.8, two 'Alternative to Admission' beds for Intermediate Care have been provided at a care home in West Norfolk which have been well used and have received very favourable comments from carers. These beds are used by the DIST as appropriate as part of their secondary care community based service.

Way Forward:

- WNCCG will monitor the use of the 'Alternative to Admission' beds on availability, adequacy and quality.

3.7 Objective 12: Improved end of life care for people with dementia

- Dementia is a terminal illness and information suggests that 80% of people with dementia have Care Homes as their place of death.

Action Taken:

- WNCCG has commissioned a Hospice at Home Service for End of Life care lead by Norfolk Community Health and Care NHS Trust (NCHC), working with Marie Curie and Norfolk Hospice (Tapping House) and the service is provided to people with dementia though not as frequently as would be expected.

Way Forward:

- Dialogue between care professionals from the Hospice at Home Service and NSFT is being promoted through the West Norfolk Dementia Network.

- WNCCG will support work with Care Homes to enhance training and confidence of Carers in the Homes who are so important to the quality of life of people with dementia

3.8 Objective 13: Care and Support at a time of crisis at Home or in a Residential Setting

Action Taken:

- The need for improved care and support for people with dementia and those who care for them when a crisis occurs has been recognised by the pilot introduction of the DIST by NSFT as part of their Trust Services Strategy (TSS) implementation in place of inpatient beds on Chase Ward at Chatterton House. The DIST is designed to provide intensive care including psychological and behavioural components to a patient for up to six weeks at a time to support them and their carer(s) through a crisis in their own home setting, potentially avoiding the need for inpatient care. In support of the DIST there are two 'Alternative to Admission beds' see (3.6) in West Norfolk and access to specialist beds at the Julian Hospital in Norwich for those few patients who have more complex and challenging needs.

- Over the nine months between August 2013 and April 2014 DIST took an average of 27 new referrals and discharged an average of 19 patients each month, many more than had received a service through the inpatient beds.

Way Forward:

- The pilot appears to have been a success in terms of the number of WNCCG patients seen and the favourable views expressed about the new service from people with dementia and their carers. However, given complications with recruitment which delayed the start of the pilot, WNCCG will extend the DIST pilot period, which includes the suspension of Chase and Tennyson Wards at Chatterton House, to have more information and to allow more time to gain the response of GPs to the changed service design and to consult more users of the service and their carers more extensively.

- Work with Care Homes to enhance training about Dementia and give confidence of Carers in the Homes who are so important to the quality of life of people with dementia as in Winchley Care Home (see 3.1).

4. CONCLUSION

The West Norfolk Action Plan for Dementia was quickly superseded by action being taken or by events. This Statement of Strategic Direction is likely to require review and replacement within 6 months.

System-wide review of health services in West Norfolk

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

A report from NHS West Norfolk Clinical Commissioning Group on the review of health and social care systems in West Norfolk in response to financial pressures, demographic trends and rising demand for healthcare.

1. Background

1.1 The Chief Officer of NHS West Norfolk Clinical Commissioning Group (CCG) reported to Norfolk Health Overview and Scrutiny Committee (NHOSC) on 16 January 2014 about a system wide review of services underway in west Norfolk. The review had been instigated because the way in which health and social care were currently configured in west Norfolk was financially unsustainable. It was considered that the only way in which long term sustainability of the area's health and social care services could be achieved was through system reconfiguration and enhancing integrated care with adult social service.

1.2 In January phase 1 of the review had been completed and phase 2 was starting. This was expected to produce a 'blueprint' for future service reconfiguration in west Norfolk within 6 months. It appeared likely that the review would eventually lead to proposals for changes to services in west Norfolk for which consultation with NHOSC may be required.

2. Purpose of today's meeting

2.1 West Norfolk CCG has not yet reached a point where it is ready to consult NHOSC about proposals for change in west Norfolk but the CCG has been invited to update NHOSC on progress with phase 2 of the system sustainability review and the next steps. The CCG's report is attached at Appendix A.

3. Suggested approach

3.1 After the representative of the CCG has presented the report, NHOSC may wish to raise questions in the following areas:-

(a) In January 2014 NHOSC was told that there would be a 'blueprint' for future redesign of the west Norfolk services by July 2014. Would the CCG say it has arrived at that stage yet or is there further work to be done on the basic redesign plans?

(b) How will the pilot of changes to mental health services in west Norfolk (which is likely to continue to March 2015) be integrated with the work of the system-wide review?

(c) Monitor's Contingency Planning Team for the Queen Elizabeth Hospital will arrive in September 2014. Monitor usually works independently with hospitals in special measures to make the necessary changes to ensure financial sustainability. Is it realistic to expect it will work collaboratively with the West Norfolk Alliance?

(d) Since April 2014 the CCG has used Transformation Funds to cover costs for the current financial year. Given that the reconfiguration of services to achieve sustainability could take 2 – 5 years from 2015, is the funding stream secure for west Norfolk services and for the Queen Elizabeth Hospital in particular?

(e) The Clinical Reference Group's early view for the Queen Elizabeth Hospital envisages minor cases who currently go to A&E being treated elsewhere. Does this mean diversion to primary care for patients who should not have come to A&E in the first place or does it mean a separate, new service for patients who legitimately use A&E at present?

(f) The Clinical Reference Group envisages 'some' elective care at the QEH. Is there any indication as yet of what proportion of the hospital's current elective surgical procedures would be carried out elsewhere in future?

(g) The CCG's report mentions intermediate care beds as one of the integration work streams. Historically west Norfolk has had few intermediate care beds. What progress has been made in this work stream?

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Appendix A

NHS
West Norfolk
Clinical Commissioning Group

Subject:	**West Norfolk System Sustainability Programme**
Presented by:	**Kathryn Ellis, Director of Operations, West Norfolk CCG**
Submitted to:	**HOSC, September 4th 2014**
Purpose of Paper:	**Progress update**

Executive Summary:

West Norfolk CCG faces a health and social system sustainability challenge due to unrelenting financial pressures, demographic trends and rising demand for healthcare. The acute Trust, Queen Elizabeth Hospital NHSFT (QEH) is in 'special measures' with Monitor due to a financially unsustainable position and CQC concerns over quality of care. A briefing paper in October 2013 outlined the scale of the challenge facing the West Norfolk system as a whole and an update was presented in January describing the completion of the System Sustainability Programme Phase 1 and commencement of Phase 2. This paper describes current progress with this Programme of work to identify long term solutions for the locality.

1. Introduction

This paper provides an update on the System Sustainability Programme, a complex piece of work focussing on developing locally derived, clinically driven, long term solutions to the challenge we face as a Local Health Economy (LHE). This challenge can be summarised as the following:

- We know that if we continue to provide services in the way that we currently do, it will be unaffordable in the future; and
- Patients tell us that services are often fragmented and poorly coordinated and they are not sure where to go for help.

The West Norfolk Health and Social Care Alliance is addressing this challenge through a number of working groups with the aim of using integration to provide 'sustainable co-ordinated care with patients in control'. Members will be aware that the Alliance membership includes health and social care commissioners and providers, borough council, general practice and the voluntary sector. Whilst the focus is West Norfolk, some organisations have a wider catchment area and the CCG is also building strong links with Fenland Locality Commissioning Group as an associate commissioner of QEHKL and with Cambridgeshire Social Services through the local System Resilience Group in King's Lynn.

Alongside the System Sustainability programme of work, the hospital regulator Monitor is sending a Contingency Planning Team (CPT) into The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (QEHKL) to develop options for ensuring a sustainable District General Hospital configuration. The CPT and the Clinical Commissioning Group (CCG) will work closely together drawing on the results of the System Sustainability Programme work-streams to develop local solutions for the acute trust and the LHE. This approach is quite different from previous CPT interventions elsewhere in the country where Monitor has directed the programme in a linear fashion, without addressing the wider LHE context. West Norfolk CCG has managed to achieve a

more collaborative approach on this occasion, assisting Monitor to select the CPT and ensuring that the work completed by the System Sustainability Programme, i.e. locally developed intelligence, is incorporated into the CPT plan.

2. The national Integration Pioneer Programme

HOSC may remember that the West Norfolk Alliance was initially selected as one of the 15 national 'Integration Pioneers' but just prior to the announcement this decision had to be revoked due to the acute trust being put into Special Measures by Monitor. However, the Alliance has since been awarded 'Special Status' which has resulted in us receiving the same level of support and access to resources as the other Pioneers and we are seen as a 'test case' for creating system integration as the solution to an unsustainable LHE. The support available has included invitations to a number of seminars and events, focusing on un-blocking the barriers to integration and supporting the implementation of innovative solutions. A local development support manager has also been attached to the Alliance, to agree a development programme and the evaluation process.

3. System Sustainability Programme structure

There are a number of inter-related work-streams exploring the current position, the future potential for improvement and the process for achieving it. The whole programme is coordinated through a Programme Management Office (PMO) comprehensive plan. The reporting structure for the programme is illustrated at Appendix 1.

The PMO Operational Group reviews the weekly progress made by each of the project groups and reports weekly to the CCG, Monitor and NHS England. The project groups include:

- Clinical Reference Group and associated Care Pathway sub-groups (maternity, paediatrics and frail elderly);
- Workforce Transformation Group;
- IM&T Infrastructure Group;
- Integration Group;
- Communication & Engagement Group.

Detailed project plans have been developed for each of the project groups and these are incorporated within the system sustainability programme plan.

3 Clinical Reference Group

The Clinical Reference Group provides a focal point for identifying emerging themes across the various work-streams as well as identifying the clinical interdependencies that are required to support future services in the local acute hospital setting. Membership comprises some 18 senior clinical colleagues attending from the main NHS and social care providers in West Norfolk. The main focus of the group is to inform the future development of clinical services through four “envelopes of clinical care”:

- Maintaining independence and health and wellbeing, with care provided in the community;
- Transfer to a local acute hospital (secondary care setting)for acute intervention;

- Transfer from secondary care to tertiary care (outside of West Norfolk);
- The returning "home" process – discharge planning.

The CRG provides clinical oversight to the programme in order to identify the potential service options that support the wider work which will progress with Monitor's Contingency Planning Team (CPT) that informs the local specified services required at the QEHKL, informed by the detailed work being undertaken by the three care pathway groups:

- frail elderly care;
- maternity care;
- paediatric care

4. Integration work-stream

Work has progressed in the following schemes, establishing terms of reference and project plans:

- Establishing a consistent Integrated Care Organisation Model across the CCG;
- Establishing a more integrated reablement service;
- Hospital discharge – social care 7 day working;
- Supporting independence and well-being – creating a community care navigator network;
- Dementia care – improving community support and diagnosis;
- Intermediate care beds.

The integration work-stream is responsible for implementing the Better Care Fund (BCF) Plan, which will be overseen by the Health and Wellbeing Board. This work would be carried out regardless of the BCF programme, as it is part of the Alliance integration plan, so funding from the CCG is already committed to the initiatives and will be drawn from the part of the BCF allocated to them.

5. Enabling work-streams

The other work-streams, whilst having their own project plans, act as enablers to pick up issues for exploration that have been highlighted by the clinical pathway and integration groups, such as how to prepare the workforce to deliver re-configured services and how to develop more effective financial and contracting mechanisms.

5.1 The workforce work-stream has carried out a stocktake of current workforce challenges in the locality across organisations and will be initiating a number of initiatives to address recruitment, retention and staff skills development to enhance integration.

5.2 The IM&T work-stream has conducted an assessment of the IM&T systems across the Alliance partners and has created a draft data sharing and information governance agreement. A major innovation this group is implementing is a 'Smartcard' for patients to give permission to those caring for them to share information about their care. A pilot is commencing in September using this card with 4 care homes in West Norfolk, supported by a medical remote triage system.

5.3 The communications and engagement work-stream has coordinated information on the Alliance which has been shared at the Alliance launch and within all the organisations. A website has been established and will be a publicly available resource for information on the Programme. A series of stakeholder events are planned and will be built on by the CPT once in place.

6. Early findings of clinical group

The work of the Clinical Reference Group has helped to determine an early view of what services at the local acute Trust should look like:

- It should be a centre of excellent care for the majority of West Norfolk patients' health needs, i.e. elderly care (hips, knees, eyes) and maternity;
- It should have senior clinical triage at the 'front door' providing 24/7 emergency assessment in medicine, surgery, mental health and injuries;
- Minors in A&E could possibly be treated in an alternative setting;
- There should be a MDT (multi-disciplinary team) approach to care, both in hospital and across all settings;
- There should be a frail elderly urgent care pathway with effective proactive discharge planning;
- There should be some elective care, the scope of which should be determined by:
  - What can be done to a high standard locally;
  - What could be done locally supported by a clinical network/secondary care partnership with clinical rotation with a specialist centre; and
  - What should definitely only be done in a specialist centre.
- An accessible maternity service, high performance and quality outcomes from the service, options for care are essential, with consistency of care and information throughout the patient journey.
- An efficient acute paediatric service with an appropriate setting for patients self-presenting to A&E, smooth transitions between secondary and tertiary centres, with the process to discharge clear, parents and carers sufficiently supported to keep their children well and enabled to care for their children when unwell.

The early findings above highlight key elements of care which will be tested at clinical workshops, using a variety of clinical scenario to test what other services might need to be 'layered' on top of the key elements identified, to ensure that patients in West Norfolk will receive safe care in the right place. This helps us to articulate what type of consultants should be available, define the medical and non-medical teams they need to support them, and therefore the shape of the workforce and the resources they need to provide the service.

7. Working with Monitor CPT

The Monitor CPT is expected to be in place late-September and will be directed by Monitor to run a strictly governed process to determine options for securing a sustainable District General Hospital. The Alliance will work very closely with the CPT, sitting alongside each other and reporting through the same routes, to ensure one programme of work is conducted, not two.

8. Public involvement

Patients and the public have been involved in reviewing services in a variety of ways to date, through attending our pathway groups on dementia and End of Life care, through attending stakeholder events and public conferences and responding to surveys. The CCG and wider Alliance also regularly presents at a variety of fora, such as Mental Health, Older People, and the

Disability Forum. Public involvement will be a key priority in the coming months as it is essential that they have a clear understanding of the challenge facing the system and are involved in helping to decide what to do about it. A series of events are planned for September by the CCG and there will be a further comprehensive public involvement plan developed once the CPT arrives.

9. Implementation timeframe

The timescale for the implementation of the system-wide change in West Norfolk should be considered as having several stages. The initial CPT programme will report at the end of January 2015 on proposed options for the locality. At this point, depending on the recommendations, there is likely to be a public consultation. NHOSC will also be formally consulted, allowing sufficient time for debate before any changes affecting patients will be implemented. Subsequent to this, there will be an implementation stage, which again, depending on the proposals and outcome of consultation may take 2-5 years to be fully completed.

10. Funding

In January 2014 NHOSC heard that the CCG had secured £200,000 of transitional funding to be used in the west Norfolk health system until April 2014. This funding was specifically allocated for the costs of running the System Sustainability Programme. Since April, the CCG has allocated resources from their Transformation Fund to cover the costs for this financial year. This funding will be substantially added to by the Monitor CPT resource joining the programme and providing some fully-funded additional capacity and expertise.

11. Recommendation

Members are asked to note the progress of the West Norfolk Alliance System Sustainability Programme. Further information will be brought in good time to alert HOSC to any likely major service changes that will require formal consultation.

Proposed relocations of NHS community healthcare services

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

Norfolk Community Health and Care NHS Trust will consult the committee about proposed relocation of community health care services in Norfolk as part of a rationalistion of the Trust's estate.

1. Introduction

1.1 Norfolk Community Health and Care NHS Trust (NCH&C) is proposing to relocate some of its services as part of a rationalisation process to make savings through best use of its estate.

1.2 In the first year NCH&C's relocation plans affect community health services currently based in Norwich and Sheringham. The relocations range between a distance of 0.6 miles and 5.4 miles. Services to patients would not be reduced under these proposals.

1.3 Full details of the proposed relocations and the pre-engagement process with Clinical Commissioning Groups, GPs and NHS England are provided in NCH&C's report at Appendix A.

2. Purpose of today's meeting

2.1 NCH&C will attend today's meeting to seek NHOSC's view on whether the Committee considers the current relocation plans as a substantial variation to service and, if so, to consult the Committee about the proposals.

Under the Health and Social Care Act 2012 local NHS commissioners and providers are required to consult NHOSC about any proposals for substantial variations or developments in local services. 'Substantial' is not defined in law but is for the NHS body and health scrutiny body to agree in each case. It can be a minor change in service that affects a great number of people or a change that affects a small number of people but has a very great impact on the individuals' lives.

2.2 The Trust has recently completed a patient / public engagement process regarding the proposals and a representative will present the feedback at today's meeting.

3. Suggested approach

3.1 After receiving NCH&C's report and presentation, NHOSC may wish to:-

(a) Raise any questions with NCH&C and the commissioners to clarify Members' understanding of the proposals.

(b) Consider whether or not it regards NCH&C's proposals, or any part of them, as a substantial variation in service.

If the proposals are not regarded as a substantial variation in service then no further action is required. If the proposals are regarded as substantial then NHOSC may wish to:-

(c) Consider whether or not it wishes to make any comments or recommendations for NCH&C to take into account before the Trust decides on relocation of services.

(d) Decide whether or not it requires NCH&C to report back with its decisions on relocation of services, at which point NHOSC could consider:-

a. Has the consultation with the committee been adequate?
b. Are the proposals in the interests of the local health service?

Any further steps that NHOSC might wish to take in exercise of its health scrutiny powers could also be considered at that point.

3.2 The current proposals form the initial stage of a rationalisation of NCH&C's services which is likely to take place over several years. NHOSC may wish to ask NCH&C to inform it in good time of any future proposed relocation of services through the NHOSC Briefing.

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Estates Rationalisation – Public & Service User Engagement Output Report – 28 August 2014

Presented by:

Mark Easton – Interim Chief Executive of NCH&C

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1.0 Introduction

Norfolk Community Health & Care NHS Trust (NCH&C) would like to centralise and bring services together across some of the Trust's largest locations to improve organisational and clinical efficiencies, maintain or enhance on site facilities and reduce costs and carbon. To do this, the Trust is proposing to relocate a number of services in line with its board approved five year strategy. These proposals will make no change to the services we provide, other than their delivery location and in some cases they will improve access by car or public transport. Proposals are planned to be implemented from the 1st October 2014 subject to feedback received from the public, service users and stakeholders during the consultation programme and approval from the Trust board on the 24th September 2014. The following table outlines the services proposed to relocate, the number of active patients affected and the additional travel required:

Locality	Current Location	Service	Number of Active Patients *	Proposed Location Information	Distance from Current Location
Norwich	Adelaide Street Health Centre	**Looked After Children** offers countywide services to children and young people in the care of the Norfolk County Council.	1297	**Upton Road Children's Centre** is the key centre for local Children's Services in Norwich which offers children, young people and their carer's access to a range of professional clinics. Patients will experience the same amount of parking facilities and better access from A47 and A11.	0.9 miles
		Paediatric Speech & Language Therapy is a Service for children who have difficulty communicating, understanding, speaking, swallowing, drinking or eating.	26	**Norwich Community Hospital** is NCH&C's largest site and offers a diverse range of expert services for children, young people and adults. Patients will benefit from larger pay and display parking facilities.	0.6 miles
	Bowthorpe Health Centre	**Paediatric Speech & Language Therapy** – as above.	64	**Norwich Community Hospital** is NCH&C's largest site and offers a diverse range of expert services for children, young people & adults. Patients benefit from larger pay & display parking facilities.	2.2 miles
		Dental Services provided for people of all ages in Norfolk with Learning Disabilities.	299	One of the following locations depending on the needs of the patient: **Norwich Community Hospital** – as above. **Thorpe Health Centre** is another key health centre within the Norwich locality offering greater specialist facilities for patients. Patients will experience the same amount of parking.	3.0 or 3.9 miles
	West Pottergate Health Centre	**Family Support Services** offers counselling and other forms of psychological support to help people cope with the emotions and changes faced during illness, end-of-life care and bereavement.	32	**Norwich Community Hospital** is NCH&C's largest site and offers a diverse range of expert services for children, young people and adults. Patients will benefit from larger pay and display parking facilities.	1.2 miles
		Asperger Services offers assessment, guidance and support for people who have been diagnosed with Asperger Syndrome	200		

North	Sheringham Health Centre	**Continence Clinics** offers a specialised team of nurses and physiotherapists dedicated to providing an assessment and treatment plan for adults who have continence issues.	70	**Kelling Hospital** is NCH&C's largest site in the North locality and offers patients expert rehabilitation within a welcoming, relaxed, and professional care setting.	5.4 miles
		Leg Ulcer Clinics provides assessment, management and treatment of venous leg ulcers including health promotion and follow up care in order to prevent recurrence.	8		
		Muscular Skeletal Physiotherapy offers assessment, treatment, advice, education and support on a range of musculoskeletal problems.	60		

** Active patients as of 20.08.14. Numbers may vary over time depending on referral / discharge from care.*

Locality based project groups represented by a range of service and clinical disciplines across the Trust have met on a fortnightly basis to manage delivery of these proposals and report progress to our Trust Board. Equality and quality impact assessments were completed prior to the launch of public and service user engagement on the 1st August 2014. These assessments tell us that although the staff and the service will remain the same, service users may experience positive or negative impacts on one of the following, depending on their personal circumstance and the proposed location:

- Travel to and from appointments
- On site parking facilities
- Service delivery environment

Please see section 5, appendix 1 sets out details of the equality and quality impact assessments for public and service user engagement.

The consultation programme launched on the 1st of August 2014 and will conclude on the 11th of September 2014. This report provides details and outputs of the public and service user engagement which closed on the 29th of August 2014, for consideration by the Norfolk Health Overview & Scrutiny Committee (HOSC).

2.0 Pre Engagement Feed back

The proposals have been discussed with Norfolk CCGs and NHS England. The following summarises pre-engagement feedback received.

2.1 Clinical Commissioning Groups (CCG's)

North Norfolk CCG

General Feedback:

The North Norfolk CCG recommended that the Trust undertake engagement with GP stakeholders and the CCG engagement manager. They also stated that estates planning should include a step to calibrate the plan in line with CCG planning. Overall they support the requirement to rationalise the estate and become involved in a wider formation of strategy around asset development.

The Trust met with the GP's at Sheringham, Market Surgery (Aylsham), and Staithe Surgery (Stalham), in response to these recommendations. In response to the concerns raised by GP's at Staithe and Market Surgery, the Trust has excluded clinical services from its proposals for these two locations.

The CCG have expressed concern about the potential financial impacts of the proposed relocations under rules which permit NHS Property Services / Community Health Partnerships to pass on the cost of voids to the local CCGs. The Trust is aware that paragraph 4.3.1 of the guidance to the Local Authority (Public Health and Wellbeing Boards and Health Scrutiny) Regulations 2013, recommends that providers do not present directly to the Health Overview and Scrutiny Committee and that the local CCG must exercise the obligation to present any proposal on behalf of the provider. The Trust has sought and received confirmation from North Norfolk and Norwich CCGs that the engagement and consultation process has been robust and appropriately applied, and has committed to working together with commissioners to assist in the mitigation of cost pressures resulting from the process.

Sheringham Health Centre

The GP's highlighted the potential loss of co-location benefits resulting from the proposed relocation of NCH&C services and showed concern for particular patient groups. They believe that the general public may see them as responsible for the service relocation and are concerned about the reduction in income from NCH&C.

In response to these concerns NCH&C has maintained continued liaison with the practice to ensure they remain aware of the planned developments. NCH&C provided additional drop in services for general public / patient feedback on the service proposals to answer questions raised.

Norwich CCG

General Feedback:

The Norwich CCG recommended that the Trust undertake service user engagement alongside the CCG Engagement Manager. They also recommended meetings with the affected GP practices as a courtesy and raised concern around impacts on the patient groups for Adelaide Street due to the poverty known in this area. Norwich CCG confirmed that they were also planning a commissioning strategy based on a locality principle with hub and spoke approach to property. The Trust have contacted the affected GPs in response to these recommendations and are due to meet with each in September.

South & West Norfolk CCGs

Although there are no proposals affecting the South and West Norfolk CCGs this year, NCH&C met with each in advance of proposals in future years.

2.0 Pre Engagement Feed back

2.2 NHS England (NHSE)

The rationalisation plan affects some services directly commissioned by NHSE e.g. Health Visitors. A meeting held with NHS England confirmed:

- The services changes proposed were recognised and understood to resent minimal affect to the contracted service requirement;
- Welcomed Trust steps taken toward the engagement of patient / public groups and CCGs.
- Stated they were assured by the plans explained and steps taken, but would like to continue to be kept involved.

3.0 Public & Patient Engagement

Norfolk Community Health & Care (NCH&C) have engaged with the public and its service users on the relocations proposals. The following summarises engagement methods used.

3.1 Public Engagement

NCH&C have agreed with the CCG engagement managers to engage with affected service users rather than the wider public. The Trust launched a page on the NCH&C public internet site on the proposed relocation of services which provides members of the public with ways to get in touch with the Trust regarding these proposals.

3.2 Service User Engagement

NCH&C consulted with the North Norfolk and Norwich CCG engagement managers to develop and agree materials to be used for service user engagement. Materials consisted of an introductory letter, relocation questionnaire and information on the alternative transport options available. Details of how to respond were provided along with alternative ways for service users to feedback to NCH&C such as an electronic version of the questionnaire, email address and telephone number. Please see 5.2 for an example of the materials used.

3.0 Public & Patient Engagement

The following table summarises the method of engagement for each of the nine services across four locations. The North Norfolk and Norwich CCG engagement managers advised NCH&C that active patients should be contacted individually, or via a representative group / society where appropriate, to outline the proposal, provide information on alternative transport and obtain feedback over an engagement period of 4-6 weeks.

Location	Service	Method of Engagement
Adelaide Street Health Centre	Looked After Children	Norfolk County Council (NCC) contact foster carers by email on a weekly basis as part of the service. They therefore advised that this would be the most appropriate method to obtain feedback for children in foster care. NCC agreed to send materials out on behalf of NCH&C due to data protection considerations. Materials were sent by email to 306 foster carers on the 13th August 2014. In addition, NCH&C circulated engagement materials to the In Care Council meeting members for feedback on behalf of all other service users.
	Paediatric Speech & Language Therapy	Materials were sent by post to 26 service users on the 1st of August 2014 as advised by the NCH&C service lead.
Bowthorpe Health Centre	Paediatric Speech & Language Therapy	Materials were sent by post to 64 service users on the 1st of August 2014 as advised by the NCH&C service lead.
	Dental Services	Materials were sent by post to 299 service users on the 4th of August 2014 as advised by the NCH&C service lead. Of the 299, 179 were sent to the relevant care home manager for them to establish users which were able to participate.
West Pottergate Health Centre	Family Support Services	Due to the nature of this service, the NCH&C service lead identified a selection of users to participate. Materials were sent by post to four service users on the 1st of August 2014.
	Asperger Services	Current service users will not be affected by the relocation due to discharge prior to the 1st October 2014. Therefore NCH&C engaged with Aspergers East Anglia to obtain feedback on behalf all future service users.
Sheringham Health Centre	Continence Clinics	Materials were distributed to patients attending appointments during clinics held between the 1st of August 2014 and the 29th August 2014. The number of questionnaire distributed will be confirmed during the presentation on the 4th September. Additional drop in services were provided by clinical and non clinical representatives from the project group during clinics held on the 15th and 21st of August to answer any questions raised.
	Leg Ulcer Clinics	
	Muscular Skeletal Physiotherapy	

3.0 Public & Patient Engagement

3.3 Output for Consideration

Due to the date of this report, a summary of public and patient engagement will be presented at the NHOSC meeting on the 4th September 2014.

4.0 Next Steps & Recommendations

4.1 Next Steps

The consultation of NHOSC presents one of the final elements of engagement outlined in the consultation programme. A summary of findings and recommendations arising from stakeholder engagement will be prepared by the Trust project team following closure of engagement on the 11th September 2014. The following key activities will then occur:

a) Presentation of feedback and findings to Trust Executive Team on the 16th September 2014
b) Issue of feedback, findings and summary recommendations to the Trust Board on the 17th September 2014
c) Decision and approval of the Trust Board on the 24th September 2014
d) Subject to the above approvals, implement agreed relocations from the 1st October 2014

5.1 Impact Assessments

Equality Impact Assessment (EQIA)

Scheme Name	Estates Rationalisation Year 1

1. Project Summary		EQIA Completion Details
Title: Estates Rationalisation Year 1		Names and Post Titles of staff involved in completing the EQIA:
Project Status: (see above)	Proposed	Mark Page, Assistant Director - Estates, Facilities & Procurement
		Samantha Whiteley, Project Manager
Associated Projects:		
1.	Estates Rationalisation Year 2	
2.	Estates Rationalisation Year 3	
3.	Estates Rationalisation Year 4	
3.	Estates Rationalisation Year 5	Date: 29.07.14

2. Project Details

Who is likely to be affected by the project?

Staff [ ] Patients [X] [X]

3. Project impacts

Which elements within the Equality Act 2010 are impacted upon	Probable impact? Positive	Adverse	None	High, Med. or Low	Please explain. Include any mitigating actions in Section 7. below
Age		X		Low	The relocation of services from current locations to proposed may affect the travel / access options of the service user. Mobility of a service user may present further restrictions as a result of longer travel times. Facilties for service users in locations receiving the transferred services, will require similar environments / facilities for patient / public users e.g. LAC services.
Disability		X		Low	Services will be accommodated in fully compliant premises, however, some service users may experience travel / access issues as a result of change.
Gender re-assignment			X		
Marriage & civil partnership			X		
Pregnancy & Maternity		X		Low	Some services are accessed by service users with young children. The proximity of services to user groups may provide greater convenience currently than the options for relocation. Travel and access may therefore be affected for this group.
Race inc. nationality and ethnicity			X		
Religion or Belief			X		
Gender			X		
Sexual orientation			X		

3. Project impacts (cont.)

In addition to the above, it would be helpful if you could consider any implications of this project e.g. sustainability, travel.

	Probable impact? Positive	Adverse	None	High, Med. or Low	Please explain
Travel	Yes	Yes		Medium	Relocation distances are minimised through selection of nearby properties. In some rural parts, availability of public transport may decrease opportunity for service access. Distance required to travel may, in some cases, decrease.
Clinical Services	Yes			Medium	Planned provision of services remains constant. Appointments and availability of service is not reduced by relocation to another site. Some sites offer enhanced access / services e.g. Norwich Community Hospital.

4. Differential Impact identified

Considering the type of differential impact identified, is this discriminatory according to legislation?

Yes (Complete all of section 4) [ ] No (Go to section 5) [X]

5. Type of Discrimination

If the type of discriminatory action identified is not unlawful, does it still have an adverse affect?

6. Proposals

How could the identified adverse effects be minimised or eradicated?

Adverse effects are mitigated through a range of actions which include:
- Providing service users with adequate travel information;
- Ensuring new Facilties accommodate the needs of service users e.g. disability access
- Engaging with service users to identify the specific impacts and gauge their views on the proposals , thus enabling additional action to be planned.

Would such changes ensure that the project complies with all relevant legislation, therefore making it legal and good practice?

Yes — If No, what reasonable adjustments would be required to ensure compliance?

7. Project Implementation

Upon consideration of the information gathered within the EQIA, the Assistant Director agrees that the project should be implemented.

Name and Title of Assistant Director: (Please print) MARK PAGE **Date:** 29/07/14

8. Proposed date for Review

Please detail the date for review: 01 September 2014

Quality Impact Assessment (QIA)

Current Location	Proposed Location	Description of Quality Impact What is the impact on quality resulting from relocation?	Patient Safety	Clinical Effectiveness	Patient Experience	Defined Tolerance Level What level of risk is acceptable?	L How likely is it to happen?	C If it does happen what will be the consequence?	Score	Quality Indicator What will we use to measure this?	Method of Monitoring On what system / process?	Quality Impact Mitigation What will we do to try and prevent this from happening?				L Now how likely is it to happen?	C and the consequence?	Score
												Action	Owner	End Date	Progress			
Sheringham Health Centre	Kelling Hospital	Appointment delays / cancellations caused by increase in travel required		√	√	4	2	4	8	1. No of weeks waiting 2. No of complaints	1. Performance Reports 2. DATIX reports	Evaluate impact for current service users using output of service user enagegment.	S. Whiteley	29/08/14	15.08.14 Some responses received - travel by car, some agree others neither agree or disagree but all responded will need to travel further than they do now as sheringham based.	2	4	8
Adelaide Street Health Centre	Norwich Community Hospital	Appointment delays / cancellations caused by increase in travel / parking payments required		√	√	4	2	4	8	1. No of weeks waiting 2. No of complaints	1. Performance Reports 2. DATIX reports	Evaluate impact for current service users using output of service user engagement.	S. Whiteley	29/08/14	15.08.14 Some responses received - already travel from Kings Lynn so agree / neither agree or disagree with changes. no issues raised re: parking to date.	1	4	4
Adelaide Street Health Centre	Norwich Community Hospital	Reduced uptake of service / increase in 'missed' appointments due to ineffective communication of new contact information		√	√	4	2	4	8	1. No of weeks waiting	1. Performance reports	Operational staff to ensure stationary is updated from 1st of October 2014.	S. Wynne	01/10/14	15.08.14 Awaiting proposal approval	1	4	4
Adelaide Street Health Centre	Upton Road Children's Centre	Appointment delays / cancellations caused by increase in travel required		√	√	4	2	4	8	1. No of weeks waiting 2. No of complaints	1. Performance Reports 2. DATIX reports	Evaluate impact for current service users using output of service user enagegment.	S. Whiteley	29/08/14	15.08.14 Some responses received - travel by car, some agree others neither agree or disagree but all responded will need to travel further than they do now as sheringham based.	2	4	8
Adelaide Street Health Centre	Upton Road Children's Centre	Reduced uptake of service / increase in 'missed' appointments due to ineffective communication of new contact information		√	√	4	2	4	8	1. No of weeks waiting	1. Performance reports	Operational staff to ensure stationary is updated from 1st of October 2014.	B. Small	01/10/14	15.08.14 Awaiting proposal approval	1	4	4
Bowthorpe Health Centre	Thorpe Health Centre	Appointment delays / cancellations caused by increase in travel required		√	√	4	2	4	8	1. No of weeks waiting 2. No of complaints	1. Performance Reports 2. DATIX reports	Evaluate impact for current service users using output of service user enagegment.	S. Whiteley	29/08/14	15.08.14 Some responses received - travel by car, some agree others neither agree or disagree, some will travel less to thorpe. Some concerns raised by those offered either NCH / Thorpe with the distance to Thorpe due to mobility.	2	4	8
Bowthorpe Health Centre	Thorpe Health Centre	Reduced uptake of service / increase in 'missed' appointments due to ineffective communication of new contact information		√	√	4	2	4	8	1. No of weeks waiting	1. Performance reports	Operational staff to ensure stationary is updated from 1st of October 2014.	A. McQuistin	01/10/14	15.08.14 Awaiting proposal approval	1	4	4

Current Location	Proposed Location	Description of Quality Impact What is the impact on quality resulting from relocation?	Patient Safety	Clinical Effectiveness	Patient Experience	Defined Tolerance Level What level of risk is acceptable?	L How likely is it to happen?	C If it does happen what will be the consequence?	Score	Quality Indicator What will we use to measure this?	Method of Monitoring On what system / process?	Quality Impact Mitigation What will we do to try and prevent this from happening?				L Now how likely is it to happen?	C and the consequence?	Score
												Action	Owner	End Date	Progress			
Bowthorpe Health Centre	Norwich Community Hospital	Appointment delays / cancellations caused by increase in travel / parking payments required		√	√	4	2	4	8	1. No of weeks waiting 2. No of complaints	1. Performance Reports 2. DATIX reports	Evaluate impact for current service users using output of service user engagement.	S. Whiteley	29/08/14	15.08.14 Some responses received - Some disagree because of parking charges and further to travel.	2	4	8
Bowthorpe Health Centre	Norwich Community Hospital	Reduced uptake of service / increase in 'missed' appointments due to ineffective communication of new contact information		√	√	4	2	4	8	1. No of weeks waiting	1. Performance reports	Operational staff to ensure stationary is updated from 1st of October 2014.	A. McQuistin, S. Wynne	01/10/14	15.08.14 Awaiting proposal approval	1	4	4
West Pottergate Health Centre	Norwich Community Hospital	Appointment delays / cancellations caused by increase in travel / parking payments required		√	√	4	2	4	8	1. No of weeks waiting 2. No of complaints	1. Performance Reports 2. DATIX reports	Evaluate impact for current service users using output of service user engagement.	S. Whiteley	29/08/14	15.08.14 No responses to date.	2	4	8
West Pottergate Health Centre	Norwich Community Hospital	Reduced uptake of service / increase in 'missed' appointments due to ineffective communication of new contact information		√	√	4	2	4	8	1. No of weeks waiting	1. Performance reports	Operational staff to ensure stationary is updated from 1st of October 2014.	T. Dryhurst, P. Humphreys / Meadhbh Hall	01/10/14	15.08.14 Awaiting proposal approval	1	4	4

5.2 Engagement Materials

Elliot House
130 Ber Street
Norwich
NR1 3FR

Tel: 01603 697404 (message only service)
Email: RelocationProposals@nchc.nhs.uk
Website: www.norfolkcommunityhealthandcare.nhs.uk

Dear Service User

RE: Leg Ulcer Survey

We are writing to ask if you would kindly complete the enclosed survey as someone who has used the Leg Ulcer Service at Sheringham Health Centre in the past 12 months.

Norfolk Community Health and Care NHS Trust is looking to further improve the delivery of efficient health and care services to our patients by exploring the possibility of providing the Leg Ulcer Service from an alternative location nearby.

Before we make any decisions, we would like to ask you what you think about the move and, although the service provided will not be affected by this change, we would like to take the opportunity to ask you what you think of the current service, what's good about it at the moment and what could be improved.

Have your say
The enclosed survey should only take a few minutes to complete. Once completed, please return it using the pre paid envelope provided.

Alternatively, you can complete the survey online at:
https://www.surveymonkey.com/s/LegUlcer-Sheringham

If you would like to discuss this proposal before completing the survey, please do not hesitate to contact me.

Yours Sincerely,

Beverley Kemp
Team Lead

Proposed relocation of the Leg Ulcer Service

Norfolk Community Health and Care NHS Trust (NCH&C) are proposing to relocate the Leg Ulcer Service from Sheringham Health Centre to Kelling Hospital with effect from October 1, 2014.

This proposal aims to make better use of NHS property and reduce the Trust's impact on the environment. The service you receive and the staff who provide your care will not be affected; however, you may experience some changes to your travel to and from your appointments on or after October 1, 2014. Please see the attached travel outline for more information.

We would like to hear your views and understand the effect this may have, if any, on your experience of our service. This will help us identify any considerations we may need to take into account when finalising the proposal. Please can you take a few minutes to complete the questionnaire below and return it using the pre paid envelope provided by the August 29, 2014.

NCH&C will evaluate the responses received and provide general feedback on the proposal via our Trust website www.norfolkcommunityhealthandcare.nhs.uk by September 11, 2014. Should you wish to receive some individual feedback, please provide your name and address below:

_____

_____

Confidentiality
Reponses will be shared with NCH&C's Trust Board and the Norfolk Health Overview and Scrutiny Committee to enable them to consider respondents' views. All responses will remain anonymous.

Relocation Questionnaire

1. Are you:

Providing your own response ☐ Responding on behalf of someone ☐

*If responding on behalf of someone, please provide their answers for each question. You may also be interested in providing your personal views in section 11

2. How many times have you attended the Leg Ulcer Service at Sheringham Health Centre in the last 12 months?

_____

3. What three things worked well for you when using this service at Sheringham Health Centre?

1._____
2._____
3._____

4. What three things could have worked better at Sheringham Health Centre?

1._____
2._____
3._____

5. How do you currently travel to your appointments at Sheringham Health Centre?

On Foot ☐ By Bicycle ☐ By Car ☐ By Bus ☐ By Taxi ☐

Other, please specify:

_____

6. How long does it currently take you to get to Sheringham Health Centre?

Under 10 minutes ☐ 20-45 minutes ☐ Over 60 minutes ☐

10-20 minutes ☐ 45-60 minutes ☐

7. How would you travel to Kelling Hospital?

On Foot ☐ By Bicycle ☐ By Car ☐ By Bus ☐ By Taxi ☐

Other, please specify:

_____

8. Do you think it will take you less or more time to get to Kelling Hospital?

Less Time ☐ More Time ☐ About the same ☐ Don't Know ☐

9. Do you agree or disagree with the proposal to relocate the Leg Ulcer Service from Sheringham Health Centre to Kelling Hospital?

Strongly Agree ☐ Neither Agree nor Disagree ☐ Strongly Disagree ☐

Tend to Agree ☐ Tend to Disagree ☐

10. If you indicated that you tend to **disagree** or **strongly disagree**, please can you tell us why?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

11. If responding on behalf of someone are there any comments you would like to make?

_____
_____
_____
_____
_____
_____
_____
_____

Equalities Questionnaire (Optional)

Answering these monitoring questions helps us confirm if we are providing fair and equal access to all groups of people who need our services. It helps us understand if people are not using our services why that might be.

These questions are optional and if you don't feel comfortable then you don't have to give the information. Some people worry about giving information that may seem personal. Please be assured that the monitoring data below is treated as confidential under the Data Protection Act.

1. Are you:

Male	☐	Female	☐	Transgender	☐	Prefer not to say	☐

2. Do you have a disability or long term condition?

Yes	☐	No	☐	Prefer not to say ☐

3. Are you:

Under 25	☐	45 - 54	☐	75 - 84	☐
25 - 34	☐	55 - 64	☐	Over 85	☐
35 - 44	☐	65 - 74	☐	Prefer not to say	☐

4. Which of these groups do you consider you belong to? Prefer not to say ☐

White White British □ White Irish □ White Scottish □ White Welsh □ White Other (please specify) ……..	**Mixed Heritage** White and Black Caribbean □ White and Black African □ White and Asian □ Mixed Other (please specify) ……..	**Asian or Asian British** Indian □ Pakistani □ Bangladeshi □ Asian Other (please specify) ……
Black or Black British Caribbean □ African □ Black Other (please specify) ……..	**Chinese or other ethnic group** Chinese □ Any other (please specify) ……..	Gypsy/Traveller □ Other(please specify) …….. ……..

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5. What religion, religious denomination or body do you belong to?

None	☐	Roman Catholic	☐	Sikh	☐
Other Christian	☐	Muslim Buddhist	☐	Prefer not to say	☐
Church of England	☐	Pagan	☐	Other (please specify): ……..	

6. Are you:

Heterosexual	☐	Gay/Lesbian	☐	Bisexual	☐	Prefer not to say	☐

Thank you for sharing your views with us.

Please return your completed questionnaire by using the pre paid envelope provided.

Alternatively, you can complete the survey online at:

https://www.surveymonkey.com/s/LegUlcer-Sheringham

Proposed relocation of the Leg Ulcer Service

Norfolk Community Health and Care NHS Trust (NCH&C) is proposing to relocate the Leg Ulcer Service from Sheringham Health Centre, Cromer Road, Sheringham NR26 8RT to Kelling Hospital with effect from October 1, 2014.

Kelling Hospital

High Kelling, Holt, NR25 6QA Tel: 01263 713333

Overview

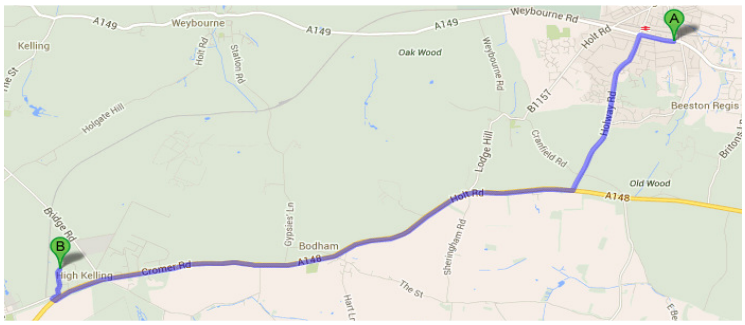
Kelling Hospital, close to the north Norfolk coast, offers patients expert rehabilitation within a welcoming, relaxed, and professional care setting. The hospital's 24-bed ward enables patients to receive professional care from our experienced nurses, therapists and support staff. Meanwhile, a range of clinics mean patients are able to access the care they need at a location which is convenient for them.

Parking and Visiting

There is a large car park available on site, including disabled spaces. There is no charge for car parking on this site. Priority is given to patients attending appointments. We advise all of our patients to arrive at this unit with enough time to find a car parking space before their appointment is due to start.

Journey Information

The information below shows the transport options available between Sheringham Health Centre and Kelling Hospital (approximately 6 miles). For information on how to get to Kelling Hospital from your home address or any other location, please visit the official Transport Direct website at: http://www.transportdirect.info/Web2/JourneyPlanning/.



Transport	Duration
Travel by bus:	25 minutes
Take a car:	11 minutes

If you need help getting to and from your appointment please contact the patient transport service on **0845 850 0774** to see if you are eligible or ask for advise on alternative options.

Need help?

Tel: 01603 697404 (message only service)
Email: RelocationProposals@nchc.nhs.uk
We aim to respond within 48 working hours

Working protocol with Healthwatch Norfolk

Report by Maureen Orr, Democratic Support and Scrutiny Team Manager

The committee is asked to approve a revised working protocol with Healthwatch Norfolk to reflect the new system of governance at Norfolk County Council.

1. Working protocol with Healthwatch Norfolk

1.1 Local Healthwatches were established by the Health and Social Care Act 2012 replacing the former Local Involvement Networks. Local Healthwatches have a statutory right to refer issues of concern to the appropriate committees of the County Council and, given their complementary powers, it makes sense for local Healthwatches and health scrutiny committees to coordinate their activities where possible.

1.2 On 7 March 2013 Norfolk Health Overview and Scrutiny Committee received a working protocol between the scrutiny committees and panels of Norfolk County Council and Healthwatch Norfolk. The protocol was also approved by the Healtwatch Norfolk Board and later by Community Services Overview and Scrutiny Panel and Children's Services Overview and Scrutiny Panel.

1.3 With the change to a committees system of governance at Norfolk County Council in May 2014 revisions are required to the working protocol with Healthwatch Norfolk. A revised version, showing the changes to the original document, is attached for NHOSC's comments and approval. Adult Social Care, Children's Services and Communities Committees and Healthwatch Norfolk will also be asked to agree the new working protocol.

2. Action

2.1 NHOSC is asked to approve the revised working protocol with Healthwatch Norfolk.

IN TRAN communication for all	If you need this report in large print, audio, Braille, alternative format or in a different language please contact Customer Services on 0344 800 8020 or 0344 800 8011 (Textphone) and we will do our best to help.

WORKING PROTOCOL BETWEEN COUNTY COUNCIL SCRUTINY AND SERVICE COMMITTEES ~~AND PANELS~~ AND HEALTHWATCH NORFOLK

The Health and Social Care Act 2012 introduced local Healthwatches to provide a collective voice for patients and carers and advise Clinical Commissioning Groups and social care commissioners on the shape of local care services to ensure they are informed by the views of the local community. Local Healthwatches are commissioned by upper tier local authorities ~~and replace the former Local Involvement Networks~~. A Local Healthwatch representative is one of the statutory members of the Health and Wellbeing Board.

Norfolk County Council respects the independence of Healthwatch Norfolk and recognises that there should be clear separation between the roles of the two organisations. This document sets out a protocol for how Healthwatch Norfolk and the County Council's scrutiny and service committees ~~and panels~~ will work together in relation to:-

- Exchange of information
- Referrals of issues to the health scrutiny committee and for the consideration of service committees ~~/ panels~~
- Co-ordination of activities

The relevant ~~scrutiny~~ committees ~~/ panels~~ are:-

- ~~Community Services Overview and Scrutiny Panel~~
- ~~Children's Services Overview and Scrutiny Panel~~
- Norfolk Health Overview and Scrutiny Committee – for scrutiny of NHS commissioned services and integrated health and social care services where the NHS is lead commissioner
- Adult Social Care Committee – for consideration of issues relating to social care services or integrated services where the County Council is lead commissioner
- Children's Services Committee – for consideration of issues relating to social care services or integrated services where the County Council is lead commissioner
- Communities Committee – for consideration of issues relating to County Council commissioned public health services.

This protocol will be subject to approval by these committees ~~/ panels~~ and Healthwatch Norfolk Board.

Exchange of information

1. In order to provide opportunities for regular exchange of information between the two organisations, informal meetings will be held between the appropriate ~~scrutiny~~ committee chairmen and the Chairman of the Healthwatch Norfolk Board on a regular basis. The main objectives of these meetings will be:-

a) to enable any issues arising to be discussed at an early stage (this will not prohibit Healthwatch Norfolk ~~-~~from contacting the Council with urgent concerns, either by telephone or email).

b) to discuss opportunities for co-ordination of Healthwatch Norfolk and ~~scrutiny~~ relevant committee ~~/ panel~~ activities in relation to particular issues.

2. Copies of the County Council's Health Overview and Scrutiny Committee, ~~Community Services Overview~~ Adult Social Care Committee ~~and Scrutiny Panel~~ and ~~the~~ Children's Services ~~Overview and Scrutiny Panel~~ Committee and Communities Committee agendas are ~~will be made~~ available to Healthwatch Norfolk on the County Council website and representatives of Healthwatch Norfolk will be welcome to attend public sessions of these committees ~~/ panels~~. Requests to address a committee ~~/ panel~~ should be made in advance to, and will be at the discretion of, the Chairman.

3. The appropriate scrutiny support or service department officer ~~/ manager~~ will receive a copy of the Healthwatch Norfolk's agenda papers and minutes for each meeting.

4. Healthwatch Norfolk may wish to nominate an individual to be the liaison person with each ~~scrutiny committee / panel~~ of the relevant committees.

5. By invitation of the Healthwatch Norfolk Board, a scrutiny support or service department officer ~~/ manager~~ may attend a Healthwatch Norfolk Board meeting where an item on the agenda relates specifically to an issue on which their ~~scrutiny officer~~ input is necessary and will help to inform debate or where the officer will glean information useful to the scrutiny or service committee ~~/ panel~~.

Referrals of issues to scrutiny and service committees ~~/ panels~~

6. Under the ~~Local Government and Public Involvement in Health Act 2007 and~~ Health and Social Care Act 2012 local Healthwatches can refer a matter relating to health and social care services to the appropriate ~~scrutiny~~ committee of a local authority. With the introduction of a committees system of governance at Norfolk County Council in May 2014 Norfolk Health Overview and Scrutiny Committee is the only relevant scrutiny committee remaining is the. However, Healthwatch Norfolk may also refer matters to the relevant service committees for consideration. At Norfolk County Council matters may be referred to:

- ~~Community Services Overview and Scrutiny Panel~~ Adult Social Care Committee
    - adult social care issues

- integrated health and adult social care issues, where commissioning is led by ~~services are jointly commissioned by the NHS and the~~ County Council commissioners.

- Children's Services ~~Overview and Scrutiny Panel~~Committee
  - children's social care issues
  - integrated health and children's social care issues, where ~~services are jointly commissioned by the NHS and the~~ commissioning is led by County Council commissioners.

- Communities Committee
  - public health issues

- Norfolk Health Overview and Scrutiny Committee (NHOSC)
  - adult and children's health issues, where services are commissioned by NHS commissioners
  - adult and children's integrated health and social care issues, where commissioning is led by NHS commissioners.

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7. Referrals to these committees ~~/ panels~~ should:

a) Only come from the Healthwatch Norfolk Board.
b) Be directed to the appropriate s~~S~~crutiny officer or service department ~~Support Oo~~fficer~~/Manager~~.
c) Be in writing but may be in electronic form.
d) Raise matters of great concern to Healthwatch Norfolk following unsuccessful attempts to achieve local resolution with the appropriate health and social care commissioners and providers.
e) Raise matters which Healthwatch Norfolk wishes to raise as good practice.

8. The committee ~~/ panel~~ must:

a) acknowledge receipt of the referral within 20 working days beginning with the date on which the referral was made; and
b) keep the referrer informed of the committee's actions in relation to the matter.
c) take into account any relevant information provided by Healthwatch Norfolk.
d) decide whether or not the referral is within its terms of reference and it can add value through scrutiny (NHOSC) or review of the issue (service committees).

9. The committee ~~/ panel~~ could decide that:

a) it does wish to scrutinise or review ~~-~~the issue and does so at the meeting, or
b) it does wish to scrutinise or review the issue, and adds it to the forward work programme and agrees a date for the scrutiny
c) it does not wish to scrutinise or review the issue.

10. The Chairman of the relevant committee ~~/ panel~~ will provide a response to the Chairman of Healthwatch Norfolk regarding the committee's ~~/ panel's~~ consideration of the referral.

Co-ordination of activities

11. It is understood that Healthwatch Norfolk is an independent organisation that will develop its own work programme and that the ~~scrutiny~~ committees ~~/ panels~~ of the County Council are likewise free to pursue the issues that Members consider to be of greatest concern. It is also acknowledged that there can be mutual benefit in co-ordination of activity between Healthwatch Norfolk and ~~scrutiny~~ council committees ~~/ panels~~ to achieve the best outcomes for health and social care service users.

12. The chairmen of Healthwatch Norfolk Board and the relevant ~~scrutiny~~ committees ~~/ panels~~ will discuss opportunities for co-ordination of activities at regular informal meetings (see 1).

13. Healthwatch Norfolk will be encouraged to consider ~~scrutiny~~ the relevant committee ~~/ panel~~s' forward work programmes and, if appropriate ~~identify which items, if any, they wish to~~:

- ~~assist with the scoping, and~~
- Identify issues into which they would wish to have an input. This will normally be by providing a written representation for inclusion in the officer report presented to the committee / panel.
- ~~g~~Give views on how a policy or strategy is working, or what impact decisions are having.
- ~~Identify issues into which they would wish to have an input. This will normally be by providing a written representation for inclusion in the officer report presented to the committee / panel.~~
- Assist with the scoping of NHOSC scrutiny reviews or service committee working group reviews.

14. The ~~scrutiny~~ committee ~~/ panel~~ may, if it feels it will be conducive to its work, invite a member of Healthwatch Norfolk to join a working group which it has instigated to ~~investigate~~ scrutinise or review a specific issue. The Healthwatch Norfolk member would be co-opted to the working group in a non-voting capacity.

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15. Healthwatch Norfolk may invite a member of a ~~scrutiny~~ relevant committee ~~/ panel~~ to join a working group which it has instigated to investigate a specific issue.

16. ~~Scrutiny c~~Committees ~~/ panels~~ may wish to commission Healthwatch Norfolk to undertake specific pieces of research or other work relevant to scrutiny reviews (NHOSC) or working group reviews (service committees). In these instances a specification for the work and the terms of the commission will be agreed by the relevant ~~scrutiny~~ committee ~~/ panel~~ before being presented to the Healthwatch Board.

9 July 2014 ~~20 February 2014 (amendments by Healthwatch Norfolk)~~

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 2014

Meeting dates	*Briefings/Main scrutiny topic/initial review of topics/follow-ups*	*Administrative business*
16 Oct 2014	Delayed discharge from hospitals in Norfolk – responses to the recommendations of the scrutiny task & finish group NHS complaints handling in Norfolk – to receive Healthwatch Norfolk's report. Health and Wellbeing Strategy 2014-17 – a progress update from the Health and Wellbeing Board.	
27 Nov 2014	NHS workforce planning for Norfolk – to examine workforce planning for GPs and other NHS services in which local services are currently experiencing recruitment difficulties. Wheelchair provision by the NHS, Central and West Norfolk – update from the commissioners and service providers on progress with engaging children, young people and families who use the wheelchair service. Stroke services in Norfolk – responses to the recommendations of the scrutiny task & finish group	*Moved from 16 October meeting to allow time for a response from Norfolk Stroke Network*

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

Provisional dates for reports to the Committee / items in the Briefing 2014-15

2014 – In the NHOSC Briefing - Availability in the local NHS of NICE recommended treatments and drugs. (Raised by Cllr P Balcombe at NHOSC on 17 April 2014 as a proposed item for the NHOSC agenda. It is suggested that a research paper on the local position be included in the NHOSC Briefing before the end of 2014)

2015 – In the NHOSC Briefing – Oral Health Needs Assessments (requested from NHS England at NHOSC on 17 July 2014)

NHOSC Scrutiny Task and Finish Groups

Task & finish group	Membership	Progress
Liver resection services (follow up on the recommendations of the former Cambridgeshire, Norfolk and Suffolk Joint Health Scrutiny Committee on Liver Resection Services)	Cllr Michael Chenery of Horsbrugh Cllr Alexandra Kemp Cllr Margaret Somerville (Substitute for all members – Dr Nigel Legg)	Meeting with NHS England to be arranged for late October 2014.

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

Clinical Commissioning Groups

North Norfolk - Mr J Bracey

South Norfolk - Dr N Legg (substitute Mr R Kybird)

Gt Yarmouth and Waveney - Mrs S Weymouth

West Norfolk - M Chenery of Horsbrugh

Norwich - Mr J Bracey

NHS Provider Trusts

Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust - Mrs A Claussen Reynolds

Norfolk and Suffolk NHS Foundation Trust (mental health trust) - M Chenery of Horsbrugh

Norfolk and Norwich University Hospitals NHS Foundation Trust	-	Dr N Legg Mrs M Somerville
James Paget University Hospitals NHS Foundation Trust	-	Mr C Aldred
Norfolk Community Health and Care NHS Trust	-	Mrs J Chamberlin (substitute Mrs M Somerville)

Norfolk Health Overview and Scrutiny Committee 4 September 2014

Glossary of Terms and Abbreviations

A&A	Access and assessment
ATA	Alternative to admission
BCF	Better Care Fund
CCG	Clinical Commissioning Group
CHC	Continuing health care
CIP	Cost improvement programme
CLL	Complexity in later life
CPT	Contingency planning team
CQUIN	Commissioning for Quality and Innovation
CRG	Clinical Reference Group
DATIX	A leading supplier of patient safety incidents healthcare software
DCLL	Dementia and Complexity in Later Life
DIST	Dementia Intensive Support Team
DNA	Did not attend
DTOC	Delayed transfers of care
EQIA	Equality impact assessment
HOSC	Health Overview and Scrutiny Committee
IM&T	Information management and technology
LAC	Looked after children
LHE	Local health economy
LOS	Length of stay
NCC	Norfolk County Council
NCH	Norwich Community Hospital
NCH&C (NCHC)	Norfolk Community Health and Care NHS Trust
NHOSC	Norfolk Health Overview and Scrutiny Committee
NHSE	NHS England
NICE	National Institute for Health and Care Excellence
NSFT	Norfolk and Suffolk NHS Foundation Trust (the mental health trust)
OoA	Out of area
OSC	Overview and Scrutiny Committee
PbR	Payment by Results
PCDP	Primary Care Dementia Practitioner
PMO	Programme Management Office
QEH / QEHKL	Queen Elizabeth Hospital, King's Lynn
RCA	Root cause analysis
SI	Serious incidents
TSS	Trust Service Strategy (Norfolk and Suffolk NHS Foundation Trust's Service Strategy 2012-16)

WNCCG	West Norfolk Clinical Commissioning Group