Norfolk County Council

Norfolk Health Overview and Scrutiny Committee

Date: **Thursday 30 May 2019**

Time: **10.00am**

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

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

Those members of the public or interested parties who have indicated to the Committee Officer, Hollie Adams (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. Speaking will be for the purpose of providing the committee with additional information or a different perspective on an item on the agenda, not for the purposes of seeking information from NHS or other organisations that should more properly be pursued through other channels. Relevant NHS or other organisations represented at the meeting will be given an opportunity to respond but will be under no obligation to do so.

Membership

MAIN MEMBER	SUBSTITUTE MEMBER	REPRESENTING
Michael Chenery of Horsbrugh	Mr D Bills / Mrs P Carpenter / Mr G Middleton / Mr T Smith / Mr F Whymark	Norfolk County Council
Mr F Eagle	Mr D Bills / Mrs P Carpenter / Mr G Middleton / Mr T Smith / Mr F Whymark	Norfolk County Council
Ms E Flaxman-Taylor	*Vacancy*	Great Yarmouth Borough Council
Mrs W Fredericks	*Vacancy*	North Norfolk District Council
Vacancy	*Vacancy*	Borough Council of King's Lynn and West Norfolk
Vacancy	Mr M Fulton-McAlister	Norwich City Council
Mr D Harrison	Mr T Adams	Norfolk County Council
Vacancy	Mr R Foulger	Broadland District Council
Mrs B Jones	Mrs J Brociek-Coulton / Ms E Corlett	Norfolk County Council
Mr C Jones	Mrs J Brociek-Coulton / Ms E Corlett	Norfolk County Council
Dr N Legg	*Vacancy*	South Norfolk District Council
Mr R Price	Mr D Bills / Mrs P Carpenter / Mr G Middleton / Mr T Smith / Mr F Whymark	Norfolk County Council
Mrs M Stone	Mr D Bills / Mrs P Carpenter / Mr G Middleton / Mr T Smith / Mr F Whymark	Norfolk County Council
Mr P Wilkinson	Ms S Dowling	Breckland District Council

Mrs S Young	Mr D Bills / Mrs P Carpenter / Mr G Middleton / Mr T Smith / Mr F Whymark	Norfolk County Council

For further details and general enquiries about this Agenda please contact the Committee Officer:
Hollie Adams on 01603 223029
or email committees@norfolk.gov.uk

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A g e n d a

1. Election of Chairman

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

2. Election of Vice-Chairman

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

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

4. Minutes

To confirm the minutes of the meeting of the Norfolk Health Overview and Scrutiny Committee held on 11 April 2019. (Page **5**)

5. Members to declare any Interests

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

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

If you do not have a Disclosable Pecuniary Interest you may nevertheless have an **Other Interest** in a matter to be discussed if it affects, to a greater extent than others in your division

- Your wellbeing or financial position, or
- that of your family or close friends
- Any body -
    - Exercising functions of a public nature.
    - Directed to charitable purposes; or
    - One of whose principal purposes includes the influence of public opinion or policy (including any political party or trade union);

Of which you are in a position of general control or management.

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

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

7. Chairman's announcements

8. Local action to address health and care workforce shortages (Page **13**)

A report by Norfolk and Waveney Sustainability and Transformation Partnership (STP) Workforce Workstream Lead

9. Joint health scrutiny committees' terms of reference (Page **31**)

Amendments to reflect the establishment of East Suffolk Council.

10. Norfolk Health Overview and Scrutiny Committee appointments (Page **42**)

Appointments of Members to:-

(a) Great Yarmouth and Waveney Joint Health Scrutiny Committee
(b) Link roles with local NHS Clinical Commissioning
(c) Link roles with local NHS Provider Trusts

11. Forward work programme (Page **46**)

To agree the committee's forward work programme

Glossary of Terms and Abbreviations (Page **49**)

Chris Walton
Head of Democratic Services

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Date Agenda Published: 21 May 2019

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Norfolk County Council

NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE
MINUTES OF THE MEETING HELD AT COUNTY HALL, NORWICH
on 11 April 2019

Present:

Michael Chenery of Horsbrugh (Chairman)	Norfolk County Council
Dr C Jones (sub for Ms E Corlett)	Norfolk County Council
Mr F Eagle	Norfolk County Council
Mrs S Fraser	Borough Council of King's Lynn and West Norfolk
Mr D Harrison	Norfolk County Council
Mrs B Jones	Norfolk County Council
Dr N Legg	South Norfolk District Council
Mr R Price	Norfolk County Council
Mrs S Young	Norfolk County Council

Also Present:

David Barter	Head of Commissioning, NHS England Midlands and East (East)
Debbie Walters	Contract Manager, Primary Care Dental, NHS England Midlands and East (East)
Tom Norfolk	Chairman, Norfolk Local Dental Network
Nick Stolls	Secretary, Norfolk Local Dental Committee
Alexandra Kemp	County Councillor for Clenchwarton and King's Lynn South
Judith Bell	Operations Manager, Healthwatch Norfolk
Frank Sims	Chief Officer, South and North Norfolk CCGs (South Norfolk is the lead CCG for mental health commissioning)
Clive Rennie	Assistant Director Integrated Commissioning (Mental Health and Learning Disabilities), representing the CCGs
Denise Clark	Interim Head of Specialised Mental Health, Regional Specialised Commissioning, NHS England Midlands and East (East).
Julie Frake Harris	Director of Operations, Cambridge and Peterborough NHS Foundation Trust (provider of Norfolk Community Eating Disorders Service for adults over 18 years, central and west Norfolk)
Linda Stevens	Deputy Locality Manager, Norfolk and Suffolk NHS Foundation Trust (covering NSFT Eating Disorder services across Norfolk)
Dr Louise Brabbins	Specialised Eating Disorders Psychiatrist, Community Eating Disorders Service (GY&W), Norfolk and Suffolk NHS Foundation Trust
Yolande Russell	Chief Executive Officer, Eating Matters (provider of services for adults over 18 years with mild eating disorders across Norfolk and Waveney)
Tom Quinn	Director of External Affairs, Beat eating disorders charity
Sarah Middleton	Service user

Jane Poppitt	Norfolk Community Eating Disorders, Cambridge and Peterborough NHS Foundation Trust
Davia Barzdaitiene	Norfolk Community Eating Disorders, Cambridge and Peterborough NHS Foundation Trust
Madeleine Thatham	Norfolk Community Eating Disorders, Cambridge and Peterborough NHS Foundation Trust
Fiona Lain	Norfolk and Suffolk NHS Foundation Trust
Dr Marita Bulto	Norfolk and Suffolk NHS Foundation Trust
Helen Waters	Trustee, Eating Matters
Diane Smith	Transformation Manager, Mental Health and Learning Disabilities, South Norfolk CCG
Maureen Orr	Democratic Support and Scrutiny Team Manager
Chris Walton	Head of Democratic Services
Tim Shaw	Committee Officer

1 Apologies for Absence

1.1 Apologies for absence were received from Mrs A Claussen-Reynolds, Ms E Corlett, Ms E Flaxman-Taylor, Mr D Fullman, Mr G Middleton, Mr F O'Neill and Mr P Wilkinson.

2. Minutes

2.1 The minutes of the previous meeting held on 28 February 2019 were confirmed by the Committee and signed by the Chairman.

3. Declarations of Interest

3.1 There were no declarations of interest.

4. Urgent Business

4.1 There were no items of urgent business.

5. Chairman's Announcements

5.1 The Chairman drew the Committee's attention to a health scrutiny training session for Members that would be held in the Conference Room, South Wing, County Hall on Tuesday 28 May 2019 starting at 2 pm.

5.2 The Chairman said that this was the last meeting of the NHOSC that Tim Shaw would routinely attend. Tim had regularly attended health scrutiny meetings since the inception of the NHOSC and would be supporting other committees when the County Council's new system of governance was introduced in May 2019. Members thanked him for his support.

6 Access to NHS Dentistry in Norfolk

6.1 The Committee received a suggested approach by Maureen Orr, Democratic Support and Scrutiny Team Manager, to a report on access to NHS dentistry across Norfolk and a follow-up on action to improve access to NHS dentistry in the west Norfolk area.

6.2 The Committee received evidence from David Barter, Head of Commissioning, NHS England Midlands and East (East), Debbie Walters, Contract Manager, Primary Care Dental, NHS England Midlands and East (East), Tom Norfolk, Chairman, Norfolk Local Dental Network and Nick Stolls, Secretary, Norfolk Local Dental Committee.

6.3 The Committee also heard from Alexandra Kemp, County Councillor for Clenchwarton and King's Lynn South and Judith Bell, Operations Manager, Healthwatch Norfolk.

6.4 The Chairman drew the Committee's attention to paragraph 3.4 of the covering report about commercial confidentiality. He said the NHS England representatives were not able to answer questions that could potentially compromise the ongoing procurements for special care dentistry, primary care orthodontic services and dental out of hours services. Yesterday NHS England (East) had distributed pre-election guidance which meant that the speakers were also not able to answer questions (e) or (h) on page 21 of the agenda papers. It would be possible to obtain answers to these questions later.

6.5 Alexandra Kemp said that two pensioner constituents had contacted her about having to travel to Skegness in Lincolnshire and to Suffolk to access treatment, because NHS Dental Surgeries in King's Lynn had written to patients to say they had been deregistered and that they could no longer be treated even though there was no formal process for registration. Alexandra Kemp asked what steps the NHS had taken to map the needs and provide enough NHS dental provision in King's Lynn and West Norfolk, including for children, pensioners and vulnerable groups. She also asked why there was no integrated health plan and cost-benefit analysis for Dental Health and Prevention in the STP Plan; how much money was spent on the high number of children, reported in the press, as having teeth extracted at the Queen Elizabeth Hospital because they could not access dental treatment, and how much money was spent in acute hospitals on issues such as heart problems, caused or contributed to, by the neglect of dental hygiene, with the lack of access to NHS Dentistry.

6.6 Judith Bell, Operations Manager, Healthwatch Norfolk, said that Healthwatch Norfolk had a good working relationship with the local dental profession and was in regular contact with the Norfolk Local Dental Committee about issues of patient access to NHS dental services and dental practices that were taking on NHS patients. Healthwatch Norfolk had conducted a quick test of availability of NHS dentistry by phoning all 50 dental practices that were listed in the report from NHS England as NHS practices. This had shown that 14 dental practices were accepting NHS patients (28%); 22 were not accepting NHS patients (although 4 had said they would be later in the year) (44%); 2 were orthodontists and so provided a specialist/ not general service (4%) and 12 could not be contacted on the phone (24%).

6.7 During discussion the following key points were made:

- The speakers from NHS England Midlands and East (East) said that action continued to be taken to improve access to dental services for patients from all parts of west Norfolk, including for the families of service personnel at RAF Marham, however, due to issues of commercial confidentiality the current position regarding the completion of the procurement processes for special care dentistry, primary care orthodontic services and dental out of hours services could not be reported to the Committee at this time.

- Members were assured that funds released by the closure of dental practices in Snettisham and East Harling would be fully re-allocated towards the recommissioning of dental activity in West Norfolk and South Norfolk.
- It was pointed out that alternative arrangements for patients from East Harling were now in place and those for Snettisham had yet to be completed.
- The Committee was informed that NHS England (East) would recommission dental services in the Unthank Road area of Norwich, following the closure of a dental practice.
- The speakers explained to the Committee how dental services in primary care were commissioned and delivered. They referred to the many strengths in the current system that they wanted to maintain and build upon. They also described the challenges that they needed to address in the interests of sustainability, efficiency and improved quality, and in meeting their goals of improving oral health and continuing to improve access to NHS dental services.
- It was pointed out that a full list of dental practices and performance data was available in the report presented to the Committee.
- Members were concerned that this data showed that none of the dental practices had achieved their 96% UDA (Unit of Dental Activity) activity targets.
- In reply to questions, the speakers from East said that the data on achievement of activity targets did not represent a complete financial year. Where dental practices failed to deliver on contracted activity they were more closely monitored and could have dental activity withdrawn.
- The speakers from East added that their approach to commissioning was based on improving oral health and good clinical outcomes; NHS England (East) continued to design potential new contractual arrangements for NHS dentistry based on quality and outcomes and supported a focus on preventative care and continuing care rather than purely dental activity.
- The Secretary to the Local Dental Committee (LDC) said that the increase in the unused dental budget (known as clawback money) which had continued to rise year on year was a sign that activity targets had become more difficult to achieve. The dental profession wanted clawback money recycled back into dental practices and used to fund ‘flexible commissioning’.
- The Committee heard that flexible commissioning could mean some of the clawback money was used to provide additional emergency slots in dental practices to take the pressures off the existing emergency care providers or possibly to expand domiciliary services and care home treatments. The Secretary to the LDC said that they were in constructive discussions with the commissioners to arrive at a position where patients might access specialist orthodontic services more readily.
- The Committee was informed that it was likely that restorative dentistry at the Norfolk and Norwich hospital (NNUH) would be re-established. Funding was in place and there was interest in the role. It was hoped that a programme could be established to upskill General Dental Practitioners for dental surgery.
- The re-procurement of services would allow the shortcomings in the Kings Lynn area, which was one of the worst areas for the availability of specialist orthodontic activity, to be addressed.
- It was noted that community dental services were available for people with special care needs and that when the public required access to out of hours emergency dental treatment they were asked to contact NHS 111 in the first instance.
- The Committee asked for changes to special care dentistry, primary care orthodontic and dental out of hours services as a result of the current re-procurements to be reported to a future meeting of the Committee.

- The Secretary to the Norfolk LDC said that the Dental Strategy Group's 2018 review of current service provision in Norfolk had shown that 75% of all dental practices and 84% of the largest dental practices were struggling to recruit dentists. Some 67% of dentists were known to be considering reducing their working hours or leaving NHS dentistry.
- Members discussed the difficulties in recruiting dentists to work in rural areas of Norfolk. Members were informed that Norfolk's recruitment difficulties were like those found in rural areas elsewhere in the country. Newly-qualified dentists from urban areas were often unwilling to work in rural areas and looked to move to London, Birmingham and other large English cities to find suitable employment.
- The Chairman of the Local Dental Network said that there was sufficient student demand in Norfolk for a school for dental therapists to be set up in the Norwich area. The proposed new school could run on similar lines to a school for dental therapists run by Essex University. The necessary permissions to build such a school in Norfolk (with similar governance arrangements as for the school in Essex) were being explored. The proposed new school could take on students from September 2020. In the meantime arrangements were being made with the Essex school for dental therapists to take up placements in Norfolk.
- The Chairman of the Local Dental Network added that dental therapists were more likely to remain in the area where they completed their training.
- In reply to questions about the role of dental therapists on graduation, the Chairman of the Local Dental Network said that they were increasingly important members of all dental teams and likely to be a particularly important component of future NHS dental care. More dental practices were taking on dental therapists to handle much of the routine dental work. Provided they had completed appropriate training, dental therapists could perform extended duties and provide treatment under supervision in a range of places in the community, such as schools and care homes.
- A Member then questioned whether a Norfolk dental school would improve the availability of dental care for Norfolk patients; he said that there were excellent learning facilities for doctors, nurses and paramedics in Norfolk but there remained a lack of doctors, nurses and paramedics.
- Members were of the view that the main barriers to public access to dental services were the cost of dental care, perceptions of need, lack of access and dental anxiety.
- Members said that patients wanted to be able to access clearer information about the dental charges system.
- Members also said that continuing care from a familiar dental practice over time had benefits for a patient's oral health. Children living in areas of social deprivation were less likely to attend for restorative care; their irregular pattern of dental attendance mirroring that of their parents.
- In reply to questions, the Secretary to the Norfolk LDC said that Children's Centres were places where hard to reach families could obtain information on a casual basis about dental issues that they were unable to access through normal day to day activities. The closure of most of these centres could significantly weaken the impact on hard to reach groups of planned new programmes of oral health education for children.

6.8 The Committee noted the information provided in the report and during the discussion at today's meeting.

6.9 It was agreed that speakers from NHS England Midlands and East (East) and the Local Dental Network should return to the Committee with a progress update in

around 6 months' time (to be scheduled for November 2019). The report to include (not exclusively):

- The outcome of current procurements for special care dentistry, primary care orthodontic and dental out of hours services.
- The commissioners' response to the Local Dental Committee's suggestion of 'flexible commissioning' (e.g. additional emergency slots in practices, or expansion of domiciliary or care home treatments).
- Progress towards establishing dental therapy training in Norfolk.
- Progress toward provision of restorative dentistry at the Norfolk and Norwich Hospital.
- An update on progress towards provision of dental services at RAF Marham for the families of service personnel and the public.

It was further agreed that a representative from RAF Marham should be invited to attend the meeting when this topic was next discussed, should this become necessary.

7 Eating Disorder Services

7.1 The Committee received a suggested approach by Maureen Orr, Democratic Support and Scrutiny Team Manager, to an examination of access to eating disorder services for patients in Norfolk including adults and children, community and specialist in-patient services.

7.2 The Committee received evidence from Frank Sims, Chief Officer, South and North Norfolk CCGs (South Norfolk is the lead CCG for mental health commissioning), Clive Rennie, Assistant Director Integrated Commissioning (Mental Health and Learning Disabilities), representing the CCGs, Denise Clark, Interim Head of Specialised Mental Health, Regional Specialised Commissioning, NHS England Midlands and East (East), Julie Frake Harris, Director of Operations, Cambridge and Peterborough NHS Foundation Trust (provider of Norfolk Community Eating Disorders Service for adults over 18 years, central and west Norfolk), Linda Stevens, Deputy Locality Manager, Norfolk and Suffolk NHS Foundation Trust (covering NSFT Eating Disorder services across Norfolk), Dr Louise Brabbins, Specialised Eating Disorders Psychiatrist, Community Eating Disorders Service (GY&W), Norfolk and Suffolk NHS Foundation Trust and Yolande Russell, Eating Matters.

7.3 The Committee also heard from Tom Quinn, Director of External Affairs for BEAT (the national Eating Disorders charity) and Sarah Middleton, a service user.

7.4 Sarah Middleton, s service user, said that she had lived with anorexia for more than 30 years and was concerned that patients were often not deemed ill enough to access treatment from the NHS but too ill to obtain support from charities. She said that while she was able to discuss her condition with her GP, GPs were not best placed to provide the kind of specialist help that people in her position needed.

7.5 Tom Quinn, Director of External Affairs for BEAT said that the charity provided helplines / moderated online forums for those affected by eating disorders and remained concerned that because treatment was only accessible to the most severely ill this was sending the wrong message to people with eating disorders considered to be not ill enough to deserve treatment. The long waiting times to be seen by a GP had left GPs in the difficult position of being responsible for patients they might not be best placed to help.

7.6 During discussion the following key points were made:

- The Committee was informed about the areas of responsibility of each of the organisations that were represented at today's meeting.
- The information showed that there were lengthy waiting times for eating disorders services.
- The Committee noted that the national access and waiting time standards for eating disorders services for children and young people did not apply for adult services.
- The Committee was informed that Children's and Young Peoples Eating Disorder Services across the Norfolk and Waveney area were commissioned from Norfolk and Suffolk NHS Foundation Trust (NSFT).
- Public Health England had been commissioned to undertake a review of demographics and capacity in relation to eating disorders in-patient beds. The local review in the eastern region would be completed imminently. A national review was also underway.
- The Committee heard that the specialist and community eating disorder services were looking at co-ordinating with each other and with primary care to ensure that patients were safely transferred between the services or discharged from eating disorder services.
- It was pointed out that NICE quality standards stated that people with eating disorders who were supported by more than one service should have a care plan that explained how the eating disorder services would work together.
- It was also pointed out that Norfolk Community Eating Disorders Service (NCEDS) was a small but highly specialised team of dedicated clinicians who prioritised patients according to need and clinical risk. The NCEDS was run by CPFT who provided the services that were explained in the report.
- In reply to questions, the speakers said that the restriction of NCEDS services to severe cases only had been a temporary emergency measure due to a shortage of suitably trained and appropriately qualified specialist staff. The CPFT had now successfully recruited new clinical staff and the service was expected to return to normal operating staffing numbers/criteria by July 2019.
- The limited capacity of NCEDS and of other eating disorder service providers would, however, continue to mean that most adults with an eating disorder were unable to access specialist treatment and had to rely on on-line services for help.
- In reply to questions, the speakers agreed to provide details after the meeting about the on-line services that were available to people living in Norfolk, how these on-line services could be accessed and the range of outcomes that were available for those who used them.
- Members were concerned that in practice patients had to have a body mass index (BMI) of below 15 to qualify for treatment but that BMI did not provide an accurate assessment of risk. Access based on BMI could mean those who were desperate for help attempted to lose more weight. As people waited for treatment a severe deterioration in condition often led to planned or emergency hospital admission.
- The Committee noted that those people who had not been able to obtain treatment relied on GPs or other non-specialists, who might not be best placed to spot the signs of deterioration in the patients' mental condition. The workload and responsibility that was placed on GPs to manage vulnerable patients meant that GPs could run the risk of working over and above their levels of competency.

7.7 NHOSC noted the information provided in the report and during the discussion at today's meeting.

7.8 The CCG representatives were asked to provide research evidence regarding the effectiveness of the online treatment resources available to patients with eating disorders in Norfolk.

7.9 The CCG representatives and NHS England Midlands and East (East) were asked to return to NHOSC with a progress update in around 6 months' time *(*to be scheduled for November 2019*)*.

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 for NHOSC meetings was agreed with the addition of the following items:

28 November 2019

- Access to NHS dentistry
- Eating disorder services

8.3 The Committee also agreed that information should be included in the NHOSC Briefing on the systems used by IC24 (the NHS 111 and primary care out of hours provider) to find addresses in Norfolk, especially in rural areas where there might be unadopted roads and no street lighting.

Chairman

The meeting concluded at 12.50 pm

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Local action to address health and care workforce shortages

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

Examination of the Norfolk and Waveney Sustainability Transformation Partnership workforce workstream's local action to address and mitigate the effects of national workforce shortages affecting health and care services.

1.0 Purpose of today's meeting

1.1 Norfolk Health Overview and Scrutiny Committee (NHOSC) added 'Local action to address health and care workforce shortages' to its forward work programme on 6 December 2018 after hearing reports about shortage of healthcare workers for Continuing Healthcare patients.

In previous months the committee had heard reports of ongoing workforce shortages in many other areas of local healthcare (e.g. primary care including general practice and dentistry, mental health and acute care).

1.2 The Norfolk and Waveney Sustainability Transformation Partnership (STP) workforce workstream lead has been asked to provide a short report for today's meeting including:-

- Data to illustrate the current local workforce situation (demand and capacity)
- Local action currently underway to address workforce shortages
- Progress towards developing a new multi-agency workforce strategy for Norfolk and Waveney

The report is attached at **Appendix A** and representatives from the STP workforce workstream will attend to answer Members' questions.

2.0 Background information

2.1 Previous reports to NHOSC

2.1.1 In 2015 NHOSC set up a Member task and finish group to examine 'NHS Workforce Planning in Norfolk' in detail. The group's report, which included 8 recommendations, is available via the following link to the NHOSC 16 July 2015 committee pages.

2.1.2 The recommendations related to the following areas:-

- Liaison between the NHS and local planning authorities to plan capacity for growing local needs
- Local provision of healthcare education and training
- Support for healthcare workers
- Promoting awareness of healthcare career opportunities
- Public engagement and information about the change to the primary care skill mix
- Realistic forecasting of workforce requirements based on predicted local needs rather than predicted funding levels

Responses from the NHS and other organisations concerned were reported to NHOSC 15 October 2015. All the recommendations were accepted fully or in part except for one to the Norfolk and Cambridgeshire Local Enterprise Partnerships regarding work with higher education institutes to support recruitment of healthcare students and workers to Norfolk. The LEPs recognised the importance of the issue but explained that they did not have the capacity to support a specific campaign.

2.1.3 NHOSC received a follow-up report on 'Initiatives to address NHS workforce issues in Norfolk' from Norfolk and Suffolk Workforce Partnership / Health Education East of England in May 2016. The report is available via the following link to NHOSC 26 May 2016. At that stage the highest NHS vacancy rates were reported in the Great Yarmouth and Waveney (10%) and West Norfolk CCG (7.9%) areas. Employers' initiatives to fill the gaps included:-

- International recruitment
- Employing newly qualified staff locally
- Improving retention
- Various 'grow your own' staff initiatives
- New models of care – reducing cost but maintaining or improving quality

Health Education England (HEE) / Norfolk and Suffolk Workforce Partnership were actively commissioning to increase the future workforce and developing the existing workforce to maximise supply.

In the October 2016 NHOSC Briefing, as a follow-up to the May report, Members received detailed information on rates of attrition of students in nursing and various allied healthcare professional courses at the University of East Anglia, information on where students go on to work when they graduate and an evaluation of the Collaborative Learning in Practice (CLiP) project. CLiP was introduced in 2014 to support increased capacity and quality of training placements in acute medicine, surgery, paediatrics, mental health and community areas. The October 2016 Briefing is available on request from maureen.orr@norfolk.gov.uk . In summary:-

- Attrition rates varied across the different professional courses. At the time the latest figure for active adult nursing 3 year programmes (the Jan 2015 – Jan 2018 course) showed a withdrawal rate of 9.18%. The

latest figure for percentage of adult nursing students employed within NHS East of England on completion of their course (Jan 2013 – Jan 2016) was 83.72% (of those with known destinations, which was 43 out of 44 students)
- The CliP project was considered a success, although some adjustments were needed to make the model more adaptable in different situations. The evaluation noted CLiP's dependence on a good balance of staff, patients and students on any one shift.

2.2 Norfolk and Waveney STP Implementation Plan, December 2017

2.2.1 The Norfolk and Waveney STP Implementation Plan December 2017 which was published on Healthwatch Norfolk's website included the following expected outcomes regarding workforce:-

- Increased strategic capacity to deliver workforce & education requirements across the STP
- Increased strategic and operational capacity to deliver workforce & education requirements across the STP in primary and community care
- Systematic approach to workforce supply and education engagement across the STP to inform planning
- Increased clinical capacity in primary care, reduce the pressure on practices where there are GP vacancies and gaps in the GP Training Scheme
- Reduce risk of downturn in non-medical students as we move to self-funding
- Increased skill mix as work based opportunities increase with the Apprenticeship Levy
- Increased opportunity for practitioners to work to top of licence as skill mix improves
- Maximise HEE investment in the STPs existing workforce, aiding retention and aligning workforce to deliver new models of care
- Improve system working and collaboration across the STP to support new models of care
- Retain talent and improve retention through investment in and development of individuals and teams

2.3 Norfolk and Waveney Demand and Capacity review, January 2019

2.3.1 The Norfolk and Waveney Demand and Capacity Review January 2019 now published on the newly launched '*in* good health – The Norfolk and Waveney Health and Care Partnership' (i.e. Norfolk and Waveney STP) website included the following information about the local **primary care** workforce:-

- Primary care under pressure, with a ~9% of unmet demand compounded by a GP workforce declining by 1% per annum
- Workforce challenges differ across Primary Care Networks (PCNs) (e.g. Gorleston has a 28% shortfall in GPs vs national average)

- Leveraging alternative workforce models across the PCNs could bridge the demand gap in ~4 years
- By utilization of the wider workforce, including mental health and physiotherapists capacity in primary care could be increased to meet the current 9% shortfall. According to available sources:-
    - 30% of all GP appointments relate to mental health
    - Between 9 and 32% of GP appointments are musculoskeletal (MSK) and could be dealt with by a physiotherapist
    - Advanced nurse practitioners (ANPs) can see 8-30% of patients instead of GPs
    - 1-16% of GPs time can be saved by improving administrative support
    - Electronic consultation systems, eliciting patients' symptoms and navigating to the most appropriate service, reduce demand by up to 7%
- System working can unlock efficiency opportunities that would be unachievable through local efforts, including workforce synergies
- Increasing capacity ~24% by 2023 (to make up the current shortfall, cover a predicted 10% increase in demand and leaving 4% spare capacity) would require an additional 470 full time equivalents (FTEs) (~20% increase) 195 from primary care, 125 from mental health and 125 from MSK:-
    - 20 GPs
    - 55 Nurses including 20 ANPs
    - 120 Admin Staff
    - 125 MH / Wellbeing staff
    - 125 Physios and MSK

  (NB figures are as quoted in the Demand & Capacity Review)
- Additional workforce will cost an additional ~£20m/year by 2023. Some of the increase may be mitigated by redeployment of staff from other areas e.g. Norfolk and Suffolk NHS Foundation Trust

The next steps envisaged in the Demand and Capacity Review included developing a high level strategy plan including workforce and financial implications in the short term and in the medium term (1 year):-

- The STP Primary and Community Care workstream supporting and directly managing recruitment campaigns
- The Local Delivery Groups and Community Teams developing a workforce strategy accounting for skill mix and new models of care.
- The Mental Health Primary Care workstream ensuring secondary care teams are adequately provisioned to offer services in primary care.

NHS guidelines for Primary Care Networks (PCNs) envisage fully interoperable IT, workforce and estates across networks, with sharing between networks as needed. The Demand and Capacity Review, January 2019, noted that maturity of PCN based models in Norfolk and Waveney was low.

2.4 **National background information**

2.4.1 The STP Lead Nurse and Director of Workforce's report at **Appendix A** includes references to several recent national-level publications (accessible via the following links):-

The healthcare workforce in England - make or break, November 2018 – highlighted the scale of workforce challenges.

The NHS Long Term Plan, January 2019 – referred to steps the NHS will take to increase the numbers of doctors, nurses, midwives, allied health professionals and other staff (pages 78 – 90). A new national NHS workforce implementation plan is expected to be published after the autumn 2019 spending review.

Closing the gap - key areas for action on the health and care workforce, March 2019, published by The Health Foundation, The King's Fund and Nuffield Trust in March 2019 - set out interventions that could help to ameliorate the current national healthcare workforce shortages, particularly in relation to nursing and general practice.

The report at Appendix A also refers to some specific national-level factors including:-

NHS bursary reform – since 1 August 2017 new nursing, midwifery and most allied health students have no longer received NHS bursaries. Instead they have access to the same student loans system as other students.

Pension and tax policy – the annual allowance introduced in 2016 restricts the amount of tax relief available to those with a threshold income of over £110,000. This affects some senior medical and other staff.

European Union exit – this is an uncertain area but there has been concern that the UK's impending exit could compound existing NHS workforce shortages.

The National Institute of Economic and Social Research's Brexit and the Health & Social Care Workforce in the UK report (6 November 2018) examined trends in the NHS workforce up to mid 2017 and estimated the potential effect of EU exit on the NHS workforce.

2.4.2 Some recent reports from the Health Service Journal may also be of interest to the committee:-

Local responsibility for NHS workforce policy - on 7 March 2019 the Health Service Journal reported that local areas were to be given much greater control of NHS workforce policy with responsibilities being devolved to local areas from national bodies.

Nurse staffing fill rate statistics - on 16 April 2019 the Health Service Journal reported that nurse staffing fill rate data for hospitals in England were no longer being published. The figures, which showed where hospitals had not filled their nursing shifts as planned, had been published on the NHS Choices website since 2014. They were introduced following the Francis Inquiry into failings at Mid Staffordshire NHS Foundation Trust.

NHOSC has received these figures within reports regarding individual Trusts in the past. They were regarded as a useful indicator in relation to patient safety.

The published measure is now 'care hours' per day, which combines registered nursing with non-registered care assistant hours and offers no comparison against planned staffing levels.

3.0 Suggested approach

3.1 After the NHS representatives have introduced their report at Appendix A, Members may wish to examine the following areas:-

Local action

(a) Are the STP partners confident that their current forecasting of future staffing requirement is more robust than in the past?

(b) Do the STP partners consider that the primary care capacity increases envisaged in the Norfolk and Waveney Demand and Capacity Review are achievable? (i.e. ~24% capacity increase at an additional staff cost of £20m per annum by 2023).

(c) To what extent will the development of Primary Care Networks in Norfolk and Waveney help with the staffing of general practice?

(d) The 'Closing the Gap' report published nationally in March 2019 identified that the shortage of registered nurses and midwives created the biggest gap in the NHS workforce by far and recruitment needed to be expanded at scale and pace. To what extent will Trainee Nursing Associates and other initiatives in Norfolk and Waveney bridge the gap?

Co-operation between the STP partners

(e) To what extent are the Norfolk and Waveney STP partners co-operating in the recruitment and deployment of staff across their various organisations?

(f) What new ideas or action arose from the STP's workforce workshop on 10 April 2019?

Engagement with the public

(g) What more can be done to inform the public about the need for change to the staffing mix within local health services?

(h) What reassurance can the STP partners provide the public that quality can be maintained or improved despite a smaller proportion of most highly qualified practitioners within the overall workforce?

National influences on the local situation

(i) What challenges and opportunities are presented by the national plans to devolve more responsibility for workforce issues to Sustainability Transformation Partnerships (STPs) and Integrated Care Systems (ICSs)?

(j) According to '*NHS England and NHS Improvement funding and resource 2019/20: supporting 'The NHS Long Term Plan"* (29 March 2019) NHS E, NHS I, and Health Education England are working with partners to develop a cross-system national Workforce Implementation Plan which will be published in late 2019. To what extent can the local system take action in advance of this national plan?

4.0 Action

5.1 The committee may wish to consider whether to:-

(a) Make comments and / or recommendations based on the information received at today's meeting.

(b) Ask for further information via the NHOSC Briefing or to examine specific aspects of the subject at a future meeting.

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in good health
The Norfolk and Waveney Health and Care Partnership

Subject:	**Workforce Update**
Prepared By:	Anna Morgan, STP Lead Nurse & Director of Workforce
Submitted To:	Health Overview and Scrutiny Committee – May 2019
Purpose of Paper:	To outline the key workforce challenges nationally and locally and discuss opportunities to address them.

Summary:

Introduction – The Norfolk and Waveney Sustainability Transformation Partnership (STP) workforce workstream provides assurance to the STP Executive on activity to progress the priorities for workforce. This report highlights the local and national workforce issues and details local action to address and mitigate the effects of national workforce shortages affecting health and care services.

National perspective – 'Closing the gap' (Health Foundation, Kings Fund, Nuffield Health, March 2019) describes staffing as the make-or-break issue for the NHS in England. It highlights that workforce shortages are already having a direct impact on patient care and staff experience and that urgent action is required to avoid a vicious cycle of growing shortages and declining quality.
The document suggests a number of reasons that have contributed to the current problem. These are as follows: the workforce has not been a policy priority – responsibility for it is fragmented nationally and locally, the information the NHS needs to understand and plan its workforce remains poor, and the NHS has not invested in the leadership capability and skills needed to manage the workforce effectively. Although there are shortages of registered staff across all professions, nursing and midwifery together create the biggest gaps by far and recruitment needs to be expanded at scale and pace.

The NHS long-term plan was published in January this year and sets out ambitions for the health service in the context of the recent funding settlement. A workforce implementation plan will be launched soon and will address not just specific policy areas but also the roles, responsibilities, skills and capabilities needed across the system for more effective workforce planning.

Health Education England (HEE) – provides support to STPs through Local Workforce Action Boards (LWABs). They have two areas of responsibility; supporting STPs across a broad range of workforce and HR activity; and the local delivery of HEE mandate and other key workforce priorities. The N&W Local Workforce Action Board which includes representatives from all providers across our N&W health and social care organisations, and HEE, completed a diagnostic in late 2017 which highlighted our N&W workforce challenges (see appendix 1). To begin to address these challenges the LWAB agreed 4 ambitions and developed actions to achieve against these in 2017/18.

Positive progress has been made in the following areas:

- **Trainee Nursing Associates** (TNA) – 162 TNA's have commenced their 2 year work-based learning programme since September 2018.
- **Advanced Care Practitioners** (ACP) – 56 full time MSc courses were approved in 2018/19
- **Joint roles and rotations –** Pilots for joint roles/rotations in place, e.g. Advanced Nurse Practitioners across primary care/community and rotations for paramedics in community/primary care in development.
- **Culture** – An extensive leadership development offer for all STP work streams is in place, running between April and August 2019. A staff engagement plan has also been agreed and is in progress.

The learning from the work over the last year on implementing the ambitions has been really valuable. In particular in the coming year we will need to invest more support and focus into the Apprenticeships, Advanced Clinical Practice and Up-skilling the workforce.

In addition **LWAB** have identified the urgent need to develop a **workforce strategy.** The first workshop to develop a strategy around the wider workforce was held on 10th April and saw over 130 delegates attend to consider the role of workforce around the four recognised big trends impacting our health and care workforce; Prevention and tackling inequality, new technologies and ways of working, collaboration for innovation, and working to the best of our abilities. Information from this day, along with a series of further engagements with staff, employers, patients and our wider population over the next 5-6months will provide the intelligence for the strategy. A workforce strategy will enable partners to recognise the tensions between an organisational workforce plan and how that links to an STP wide workforce plan.

Recommendation:

- Note the content of this report

1. National Context

1.1 According to 'Closing the gap' (Health Foundation, Kings Fund, Nuffield Health, March 2019) the workforce challenges in the NHS in England now present a greater threat to health services than the funding challenges. Across NHS trusts there is a shortage of more than 100,000 staff. Based on current trends, the projected gap between staff needed and the number available could reach almost 250,000 by 2030. If the emerging trend of staff leaving the workforce early continues and the pipeline of newly trained staff and international recruits does not rise sufficiently, this number could be more than 350,000 by 2030.

1.2 The current shortages are due to a number of factors, including the fragmentation of responsibility for workforce issues at a national level; poor workforce planning; cuts in funding for training places; restrictive immigration policies exacerbated by Brexit; and worryingly high numbers of doctors and nurses leaving their jobs early.

1.3 There is also anecdotal evidence that the impact of cost improvement programmes on Provider organisations and the uncertainty of contracts and tendering has led to significant reductions in workforce and a lack of confidence and ability to plan for the future.

1.4 Central investment in education and training has dropped from 5% of health spending in 2006/7 to 3% in 2018/19. Had the previous share of health spending been maintained, investment would be £2bn higher. Current workforce shortages are taking a significant toll on the health and wellbeing of staff. There is also evidence of discrimination and inequalities in pay and career progression. If substantial staff shortages continue, they could lead to growing waiting lists, deteriorating care quality and the risk that some of the £20.5bn secured for NHS front-line services will go unspent: even if commissioners have the resources to commission additional activity, health care providers may not have the staff to deliver it.

1.5 The NHS long-term plan was launched in January this year and it sets out the ambitions for the health service in the context of the recent funding settlement. The plan must be clearly linked to a strategy to address the workforce crisis, otherwise it will simply be a wish list rather than a credible path to a sustainable future for the health service. Given the scale of the challenge and emerging global shortages of health professionals, a credible workforce strategy will need to plan for a degree of oversupply of NHS staff.

1.6 The long-term plan and a supporting workforce strategy will need to pass five key tests. The tests require a funded and credible strategy to:

- address workforce shortages in the short term
- address workforce shortages in the long term
- support new ways of working
- address race and gender inequalities in pay and progression
- strengthen workforce and service planning at all levels of the system.

1.7 Many of the same issues are affecting the social care workforce: for example, vacancies in adult social care are rising, currently totalling 110,000, with around 1 in 10 social worker and 1 in 11 care worker roles unfilled. Any strategy for shoring up the NHS workforce cannot be viewed in isolation from the need to invest in and support the social care workforce.

2.0 The Health Care Workforce in England, Make or Break? (Health Foundation, Kings Fund, Nuffield Health, Nov 2018).

Note - the following section contains information and quotes from the above paper. This is a summary of the paper findings for members information.

2.1 This paper highlights that on current trends, in 10 years' time the NHS will have a shortfall of 108,000 fulltime equivalent nurses. Half this gap could be bridged by increasing the number of nurses joining the NHS from training. This would require 5,000 more nurses to start training each year by 2021, reducing the drop-out rate during training by a third and encouraging more nurses to join the NHS once they qualify. To achieve this, the government needs to significantly increase the

financial support to nursing students with ‘cost of living’ grants of around £5,200 a year on top of the means-tested loan system.

2.2 Further action, including covering the costs of tuition fees, should be taken to triple the number of nurses training as postgraduates. This is essential to address the financial problems trainee nurses face while studying that deter students from starting a nursing degree and are a factor in the high drop-out rate (attrition) during training. The availability and quality of clinical placements is another key priority for reform as part of a wider strategy to increase the numbers completing training. While policy action and investment could transform the outlook for nurse staffing shortages over the next decade, the prospects until the end of the parliament are much more worrying. To avoid nurse staffing shortages acting as a major brake on the delivery of the NHS long-term plan, international recruitment will need to play a substantial role in the NHS workforce implementation plan. We estimate that an additional 5,000 internationally recruited nurses will be needed each year until 2023/24.

2.3 **Team-based general practice** – National efforts to increase the number of GPs need to continue, but the stark reality is that even with a major focus on increasing the number of GPs in training, the numbers of GPs in the NHS will fall substantially short of demand and of the government’s target of an additional 5,000 GPs. The only way forward is to make substantial progress towards a new model of general practice with an expanded multidisciplinary team drawing on the skills of other health care professionals.

2.4 **Making the NHS a better place to work and build a career for all staff** – Beyond the specific actions on nursing and general practice, the workforce implementation plan must focus on how the NHS can become a better employer and a place where staff want to build a career. Building on what already exists in the NHS Constitution, the NHS needs an explicit statement of the universal ‘offer’ to staff – including, but not limited to, their legal rights. It should cover fair treatment for all staff but also what staff can expect in terms of pay and opportunity, continuing professional development, work–life balance and proper appraisal.

2.5 Other steps to boost retention include more focus on supporting staff who are at the beginning and end of their NHS career. Meaningful action on equality and inclusion must be at the heart of this, building on existing initiatives, so that all NHS organisations have concrete action plans to tackle discrimination and inequality. Pay and reward are tangible signs of how far staff are valued and have a clear impact on retention. The current Agenda for Change pay deal runs until 2021. Beyond then pay in the NHS will need to continue to rise in real terms in line with wider economy earnings.

2.6 Alongside pay, the NHS pension scheme is frequently cited as a barrier to retention, particularly for more experienced staff, who have been impacted by changes to wider pension policy. The NHS should urgently look at options for more flexibility, similar to the local government pension scheme. Rapidly changing patient needs and technological advances mean all frontline staff will need to adapt and enhance their skills. Current progress is much too slow. The failure to investment in the development of existing staff also sends a powerful, negative signal about the NHS’s commitment to its people and their career development. A fourfold increase in the current workforce development budget is required to accelerate change and support people. Compassionate and inclusive leadership will be key to successful implementation of many of the recommendations set out.

2.7 **Social care** – The close interrelationship between the NHS and social care is highlighted and in particular to ensure that addressing shortages in the NHS must not come at the expense of the already stretched social care workforce. A series of policy changes are required to improve recruitment and retention in social care, including a sector-specific route for international migration that works for social care post-Brexit, as current proposals will not be adequate. More fundamentally, we recognise that workforce challenges in this sector reflect its poor pay, terms and conditions. This can only be addressed by government – first through additional funding in the 2019 Spending Review, and in the longer term through comprehensive reform of adult social care funding.

3.0 Local Context

3.1 Health Education England (HEE) is an executive non-departmental public body of the Department of Health. Their function is to provide national leadership and coordination for the education and training within the health and public health workforce within England. HEE exists for one reason only: to support the delivery of excellent healthcare and health improvement to the patients and public of England by ensuring that the workforce of today and tomorrow has the right numbers, skills, values and behaviours, at the right time and in the right place.

3.2 HEE supports Sustainability and Transformation Partnerships (STPs) through Local Workforce Action Boards (LWABs). They have two areas of responsibility – supporting STPs across a broad range of workforce and HR activity, and the local delivery of HEE mandate and other key workforce priorities. This includes developing a clear understanding of the current and future workforce – through robust workforce intelligence; a robust workforce strategy; a workforce transformation plan; and leadership and organisational development support to enable staff, patients and carers to confidently and competently lead change across pathways, organisations and systems.

3.3 The N&W LWAB which includes representatives from providers across our N&W health and social care organisations, and Health Education England, completed a diagnostic in late 2017 which highlighted the following workforce challenges (see appendix 1 for details):

- Social care is facing significant recruitment problems, especially in domiciliary care
- General practices have difficulties recruiting GPs due to high retirements and low local training fill rates, especially in West Norfolk and Great Yarmouth & Waveney
- NHS vacancies are increasing
- Nursing and medical workforce supply shortages are predicted to continue over the next 5 years based on current service and supply models
- Ageing workforce – imminent retirements and loss of experienced staff and clinical leadership as staff retire with no clear succession planning
- Retention/avoidable losses (non-medical) are linked to work/life balance, and lack of development opportunities

3.4 More recently a review carried out by Boston Consulting Group made similar findings, grouping the risks by sector; Primary Care, Acute, Community, Social Care and Urgent and Emergency Care. N&W also has particular challenges around the mental health workforce with significant challenges on retention of staff and recruitment in a Trust in special measures. Not all mental health workforce is the responsibility of NSFT, recognition is needed for the contribution of our workforce in primary care, IAPT and the role of the wider community and the voluntary sector.

3.5 The National workforce strategy set out by HEE in 2017 (Facing Facts, Shaping the Future) summarised the key areas that any local workforce plans should address. These include:

- Focus on reducing demand and consideration of changing services to meet needs
- Increase productivity and manage retention
- Integrating care is vital
- Focus on public health and the public health workforce
- Valuing staff and staff engagement are key to reducing variation and delivering lasting productivity gains
- Regulation, up-skilling and advanced clinical practice is vital in supporting future skill mix
- Improve the mental health and well-being of staff
- Consider the impacts of technology and give greater support and training to self-carers, carers and volunteers

3.6 The LWAB developed and agreed 4 main ambitions to steer investment from HEE and prioritise workforce activities. These ambitions are as follows:

- Ambition 1 – Implement new roles and new ways of working
- Ambition 2 – Leadership Development
- Ambition 3 – Up-skill the workforce
- Ambition 4 – Increase/improve supply and retention

4.0 Progress on our Ambitions to date

4.1 In July 2018, a work plan was developed under the Leadership of Anna Morgan (SRO for Workforce) and Emma Wakelin (Head of Workforce Transformation). This took the ambitions developed by the LWAB in 2016/17 and has delivered the following:

4.2 Ambition 1 (New roles and new ways of working): Immediate focus on implementing 3 key roles to create opportunities to 'grow our own' workforce for both school leavers/mature entrants with low educational attainment to take up apprenticeship pathways, and for staff who have degree level attainment wishing to advance their careers.

a) **Trainee Nursing Associates (TNA)** – 162 TNA's have commenced their 2 year work-based learning programme since September 2018. The N&W TNA Partnership is recognised by HEE as an exemplar for its outcomes and partnership working through inclusion of health and care providers. A 2 year growth plan is in development. A Nursing Associate is a new role within the nursing team. Nursing associates work with healthcare support workers and registered nurses to deliver care for patients and the public. This role is designed to help bridge the gap between health and care assistants and registered nurses. The Nursing Associate is a stand-alone role that will also provide a progression route into graduate level nursing. It is regulated in England by the Nursing & Midwifery Council.

b) **Advanced Care Practitioners (ACP)** – 56 full time MSc courses were approved this year. Work is on-going to develop a system wide approach to education commissioning for 19/20 to ensure that we develop future ACPs based around our population health management needs, and that an infrastructure is in place to allow ACPs to work flexibly across the system. An ACP is a registered health practitioner with a number of years of experience and advanced practice/skills. An ACP can work in GP surgeries as part of the practice team, in the community, in hospitals and clinics all of which includes working alongside doctors, nurses, healthcare assistants and a variety of other health care professionals. Advanced care practitioners have a very varied role that is hugely rewarding and satisfying.

4.3 Ambition 2 (Leadership): There are a number of activities that will enable our STP to develop a new culture of continuous improvement which facilitates the shift in staff behaviours from organisation focus to working differently as "one" service, and encourage the sharing and development of talent across the system to improve the local population's health and social care experience. Current progress includes the following:

- **Culture –** Partnership with a digital expert has enabled us to take a baseline measurement of current culture across health and care organisations so that we can measure improvement. This involves the design and delivery of a digital platform linked to our STP website to engage staff across the STP in conversations that will enable us to create the culture for a successful care system. The first conversation launches on 21st May and is open to all members of workforce across health and care in Norfolk and Waveney and is called **#WeCareTogether**.
- **Systems Leadership –** An extensive leadership development offer for our workforce is in place, running between April and August 2019.
- **Director Level development –** A programme is being developed following a successful bid for funding from NHSE which will develop a cohort of peers across health and care through a programme of shared learning, networks, and service improvement.
- **Primary Care Network (PCN) development –** A package of support to leaders within our emerging PCNs is being developed through collaboration with our GP Provider Organisations and Local Delivery Groups.
- **Networks and Expertise** – Organisational Development (OD) Leads Network in place with representation from Secondary Care, Social Care, and Primary Care. Change Agents are being recruited to support the culture development programme.

4.4 Ambition 3 (Up-skilling): We will explore options to improve the development of the workforce, this includes students on placements, Learning Beyond Registration (LBR), apprenticeships,

education for patients and their carers, volunteers and staff across the whole health and care sector including care homes.

- **Maximising LBR investment –** We have worked through LWAB to maximise funding for LBR of staff across NHS Provider and Primary Care organisations. This has included an increase in the numbers of training places for independent prescribers
- **Apprenticeships –** Work is on-going to develop further apprenticeship levy options to develop both new and existing staff. This will continue to be marketed heavily across schools, colleges and job centre plus this year, with business cases developed to support organisations in maximising funding for staff development

4.5 Ambition 4 (Supply and retention): We will make Norfolk & Waveney STP an employer of choice by working together locally and with relevant regional and national public bodies to create attractive local employment offers, support staff mobility and improve recruitment, retention and succession planning across the system.

- **General Practice Five year forward View (GPFV) retention Plan*** - Clear recruitment targets and retention schemes are now in place and supported by NHSE
- **General Practice Nurse (GPN) Workforce Plan*** - Focus on increasing placement capacity, GPN and ANP development, and retention of GPNs through a Careers Plus scheme (to be piloted in Norwich)
- **Workforce Winter Resilience Plan and Winter Charter** - Presented to A&E Delivery Board in September and now requires support to make transformative changes now for next winter
- **Partnership Working** - with other STPs in EoE to address agency and locum caps collectively
- **Joint roles and rotations** - Pilots for joint roles/rotations in place, e.g. Advanced Nurse Practitioners across primary care/community and rotations for paramedics in community/primary care in development
- **Nursing supply** - our Directors of Nursing work closely with our local universities to ensure supply onto programmes is successful and that attrition during training is low. Routes into nursing have been expanded allowing applicants a choice of flexible routes best suited to their personal circumstances. This includes both traditional degree and MSc studies, as well as work based routes through apprenticeship programmes.

*We have committed to aligning the work plan of the Primary Care Workforce/GPFV work being led by GY&W CCG, with the STP Workforce Workstream going forward to provide a single system response to workforce, and maximise team resource.

4.6 The learning from the work over the last year on implementing the ambitions has been really valuable. In particular in the coming year we will need to invest more support and focus into the following areas to enable us to take immediate actions that will transform the workforce:

- **Apprenticeships –** (growing our own) Work with organisations across health and care to understand supply needs, develop the business case to support small organisations to have apprentices, strengthen placement opportunities, provide more support to clinical teams to ensure apprentices achieve requirements of their training and work with non-levy paying partners to access levys of levy paying organisations.
- **Advanced Clinical Practice –** (supporting skill-mix developments, developing confidence of registrants). Support the development of clinical placements for physicians associates, advanced nurse practitioners, specialist paramedics and advanced care practitioners and in doing so this will create placement circuits for rotation posts, develop more joint roles, develop and publish the governance framework to support these roles.
- **Up-skilling –** (reducing demand, valuing and developing our current workforce) Invest in programmes such as health coaching, quality improvement and clinical skills labs and deliver them in multidisciplinary cross sector groups within PCNs where possible.

5. National Guidance, NHS Long Term Plan (LTP)

5.1 Following the recent publication of the NHS Long Term Plan (LTP), NHS Improvement has been tasked by the Prime Minister and Secretary of State for Health and Social Care to develop an interim Workforce Implementation Plan ahead of the final Implementation Plan for the NHS LTP.

5.2 The Interim Plan will include a 2019/20 action plan together with a more detailed vision of how our workforce will transform over the next ten years. The five emerging themes for workforce are:

- **Theme 1:** We can make a significant difference to our ability to recruit and retain staff by making the NHS a better place to work
- **Theme 2:** If our workforce plan is to succeed we must start by making real changes to improve the leadership culture in the NHS
- **Theme 3:** Although there are workforce shortages in a number of professions, disciplines and regions, the biggest single challenge we currently face nationally is in the nursing and midwifery profession
- **Theme 4:** To deliver on the vision of 21st century care set out in the LTP will not simply require 'more of the same' but a different skill mix, new types of roles and different ways of working
- **Theme 5:** We must look again at respective roles and responsibilities for workforce across the national bodies and their regional teams, ICSs, and local employers, to ensure we are doing the right things at the right level.

5.3 STP CEO's and Chairs have received an outline of the emerging priorities and actions, and provided feedback on the five themes to Baroness Harding in March. A system wide response was also submitted by the STP Executive, and we will ensure that the development of our N&W future vision and strategy considers these themes and actions.

6. Development of a N&W Health & Care Workforce Strategy

6.1 The NHS LTP, planning guidance for STPs, and our local ambition to move to a shadow integrated Care System in 2019/20 sets the direction of travel for us to develop a N&W vision and long term strategy for workforce.

6.2 Our ability to design a realistic system plan for our workforce rests upon the creation of the right conditions for our workforce and citizens to consider how we bridge the gap and design a new workforce fit for the future. Over the next 6 months we will undertake a series of activities which will produce a strategy for consultation with STP wide partners. A series of workshops, focus and task and finish groups will create time and space for:

- **Communication** – Ensure our audience understand the vision and priorities of the STP, its ambition for an integrated care system, and our workforce and population profile. It is also critical to distinguish the role and responsibilities of the STP Workforce Workstream (system) and the role of others (employers) to ensure our work is focussed.
- **Conversation** – Allowing people to make connections, share best practice, challenges, and to understand our roles within the system
- **Contribution** – Facilitating and encouraging contribution from participants to shape a way forward together. Every voice is important.

6.3 The first workshop was held on 10th April and saw over 130 delegates attend, providing a broad representation of our system workforce, employers and citizens. This was the first time a whole system conversation will have taken place and was a perfect launch pad to set the right conditions for the work required over the coming months.

6.4 N&W Workforce Risks

6.4.1 Our strategy needs to address our greatest risks, the top four risks are highlighted below. A full risk assessment on workforce will be carried out as part of developing the strategy.

Risk	Potential Mitigation
1. Retention of our workforce	• Building positive cultures • Flexible working, aligned terms and conditions across organisations • Offer robust rotations across organisations • Focus on staff health and well being • Develop post retirement return to practice offer
2. Gaps in Registrants across professions	• Develop a 'grow our own' workforce • Focus on maximising apprenticeship pathways across health and care • Up-skill the current workforce • Developing a strategy that recognises the contribution of the wider workforce in our communities
3. Supply timelines for the workforce (e.g. Timeline for Medical workforce is 8-11 years)	• Increase other roles to complement medical and non-medical practitioners • Increase recruitment into key medical roles • Build a N&W Academy
4. Accountability & Confidence in new roles	• Translate accountability across professional groups • Support new roles by providing robust placements • Provide better post registration education support • Provide infrastructure to support new roles e.g. joint posts/roles across providers
5. Brexit	• Employing organisations have undertaken reviews to consider the impact of Brexit • Members of our workforce are kept up to date with any changes or information affecting them • We work closely with NHSE to monitor any impact on international recruitment

7. Conclusion

7.1 The national and local context paints a challenging position for workforce across health and care and we need to have robust actions in place for both the short term and long term view. We have developed a successful partnership to grow a new workforce of nurses and have a clear set of workforce ambitions set out and monitored by our Local Workforce Action Board.

7.2 We have a collaborative approach in place to develop a health and care workforce strategy which we will launch in the autumn which will provide our system with clear SMART actions building on our LWAB ambitions and responding to both the NHS Long Term Plan and reflecting our local needs.

7.3 We have commenced an STP wide engagement strategy **#WeCareTogether** to create the right conditions for our workforce and citizens for the future.

Appendix 1 – The Local Workforce Action Board (LWAB) Diagnostic

LWAB includes representatives from providers across health, social care and Health Education England, completed a diagnostic in late 2017 which highlighted the following workforce challenges:

- Social care is facing recruitment problems, especially in domiciliary care where 12% of posts are vacant and there is a shortfall of registered nurses (6% across social care/care homes).

- General practices have difficulties recruiting GPs due to high retirements and low local training fill rates, especially in West Norfolk and Great Yarmouth & Waveney. Current GP vacancy levels are around 10%.

- NHS Vacancies are increasing – currently 8.9%, including over 500 nursing and 200 medical posts. Mental Health, Community and Great Yarmouth & Waveney are particularly affected. Current top 3 vacancy hotspots: A&E Doctors (23%), Acute Medicine Doctors (20%) and Diagnostic Radiographers (18%). Also, there is a shortage of nurses qualified in a speciality, e.g. neonatal nurses and district nurses.

- Nursing and medical workforce supply shortages are predicted to continue over the next 5 years based on current service and supply models. Forecast supply gaps for year 2021, especially Psychiatric Nurses (27%) and Medical Doctors: Paediatric Surgery (48%), Acute Internal Medicine (35%), Child & Adolescent Psychiatry (31%) and Dermatology (28%). Forecast over-supply of Psychologists, Midwives and Paediatrics Medical Consultants.

- Ageing workforce – imminent retirements and loss of experienced staff and clinical leadership as staff retire with no clear succession planning. Nearly a quarter of carers and 17% of adult nurses are due to retire in the next 5 years based on a retirement age of 60 years. The actual figure might be even higher due to early retirements, especially for nurses and midwives with a special class status (e.g. up to 35% for midwives).

- Medical retirement hotspots over the same time period: Psychiatry (30%), Obstetrics & Gynaecology (27%) and Medicine (19%) Consultants and GPs (23%).

- Retention/avoidable losses (non-medical) – In 2016/17, 9% of NHS staff leavers left for a better work-life balance, 7% for promotion elsewhere and 2.5% cited lack of opportunities. Work-life balance is a particular issue for clinical support staff (11% left for this reason). Social care turnover is particularly high (28%), especially domiciliary care worker (46%). 19% of paid carers leave social care with no job to go to.

- Over-reliance on international recruitment and agencies to fill supply gaps. We need to look at alternative solutions due to Brexit and caps on migration and agency spend.

- Shrinking pool of potential young employees with different expectations (“Generation Z”). The number of 15-24 year olds is predicted to reduce by -4% over 5 years, whilst the total population is expected to grow by + 3%. A more targeted approach is needed to attract young people to health and social care rather than other sectors and to make best use of the opportunities of the apprenticeship levy.

- Need to use the workforce more effectively to deliver savings, review skill-mix to bridge supply gaps and clarify future service delivery models and join up plans across health and social care to determine longer term workforce demands. NHS operating plans forecast -5% reductions in posts over next 5 years to meet financial challenge (above Midlands & East average of -3%), whilst the population is expected to grow by 3%.

- Fragmented approach to workforce development across health and social care. Need to join up conversations around apprenticeships across the system.

Appendix 2 – The Boston Consulting Group Review (Summary paper to the STP Exec in January prepared by Julie Cave STP Chief Operating Officer).

Background

1. The Boston Consulting Group review of demand and capacity reported to the STP Executive in December 2018. It concluded that the STP has key challenges, being:
   i. A growing and ageing population
   ii. Primary care working to capacity, with a shrinking GP workforce;
   iii. Acute inpatient bed capacity cannot meet demand;
   iv. Community services cannot meet demand from acutes;
   v. Social care DToCs are high and there is a lack of home care capacity;
   vi. The system has significant financial challenges.

2. The review highlighted that:
   i. Demand and capacity is mismatched and could result in a 500 bed deficit by 2023 in a 'do nothing' scenario.
   ii. Current system issues cannot be addressed by any single provider. Collective interventions across the system could create a sustainable position.
   iii. Even given the potential solutions within the review it is estimated that there will be a shortfall of 140 beds so further capacity / new models of care will be required.

3. Representatives from the three acutes plus STP met on 16th January to propose next steps in taking forward the recommendations from the review.

Next Steps

4. The demand and capacity issues could potentially be covered by any one of three work streams, being Acute Transformation, Urgent & Emergency Care and Primary & Community Care. However the issues fall across the whole system and none of those work streams can cover the whole problem.
5. As such the group recommends that a new Demand & Capacity work stream is established with senior director level representation from across the acutes, community, social care and primary care. These representatives should also cover one of the three work streams, as above.
6. Whilst much work has been done in recent years to address the capacity shortfalls this has largely been fire-fighting with little strategic thinking on how we can address the issues in the longer term across the whole system. The Demand & Capacity work stream will establish a short, medium and long term plan with a significant part of its work to focus on the longer term strategy.
7. The links to the other work streams will mean that those work streams may undertake actions in relation to demand and capacity and report back to the Demand & Capacity programme as appropriate.
8. The Demand & Capacity Programme Board will be led by a programme director. It is the recommendation from the group that the Director of Strategy at JPUH undertakes this role.
9. Task and Finish groups will lead individual pieces of work as required and membership will be sought from appropriate organisations across the system.
10. The Programme Board will consider all the recommendations within the BCG review and report back on our response to each. The plans will build upon the new models of care that are currently being planned. The recommendations will drive the work plan and strategic direction.

Joint health scrutiny committees' terms of reference

Report by Maureen Orr, Democratic Support and Scrutiny Team Manager

The committee is asked to agree minor amendments to the Great Yarmouth and Waveney Joint Health Scrutiny Committee (GY&W JHSC) 'Structure and Terms of Reference' document and the draft terms of reference for the potential Norfolk and Waveney Joint Health Scrutiny Committee to reflect the establishment of East Suffolk Council on 1 April 2019

1.0 Background

1.1 Joint health scrutiny committees

Regulation 30 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 requires a joint committee to be established if health scrutiny members wish to receive a consultation on proposed substantial changes to health services affecting an area that crosses county council or unitary authority boundaries.

1.2 Great Yarmouth and Waveney Joint Health Scrutiny Committee (GY&W JHSC)

This joint health scrutiny committee, which was established in 2007 and meets quarterly, is the statutory health scrutiny body for receiving consultations relating to the Great Yarmouth and Waveney Clinical Commissioning Group (CCG) area.

1.3 A potential Norfolk and Waveney Joint Health Scrutiny Committee

Draft terms of reference for a potential Norfolk and Waveney Joint Health Scrutiny Committee were agreed by Norfolk Health Overview and Scrutiny Committee (NHOSC) on 6 April 2017 and by Suffolk Health Scrutiny Committee (SHSC) on 12 July 2017. This was in preparation for any potential consultation from the Norfolk and Waveney Sustainability Transformation Partnership (STP) relating to proposals for substantial changes to services in Waveney and part or all of Norfolk beyond the Great Yarmouth area, which would require a joint committee with representation from a wider area than the GY&W JHSC.

To date there have been no such proposals from the STP and the Norfolk and Waveney Joint Health Scrutiny Committee has not been formally established. It is, however, advisable to keep the draft terms of reference up-to-date so

that the joint committee could be quickly convened should the STP bring forward proposals.

In line with the agreed draft terms of reference the joint committee would include all members of NHOSC and two members from SHSC. SHSC will be asked to make nominations on 11 July 2019.

The joint committee would be established on a task and finish basis by agreement between the Chairmen of NHOSC and SHSC in the event of proposals for substantial changes to services in the Norfolk and Waveney STP area as outlined above.

2.0 Proposed amendments

2.1 The establishment of East Suffolk Council on 1 April 2019 affects the terms of reference for GY&W JHSC and the potential Norfolk and Waveney Joint Health Scrutiny Committee as both mention the former Waveney district council.

2.2 The proposed amendments to the GY&W JHSC 'Structure and Terms of Reference' document are set out in the copy attached at **Appendix A**. The amendments are:-

Paragraph 1.3

- The reference to 'Waveney District Council' is replaced by 'East Suffolk Council'.

- The reference to 'adjoining districts' is removed but the geographic catchment area for members eligible to serve on GY&W JHSC remains the same as it is now, i.e. members who represent residents living within the Great Yarmouth and Waveney Clinical Commissioning Group (CCG) area or districts where a proportion of their residents look in the first instance to the James Paget University Hospital NHS Trust (JPUH) for acute services.

2.3 The proposed amendment to the draft terms of reference for the potential Norfolk and Waveney Joint Health Scrutiny Committee are set out in the copy attached at **Appendix B.** There is one amendment:-

Paragraph 3.1 – the reference to 'Waveney District Council' is replaced by 'East Suffolk Council'.

2.0 Process

Amendments to both sets of terms of reference documents must be agreed by both NHOSC and SHSC. Amendments approved by NHOSC today will be presented to SHSC for agreement on 11 July 2019 (subject to approval of Suffolk's corporate calendar at their County Council AGM on 23 May 2019).

3.0 Action

3.1 The committee is asked to:-

- Approve the amendments to GY&W JHSC Structure and Terms of Reference set out at Appendix A.

- Approve the amendment to the potential Norfolk and Waveney Joint Health Scrutiny Committee draft terms of reference set out at Appendix B.

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Great Yarmouth and Waveney Joint Health Scrutiny Committee
Structure and Terms of Reference

1. Structure of the Committee

1.1 The committee to be composed of six members.

1.2 Both authorities to appoint three members to the committee.

1.3 The membership to be drawn from members of Norfolk Health Overview and Scrutiny Committee (NHOSC) and Suffolk Health Scrutiny Committee (SHSC) including the Great Yarmouth Borough Council member of NHOSC~~,~~ and the ~~Waveney District Council~~ East Suffolk Council member of SHSC. The other two members from NHOSC and SHSC respectively may be appointed from ~~adjoining districts to~~ members who represent residents living within the Great Yarmouth and Waveney Clinical Commissioning Group area or districts where a proportion of their residents look in the first instance to the James Paget University Hospital NHS Foundation Trust for acute services.

1.4 There is no requirement for the appointments to the joint committee to be in line with the political balance on Norfolk County Council or Suffolk County Council.

1.5 To be quorate the committee requires three committee members to be present.

1.6 Each authority is allowed to substitute for the committee members.

1.7 The resourcing and costs of the committee will be shared between the two authorities.

2. Terms of Reference

2.1 The Joint Scrutiny Committee will meet for scrutiny of the health service in the Great Yarmouth and Waveney locality, as deemed necessary by the Chairmen of either Norfolk Health Overview and Scrutiny Committee and the Suffolk Health Scrutiny Committees.

2.2 General health service issues within the Great Yarmouth and Waveney area will be scrutinised either by Great Yarmouth and Waveney Joint Health Scrutiny Committee or by Norfolk Health Overview and Scrutiny Committee and / or Suffolk Health Scrutiny Committee as deemed necessary by the Chairman of either Norfolk Health Overview and Scrutiny Committee and / or Suffolk Health Scrutiny Committee.

2.3 In carrying out review and scrutiny of a particular matter the Committee shall have regard to any guidance issued by the Secretary of State; invite

interested parties to comment on the matter; and take account of relevant information available to it.

2.4 Norfolk County Council and Suffolk County Council have arranged for the Joint Health Scrutiny Committee to have the power to make referrals to the Secretary of State in response to 'substantial variation' in respect of health services within the Great Yarmouth and Waveney area. The Joint Health Scrutiny Committee must notify Norfolk County Council and Suffolk County Council of its intention to make such a referral before the referral is made.

2.5 Where the Joint Health Scrutiny Committee makes such reports and recommendations the report will be consensual and shall include:
- An explanation of the matter reviewed or scrutinised;
- A summary of the evidence considered;
- A list of participants involved in the review or scrutiny;
- Any recommendations on the matter reviewed or scrutinised.

2.6 The Joint Health Scrutiny Committee does not have the power to call in Cabinet decisions of either Suffolk County Council or Norfolk County Council.

As agreed by:-

Norfolk Health Overview and Scrutiny Committee - ~~29 May 2014~~ date to be added
Suffolk Health Scrutiny Committee – ~~2 July 2014~~ date to be added

NORFOLK AND WAVENEY JOINT HEALTH SCRUTINY COMMITTEE

DRAFT TERMS OF REFERENCE

1.	**Legislative basis**
1.1	The National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Localism Act 2011 sets out the regulation-making powers of the Secretary of State in relation to health scrutiny. The relevant regulations are the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 which came into force on 1st April 2013.
1.2	Regulation 30 (1) states two or more local authorities may appoint a joint scrutiny committee and arrange for relevant health scrutiny functions in relation to any or all of those authorities to be exercisable by the joint committee, subject to such terms and conditions as the authorities may consider appropriate.
1.3	Where an NHS body consults more than one local authority on a proposal for a substantial development of the health service or a substantial variation in the provision of such a service, those authorities are required to appoint a joint committee for the purposes of the consultation. Only that joint committee may: • make comments on the proposal to the NHS body; • require the provision of information about the proposal; • require an officer of the NHS body to attend before it to answer questions in connection with the proposal.
1.4	This joint committee has been established on a task and finish basis, by Norfolk County Council and Suffolk County Council.
2.	**Purpose**
2.1	The purpose of the joint committee is:- To receive, consider and respond to proposals for reconfiguration of services arising from the implementation of Norfolk and Waveney Sustainability Transformation Plan and affecting patient pathways for the populations of Norfolk and Waveney in relation to: • the extent to which the proposals are in the interests of the health service in Norfolk and Waveney; • the impact of the proposals on patient and carer experience and outcomes and on their health and well-being; • the quality of the clinical evidence underlying the proposals; • the extent to which the proposals are financially sustainable
2.2	To make a timely response to the consulting body and other appropriate agencies on the proposals.

2.3	To consider and comment on the extent to which patients and the public have been involved in the development of the proposals and the extent to which their views have been taken into account.
2.4	The joint committee may receive, consider and respond to a number of consultations during the implementation of the Norfolk and Waveney Sustainability Transformation Plan and may adjourn for periods between consultations.
2.5	The joint committee will not receive, consider or respond to consultations on proposals for which the geographic footprint corresponds to the areas covered by Norfolk Health Overview and Scrutiny Committee or Great Yarmouth and Waveney Joint Health Scrutiny Committee. The joint committee may receive consider and respond to consultation on proposals for which the geographic footprint includes Waveney and any part of Norfolk beyond the Great Yarmouth Borough area.
3.	**Membership/chairing**
3.1	The joint committee will consist of the 17 members including the 15 members of Norfolk Health Overview and Scrutiny Committee and 2 members of Suffolk Health Scrutiny Committee. One of the Suffolk Health Scrutiny Committee representatives will be the East Suffolk Council ~~Waveney District Council~~ representative on Suffolk Health Scrutiny Committee and the other will be a County Councillor member of Suffolk Health Scrutiny Committee.
3.2	Each authority may nominate a substitute member for each member of the joint committee. Only a nominated substitute may attend in the event of a member's absence.
3.3	The proportionality requirement will not apply to the joint committee, provided that each authority participating in the joint committee agrees to waive that requirement, in accordance with legal requirements and their own constitutional arrangements.
3.4	The individual authorities will decide whether or not to apply political proportionality to their own members.
3.5	The Chairman of Norfolk Health Overview and Scrutiny Committee will chair the joint committee. The joint committee will elect a Vice-Chairman at its first meeting.
3.6	The joint committee will be asked to agree its Terms of Reference at its first meeting.
3.7	Each member of the joint committee will have one vote.
4.	**Co-option**

4.1	The joint committee may co-opt representatives of up to a maximum of four organisations with an interest or expertise in the issue being scrutinised as non-voting members, but with all other member rights.
4.2	Any organisation with a co-opted member may send a substitute member.
5.	**Supporting the Joint Committee**
5.1	The lead authority will be Norfolk County Council.
5.2	The lead authority will act as secretary to the joint committee. This will include: • appointing a lead officer to advise and liaise with the Chairman and joint committee members, ensure attendance of witnesses, liaise with the consulting NHS body and other agencies, and produce reports for submission to the health bodies concerned; • providing administrative support; • organising and minuting meetings.
5.3	The lead authority's Constitution will apply in any relevant matter not covered in these terms of reference.
5.4	Where the joint committee requires advice as to legal or financial matters, the participating authorities will agree how this advice is obtained and any significant expenditure will be apportioned between participating authorities. Such expenditure, and apportionment thereof, would be agreed between the participating authorities before it was incurred.
5.5	The lead authority will bear the staffing costs of arranging, supporting and hosting the meetings of the joint committee. Other costs will be apportioned between the authorities. If the joint committee agrees any action which involves significant additional costs, such as obtaining expert advice or legal action, the expenditure will be apportioned between participating authorities. Such expenditure, and the apportionment thereof, would be agreed with the participating authorities before it was incurred.
5.6	Suffolk County Council will appoint a link officer to liaise with the lead officer and provide support to the members of the joint committee.
5.7	Meetings shall be held at venues, dates and times determined by the lead authority.
6.	**Powers**
6.1	In carrying out its function the joint committee may: • require officers of appropriate local NHS bodies to attend and answer questions; • require appropriate local NHS bodies to provide information about the proposals;

	• obtain and consider information and evidence from other sources, such as local Healthwatch organisations, patient groups, members of the public, expert advisers, local authorities and other agencies. This could include, for example, inviting witnesses to attend a joint committee meeting; inviting written evidence; site visits; delegating committee members to attend meetings, or meet with interested parties and report back. • make a report and recommendations to the appropriate NHS bodies and other bodies that it determines, including the local authorities which have appointed the joint committee. • consider the NHS bodies' response to its recommendations; • refer the proposal to the Secretary of State if the joint committee considers: ➢ it is not satisfied that consultation with the joint committee has been adequate in relation to content, method or time allowed; ➢ that the proposal would not be in the interests of the health service in its area.
7.	**Public involvement**
7.1	The joint committee will meet in public, and papers will be available at least 5 working days in advance of meetings
7.2	The participating authorities will arrange for papers relating to the work of the joint committee to be published on their websites, or make links to the papers published on the lead authority's website as appropriate.
7.3	A press release will be circulated to local media at the start on the establishment of the joint committee and when it is reconvened after any period of adjournment..
7.4	Local media will be notified of all meetings.
7.5	Patient and voluntary organisations and individuals will be positively encouraged to submit evidence and to attend.
7.6	Members of the public attending meetings may be invited to speak at the discretion of the Chairman.
8.	**Press strategy**
8.1	The lead authority will be responsible for issuing press releases on behalf of the joint committee and dealing with press enquiries
8.2	Press releases made on behalf of the joint committee will be agreed by the Chairman or Vice-Chairman of the joint committee.
8.3	Press releases will be circulated to the link officers.
8.4	These arrangements do not preclude participating local authorities from issuing individual statements to the media provided that it is made clear that these are not made on behalf of the joint committee.

9.	**Report and recommendations**
9.1	The lead authority will prepare a draft report on the deliberations of the joint committee, including comments and recommendations agreed by the committee. The report will include whether recommendations are based on a majority decision of the committee or are unanimous. The draft report will be submitted to the representatives of participating authorities for comment.
9.2	The final version of the report will be agreed by the joint committee Chairman.
9.3	In reaching its conclusions and recommendations, the joint committee should aim to achieve consensus. If consensus cannot be achieved, minority reports may be attached as an appendix to the main report. The minority report/s shall be drafted by the appropriate member(s) or authority concerned.
9.4	The report will include an explanation of the matter reviewed or scrutinised, a summary of the evidence considered, a list of the participants involved in the review or scrutiny; and an explanation of any recommendations on the matter reviewed or scrutinised.
9.5	If the joint committee makes recommendations to the NHS body and the NHS body disagrees with these recommendations, such steps will be taken as are "reasonably practicable" to try to reach agreement in relation to the subject of the recommendation.
9.6	If the joint committee does not comment on the proposals, or the comments it provides do not include recommendations, the joint committee must inform the NHS body as to whether it intends to exercise its power to refer the matter to the Secretary of State and, if so, the date by which it proposes to do so.
9.7	In the event that the joint committee refers the matter to the Secretary of State the report made will include:- • an explanation of the proposal to which the report relates; • the reasons why the joint committee is not satisfied; • a summary of the evidence considered, including any evidence of the effect or potential effect of the proposal on the sustainability or otherwise of the health service in the area; • an explanation of any steps taken to try to reach agreement in relation to the proposal; • evidence to demonstrate that the joint committee has complied with arrangements for appropriate notification of timescales for its decision to refer; • an explanation of the reasons for the making of the report; and • any evidence in support of those reasons.
9.8	The joint committee may only refer the matter to the Secretary of State:- • in a case where the joint committee has made a recommendation which the NHS body disagrees with, when;

	i) the joint committee is satisfied that all reasonably practicable steps have been taken by the NHS body and the joint committee to reach agreement; or ii) the joint committee is satisfied that the NHS body has failed to take all reasonably practicable steps to reach agreement. • if the requirements regarding notification of the intention to refer above have been adhered to.
10.	**Quorum for meetings**
10.1	The quorum will be a minimum of five members with at least one from each of the participating authorities.

Norfolk Health Overview and Scrutiny Committee appointments

Report by Maureen Orr, Democratic Support and Scrutiny Team Manager

The Committee is asked to appoint Members to Great Yarmouth and Waveney Joint Health Scrutiny Committee and link members with local Clinical Commissioning bodies and NHS provider trusts.

1. Appointments

1.1 The following lists show the roles to which NHOSC makes appointments, the names of members who currently serve in these roles and the vacancies that currently exist. NHOSC is asked to make appointments to vacant roles and re-appoint or change current appointees.

1.2 **Great Yarmouth and Waveney Joint Health Scrutiny Committee**

Meets quarterly; next scheduled meeting Friday 12 July 2019. The joint committee is composed of six members, three from Suffolk Health Scrutiny Committee and three from NHOSC. The three nominations are not required to be in line with the political balance of Norfolk County Council. One must be the Great Yarmouth and Waveney Borough Council member of NHOSC. The other two may be appointed from the Great Yarmouth area or districts where a proportion of their residents look in the first instance to the James Paget University Hospital NHS Foundation Trust for acute services. Other members of NHOSC can substitute for the joint committee members as and when required.

Current NHOSC appointees (3)
Ms E Flaxman-Taylor *(the Great Yarmouth Borough Council member of NHOSC)*
Dr N Legg
Mr R Price

1.3 **Clinical Commissioning links** (1 for each CCG and 1 for the Joint Strategic Commissioning Committee)

Link members are nominated to attend CCG 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 CCG's area and alert NHOSC to any issues that may require the committee's attention.

The nominated member or a nominated substitute may attend in the capacity of NHOSC link member. It is not essential for NHOSC to nominate substitute CCG links but it may nominate substitutes if it wishes. The CCG meetings are open to the public and other members may therefore attend as members of the public if they wish.

The named members below are those who are currently appointed to these roles.

Commissioner	**Meeting schedule**	**NHOSC link**	**Substitute**
Great Yarmouth and Waveney CCG	Every other month in Beccles; next meeting Thurs 25 July 2019, 1.30 – 5.00pm	Ms E Flaxman-Taylor	***VACANCY***
North Norfolk CCG	Every other month in Aylsham, next meeting Tues 23 July 2019, 9.00 – 11.00am)	M Chenery of Horsbrugh	Mr D Harrison
Norwich CCG	Every other month in Norwich, usually at 2.00pm; next meeting Tues 23 July 2019	***VACANCY***	Ms B Jones
South Norfolk CCG	Every other month, usually at Bawburgh Village Hall; next meeting Tuesday 23 July 2019, 1.30 – 3.30pm	Dr N Legg	Mr P Wilkinson
West Norfolk CCG	Every other month in King's Lynn; next meeting Thurs 1 August 2019, 9.15am	M Chenery of Horsbrugh	Mrs S Young
Norfolk and Waveney Joint Strategic Commissioning Committee	Every other month in various locations, usually at 1.30pm; next meeting Tues 18 June 2019 at Beccles	M Chenery of Horsbrugh – for meetings in west and north Dr N Legg – for meetings in east and south	Dr N Legg M Chenery of Horsbrugh

1.4 **NHS Provider Trust links** (1 for each local NHS provider organisation)

Link members are nominated to attend local NHS provider organisation meetings held in public in the same way as a member of the public might attend. Their role is to observe the meetings, keep abreast of developments in provider organisations and alert NHOSC to any issues that may require the committee's attention.

The nominated member or a nominated substitute may attend in the capacity of NHOSC link member. It is not essential for NHOSC to nominate substitute provider trust links but it may nominate substitutes if it wishes. The trust meetings are open to the public and other members may therefore attend as members of the public if they wish.

The named members below are those who are currently appointed to these roles.

Provider Trust	**Board meeting schedule**	**NHOSC link**	**Substitute**
James Paget University Hospitals NHS Foundation Trust	Every other month at the hospital; next meeting Fri 26 July 2019, 9.30am	Ms E Flaxman-Taylor	***VACANCY***
Norfolk Community Health and Care NHS Trust	Monthly at various locations in Norfolk; next meeting Weds 26 June 2019, 9.30 – 1.30pm in Cromer	***VACANCY***	***VACANCY***
Norfolk & Norwich University Hospitals NHS Foundation Trust	Every other month at the hospital; next scheduled meeting Fri 31 May 2019, 9.30am	Dr N Legg	Mr D Harrison
Norfolk & Suffolk NHS Foundation Trust	Most months at various locations in Norfolk or Suffolk; usually on a Thurs afternoon but next meeting Fri 26 July 2019, 9.30 – 3.30pm in Norwich	Michael Chenery of Horsbrugh	Ms B Jones
Queen Elizabeth Hospital NHS Foundation Trust	Every other month at the hospital; next meeting Tues 30 July 2019, 10.30am	Mrs S Young	M Chenery of Horsbrugh

2. Action

2.1 The Committee is asked confirm current appointments or make new appointments to:-

(a) **Great Yarmouth and Waveney Joint Health Scrutiny Committee** (see paragraph 1.2)

- Three members.
    - One must be the Great Yarmouth Borough Council representative on NHOSC
    - The other two must represent areas where a proportion of the population looks to the James Paget University Hospitals NHS Trust for acute services.

(b) **Clinical commissioning link roles** (see paragraph 1.3)

- Great Yarmouth and Waveney CCG - appoint a substitute link member
- Norwich CCG – appoint a link member
- Confirm the other named clinical commissioning link members in their roles or appoint different link members and substitutes

(c) **NHS Provider Trust links** (see paragraph 1.4)

- James Paget University Hospitals NHS Foundation Trust – appoint a substitute link member
- Norfolk Community Health and Care NHS Trust – appoint a link member and a substitute
- Confirm the named provider trust link members and substitute link members in their roles or appoint different link members and substitutes.

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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 2019

Meeting dates	*Briefings/Main scrutiny topic/initial review of topics/follow-ups*	*Administrative business*
25 July 2019	The Queen Elizabeth Hospital NHS Foundation Trust - response to the Care Quality Commission report – progress report Norfolk and Suffolk NHS Foundation Trust - response to the Care Quality Commission report – progress update	
5 Sept 2019	Access to palliative and end of life care – progress since October 2018 Physical health checks for adults with learning disabilities – update since September 2018 Ambulance response and turnaround times in Norfolk • Plans to help patient flow in winter 2019-20 • Progress with pathways for mental health patients • The interface between EEAST and the NHS 111 service	*Date subject to NHOSC agreement*
10 Oct 2019	Children's speech and language therapy (central and west Norfolk) – update since 28 Feb 2019 Adult autism – access to diagnosis – to examine waiting times to diagnosis.	

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 2019

May 2019 (in the Briefing)	-	IC24 navigation systems – information regarding the systems used by IC24 (the NHS 111 and primary care out of hours provider) to find addresses in Norfolk, especially in rural areas where there may be unadopted roads and no street lighting.
July 2019 (in the Briefing)	-	Continuing healthcare – update on trends in referrals and assessment of eligibility for CHC and explanation of those trends.
28 Nov 2019 (on the agenda)	-	Access to NHS dentistry – update to 11 April 2019 report
	-	Eating disorder services – update to 11 April 2019 report

Other activities

Visit to be arranged	-	Follow-up visit to the Older People's Emergency Department (OPED), Norfolk and Norwich hospital to be arranged after expansion works are completed in 2019-20.

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	-	Ms E Flaxman-Taylor
West Norfolk	-	M Chenery of Horsbrugh (substitute Mrs S Young)
Norwich	-	*VACANCY* (substitute Ms B Jones)

Norfolk and Waveney Joint Strategic Commissioning Committee

For meetings held in west and north Norfolk	-	M Chenery of Horsbrugh
For meetings held in east and south Norfolk	-	Dr N Legg

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	-	Ms E Flaxman-Taylor
Norfolk Community Health and Care NHS Trust	-	*VACANCY* (substitute *VACANCY*)

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Norfolk Health Overview and Scrutiny Committee 30 May 2019

Glossary of Terms and Abbreviations

ACP	Advanced Care Practitioner
A&E	Accident & Emergency
ANP	Advanced Nurse Practitioner
BCG	Boston Consulting Group
CCG	Clinical Commissioning Group
CEO	Chief Executive Officer
CIL	Community Infrastructure Levy
CLIP	Collaborative Learning in Practice
DToC	Delayed transfers of care
ECCH	East Coast Community Healthcare
ECL	East Coast Hospice Ltd
EoE	East of England
EPaCCS	Electronic Palliative Care Coordination System
FTE	Full time equivalent
GPFV	General Practice Five Year Forward View
GPN	General Practice Nurse
GSF	Gold Standards Framework – a model that enables good practice to be available to all people nearing the end of their lives, irrespective of diagnosis. It provides a framework for a planned system of care in consultation with the patient and family. It promotes better coordination and collaboration between healthcare professionals and helps to optimise out-of-hours care to prevent crises and inappropriate hospital admissions
GY&W CCG	Great Yarmouth and Waveney Clinical Commissioning Group
GY&W JHSC	Great Yarmouth and Waveney Joint health Scrutiny Committee (which includes Members from Norfolk and Suffolk Health overview and Scrutiny Committees)
HEE	Health Education England
IAPT	Improving Access to Psychological Therapies
ICS	Integrated Care System
IPU	In-patient unit
IT	Information Technology
JPUH	James Paget University Hospital
LBR	Learning beyond registration
LEP	Local Enterprise Partnership
LTP	Long Term Plan
LWAB	Local Workforce Action Board
MDT	Multi Disciplinary Team

MND	Motor neurone disease
MSK	Muscoloskeletal
NCC	Norfolk County Council
NCH&C (NCHC)	Norfolk Community Health and Care NHS Trust
NHOSC	Norfolk Health Overview and Scrutiny Committee
NHS E	NHS England
NHSI	NHS Improvement (formerly Monitor and the Trust Development Authority) – regulator of NHS Foundation Trusts, other NHS Trusts and independent providers that provide NHS funded care. It oversees these organisations and offers support that providers need to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable.
NHTH	The Norfolk Hospice Tapping House
NICE	National Institute for Health and Care Excellence
NNUH (N&N, NNUHFT)	Norfolk and Norwich University Hospitals NHS Foundation Trust
NSFT	Norfolk and Suffolk NHS Foundation Trust (the mental health trust)
N&W	Norfolk and Waveney
OD	Organisational development
PCN	Primary Care Network
PPoC	Preferred Place of Care
QEH	Queen Elizabeth Hospital, King's Lynn
SHSC	Suffolk Health Scrutiny Committee
SMART	Specific, measurable, achievable, realistic, time-bound (or timely)
SPC	Specialist palliative care
SRO	Senior Responsible Officer
STP	Sustainability & transformation plan / partnership
TNA	Trainee Nurse Associate
WNIPCS	West Norfolk Integrated Palliative Care Service