Norfolk County Council

Norfolk Health Overview and Scrutiny Committee

Date: **Thursday 28 May 2015**

Time: **10.00am**

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

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

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

Membership

MAIN MEMBER	SUBSTITUTE MEMBER	REPRESENTING
Mr C Aldred	Mr P Gilmour	Norfolk County Council
Vacancy	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
Mr B Bremner	Mrs M Wilkinson	Norfolk County Council
Mr D Harrison	Mr B Hannah	Norfolk County Council
Mr R Bearman	Ms E Morgan	Norfolk County Council
Vacancy	Mr R Richmond	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
Vacancy	*Vacancy*	Great Yarmouth Borough Council
Vacancy	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

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

1. Election of Chairman and Vice Chairman

The Chairman to be elected from the County Council Members on the Committee.

The Vice Chairman to be elected from the other Members on the Committee.

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

3. Minutes

To confirm the minutes of the meeting of the Norfolk Health Overview and Scrutiny Committee held on 16 April 2015. (Page 5)

4. 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.

5. **To receive any items of business which the Chairman decides should be considered as a matter of urgency**

6. **Chairman's announcements**

7. **10.10 – 11.00** **System wide review of health services in West Norfolk** (Page 11)

A report by West Norfolk Clinical Commissioning Group

11.00 – 11.10 **Break at the Chairman's discretion**

8. **11.10 – 11.55** **Continuing Health Care**

Norwich, North Norfolk, South Norfolk and West Norfolk Clinical Commissioning Groups will inform the committee forthcoming proposals for changes to continuing health care policy. (Page 25)

9. **11.55 – 12.00** **Norfolk Health Overview and Scrutiny Committee appointments** (Page 40)

The committee is asked to appoint members to Great Yarmouth and Waveney Joint Health Scrutiny Committee.

10. **12.00 – 12.10** **Forward work programme** (Page 42)

To consider and agree the forward work programme

Glossary of Terms and Abbreviations (Page 45)

Chris Walton
Head of Democratic Services

County Hall
Martineau Lane
Norwich
NR1 2DH

Date Agenda Published: 19 May 2015

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

Norfolk County Council

NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE
MINUTES OF THE MEETING HELD AT COUNTY HALL, NORWICH
On 16 April 2015

Present:

Mr C Aldred	Norfolk County Council
Mr R Bearman	Norfolk County Council
Mr B Bremner	Norfolk County Council
Mr M Carttiss (Chairman)	Norfolk County Council
Michael Chenery of Horsbrugh	Norfolk County Council
Mr D Harrison	Norfolk County Council
Mrs M Somerville	Norfolk County Council
Mrs S Weymouth	Great Yarmouth Borough Council
Mr A Wright	King's Lynn and West Norfolk Borough Council

Substitute Member Present:
Miss J Virgo for Mrs J Chamberlin

Also Present:

Michael Scott	Chief Executive, Norfolk and Suffolk NHS Foundation Trust
Debbie White	Director of Operations Norfolk and Waveney, Norfolk and Suffolk NHS Foundation Trust
Marcus Hayward	Locality Manager West Norfolk, Norfolk and Suffolk NHS Foundation Trust
Amanda Ellis	Chief Inspector, Norfolk Constabulary
Maureen Begley	Commissioning Manager, Integrated Mental Health Learning Difficulties Team, Norfolk County Council
Norman Smith	North Norfolk District Councillor. He established Norfolk Suicide Bereavement Support Group and Lifeline (a 24 hour telephone helpline for people in distress).
Terence O'Shea	Campaign to Save Mental Health Services in Norfolk and Suffolk
Clive Rennie	Integrated Commissioner
Michael Ladd	Chairman of Suffolk Health Scrutiny Committee
Chris Cobb	Director of Medicine and Emergency Services, Norfolk and Norwich University Hospitals NHS Foundation Trust
Dr Helen May	Associate Medical Director for Emergency Care, Norfolk and Norwich University Hospitals NHS Foundation Trust

Suzie Robinson Southey	Consultant Nurse, Emergency Care, Queen Elizabeth Hospital, King's Lynn
Mark Henry	Interim Director of Operations, James Paget University Hospitals NHS Foundation Trust
Barry Pinkney	Service Manager, Emergency Division, James Paget University Hospitals NHS Foundation Trust
Dr Donna Wade	A&E Consultant, James Paget University Hospitals NHS Foundation Trust
Chris Walton	Head of Democratic Services
Maureen Orr	Democratic Support and Scrutiny Team Manager
Tim Shaw	Committee Officer

1 Apologies for Absence

Apologies for absence were received from Mr J Bracey, Mrs A Claussen-Reynolds, Mrs J Chamberlin, Mr R Kybird, Dr N Legg and Mrs C Woollard.

2. Minutes

The minutes of the previous meeting held on 26 February 2015 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: Mr John Bracey, Mr Tony Wright and Mrs Shirley Weymouth

5.1 The Chairman paid tribute to the significant contribution that Mr John Bracey and Mr Tony Wright had made to the work of the Norfolk Health Overview and Scrutiny Committee during their many years of service on the Committee. The Chairman said that Mr Bracey and Mr Wright were due to retire as Councillors before the next meeting of the Committee. Mr Wright had served on the Committee since its inception in 2002 and Mr Bracey had served on the Committee since 2005. They had both served as Members on many health scrutiny working groups and Mr John Bracey had served as a former Member of the Great Yarmouth and Waveney Joint Health Scrutiny Committee.

The Chairman expressed appreciation for the wise advice he had personally received from both Councillors during the time that they had been his Vice-Chairman; Mr Bracey (2009- 2014) and Mr Wright (2014-2015).

5.2 The Chairman also congratulated Mrs Shirley Weymouth on becoming Mayor Elect of Great Yarmouth Borough Council; Mrs Weymouth would be unlikely to serve as a Member of the Committee during her year as Mayor.

6 Mental health services provided by Norfolk and Suffolk NHS Foundation Trust

6.1 The Committee received a suggested approach from the Democratic Support and Scrutiny Team Manager to an update from Norfolk and Suffolk NHS Foundation Trust (NSFT) on the effects of changes to services in the 2012-16 Service Strategy and action to address the findings of the Care Quality Commission's latest inspection report.

6.2 The Committee received evidence from Michael Scott, Chief Executive, Norfolk and Suffolk NHS Foundation Trust, Debbie White, Director of Operations Norfolk and Waveney, Norfolk and Suffolk NHS Foundation Trust, Marcus Hayward, Locality Manager West Norfolk, Norfolk and Suffolk NHS Foundation Trust and Amanda Ellis, Chief Inspector, Norfolk Constabulary. The Committee also heard from Norman Smith, a North Norfolk District Councillor (Mr Smith had established Norfolk Suicide Bereavement Support Group and Lifeline, a 24 hour telephone helpline for people in distress) and Terence O'Shea**,** Campaign to Save Mental Health Services in Norfolk and Suffolk.

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

- It was pointed out that in the first four months of 2015 there had been a considerable overall increase in the number of referrals to the NSFT (via centralised Access and Assessment Services). This had resulted in higher caseloads, and in increased NSFT waiting times, and more pressure on multi –disciplinary community mental health services that supported people at home.
- The high referral rate for mental health services had reduced NSFT's capacity to provide ongoing monitoring and crises prevention.
- At the same time as there had been an increase in demand for its services the funding for NSFT services had continued to decline in real terms.
- The NSFT continued to press for additional funding from the CCGs for mental health services.
- The new centralised Access and Assessment service, which was a significant part of the NSFT's 2012-16 Service Strategy, was due to be decentralised by June 2015.
- The NSFT had recently opened Thurne Ward at the NNUH with 12 additional short stay assessment beds.
- During the week that preceded the Committee meeting, staffing levels on Thurne Ward had increased and the ward had now achieved full capacity.
- With the opening of Thurne Ward, the NSFT was close to achieving the total number of in- patient beds that were required in the central Norfolk area.
- In response to questions, it was pointed out that the NSFT had a strong relationship with the Norfolk Constabulary through the work of an initiative at Wymondham where the first integrated Mental Health Team in the country was established in the Police Control Centre from 8 am to 10 pm seven days a week. The witnesses said that the Police Control Centre had close links with mental health liaison services at A&E departments at the NNUH

and at the QEH, as well with the Ambulance Control Room, where a limited mental health nursing support service was available until 2 am.

- The NSFT also worked closely with MIND and Relate. The MIND crisis line was open 24 hours a day, 7 days a week.
- It was pointed out that the QEH was reviewing its liaison arrangements with the Police in the light of the initiative that had been taken in the central Norfolk area.
- Mental health staff in the King's Lynn area had a case load of between 10 and 15 cases with a mixture of case severity.
- Research had shown that more people with mental health issues attended A&E at the QEH than attended A&E at the other two acute hospitals in Norfolk. Most of those who visited the QEH with mental health problems lived within a 5 mile radius of the hospital.
- The NSFT had put together an action plan to address the issues raised in the CQC report and most of those issues that related to physical environmental constraints had been resolved.
- A payment by results policy had not been introduced for mental health services and it was unlikely for such a policy to be introduced in the future.
- NSFT staff sickness and staff recruitment rates had improved significantly in recent months but staff retention within the NSFT remained an issue to be resolved.
- Given that the NSFT was required to increase its staffing levels to maintain safe services, the NSFT was continuing to employ qualified nursing staff. In the last 12 months the NSFT had taken on some 225 new clinical staff.
- In recent years there had been significant pressure on adult acute beds in central Norfolk, with high levels of out-of-area placements. This had reached its peak in October 2014 when managerial changes to mental health social care had led to a temporary disruption in the service available to people who were supported in the community. Since that time there had been a significant fall in the number of out of county placements to between 5 and 9 out of county placements at one point in time. Most of the patients who were placed out of county were placed in Essex and Hertfordshire but there were a few cases of placements much further afield in the country. A private ambulance service was contracted to provide transport from Norwich for out of county placements.
- The witnesses said that while mental health patients were not always seen by mental health staff as often as they should be, all such patients were allocated a named care co-ordinator and given the telephone numbers for MIND and the NSFT crisis support line.
- Mr Norman Smith, a North Norfolk District Councillor who had established the Norfolk Suicide Bereavement Support Group and Lifeline, a 24 hour telephone helpline for people in distress, explained the work of this crisis support group and how it sought to provide support to those living in the community.
- Mr Terence O'Shea**,** from the Campaign to Save Mental Health Services in Norfolk and Suffolk said that the Campaign had identified what it regarded as a number of significant shortcomings in the operation of the NSFT which it considered were not being adequately addressed but was finding it difficult to engage with the management of the NSFT.
- It was pointed out that the opening of 12 beds in Thurne Ward would be off-set by the closure of beds at Carlton Court but NSFT expected that investment in community mental health services would reduce the demand for acute mental health assessment beds. The Trust aimed for zero out of area placements (except for those who required specialist services).

6.4 The Committee noted the information contained in the report from the NSFT.

6.5 The Committee **agreed** to continue with the planned scrutiny of West Norfolk CCG's consultation on 'Changes to mental health services in west Norfolk (development of dementia services)' on 16 July 2015 and to look at the mental health service implications of 'Changes to services arising from system wide review in West Norfolk' when the CCG reported to the Committee on that subject on 28 May 2015.

7 Service in A&E following attempted suicide or self-harm episodes

7.1 The Committee received a suggested approach from the Democratic Support and Scrutiny Team Manager to a report from Norfolk and Norwich University Hospitals NHS Foundation Trust, James Paget University Hospital NHS Foundation Trust, Queen Elizabeth Hospitals NHS Foundation Trust and Norfolk and Suffolk NHS Foundation Trust on the protocols used when patients who had attempted suicide or self- harm arrive in A&E.

7.2 The Committee received evidence from Michael Scott, Chief Executive, Norfolk and Suffolk NHS Foundation Trust, Chris Cobb, Director of Medicine and Emergency Services, Norfolk and Norwich University Hospitals NHS Foundation Trust, Dr Helen May, Associate Medical Director for Emergency Care, Norfolk and Norwich University Hospitals NHS Foundation Trust and Suzie Robinson Southey**,** Consultant Nurse, Emergency Care, Queen Elizabeth Hospital, King's Lynn, Mark Henry, Interim Director of Operations, James Paget University Hospitals NHS Foundation Trust, Barry Pinkney, Service Manager, Emergency Division, James Paget University Hospitals NHS Foundation Trust and Donna Wade, A&E Consultant, James Paget University Hospitals NHS Foundation Trust. The Committee also heard from Norman Smith, a North Norfolk District Councillor.

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

- Witnesses from each of Norfolk's acute hospitals and from the NSFT explained the protocols and procedures used by A&E departments and the NSFT in circumstances of attempted suicide or self-harm.
- They said that no patient who was discharged from one of Norfolk's acute hospitals following attempted suicide or self-harm left hospital without a support plan having first being put in place.
- They also said that the A&E departments had jointly agreed protocols to ensure that patients who had attempted suicide or self-harm were discharged to a safe environment.
- It was pointed out that the JPH did not have a seven day a week liaison service but relied on a mental health liaison practitioner who supported the work of the JPH on a Monday to Friday basis.
- There was a small seven day a week liaison service provided to the NNUH although at weekends and out of hours this service was reduced.
- A small liaison service was available at the QEH from 8am to 11 pm, seven days a week.
- Nursing staff at the NNUH received training about attempted suicide and incidents of self-harm within 6 months of their appointment. This training was then updated on a yearly basis. Doctors at the NNUH received four monthly updates on self-harm issues. Training on how to deal with patients with mental health issues was also provided to security staff at the hospital.
- The acute hospitals and the NSFT had similar managerial plans and risk assessments for dealing with patients with a history of self-harm.

- Young people were not discharged from hospital without an assessment by a specialist. After-care programmes of support were in place for both children and adults with mandatory follow up in the week following discharge from hospital.
- The support available from charities to ex-military personnel following attempted suicide or self-harm was usually of a very high standard.
- The witnesses said that training for nurses on mental health issues was provided at the QEH in a similar way to that at the NNUH. The training of nurses at the JPH was usually undertaken on a one to one basis and made available to doctors at the JPH every two months.
- The witnesses believed that cases of attempted suicide and self-harm were no higher in Norfolk than they were elsewhere in the country. However, the number of cases throughout England had increased in recent years.
- The number of admissions to hospital in Norfolk as a result of self harm was higher than the England average.
- Mr Norman Smith, a North Norfolk District Councillor (Norfolk Suicide Bereavement Support Group and Lifeline, a 24 hour telephone helpline for people in distress) explained the work of this crisis support group in supporting people following attempted suicide and episodes of self-harm.

7.4 The Chairman said that he was grateful to Mrs M Somerville and Ms S Bogelein for having asked for the subject of attempted suicide and episodes of self-harm to be added to the Committee's forward work programme.

7.5 The Committee **agreed** to ask Norfolk & Suffolk NHS Foundation Trust and the three acute hospitals to provide an update report in 12 months.

8 Forward work programme

8.1 The proposed forward work programme was **agreed** with the addition of an update on 'Service in A&E following attempted suicide or self-harm episodes' in April 2016.

Chairman

The meeting concluded at 12.40 pm

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

Norfolk Health Overview and Scrutiny Committee
28 May 2015
Item no 7

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 On 16 January and 4 September 2014 NHS West Norfolk Clinical Commissioning Group (CCG) reported to Norfolk Health Overview and Scrutiny Committee (NHOSC) 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 services.

1.2 The Queen Elizabeth Hospital, King's Lynn, has been in special measures with Monitor, the hospital regulator, since October 2013. In March 2015 the hospital was forecasting a 2014-15 deficit of £14.9million.

The CCG was forecasting a surplus in 2014-15 of £2.2m (i.e. 1% of funding, in line with NHS England's expectations).

1.3 In September 2014 NHOSC heard that the West Norfolk Health and Social Care Alliance had a number of working groups aiming to achieve integration of services to achieve sustainable co-ordinated care for patients. The Alliance included:-

- NHS West Norfolk Clinical Commissioning Group (WNCCG)
- Norfolk Community Health and Care NHS Trust (NCH&C)
- The Queen Elizabeth Hospital NHS Foundation Trust
- Norfolk County Council
- Borough Council of King's Lynn & West Norfolk
- West Norfolk Voluntary and Community Action (WNVCA)
- Norfolk & Suffolk NHS Foundation Trust (NSFT)

Patients and the public in west Norfolk were involved in the review of the services through various surveys, stakeholder events and conferences.

Alongside the Alliance's system sustainability work, Monitor was to send a Contingency Planning Team (CPT) into the Queen Elizabeth Hospital in late September 2014 to start work on developing options for a sustainable district general hospital. The CPT report is expected to be available at the end of June 2015.

1.4 In September 2014 it appeared likely that these pieces of work could lead to proposals for changes to services in west Norfolk for which consultation with NHOSC would be required. The CCG assured the committee that further information would be brought in good time to alert NHOSC to any likely major service change that would require formal consultation.

2. Purpose of today's meeting

2.1 Dr Sue Crossman, Chief Executive of NHS West Norfolk CCG will attend today's meeting to update the committee on the system review work and potential changes to local services arising from it. Her report is attached at Appendix A.

2.2 The CCG has engaged with patients and public during the west Norfolk system wide review process. At present it is focusing on creating a community frailty service and improving urgent care, with an emphasis on greater integration of community and primary care. It is not at this stage proposing any change to local services that it would consider a 'substantial variation' on which formal consultation with this committee is required under the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

2.3 Today's report is therefore to keep the committee up to date with progress in west Norfolk and an opportunity for NHOSC to seek reassurance from the CCG that it will consult the committee on any proposals for 'substantial variation' of services that may arise from the review or CPT work at a later date, and that consultation would take place before any substantial change was made.

2.4 The committee should bear in mind that 'substantial variation' is not defined in health scrutiny law. It is for the committee and the CCG to reach a view on whether formal consultation with NHOSC is required. It is for the CCG alone to decide whether formal public consultation is appropriate in each case.

3. Suggested approach

3.1 After Dr Crossman has presented her report, NHOSC may wish to raise questions in the following areas:-

(a) On 16 April 2015 NHOSC heard that the QEH experiences a high number of mental health related attendances in A&E (an average of 83 per month in 2014) and it was important for custom and practice in the west Norfolk health system to change so that attendances would reduce. How far does will it be possible to develop the initiatives set out in paragraph 3.8 of Dr Crossman's

report given the difficulties of recruiting mental health staff in the community in west Norfolk?

(b) The Contingency Planning Team brought in by Monitor for the Queen Elizabeth Hospital is finished its review in February 2015 and is expected to report by the end of June 2015. Based on the CCG and West Norfolk Health and Social Care Alliance's knowledge of the work, is the CPT's 'preferred solution' for achieving sustainable services in west Norfolk by 2019 likely to co-incide with the Alliances' own wishes for the future of the hospital and the best interests of the local health economy?

(c) Which organisation has the final say on how QEH services will be configured following the CPT review?

(d) Some changes have already taken place as a result of the Alliance's work, e.g. 'care navigators' to help patients find the services they need; 'hospital care at home team' to support people to get out of hospital earlier or to avoid going in. When does the CCG plan to evaluate these changes and are there any early indications of how successful they have been so far?

(e) Bearing in mind the difficulties of sharing information across services because of data protection and IT restraints, how practical is the Alliance's goal of a shared 'smart card' a shared care record across health and social care (see Appendix A paragraph 3.3).

(f) Dr Crossman's report mentions that terms and conditions for new social workers have been changed so that they will operate flexibly over 7 days (Appendix A paragraph 3.4). Is this the same for social workers from all three authorities that work with the QEH? (Cambs, Lincs and Norfolk).

(g) NHOSC currently has a scrutiny task and finish group looking at NHS Workforce Planning in Norfolk. It is clear to the group that staff recruitment in west Norfolk is particularly challenging in terms of nurses, therapists, doctors, consultants, paramedics, mental health and community health professionals. Dr Crossman's report mentions the challenges (Appendix A paragraph 3.7). How much of a risk are workforce shortages for the sustainability of services in west Norfolk?

4. Action

4.1 The CCG has indicated that there may, at a later stage, be proposals concerning specific service lines or care pathways that would qualify as 'substantial variations' for which consultation with this committee, and with the public, would be required. NHOSC may wish to ask the CCG to confirm that:-

a) It will give notification in good time about any proposals for significant changes to services so that agreement can be reached

on whether they are ‘substantial variations’ on which consultation with NHOSC is required.

b) Consultation with NHOSC on proposals for ‘substantial variations’ will take place in advance of changes being made, except in cases where there are urgent safety reasons for immediate change.

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.

Agenda Item: 7
Appendix A

NHS
West Norfolk
Clinical Commissioning Group

Subject:	**West Norfolk System Sustainability Update**
Presented by:	**Dr Sue Crossman, Chief Officer**
Submitted to:	**Norfolk Health Overview & Scrutiny Committee, 28 May 2015**
Purpose of Paper:	**Information and Debate**

Executive Summary:

West Norfolk has been undertaking an intensive programme of work to investigate the underlying factors contributing to an increasing challenge in maintaining local, sustainable health services.

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (QEH) has been in Special Measures since October 2013 with improvement plans in place for the regulatory bodies Monitor and the Care Quality Commission (CQC). A Monitor Contingency Planning Team (CPT) commenced a five month programme of work in September 2014 to investigate the causes of the financial and clinical sustainability problems in QEH and the wider West Norfolk health system. The aim of the programme was to identify a 'preferred solution' which would create a sustainable configuration of services by 2019.

The final output from the CPT will be published by Monitor at the end of June and there will be a joint local response from the CCG and QEH released at the same time.

This paper outlines areas of consensus among local partners and some key developments that will be taken forward.

1 INTRODUCTION

West Norfolk has been undertaking an intensive programme of work involving health partners across the system, to explore significant local challenges to providing health services. As part of this, Monitor commissioned a Contingency Planning Team (CPT) which commenced a five month programme of work in September 2014 to investigate the causes of the financial and clinical sustainability problems in The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (QEH) and the wider West Norfolk system. The aim of the CPT programme was to identify a 'preferred solution' which would create a sustainable configuration of services by 2019.

1.1 The national context

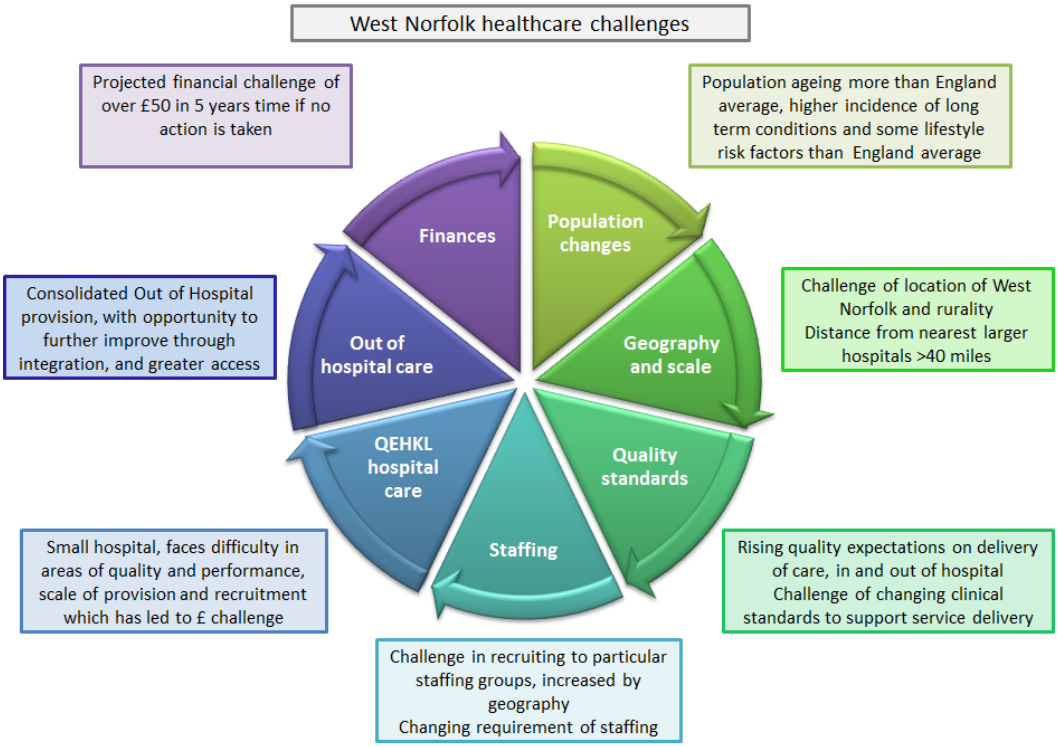
Nationally there are significant challenges now, and for future delivery of healthcare services. These challenges include substantial financial efficiency requirements coupled with rising costs of delivering healthcare. Changing demography and growing health needs, challenge to future hospital models, rightly rising clinical standards and patient expectations for delivery are all pressures in addition to the need to improve quality and reduce variation in performance of healthcare services. The national message is absolutely clear; transformational change is required in the way that we deliver healthcare services to avoid the '3 gaps' identified by Simon Stevens, NHS England Chief Executive, of 'Health and Wellbeing', 'Care and Quality' and 'Funding and Efficiency'.

1.2 The local picture

This national picture is mirrored locally in West Norfolk, but felt more 'acutely' for the following reasons:

- A population that is ageing quicker than the national average with higher incidence of long term conditions and lifestyle risk factors;
- Challenges faced by the geography of West Norfolk, including rurality and proximity to other major NHS centres;
- Challenges faced in recruiting and retaining workforce;
- The scale of provision of acute hospital services at QEH, a small district general hospital;
- The Care Quality Commission (CQC) hospital inspection and linked requirements for additional investment to improve the quality of services delivered at the QEH.

The diagram below summarises the challenges faced in West Norfolk.



Locally NHS partners have made concerted, incremental short to medium term improvements in responding to the above challenges; however to fully meet the size of the challenge set out, more fundamental long term change is required.

1.3 Dealing with the challenges – our System Sustainability Programme

In January 2014, the CCG made recommendations to the Governing Body to establish a 'System Sustainability' programme of work, engaging clinicians and managers across the health and social system, to explore solutions to the problems of the future financial and clinical unsustainability of local services. The CCG has long believed that working closely with partner provider and commissioner organisations across health, social care, borough council and voluntary sector is imperative to deliver the best care to our population, as demonstrated in the work of the West Norfolk Alliance. The CCG therefore set up a West Norfolk Alliance intensive programme of work in March 2014, with clinical work-streams focused on maternity, urgent care, frailty and paediatrics. These were chosen as they represented critical cohorts that depend heavily on locally available services. The recommendations from these Clinical Working Groups were presented to Monitor and the CPT in July 2014 and it was agreed that they would form the foundation for the CPT programme of work. Groups on Mental Health and Elective Care were also convened in the autumn.

2 Monitor and the CPT

In March 2014, health regulator Monitor announced plans to send in a team of experts to address concerns about the sustainability of services for patients at the QEH. The Trust had been in breach of its operating conditions since January 2012 and was placed into 'special measures' by the CQC in October 2013. At the time, Monitor had concerns around the quality of care and leadership and the predicted deficit of £14.9million for 2014/15.

The Monitor CPT began on 1 October 2014 with the purpose of working with and across the health economy in West Norfolk and beyond, building on the reports from the earlier local System Sustainability programme to find a system-wide solution to the operational, clinical and financial challenges faced by the QEH. The CPT was a consortium comprising McKinsey and

Company, PA Consulting and a number of individual associates with health system specialist knowledge, skill and experience and the team was in place until the end of February 2015.

Engaging with local people and clinicians was a key consideration of the programme. The CPT established a Patient and Public Engagement Group in addition to Clinical Working Groups to ensure that patient opinion was included in developing the thinking and local people had an opportunity to shape the clinicians' work. A series of drop-in events were held throughout January 2015 giving local people the opportunity to find out more and to feed back on the work so far. More detail about these events can be found in the section on "Our engagement work".

The initial findings from the first phase of the CPT programme concurred with the conclusions presented in the 2013 publication of the CCG 'Case for Change' and provided more detailed evidence about the scale of the challenge. The CCG outlined this further information in a second document 'Evidence for Change' in January 2015, reiterating the need for services to change in order to be sustainable into the future. A summary booklet was produced which explained the report's findings in simple terms. Both reports can be found on the West Norfolk CCG website and were made available in other formats on request. The report describes the key national and local challenges, as outlined above, and details a number of opportunities for improvements which include greater efficiency, better use of technology, better integration of services and better use of estates. These are opportunities that local clinicians and health and care leaders are currently looking at as they work together across West Norfolk to develop options for some long-term solutions to the challenges.

3 Post CPT Transformation Programme

Since the completion of the CPT programme, the CCG has reviewed local commissioning priorities and identified a number of programmes of work to take forward in 2015/16.

The CCG's three key objectives for 2015/16 are:

1. To deliver operational resilience throughout the year, ensuring sustainable compliance with NHS Constitution standards and Mandate commitments.

2. To ensure financial sustainability via robust financial planning and management, and QIPP delivery.

3. To maintain progress on integration and transformation of high quality service delivery with West Norfolk 'Alliance' partners across health, social care, borough council and third sector.

Key work programmes based on these objectives are:

Urgent priorities	Medium priorities	Longer term priorities
Dementia Frailty Urgent Care Mental Health Primary Care Integration – Better Care Fund (BCF) Continuing Healthcare End of Life Care Medicines Management	Elective Care Integration – enabling work Cancer Diabetes Care	Paediatrics Maternity Care

Many of these work programmes, particularly the urgent priority ones, have overlaps in terms of the intended outcomes for patients and can be grouped together under 'community frailty care', 'urgent care' and 'integrated care', building on the learning gained from the locally led Alliance Clinical Reference Groups. Given the demography of West Norfolk's population in terms of elderly growth and pressures on the acute trust, the overarching 'problem statement' we need to address is: "How can we help frail elderly people maintain their health and independence in the community?" with sub-questions to address the individual work-streams.

3.1 Community Services for the Frail

Recognising the frequently negative consequences for elderly frail people when they are admitted to a residential home or hospital, it is imperative that they are known to social and health services in good time to support their wellbeing. Unfortunately, many of these people are 'invisible' to our services until they have a crisis such as a fall or sudden worsening of a long term condition. Our goal is therefore to connect communities with our services both informally and formally through effective networks and joint working so that citizens, carers, volunteers and professionals can connect swiftly with proactive support.

The West Norfolk CCG Alliance therefore plans to create an integrated frail elderly community centre in a multi-disciplinary hub through a phased approach to co-locating teams and streamlining referral routes across community, social care and mental health. This will incorporate other initiatives already put in place to support residents to stay well and independent and to avoid crises resulting in hospital attendance or admission to either hospital or a care home. These will include prevention advice, pro-active treatments, carer support, housing advice and other voluntary sector initiatives in a one-stop-shop. Primary care will play a lead role in the centre, working closely with a large central general practice implementing their 'pyramid of care' model employing GPs with a Special Interest in frail elderly care and using a universal frailty score to identify patients in primary care who should be referred to the hub. The same frailty score will be used across health and social organisations.

One key element of the frailty service will be a multi-agency rapid response capability aimed at building emergency, temporary (72hr) support packages in order to avoid unnecessary urgent admissions into either hospital or care homes. This will allow time for a full assessment to be undertaken and a more considered support plan to be put into place, ideally allowing the individual to remain in their own home.

Dementia care will be a key component of the community frailty hub, with a team of specialist nurses working alongside other community staff to improve early diagnosis and support for people living with dementia.

3.2 Urgent Care

The Clinical Pathway Group exploring urgent care was clear that the population of West Norfolk require local access to comprehensive emergency care to a level that can ensure sustainable clinical expertise and adequate staffing. This currently means that some emergency care, such as cardiac stenting, serious trauma including those requiring neurosurgery, is not carried out at King's Lynn. This is entirely appropriate and safe. However, what is required at King's Lynn without doubt is a high level of expertise in clinical assessment of patients and rapid senior clinical decision making about treatment. In order to provide this most effectively, services need to be provided appropriately at the 'front door' of the hospital to ensure rapid assessment by the right clinician. This requires a carefully designed clinical team with excellent leadership and clear protocols. The Alliance partners will be working with QEH to review the recommendations made by the CPT and the local Clinical Reference Group and develop

proposals about the most efficient and effective way to deliver urgent care across primary and secondary care.

3.3 Integrated Care

In our discussions locally with people and their carers they said that they often experienced care as being fragmented and were frequently frustrated at having to repeat their "story" to different professionals who seemed unable to communicate with each other. They voiced a similar expectation that care should be built around their needs and wishes and should be properly co-ordinated. A quote from the National Voices work summed up the aspirations of people in West Norfolk:
"My care is planned with people who work together to understand me and my carer(s), put me in control, and co-ordinate and deliver services to achieve my best outcomes."

Put simply, integrated care in West Norfolk is defined as **"**person-centred, co-ordinated care". The intention is to deliver fundamental change in the way professionals and organisations work together so that the person receiving the care experiences a real difference. As a national 'Integrated Pioneer' site we are committed to progressing integrated working across health, social care and beyond.

Our targets are to:

- Improve the outcomes for individuals and their communities;
- Reduce the number of people staying unnecessarily in hospital or moving permanently into residential or nursing home care;
- Achieve low rates of unplanned hospital admissions, shorter lengths of stay and no delayed discharges.

Under the umbrella of the West Norfolk Alliance and building on work already in train, we intend to:

- Work closely with the Borough Council and local voluntary organisations to promote early intervention and prevention, supporting people to self-help and supporting the development of strong communities;
- Provide services focused around the individual with care coordinated through multi-disciplinary teams based around primary care and supported by voluntary sector "care navigators";
- Ensure that information can be shared across professionals through the development of a "smart card" and shared care record;
- Promote single assessment models wherever practical and make every contact count through professionals supporting shared goals around health education, health improvement and prevention or worsening of long-term conditions;
- Break down existing silo working through commissioning collaborative services delivered through partnership arrangements and utilising new contracting models;
- Go beyond the traditional health and social care service providers, involving for example housing and the voluntary sector in developing innovative solutions to providing better coordinated care;
- Co-locate staff to provide both a single referral pathway into community services – mental health, community health, and social care – and a rapid response capacity aimed at avoiding unnecessary admissions into acute hospital or care homes.

These goals are synonymous with those of the frailty service, so addressing them will create positive outcomes for several work-streams. Several of these initiatives are already progressing with pace.

3.4 Social care 7 day model

A System Resilience Group coordinates health and social care across the local area, including representatives from West Norfolk, Cambridgeshire and Lincolnshire. Social Services is integrated at QEH within the Rapid Assessment Team, working with nurses and therapists to enable patients to be discharged into the community who do not require medical admission and to coordinate falls related support. The Rapid Assessment Team operates 7 days a week and is being enhanced this year to extend the weekend operating hours. A team of Social Workers also supports discharge of patients back into the community and recruiting terms and conditions of employment have been changed so that new workers will operate flexibly over 7 days.

The QEH has regular Care Home Forums to encourage cooperative working, which has included work on supporting discharges over 7 days. Access to domiciliary care provision over 7 days is also being supported through the new outcomes based contracts which West Norfolk will be the first to apply in Norfolk, from November. In addition, the Norfolk First Support Reablement service and Norfolk Swift Response service fully operate 7 days a week, 24 hours a day in the case of the Swift's team.

3.5 Short term funded schemes

Non-recurrent 2015/16 Operational Resilience funding for West Norfolk is £1,162k and Cambridgeshire and Peterborough CCG have committed £200k from their allocation to support Wisbech patients within the West Norfolk system.

Funding has already been committed for continuation of the Hospital Care at Home Service (Virtual Ward) and to support continuation of the Mental Health Assessment and Liaison Team, both of which have had a positive impact on admission avoidance and supported discharge.

As part of previous discussions, it was agreed that a proportion of the resilience funding should be set aside for intermediate care bed provision to support discharges. It is also recommended that a reasonable level of funding is held back in a contingency pot for allocation later in the year.

In addition, West Norfolk CCG has received the following proposals for consideration:

1 "Choose me not A&E" summer and winter campaign

2 'Discharge to Assess' for care packages

3 Weekend GP in ED - continuation

4 Weekend Social Worker provision

5 Norfolk First Response Hospital Liaison Officer

6 Falls Prevention Scheme (free home assessments, adaptations, onward referrals to other community support)

7 British Red Cross Weekend (Friday – Sunday) Discharge Service

8 Airedale Tele-health

9 Operational Resilience Support Officer

10 PTS Transport

As funding is limited this year it will not be possible to approve all of these bids, therefore a prioritisation exercise will be required.

Recent other short term initiatives the CCG has put in place include three 'care navigators' to support elderly patients find the services they need, a range of general practice based schemes to support the frail elderly through the '£5 per head' initiative and additional dementia support, such as an Admiral Nurse and a pilot of the Burford 'SPECAL' approach to supporting families and people living with dementia. These will be evaluated before deciding whether to continue the services.

3.6 Intermediate care beds

A review is underway to do a stock-take of intermediate care beds by type and location and to assess whether there is enough of the type for which there is most demand. A working group is being convened to examine the evidence and agree how to ensure capacity is adequate and appropriate for winter 2015/16. The review will report to the System Resilience Group, where recommendations will be made to the CCG about any changes to the commissioning of community beds. Early suggestions include using additional therapists to support more active rehabilitation in existing bed-stock, 'block-purchasing' beds for step-up/step-down use and exploring potential beds not currently commissioned.

3.7 Workforce, recruitment and retention

West Norfolk CCG, and other local public sector employers, have worked together to promote West Norfolk to potential employees, providing information on some of the employment opportunities on offer.

The 'Working in West Norfolk' website **www.workinginwestnorfolk.co.uk** was produced by the West Norfolk Strategic Partnership which includes the Borough Council of King's Lynn & West Norfolk, Freebridge Community Housing, the College of West Anglia and QEH. The website not only promotes the area's many qualities and facilities, it has also been designed with specific information incorporated including health, education, housing and transport links.

Alongside the website, two films have been produced which share the real life experiences of people already working here, highlighting the benefits they have found in both their personal and professional lives. The website has information on available vacancies within the partner organisations, guidance on completing CVs, case studies of people working in the area and general information on living in West Norfolk.

Other workforce initiatives include developing a practice nursing education framework, exploring the opportunity to develop local nurse training and establishing cross-organisational induction programmes. We have also been running 'integration' workshops and the West Norfolk Alliance is planning a leadership programme to empower grass-roots practitioners to provide better integrated care.

Medical workforce challenges are also an acute problem, with difficulties recruiting to both general practice and hospital specialties, compounded by the age profile of West Norfolk GPs. The Alliance partners have met with Health Education England and the Academy of Royal Colleges to discuss future role developments and educational preparation to prepare medical staff fit for a rural District General Hospital in the future. Work continues to influence this at a national level and at a more local level with the GP trainers.

3.8 Mental Health

For mental health services in 2015/16, the focus is on liaison, crisis response and home treatment (CRHT), early intervention and Admission Avoidance packages.

- The Liaison service has proved to be effective in addressing the high numbers of mental health related A&E attendances and so we will be looking to further develop this service in line with the CRHT service.
- The focus of the CRHT team is to provide a community based crisis response, and also to provide active home treatments as an alternative to admission as well as supported early safe discharge.
- Alignment of the two teams will facilitate better response to crises and alternatives to A&E. The focus is to establish early/emergency assessment to enable patients to be redirected away from A&E.

Other areas for development are:

- Early Intervention Team – in recognition of the high risks and rate of admission of those who are experiencing first episode psychosis;
- Admission Avoidance Support Packages – delivered by West Norfolk MIND.

As well as the services mentioned the CCG will be working with the Norfolk & Suffolk NHS Foundation Trust regarding caseloads and staffing to ensure services are aligned and supported, avoiding pressure points and duplication.

4 CONCLUSION

West Norfolk continues to be the focus of much collaboration and the CCG will be continuing, together with colleagues from across the health and social community, to lead the work of the System Transformation programme to address the urgent challenges we face. Future progress will be reported to HOSC, giving good notice of any potential major service changes before they go out for public consultation. At present, the focus is on creating a community frailty service and improving urgent care, with an emphasis on greater integration of community and primary care.

Norfolk Health Overview and Scrutiny Committee
28 May 2015
Item no 8

Continuing Health Care

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

Norwich, North Norfolk, South Norfolk and West Norfolk Clinical Commissioning Groups, will inform the committee about outline proposals for a forthcoming consultation on changes to Continuing Health Care policy in their areas.

1. Background

1.1 Norwich, North Norfolk, South Norfolk and West Norfolk Clinical Commissioning Groups (CCGs) intend to launch a public consultation from approximately mid June to mid September 2015 (dates to be confirmed) about changes to Continuing Health Care (CHC) policy in their areas.

1.2 CHC is a package of ongoing care that is arranged and funded solely by the NHS, where a person has been assessed and found to have a 'primary health need' as set out in national guidance. CHC includes elements that in the absence of a 'primary health need' would be met by social care but the whole CHC package, including those elements, is provided by the NHS free of charge to the patient.

1.3 The four CCGs collectively spent £58m on NHS continuing health care patients in 2014-15. They currently have a combined total of around 1007 patients in receipt of NHS CHC in their areas.

1.4 It is understood that Great Yarmouth and Waveney CCG is looking at CHC policy with the Suffolk CCGs and may propose changes in its area at a later date.

2. Purpose of today's meeting

2.1 North East London Commissioning Support Unit (NEL CSU) is preparing the consultation on behalf of the four CCGs. Representatives of the CCGs and the CSU will attend the meeting to present an outline of the areas on which they plan to consult and to seek the committee's comments about their proposed consultation process.

2.2 NEL CSU's presentation is attached at Appendix A.

3. Suggested approach

3.1 After the CCG and CSU representatives have given their presentation the committee may wish to:-

(a) Comment on the outline proposals for CHC and the consultation process.
(b) Agree to receive formal consultation from the CCGs on 16 July 2015.
(c) Agree to provide a formal response to the consultation on 3 September 2015.

3.2 Following the end of the consultation process each of the four CCGs will decide on the changes they wish to make to CHC policy in their own area. These decisions will then be reported to NHOSC, which will have the opportunity to conclude whether it considers that consultation with the committee has been adequate and whether the final proposed changes are in the interests of the local health service.

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.

NHS Continuing Healthcare

28 May 2015

NHS North Norfolk Clinical Commissioning Group, NHS Norwich Clinical Commissioning Group, NHS South Norfolk Clinical Commissioning Group, NHS West Norfolk Clinical Commissioning Group.

Introduction

- CCGs in central and west Norfolk (excluding Great Yarmouth and Waveney CCG) have been working together to think about NHS Continuing Healthcare.
- This work is guided by the requirement to implement the National Framework for the delivery of NHS Continuing Healthcare (CHC) and the National Operating Model.

What outcome are we hoping to achieve?

CCGs are working to publish a comprehensive guide for patients and families setting out how NHS CHC is implemented. This is in line with good practice elsewhere.

This will outline for the public:

- The implementation of the National Framework and how this is taken forward locally
- Local policies over which CCGs have discretion.
- Links to other policies and arrangements such as mental health section 117 arrangements

What is today all about?

Opportunities:

- For us to share our outline proposals and current thinking about consultation and engagement.
- For us to benefit from your experience in planning our consultation.
- For you to offer guidance on anything we may need to add or consider
- For you to advise on what more we might need to do to help the public engage.

What is NHS Continuing Healthcare (NHS CHC)?

- A package of ongoing care that is arranged and funded solely by the NHS, where the person has been found to have a ‘primary health need’ as set out in the National Guidance.
- This package of ongoing care is provided to someone aged 18+, to meet the needs which have arisen as a result of disability, accident or illness.
- The services provided as part of any package should be seen in the wider context of best practice and service development for each client group.
- Eligibility for NHS Continuing Healthcare places no limits on the settings in which a package of support can be offered or on the type of service delivery.
- The National Framework for NHS Continuing Healthcare and NHS funded nursing care published November 2012, provides the national policy, processes and definitions, which are used locally as the basis of the processes and wider policies which underpin practice in Norfolk.

Implementing the National Framework

All CCGs seek to implement the National Framework for NHS Continuing Healthcare. The National Framework defines, for example:

- How screening is undertaken to identify people who may be suitable for an assessment of eligibility for NHS CHC – “the Checklist”
- Processes for the assessment of eligibility is undertaken through the completion of “ the Decision Support Tool”
- Reviews of patients to ensure care continues to meet changing needs and that eligibility is reassessed at three months and then as a minimum annually
- How interfaces with joint funding arrangements should be applied.

We are not in a position to consult on the national framework as is a national document so we will focus on those elements of CHC where CCG have discretion.

Key statistics

- The four CCGs collectively spent £58m on NHS CHC patients in 2014/15.

- The four CCGs have a combined total of 1007 patients in receipt of NHS CHC funding. Of these:
  - 314 patients are cared for in their own homes (83 within this group have personal health budgets and commission their own care)
  - 646 patients are cared for within care homes/ supported living
  - 47 patients are on special end of life care packages

Note that this patient population changes daily.

The figures obtained correspond to the data extract from Broadcare, April 2015.

What do we want to achieve with this work?

- CCGs want an open and transparent approach to delivering NHS CHC which provides fairness and equity across our CCGs' area, within the resources available to us.
- We want to produce comprehensive and helpful documents for patients and the public, which explain everything there is to know about NHS CHC locally.

Already we have:

- looked at information produced by other CCGs on NHS CHC delivery in their areas and identified areas of good practice
- Identified areas where we lack a written approach or process and/or gaps in locally-published policies and processes where CCGs have discretion
- considered where patients and families have contacted us with concerns and complaints and where we need to improve our consistency of our approach.

Five potential areas for engagement with our public, stakeholders and patients are…

- Planning Care Together – how do we achieve high quality care that meets identified patient need in a manner affordable for the NHS?
- Respite care, leisure and holidays – what provision should there be to ensure carers are supported appropriately?
- Choosing out of area placements – helping families understand the implications.
- Acceptance of care packages – guidance proposed for self funding patients who wish to decline NHS CHC funded options.
- Withdrawal of services when people are no longer eligible – how do we better manage transition back to local authority or self funding.

We are meeting key patient groups in early June and Local Authority leads so these may change. CCG sign off may also change the final wording of the proposals.

Who might be affected by our potential areas of development?

- planning care together proposals and respite care proposals are still in development and will be of interest to patients who are cared for at home but would not, we anticipate, affect all patients in this group.
- Out of area placements affect 5-10 families a year.
- Acceptance of care packages affects only 2-3 patients per year from our experience.
- Withdrawal of funding arrangements when patients are assessed as no longer eligible for NHS CHC would be of interest to all patients and also the wider public. In the same way that a patient can be discharged from the care of a consultant when the treatment has finished, there are patients who no longer need CHC over time or whose circumstances have changed.

Our planned consultation

- Engagement with key patient group sector leads to finalise the areas for the consultation.
- 13-week consultation: mid/late June – mid/late September (tbc).
- Use of the Norfolk ‘Your Voice’ website to engage with local people.
- Locally-run engagement using stakeholder groups and community network meetings to share our consultation and gain people’s views. Specific meetings with key stakeholders and patient groups.
- Letter to all current patients (including those cared for out-of-area) encouraging them to give their views. Posters to go to GP practices. Distribute consultation documents to elected representatives, and to community and voluntary groups to use as required. Healthwatch have offered help to distribute information.
- Make documentation available in alternative formats as required e.g. easy read.

Ongoing engagement with HOSC suggested

- We wanted to talk to you today to inform you about the process and plan for the consultation.
- We would like to come back to you in July as part of the consultation to present our proposals and draft processes.
- We understand you may wish to formulate a view and respond to us at your September meeting. This will be within our proposed consultation period.
- We will plan to bring you the results of the consultation in January 2016 with a summary of CCG decisions which have been made as a result.

To know more

If you would like to discuss any element of this presentation, please contact our engagement team on:

Tel: 01603 257000
Email: max.bennett@nelcsu.nhs.uk
www.nelcsu.nhs.uk

Norfolk Health Overview and Scrutiny Committee appointments

Report by Maureen Orr, Democratic Support and Scrutiny Team Manager

The Committee is asked to appoint members to Great Yarmouth and Waveney Joint Health Scrutiny Committee.

1. Great Yarmouth and Waveney Joint Health Scrutiny Committee

1.1 Great Yarmouth and Waveney Joint Health Scrutiny Committee consists of three members appointed by Norfolk Health Overview and Scrutiny Committee (NHOSC) and three members appointed by Suffolk Health Scrutiny Committee. The joint committee meets quarterly, with the next meeting scheduled for 22 July 2015. The agenda for 22 July meeting will be dispatched before the next meeting of NHOSC, which is scheduled for 16 July 2015. NHOSC is therefore asked to make appointments to the joint committee today.

1.2 Nominations to the joint committee are not required to be in line with the political balance of Norfolk County Council. Other members of NHOSC can substitute for the joint committee members as and when required.

1.3 The terms of reference for the joint committee require NHOSC to appoint three members. One must be the Great Yarmouth and Waveney Borough Council member on NHOSC and the other two may be appointed from adjoining districts to Great Yarmouth and Waveney where a proportion of their residents look in the first instance to the James Paget University Hospital NHS Foundation Trust for acute services.

1.4 The current NHOSC appointees to the joint committee are:-

Mr M Carttiss
Mr C Aldred
Vacancy (the Great Yarmouth and Waveney Borough Council appointee to NHOSC)

2. Other NHOSC appointments

2.1 NHOSC also appoints members to act as link members with local NHS Trusts and Clinical Commissioning Group. The committee will be asked to appoint members to any vacancies that exist in these roles at its next meeting on 16 July 2015.

2. Action

2.1 The Committee is asked to:-

(a) Confirm the appointment of the Great Yarmouth and Waveney Borough Council member to Great Yarmouth and Waveney Joint Health Scrutiny Committee, in line with the joint committee's terms of reference.

(b) Confirm the two current appointments to Great Yarmouth and Waveney Joint Health Scrutiny Committee (see paragraph 1.4), or appoint other members who meet the criteria in the joint committee's terms of reference (see paragraph 1.3).

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.

Norfolk Health Overview and Scrutiny Committee

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

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

Proposed Forward Work Programme 2015

Meeting dates	*Briefings/Main scrutiny topic/initial review of topics/follow-ups*	*Administrative business*
16 July 2015	Development of dementia services in West Norfolk – report to the committee from West Norfolk CCG regarding permanent changes following the end of the trial period in March 2015. Plans to maintain and improve access to primary care services in Norwich and surrounding areas - consultation by NHS England Midlands and East (East) about walk-in and primary care services in Norwich following strategic review by Enable East. Continuing Health Care – consultation by Norwich, North Norfolk, South Norfolk and West Norfolk CCGs on proposed changes to policy. NHS workforce planning in Norfolk - report of the scrutiny task & finish group.	*Subject to confirmation by NHOSC 28/5/15*
3 Sept 2015	Diabetes Care within Primary Care Services in Norfolk – NHS England Midland and East (East), Central Norfolk Diabetes Network and West Norfolk Clinical Commissioning Group will report on the services delivered in primary care. Continuing Health Care – to agree NHOSC's comments in response to consultation received on 16 July 2015.	*Subject to confirmation by NHOSC 28/5/15* *Subject to confirmation by NHOSC 28/5/15*
15 Oct 2015	Policing and Mental Health Services - an update from the Police & Crime Commissioner for Norfolk, Norfolk and Suffolk NHS Foundation Trust and Norfolk	

	Constabulary (further to the presentation given to NHOSC in October 2014).	

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 2015-16

3 Dec 2015 – Stroke Services in Norfolk – update (12 months after the responses to stroke recommendations, presented to NHOSC 27 November 2014).

Jan 2016 – Development of Dementia Services in West Norfolk – final consideration of the CCG's proposals (depending on the report on 16 July 2015)

Jan 2016 – Continuing Health Care – final consideration of the four CCGs' proposals (depending on confirmation by NHOSC on 28 May 2015)

Feb 2016- Ambulance response times and turnaround times in hospitals in Norfolk (an update to the East of England Ambulance Service NHS Trust, Norfolk and Norwich University Hospitals NHS Foundation Trust and Clinical Commissioning Group report presented in February 2015)

Apr 2016 – Service in A&E following attempted suicide or self-harm episodes (an update to the report presented in April 2015 by Norfolk and Suffolk NHS Foundation Trust and the three acute hospitals)

NHOSC Scrutiny Task and Finish Groups

Task & finish group	Membership	Progress
NHS Workforce Planning in Norfolk	Cllr Michael Chenery of Horsbrugh Cllr Alexandra Kemp Cllr Nigel Legg Cllr Margaret Somerville (Chairman) Alex Stewart – Healthwatch Norfolk Robert Kybird (co-opted, non voting lay member)	The Group met NHS representatives on 10 Feb, 20 & 31 March, 22 April, 12, 14 & 21 May and expects to report back to NHOSC in July 2015.

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

Clinical Commissioning Groups

North Norfolk	-	*Vacancy* (substitute M Chenery of Horsbrugh)
South Norfolk	-	Dr N Legg (substitute *Vacancy*)
Gt Yarmouth and Waveney	-	*Vacancy* (substitute Mrs J Chamberlin)
West Norfolk	-	M Chenery of Horsbrugh (substitute *Vacancy*)
Norwich	-	*Vacancy* (substitute Mrs M Somerville)

NHS Provider Trusts

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

Norfolk Health Overview and Scrutiny Committee 28 May 2015

Glossary of Terms and Abbreviations

A&E	Accident and Emergency
BME	Black Minority Ethnic
BMI	Body mass index
CCG	Clinical Commissioning Group
CHC	Continuing health care
CPT	Contingency Planning Team
CVD	Cardiovascular disease
DESP	Diabetes eye screening programme
EAAT	East Anglia Area Team
EADESP	East Anglia diabetes eye screening programme
GMS	General Medical Services
GP	General practitioner
GPhC	General Pharmaceutical Council
GP2DRS	A system linking screening programmes with GP systems
GpwSI	General Practitioner with a Special Interest
HbA1c	'Glycosylated haemoglobin' molecule – by measuring glycated haemoglobin clinicians are able to get an overall picture of average blood sugar levels over a period of weeks / months. For people without diabetes the range is 20-41 mmol/mol (4-5.9%). For people with diabetes and HbA1c level of 48 mmol/mol (6.5%) is considered good control. For people at greater risk of hypoglycaemia (lower than normal blood pressure) a target of HbA1c or 59 mmol/mol (7.5%) is to reduce the risk of hypos.
IFCC	International Federation of Clinical Chemistry
IT	Information technology
NCH&C (NCHC)	Norfolk Community Health and Care NHS Trust
NHOSC	Norfolk Health Overview and Scrutiny Committee
NICE	National Institute for Health and Care Excellence
NNUH (N&N, NNUHFT)	Norfolk and Norwich University Hospitals NHS Foundation Trust
NSFT	Norfolk and Suffolk NHS Foundation Trust (the mental health trust)
OOH	Out of hours
QEH	Queen Elizabeth Hospital, King's Lynn
QIPP	Quality, innovation, productivity and prevention
QOF	Quality outcomes framework

READ	Read codes were developed in the 1980s and are currently used to code clinical data in primary care in the United Kingdom
TBC	To be confirmed
WNCCG	West Norfolk Clinical Commissioning Group
WNVCA	West Norfolk Voluntary and Community Action