Norfolk County Council

Norfolk Health Overview and Scrutiny Committee

Date: **Thursday, 22 February 2018**

Time: **10:00**

Venue: **Edwards Room, County Hall, Martineau Lane, Norwich, Norfolk, NR1 2DH**

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
Mrs J Brociek-Coulton	Ms L Grahame	Norwich City Council
Michael Chenery of Horsbrugh	Mr S Eyre	Norfolk County Council
Ms E Corlett	Miss K Clipsham/Mr M Smith-Clare	Norfolk County Council
Mr F Eagle	Mr S Eyre	Norfolk County Council
Mrs M Fairhead	Vacancy	Great Yarmouth Borough Council
Mrs S Fraser	Mr T Smith	King's Lynn and West Norfolk Borough Council
Mr A Grant	Mr S Eyre	Norfolk County Council
Mr D Harrison	Mr T Adams	Norfolk County Council
Mrs L Hempsall	Mr J Emsell	Broadland District Council
Mrs B Jones	Miss K Clipsham/Mr M Smith-Clare	Norfolk County Council
Dr N Legg	Mr C Foulger	South Norfolk District Council
Mr R Price	Mr S Eyre	Norfolk County Council
Mr P Wilkinson	Mr R Richmond	Breckland District Council
Vacancy	Vacancy	North Norfolk District Council
Mrs S Young	Mr S Eyre	Norfolk County Council

For further details and general enquiries about this Agenda please contact the Committee Officer:

Tim Shaw on 01603 222948 or email committees@norfolk.gov.uk

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A g e n d a

1		**To receive apologies and details of any substitute members attending**	
2		**NHOSC minutes of 11 January 2018**	**Page 5**
3		**Declarations of Interest** 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		**Any items of business the Chairman decides should be considered as a matter of urgency**	
5		**Chairman's Announcements**	
6	**10.10-11.00**	**Physical health checks for adults with learning disabilities** **Appendix A** (Page 16) - Summary of the Health and Care of People with Learning Disabilities 2016-17 - NHS Digital **Appendix B** (Page 19) - Clinical Commissioning	**Page 11**

Groups' report

	11.00-11.10	**Break at Chairman's discretion**	**Page**
7	**11.10-12.00**	**Continuing healthcare**	**Page 28**
		Appendix A (Page 32) - CCGs' response to NHOSC speakers 23 February 2017 **Appendix B** (Page 36) - CCGs' responses to NHOSC recommendations	
8	**12.00-12.05**	**Norfolk Health Overview and Scrutiny Committee appointment** To appoint a link Member with Norfolk Community Health and Care NHS Trust	**Page 58**
9	**12.05-12.15**	**Forward work programme** To agree the committee's forward work programme	**Page 59**
10		**Glossary of terms and abbreviations**	**Page 62**

Chris Walton
Head of Democratic Services
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Date Agenda Published: 14 February 2018

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Norfolk County Council

NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE
MINUTES OF THE MEETING HELD AT COUNTY HALL, NORWICH
on 11 January 2018

Present:

Michael Chenery of Horsbrugh (Chairman)	Norfolk County Council
Mrs J Brociek-Coulton	Norwich City Council
Ms E Corlett	Norfolk County Council
Mr F Eagle	Norfolk County Council
Mrs S Fraser	King's Lynn and West Norfolk Borough Council
Mr A Grant	Norfolk County Council
Mr D Harrison	Norfolk County Council
Mrs L Hempsall	Broadland District Council
Dr N Legg	South Norfolk District Council
Mr R Price	Norfolk County Council
Mr P Wilkinson	Breckland District Council
Mrs S Young	Norfolk County Council

Also Present:

Roberta Fuller	Deputy Chief Operating Officer, Norfolk and Norwich University Hospitals NHS Foundation Trust
Sam Cayford	Healthy Living Manager, South Norfolk Council
Melanie Craig	Chief Officer, Great Yarmouth and Waveney CCG
Tracy McLean	Head of Children, Young People and Maternity Services for Norfolk and Waveney, hosted by Great Yarmouth & Waveney CCG
Alan Hunter	Head of Service (Children), Norfolk Community Health and Care NHS Trust
Roisin Fallon-Williams	Norfolk Community Health and Care NHS Trust
Roy Reynolds	Member of North Norfolk District Council attending as an observer
Maureen Orr	Democratic Support and Scrutiny Team Manager
Chris Walton	Head of Democratic Services
Tim Shaw	Committee Officer

1. Apologies for Absence

Apologies for absence were received from Mrs M Fairhead, Great Yarmouth Borough Council and Mrs B Jones, Norfolk County Council.

The Committee was informed that a replacement Member and substitute for Mr Glyn Williams (who had resigned from North Norfolk District Council due to ill health) would be appointed to NHOSC when the District Council next met on 21st February 2018. In the meantime, Mr Roy Reynolds, a Member of North Norfolk District Council, was in attendance at today's NHOSC as an observer (sitting in the public seating area).

2. Minutes

The minutes of the previous meeting held on 14 December 2017 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 Visit to the new Older People's Emergency Department at the Norfolk and Norwich Hospital

The Chairman reminded Members that they were invited to see the new Older People's Emergency Department at the Norfolk and Norwich Hospital on Friday 26 January 2018 from 3.00 to 4.00pm. The visit would start with a presentation and opportunity to ask questions about the new service, followed by a tour of the department. Up to 10 Members could take part in the visit and so far 6 Members had booked a place. If any other Members wanted to take part then they were asked to contact Maureen Orr.

5.2 Visits to NSFT mental health facilities in central and west Norfolk

The Chairman reminded Members that the NSFT had offered dates in March 2018 for Members to visit its facilities in central and west Norfolk. Members who wanted to attend and had not already contacted Maureen Orr were asked to do so.

6 Delayed discharges / transfers of care – the District Direct pilot

6.1 The Committee received a suggested approach by Maureen Orr, Democratic Support and Scrutiny Team Manager, to a report on District Direct which was being piloted by five district councils (South Norfolk, North Norfolk, Breckland, Broadland and Norwich) and the Norfolk and Norwich Hospital to support patient discharge and its effect on delayed discharges / transfers of care.

6.2 The Committee received evidence from Roberta Fuller, Deputy Chief Operating Officer, Norfolk and Norwich University Hospitals NHS Foundation Trust and Sam Cayford, Healthy Living Manager, South Norfolk Council.

6.3 The following key points were noted:

- District Direct was the name given to a pilot scheme that involved five district council officers (from South Norfolk, North Norfolk, Breckland, Broadland and Norwich) each being seconded for one day per week to work within the NNUH integrated discharge team to support patients to return home.
- The district officers had experience in dealing with homelessness, housing adaptations and benefits and were familiar with a wide range of measures to support patients' return to their own homes.
- The speakers explained how District Direct contributed to the overall array of hospital discharge services and answered questions about the wide range of NNUH discharge services that were available.
- It was noted that District Direct was one of several schemes that the NNUH was participating in to support hospital discharge across Norfolk and to enable people to return to or stay in their own homes. Examples, mentioned in the report, included Home First crisis homecare, Healthy Homes Project and Hospital Care at Home.
- It was hoped that the District Direct pilot could be rolled out to the Queen Elizabeth and James Paget Hospitals, community hospitals, mental health inpatients and prison release.
- The speakers said that NHS England had chosen to use the District Direct pilot as a case study of best practice and would be sharing details of the pilot nationally.
- The District Councils had funded the pilot scheme from its inception in September 2017 until December 2017.
- In December 2017 the NNUH had taken on the funding of the pilot scheme in order to maintain the momentum of the initiative until the end of the current financial year by which time it was hoped that more sustainable funding could be secured.
- The pilot had saved 385 bed days over 17 weeks (5-day week) leading to a saving of £77,000.
- It was estimated that over the course of a year (7-day week) District Direct could lead to a saving of £330,690.
- The pilot had halved average length of stay in older people's beds.
- The overall length of patient stay in hospital had been reduced by 42%.
- It was pointed out that many delayed discharges involved the kinds of housing related issues that were not dealt with quickly enough in the past.
- The speakers said that a detailed evaluation of the pilot scheme would be undertaken in February 2018. The results of the evaluation would be shared widely with interested parties (including the County Council) with a view to securing long-term funding for extending the scheme to 7 days a week with a focus on A&E as well as on hospital wards. The speakers said that a seven day scheme would provide for a more consistent service that better met NNUH requirements.

6.4 Members commented that:-

- On the evidence that they had so far received the continuation of District Direct appeared to be desirable.
- A robust evaluation of the cost effectiveness of the pilot would be necessary to make the business case for it to become a core service and be extended to 7 day working with a focus on A&E as well as on hospital wards.

- The evaluation study should include examples of effective practice in certain District Council areas, which others might wish to implement.

6.5 The Committee **agreed** to receive information on the evaluation of the District Direct pilot in the NHOSC Briefing. Depending on the evaluation findings, NHOSC might wish to revisit the subject at a future meeting.

7 Children's autism services (central & west Norfolk) – assessment and diagnosis

7.1 The Committee received a suggested approach by Maureen Orr, Democratic Support and Scrutiny Team Manager, to an update report from NHS commissioners and providers on action to reduce waiting times.

7.2 The Committee received evidence from Melanie Craig, Chief Officer, Great Yarmouth and Waveney CCG, Tracy McLean, Head of Children, Young People and Maternity Services for Norfolk and Waveney, hosted by Great Yarmouth & Waveney CCG, Alan Hunter, Head of Service (Children), Norfolk Community Health and Care NHS Trust and Roisin Fallon-Williams, Norfolk Community Health and Care NHS Trust

7.3 The following key points were noted:

- In September 2017, as a result of the identification of increased demand and unacceptably long waiting times for diagnostic assessment for Autism Spectrum Disorder (ASD), the four Norfolk CCGs (which excluded Great Yarmouth and Waveney) had agreed £250,000 of additional investment that was being used to increase staffing capacity within the service.
- Details regarding the additional posts could be found at paragraph 3 of the report, at pages 31 and 32 of the agenda. Norfolk Community Health and Care (NCHC) had received approval to commence recruitment to these posts which were either advertised/subject to interview or already filled.
- The main threat to the achievement of reduced waiting times for assessment and diagnosis of children's ASD in central and west Norfolk was identified as lack of staffing and staff absence due to failure to recruit, sickness, maternity leave or resignation.
- It was noted that the table at paragraph 5.4 of the report (on page 33 of the agenda) demonstrated a significant reduction in numbers of children waiting over 52 weeks.
- It was anticipated that by 1st May 2018, the agreed trajectory (set out in the report) for improvement in waiting times for assessment for autistic spectrum disorders would mean that no child waited more than 52 weeks for assessment to commence; provided the predicted staffing was available.
- By 1st May 2019 it was anticipated that no child would be waiting more than 18 weeks.
- There was senior level oversight of progress against the agreed waiting times trajectory and decisions about funding were taken by the Joint Commissioning Committee which included all the CCGs.
- The speakers said that a single waiting list had been introduced for all patients. All referrals were triaged on the basis of clinical need, however, Looked After Children received preferential access because of their state of vulnerability and complex needs. Looked After Children (LAC) on the ASD pathway were tracked on the number of weeks waited to date and number of weeks on the pathway whilst undergoing assessments.

- Children who were excluded from school were also tracked on the system and prioritised because of their vulnerability and complex needs.
- Of all those referred to the service for an assessment, 75% -80% were diagnosed with ASD. The families of those who were not diagnosed with ASD were signposted to other means of support such as that available from Autism Anglia and through the work of schools and children's services. By the time of their diagnosis the requirements of many of these children were already well known about for other reasons.
- All the families who had been waiting over 52 weeks, with no appointment booked for assessment to commence, had been offered a place on a Positive Behaviour Support Programme (PBSP). Some families decided not to take up a place on a PBSP as they considered they had already developed the necessary skills.
- Healthwatch Norfolk was gathering experiences from parents/carers of children/young people (18 and under) with ASD (or possible ASD) who were trying to access help and support from health and social care services. The information that was being collected included experiences with the diagnostic services and post diagnostic support services across the county and would be shared widely when the study had been completed.

7.4 The Committee **agreed** to ask Norfolk Community Health and Care NHS Trust to provide details about the number of over 52 week waiters with no appointment booked for assessment to commence who had taken up the offer of a place on a Positive Behaviour Support Programme.

7.5 The Committee also **agreed** to receive an update in the NHOSC Briefing (internal briefing) on progress against the agreed trajectory for improvement in waiting times for assessment for autistic spectrum disorders.

8 Forward work programme

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

8.2 The forward work programme was **agreed** as set out in the agenda papers with the addition of Maternity services to be added to NHOSC's Forward Work Programme for 12 July 2018.

It was noted that the situation regarding provision of Speech and Language Drop in Sessions at Angel Road Children's Centre, Norwich, would be followed up in advance of the SLT item on 5 April 2018 agenda.

8.3 The Committee asked for information on the following items to be included in the NHOSC Briefing:-

- Community Pharmacy and the effects of the shortage / high cost of medicines, and the types of medicines affected.

- Sexual Health Services in Norfolk.

- Evaluation of the District Direct pilot (see minute 6 above)

Chairman

The meeting concluded at 12.30 pm

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Norfolk Health Overview and Scrutiny Committee
22 February 2018
Item no 6

Physical health checks for adults with learning disabilities

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

Examination of the take-up of physical health checks for adults with learning disabilities in Norfolk.

1. Background

1.1 On 27 September 2017 Norfolk Health and Wellbeing Board received a report on 'Transforming Care Partnership – Services for Adults with a Learning Disability'. The Board noted that there was a lower life expectancy for people with learning difficulties and considered it would be useful to understand the level of physical health checks for adults with learning difficulties across Norfolk and what is being done about those people not coming forward for checks. It was suggested that Norfolk Health Overview and Scrutiny Committee (NHOSC) might wish to investigate this area. NHOSC added the subject to its Forward Work Programme on 26 October 2017.

1.2 As reported to the Health and Wellbeing Board in September 2017, the Norfolk and Waveney CCGs are working to ensure that physical health checks are implemented for people with learning disabilities including new cancer screening programmes. There is ongoing work to align health and social care Learning Disability Registers to support this aim. The outcome of the work will be:-

- To make a significant and sustained increase the number of people on Learning Disability (LD) registers, and increase the number of people who have LD health checks.
- To raise awareness of annual health checks and the primary care pathway, including medication reviews and the summary care record, for people with LD amongst local people.
- To ensure that annual health checks are done consistently and to a high standard across the Transforming Care Partnership (TCP), including medication reviews (STOMP – Stopping Over-Medication of People with a Learning Disability).
- To increase the use of summary care records for people with LD.

2. Annual Health Check for young people and adults with learning disabilities

2.1 NHS Annual Health Checks for adults with learning disabilities are offered under a different scheme from the Health Checks for adults aged 40 – 74

in the general population. Health Checks for 40 – 74 year olds are commissioned by Public Health, Norfolk County Council, and can be provided at pharmacies as well as at GP practices. They assess people's risk of heart disease, stroke, kidney disease, diabetes and dementia every five years.

2.2 NHS Annual Health Checks for adults with learning disabilities are commissioned by local Clinical Commissioning Groups (CCGs) who have taken over the responsibility for GP primary care commissioning from NHS England. GP practices are encouraged to identify all patients aged 14 and over with learning disabilities, to maintain a learning disabilities 'health check' register and to offer individuals an Annual Health Check, which includes producing a health action plan.

2.3 The learning disabilities health check scheme is one of a number of GP enhanced services. Enhanced services are voluntary for GP practices, who may or may not contract to deliver them. The payment they receive for each learning disabilities health check is £140 (under the 2017-18 contract). A template is available for guidance of GPs carrying out the tests but use of the template is at their discretion.

2.4 The NHS Choices website provides public information about Learning Disabilities Annual Health Checks:-

- The Annual Health Check scheme is for adults and young people aged 14 and over with learning disabilities who need more support and who may otherwise have health conditions that go undetected.
- People aged 14 and over who have been assessed as having moderate, severe or profound learning disabilities, or people with a mild learning disability who have other complex health needs, are entitled to a check.
- Those who are known to their local authority social services, and who are registered with a GP who knows their medical history, should be invited by their GP practice to come for an Annual Health Check.
- The Annual Health Check takes up to one hour and can be much quicker depending on:
    - How often the person normally visits their doctor
    - Their overall health and wellbeing
    - Their lifestyle (for example whether they drink alcohol or smoke)
    - How much of the consultation they decide to consent to
- During the health check the GP or practice nurse will carry out the following for the patient:-
    - a general physical examination, including checking their weight, heart rate, blood pressure and taking blood and urine samples
    - assessing the patient's behaviour, including asking questions about their lifestyle, and mental health
    - a check for epilepsy
    - a check on any prescribed medicines the patient is currently taking

    - a check on whether any chronic illnesses, such as asthma or diabetes, are being well managed
    - a review of any arrangements with other health professionals, such as physiotherapists or speech therapists
- If the person's learning disability has a specific cause, the GP or practice nurse can do extra tests for particular health risks. For people with Down's syndrome, for example, they may do a test to see whether their thyroid is working properly.
- The Annual Health Check is also a good opportunity to review any transitional arrangements that take place when a patient turns 18.
- The GP or practice nurse will also provide the patient with any relevant health information, such as advice on healthy eating, exercise, contraception or stop smoking support.
- Where the patient's needs relating to their learning disability are written down in a health profile or health action plan the GP or nurse can put 'reasonable adjustments' in place to help people have a successful health check. Adjustments can include:-
    - using pictures, large print, and straightforward language to help explain what is happening
    - booking longer appointments
    - scheduling an appointment that starts at the beginning or end of the day, so people don't have to wait

3. National situation

3.1 That people with learning disabilities suffer poorer health, lower life expectancy and a higher level of preventable deaths than the general population has been recognised for some time. There have been numerous investigations, reports and recommendations aimed at improving the situation and while there has been progress there is room for improvement. The Equality and Human Rights Commission's 'Is England Fairer?' report published in April 2016 summarised the progress made since 2010 and the inequalities that still exist in the health and care of people with learning disabilities compared to the general population:- https://www.equalityhumanrights.com/en/britain-fairer/england-fairer-introduction/englands-most-disadvantaged-groups

3.2 One of the Commission's concerns was the finding that three quarters of Joint Strategic Needs Assessments (JSNAs) included no information on the number of children with learning disabilities in their area and 19 out of 20 gave no indication of future prevalence (Baines and Hatton, 2014).

3.3 A summary of the 'Health and Care of People with Learning Disabilities: 2016-17' published by NHS Digital in December 2017 (attached at **Appendix A**) includes data collected from over half of GP practices in England to identify differences in the treatment, health status and outcomes of people with learning disabilities compared to the rest of the population. The data collection for this survey appears to have covered less than 40% of patients registered in Norfolk but with 57.4% coverage of patients across England as a whole, it provides some useful context.

4. Purpose of today's meeting

4.1 The focus of today's meeting is to ascertain the level of Annual Health Checks for people with learning disabilities that are offered and taken up across Norfolk and ask what more the commissioners could do to increase the numbers.

4.2 The relevant CCG commissioners have been asked to report to NHOSC on the local situation with:-

- Information on life expectancy of people with learning disabilities compared to the general population
- Other information on the physical health of adults with learning disabilities in Norfolk, e.g. prevalence of long term conditions and other physical ill-health compared to the general population
- Information on what the Learning Disabilities Health Check Scheme is; who commissions local GPs to provide it; how many local GPs provide it across Norfolk and the geographic spread
- How many adults with learning disabilities are resident in Norfolk and how many of them are registered to receive the annual health check in each CCG area?
- How many of those who are registered to receive the annual health check were offered it in the past year, and how many of those took it up in each CCG area?
- What is being done to encourage more adults with learning disabilities to be registered for annual health checks and to attend for the health check?
- What is the level of investment in this service in each CCG area?

4.3 South Norfolk CCG is the lead CCG for the Norfolk and Waveney Sustainability Transformation Plan (STP) for learning disabilities and Great Yarmouth and Waveney CCG is the lead for primary care. The two CCGs have provided the report at **Appendix B** and representatives will attend to answer Members' questions.

5. Suggested approach

5.1 After the CCG representatives have presented their report, the committee may wish to discuss the following areas:-

(a) Do the commissioners have sufficient local information on the prevalence of learning disabilities, or the numbers of young people and adults with learning disabilities in Norfolk, to reliably assess what proportion of the total numbers with learning disabilities are currently included on local GPs' learning disabilities 'health check' registers, and to plan for future needs?

(b) What are the CCGs' comments about the difference between the 2011 national estimate of the number of adults with learning disabilities living in Norfolk and Waveney (21,786 in total, of which 3315 were counted as having severe or moderate disabilities and 5136 with Autistic Spectrum Disorder) and the number currently included on GP learning disability registers (5,435 in 2016/17)?

(c) What progress has there been towards resolving the data quality issues around learning disabilities annual health checks and when do commissioners expect to have reliable data to enable them to monitor progress?

(d) How can the commissioners be assured of the quality of the 'Annual Health Check' provided, particularly in practices where the national templates for carrying out the check are not in use?

(e) What is being done to increase the take-up rate of learning disabilities annual health checks offered to young people and adults with learning disabilities?

(f) Increasing the take-up of learning disabilities annual health checks would require extra payments to primary care. What increase in expenditure have the CCGs planned to incur in this respect?

6. Action

6.1 Following the discussions with representatives at today's meeting, Members may wish to consider whether:-

(a) There is further information or progress updates that the committee wishes to receive at a future meeting or in the NHOSC Briefing.

(b) There are comments or recommendations that the committee wishes to make as a result of today's discussions.

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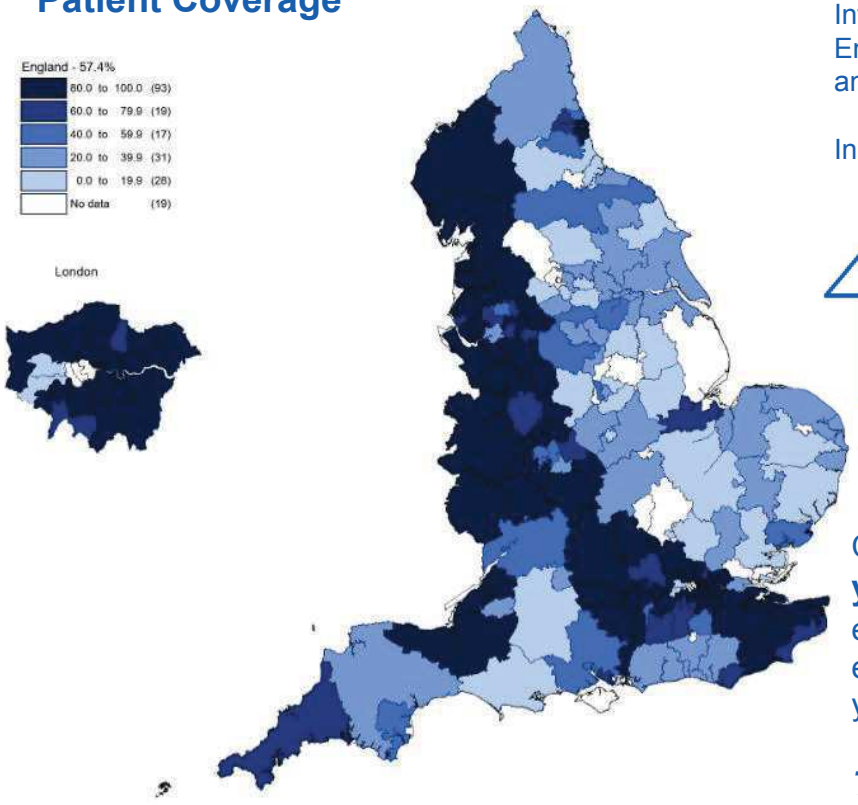
Health and Care of People with Learning Disabilities: 2016-17

Patient Coverage



Information on people with and without learning disabilities was collected from over half of GP practices in England in 2014-15, 2015-16 and 2016-17, to identify potential differences in the treatment, health status, and outcomes of people with learning disabilities compared with the rest of the population.

In 2016-17, 1 in 218 people (0.46 per cent of the population) were recorded as having a learning disability.

57.4 per cent of patients registered in England were included in these data, an **increase** from 51.2 per cent in 2014-15.

79.5 per cent of eligible patients with a learning disability aged 60-69 received **screening for colorectal cancer**, an **increase** from 68.6 per cent in 2014-15. 86.0 per cent of eligible patients without a recorded learning disability received this screening in 2016-17.

Combining data from 2014-15 to 2016-17, a **female** with learning disabilities had almost an **18 year lower life expectancy** compared to females without a learning disability (a 66 year life expectancy compared to 84 years). **Males** with a learning disability had a **14 year lower** life expectancy compared to males with no recorded learning disability (66 years compared to 80 years).

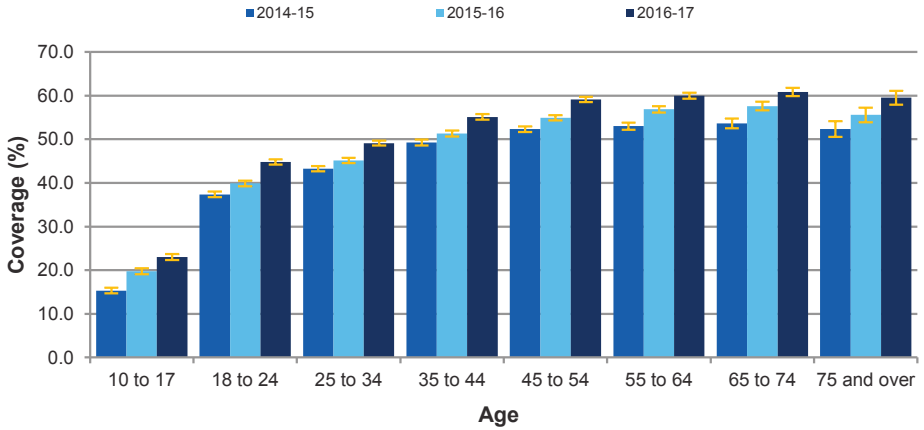
To see the full 2016-17 dataset visit the interactive report available here

Published: 12 December 2017
Author: Primary Care Domain, NHS Digital
Responsible Statistician: Adam Langron

www.digital.nhs.uk
enquiries@nhsdigital.nhs.uk

Health Promotion: Health Checks and Influenza Immunisations

Proportion of patients with a learning disability who had a learning disability health check in the year, 2014-15 to 2016-17

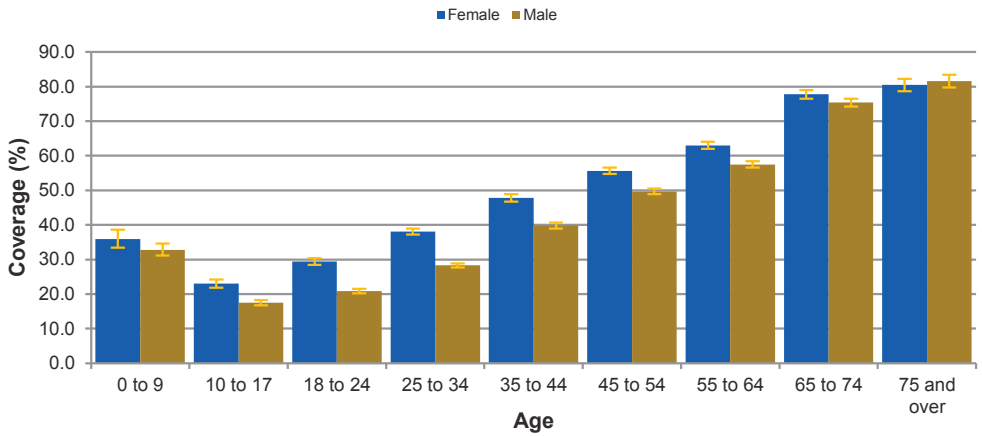


Overall, 49.7 per cent of patients with a learning disability received an annual learning disability health check in 2016-17. This is an increase from 43.2 per cent in 2014-15.

The proportion of patients with a learning disability receiving a health check increased in all age groups compared to 2014-15, the largest increase was in patients aged 10 to 17.

Annual learning disability health checks were introduced in 2008-09 for people aged 14 and over.

Proportion of patients with a learning disability who received a seasonal influenza immunisation, by age and sex, 2016-17



41.9 per cent of patients with a learning disability received a seasonal influenza immunisation in 2016-17 compared to 40.8 per cent in 2014-15. However in patients aged 0 to 9, the proportion who received a flu immunisation increased from 24.5 per cent to 33.8 per cent between 2014-15 and 2016-17. Nasal spray immunisations for children started to be introduced in 2013.

Overall, in 2016-17, 66.0 per cent of patients aged 65 or over received a seasonal influenza vaccination by their GP practice. This includes both patients with and without a learning disability. (These data are available from the GP Contract Services publication: https://digital.nhs.uk/catalogue/PUB30049)

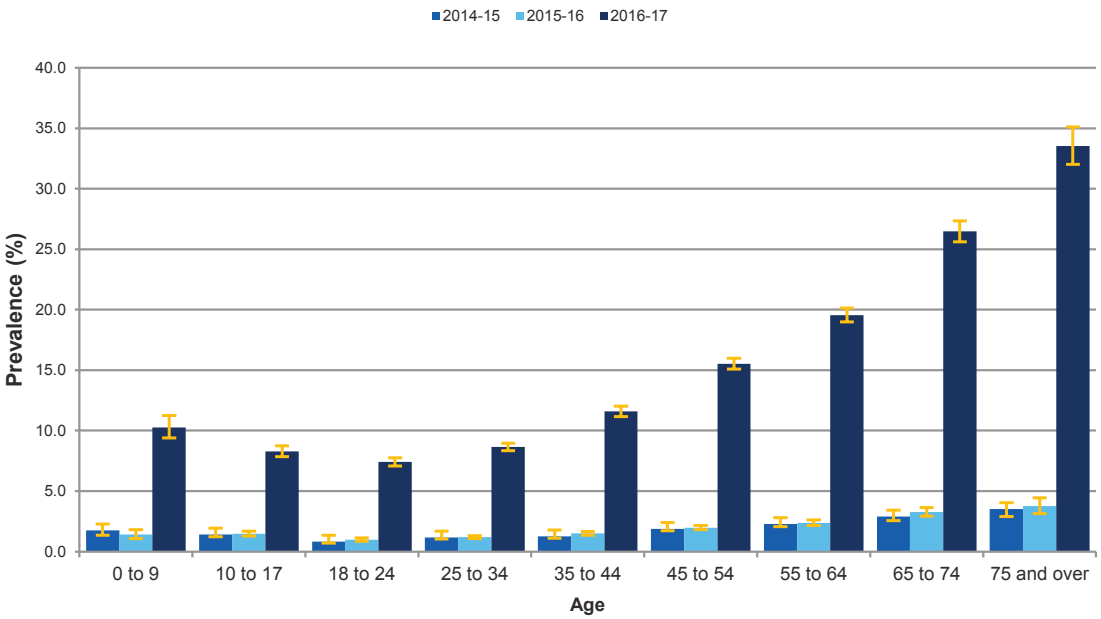
The confidence intervals displayed on the charts show the range in which there can be 95 per cent confidence that the true coverage lies for the entire population. Where the confidence intervals for each year do not overlap the difference in the coverage between the two periods is considered statistically significant.

Published: 12 December 2017
Author: Primary Care Domain, NHS Digital
Responsible Statistician: Adam Langron

www.digital.nhs.uk
enquiries@nhsdigital.nhs.uk

Chronic Constipation and Dysphagia

Chronic constipation prevalence (per cent) in patients with a learning disability, 2014-15 to 2016-17



Chronic constipation

The overall rate of constipation identified in patients with a learning disability was 13.1 per cent in 2016-17. This is an increase from 1.6 per cent in 2014-15. The rate increases with age and is highest in patients aged 75 and over (33.5 per cent).

The large increase in the number of patients with a learning disability and chronic constipation could be due to factors such as improved recording in primary care. It is likely that constipation was under diagnosed in previous years* rather than a true increase in prevalence of this magnitude.

*https://www.gov.uk/government/publications/reasonable-adjustments-for-people-with-learning-disabilities/constipation

Dysphagia

Overall, 3.0 per cent of patients with a learning disability also had a diagnosis of dysphagia, with the highest prevalence recorded in patients aged 75 and over (6.3 per cent). The most detailed UK study** on the prevalence of dysphagia in people with learning disabilities suggests that prevalence is likely to be around 8.0 per cent.

**Chadwick DD & Jolliffe J, 'A descriptive investigation of dysphagia in adults with intellectual disabilities', Journal of Intellectual Disability Research, 2009, 53:1 pp. 29-43

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Learning Disability Health Checks

Alison Leather Director of Quality NNCCG/SNCCG

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Local prevalence and incidence

Norfolk and Waveney STP – Learning Disability QOF Prevalence data 2016/17

Shown as % - data source Public Health England website

Year	Great Yarmouth and Waveney CCG	West Norfolk CCG	South Norfolk CCG	Norwich CCG	North Norfolk CCG	England Average
2014/15	0.5	0.5	0.5	0.7	0.7	0.4
2015/16	0.6	0.5	0.6	0.7	0.7	0.5
2016/17	0.6	0.6	0.6	0.7	**0.8	0.5

*Norfolk and Waveney STP has a higher than England average LD prevalence
**North Norfolk has the second highest LD prevalence within the Midlands and East region.

Local prevalence and incidence

- As of 2011 national estimates predicted that there were 21,786 adults with learning disability living in Norfolk (including Waveney) in 2010, 3315 of whom were counted as having severe or moderate disabilities and 5136 with ASD.
- In contrast, local service data recorded a total of 2627 people with learning disability for 2010.
- Local registers for children show 1522 males and 597 females, with identified prevalence rising to peak within teenage years i.e. at the point of transition from children's to adult services, as the condition becomes apparent during the child's development. In December 2010 there were 624 children registered aged 15 and above.
- Nationally the average age of death for people with a learning disability:
    - 67.5 for people with a mild learning disability
    - 64 for people with a moderate learning disability
    - 59 for people with a severe learning disability
    - 46 for people with profound and multiple learning disabilities
- Nationally 38% of people with a learning disability die from avoidable causes, compared with 9% of the general population
- Research suggests that there are a number of health conditions that people with a learning disability are more likely to experience, including:
    - being underweight or overweight
    - dementia
    - epilepsy
    - respiratory disease.

Learning Disability Health Checks: how are they commissioned?

- The LD Health Check programme is commissioned by the local Clinical Commissioning Groups (CCG's) and delivered within primary care.
- There are key objectives and priorities for both CCG's and STP's which serve as markers of success; three of these are specifically related to outcome measures for people with learning disabilities:
    - Reliance on specialist inpatient care for people with learning disability and/or a autism
    - Proportion of people with a learning disability on the GP register receiving an annual health check
    - Completeness of the GP learning disability register (this is a new indicator from 2017/18)
- Local authorities also have two indicators relating to people with learning disabilities:
    - The number of people with learning disabilities in paid employment
    - The number of people with a learning disability in their own home or with their family. This indicator has an impact on the CCGs indicator noted above.

Learning Disability Health Checks: who should have one?

- All patients aged 14 and over that have moderate to severe learning disabilities are eligible for an Annual Health Check.
- All patients on the GPs' Learning Disability Register are entitled to and should be invited to receive an annual LD Health Check.
- GPs must liaise with local authorities to identify which of their registered patients are known to the local authority and vice versa because of their learning disabilities and ensure these patients are captured on the GPs Learning Disabilities Register so they can be invited for an annual health check

Learning Disability Health Checks: what are they?

- The LD Health Check programme has two components:
    - Annual health check for patients with learning disabilities.
    - Completeness of the GP Learning Disability Register.
- The Health Check considers the patients physical and mental health ranging from, screening, lifestyles advice, medication accuracy, transition arrangements on attaining the age of 18, communication methods, family carer needs and self- care and management
- Following the LD annual health check a health action plan should be produced that addresses the patient's needs, best practice would be to do this in conjunction with the patient, family, carer and other agencies involved and a copy given to the patient in format suitable to their specific needs. Update the patient's medical records with relevant information following the health check.

How are we doing?

- As of August 2017 NHSE data obtained shows that all practices across the Norfolk and Waveney STP were signed up to the LD Health Checks programme.
- Activity by practice level is varied.
- No conclusions can be drawn at this stage as there are a number of data quality issues e.g. number of health checks carried out do not match the number of people on the GP LD register, some practices are duplicating which is showing percentage increase, incorrect coding.
- North and South CCG have conducted an audit of their practice data and a currently awaiting the results.
- The current national and CCGs target is 50% of patients on the GP LD register receive a health check with an aim to stretch the target to 65%.
- All CCGs achieved above the 50% target for 2016/17, with South Norfolk 64% and Great Yarmouth and Waveney 56% moving closer to the stretch target.

How are we doing?

Table 1:	LD Health Check Activity Summary over the last 3 years								
CCGs	**2014/15**	**2015/16**	**2016/17**						
	Number of Patients on LD register in 2014/15	Number of LD patients who received a health check in 2014/15	% of LD patients who received a health check in 2014/15	Number of Patients on LD register in 2015/16	Number of LD patients who received a health check in 2015/16	% of LD patients who received a health check in 2015/16	Number of Patients on LD register in 2016/17	Number of LD patients who received a health check in 2016/17	% of LD patients who received a health check in 2016/17
Great Yarmouth and Waveney	885	473	53%	1054	485	46%	1049	587	56%
North Norfolk	658	535	81%	1090	955	88%	1249	683	55%
Norwich	648	454	70%	1213	548	45%	1300	696	54%
South Norfolk	893	640	72%	1171	499	43%	1116	716	64%
West Norfolk	423	302	71%	668	271	41%	721	374	52%
Total	3507	2404	68%	5196	2758	53%	5435	3056	56%

Next Steps

- Data cleansing including looking at data recording within primary care
- Audit practices on Learning Disability register completion and methods
- Work with practices to increase LD health checks take up with aim of delivering stretched target
- Ensure two way flow of information from primary and social care
- Patient summary care records are updated and visible to all health care professionals
- Look at methods of communicating with Learning Disability patients and ensure practices apply Accessible Information Standard
- Primary Care Commissioning Board to monitor quarterly performance data on Learning Disability health checks take up.

Continuing Healthcare

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

Examination of the effects of the new policy and guidance introduced by Norwich, North Norfolk, South Norfolk and West Norfolk Clinical Commissioning Groups in 2016 regarding the provision of NHS Continuing Healthcare.

1. Background

1.1 On 25 February 2016 Norfolk Health Overview and Scrutiny Committee (NHOSC) received a presentation from representatives of Norwich, North Norfolk, South Norfolk and West Norfolk Clinical Commissioning Group (the CCGs) on new policy, guide and procedure documents for delivering NHS Continuing Healthcare (NHS CHC) to patients who had been assessed as eligible for CHC under the National Framework for NHS Continuing Health Care (Department of Health).

1.2 The National Framework, which the local CCGs did not change, defined 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 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.

The new local policy, guide and procedures aimed to ensure fairness and equity in provision of CHC across the four CCG areas for patients who had been assessed as eligible under the National Framework.

1.3 NHOSC heard the Healthwatch Norfolk would be undertaking an evaluation of the impact of the new CHC policy six months after it was implemented and asked for an update in February 2017.

1.4 NHOSC received the update from the four CCGs on 23 February 2017 and Healthwatch Norfolk presented the results of its evaluation. The

papers are available on the Norfolk County Council website NHOSC 23 Feb 2017 (item 6).

NHOSC asked the CCGs to respond in writing to points that had been raised at the meeting by a service user and by a representative of Equal Lives. The responses were received on 23 March 2017 and forwarded to the individuals concerned. A copy is attached at **Appendix A**.

1.5 Following the meeting Members agreed to make recommendations to the CCGs regarding communication, service quality monitoring, patient experience surveying, partnership working with other agencies and waiting times. The recommendations, responses received in May 2017 and updates for today's meeting are attached at **Appendix B**.

2. Purpose of today's meeting

2.1 As well as updating NHOSC on the past year's action in response to the committee's 2017 recommendations the central and west Norfolk CCGs have been asked to provide information on:-

- Numbers of complaints and any trends in subject matter
- Results of any analysis on complaints and feedback from patients, family members and carers
- Waiting times for CHC cases to be considered by the Complex Case Review Panels (CCRPs)
- The settings in which patients receive CHC care (i.e. has there been an increase / decrease in those who receive it in a residential care home / their own home)
- Trend in the overall numbers receiving CHC

They have also been asked to update NHOSC on developments in the CHC process since February 2017 (such as the transfer of the process from North East London Commissioning Support Unit to Norfolk Continuing Care Partnership) and the implications of the Norfolk and Waveney Sustainability Transformation Plan (STP) for future delivery of CHC across Norfolk.

The CCGs have also been asked to comment specifically on the following areas:-

- Consistency of decision-making and service delivery across the four CCRP areas
- Provision of a 'safety net' for occasions where the agency delivering healthcare fails to deliver (for whatever reason) so that patients cared for at home are enabled to remain at home in those situations

Information provided by the CCGs / Norfolk Continuing Care Partnership is included in Appendix B.

2.2 Representatives from the CCGs and Norfolk Continuing Care Partnership (which is a partnership formed by the Norwich, North Norfolk, South

Norfolk and West Norfolk CCGs and is an NHS organisation) have been invited to today's meeting to discuss the implementation of the CHC policy in the past year. A representative from Adult Social Services will also be in attendance to assist with any questions that may arise.

3. Suggested approach

3.1 After the CCG representatives have presented their report, the committee may wish to discuss the following areas:-

(a) In February 2017 there was a large disparity between average waiting times between CHC referral and assessment between the central CCGs and West Norfolk CCG. In Appendix B, response to NHOSC's recommendation 5, the graphs showing median days taken for eligibility decisions in 2017-18 show that the 28 day standard is not being met and waits in West Norfolk still appear to be longer than in central Norfolk. What is being done specifically to address the situation in the west?

(b) The CCG / NCCP report mentions issues related to staff availability and that both Norfolk Continuing Care Partnership and Norfolk County Council are recruiting additional staff to ensure there is sufficient capacity to undertake assessments within the required timescales. How many and what type of additional staff are required and when are they expected to start?

(c) The CCGs / NCCP intend to work with Heathwatch Norfolk to:-

- Review standard letters to ensure appropriate tone and clear content
- Explore mechanisms to seek patient / relatives feedback with regard to how processes were explained to them
- Seek advice on the appraisal & selection of suitable methods for gathering patient and families' experience of CHC
- Explore mechanisms to seek patients' and relatives' feedback on alternative or respite care provision

When is this work scheduled to start?

(d) During 2018 NCCP intends to implement a system to ensure that patients receive a regular review of their package of care by staff familiar with their case, to ensure that the care delivered meets the patient's needs. When are these reviews scheduled to start and how will NCCP ensure consistency?

(e) Norfolk Continuing Care Partnership (NCCP) has a Strategic Board with Director level membership from all 5 CCGs and Norfolk County Council. What is the wider governance structure around the partnership? Does the NCCP Strategic Board report to the five CCG Governing Bodies?

(f) Does the representation of Great Yarmouth and Waveney CCG on the NCCP Strategic Board mean that local CHC policy in the Great Yarmouth and Waveney area will be aligned with the rest of Norfolk?

4. Action

4.1 Following the discussions with representatives at today's meeting, Members may wish to consider whether:-

(a) There is further information or progress updates that the committee wishes to receive at a future meeting or in the NHOSC Briefing.

(b) There are comments or recommendations that the committee wishes to make as a result of today's discussions.

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23rd March 2017

Dear Maureen

Thank you for your feedback following the NHOSC committee meeting on 23rd February.

You requested a full written response to the comments made by Mark Harrison, (Chairman, Equal Lives) and the written questions from Caroline Fairless Price, (CHC Service User).

Feedback for comments received from Equal Lives Chairman, Mr Mark Harrison;

1. **Low take up in Norfolk of carers directly employed by individuals under a Personal Health Budget arrangement**

Response – All patients receiving domiciliary care have the opportunity to request a Personal Health Budget (PHB). The Commissioning Support Unit offer this to all patients at the point of assessment for Continuing Health Care. The CCGs ensure that there is support for individuals to administer the budget themselves or via a third party organisation if they prefer. The CCGs support partial PHBs that individuals may use to directly commission a proportion of their care package to make this option as accessible as possible.

In June 2013 there were 30 PHBs across central and West Norfolk. This had risen to 99 in June 2016 and currently stands at 103 service users with a PHB. The CCGs are committed to increasing the number of patients that have a personal health budget in Norfolk and are working in collaboration with Social Care colleagues via our integrated commissioning teams to promote this.

2. **The maintenance of quality standards within service contracts is essential to enable the CCGs to hold providers to account for the quality of care they provided.**

Response – The CCGs have recently written and implemented new contracts for all Nursing, Residential and Domiciliary providers. These contracts commenced in October 2016. All contracts set out a required quality schedule and providers are asked to submit information about specified quality markers on a quarterly basis. We have senior registered nurses working within the CSU and CCGs that have a programme of inspections and a system to flag concerns with individual nursing and

residential providers. Where concerns are raised, NHS staff will work with providers to support them in addressing and improving performance. In addition, the Care Quality Commission feedback for all providers is monitored and local action taken to ensure swift and supportive responses occur to safeguard patients.

3. **For many vulnerable individuals in society who are not financially self-sufficient, there remains little medical provision outside of a hospital setting other than through a CHC package.**

Response – where patients require medical provision outside of hospital the NHS commissions and provides an extensive Community Nursing and Therapy service in conjunction with GP surgeries and Nurse Practitioner services. Access to medical services Out of Hours is provided via calling 111 for urgent treatment, and 999 for emergencies. The NHS National Framework for Continuing Health Care sets out criteria for assessing eligibility of individuals to receive fully funded NHS care. The threshold for NHS CHC funding is set nationally and is intended to support those individuals with complex, unpredictable and intense needs according to the framework.

Feedback for CHC Service User; Mrs Fairless Price asked;

1. **Will the CCGs ensure that this is removed from all their documentation?**

Response - The proposal that packages should be reviewed if the cost of domiciliary care is more than 5% above that of residential care will be removed from the CCGs Policy as it has never been enacted. All packages of care above a threshold of £750 are reviewed by a Complex Case Review Panel to ensure that proposed packages of care meet patients' needs, reflect patients' preferences and are met in a cost effective and clinically safe manner.

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

Response - Patients receive a review of their eligibility to receive Continuing Health Care funding in line with the statutory review period specified in the NHS Framework and may also receive a care review in response to a change in clinical condition.

During a CHC eligibility review, the registered clinician will review each patient's health care needs in detail. This needs based assessment is used as a mechanism to review the patients' health, whether the package of care is appropriate and meeting patients' assessed needs, and whether care packages could / should be altered. This is in accordance with the statutory requirements of the NHS Framework.

Where a patient has a Personal Health Budget they may have two review meetings; one for eligibility and clinical need, the second for budget management and employer responsibilities. Meetings are now held separately following feedback that, where both meetings were held at the same time this could be overly demanding for patients.

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

Response - The provision of urgent and emergency NHS health care is available via a variety of both community and hospital routes. Urgent care needs also arise in relation to the ongoing support required to maintain health and well-being for patients living at home with long term conditions receiving NHS funded domiciliary care or who choose to have a Personal Health Budget (PHB) and employ their own staff.

Contingency care planning is always discussed with patients / care agencies so that in the event of a breakdown in care, alternative support arrangements can quickly be put in place. The individual nature of patients' home circumstances means that a variety of sources may be available and preferable to the patient e.g. support from family members instead of a care agency. Patients that receive a PHB have an allocation of contingency funds to support a situation where additional care may be required and should have a contingency care plan in place ready for activation. Where a breakdown in care may occur over a longer period, the CHC Team at the Commissioning Support Unit (CSU) will assist to arrange an interim care package to meet a patient's needs.

In the event that a short term breakdown in care cannot be managed by the proposed contingency care plan arrangements there are other options available. The 24 hour Social Services care route is available to all patients as part of the duties of care outlined in the Care Act (2014). The Swifts and Night Owls team commissioned by Social Services is part funded by the NHS and available to patients who require urgent support; the virtual ward facilities in Norwich and West Norfolk can provide short term night sits if required and periods of care during the day.

Where a patient requires NHS funded support for a long term condition they should have a documented Care Plan, as set out by the NHS Framework for Continuing Health Care, which describes and documents their individualised care requirements. This Care Plan is intended to guide health professionals to deliver individualised care that meets a patients needs and achieves the health outcomes required. Care plans are vital where there is unexpected gap in care provision and assists emergency support teams to deliver care. There are approximately 250 patients receiving domiciliary care and 100 patients with a PHB in Norfolk. Where a patient requires urgent support from an unfamiliar carer these Care Plans should guide the carer in delivering the individualised care required.

4. **Are the CCGs and NCC going to develop commissioning and recording using the Harwood Care and Support Charter?**

Response - The CCGs in central and West Norfolk subscribe to the principles outlined in the Harwood Care and Support Charter. We act as role models for this way of working in line with colleagues from NCC. However, not all community providers are signed up to the Charter and to meet current demand we must maximise access to available care. Whilst we would be pleased to support the commissioning of care from organisations that are using the Harwood Care and

Support Charter, this cannot at present be a prerequisite to commissioning NHS funded Continuing Health Care.

I can confirm that we have received your email and the document outlining NHOSC's agreed recommendations regarding Continuing Healthcare and will be happy to provide the requested written response to the recommendations by 12 May 2017.

Yours sincerely

Rachael D Peacock

Rachael Peacock

Head of Continuing Care

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c.c Jeanette Patterson (Continuing Health Care Lead, NCC)

Jo Smithson (Chief Officer, Norwich CCG)

Nikki Cox (Director of Operations, Norwich CCG)

Rob Jakeman (Integrated Commissioner, West Norfolk CCG)

NHS
Norfolk Continuing Care Partnership

Managing Continuing Care services on behalf of the NHS Clinical Commissioning Groups in central and west Norfolk

Report for Norfolk Health and Scrutiny Committee – 22nd February 2018

Continuing Healthcare in Norfolk

Report Prepared by; Rachael Peacock, Head of Adult Continuing Healthcare
Jill Shattock, Director of Integrated Continuing Care

1. Introduction and Background

This report provides an update on the Continuing Healthcare (CHC) service delivery work conducted by the Norwich CCG, South Norfolk CCG, North Norfolk CCG and West Norfolk CCG over the past year. The report includes information on significant changes that have occurred in the way the service is managed and the transition from an 'arm's length' delivery mechanism to an in-house, CCG partnership, hosted by Norwich CCG. The report also updates against the recommendations made by the Norfolk Health and Overview Scrutiny Committee (NHOSC) in February 2017.

1.2 On 23rd February 2017, Norfolk Health Overview and Scrutiny Committee (NHOSC) received a presentation from Rachael Peacock, Jeanette Patterson, Nikki Cocks and Rob Jakeman on behalf of the four CCGs, Norwich, North Norfolk, South Norfolk and West Norfolk. The presentation provided an annual update of the progress and impact since April 2016 of implementing local policy, guidance and procedure documents for delivering NHS CHC to patients who have been assessed as eligible under the National Framework for NHS Continuing Healthcare (Department of Health, 2012). In response to the presentation, NHOSC made a series of 5 recommendations and a subsequent action plan from the CCGs was submitted to NHOSC on 15th May 2017.

1.3 The CCGs have also been requested to provide additional contextual quantitative and qualitative information regarding CHC service provision to NHOSC in regards to;

- Numbers of complaints and any trends in subject matter
- Waiting times for CHC cases to be considered by the CCRPs
- Consistency of decision-making and service delivery across the four Complex Case Review Panels (CCRPs)
- The settings in which patients receive CHC care (i.e. has there been an increase / decrease in those who receive it in a residential care home / their own home)
- Trend in the overall numbers receiving CHC
- The need for a 'safety net' on occasions where the agency delivering healthcare fails to deliver for whatever reason (to enable patients cared for at home to remain at home in those situations).

2. CHC Service Transition

2.1 Between June and October 2016 the CCGs carried out a review of CHC to look at the service and alternative models for future delivery. This work sought to understand the current service, the weaknesses and barriers experienced, the inter-relationships of CHC within the Norfolk health and social care system and the impact of this. This included collating best practice and lessons learned from across the Norfolk system and others, while exploring evidence to support moving to an alternative model and culminating in a case for change.

2.2 The CCGs recognised that the outsourced service model was limited to the basic components of the CHC framework and provided a transactional service in the main. The service required significant commissioning management resource and oversight and required four sets of duplicated processes, discussions and ways of doing business between CCGs and the Commissioning Support Unit (CSU).

2.3 A key consideration for the service transition was the achievement of strategic priorities (Appendix 1) which included the ambition to reduce duplication, unwarranted variation and ensure positive change within the health and social care system to benefit patients and service users. By working together and using the STP footprint, CCGs sought to develop integration opportunities, flexibility to make operational changes and to deliver efficiency and value for money initiatives.

2.4 The benefits of this new model of working are many, including improved development and progression opportunities for staff underpinned by recruitment, retention and succession planning; greater capacity in the team to deliver a high quality assessment and care coordination service; strong and stable management to drive forward innovation and the strategic priorities; and value for money. Better links with existing CCG projects will line up and maximise cross working potential especially in areas such as quality monitoring in the domiciliary care area. An opportunity to streamline work currently duplicated in different CCGs and in Norfolk County Council (NCC) was also acknowledged. It was felt that patient experience could be improved and market development and assurance enhanced.

2.5 The proposed model for CHC in Norfolk is based on a 'lift and shift' approach of the current staffing and structure in the CSU. It was essential to avoid any loss of staff and no redundancies or redeployments were necessary in the service transition. This initial starting point will be enhanced by a stronger management team, additional clinical roles, and a greater support infrastructure including HR and training and audit roles. This is underpinned by a governance structure that recognises both the provider and commissioner aspects of an in-housed CHC service.

2.6 The proposed partnership model is providing a foundation for future integrated working. The governance structure for the Norfolk Continuing Care Partnership includes a Strategic Board with Director level membership from all 5 CCGs and NCC.

2.7 The service transitioned on the 1st November 2017 and the Norfolk Continuing Care Partnership (NCCP) was formed. The transition is the first of a series of phases (see Appendix 2) and allows for the service to transition and stabilise and for the newly appointed leadership team to become established. During this phase ongoing recruitment is taking place to fortify key areas of the service.

2.8 In the next phase of the work (see Appendix B) other concurrent related projects run by individual CCGs as part of the Quality, Innovation, Productivity and Prevention (QIPP) agenda will become part of the 'Business as Usual' (BAU) work of the NCCP business unit. Opportunities for closer working with NCC will be identified and explored in line with the strategic priorities of the service.

3. Progress Update on Norfolk Health and Overview Scrutiny Committee Recommendations - 23.2.2017

	NHOSC Recommendation	CCG Response
1.	a) The CCGs address the findings in the Healthwatch Norfolk survey - Improvement to both verbal and written communication of the different stages of the process, the outcome of each stage, and the notification of decisions including funding decisions	***Improvement in verbal communication*** **INITIAL RESPONSE – MAY 2017** The CCGs have agreed to fund an education and development post to work with staff to improve their knowledge, skills and competency in relation to Continuing Health Care. Staff development will include focusing on communication and information sharing. Through use of their 'Feedback Centre', Healthwatch Norfolk will assist the CCGs in gathering patient and families' feedback on verbal communication with patients and families who have experienced the CHC pathway, to assess any improvements. **UPDATE – FEBRUARY 2018** Provision has been made for two full time educational posts within the NCCP business unit. The job descriptions have been developed and recruitment is underway. A meeting has been scheduled with Healthwatch to explore mechanisms to seek patient / relatives feedback with regard to both verbal communication by members of NCCP staff. ***Improvement in written communication*** - ***Regarding stages of the process*** - ***Outcome of each stage*** - ***Notification of decisions (including funding decision)*** **INITIAL RESPONSE – MAY 2017** Using the expertise of their volunteers, Healthwatch Norfolk will assist in reviewing a sample of anonymised CHC letters and processes for informing patients to check tone and content. The CCGs will conduct an audit of information giving to ensure clear notification is given at each stage and in a timely way. **UPDATE - FEBRUARY 2018** The suite of standard template letters used by NELCSU will be amended in conjunction with Healthwatch to ensure the tone and

		content of written communication reaches a high standard is clear and easily understood. The proposed CCG information giving audit will commence late in 2018 as part of phase 3 of service transition
	b) CCGs to ensure people are well-informed about what they might be eligible for and what services are available, without raising expectations	***People are well informed about what they might be eligible for*** **INITIAL RESPONSE - MAY 2017** CCGs will ensure that their websites contain links to relevant national leaflets about the CHC assessment process and local information detailing what is/is not funded via CHC. **UPDATE - FEBRUARY 2018** The change to NCCP is published on each CCGs website with a downloadable information sheet and contact details CCG websites contain links to a CHC easy read version of the local guidance. Both the easy read and standard versions of the patient guide to CHC services set out the processes for assessment of eligibility for NHS CHC Funding and include details of what may and may not be funded by the NHS. NHS CHC Contracting Policy is available on each website (this includes reference to the way the CCRP functions. The Norfolk policy is due to be updated to reflect the significant changes that have occurred). Links are available on the each of the CCG websites to signpost patients to national NHS guidance https://www.nhs.uk/conditions/social-care-and-support/nhs-continuing-care/? ***People to be well informed of the services available*** **INITIAL RESPONSE - MAY 2017** General information about services will be available from leaflets. More detailed bespoke information will be tailored to need by the CHC clinical staff who are undertaking that patient's assessment. Healthwatch Norfolk will assist in reviewing national and local information on eligibility for CHC and CHC content of CCGs websites using the expertise of their volunteers. **UPDATE – FEBRUARY 2018**

		General information about services remains available as before. The national NHS website contains information on CHC assessments and links to the National Framework documents. More detailed information is tailored by the CHC clinical staff who are undertaking that patient's assessment. A National Strategic Improvement Programme was launched by the Department of Health in January 2017 and is expected to run for a period of 2 years. This national program of work is expected to include a review of the mandated documents within National Framework for Continuing Healthcare such as the CHC Checklist. Any changes to policy at a national level will need to be locally implemented and guidance for CCGs may change over the next 12 months. Should local policy change as a result of national directives, all CCG and NCCP guidance will be altered to comply and details will be published on the NCCP page of the CCG websites. ***Expectations to be managed*** **INITIAL RESPONSE – MAY 2017** The CCGs will assess the impact of information giving on managing patient expectation through monitoring of patient feedback and complaints. **UPDATE – FEBRUARY 2018** Following the CHC service transition and stabilisation period the NCCP senior management team will link with Healthwatch to explore mechanisms to seek patient / relatives feedback with regard to how processes were explained. Complaints are monitored formally on a monthly basis with a Key Performance Indicator linked to this service measure and a written paper being submitted to the Operational Management Group which is chaired by a Non-Executive Director. The Operational Management Group is the forum whereby the member CCGs receive assurance on the various aspects of service delivery. All complaints are initially received by the Head of Adult CHC and all response letters are signed off by the Director of Integrated Continuing Care. In this way the senior management team within the NCCP are aware on a continued basis of all complaints received and of the outcomes. This senior involvement enables the NCCP business unit to actively learn from processing complaints and to implement service adaptations in response to feedback where necessary.

	c) CCGs to consider whether to commission more advocacy services for people involved in the CHC assessment process and those in receipt of CHC so that their views are fully expressed and understood	***Consider commissioning more advocacy services for*** - ***those being assessed*** - ***those in receipt of CHC*** ***so that patient views are fully expressed and understood*** **INITIAL RESPONSE – MAY 2017** Advocacy is available for patients that lack capacity and do not have alternative suitable representation. All healthcare professionals involved in a patient's care advocate for the patient and are responsible for making 'Best Interest' decisions where necessary. The CHC nurse assigned to a case will ensure patient views are expressed, understood and upheld wherever possible. The CCGs intend to implement a model of case management to ensure patients are reviewed regularly by staff that are familiar with their case, and receive a package of care review to ensure the care delivered meets the patients' assessed clinical needs. **UPDATE – FEBRUARY 2018** CHC patients going through assessment have access to an independent mental capacity advocate (IMCA) where required in accordance with the Mental Capacity Act (2005). IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions: including making decisions about where they live and about serious medical treatment options. IMCAs are mainly instructed to represent people where there is no one independent of services, such as a family member or friend, who is able to represent the person. Where a patient has capacity to make decisions of their own has an assessment for CHC, every effort is made by nursing and social care staff to support the patient and their family to understand the proceedings and their options at each stage. This is part of the role of every member of health and social care staff. During 2018 NCCP intend to implement a model of working which ensures patients receive a package of care review regularly by staff familiar with their case, to ensure the care delivered meets the patients' assessed clinical needs.
2.	CCGs to undertake more proactive quality monitoring to check that CHC patients are	***Proactive quality monitoring to ensure CHC patients receive a service that meets their needs*** **INITIAL RESPONSE – MAY 2017** A review process for all eligible patients is set out in the National Framework for NHS Continuing Healthcare and NHS Funded

	receiving a service that meets their needs	Nursing Care. This requires a three month review for all newly eligible patients to ensure that health care needs are being met and that patients continue to meet the eligibility threshold for NHS funded care. Following this, annual eligibility reviews are undertaken and the clinician undertaking the assessment will specifically assess the package of care in place and any change in care requirement. The CCGs intend to implement a model of case management to ensure patients are reviewed regularly by staff that are familiar with their case, and receive a package of care that meets their assessed clinical needs. Whilst all patients should have access to a designated CHC clinician the CCGs acknowledge that patients with highly complex or labile health care needs will be prioritised. The planned model of case management will link clinicians to groups of health care providers in order to build and maintain proactive working relationships that provide an opportunity to monitor standards through regular contact. **UPDATE – FEBRUARY 2018** The contracting department within NCCP maintains links with care providers and undertakes routine quality monitoring (see example in Appendix 3). A series of provider forums are scheduled to take place during 2018 to improve these links. Each of these forums will have a specific focus to improve quality of care e.g. Business Continuity Planning. NCCP has senior nurses that are designated Quality Assurance Leads. These members of staff maintain close links with the NCC Quality team and share information about care providers. Where issues arise, the Quality Assurance Leads work with care providers to implement action plans to address care deficits and improve quality. Where a care provider may be identified as having issues with care quality a proactive set of welfare checks would be undertaken for all CHC funded patients receiving care from that provider. All CQC reports for Nursing, Residential and Domiciliary care providers with CHC funded patients are closely monitored and shared with NCCP team members and CCG recipients to promote an awareness of quality issues across the care providers in Norfolk. The Quality Assurance Leads attend briefing sessions with the CHC clinical teams to promote the exchange of information and to gather soft intelligence from nursing staff that can be used to identify trends. Recruitment is underway to enhance the clinical team with stronger leadership and additional clinical posts. The additional nursing

		capacity will be required to work towards a case management / care coordination approach that enables clinicians to be aligned to care providers to develop links and provide consistent support.
3.	CCGs to arrange for a more widely accessible survey of the experiences of CHC patients and families / carers, i.e. using a wider variety of methods than the previous survey, which was on-line, internet based	***Gather information on the experiences of CHC patients, families and carer*** **INITIAL RESPONSE – MAY 2017** Healthwatch Norfolk have agreed to support CCGs with advice on the appraisal and selection of suitable methods for gathering patient and families CHC experiences, taking into account the following: • An estimation that 75% of Norfolk households are 'on-line' • The survey sample is predominantly comprised of family members/carers, as representatives of the person receiving CHC • Evidence from a 2016 paper-based, postal CHC survey with SAE's in the West Norfolk locality produced a *NIL return rate* • In 2016, telephone interviews were the preferred means of contact for family carers • Use of social media platforms is increasing • Word of mouth and face-to-face survey promotion (i.e. by trusted clinicians, practitioners, nursing home care staff and VCS support workers) is proven to be very effective **UPDATE – FEBRUARY 2018** A meeting is scheduled with Healthwatch to progress this work and explore mechanisms to seek patient / relatives feedback with regard to both verbal communication by members of NCCP staff.
4.	CCGs to work in close partnership with social care and other relevant agencies including service user groups to ensure planning for an effective safety-net service for CHC patients on occasions when their usual provider is unable to deliver	***CCGs work in partnership with*** - ***NCC*** - ***Other relevant agencies*** - ***Service user groups*** **INITIAL RESPONSE – MAY 2017** CCGs are working with NCC to ensure the existing urgent social care service is able to meet the needs of CHC patients. NCC have agreed to monitor the incidence of CHC patient requests for urgent social care intervention for a 1 month period to determine the demand profile and ability to meet demand for safety netting. CCGs will work with NCC to identify other relevant agencies and routes to access temporary support for patients where appropriate e.g. Marie Curie, Red Cross, Royal Voluntary Service.

		Contingency plans are already built into care plans with those patients in receipt of Personal Health Budgets. CCGs will ensure that contingency arrangements and designated funding are in place to enable patients in receipt of a Personal Health Budget to plan for and mitigate potential problems associated with short term care breakdown. The Continuing Healthcare Brokerage team will be available Mon-Friday to support with longer term disruption in care delivery and to offer alternative options via commissioned care where necessary. **UPDATE – FEBRUARY 2018** The managers of the Norfolk First Response Service (NFS) were approached to discuss the issues of safety netting for CHC patients. Service Lead Denise Forder was not aware that this was a significant issue and agreed to assist with an audit of CHC activity in Spring 2017. An audit of the Swifts / Night Owls service took place during April and May 2017. It appears that requests for support from the NCC Swifts and Night Owls service does come from patients eligible for CHC funded care. However, these amount to a small number (1 per month) and are predominantly newly eligible Fast Track patients who are awaiting a CHC funded package to be arranged and rely on NFS / Swifts / Night Owls for a short period whilst suitable care is sourced. The senior management team of NCCP are working with CCGs to support development of care services and ensure CHC funded patients are able to access all mainstream services and sources of support in accordance with National Framework. This includes commissioning of mainstream end of life NHS services and block procurement options from third sector organisations such as Marie Curie. ***Ensure planning for an effective safety net service for CHC patients should the usual provider be unable to deliver*** **INITIAL RESPONSE – MAY 2017** Care plans should be in place for all patients in receipt of Continuing Health care in line with the best practice requirements outlined in the National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care. These care plans record both the care required and patients' preferences to provide guidance and direction for care givers. These documents enable continuity of care provision for patients that may require an episode of care from an alternative care giver. The CCGs will audit the quality and availability of care plans from a range of providers to provide assurance with regard to the effectiveness of these documents.

		The CCGs will seek specific feedback regarding experiences of alternative care provision as part of the patient survey planned. **UPDATE – FEBRUARY 2018** Care Plan audits form part of the NCCP routine Quality visits in nursing homes and are a CQC requirement for all registered care providers. (See Appendix C for an excerpt from the Care Plan audit). NCCP Quality Assurance Leads plan have started work to conduct assurance visits for domiciliary care providers and will be extending this work during 2018. A meeting is scheduled with Healthwatch to explore mechanisms to seek patient / relatives feedback with regard to alternative or respite care provision where this has been required.
5.	CCGs work to speed up the process between referral and assessment for CHC eligibility so that the average waiting time in each of the 4 CCG areas reduces to meet the 28 day standard	***Speed up referral to assessment (meet 28 day target)*** **INITIAL RESPONSE – MAY 2017** The CCGs have measures in place to record reasons for delays in assessments. However, it is acknowledged that the existing process is restricted by IT functionality and does not support accurate categorisation of reasons for delays. An alternative process is required with additional training for staff to enable more accurate reporting. Accurate data availability will enable implementation of targeted interventions to reduce delays. The CCGs are planning to in-house their CHC service within a single CCG led business unit. Investment into the clinical team is planned which will reduce assessment delays attributed to resource availability. The business unit will enable better standardisation of processes and reduce unwarranted variation between different areas of the county. **UPDATE – FEBRUARY 2018** A significant amount of work has taken place to improve performance in this area. The monitoring and reporting processes have been reviewed and NHS England request monthly and quarterly reports on the CCG performance against the 28 day assessment standard. An audit of delayed cases was undertaken in September 2017 for all 4 CCGs in the Partnership. The audit identified contributory delays and a number of internal and external factors including administrative delays, unnecessary steps in the process, lack of social work or CHC

nurse availability, delays writing up cases, varied eligibility ratification processes, lack of tracking for deferred cases.

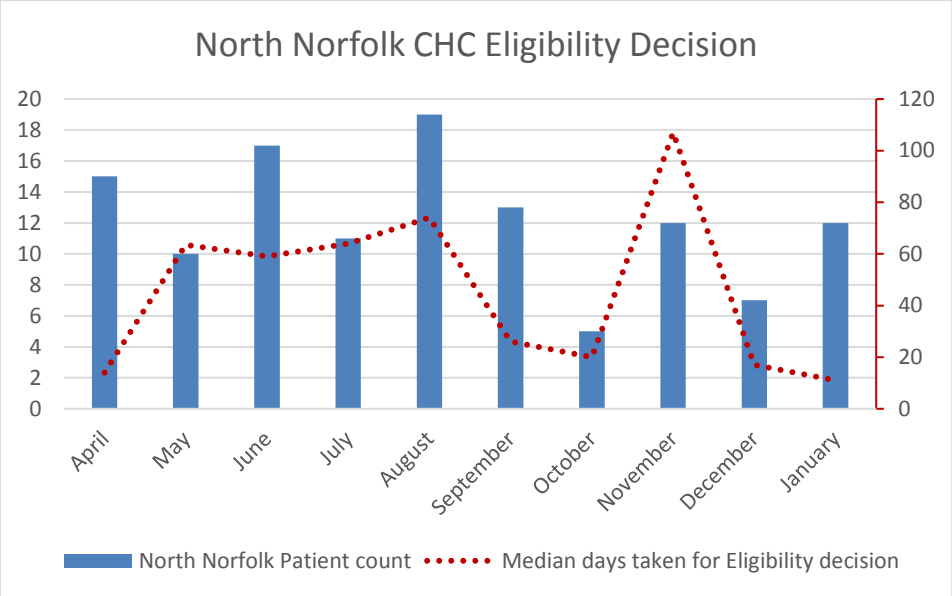
Additional enhanced leadership within NCCP has enabled Clinical Service Managers to have a smaller span of control and better oversight of staff. They are able to utilise data to monitor flow of cases, identify delays and backlogs and support administrators and clinicians to process cases more efficiently.

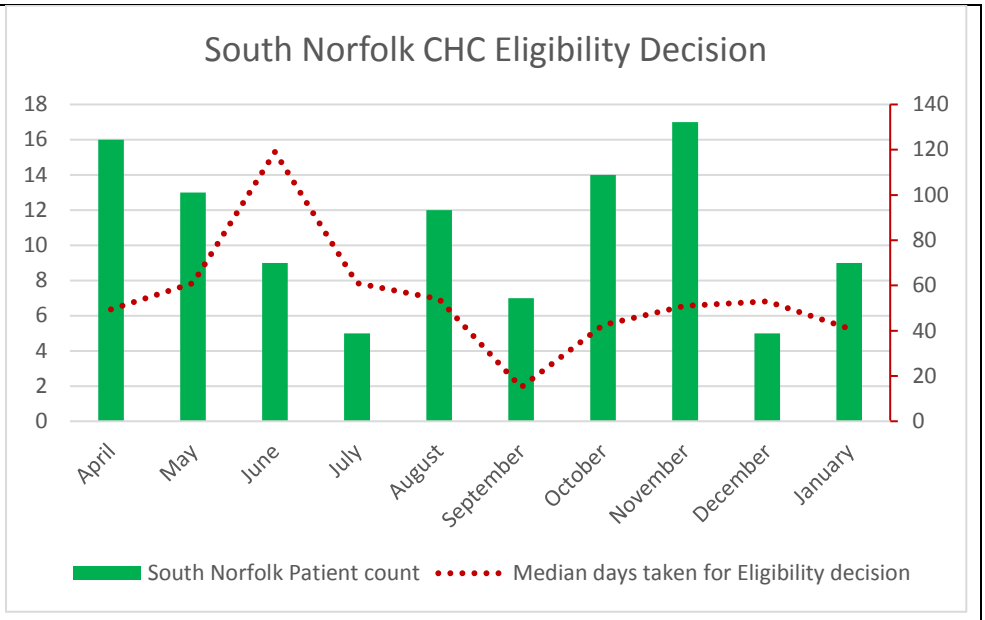
The CCGs have delegated responsibility for ratification of cases to NCCP and Eligibility Ratification Meetings are run 3 times each week. Very senior clinicians provide quality assurance and peer review recommendations ensuring they have been made based on relevant evidence and in accordance with the National Framework. A single central process eradicates unnecessary stages in the process, reduces variability across CCGs and contributes to improving the standard of assessments. Where it is necessary to defer a decision these are quickly and robustly followed up by a named member of staff and a log used to track progress towards resolution.

NCCP and NCC are working closely to address issues related to staff availability and both orgnaisations are recruiting additional staff to ensure there is sufficient capacity to undertake assessments within the required timescale.

CCGs are expected to achieve an 80% compliance against the 28 day assessment target by end of March 2018.

The graphs below show the median number of days taken, by month. The small number of cases can cause large fluctuations. The left axis shows patient numbers and the right shows the median number of days.




South Norfolk CHC Eligibility Decision
18
16
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12
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8
6
4
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0
140
120
100
80
60
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0
April
May
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July
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September
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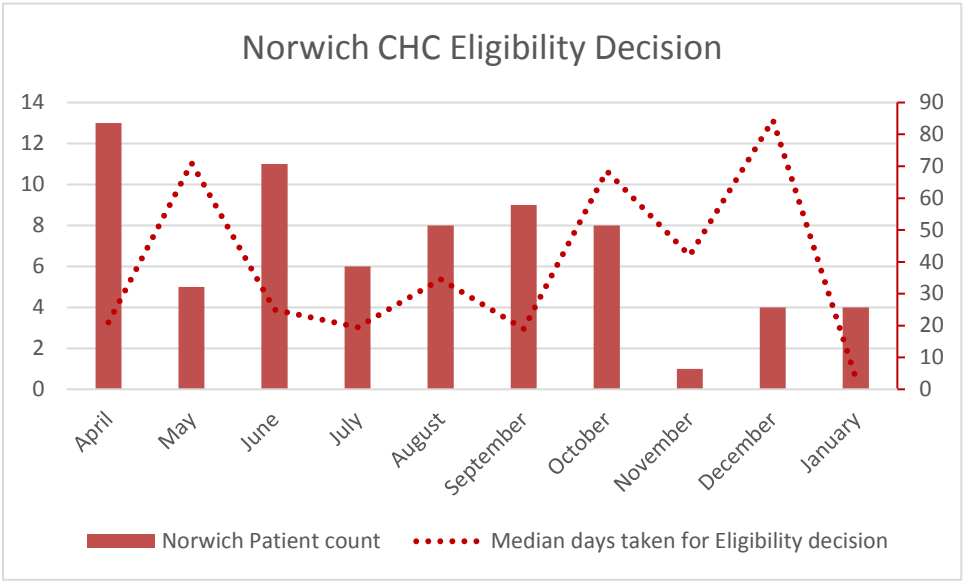
November
December
January
South Norfolk Patient count
Median days taken for Eligibility decision


Norwich CHC Eligibility Decision
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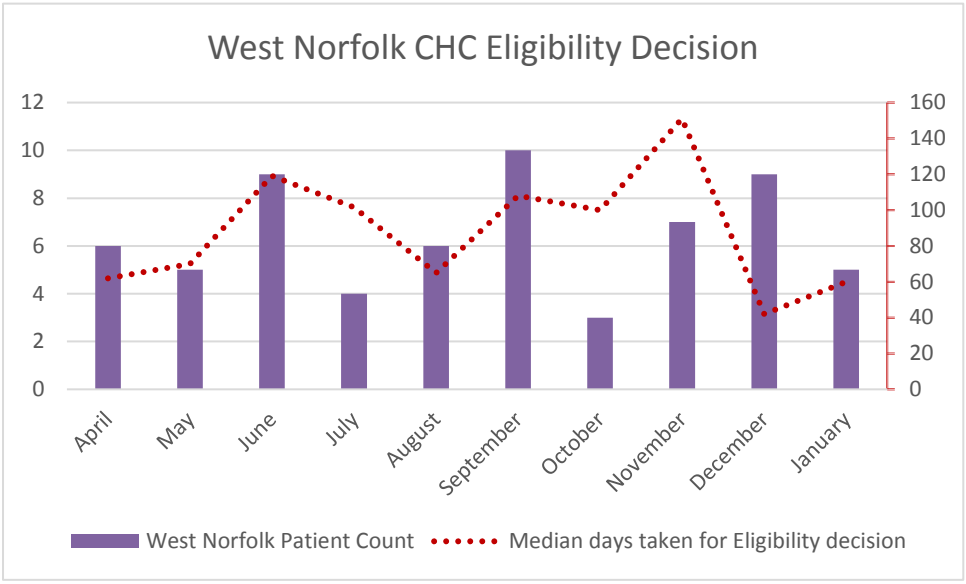
Norwich Patient count
Median days taken for Eligibility decision


West Norfolk CHC Eligibility Decision
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April
May
June
July
August
September
October
November
December
January
West Norfolk Patient Count
Median days taken for Eligibility decision

4. Contextual Data for CHC Service Delivery;

The Norfolk Health and Overview Scrutiny Committee requested NCCP to provide some additional data to provide some context and quality markers for service delivery.

4.1 CHC complaints and trends Feb 2017- Feb 2018

NCCP has continued with and refined an existing system that ensures all complaints are initially seen by a senior clinician to determine the required handling process. This is because many elements of correspondence are formal 'appeals' to the outcome of the CHC assessment process rather than complaints. CHC appeals are not classified as complaints because they are a formal part of the CHC decision making and follow a process set out in the NHS National Framework for Continuing Healthcare.

The complaints handling system includes early liaison with the complainant to ensure their wishes are understood and clarified to allow the correct process to be followed e.g. where an appeal may also include some elements of dissatisfaction with service delivery and may therefore need to be handled simultaneously via both the appeal and complaints pathways. In addition, some enquiries had previously been handled through the complaints process, rather than through a Patient Advice and Liaison Service (PALS) type of approach. This has also since been remedied and staff will routinely respond quickly, in person, to patient concerns offering a face to face meeting to discuss and address issues wherever possible.

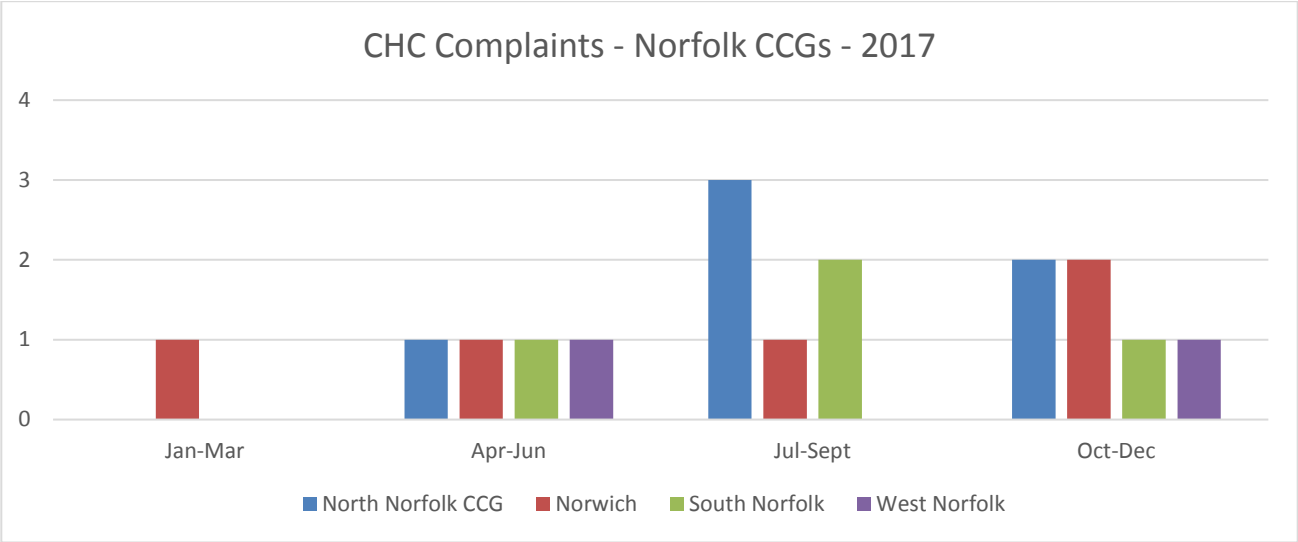
4.1.1 Categorisation of complaints was changed between 2015-16 and 2016-17 following a review which identified that historically CHC appeals were being incorrectly handled as complaints. The number of complaints reported in previous years was therefore artificially inflated. The categorisation also differentiated cases/complaints where the Member of Parliament (MP) writes to raise concerns on behalf of his/her constituent. Correspondence from MPs are handled separately because NHS complaints handling legislation does not apply to MP cases / complaints.

4.1.2 The required timescale for answering complaints is 25 working days from the date the complaint has been received, to the date the final response has been sent. However it may occasionally be necessary to agree an extension to this 25 day deadline with the complainant where a case is particularly complex, multifactorial or requires information from an external source e.g. a care home provider. Where a case has been completed within an agreed extension period this is still deemed to have been completed 'within the required timescale'.

For all CHC cases that were concluded in the six months from July – December 2017, the average time between the case being received and the final response sent was 26.20 days, and the average time between case received and case closed fully was 27.67 days.

For July to December, the requirement to acknowledge each complaint within three-working days was met in 95% of cases; only one case fell outside this mark and this was due to a communication error. A total of 94% of cases were also handled within the agreed timescale for response, with one case falling outside this requirement.

4.1.3 Broken down by quarter, CHC complaints were received as follows:

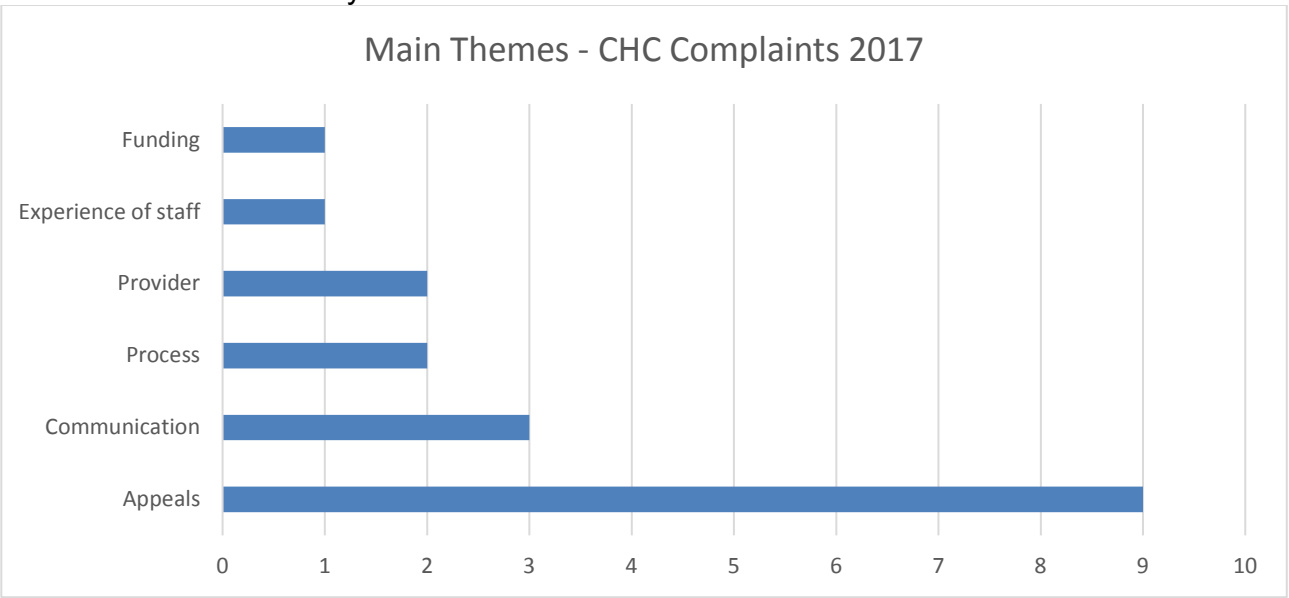


As a comparator, the Quarter 1 complaints table previously submitted to NHOSC in February 2017 has been updated with recent figures to indicate activity over the past 3 years.

Number of complaint and type of outcome
[Quarter 1 Comparison, 2015-2016, 2016-2017, 2017-2018]

Column1	Quarter 1 2015-2016	Quarter 1 2016-2017	Quarter 1 2017-2018
April	1	4	2
May	2	3	0
June	6	0	2
Total	**9**	**7**	**4**
Outcome			
Upheld	1	6	4
Partially	4	0	0
Not upheld	4	0	0
Ongoing	0	1	0

4.1.4 Thematic analysis



The chart above shows a thematic analysis of complaints received during 2017.

The thematic analysis indicates that complaints over the last 12 months predominantly relate to delays in process or communication in relation to Appeals claims (9).

In the second largest category, three complaints were received around communication, one in Quarter 1 and two in Quarter 2. In two cases relatives did not feel that information they provided at the point of CHC assessment had been taken into account, and in one case, information around care provision was not considered adequate by a patient's relatives.

In addition to the above, 8 MP complaints were received during 2017. Five of these were related to funding, 1 was related to the outcome of the CHC Assessment, 1 was related to the family experience of the process, 1 was related to a care home and a family's dissatisfaction with the care provided. Of these complaints, 2 were fully upheld and 1 was partially upheld. Where complaints were upheld there is evidence of a change in process and learning within the CHC team in response to the issues raised.

4.1.5 From April 2018 North and South Norfolk CCGs will be hosting the corporate complaints service on behalf of themselves, Norwich CCG and West Norfolk CCG, to bring greater consistency to the processes for receiving, handling and responding to complaints across central and West Norfolk. As NCCP is a CCG hosted service, all CHC complaints will be included in this arrangement. The CCGs plan to provide their complaints service 'in house' to enable closer monitoring of themes and trends and to have greater responsibility for liaising with complainants and MPs to address issues arising.

4.2 Consistency of decision-making across the four Complex Case Review Panels (CCRPs)

Prior to November 2017 each CCG ran its own Complex Case Review Panel with staff from each respective CCG involved in decision making. With the formation of a Partnership each CCG has delegated authority to NCCP to run their Complex Case Review Panels as a single central process. Four panels are run each week. This has

improved consistency in decision making and reduced variation across the CCGs because decisions are made by a small number of highly experienced clinical staff.

4.3 Waiting times for CHC cases to be considered by the CCRPs

NCCP does not collect data around waiting times for sign off of cases at the Complex Case Review Panel. This is because panels run very frequently and this is not a significant cause for delay of a care package commencing. Care packages can commence ahead of the paperwork where necessary and would be authorised by a member of the NCCP senior management team to minimise delays.

4.4 The settings in which patients receive CHC care

NHOSC invited the CCGs to comment on whether there has there been an increase / decrease in those who receive NHS CHC funded care in a residential care home or in their own home.

The CHC data below indicates the split between residential care home packages and domiciliary care packages has been provided for Q1 and Q2 to enable comparison over the previous 3 years.

	2015/16				2016/17				2017/18			
	Q1		Q2		Q1		Q2		Q1		Q2	
	Res	Dom	Res	Dom	Res	Dom	Res	Dom	Res	Dom	Res	Dom
North Norfolk CCG	75%	25%	75%	25%	73%	27%	71%	29%	62%	38%	68%	32%
Norwich CCG	75%	25%	75%	25%	74%	26%	73%	27%	54%	46%	71%	29%
South Norfolk CCG	68%	32%	69%	31%	66%	34%	66%	34%	63%	37%	72%	28%
West Norfolk CCG	68%	32%	53%	47%	63%	37%	62%	38%	55%	45%	68%	32%
All CCGs	**71%**	**29%**	**68%**	**32%**	**69%**	**31%**	**68%**	**32%**	**59%**	**41%**	**70%**	**30%**

Table 2. Spread (%) of patients between residential or domiciliary NHS continuing healthcare settings by CCG

The data indicates that there has been fluctuation but no significant overall change in the percentage split of patients that receive care in a domiciliary setting compared to a residential setting over the last 3 years.

4.5 Contingency care arrangements – ('safety net' to prevent admission to alternative care environment)

NHOSC asked NCCP to comment specifically about contingency care arrangements to avoid admission to an alternative care environment. NCCP work closely with patients and their families to listen to and respect their preferences and to support patients to

receive care safely in their preferred environment wherever possible. The NCCP Brokerage team has designated clinicians who are able to support care arranging using access to the most appropriate provider to meet patient's assessed clinical need. The need for robust contingency care arrangements runs throughout the organisation and measures have been put in place in the following areas;

4.5.1 Contracting;

- CCG contracts include a section about care provision, continuity and duty of care
- Contracts have been amended to support the Inclusion of 'golden hours' for domiciliary care providers that allows periods of additional uplifted care to acknowledge fluctuation in care needs at times
- Additional services policy allows temporary unauthorised uplift in care homes over weekends to enable providers to adjust care according to clinical need

4.5.2 Brokerage

- CHC Brokerage will work with patients, relatives and providers to source alternative care or offer temporary respite placements when notified that care needs are not being met. This includes linking with mainstream NHS services if private sector care provision is not available e.g. Care at Home Team.
- CHC clinicians work with families to offer regular domiciliary respite care in their own home, especially where family members are regular caregivers. This serves as a backup contingency plan also to develop familiarity with a range of care givers (policy under development to harmonise with NCC respite care provision).

4.5.3 Bespoke solutions

- PHB patients are provided with funds and support to prepare localised contingency arrangements relevant to their circumstances. This does not exclude PHB holders from accessing all other safety net options, but provides additional flexibility for those that would prefer to put their own contingency arrangements in place.
- Many agencies will train additional carers especially where care is particularly complex and requires a high degree of carer training to deliver care e.g. patients dependent on ventilatory support at home. These are generally packages of care where 24 hours 1:1 care is required, by staff specifically trained to operate ventilatory devices. NCCP authorises additional funding to support this contingency measure where clinically indicated.

4.5.4 Individuals in receipt of NHS CHC funded care have exactly the same rights as all other citizens under the Care Act including access to care in times of emergency. The NHS fund an array of care services round the clock for those in need of medical or nursing care in urgent situations. In a similar way the social care services provide round the clock, responsive services for those in need of urgent, short term, social care support. This includes individuals in receipt of NHS CHC funding. In addition to the local contingency measures put in place by NCCP, patients in receipt of NHS CHC funding continue to have access to;

Mainstream NHS services

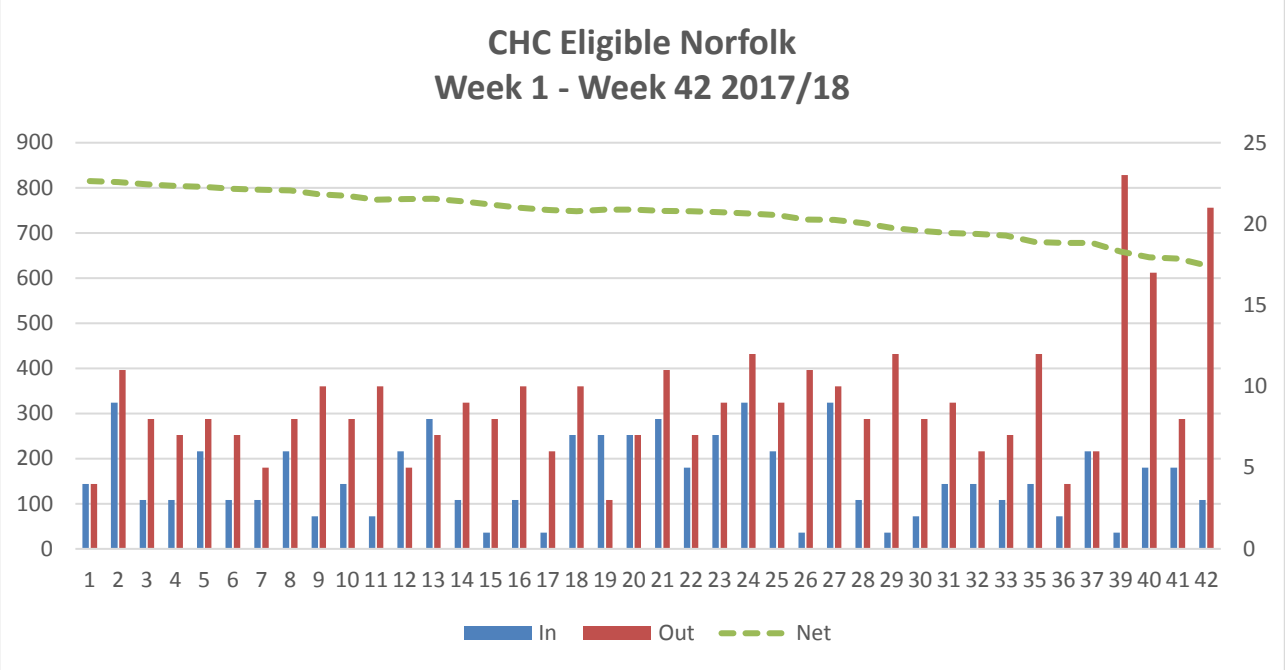
- The national mainstream NHS safety net for health can be accessed 24 hours a day via telephone to 111, Out of Hours Doctors, Community Nursing Teams, Virtual Ward teams, Ambulance services, Walk-In and Urgent Care Centres, and as a last resort A&E.

Mainstream Social Care services

- A mainstream safety net for social care can be accessed through NCC Swifts / Night Owls (which is partially NHS funded) to deliver urgent social care to patients in their own home and prevent deterioration in physical wellbeing.
- Safeguarding services via the Multi Agency Safeguarding Hub
- Learning Disability Crisis Intervention Team
- Duty Social Work teams for Children

4.6 Trend in the overall numbers receiving CHC

The number of patients eligible to receive CHC funded care has decreased over the last 12 months.



This is due to a number of factors including additional CCG investment in re-ablement and convalescent pathways which help patients leave hospital earlier and promote recovery prior to assessment for long term care needs, in line with the NHS National Framework for CHC.

Weeks 39 – 40 show a significant increase in the number of patients no longer eligible for CHC funding and may be attributed to the seasonal increase in end of life care over the winter period.

National work focused on improving consistency in decision making and clarifying eligibility considerations has also contributed to improving processes and application of the National Framework in Norfolk.

Closer working with NCC colleagues is helping to address cases which may have previously been on the borderline of CHC eligibility and has enabled a more consistent approach to considering those patients who would benefit from joint health and social care provision. Since the CHC service transition on 1st November 2017 a Joint Panel has been held fortnightly to enable closer working between NCC and NCCP.

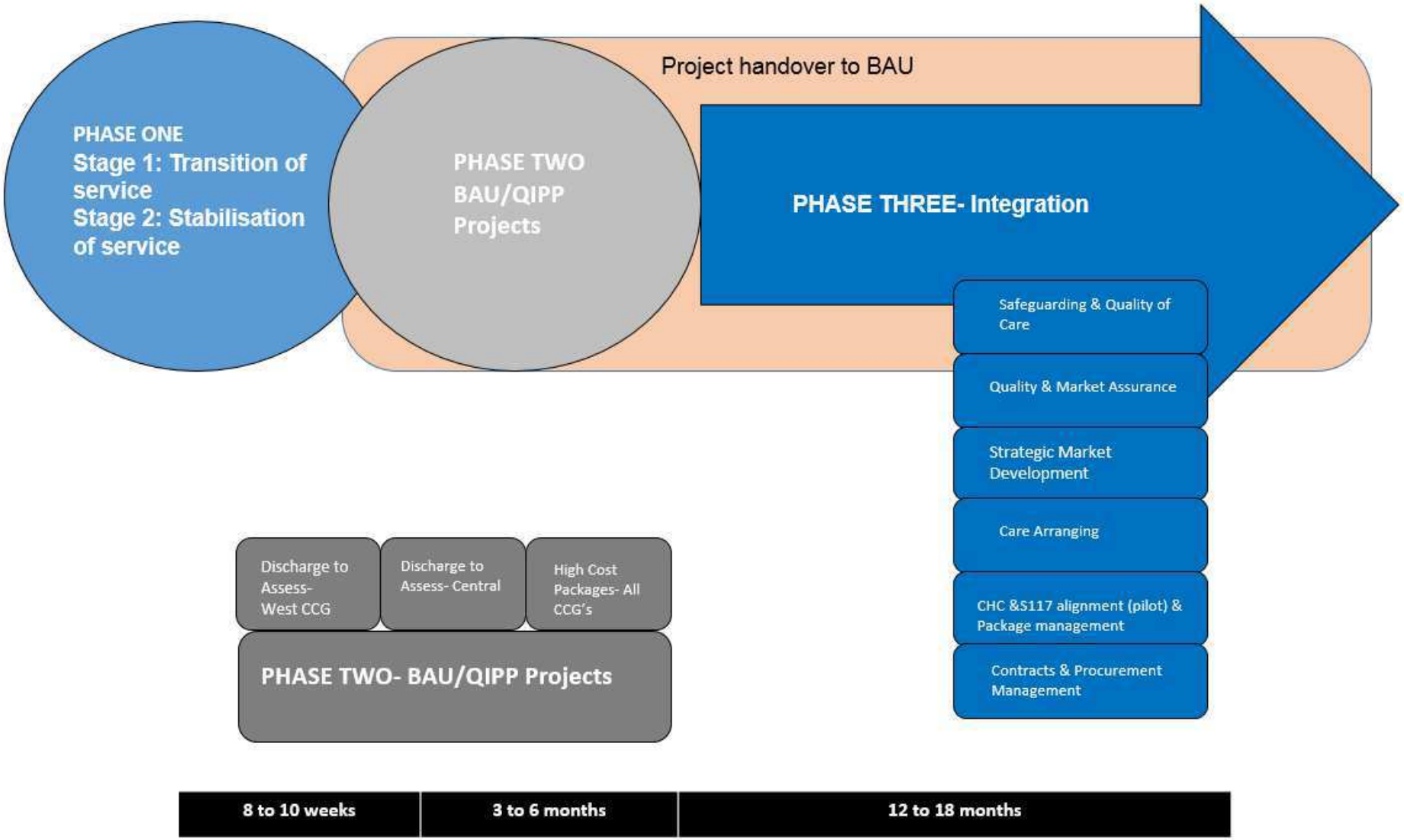
Appendices Document Title		Document location
1	NCCP Strategic Priorities	Attached
2	NCCP Developmental Phases	Attached
3	NCCP Quality Audit Tool – Provider Care Plans	Attached

Appendix 1 - Norfolk Continuing Care Partnership Strategic Priorities

How we will know we have achieved our ambition. How we will measure success. How we will contunie to measure how we are doing…….

Priority Area	Measures	Evidence/Outcomes
To reduce unwarranted variation across the county	Measure a Measure b Measure c	Centralised process for eligibility ratification Single Complex Case Review Panel for all cases Benchmarking against national standards
To improve experience and outcomes	Measure a Measure b Measure c	Active patient feedback mechanisms in place to monitor and learn from practice Virtual patient forum to provide interaction, support and advise System of peer review to share learning and drive improvement
To ensure the highest levels of patient safety and quality of care	Measure a Measure b	Individual Care Agreement in place for each patient specifically stating care requirements Contracts in place with all Nursing, Residential and Domiciliary Providers with quality assurance measures explicitly stated and monitored quarterly
To ensure value for money	Measure a Measure b Measure c	Package of care reviews undertaken regularly Quality Assurance mechanisms for both eligibility and provision of packages of care in line with CHC framework Reporting structures in place to monitor cost and benchmark both locally and nationally
To ensure exacting service standards for quality assurance and compliance	Measure a Measure b Measure c	Quality assurance of all care providers in liaison with social care partners Proactive Quality team working with providers to drive up standards All care providers to be in contract with the CCGs
To drive continuous improvement through the operational business while ensuring alignment with strategic aims including integration agenda	Measure a Measure b Measure c	Workforce development programme to link local and national improvement aims Process for review of strategic aims with staff via a robust appraisal process Competency framework developed and implemented Workforce strategy to develop and retain optimism staffing model making CHC a desirable career option

Appendix 2 - Norfolk Continuing Care Development Phases



Appendix 3 - Excerpt from NCCP Quality Audit Tool – Provider Care Plans

Documentation E4- How are people supported to maintain good health, have access to healthcare services and receive ongoing healthcare support?		
Are there risk assessments for the following? **care files reviewed:** 1 / 2 / 3 / 4		**Number of**
Are risk assessments/care / support plans regularly reviewed (at least monthly)?		
Are detailed care / support plans in place for above risk assessments?		
Is there depth and detail in the progress notes?		
Are care / support plans person centred?		
Are personal histories (Life stories), preferences recorded?		
If in use, are repositioning charts filled in correctly?		
Are the repositioning charts reflective of the care planned i.e. frequency?		

Norfolk Health Overview and Scrutiny Committee appointment

Report by Maureen Orr, Democratic Support and Scrutiny Team Manager

The Committee is asked to appoint a link member with Norfolk Community Health and Care NHS Trust.

1. Appointment of a link Member

1.1 Norfolk Health Overview and Scrutiny Committee nominates link members to attend local NHS provider and commissioner organisations meetings held in public in the same way as a member of the public might attend. Their role is to observe the CCG meetings, keep abreast of developments in the CCGs area and alert NHOSC to any issues that may require the committee's attention.

1.2 The nominated member or a nominated substitute may attend in the capacity of NHOSC link member.

1.3 A vacancy exists for a link member with Norfolk Community Health and Care NHS Trust (NCH&C). NCH&C Board meetings in public are held on the last Wednesday of every month, usually at Norwich Community Hospital starting at 9.30am.

Cllr Lana Hempsall is the nominated substitute link for NCH&C.

2. Action

2.1 The Committee is asked to:-

(a) Appoint a link Member with Norfolk Community Health and Care NHS Trust

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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 2018

Meeting dates	*Briefings/Main scrutiny topic/initial review of topics/follow-ups*	*Administrative business*
5 April 2018	Children's speech and language services – progress update since 7 September 2017 Norfolk and Suffolk NHS Foundation Trust – mental health services in Norfolk – an update on progress since 7 December 2017	
24 May 2018	Access to NHS dentistry in West Norfolk (including for service personnel's families at RAF Marham)	
12 July 2018	Maternity services – delivery of maternity reforms by the Local Maternity System	
6 Sept 2018		

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

Provisional dates for report to the Committee / items in the Briefing 2018

May 2018 Briefing
- evaluation of the District Direct pilot (follow-up to 11/1/18 NHOSC)
- Progress against the trajectory for improvement in waiting times for assessment and diagnosis for autistic spectrum disorders (follow-up to 11/1/18 NHOSC)

To be scheduled –Implementation of the Suicide Prevention Action Plan 2016-21 (relating to the county-wide Suicide Prevention Strategy) - progress by service providers. **Note** – Communities Committee is due to receive an update on the

Action Plan on 7 March 2018. NHOSC may wish to decide where to focus after that date.

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

Clinical Commissioning Groups

North Norfolk	-	M Chenery of Horsbrugh (substitute Mr D Harrison)
South Norfolk	-	Dr N Legg (substitute Mr P Wilkinson)
Gt Yarmouth and Waveney	-	Mrs M Fairhead (substitute Mr A Grant)
West Norfolk	-	M Chenery of Horsbrugh (substitute Mrs S Young)
Norwich	-	Ms E Corlett (substitute Ms B Jones)

NHS Provider Trusts

Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust	-	Mrs S Young (substitute M Chenery of Horsbrugh)
Norfolk and Suffolk NHS Foundation Trust (mental health trust)	-	M Chenery of Horsbrugh (substitute Ms B Jones)
Norfolk and Norwich University Hospitals NHS Foundation Trust	-	Dr N Legg (substitute Mr D Harrison)
James Paget University Hospitals NHS Foundation Trust	-	Mrs L Hempsall (substitute Mrs M Fairhead)
Norfolk Community Health and Care NHS Trust	-	*Vacancy* (substitute Mrs L Hempsall)

Norfolk Health Overview and Scrutiny Committee 22 February 2018

Glossary of Terms and Abbreviations

A&E	Accident and emergency
ASD	Autistic spectrum disorder
BAU	Business as usual
CCG	Clinical Commissioning Group
CCRP	Complex Case Review Panel
CHC	Continuing Healthcare
CSU	Commissioning Support Unit
GP	General Practitioner
GYWCCG	Great Yarmouth and Waveney Clinical Commissioning Group
HR	Human resources
IMCA	Independent Mental Capacity Advocate
Labile	Liable to change; easily altered
LD	Learning Difficulties / Disability
NCC	Norfolk County Council
NELCSU	North East London Commissioning Support Unit – formerly contracted by the central and west CCGs to support the Continuing Health Care process
NFS	Norfolk First Response Service
NHOSC	Norfolk Health Overview and Scrutiny Committee
NNCCG	North Norfolk Clinical Commissioning Group
NHSE	NHS England
PHB	Personal health budget
QIPP	Quality Innovation Productivity and Prevention - A Department of Health and Social Care agenda, looking at health economy solutions to meet local financial challenges
QOF	Quality Outcomes Framework – the annual reward and incentive programme for GP practices. It rewards practices for provision of quality care and helps standardise improvement in the delivery of primary medical services
SNCCG	South Norfolk Clinical Commissioning Group
S117	Section 117 aftercare – refers to section 117 of the Mental Health Act which gives some people who have been kept in hospital under the Act the right to free help and support after they leave hospital.
STP	Sustainability & transformation plan
TCP	Transforming Care Partnership
VCS	Voluntary & community sector / voluntary & charitable sector