Norfolk County Council

Norfolk Health Overview and Scrutiny Committee

Date: **Thursday 16 July 2015**

Time: **10.00am**

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

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

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

Membership

MAIN MEMBER	SUBSTITUTE MEMBER	REPRESENTING
Mr C Aldred	Mr P Gilmour	Norfolk County Council
Mr R Bearman	Ms E Morgan	Norfolk County Council
Mr B Bremner	Mrs M Wilkinson	Norfolk County Council
Ms S Bogelein	Ms L Grahame	Norwich City Council
Mr M Carttiss	Mr N Dixon / Mrs S Gurney/ Mrs A Thomas/ Miss J Virgo	Norfolk County Council
Mrs J Chamberlin	Mr N Dixon / Mrs S Gurney/ Mrs A Thomas/ Miss J Virgo	Norfolk County Council
Michael Chenery of Horsbrugh	Mr N Dixon / Mrs S Gurney/ Mrs A Thomas/ Miss J Virgo	Norfolk County Council
Mrs A Claussen-Reynolds	Mr N Smith	North Norfolk District Council
Mr D Harrison	Mr B Hannah	Norfolk County Council
Mrs L Hempsall	Mr J Emsell	Broadland District Council
Dr N Legg	Mr C Foulger	South Norfolk District Council
Mrs S Matthews	Mr R Richmond	Breckland District Council
Mrs M Somerville	Mr N Dixon / Mrs S Gurney/ Mrs A Thomas/ Miss J Virgo	Norfolk County Council
Mrs S Weymouth	Mrs M Fairhead	Great Yarmouth Borough Council

Mrs S Young	Vacancy	King's Lynn and West Norfolk Borough Council

For further details and general enquiries about this Agenda please contact the Committee Administrator:
Tim Shaw on 01603 222948
or email timothy.shaw@norfolk.gov.uk

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

2. Minutes

To confirm the minutes of the meeting of the Norfolk Health Overview and Scrutiny Committee held on 28 May 2015. (Page 5)

3. Members to declare any Interests

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

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

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

If you do not have a Disclosable Pecuniary Interest you may nevertheless have an **Other Interest** in a matter to be discussed if it affects:

- your well being or financial position
- that of your family or close friends
- that of a club or society in which you have a management role
- that of another public body of which you are a member to a greater extent than others in your ward.

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

4.		**To receive any items of business which the Chairman decides should be considered as a matter of urgency**	
5.		**Chairman's announcements**	
6.	**10.10 – 10.50**	**Development of dementia services in West Norfolk**	(Page 12)
		Appendix A - A report by West Norfolk CCG regarding permanent changes to dementia services following the end of a trial period in March 2015.	(To follow)
	10.50 – 11.00	**Break at the Chairman's discretion**	
7.	**11.00 – 11.45**	**Access to Primary Care Services in Norwich**	(Page 17)
		Appendix A - NHS England Midlands and East (East)'s plans to maintain and improve access to walk-in and primary care services in Norwich and surrounding areas following strategic review by Enable East.	(Page 20)
8.	**11.45 – 12.00**	**NHS workforce planning in Norfolk**	(Page 28)
		Appendix A - Report of the scrutiny task and finish group.	(Page 30)
9.	**12.00 – 12:10**	**Norfolk Health Overview and Scrutiny Committee appointments**	(Page 86)
		The committee is asked to appoint link members for Clinical Commissioning Groups and provider trusts.	
10.	**12.10 – 12.20**	**Forward work programme**	(Page 89)
		To consider and agree the forward work programme	
Glossary of Terms and Abbreviations			(Page 92)

Chris Walton
Head of Democratic Services

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Date Agenda Published: 8 July 2015

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Norfolk County Council

NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE
MINUTES OF THE MEETING HELD AT COUNTY HALL, NORWICH
On 28 May 2015

Present:

Mr C Aldred	Norfolk County Council
Mr B Bremner	Norfolk County Council
Mr M Carttiss (Elected Chairman)	Norfolk County Council
Mrs J Chamberlin	Norfolk County Council
Michael Chenery of Horsbrugh	Norfolk County Council
Mr D Harrison	Norfolk County Council
Dr N Legg	South Norfolk District Council
Mrs S Matthews	Breckland District Council
Mrs M Somerville	Norfolk County Council

Substitute Member Present:
Mrs S Young from King's Lynn and West Norfolk Borough Council

Also Present:

Dr Sue Crossman	Chief Officer, West Norfolk Clinical Commissioning Group
Cllr Alexandra Kemp	County Councillor for Clenchwarton and King's Lynn South
Dr Anoop Dhesi	Chairman, North Norfolk Clinical Commissioning Group
Amanda Cousins	Associate Director of Delivery Improvement and Transformational Change, North East London Commissioning Support Unit
Jane Webster	Head of Commissioning, West Norfolk CCG
Steve Goddard	Norwich City Council
Fennie Gibbs	Healthwatch Norfolk
Becky Judge	Royal College of Nursing
Dr Patrick Thompson	NCH&C Governor
Edward Libbey	Chairman of QEH NHS FT
Mark Harrison	Equal Lives
Caroline Fairless-Price	Norwich Independent Living Group Member
Sally Frow	PA to Caroline Fairless-Price
Chris Coath	Assistant Director (Commissioning), Out of Hospital Care, South Norfolk Clinical Commissioning Group
Ian Monson	Member of Norfolk County Council
Alex Stewart	Healthwatch Norfolk
David Bradford	Norwich City Councillor
Max Bennett	North East London Commissioning Support Unit
Chris Walton	Head of Democratic Services
Maureen Orr	Democratic Support and Scrutiny Team Manager
Tim Shaw	Committee Officer

1(a) Election of Chairman

Resolved (unanimously)
That Mr M R H Carttiss be elected Chairman of the Committee for the ensuing year.

(Mr M R H Carttiss in the Chair)

1(b) Election of Vice-Chairman

Resolved (unanimously)
That Dr N Legg be elected Vice-Chairman of the Committee for the ensuing year.

2 Apologies for Absence

Apologies for absence were received from Mr R Bearman, Mrs A Claussen-Reynolds and Mrs C Woollard.

3. Minutes

The minutes of the previous meeting held on 16 April 2015 were confirmed by the Committee and signed by the Chairman.

4. Declarations of Interest

There were no declarations of interest.

5. Urgent Business

There were no items of urgent business.

6. Chairman's Announcements

6.1 Welcome to Mrs Shirley Matthews from Breckland District Council.

The Chairman welcomed Mrs Shirley Matthews to her first meeting of the Committee. It was noted that Mrs Matthews had been appointed as the Member from Breckland District Council on the Committee.

It was noted that following the elections on 7 May 2015 several other district councils had yet to confirm their appointments.

6.2 Forthcoming Induction Session for New Members

The Chairman said that an induction session for new Members and substitute Members of NHOSC would be held in the Conference Room, South Wing at County Hall on Thursday 2 July 2015 at 2 pm. The session would also be open to all Members of the County Council and all other Members of the Committee who might wish to attend. The Head of Democratic Services and the Democratic Support and Scrutiny Team Manager would provide those attending the induction session with an introduction to health scrutiny law and the local health service context.

6.3 Diabetes care within primary care services in Norfolk

The Chairman said that 'Diabetes care within primary care services in Norfolk' was scheduled as an item for today's meeting but was postponed prior to publication of the agenda because NHS England Midlands and East (East) had not confirmed that they would attend the meeting. The Chairman had agreed to this postponement, after discussion with the Democratic Support and Scrutiny Team Manager, because NHS England Midlands and East (East) was the responsible commissioner of primary care in Norfolk and it was important that they should attend the Committee to answer Members questions. NHS England was scheduled to attend the Committee on 26 February 2015 but on that occasion was unfortunately unable to send a representative on the day. The regional team had been reorganised around that time and was short staffed in some areas. This was unfortunately still the case.

The Chairman added that the Democratic Support and Scrutiny Team Manager had now received an assurance from the Locality Director that NHS England Midlands and East (East) would send a representative to the Committee's meeting on 3 September 2015, should the Committee decide to put 'Diabetes care within primary care services in Norfolk' on its agenda for that meeting. (which was subsequently agreed at item 10 on this agenda).A representative from West Norfolk Clinical Commissioning Group and the Co-Chairman of the Central Norfolk Diabetes Network who were also scheduled to attend today's meeting for the diabetes item would be invited to attend on 3 September 2015.

7 System wide review of health services in West Norfolk

7.1 The Committee received a suggested approach from the Democratic Support and Scrutiny Team Manager to a report from NHS West Norfolk Clinical Commissioning Group on the review of health and social care systems in West Norfolk in response to financial pressures, demographic trends and rising demand for healthcare.

7.2 The Committee received evidence from Dr Sue Crossman, Chief Officer, West Norfolk Clinical Commissioning Group and Jane Webster, Head of Commissioning, West Norfolk CCG.

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

- The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (QEH) was placed in special measures in October 2013.
- In September 2014 the Monitor Contingency Planning Team (CPT) had commenced a five month programme of work to investigate the causes of the financial and clinical sustainability problems in the QEH and the wider West Norfolk health system. By March 2015 the CPT had completed its draft report. This was due to be presented in its final form to the Monitor Board in June 2015 when Monitor was expected to consider the future status of the QEH.
- The West Norfolk Clinical Commissioning Group and the QEH were expected to publish their joint response to the CPT report at the same time as the Monitor Board was due to consider the CPT report.
- The joint response would be published on the West Norfolk CCG website and made available in other formats on request.
- The CCG awaited clarification on a number of important national issues that impacted on its plans for health and social care integration including

conflicting national comments about information sharing and risk aversion.

- Engaging with local people was a key consideration of the recovery programme. A series of drop-in events were continuing to be held to give local people the opportunity to find out more and to feed back on the work that had been done so far.
- In the course of discussion, having given due notice prior to the start of the meeting, and at the discretion of the Chairman, Cllr Alexandra Kemp, County Councillor for Clenchwarton and King's Lynn South, asked of Dr Sue Crossman the following question:
  "To improve recovery and well-being, reduce costly out-of-county placements and deliver more local care in a community setting, could the CCG pioneer funding the running of residential care farms in west Norfolk, an area rich in rural tranquillity, and farms looking to diversify, including farms in Clenchwarton and West Winch in this Division?"
  Dr Crossman gave the following answer to this question:
- Care farms were of particular benefit to people with low level mental health needs who were in a position to use their personal budgets to increase the number of care choices that were open to them. As such this issue was more a matter for adult social services than it was for the NHS which had to concentrate most of its limited resources on those with more severe mental health needs who would benefit from interventions in a hospital or home setting.
- It was not always possible to avoid making use of out of county placements; the needs of the patient were always the most important considerations.
- The challenges that were faced in west Norfolk included the rural geography of the area and a population that was ageing quicker than the national average.
- The West Norfolk CCG Alliance supported by the QEH were planning to have three or four strategically placed multi-disciplinary hubs from where it would be possible to have health and social organisations provide an integrated mental health care liaison service for those living in west Norfolk. From these hubs it would be possible to carry out crisis assessments and provide a single referral pathway into community services aimed at avoiding unnecessary admissions into acute hospital or care homes.
- The CCG valued having been given the opportunity to keep the Committee informed of developments concerning the review of health and social care systems in west Norfolk.

7.4 The Committee noted the West Norfolk Clinical Commissioning Group confirmed that it was not expecting there would be any proposals for major service reconfiguration in west Norfolk at this stage and that it would consult with the Committee on any such proposals that might arise in future. The Committee confirmed that it did not expect the CCG to attend with further reports about the system-wide review unless a 'substantial variation' in service was proposed.

8 Continuing Health Care

8.1 The Committee received a suggested approach from the Democratic Support and Scrutiny Team Manager to outline proposals from Norwich, North Norfolk, South Norfolk and West Norfolk Clinical Commissioning Groups for a forthcoming consultation on changes to Continuing Health Care (CHC) policy in their areas.

8.2 The Committee received evidence from Dr Anoop Dhesi, Chairman, North Norfolk Clinical Commissioning Group and Amanda Cousins, Associate Director of Delivery Improvement and Transformational Change, North East London

Commissioning Support Unit.

8.3 The evidence that the witnesses presented to the Committee included a detailed PowerPoint presentation. This has been placed on the County Council's NHOSC Committee papers website.

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

- The witnesses said that the four CCGs were looking to provide patients and their families with a comprehensive guide to CHC that explained how the National Framework, and those local policies on CHC over which the four CCGs had discretion, would be taken forward locally. The CCGs would focus their consultation on those elements of CHC where CCGs had discretion because the CCGs were not in a position to consult on the national framework.
- This was in line with good practice elsewhere.
- During the PowerPoint presentation it was pointed out that the four CCGs collectively spent £58m on NHS CHC patients in 2014/15. The four CCGs had a combined total of 1,007 patients at the current time in receipt of NHS CHC funding. The detailed breakdown of the number of patients in receipt of CHC could be found in the PowerPoint presentation.
- In reply to Members' questions the witnesses pointed out that a patient could be discharged from the care of a consultant when their treatment had finished and that there were patients who no longer needed CHC over time or whose circumstances had changed.
- In reply to further questions the witnesses said that the local consultation was not about placing limits on CHC expenditure and that it was not possible to provide the Committee with "yes" or "no" answers to questions as to whether the consultation would result in "less" or "more" money being made available for Continuing Health Care. The eligibility for NHS Continuing Healthcare placed no limits on the settings in which a package of support could be offered or on the type of service delivery.
- Withdrawal of services when people were no longer eligible, and how the NHS could better manage the transition back to local authority or self-funding, were key elements of the consultation.
- Caroline Fairless-Price, a Continuing Healthcare Patient and Norwich Living Group Member, said that it was very difficult for anyone to meet the national criteria used to assess eligibility for continuing healthcare. She said that the group of people receiving CHC had particularly complex needs and required individual solutions to meet their needs. She said that she was concerned that the consultation might be part of a wider agenda about placing caps on health expenditure in the four CCG areas for some of the most vulnerable people in the community. Caroline Fairless-Price went on to point out that the County Council had developed the Harwood Care and Support Charter as a tool to help individuals explain their needs to organisations. In reply, the witnesses said that they would report back to the CCGs the comments that had been made about using the Harwood Care & Support Charter card to open meaningful discussions with those who required help.
- Mark Harrison, Chief Executive of Equal Lives, asked what national benchmarking data was available to show where the Norfolk CCGs' current spending on Continuing Health Care stood in comparison to CCGs in other parts of the country. In reply, the witnesses said that they would be willing to provide Members of the Committee and Mark Harrison with this information.
- The witnesses said that they would be meeting in early June with key patient groups and Local Authority leads to explain the consultation process.

8.5 The Committee agreed that, subject to the CCGs' timetable, a consultation document on Continuing Health Care could be circulated to Members of the Committee at the time of the next meeting on16 July 2015 but that an item would not be included on the agenda for that meeting. Instead 'Continuing Health Care' would be on the agenda for the meeting on 3 September 2015 at which time representatives of the CCG & Commissioning Support Unit would attend. Representations from other interested parties could also be heard at the meeting on 3 September 2015 at which time the Committee was expected to agree its response to the CCGs.

9 Norfolk Health Overview and Scrutiny Committee appointments

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

9.2 The Committee agreed to appoint the following Members to serve on the Great Yarmouth and Waveney Joint Health Scrutiny Committee for 2015/16:

Mr M Carttiss
Mr C Aldred
Vacancy (the Great Yarmouth Borough Council appointee to NHOSC yet to be nominated by the Borough Council).

9.3 The Committee also agreed to make the following appointments for 2015/16:-

Formal links with CCGs:-
North Norfolk CCG – M Chenery of Horsbrugh
South Norfolk CCG – Dr N Legg
Great Yarmouth & Waveney CCG – Mrs J Chamberlin
West Norfolk – M Chenery of Horsbrugh
Norwich – Mr B Bremner & substitute Mrs M Somerville

Formal links with NHS Provider Trusts
Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust – substitute link member – M Chenery of Horsbrugh
Norfolk and Suffolk NHS Foundation Trust – M Chenery of Horsbrugh
Norfolk and Norwich University Hospitals NHS Foundation Trust – Dr N Legg; substitute Mrs M Somerville
James Paget University Hospitals NHS Foundation Trust – Mr C Aldred; substitute Mrs M Somerville
Norfolk Community Health and Care NHS Trust – substitute link member – Mrs M Somerville

9.4 The Committee agreed to make the remaining appointments at its next meeting on 16 July 2015:-

Link member for:-
Norfolk Community Health & Care NHS Trust
Queen Elizabeth Hospital NHS Foundation Trust

Substitute link members for:-
North Norfolk CCG
South Norfolk CCG

Great Yarmouth and Waveney CCG
West Norfolk CCG
Norfolk and Suffolk NHS Foundation Trust

10 Forward work programme

10.1 The forward work programme was agreed with the following amendment:-

'Continuing Health Care' to be removed from 16 July 2015 agenda

The Committee noted that the 'Development of dementia services in West Norfolk' which was on the draft agenda for the meeting on16 July 2015 was expected to be a consultation from the CCG regarding permanent changes following the trial period in March 2015.

10.2 The Democratic Support and Scrutiny Team Manager agreed to find out and let Members have details about reports in the media of a medical practice moving in Cromer.

Chairman

The meeting concluded at 1:10 pm

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Development of dementia services in West Norfolk

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

NHS West Norfolk Clinical Commissioning Group will present its engagement plans regarding permanent changes to dementia services following the end of a two year trial period.

1. Background

1.1 Early in 2013 Norfolk Health Overview and Scrutiny Committee (NHOSC) and Suffolk Health Scrutiny Committee established a formal joint committee on a task and finish basis to examine the radical redesign of mental health services outlined in Norfolk and Suffolk NHS Foundation Trust's (NSFT) Trust Service Strategy (TSS) 2012 -16. The joint committee's report which was presented to NHOSC on 20 June 2013 recommended, amongst other things, that Clinical Commissioning Groups should take the lead to consult the health scrutiny committees in Norfolk and Suffolk before making any substantial changes 'on the ground' during the implementation of the Strategy.

1.2 NSFT's approach in west Norfolk was to establish a pilot Dementia Intensive Support Team (DIST) in August 2013 to provide care to patients in the community and stop using 12 beds in Tennyson Ward and 12 dementia assessment beds on Chase Ward at Chatterton House on a trial basis whilst developing the DIST.

2 'Alternative to Admission' (ATA) beds were made available at The Paddocks Care Home in Swaffham for people with dementia in need of nursing care. The DIST service supports patients using these beds through in-reach, providing specialist support and treatment advice and prescribing to the Paddocks Care Home staff. The service also referred patients with the most challenging conditions to 3 specialist beds in Blickling Ward and 2 assessment beds in Sandringham Ward at the Julian Hospital in Norwich. These beds have been designated for patients from west Norfolk.

Patients over the age of 65 with mental health needs, but not age related needs, continued to be supported by adult community services and if in need of acute care were admitted to an all age adult acute bed. 3 beds were designated for people over the age of 65 on the 20 bedded Churchill Ward at the Fermoy Unit, Queen Elizabeth Hospital, King's Lynn.

1.3 Although the changes were partly necessitated by the requirement for NSFT to reduce its costs by 20% over the 4 years from 2012-16, NHOSC was assured that if the pilot was not successful it would be possible, with the necessary re-investment, to reinstate the all the beds taken out of the system on a trial basis. NHOSC was also assured that the carers of patients referred to the Julian Hospital in Norwich would be given information about financial support for travel costs. The CCG also said that it expected to hold a public consultation, and to consult with NHOSC, before any decision was taken to permanently operate the DIST and close the beds.

1.4 NHOSC received information about the impact of the DIST from the CCG and NSFT on 4 September 2014. The evaluation had first been received by the CCG Governing Body on 29 May 2014 and was considered by it again on 31st July 2014 in the context of its wider 'Statement of Strategic Direction for improving service for people with dementia'.

Although the DIST pilot appeared to be a success in terms of the numbers of people receiving care and the favourable views about the new service from people with dementia and their carers, the CCG decided not to proceed to formal consultation about making the change permanent at that point and instead agreed to extend the pilot to March 2015. The reasons given for its decision were:-

- Complications with recruitment had delayed the start of the pilot.
- An extended pilot period would provide more extensive information to inform service evaluation.
- An extended pilot period would provide the opportunity to gain a fuller response from GPs to the changed service design and to consult more extensively before any formal consultation takes place.
- There was higher than expected demand for community services.

1.5 In January 2015 the CCG Governing Body received a further positive service evaluation report on the DIST and agreed to run a formal 90 day consultation on the continuation of the DIST with the permanent closure of the beds 24 beds that were formerly at Chatterton House.

1.6 During the preparatory work for the consultation the CCG received advice from NHS England that a formal public consultation was not appropriate and that an engagement exercise would be a more suitable way forward. NHS England felt that the proposal:-

- Was not a major service change
- Had been in place in pilot form for two years and had been shown to be effective and evaluated well by the patients and carers who had used them
- Was consistent with national policy and best practice
- Was consistent with the model elsewhere in the county

- As the pilot service had been evaluated as an improvement on the previous inpatient model, there was no clinical evidence to support reverting to the old model.

1.7 On 21 May 2015 the CCG Governing Body decided to reverse its decision to conduct a 90 day consultation and instead approved an engagement exercise about the move from a pilot to permanent service. It agreed to publish a document which would:-

- Describe what a good model of dementia care is
- Fully describe dementia services prior to the pilot phase of DIST
- Fully describe DIST, how it differs from before and how it has affected west Norfolk patients
- Describes the evaluated benefits of the DIST.

It also agreed to hold a series of targeted engagement events to gather feedback and service user / carer views. The target audience for engagement included Norfolk Health Overview and Scrutiny Committee and Healthwatch Norfolk as well as local patient groups, older peoples' organisations and forums.

2. Purpose of today's meeting

2.1 A representative of NHS West Norfolk CCG will attend today's meeting to present the CCG's engagement plans, answer the committee's questions regarding the operation of the DIST and reduction of dementia beds in west Norfolk and receive any comments the committee may wish to make.

The CCG's report and engagement document are attached at Appendix A *(to follow).*

2.2 After a trial period of two years, it seems reasonable not to regard the change from pilot to permanent as a change in service that requires public consultation. However, the proposal to establish a DIST and close dementia beds in King's Lynn was originally regarded by both the CCG and NHOSC as a substantial variation in service.

The fact that a small number of patients were required to travel to Norwich for assessment and treatment that involves a relatively long stay in hospital was a matter of particular concern to members. Average lengths of stay of 56 days for west Norfolk patients at the Julian Hospital, Norwich during the first 9 months of the trial, were reported to NHOSC in September 2014.

2.3 NHOSC may wish to exercise its process for final consideration of the matter at today's meeting (see paragraph 4.2 below). This is on the basis that whatever comments are given to the CCG during the engagement process, the substantial changes in service have already taken place.

3. Suggested approach

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

(a) In September 2014 NHOSC heard that there was a downward trend in the number of referrals from west Norfolk to the Julian Hospital and in the average length of time these patients stayed in Norwich. Have these downward trends continued?

(b) How many patients have been referred to the Julian Hospital in the past two years?

(c) Are all west Norfolk dementia patients referred to the Julian Hospital accounted for in the evaluation, or only those who were treated in the west Norfolk designated beds?

(d) How many of the carers of patients referred to the Julian Hospital received financial support with travelling costs?

(e) Is there any evidence that further referrals have not been made due to lack of capacity in beds at the Julian Hospital or in the Alternative to Admission beds in Swaffham?

(f) What response has the CCG received from patients, carers and older people's forums and organisations in the engagement process so far?

(g) NHOSC is aware of the difficulties in recruiting mental health staff to the community teams in west Norfolk? What affect has this had on the DIST?

(h) In September 2014 NHOSC heard that demand for mental health services in the community were much higher than expected. Is the DIST properly resourced to meet the demand?

(i) Has NSFT realised the savings that it expected to make with the introduction of the DIST?

4. Action

4.1 NHOSC may wish make comments to West Norfolk CCG in response to the engagement document presented at today's meeting. In which case the committee is asked to:-

(a) Agree the wording of any comments to the CCG

4.2 NHOSC may wish to exercise the process for final consideration of the changes to dementia services in west Norfolk, in which case the committee is asked to consider:-

(a) Has the consultation **with the committee** been adequate?

(b) Are the changes to dementia services in west Norfolk in the interest of the local health service?

If the answer to either of these questions is 'no', NHOSC is asked to consider whether it wishes to make recommendations for action to the CCG.

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Access to primary care services in Norwich

Suggested approach from Maureen Orr, Scrutiny Support Manager

The committee will receive a report from NHS England (East) regarding plans to maintain and improve access to primary care services in Norwich and surrounding areas.

1. Background

1.1 In January 2015, Norfolk Health Overview and Scrutiny Committee (NHOSC) received a briefing from NHS England East Anglia Area Team (EAAT) regarding Timber Hill GP surgery and walk-in centre, which mentioned that EAAT was working closely with Norwich CCG to develop longer term plans to maintain and improve access to primary care services for the population served by practices in Norwich and surrounding areas.

1.2 Enable East had been commissioned as an independent organisation to undertake a strategic review, the purpose of which was to collect, review and analyse the evidence available and produce a written report with recommendations to the East Anglia Management Team and the Board of Norwich CCG. This was to be delivered at the beginning of March and, if appropriate, it was expected that there would be formal consultation on any proposed substantial changes to primary care services.

1.3 Norwich CCG's Operational Plan 2015-17 for primary care says that it will work towards integration of community services in 4 City localities 'wrapped' around practices. The services will include:-

GPs
Practice nurses
Dieticians
Healthcare Assistants
Community Nurses
Voluntary Sector Co-ordinator
Physios & Occupational Therapists
Podiatry
Diagnostics
Consultants
Trainees
Mental health workers

1.4 Members have been kept informed via the NHOSC Briefing about the relocation of Norwich walk-in centre and the Timber Hill GP practice to

Rouen House, Rouen Road, Norwich. There has been reorganisation in NHS England since January 2015 and the team responsible for this work is now called NHS England Midlands and East (East) (NHSE M&E(E)).

1.5 As reported in the May Briefing, the phased relocation of the GP practice and walk-in centre started on 1 June 2015. The services are running at reduced capacity during the 10 week phased relocation process, while the fitting out of Rouen House continues. Midwifery and phlebotomy services have temporarily been relocated to Norfolk Community Health and Care NHS Trust's premises in Adelaide Street, Norwich.

1.6 The GP walk-in centre is contracted to be open from 7.00am to 9.00pm daily but since 18 August 2014 has been operating with reduced opening hours from 9.00am to 7.00pm daily. The four hour reduction was necessary because the practice was unable to recruit enough GPs and practice nurses to maintain its full walk-in centre opening hours. The reduced hours have continued at Rouen House but the aim is to return to full opening hours when the necessary staff are in place.

2. Purpose of today's meeting

2.1 NHS England M&E(E) has submitted the report attached at Appendix A. It intends to continue with both the GP registered list service and walk-in service at Rouen Road, Norwich beyond 2016 and there is no proposal for a radical change to the services. There will be engagement with the public and stakeholders in the coming months to inform them of NHS England's intentions and to obtain views on the existing services. A copy of the patient and public survey is to follow these papers and will be circulated to HOSC members prior to the meeting on 16 July.

2.2 Representatives from NHS E M&E(E) will be present at today's meeting to present their report and answer members' questions about the recently relocated walk-in & registered list service and the intentions for the future. NHS E M&E(E) would also be pleased to receive NHOSC members' comments on their patient and public survey.

3. Suggested approach

3.1 After the representatives from NHS England M&E(E) have presented their report Members may wish to discuss the following areas with them:-

(a) Phased relocation of the GP practice (registered list) and walk-in service to Rouen Road started in June 2015; when is it expected to be complete?

(b) When is it expected that the midwifery and phlebotomy services, temporarily being provided at Norfolk Community Health and Care NHS Trust's premises in Adelaide Street, Norwich, will be moved to Rouen Road?

(c) What is the current situation regarding access to the services in Rouen Road in terms of car parking for disabled patients?

(d) What was the outcome of the Practice's discussions with Castle Mall landlords about extending the offer of the free first hour parking in the Mall to patients at the Rouen Road health centre?

(e) Has patient feedback about satisfaction with the relocated service been collected? If so, what is the reaction to date?

(f) Given the difficulties of recruiting GP and other staff for general practice, what is the Practice's strategy for reinstating the walk-in centre's full opening hours of 7.00am to 9.00pm daily.

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NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE

TITLE OF PAPER: Access to primary care services in Norwich

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1 PURPOSE

1.1. To inform Norfolk Health Overview & Scrutiny Committee about access to primary care services in Norwich and surrounding area and to seek feedback.

2 BACKGROUND

2.1. In October 2007, health minister Lord Darzi announced new investment to develop 150 GP-led health centres that offered both a list based GP practice and a GP-led service open to any member of the public, including those registered with a GP practice elsewhere to access GP services through walk-in appointments. Under the Equitable Access to Primary Medical Care (EAPMC) programme, each primary care trust was expected to commission at least one GP-led health centre.

Following a national procurement, Norwich Practices Ltd (formerly Timber Hill) was awarded an initial 5 year APMS contract in 2009 to provide GP registered list services and a walk-in service in Norwich. The contract was extended in July 2014 to July 2016 to enable a review of the walk-in centre services to be undertaken.

2.2 Norwich Practices' also provide physiotherapy and phlebotomy services under the terms of the same contract. The intention is to pass responsibility for commissioning these two services to Norwich CCG on expiry of the contract in July 2016.

2.3 Norwich Practices' has recently relocated to Rouen House in Norwich and NHS England has given a legal commitment that primary medical services will be provided from that location for at least 10 years with an option to renew at the end of that period.

GP services for registered patients are currently provided 8 am – 8 pm, 7 days/week. The current list size is 9,389 un-weighted (8,117 weighted).

Walk-in Centre services are provided from 7 am – 9 pm (a temporary amendment to these opening hours is in place (9 am – 7 pm); a return to contracted hours is planned on completion of fit out subject to successful GP recruitment). In 2014/15, there were 64,500 contacts for the walk-in centre service.

3 CONTEXT

3.1. In April 2013, NHS England took over responsibility for direct commissioning of all primary care services including walk-in centre services. Since that time, a number of reviews looking at primary care service provision and the walk-in centre service in Norwich have been undertaken or commissioned by NHS England and/or Norwich CCG. Further detail regarding each of the reviews is attached as Appendix 1.

Population profile in Norwich

3.2 Norwich has been identified as the main focus for growth in the East of England for new homes and jobs, leisure, cultural and educational development. Housing growth in the city of Norwich is forecast to increase by 3000 new homes by 2026 with growth in the surrounding area of approximately 15,000 new homes.

3.3 The current population of Norwich: 134,300. This has increased by almost 10% in the period 1991-2011. This was greater than in the rest of Norfolk (7.7%) and for England, which was over 7.2%.[1]

3.4 The main growth in population in Norwich over the last 10 years has been amongst the "working age" group (aged 16-64) and this is well above county and national rates[2]. However, the higher numbers of 16-29 might be partially explained by the high student population in Norwich (15,000 at UEA plus 1,500 at NUA). [3],[4]

3.5 The city has a high proportion of young people aged 20-29 (21.2 per cent) compared with just 11.9 per cent in Norfolk and 13.66 per cent in England (Norwich City Council Housing strategy 2013-2018: 2013). [5]

3.6 The population is predominantly of white ethnic origin 5.5% higher than the national average. However, the proportion of people from black and minority ethnic groups has increased from 3.2 per cent in 2001 to 9.2 per cent in 2011. [6]

3.7. The Office for National Statistics (2011) projects that the population of Norwich is set to rise by 10,000 over the next eight years.

Projected population growth for Norwich – source - Office for National Statistics (2011)

2014	2015	2016	2017	2018	2019	2020	2021
137,700	139,100	140,400	141,500	142,500	143,500	144,300	145,00

3.8. Although there is projected to be a significant percentage increase in the older population the majority of the population increase in Norwich will be within the age range currently making use of the Walk-in Centre.

3.9 Historically, registered lists of the practices in central Norwich have increased by 5085 (4.3%) over the last 5 years, 0.86% per annum. There is also increased pressure on existing practice premises with 6 practices reporting their premises would be unable to meet future population growth planned for the next 5 - 10 years.

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[1] All figures in this section are taken from the Office of National Statistics (ONS) http://www.ons.gov.uk/ons/search/index.html?pageSize=50&sortBy=none&sortDirection=none&newquery=norwich+population

[2] http://www.norwich.gov.uk/HealthyNorwich/Documents/HealthAndWellbeingStrategy20130227.pdf

[3] http://www.uea.ac.uk/

[4] http://www.nua.ac.uk/norwich/

[5] Norwich City Council (2013) Housing strategy 2013-2018 http://www.norwich.gov.uk/Housing/HousingStrategies/Documents/HousingStrategy201318.pdf

[6] All figures in this section are taken from the Office of National Statistics (ONS) http://www.ons.gov.uk/ons/search/index.html?pageSize=50&sortBy=none&sortDirection=none&newquery=norwich+population

4 National view

4.1 In October 2013, NHS England announced a proposal to implement seven-day, 8 am – 8 pm, GP access to "help thousands who struggle to find GP appointments that fit in with their family and work life." Pilot schemes are in place across England operating extended and more flexible access including email, Skype and phone consultations.

4.2 In addition to these schemes, NHS England has published a national strategic framework, the Five Year Forward Plan ("the Plan"), for commissioning of GP services that addresses key challenges facing the sector: an ageing population, growing co-morbidities and increasing patient expectations; increasing pressure on NHS financial resources, growing dissatisfaction with access to services and persistent inequalities in access and quality of primary care; and growing workforce pressures.

4.3 The Plan cites that the foundation of NHS care belongs in primary care where there will be increased accessibility via a 7 day service, more specialist services closer to home and clinically led co-commissioning to put patients at the heart of the NHS and lead the integration challenge.

4.4 In October 2014, to help improve access, patients saw the introduction of Patient Choice which enables patients to register with a practice closer to their workplace or home without a need for the registering practice to provide home visits. An enhanced service was commissioned to encourage practices to provide home visits to patients living in their area but registered out of area with another practice. It should be noted that practices may choose not to register patients outside their practice boundary. .

4.5 From April 2015, practices must promote and offer the facility for patients to manage appointments online, order repeat prescriptions and provide access to their individual records electronically. In addition, CCGs are being actively encouraged to work with practices to develop electronic prescription services.

4.6 A four year programme of investment in GP practices was announced in March 2015 when practices were actively encouraged by NHS England to apply for infrastructure funds to help improve practice premises. An initial round of applications has been agreed and the programme for future bids will be announced shortly.

5 Review of Walk-in Centres by Monitor

5.1 Following reports of walk-in centre closures, Monitor undertook a review of services in England to understand:-

- why walk-in centre services are closing?
- what is the potential impact of closures on patients, and
- are commissioning arrangements and practices related to walk-in centres working in the patients' interests.

5.2 In their report, Monitor highlighted factors that are most likely to be relevant to commissioners making decisions about walk-in centres, including:

- assessing patients' needs in the local area and understanding the role that walk-in centres play in meeting them;
- deciding what services to procure and from whom when a contract for a walk-in centre is due to expire;
- considering whether services can be delivered in a more integrated way;
- managing conflicts of interest; and
- ensuring transparency in decision-making.

6 Local vision

6.1 There are 23 GP practices in Norwich CCG area (20 GMS and 3 PMS contracts), many of which are facing difficulties in recruitment of clinical staff and at least 6 practices have indicated they have limited capacity to accommodate longer term increases in population within their existing premises. Although the current Walk-in Centre service is based in the City of Norwich it does serve a significant population from other parts of Norfolk. Both North Norfolk and South Norfolk CCG practices are also experiencing difficulties in recruitment. The Central Norfolk system is working together to develop a clear strategy for urgent and unplanned care and primary care stability is seen as a critical factor in this strategic approach.

6.2 The Central Norfolk CCG's are working together with partners and practices to establish their local primary care vision. The Walk-in Centre is a shared service that presents further joint-working opportunities for Norfolk CCGs to strengthen the local health service.

6.3 The original aim of the Walk-in Centre was to improve patients' access to primary care, modernise the NHS to be more responsive to patients' busy lifestyles and offer patients more choice. However, with the increasing demands on health services, particularly A&E services (that are currently struggling with capacity issues), there is an opportunity to align the Walk-in Centre service with local strategic vision to strengthen a local "whole-system" model.

7 Next steps

7.1 Taking into consideration the factors above, the review outcomes and supporting information outlined in this report, NHS England has concluded that it would not be possible to disperse the GP registered list or to close the Walk-in Centre. It has also concluded that it would not be beneficial to make radical changes to the current specifications offered at this time.

7.2 NHS England, in conjunction with the Central Norfolk CCGs, intends to engage with patients, the public and key stakeholders during the next month to inform them about NHS England's intentions and to obtain views on existing services. It will also provide the opportunity to obtain feedback to help inform the future development of primary care services to meet local needs. Engagement will be primarily in the form of a patient and public survey, widely advertised locally, engagement with the practice's Patient Participation Group and with patients through Healthwatch Norfolk and other relevant organisations. A communications plan has been developed by NHS England.

7.3 A market provider event is also being organised for mid August to obtain feedback on the proposed specifications for both the GP registered list and Walk-in Centre services.

7.4 Subject to the outcome of engagement with market providers and patients and public, NHS England's intention is to tender for both services to ensure continuity of patient care and services at Rouen House, Norwich beyond July 2016.

7.5 NHS England will remain the lead commissioner for both services, working in close conjunction with the Central Norfolk CCGs to develop a strategic vision for primary care in Norfolk, whilst co-commissioning arrangements are developed locally.

8 Conclusion

8.1 Members of the Norfolk Health Overview and Scrutiny Committee are asked to note the report and review findings. A copy of the patient and public survey will be circulated to HOSC members separately prior to the meeting on 16 July.

Andrea Patman – Head of Commissioning, NHS England Midlands & East (East)
Fiona Theadom – Contract Manager, NHS England Midlands & East (East)

3 July 2015

SUMMARY OF REVIEW FINDINGS

1 Review undertaken by NHS England

The review carried out by NHS England was completed March 2014 and considered the capacity and resource challenges in Norwich faced by GP practices, impact of population growth on practice premises and on GP services; demographics and use of the Walk-in Centre service.

Based on the review findings, NHS England concluded that it was not possible to disperse the GP registered list and that the service would need to be re-procured to ensure continuity of care for patients in Norwich.

2 Norwich CCG review

Norwich CCG commissioned Public Health to undertake a health impact assessment of the walk-in centre service and wider urgent care service which reported to the Governing Body in April 2013. This concluded that there was a continued need for a walk-in centre service in Norwich.

3 Market survey commissioned by NHS England in April 2014

A market research study was commissioned by the NHS England to understand why patients use the Norwich Practices' Walk-in Centre over other NHS services (e.g. GP, 111, A & E) and to gain an understanding of their patient journey and experience. Face- to-face exit interviews were conducted at the centre in April 2014 and 368 patients took part. This work was part of a wider review of Walk-in centres in East Anglia undertaken by MEL Research.

Key Findings

The questionnaire was divided into five main sections. Some of the key findings include:

- 81% of patients were registered at a surgery within 20 miles
- 83% of respondents visited for their own health needs; 15% for their children's needs
- 63% of patients did not attempt to access another service prior to attending the walk-in centre, and the most popular reason given was that they did not want to have to book ahead (39%).
- Most patients were referred to the walk-in centre from a member of staff at their GP surgery (45%) or a friend / family member (43%).
- 23% of patients would have attended A & E if this walk-in centre was unavailable, patients with a 'minor wound or cut' were the most likely (62%) to attend A & E if the centre was unavailable.
- 90% of patient needs were fully met and 98% would recommend the walk-in centre to a friend
- Reducing wait times (44%) and letting patients know their place in the queue (20%) were the most popular suggestions to improve the experience.

4 Independent review of walk-in centre services (Jan – March 2015)

In January 2015, NHS England commissioned an independent review by Enable East to help inform future commissioning intentions for the Walk-in Centre service. A number of key stakeholders were involved in the review including Healthwatch Norfolk, Norfolk & Norwich NHS Foundation Trust, 111 and OOH service, East of England Ambulance Service and other healthcare organisations.

A number of options were considered in the review, including:

Option 1: Move the service to the A&E site:

- this is seen as less advantageous by those who have contributed to this review than it was last March or by the CCG in the light of the establishment of the Urgent Care Centre. This option would require patients to travel to a location outside of the city centre. Though the hospital site is

a hub for public transport, this would place more traffic pressure on the hospital site during a phase of building and change.
- the Ambulance service expects such a move would have a negative impact on their service in terms of extra journeys generated from the city centre. Public health colleagues and local Healthwatch would not support this option because of the equalities impact of a move away from the city centre and the areas of highest deprivation

Option 2: Replacement of the walk-in service by joint walk-in service operated by local practices as an extension to their national contract:
- seven day working practices are not in place and given the current pressure on list sizes and premises directing the Walk-in Centre contact back to GPs may not be practical in the short term. Such a move may result in more demand on A&E as a preferred alternative.
- if the current planned improvements in GP access succeed; then it is likely that WIC attendances will continue to fall given that GP access was cited as a primary driver to Walk-in Centre usage. This could mean that before the end of another contract on the current cost per contact basis the current Walk-in Centre model may not be viable. However given the current volume of contacts that position is unlikely to be reached within the next 3 years.

Option 3: Close the walk-in service.
- Norwich is predicted to have significant population growth in the population age range using the Walk-in Centre. At the same time initiatives to improve both primary care and A&E pressures are at early stages of development. The CCG urgent care centre is targeting those with a higher level of need than those attending the Walk-in Centre, so it is unlikely to impact significantly on this cohort of patients
- the numbers of patients from out of county and those unregistered are unlikely to find alternative arrangements within local primary care so are likely to use A&E as their service of choice if the Walk-in Centre was not there
- this option would require formal public consultation on all options and may also risk adding pressure to the overall primary and urgent care systems.

Option 4: Recommissioning a Walk-in Centre service to the same specification as now.
- Because of the current and ongoing restructuring and rebuilding of services and premises in the Norwich area, this remains a valid option and this review highlights why the current services are needed at least in the short term to manage risks and pressures in the system. However, to commission a future service along historic lines is likely to miss opportunities to align the service with current developments and gain greater value from it both in terms of use of resources and patient experience.

Option 5: Commission a revised service which includes the Walk-in Centre as part of a more integrated service model.

Usage of Walk-in Centre services by practices

When contacts at the Walk-in Centre are analysed by practice there has been a consistent pattern of surgeries from which the most contacts are generated over the last 3 years, although their ranking within it has changed each year.

The number of contacts for which the registered GP is unknown (which includes those unregistered) is a group consistently within that top ranking, generating 1,348 contacts in the 13/14 reported figures.

The largest cohort of users are not from one local practice but, when aggregated together, those registered with GPs outside of Norfolk who generated 3,163 contacts in the 13/14 reported figures.

Some out of county contacts are multiple contacts from a single practice suggesting that an individual temporarily resident in the area is using the Walk-in Centre rather than registering locally. Many others are single contacts suggesting that the Walk-in Centre is potentially providing services to holiday makers in the area. There is no detailed evidence on which to base hard conclusions about the make-up of this out of county cohort of users. However the number of contacts within the unknown and out of county categories together (4,511 contacts) make up 7.05% of the total contacts in 13/14 demonstrating they do generate significant demand in the system.

The review found great support for walk-in services from key stakeholders who deemed it a vital primary care service.

Key findings

The key findings from the review show that the service is predominately used in the following way:

- Within the hours of surgery opening times during the week
- Mainly used by younger people and working age people
- Used by people primarily because they did not have to book an appointment or because it was easier or more convenient than other options
- Mainly used by those working in the city and by young people seeking anonymity.

Given this information and evidence, Enable East recommended that a revised and extended model be commissioned incorporating the following principles:

- **Quality** - ensuring the service has the right staff, location, hours, close links to other services involved with that individual patient and robust clinical governance
- **Shared systems** - both primary and secondary care services are able to share patient information
- **Data** – detailed data collection to better understand usage and need for future walk-in centre services
- **Clarity for Patients** – where to go for what needs
- **Capacity** - Keeping sufficient capacity in the system to manage risks during the next period of significant service change in the Norwich area
- **Efficiency** - Making the most of available resources through applying the principle of 'making every patient contact count'
- **Patient focused** - Commissioning a flexible facility where a range of services targeted at the young and working age population attracted to the walk-in centre can be provided together, for example, sexual health services or preventative mental health support
- **Demand management** - Keeping the pay per contact model to ensure best value

NHS England supported the recommendation in principle. However it is felt that given the commitment NHS England has made to Rouen House facilities and the importance of ensuring that practices are suitably prepared for new developments; that the walk-in centre complements the local health economy and that development of the specification offers patients services based on local needs analysis, a similar service to that currently provided should be tendered for. NHS England, in conjunction with the Central Norfolk CCGs, intends to seek market provider comment on the vision for future development of Walk-in Centre services that may align with the local strategic vision being developed by the Central Norfolk CCGs.

NHS Workforce Planning in Norfolk

Report by the scrutiny task & finish group

The report of the scrutiny task & finish group on NHS Workforce Planning in Norfolk is presented to Norfolk Health Overview and Scrutiny Committee (NHOSC) for approval and endorsement of the recommendations.

1. Introduction

1.1 NHOSC received an initial report about NHS Workforce Planning in Norfolk on 27 November 2014. The committee decided to establish a scrutiny task and finish group to examine stroke services in detail.

1.2 The group's report is attached at Appendix A. The report includes details of the membership of the group and its terms of reference as well as its findings and recommendations.

2. Action

2.1 NHOSC is asked to:-

(a) Approve the task and finish group's report and endorse its recommendations.

(b) Direct the recommendations to the appropriate organisations / individuals asking them to respond in writing by 30 September 2015 setting out:-

a. Whether or not each recommendation is accepted;
b. Reasons for any that are not accepted.

The organisations / individuals to whom the report's recommendations are directed are:-

- Queen Elizabeth Hospital NHS Foundation Trust
- Norfolk Community Health and Care NHS Trust
- Norfolk and Suffolk NHS Foundation Trust
- Clinical Commissioning Groups in Norfolk
- Interim Director of Public Health, Norfolk County Council
- Interim Director of Children's Services, Norfolk County Council
- Health Education East of England

- NHS England Midlands and East (East)
- Local Enterprise Partnerships, Norfolk and Cambridgeshire
- Norfolk MPs

(c) In addition, NHOSC is asked to send the report to the following organisations / individuals for information:-

- Director of Adult Social Care, Norfolk County Council
- Health Overview and Scrutiny Committees in Suffolk, Cambridgeshire and Lincolnshire
- The Royal College of General Practitioners
- Mr David Prior, Parliamentary Under Secretary of State, Department of Health

(d) Schedule a report for 15 October 2015 NHOSC setting out the responses received to the recommendations.

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Norfolk Health Overview and Scrutiny Committee

Report of the NHS Workforce Planning in Norfolk Scrutiny Task & Finish Group

July 2015

Chairman's Foreword

NHS workforce planning is a subject that has been of increasing concern to Norfolk Health Overview and Scrutiny Committee members in recent years. Last year's Stroke Services Task and Finish Group noticed that staffing was a pressing issue and the deregistration of 1,500 patients from Watton Medical Practice in 2014 made it clear to us that further in depth review of the NHS workforce situation was necessary.

Even where local NHS services have the resources to allow them to recruit, they struggle to fill vacancies in many areas. The result is increasing pressure on NHS staff. The concern is that this will be felt by patients in terms of the time they wait to be seen and the quality of service they receive.

In the course of our scrutiny we looked at NHS workforce planning across the acute, community, mental health and primary care sectors. There are staff shortages in all sectors but general practice in Norfolk is experiencing very severe difficulties. The practices are a collection of small independent businesses and, as such, the sector is probably the least well able to meet challenges with a united strategic approach. With this in mind, we were very encouraged to hear that local Clinical Commissioning Groups are supporting GP practices to explore different ways of providing services with the staff available.

Work is underway at national, regional and local levels to address workforce shortages across all the healthcare sectors but it remains to be seen how much can be achieved before winter pressures start to build, particularly in primary care. General practice is the foundation of the NHS. If it fails then the already intense pressure on the hospitals is certain to rise. This summer NHS England and local CCGs should be making every effort to help local practices prepare for winter 2015-16.

I would like to thank everyone we met during our scrutiny for their time and co-operation. We fully appreciate the hard work that is already going in to address the current NHS workforce shortages and to plan for the future. We hope that the recommendations of our report will be helpful to all involved.

Councillor Margaret Somerville
Chairman of NHS Workforce Planning in Norfolk Scrutiny Task & Finish Group

Contents

	Page
Introduction	4
The national background	6
How did this situation arise?	10
Workforce information from local providers	13
• Norfolk and Norwich University Hospitals NHS Foundation Trust	14
• James Paget University Hospitals NHS Foundation Trust	15
• The Queen Elizabeth Hospital NHS Foundation Trust	15
• East of England Ambulance Service NHS Foundation Trust	16
• Norfolk and Suffolk NHS Foundation Trust	17
• Norfolk Community Health and Care NHS Trust	18
• East Coast Community Healthcare	19
• Primary care	19
○ General Practice	19
○ Dentistry	21
What is already being done to tackle workforce shortages?	21
• Doctors	22
• Regional and local initiatives to support whole system staffing	29
What more could be done?	38
Conclusion	46
List of recommendations	46

Appendices

Appendix 1 - Terms of reference	50
Appendix 2 – Information received by the Task & Finish Group	52

Report of the NHS Workforce Planning in Norfolk Scrutiny Task & Finish Group

1. Introduction

1.1 Norfolk Health Overview and Scrutiny Committee (NHOSC) received a report on NHS Workforce Planning for Norfolk at its meeting on 27 November 2014. It was prompted to ask for this report primarily because of concerns about the difficulty of recruiting new General Practitioners (GPs), which were raised during a Breckland Council scrutiny into the de-registration of patients at Watton Medical Practice in 2014. The scope was widened because of numerous other examples of local clinical staff shortages that had flashed across NHOSC's radar in recent years.

1.2 It appeared to the committee that shortages of primary and secondary healthcare staff were one of the most serious risks facing the health service in Norfolk. It agreed to establish a scrutiny task and finish group to:-

1. Understand the extent of unfilled clinical vacancies due to recruitment difficulties across primary, community and secondary care in Norfolk.
2. Understand the process of NHS workforce planning from national to local level and to understand where responsibilities lie.
3. Discuss action that is already underway, or that could be taken, to ease clinical workforce shortages in the areas identified at 1.
4. Make recommendations, if appropriate, on actions that could be taken to improve workforce planning and recruitment and retention of clinical healthcare staff.

The Group's full terms of reference are attached at Appendix 1.

1.3 Our task and finish group included four members of NHOSC, one other member of the County Council and one co-opted member of Healthwatch Norfolk:-

Cllr M Chenery of Horsbrugh
Cllr A Kemp
Cllr R Kybird (Vice Chairman)
Cllr N Legg
Cllr M Somerville (Chairman)
Mr A Stewart (Chief Executive, Healthwatch Norfolk)

Cllr Kybird continued as a member of NHOSC until Breckland Council's Annual General Meeting on 21 May 2015. After that date we invited Mr Kybird to join our meetings as a co-opted, non-voting lay member.

1.4 Most of our work was conducted at County Hall through meetings with representatives of NHS, educational and other organisations. We also

visited West Norfolk to meet with representatives of the System Resilience Group and the Principal of the College of West Anglia. We discussed all of the questions from our terms of reference with the relevant organisations and received extensive information, all of which is listed in Appendix 2 and is available on request from the Democratic Services and Scrutiny Support Team Manager. Minutes of our meetings are also available on request.

1.5 The organisations and representatives we met were:-

Healthcare education and training commissioners
Health Education East of England / Norfolk and Suffolk Workforce Partnership
Ross Collett – Head of Norfolk and Suffolk Workforce Partnership
Samantha Fowler – Transformational Lead: Workforce Planning & Development (Health & Social Care, Norfolk & Suffolk)

Healthcare education providers
University of East Anglia
Dr Richard Young – Lead Practice Development Tutor, Norwich Medical School
Professor Rosalynd Jowettt – Director of Strategic Partnerships, School of Health Sciences
College of West Anglia
Mr David Pomfret – Principal

NHS System Resilience Groups (SRGs)
Central Norfolk SRG
James Elliott – Deputy Chief Executive, Norwich CCG
West Norfolk SRG
Dr Ian Mack – Chairman, West Norfolk CCG
Dr Sue Crossman – Chief Officer, West Norfolk CCG
Great Yarmouth & Waveney SRG
Dr Jamie Wyllie - Director of Clinical Transformation, Great Yarmouth & Waveney CCG
Tracey Parkes – Head of System Integration Development, Great Yarmouth & Waveney CCG

NHS Trusts
East of England Ambulance Service NHS Trust (EEAST)
Sarah Atkins – Human Resources Business Partner
Terry Hicks – Senior Locality Manager
Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH)
Jeremy Over – Director of Workforce
Queen Elizabeth Hospital NHS Foundation Trust (QEH)
Bev Watson – Medical Director
Gerry Dryden – Director of Human Resources and Organisational Development
James Paget University Hospitals NHS Foundation Trust (JPUH)
Ginnie Stevens – Associate Director of Human Resources

Norfolk and Suffolk NHS Foundation Trust (NSFT)
Sarah Ball – Head of Human Resources
East Coast Community Healthcare (ECCH)
Helen Copeman-Murray – Clinical Education Lead
Lisa Henderson – Human Resources Business Partner
Norfolk Community Health and Care NHS Trust (NCH&C)
Anna Morgan – Director of Nursing and Quality

Norfolk County Council
Adult Social Care (integrated management with NCH&C)
Lucy Hohnen – Interim Lead Human Resources & Organisational Development Business Partner
Children's Services
Elly Starling – Lead Human Resources and Organisational Development Business Partner
Public Health
Lucy MacLeod – Interim Director of Public Health

Local Planning Authorities
South Norfolk Council
Tim Horspole – Director of Growth and Localism
Breckland Council
Mike Brennan – Operations and Contract Manger

Other organisations
Norfolk and Waveney Local Medical Committee (LMC)
Dr Tim Morton – Chairman
NHS Midlands and East (East)
Dr Christine Macleod – Medical Director

1.6 Our remit was to focus on workforce shortages in Norfolk but to fully understand the local situation we needed to look at the bigger, national picture.

2. The national background

2.1 The Shortage Occupation List (SOL) is a good place to start looking for a national picture of workforce shortages. Inclusion on the SOL makes it quicker and easier for employers to bring in professional staff from outside of the European Economic Area (EEA) to fill vacancies in these occupations. It therefore indicates a severe shortfall which is unlikely to be filled from within the UK or the rest of Europe.

The government approved UK Tier 2 SOL, valid from 6 April 2015, includes the following health and social care roles:-

Medical Practitioners	• Consultant in the following specialities: o clinical radiology o emergency medicine o old age psychiatry

	• Trainees in emergency medicine
	• Core trainee in psychiatry
	• Non-consultant, non-training, medical staff posts in the following specialities:
	  ○ emergency medicine (including specialist doctors working in accident and emergency)
	  ○ old age psychiatry
	  ○ paediatrics

Medical Radiographers	• HPC registered diagnostic radiographer • Nuclear medicine practitioner • Radiotherapy physics practitioner • Radiotherapy physics scientist • Sonographer
Health professionals not elsewhere classified	• Neurophysiology healthcare scientist • Neurophysiology practitioner • Nuclear medicine scientist
Therapy professionals not classified elsewhere	• Orthotist • Prosthetist
Paramedics	• All jobs in this occupation code
Social workers	• Social worker working in children's and family services

2.2 The Centre for Workforce Intelligence's (CfWI) 'Migration Advisory Committee (MAC) - Healthcare occupation submission - Main report for the 2014 Shortage Occupation List (SOL)' published in February 2015, included assessments of many other healthcare occupations, which for various reasons were not recommend for inclusion on the SOL. However, the fact that the assessments were done indicates concern about workforce supply in these occupations in at least some parts of the country:-

Anaesthetics NCNT (non consulting non training) doctors	Maxillofacial (head and neck) oncologists
Acute medicine consultants	Mental health nursing
Adult nurses	Midwives
Cardiac physiologists	Non-medical/ nurse endoscopists
Cardiothoracic surgeons	Occupational therapists
Community nurses	Ophthalmology NCNT doctors
Dermatology consultants	Paediatric pathology consultants

Diabetes consultants	Rehabilitation medicine NCNT (non consulting non training) doctors
District nursing	Renal consultants / NCNTs
Ear, nose & throat surgeons	Rheumatologists
Gastroenterology consultants and locums appointed for training (LATs)	School nursing
Geriatric medicine consultants	Sleep physiologists (healthcare scientists)
Haematology consultants	Social care nursing
Health visitors	Specialist nurses working in operating theatres
Paediatric and neonatal - women's diagnostics (consultants)	Specialist nurses working in paediatric and neonatal intensive care units
Plastic surgeons (general)	Stroke specialists / consultants
Practice nurses	Therapeutic radiographers
Psychiatry NCNT posts (with the exception of old age psychiatry)	

2.3 We started our scrutiny by meeting with the Chairman of the Norfolk and Waveney Local Medical Committee who left us in no doubt that it is extremely difficult to recruit GPs. We were therefore struck by the CfWI's recommendation that General Practitioner should be included in the 2015 SOL and the fact that they referred to the East of England their reasons for the recommendation:-

- There is significant evidence of shortage. In the *In-depth review of the general practitioner workforce*, the CfWI found that growth in the GP workforce had fallen behind population growth (CfWI, 2014a).
- Responses from the Royal College of General Practitioners (RCGP) and others to the CfWI call for evidence suggest that the shortage of GPs will last for at least five years, with some practices struggling to fill their duty doctor rota (RCGP, 2014). Health Education East of England (2014) reported serious GP shortages

across the east of England and said multiple attempts at recruitment have been unsuccessful.

- General Medical Council (GMC) data (2014) suggests that there is a viable GP supply from the EEA (over 20 doctors per annum) but very few GPs have joined the GP register directly from outside the EEA. However, inclusion on the SOL is important as the proposed *GP Induction and Refresher scheme* (HEE 2014) will stimulate recruitment of experienced GPs both within and outside the EEA.

Despite the CfWI's advice, the Migration Advisory Committee (MAC) did not include GPs on the 2015 SOL. In its report 'Partial Review of the Shortage Occupation Lists for the UK and Scotland' published in February 2015 the MAC says that it found it particularly difficult to determine whether or not to include GPs. It found there is a long term issue in the supply of GPs caused by three factors:-

- A failure to attract sufficient trainees
- Difficulties in attracting GPs to some geographic areas of the UK
- Work-life balance issues caused by the feminisation of the workforce and the shift towards salaried rather than partner GP positions.

In the end the MAC decided not to put GPs on the 2015 SOL. It had not identified any overall shortage of medical students flowing through medical schools and therefore judged that any shortage of GPs could be addressed by changing the incentive structure so that GP specialisation becomes more attractive relative to the hospital consultant role. The MAC noted that the Department of Health (DH) has initiated such a plan and concluded:

'Therefore, rather than immediately putting GPs on the SOL, we suggest waiting and evaluating the success of this DH initiative. In the meantime, non-EU GPs can continue to be recruited via the RLMT (Resident Labour Market Test) route'.

The requirement to complete a Resident Labour Market Test means that GPs cannot be recruited from outside the EEA as quickly as they could potentially be if the role was on the SOL.

2.4 In our later meetings with NHS acute, mental health and community organisations we heard about the difficulties of recruiting nurses. It was therefore interesting that the CfWI noted increased demand for nurses in the NHS but did not recommend adult nursing (i.e. nurses working in acute, elderly and general settings) for inclusion on the 2015 SOL because it also had evidence that employers were keeping some posts unfilled to keep costs down. It recommended that Health Education England (HEE) works closely with the Royal College of Nursing, the Health and Social Care information Centre (HSCIC) and other stakeholders to ensure better data is available to enable a better understanding of the nursing workforce in future.

2.5 The extremely high cost of locums and agency staff is a sure sign that the healthcare workforce demand and supply is seriously out of balance. We were informed of locum doctors costing £800 per session and agency nurses at £25-£30 per hour.

2.6 Although there are shortages in many occupations across the health service, it is clear to us that the challenges faced by primary care are in a different league from the rest. The Royal College of General Practitioners (RCGPs) has called for an additional 8,000 GPs by 2020 and the government has promised 5,000. Even if the government's number is achieved the difficulty is that the GP shortage is here and now and a different way of providing primary care will have to be found.

3. How did this situation arise?

3.1 The current challenges across primary and secondary care appear to be the result of a combination of factors:-

- rising need for healthcare
- requirements to improve quality by employing more staff
- inadequate workforce planning in the past.

3.2 Rising need

The rising need for healthcare is well documented. The following extracts from the NHS Five Year Forward View, published in October 2014, paint a familiar picture:-

- 'We live longer, with complex health issues, sometimes of our own making. One in five adults still smoke. A third of us drink too much alcohol. Just under two thirds of us are overweight or obese.'

- 'Long term health conditions - rather than illnesses susceptible to a one-off cure - now take 70% of the health service budget.'

- 'Almost three million people in England are already living with diabetes and another seven million people are at risk of becoming diabetic.'

The Royal College of General Practitioners estimates that GP practices are providing 370 million consultations each year to a growing and ageing population, which is more than 60 million more than they were five years ago.

3.3 Employing more staff

3.3.1 This factor has come into play particularly in acute hospitals following the 2013 Francis Report into failings at Mid Staffordshire NHS Foundation Trust. Francis recommended that:-

'The standard procedures and practice should include evidence-based tools for establishing what each service is likely to require as a minimum in terms of staff numbers and skill mix. This should include staffing on wards, as well as clinical staff.'

3.3.2 Various Royal Colleges and professional bodies have published their own guidance on staffing levels and the National Institute for Health and Clinical Excellence (NICE) has provided guidance on safe nurse staffing levels in hospitals and draft guidance for A&Es. Since June 2014 all NHS hospital trusts have been required to make information about nursing, midwifery and care staffing levels available to the public on display boards in hospitals and on-line.

The guidance has stopped short of recommending a universal minimum nurse staffing level because much depends of the individual needs of patients on a ward at any one time. The fear is that a recommended minimum would, in practice, become the target level. Nevertheless, a 1:8 nurses to patient ratio is often mentioned as one that hospitals would not wish to fall below.

NICE has also approved a patient dependency tool which has been developed by the Shelford Group. This is a systematic means of calculating safe staffing levels in relation to the actual needs of patients.

3.3.4 Across the country hospitals have been focusing on the staffing levels needed to maintain quality and have been increasing their nursing and clinical staffing establishments, which has in turn has increased vacancy rates.

It seems clear to us that this is one of the factors behind the nation-wide nursing shortage. On 24 April 2015 the Health Service Journal reported that more than four out of five acute hospitals in England were failing to meet their own targets for nurse staffing.

3.3.5 It is also interesting to note a report in 10 June 2015 Health Service Journal that NHS England has decided to suspend the work on safer staffing guidance that NICE had been carrying out on the recommendation of the Francis report. Work on safe staffing will instead be carried out within NHS England, to avoid a 'mechanistic approach' of nurse ratios. Sir Robert Francis has expressed concern about this move and clearly believes that NICE is the appropriate, independent organisation to produce safe staffing guidance for the NHS.

3.4 **Workforce planning**

3.4.1 It takes 3 years to train a nurse, 10 years to train a doctor and up to 15 years to train a medical consultant. The workforce shortages that are manifesting now clearly have their roots in past planning and commissioning decisions. People that we spoke to during the course of

our scrutiny commented that medical commissioning had been reduced 10 years ago and believed that was part of the cause of the current shortage of doctors.

3.4.2 The following extract from 'Workforce Planning in the NHS' published by The King's Fund in April 2014 gives the history of healthcare education and training and the new arrangements that were put in place by the Health and Social Care Act 2012:-

> 'Prior to the Health and Social Care Act 2012, the Secretary of State's education and training functions were largely delegated to 10 strategic health authorities (SHAs). Funding arrangements were based on historical flows rather than actual costs of provision or consideration of future workforce configurations. Furthermore, the workforce budget at SHA level was not ring-fenced, and there is a widespread view that the training budget was often used for other purposes. There were concerns that the system was too heavily focused on medical workforce development and not responsive enough to changing work patterns. It was therefore not considering future or adaptive workforce training needs, and providers and staff were not fully involved in workforce development.
>
> The Act abolished SHAs and established Health Education England, comprising a national board and 13 regional local education and training boards (LETBs). This structure was designed to allow workforce planning and commissioning on a national scale while being responsive to local needs and changing workforce requirements. Health Education England has an annual, ring-fenced training budget of £5 billion. The 13 LETBs took over most of the SHAs' tasks but seek greater provider and clinician input; trusts are required to provide forecasts of workforce needs (numbers and skills). The postgraduate deaneries now sit within the LETB structure. Contracting for education and training has moved to a tariff-based system to enable national consistency in the funding of all clinical placements (both medical and non-medical) and postgraduate medical programmes.
>
> Health Education England's stated approach is that workforce planning should ensure that the right people, with the right skills, are meeting patient needs in the most appropriate settings. For the first time, there is a body tasked with making strategic decisions about workforce planning at local and national levels. It pursues this more coherent approach by interrogating and testing LETB plans, collating inputs from national workforce advisory groups, strategic advisory groups and patient advisory groups, and other stakeholders such as Monitor, the Care Quality Commission and the Council of Deans of Health. In 2014, its annual 'call for evidence' received more than 70 submissions from medical

colleges, physician and nursing organisations, the Centre for Workforce Intelligence and other national stakeholders.'

3.4.3 Some of the people we met in the course of our scrutiny mentioned lapses in funding that had affected supply in some roles that would be particularly useful for the integrated services that health and social care are aiming to provide. For instance, we were told that there had not been investment in district nursing training for the last 8 years and that training in this role has just started again in the past year.

3.4.4 We were also interested to hear acknowledgement from some of the people we spoke to that the establishment of nursing as a graduate only profession in 2013 had caused a gap in supply of newly qualified nurses.

3.4.5 Whatever the historical causes of the current nation-wide difficulties, our main task was to focus on the local situation in Norfolk and what can be done to improve the workforce supply here.

4. Workforce information from local providers

4.1 We met with representatives of each of the acute hospitals, the community healthcare providers, the mental health trust, and the ambulance service and asked them for information about their current staffing levels, vacancy levels, temporary staff costs and recruitment strategies.

We received evidence of significant levels of vacancies for medical staff, nurses and health care staff and in other clinical staff groups. With regard to nursing, our overall impression was that in Norfolk, contrary to the CfWI national findings, the current issues are not about employers' unwillingness to recruit but about inability to recruit in sufficient numbers.

4.2 For information about general practice and primary care, we relied on the Norfolk and Waveney Local Medical Committee, the commissioners NHS England Midlands and East (East) and evidence from local GPs who we met in their roles of System Resilience Group members (via the Clinical Commissioning Groups) or as members of teaching institutions.

4.3 The following is a summary of the snapshot data and other information we gathered from each of the providers:-

4.4 **Norfolk and Norwich University Hospital NHS Foundation Trust** (NNUH)

The current number of vacancies in each discipline (doctors, nurses & other clinical staff), as at 28 February 2015

Staff group	Staff in post WTE	Vacancies WTE	Vacancies %
Nursing & Midwifery (front-line) (registered nurses and healthcare assistants)	1794.21	199.08	11.0
Medical and Dental	885.13	92.05	9.4
Other clinical staff groups	903.88	131.77	12.7

Of the 199 nursing vacancies, 132 were for registered nurses and 67 were for healthcare assistants.

Current levels of staffing in comparison to safe staffing guidance (as at February 2015)

	Registered Nursing	Healthcare Assistant
Day shifts	94%	99%
Night shifts	90%	109%

In February 2015 approximately 2% of the NNUH's clinical workforce time was delivered through use of agency staff.

In January 2015 the NNUH's pay costs were £235m against a planned position of £233m, indicating that the cost pressure of using temporary staff was £2m in the year to that date.

4.5 **James Paget University Hospitals NHS Foundation Trust (JPUH)**

The current number of vacancies in each discipline (doctors, nurses & other clinical staff) as at March 2015

Staff group	Staff in post WTE	Vacancies WTE	Vacancies %
Nursing & Midwifery (registered nurses)	796.42	78.37	9.0
Medical and Dental	274.19	50 (Unfilled 19) (Locums 31)	13.7 (5.2) (8.5)
Other clinical staff groups	243.91	13.87	5.6

The Trust has an agreed standard of Registered Nurses (RNs) 1:6 patients in the day and RNs 1:8 patients at night in general ward areas.

March 2015 nursing staffing levels

	Nursing
Day shifts	88.30%
Night shifts	91.50%

In March 2015, approximately 2.4% of clinical workforce time was delivered through use of agency staff.

In month 12 for the year 2014/15 JPUH pay costs were £119.4m against a planned position of £118.8m. Medical unplanned expenditure was £1.05m. Health Care Assistant (HCA) additional expenditure was £1.7m

4.6 **The Queen Elizabeth Hospital NHS Foundation Trust (QEH)**

Vacancy data – February 2015

Staff Group	Established FTE	Actual FTE	Vacant FTE	Vacancy %
Medical and dental consultants	135.26	117.19	18.07	13.36%
Additional clinical services	463.4	449.57	13.83	2.98%
Allied health professionals	139.05	130.69	8.36	6.01%
Medical and dental	356.68	312.65	44.03	12.34%
Nursing and midwifery registered	904.59	810.83	93.76	10.37%

In January 2015 the hospital had a vacancy rate for registered nurses and midwives of 12.6%.

The Trust was struggling to recruit into the medical workforce. There were 20 senior level consultancy vacancies.

There were significant challenges with achieving planned staffing levels particularly across medical wards, with high vacancy rates across a few wards. The Trust gave us detailed ward by ward information on shift 'fill' levels for nurses and health care assistants for January 2015. The lowest recorded 'fill' levels were 70.3% for registered nurses on day shifts in the Surgical Assessment Unit and 66.7% for health care staff on the Medical Assessment Unit at night.

4.7 East of England Ambulance Service NHS Trust (EEAST)

The staffing levels in frontline operations in Norfolk as at 31 January 2015 are shown in the table below. These numbers show that EEAST is over established in Norfolk overall due to additional Student Ambulance Paramedics, Health Care Referral Team staff and Technicians. They also show a 23% vacancy rate for paramedics and a 31% vacancy rate for Emergency Care Assistants.

NORFOLK	Budgeted Establishment as at 31 Jan 2015	Finance Adjusted Staff in Post as at 31 Jan 2015	Vacancies as at 31 Jan 2015
	wte	wte	wte
Supervisors	10.64	6.00	4.64
ECPs	13.28	12.00	1.28
Paramedic	201.29	154.27	47.02
SAPs	0.00	104.36	(104.36)
Technician	39.00	42.09	(3.09)
ECAs	94.74	65.24	29.50
HCRT Staff	0.00	22.23	(22.23)
DOMs	15.00	12.00	3.00
Depots	15.00	11.00	4.00
Senior operational management team	6.80	7.51	(0.71)
NORFOLK TOTAL	**395.75**	**436.70**	**(40.95)**

The Trust uses private and voluntary ambulance services to supplement ambulance cover, especially during peak periods of demand. The proportion of private ambulance service providers ranges between 5 and 7%in Norfolk. Between April and February the Trust spent just over £1.3 million on private ambulance providers in Norfolk but as EEAST recruits more frontline staff it will be reducing the spend on private ambulance

service providers. The Trust had recruited 400 new Student Ambulance Paramedics in 2014-15 and its net gain of front line staff was 300. EEAST is looking to recruit another 400 paramedics in 2015-16. Paramedic is on the UK Shortage Occupation List.

The Trust told us that some areas of Norfolk are more difficult to recruit to than others. Central Norfolk, including Norwich had seen positive responses but the west of the county was proving more difficult.

4.8 **Norfolk and Suffolk Mental Health NHS Foundation Trust (NSFT)**

The information presented below relates specifically to Norfolk localities.

Vacancies by Clinical Staff Group as at February 2015

Staff Group	Establishment (wte)	Staff In Post (wte)	Vacancies (wte)	Vacancy Rate
Unregistered Nursing	400.57	391.60	8.97	2.24%
Medical	109.65	91.52	18.13	16.53%
Registered Nursing	684.54	629.28	55.26	8.07%
Scientific & Therapeutic	137.03	148.36	-11.33	-8.27%

Vacancy rates varied across localities with west Norfolk being a particularly challenging location to recruit to:-

Vacancy rates by Locality as at February 2015

Locality	Vacancy Rate
Central Norfolk	8.5 %
Great Yarmouth & Waveney	5.25%
West Norfolk	12.38%

The Trust told us that Band 5 nursing posts were particularly difficult to recruit to and the vacancy rate for this staff group was 15.4%

For the period to the end of January 2015 the nurse staffing average 'fill' against establishment hours for in patient wards, was 97.9% for day shifts for registered nurses and 124.5% for unregistered care staff. For night shifts, the rate was 93.5% for registered nurses and 141.1% for unregistered care staff.

The Trust's temporary staffing costs as a proportion of total monthly staffing cost was 14.35%. However, this included all temporary staffing requirements including, for example, covering sickness absence,

additional observation requirements, and interim project assignments, and was not limited to cover for vacancies.

The Trust told us that about its recruitment and retention strategy which is having a positive impact in net recruitment. There has been an increase of 129 additional wte clinical staff in the 12 months to the end of February 2015.

4.9 **Norfolk Community Health and Care NHS Trust (NCH&C)**

Current number of vacancies in each discipline (doctors, nurses &other clinical staff) as at February 2015

	Budget	Staff in post	Vacancies	Vacancy %
Add Prof Scientific and Technic	20.40	19.96	0.4	2.16%
Additional Clinical Services	710.23	635.64	74.6	10.50%
Administrative and Clerical	488.69	483.16	5.5	1.13%
Allied Health Professionals	312.49	300.78	11.7	3.75%
Medical and Dental	58.82	34.08	24.7	42.06%
Nursing and Midwifery Registered	853.26	818.26	35.0	4.10%
Total	**2,443.89**	**2,291.88**	**152.0**	**6.22%**

NICE guidance on safer staffing levels for nursing has so far been limited to acute hospital settings but it is anticipated that guidance will be produced in 2015 in relation to community nursing (although it is not certain that it will extend to community hospitals).

NCH&C reviews staffing levels across its rehabilitation in-patient units using the Royal College of Nursing (RCN) Safer Staffing for Older People Toolkit. Its general units have staffing numbers at the lowest end of acceptable and red rated for registered nursing on late shifts.

'Red' rated shifts over the six months to November 2014

June 14	July 14	Aug 14	Sept 14	Oct 14	Nov14
15.5	13.7		12.5	13.9	

NCH&C told us about how it had worked with the local healthcare system and opened additional hospital beds and virtual ward places to meet sustained pressures during winter 2014-15. This clearly had an impact on the Trust's requirements for staff.

In 2014 the average bed occupancy level across NCH&C was running at 90.8%, which is high in a community hospital setting. At the same time patients' needs are rising because of the increased complexity of their health conditions and increased dependency. The Trust has been in discussion with commissioners to get clarity on the funding of additional staffing where patients are identified as requiring 1:1 enhanced care. This

is often when distressed patients with severe dementia require a healthcare assistant to maintain safe care.

4% of NCH&C's clinical WTE (whole time equivalent) staff are on fixed term contracts. In the financial year to February 2015 the Trust's average monthly spend on agency staff was £279,144 and on bank staff £280,851. However these figures were Trust wide and so included non-clinical posts.

The Trust told us that reliance on temporary sources of funding to fund services had led to more fixed term contracts than it would like to use.

4.10 **East Coast Community Healthcare (ECCH)**

Current number of vacancies in each discipline (clinical only) March 2015

SUMMARY	Headcount BUD	WTE BUD	Headcount Feb	WTE Feb	% Vacancies WTE Feb
Adults	506	418.90	480	383.13	8.54%
Children	192	150.24	183	140.71	6.34%
Public Health	51	44.57	48	40.91	8.21%
Medical Practice	22	16.35	21	16.22	0.80%

East Coast Community Healthcare also told us about the effect that increased complexity and dependency of patients was having on their service and requirements for staff and showed us the work it had done to calculate safe staffing levels within its four community hospitals.

Proportion of clinical staff who are temporary or have fixed term contracts (showing also headcount of bank staff)

SUMMARY (STAFFING TYPE)	Headcount	WTE
Bank	255	0.00
Fixed term	15	10.56
Permanent	622	512.25
TOTALS	892	522.81

ECCH said that up to about 18 months ago there had been no particular difficulties in recruiting clinical staff but now it was facing problems.

4.11 **Primary care**

4.11.1 **General practice**

4.11.1.1 Our conversations with a representative of the Norfolk and Waveney Local Medical Committee, NHS England Midlands and East (East) and various local GPs gave us the following information:-

- There are currently estimated to be 3,500 registered GPs in the east of England.
- By 2018 there is expected to be a shortfall of 200 GPs in the east of England.
- 24% of GPs in the east of England are over 55 years old.
- There is an Anglia area 'spike' of GPs in their early fifties.
- 10% of GPs in the east of England are under 35 years old.
- The Royal College of General Practitioners estimates that there is a current shortfall of around 3,300 GPs in England.
- All Norfolk CCGs are reporting a shortage of GPs / Practice Nurses – all running with vacancies.
- Norfolk and Waveney Local Medical Committee offers an advert function on its website. Over the 3 months to November 2014 33% of Norfolk and Waveney practices have advertised 1 or more vacancies on the site.
- Repeated advertising for GP / Practice Nursing posts is common and, sometimes, there are no applicants.
- In Norfolk and Waveney there is an average patient : GP ratio of 1 : 1,922 and in many practices it is over 1 : 2,500.
- In years gone by, when the GP contract was held by individual GPs rather than a practice, the Primary Care Trust's trigger for another GP being required was when the ratio reached 1 : 1,800.
- Local GPs are routinely working 12 hour days.

4.11.1.2 The best source of information about the NHS workforce, including GPs and general practice, is the Health and Social Care Information Centre (HSCIC). It conducts an annual census of general practice, which has a 90% return rate, and it estimates the other 10% based on information from CCGs.

4.11.1.3 In April 2015 The King's Fund published 'Workforce Planning in the NHS', an analysis of the workforce challenges across all sectors in the NHS based on HSCIC data. It highlighted **pronounced data gaps in four key areas, one of which was primary and community care**, where it says there are systematic problems in the collection of reliable workforce data. The other three areas were agency and bank staff, vacancy rates and independent and voluntary sector providers.

We were aware that a national review of the PMS (Personal Medical Services) contracts for general practice was underway and that it could reduce the funding available to some practices. Practices on a PMS

contract receive additional funding for providing additional services over and above those required by the GMS (General Medical Services) contract. We were concerned that losing this funding could destabilise some practices.

NHS England Midlands and East (East) (NHS E M&E (E)) told us that 35 practices in Norfolk reverted from a PMS to a GMS (General Medical Services) contract on 1 April 2015 as they were not providing significant additional services. These practices were to receive 4 year transitional support, i.e. a phased reduction in the premium over 4 years to give them time to plan effectively to operate at GMS rates. Funding released from the review of PMS contracts is to be reinvested to all the practices in a CCG area to ensure fairer funding for all.

4.11.1.4 It must be remembered that General Practices are not NHS organisations but small, independent, separate businesses. There are no reliable methods of measuring the size of workload that they are currently carrying or the extent of the demands that will be placed on them in future. It is our impression that no one organisation has full and clear data on the true extent of the workforce challenges facing general practice in Norfolk.

No-one we spoke to doubts that the challenge is great.

4.11.2 **Dentistry**

4.11.2.1 We enquired about the situation with the NHS dental workforce via the Local Professional Network and received some information from individual dental practices. One large practice, which encompasses 11 different surgeries in Norfolk and Suffolk, told us that in its opinion the main problem affecting NHS dental provision in Norfolk was not lack of workforce but lack of sufficient NHS contracts.

4.11.2.2 We were also mindful that in July 2014 NHOSC was informed that there had been an ongoing vacancy at the NNUH for a part-time consultant in restorative dentistry and despite extensive advertising the post remained unfilled. The role of this consultant was to:-

1. offer advice to local general dental practitioners who referred patients with complex needs and
2. take tertiary referrals from their maxilla facial colleagues following cancer surgery to place implants to retain dentures etc.
3. take referrals from orthodontic consultants who have treated children with congenitally missing teeth.

As such, the post holder would provide support to dentists in primary care. NHOSC backed a suggestion from the Norfolk Local Dental Committee that to make the post of part time consultant in restorative dentistry more attractive to prospective candidates two more sessions could be funded by the Area Team.

We were informed during our scrutiny that the NNUH had increased the advertised role to be for 8 sessions and was optimistic that it would be able to recruit a consultant to this more attractive role.

4.11.2.3 We know from the 'Oral Health in East Anglia' needs assessment prepared by Public Health England for NHS England in 2014 and evidence submitted to NHOSC in July 2014 that:-

- Some parts of Norfolk with high levels of deprivation, e.g. King's Lynn and Thetford) are not well served for NHS dental practices.
- Dentists in Norfolk experience difficulties in referring patients with complex periodontal or root filling problems for treatment. Patients have to travel to the Eastman Dental Hospital in London.

It is our impression that these are, at least in the first instance, commissioning issues rather than workforce issues. NHS dental provision is an area that NHOSC may wish to return to in the coming year.

5. What is already being done to tackle workforce shortages

5.1 NHS workforce planning is a joint responsibility of employers who are responsible for employing, maintaining and developing their own staff and Health Education England, which has 4 key roles:-

- Workforce planning
- Commissioning of education provision
- Continuing development of existing non-medical workforce (i.e. all except for doctors and consultants) and encouraging employers to invest in their staff
- Ensuring quality of the education provision it commissions.

The workforce planning is carried out in a rolling 5 year process that is currently conducted annually. Health Education England's regional branches, in our case Health Education East of England (HEEoE) collect workforce data including medical, non-medical and pre-professional workforce information from employers. They conduct challenge and review meetings with the employers to test the robustness of their plans throughout the process.

HEEoE then models commissions based on the data it receives and the data it has on population demographics and the movement of staff between the NSH and the private, voluntary and independent sector.

The decisions about the number of education and training places needed for doctors are taken by HEE nationally. The commissioning decisions for other health care staff (nurses, therapists, health care assistants etc. are taken regionally by HEEoE.

5.2 Doctors

5.2.1 National initiatives for general practice

5.2.1.1 Although the information received from the acute, mental health and community providers (in section 4) illustrates shortages in other medical specialties, in this section we will focus on the national action to improve supply of GPs.

5.2.1.2 Most of the key factors that affect the fortunes of general practice are determined nationally – GP contracts; the levels of NHS funding that go into the sector; the number of GP training places. We are therefore dependent on national action to address local difficulties.

5.2.1.3 In January 2015 the Royal College of General Practitioners (RCGP), British Medical Association (BMA), NHS England and Health Education England published 'Building the Workforce – the New Deal for General Practice' (the New Deal). The aim was to ensure that there is a skilled, trained and motivated workforce in general practice. The New Deal is part of the implementation of the NHS Five Year Forward View and the New Deal for primary care, which set out specific commitments to tackle workforce issues alongside a range of other issues. The three key strands are:-

- Improving recruitment into general practice
- Retaining doctors within general practice
- Supporting those who wish to return to general practice.

5.2.1.4 The document includes a 10 point action plan to achieve:-

1. **Promoting general practice** – the four organisations will collaborate on a marketing campaign, including a letter to all newly qualified doctors setting out the positive aspects of a future career in general practice
2. **Improve the breadth of training** – Health Education England (HEE) will work with partners to resource and additional year of post-CCT (Certificate of Completion of Training) training to candidates seeking to work in geographies in which it has historically been difficult to recruit trainees. The aim is to encourage new GP trainees to work in these areas.
   This training would be flexible, and could involve:
   A) Training in a related clinical specialty, such as paediatrics, psychiatry, dermatology, emergency medicine, and public health
   B) Training in leadership and clinical commissioning, including the acquisition of business skills through the undertaking of an MBA
   C) An academic programme of activity; or
   D) Training in an aspect of medical education and training related to primary and community care

3. **Training hubs** – NHS England will invest in the development of pilot training hubs, in which groups of GP practices can offer interprofessional training to primary care staff, extending the skill base within general practice and developing a workforce which can meet the challenges of new ways of working.
4. **Targeted support** – NHS England will work with the BMA GP committee and the RCGP to explore a time-limited incentive scheme offering additional financial support to GP trainees committee to working within specific areas for 3 years.
5. **Invest in retainer scheme** – NHS England will review the use of current retainer schemes and invest in a new national scheme, making sure that it meets the needs of both GPs and practices.
6. **Improve the training capacity in general practice** – the Government's recent announcement that there will be an extra £1 billion for investment in new primary care infrastructure will enable increased training capacity and a more positive experience for medical students and foundation year doctors working within general practice. More broadly, NHS England will work with the BMA's GP committee and the RCGP on the strategic direction of the primary care estate including to support the transfer of care into community settings.
7. **Incentives to remain in general practice** – NHS England and partners will conduct a detailed review to identify the most effective measures to encourage experienced GPs to remain within practice. Options may include a funded mentorship scheme, opportunities to develop a portfolio career for GPs approaching the end of their working life, and a clearer range of career pathways.
8. **New ways of working** – NHS England, HEE and others will collaborate to identify key workforce initiatives that are known to support general practice, including physician associates, medical assistants, clinical pharmacists, advanced practitioners (including nursing staff) healthcare assistants and care navigators. We will agree a shared programme of key pilots at scale in primary care, to invest in and trial new ways of working for these roles, demonstrating how they work across community hospitals, and within GP surgeries to support safe and effective clinical services for patients. This will support current GPs managing their workload, as well as piloting new ways of working for the future.
9. **Easy return to practice** – HEE and NHS England will publish a new induction and returner scheme, recognising the different needs of those returning from work overseas or from a career break, and work with the RCGP will take place to agree safe and proportionate standards. This will be done in close collaboration with the BMA GP committee. (The aim is to attract 300- 360 returners over 3 years to general practice and to ensure these returners are retained).
10. **Targeted investment in returners** – NHS England will make available additional investment to attract GPs back into practice, increasing over time. Targeted at the areas of greatest need, the scheme will offer resources to help with both the costs of returning

and the cost of employing these staff. A review of the performers' list in its current state and its value will be undertaken. This scheme will be developed in collaboration with the BMA GP committee and the RCGP.

5.2.1.5 This is a good plan and NHS England has provided £10 million to kick start it. This was from the £1billion additional investment for primary care infrastructure over 4 years (2015-16 to 2018-19), which was also confirmed in January 2015. The infrastructure fund is to support the development of premises and IT in general practice and all practices have been invited to make bids. The process had not reached its final conclusion at the time we received information but there had been a number of practices that had been informed their bids were successful for 2015-16 or they were deferred to 2016-17.

5.2.1.6 NHS E M&E(E) also explained to us that there will be a national review of the Carr-Hill formula which is used to distribute funding to general practice. Rather than simply paying GP practices according to the number of people registered with the practice the formula takes account of a number of factors which impact on the GP workload including age and sex of patients and the number of nursing and residential homes that the practice covers. It also takes account of the standard mortality index and average limiting long-term illness index and rurality. Concerns have been raised about the formula, in particular that it does not reflect the growing number of patients aged over 85. The national review will investigate the way that Carr-Hill operates and will take the views of all relevant stakeholders into account, including GP organisations. At the time we received this information, in June 2015, NHS England was in the process of determining how the review would work.

5.2.1.7 The timetable for implementation of the 10 point plan for general practice drawn up by the RCGP, BMA, NHS E and HEE is rapid, with all actions to be completed by the end of September 2015, although it is not clear how long it will take for these steps to produce more GPs and other primary care staff 'on the ground'.

5.2.1.8 **The Royal College of General Practitioners (RCGP) is clearly very concerned about the pace of change.** In May 2015 it published 'A blueprint for building the new deal for general practice in England', which recommends that the government should:-

- Invest 11% of the NHS budget in general practice
- Grow the GP workforce by 8,000
- Give GPs time to focus on patient care
- Allow GPs time to innovate
- Improve GP premises.

The RCP's blueprint reports on GP funding as a proportion of NHS expenditure in England since 2004-05, as shown below:-

Year	GP funding as a share of NHS expenditure
2004-05	10.5%
2005-06	11.0%
2006-07	10.5%
2007-08	9.8%
2008-09	9.3%
2009-10	8.8%
2010-11	8.5%
2011-12	8.5%
2012-13	8.5%
2013-14	8.4%

5.2.1.9 The RCGP warns of a risk of 'meltdown' in the forthcoming winter period and recommends that the government takes the following actions immediately:-

- Establish a stabilisation fund to help practices under stress as a result of high local costs that are not adequately reflected in the current funding formula. This should be implemented alongside measures to tackle the problem of under-doctored practices and areas.
- Ensure that the 10-point GP workforce plan recently agreed between NHS England, HEE, RCGP and the BMA, receives political support and additional financial backing required to take the plan forward as a matter of urgency.
- Take forward key aspects of this plan as a priority, including:
    - Stepping up the promotion of general practice as a rewarding and challenging career and improving perceptions of the profession, particularly amongst foundation doctors and medical students, and putting significant resources behind this effort.
    - Exploring what financial incentives can be offered to GP trainees to encourage them to commit to training and working in currently under-doctored area – e.g. potentially helping to pay the university fees of doctors who commit to train and work in these areas.
    - Backing the new Induction and Refresher scheme, and putting in place measures to make it easier for GPs currently working abroad to return to the UK – e.g. by abolishing the GP National Performers list, which acts as an unnecessary barrier for GPs wishing to return to practice following a break.
    - Investing in a new retainer scheme and conducting a detailed review to identify the most effective measures to encourage GPs to remain within practice, especially those over 55. Measures are needed to develop career-long support for current GPs, through training, focusing on resilience in practice.

- Recruit an extra 500 nurses into general practice by the end of 2015. Recent experience has shown considerable appetite from former nurses to pick up on opportunities to join return to nursing schemes. Until now, these have all been focussed on nursing in the acute sector. However, the practice nurse workforce could be substantially boosted through attracting nurses back into healthcare, predicated on return to nursing initiatives but focussed on GP and community services.
- Introduce a flexible careers scheme. The GP Taskforce report identifies a range of roles in which this group could contribute, for example, as GPs with special interests and in settings such as nursing homes and community hospitals.
- Conduct an urgent full scale review into how the bureaucracy, red tape and unnecessary workload currently faced by GPs can be reduced, and their time can be freed up to focus on delivering high quality patient care.
- Conduct an immediate review of Care Quality Commission (CQC) inspection and regulatory processes to eliminate unnecessary burdens for general practice, and to ensure that scrutiny is focussed in those areas where it is likely to have most beneficial impact.
- Initiate discussions with the General Practitioners committee of the BMA to replace the Quality and Outcomes Framework (QOF) with a new funding arrangement that allows GPs more freedom to focus on providing the best possible holistic care to patients and eliminates unnecessary bureaucracy.
- Provide practices with adequate levels of funding to pilot the employment of pharmacists within GP teams, in line with proposals set out in March 2015 by the RCGP and the Royal Pharmaceutical Society – and subsequently to support the implementation of this initiative at scale.

5.2.1.10 It remains to be seen whether the Department of Health and the NHS will take on board the RCGP's suggestions for immediate action and whether enough can be done before winter 2015-16.

5.2.2 **Local initiatives for general practice**

From a local perspective, and in light of the national 10 point plan, we asked Health Education East of England (HEEoE), the University of East Anglia (UEA) and NHS England Midlands and East (East) and local doctors about work already in hand to tackle GP workforce pressures in Norfolk:-

5.2.2.1 **Additional GP training places**

5.2.2.1.1 As explained in paragraph 5.1, Health Education East of England does not decide the number of training places for doctors in our region. That is done at national level. The Government mandate to Health Education England for 2015-16 has told it to ensure a minimum of 3,250 trainees per year (equating to approximately half of the annual number of trainees completing foundation training and moving into specialisations) are recruited to GP training programmes in England by 2016.

5.2.2.1.2 HEEoE lobbies for a high share of the national allocation of training places. The hope is that doctors who train in our area will go on to practice here although that, of course, is not always the case.

The number of GP training places in our region has increased from 274 in 2013 to 332 for 2015. However, this does not necessarily guarantee 332 trainee GPs. In 2013 100% of the regional trainee posts were filled. In 2014 in Norfolk 12 posts were unfilled. At the time we received information the regional training scheme was going through a second round of trying to fill places and it was not yet clear how many GP trainees would be in post this year.

5.2.2.1.3 The GP trainee places are filled by a recruitment process and depends on postgraduates choosing to apply. We heard that for London medical schools the application rate averages 5 applicants for 1 GP training place. In the rest of the country the average is 1 applicant for 1 place and the standard of applicants is not always good enough.

5.2.2.1.4 Having heard that medical schools often do not seem to encourage students to consider careers in general practice, we asked UEA and HEEoE what they do in this respect. HEEoE told us that they do encourage trainees into GP training and they have 2 specialist careers advisors for this. In fact 28% of Norwich Medical School graduates become GPs, which is high above the national average for medical schools. UEA students spend 21% of their clinical days in primary care and 79% in secondary care, which again is a higher proportion in primary care most medical schools and this year Norwich Medical School has started the 'GP apprenticeship' which gives students an additional 3 days in general practice. HEEoE is working to extend training capacity and is encouraging more GP practices to take on trainees (following an approval process for the trainer and the practice). However, we already have higher numbers of training practices in Norfolk and Suffolk (76) than in other parts of the Local Education and Training Board area.

5.2.2.1.5 Clearly, it is no use having additional local GP training places if they remain unfilled despite the best efforts locally. Many of the doctors and others we spoke to in the course of our scrutiny impressed on us just how much the image and the reality of general practice has deteriorated in recent years with a massively increased workload and a reduced proportion of NHS funding for the sector. It is simply not attractive to

medicals students who have choice of more rewarding careers in the hospital sector. At the same time, new models outlined in the Department of Health's Five Year Forward View for a sustainable NHS depend being able to provide much more healthcare outside of hospital. This is why the national plan to promote general practice and attract and incentivise trainees to go into the sector is so important. The RCGP call for 11% investment in general practice also strike us as a good idea.

5.2.2.1.6 Other local initiatives that Norfolk and Suffolk Workforce Partnership (NSWP) has underway in relation to general practice and primary care include:-

- **Physicians Associate** – a 2 year post graduate course being piloted with UEA. They plan to recruit up to a maximum of 60 students to start their training in February 2016. The places have been funded by the Higher Education Funding Council for England (HEFCE), which means there is no commissioner limit on the numbers. Physicians Associate is a new role and a new workforce supply that can be employed in acute, community and primary care settings. The role originated in the USA and 5 UK universities now offer the course (Birmingham was first). 4 more are due to introduce the course soon.
- **Pre and post registration pharmacists** - piloting working in new ways in primary care as part of a GP led multi-disciplinary service
- **Fellowships** – an initiative to retain newly qualified GPs and retiring GPs in Norfolk and Suffolk. This initiative is in the early stages of planning and negotiation with host practices and with trainees who are due to qualify this year. NSWP was not able to give a definitive number of Fellowships that would start this year.
- **Expansion of primary wider primary care teams** e.g. apprentices, higher apprentices and development of Practice Nurses.
- **Engaging GP practices in pre-registered Nurse training** to encourage primary care as a discrete career for newly qualified Adult Nurses.

5.2.2.1.7 NHS England Midlands and East (East) has been holding Norfolk GP workshops with local authority planners, public health and the CCGs to discuss future planning for general practice and the wider system (January and May 2015). CCGs have also been offering support to help GP practices network and innovate (e.g. Great Yarmouth & Waveney CCG workshop for local GP practices in May 2015).

5.3 Regional and local initiatives to support whole system staffing

HEEoE commissions education and training for non medical staff (i.e. nurses, therapists, health care assistants, paramedics, etc.) at regional level. The work is based on information supplied by local health care provider organisations about their current workforce and future requirements. The information is expected to take account of

commissioners' operational and strategic plans and the provider boards are asked to sign it off as accurate.

The local employers therefore play an active part in future planning of healthcare education and training as well as providing the training for the greater good of the NHS. They are also responsible for their own organisation's workforce planning and recruitment strategy.

It is impossible for us to reflect all of the work across the local health and social care system in this report but the paragraphs below pick out some examples.

5.3.1 **Providers**

We asked each of the local NHS provider representatives about their liaison with HEEoE for non medical workforce education and training planning, about their recruitment strategies, and about their specific initiatives to fill vacancies in areas where it is hard to recruit.

They all said that their working relationship with HEEoE was good and that constructive and strenuous efforts to improve the local workforce supply are underway. We heard about their recruitment strategies and it is clear they are working very hard to find the staff that Norfolk's health needs. The examples below give just a flavour of the work that is going on over and above the usual advertising and recruitment activities:-

5.3.1.1 **International recruitment** – nurses from the Philippines, Spain, Portugal and Allied Health Professionals from Ireland (NNUH, QEH, JPUH, NCH&C). Providers reported mixed success with overseas recruitment and retention of staff.

Return to Practice Programme - linked in with the 'National Return to Practice Campaign', this is aimed at nurses who have allowed their registration to lapse (NNUH & NSFT).

Supervised Practice Programme - offered to Registered Nurses who have not worked in the acute hospital sector for a year or more, but who have retained their registration (NNUH).

'Finder's fees' and referral incentive schemes – mentioned by the QEH and NSFT. NSFT had got 67 eligible hires through using a recruitment premium, which illustrates how effective it can be.

Recruitment premia for hard to fill posts – mentioned by JPUH and NSFT. The JPUH has recruitment retention premia approval in place for permanent recruitment for the following grades / specialities:-

- Speciality Doctor A&E,
- Consultant A&E
- Consultant Community Paediatrics
- Consultant Stroke Medicine

- Consultant Radiology

There is mixed success.

Collaborative working arrangements between providers – acute hospitals working together and with community providers and general practice (e.g. JPUH has joint posts with local primary care)

Apprenticeships – mentioned by all providers. NNUH took on 130 apprentices in 2014-15. QEH was starting with small numbers of Health Care Assistant Apprenticeships both for young people and for those of any working age.

Armed Forces service leavers and veterans – career transition into NHS roles (NNUH, EEAST & NSFT).

Collaboration with the Prince's Trust - to enable young people who are not in education, employment or training to obtain hospital work experience. (NNUH)

Streamlining programme – all local NHS Trusts are part of this programme, which recently started in our region and which already operates in London. When staff are newly appointed to a new NHS Trust the information they had to present at their previous Trust transfers through with them (speeding up commencement of employment).

5.3.2 **Health Education East of England**

5.3.2.1 The Government's Mandate to Health Education England for 2015-16, 'Delivering high quality, effective, compassionate care: Developing the right people with the right skills and the right values' describes healthcare assistants and adult social care support workers as 'the backbone of the health and care workforce' and expects HEE to 'develop the training and education of this part of the workforce, supporting progress in to nursing and midwifery, the allied health professions and social care for those who seek it'. Sections 6.40 of the Mandate require Health Education England to 'work with the Royal College of Nursing and universities to ensure that nurses currently working in the acute sector and wishing to work in the community have ready and easy access to conversion courses to enable them to so…Where necessary provision and availability should be increased'.

The Willis review 'Shape of Caring: A review of the Future Education and Training of Registered Nurses and Care Assistants' published in March 2015 also encourages development of the healthcare assistant workforce.

Health Education East of England (HEEoE) is the Local Education and Training Board (LETB) for our area (there are 12 others across the country). Within HEEoE there are four Local Workforce Partnerships:-

- Cambridge and Peterborough

- Bedfordshire and Hertfordshire
- Essex
- Norfolk and Suffolk

HEEoE told us how it is responding to its mandate and to NHS service providers' requests to effectively 'grow their own' nurses.

5.3.2.2 **Flexible nursing pathway**

A Flexible Nursing Pathway has been designed as a complementary alternative to the conventional three year degree delivery model for nurse education as currently provided by HEEoE through local Health Education Institute partners. This pathway is being piloted in 2015/16 and Norfolk & Suffolk has secured 46 commissioned places for our NHS employers across both counties.

The Flexible Nursing Pathway provides a route into nursing for staff working in Band 1-4 positions that may not have been able to access the conventional student pathway, but have completed a healthcare Foundation Degree (FD), such as assistant practitioners. The most frequently cited reason for this group not accessing nursing degree programmes is the need to continue to earn a salary and for this reason HEEoE has developed a work based 'earn as you learn' pathway, that credits their existing qualifications towards the nursing degree (through Accreditation of Prior Experiential Learning).

Typically the 'earn as you learn' pathway will take a student 2 years to complete whilst they remain in employment and upon successful completion they will qualify as an Adult Nurse.

5.3.2.3 **Collaborative learning in practice (CLIP)**

The CLIP project currently being hosted in Norfolk is a method of offering student nurses a better quality of learning in practice, which should help to keep them in training. It goes beyond the regular provision of support for students in practice, which is about 40-50% of their time with a mentor, and provides the constant supervision of a coach who does not concurrently have responsibility for patients other than those that their students are caring for. The pilot has been run by UEA School of Health Sciences, HEEOE, NNUH, JPUH, ECCH, NCH&C, QEH and NSFT and will now be rolled out in Suffolk.

5.3.2.4 **Health Ambassadors project**

The Health Ambassadors Project, which was initiated in Norfolk and Suffolk and is now being rolled out nationally, is a way of linking NHS workers (clinical and non-clinical) with schools and colleges. Staff within local Trusts put themselves forward as Ambassadors and Norfolk and Suffolk Workforce Partnership then endeavours to link up with schools and colleges in the patch. NSWP has a modest budget to support

usually 1 or 2 events that would bring students and NHS Workers together, for example they organised scenario days for students, usually in secondary or further education, where healthcare workers “act out “scenarios with students. The scenario could be a road traffic accident or something similar giving the opportunity to promote the wide range of professions who interact with a patient on their journey through the system. In addition the Ambassadors try to attend schools careers fairs and specific careers events when possible again mostly focussed on secondary and further education.

There is no complete central list of all the activities and schools that Health Ambassadors have engaged with because the some of the administration is carried out by individual Trusts but there are centrally recorded events at the following schools:-

Downham Market Academy
St Clements High School Kings Lynn
Wayland Academy
King Edward VII High School Kings Lynn

The Health Ambassadors have also taken part in two large events, one organised by UEA and Skills East which took place over two days at Norfolk Showground.

5.3.2.5 **Developing an integrated health and social care workforce**

Norfolk and Suffolk Workforce Partnership (NSWP) has funded a 12 month role to kick start some integrated workforce planning and development projects across the health and social care system in Norfolk and Suffolk. The role began in December 2014 and the projects underway in Norfolk are:-

(a) Workforce Profiling
A template for the collection of workforce data has been developed following consultation with workforce leads from stakeholders across the Norfolk Health & Social Care system.

This project will aim to identify workforce gaps across the Health & Social Care system and enable the identification of opportunities for innovative new roles which will help fill some of these gaps.

(b) Local Integrated Leadership Programme
A focus group of Health & Social Care professionals was held to co-produce a framework programme. The Suffolk system has agreed to co-fund 2 pilot programmes to test out the framework and a tender document has now been sent out to potential providers. If successful NSWP would look to develop this into a curriculum offered for use across the Health & Social Care system in Suffolk and Norfolk.

Links have been made with the existing commissioning academies in Norfolk and Lowestoft.

(c) Health & Social Care Apprenticeships
The integrated Apprenticeship programme has been successfully launched. 7 Apprentices have begun on the programme and they will rotate between the Norfolk and Norwich University Hospital and Care Home placements in Norfolk after 6 months.

A member of staff has been employed with a target of 100 new Apprenticeship starts over the next 15 months in Primary Care and with other Care providers with NHS funding.

(d) Newly Qualified Academy
N&SWP is proposing to develop an academy for newly qualified Health & Social Care professional staff for their first year in practice. A multi-agency task and finish group is being set up to co-design the programme. This aims to build on the NSFT nurse academy.

(e) Recruitment and Retention
N&SWP has met with the UEA to look at recruitment opportunities of Social Worker and Nurse students during holiday periods, as well as opportunities to recruit from early leavers from these courses. It will be aiming to enlist the student support group to own and manage this project. A recruitment and retention task and finish group has been established and NSWP is in the process of developing a communications strategy for the group. This will look to support recruitment and retention across the Health & Social Care system in Norfolk.

(f) Home Care Provider Development
A series of workshops are being organised to develop Home Care providers in-line with the roll out of the new Home Care Service Specification in West Norfolk in September. These will focus on training and development, recruitment and retention.

(g) Care Home and Carers Workforce Development
The Norfolk and Suffolk Workforce Partnership and Norfolk County Council has funded a project to increase the number of care coaches for care homes, provide outreach care coaching for family carers, as well as investing in developing a number of community learning hubs in Norfolk.

(h) Shared Learning Opportunities
An evaluation of the benefits of multi-agency training is being written to evidence the efficiencies and effectiveness of jointly commissioning workforce development programmes.

(i) Health & Social Care Careers Marketing Material
A Health & Social Care careers leaflet focussing on Apprenticeships, and promotional materials have been produced, so that Health & Social Care careers can be promoted together. These will be used at careers fairs at schools and colleges across Norfolk as part of the iCare and Health Ambassador projects.

(j) Worker Shadowing Project
The Norfolk and Suffolk Workforce Partnership is facilitating the Health & Social Care system to develop a worker shadowing scheme. NSWP has developed a pilot project in Suffolk and it is planned to use this model in the roll out across Norfolk and Suffolk.

5.3.3 **UEA**

We met with representatives of the Norwich Medical School, which provides courses for doctors, and School of Health Sciences, which provides courses for non medical health care staff, e.g. nurses, midwives, therapists, paramedics. Our interest was in how they work with Health Education East of England and with the local NHS service providers to educate and train the workforce. We also enquired about the entry routes to their courses and their provision of developmental courses that help to promote and retain the existing workforce.

They told us that the working relationships with HEEoE and local providers were good and that they challenge and work with them on the number and type of commissions to deliver the required workforce.

They told us about the following initiatives and actions that are in development or currently underway:-

School of Health Sciences

(a) Bespoke continuing development courses – work is underway with identified senior practitioners from the JPUH and NSFT on bespoke continuing development courses relating to leadership approaches.

(b) Accelerated nurse training course – the School of Health Sciences is looking to introduce a new 2 year accelerated nurse training course (Masters) which would produce nurses competent to take leadership roles. They said that this currently had an 'amber light' from the commissioners.

(c) Student nurses at the Queen Elizabeth Hospital – the School of Health Sciences is in discussions with the QEH about placement of student nurses at the hospital (none from UEA are currently placed there). The QEH would have liked UEA to provide a bespoke nursing degree at the hospital but the School of Health Sciences knows from experience that students much prefer a mix of an academic, higher education environment in addition to clinical settings. The idea currently under

consideration is for a cohort of student nurses who are studying at UEA to do their clinical placement at the QEH. They would be accommodated in King's Lynn during their placement.

(d) Liaison events for Directors of Nursing – the School of Health Sciences organises a 6 monthly event for Director of Nursing from all the local providers to exchange ideas with each other and UEA. The next one will also include Clinical Commissioning Groups.

(e) International reputation for research and proactive role in policy development - these help to attract students to study at the School of Health Sciences.

5.3.4 **System Resilience / CCGs**

5.3.4.1 System Resilience Groups (SRGs) have replaced the former Urgent Care Boards and are expected to plan for safe and efficient services for patients. They encompass all the local NHS provider commissioner and social care organisations and are led by senior officers of the Clinical Commissioning Groups. There are three System Resilience Groups in Norfolk (Central, West and Great Yarmouth & Waveney) and we decided to speak with them because their role encompasses operational resilience and capacity planning.

The System Resilience Groups are not themselves responsible for commissioning education and training, or for staffing and vacancies in provider organisations but they have a good overview of their local system and where they see problems developing they flag them up to the responsible organisations.

It was clear to us that each of the SRGs are fully aware of the challenges in their areas, have flagged them up, and are working system-wide to help alleviate them.

5.3.4.2 We also met with the Interim Director of Public Health who chairs the Norfolk and Waveney Local Health System Resilience Group (LHSRG), which includes commissioners, providers and emergency planning / resilience staff from across Norfolk and Waveney and NHS England Midlands and East (East). It is significant that in April 2015 the LHSRG noted 'There have been concerns that across the county staffing level issues, including GPs, could hinder the ability of the health system to step up in cases of incidents including infection outbreaks'. The Group agreed that a report from SRGs should come to it on a quarterly basis and that it should feed issues to SRGs as appropriate.

5.3.4.3 Some examples of the initiatives being taken forward by the SRGs, or by different groupings of their members, are highlighted below:-

(a) West Norfolk recruitment portal -This is an excellent initiative by the West Norfolk Alliance, which includes health commissioners and

providers, social care, local government and the voluntary sector from across west Norfolk. The recruitment portal, which was produced locally with Springboard at the College of West Anglia, provides all the information that people looking for jobs or thinking of moving to the west Norfolk area would need, including information about relocating, housing, education, travel and transport, health and wellbeing and things to do. It has case studies of people who have taken up jobs in the area and video clips of why people love to work in west Norfolk. There are tips for applicants as well as a full search facility for job vacancies of all types at six major local employers:-

- West Norfolk CCG
- Norfolk and Suffolk NHS Foundation Trust
- The Borough Council of King's Lynn and West Norfolk
- The Queen Elizabeth Hospital
- The College of West Anglia
- Freebridge Community Housing
-

The recruitment portal would be a very useful resource for anyone considering moving with their family to west Norfolk to take up a job. It provides a 'one-stop-shop' to search for job and other opportunities that might suit all members of the family, bearing in mind that most young families are, by necessity, two income families (95 per cent of couple families with one or two dependent children had one or both parents working in 2012 – ONS 2013). We hope that it will be very successful in attracting more applicants for NHS jobs in west Norfolk.

(b) Central Norfolk - taking account of the staffing implications of new services – Central Norfolk SRG mentioned how it agrees new services only where they are supplemented by new additional staff, not by reallocating existing staff from core services. They also require all new service proposals to show evidence of using a skill mix across providers and the system, where practical, and to be linked through clear integrated pathways of care.

(c) Great Yarmouth and Waveney workforce forum - this initiative had received £150k from HEEoE for workforce development across health and social care. It had initially focused on secondary care, particularly on the area's new Out of Hospital team, which included joint health and social care roles (similar to an Advanced Practitioners). Generic job descriptions, competencies and training plans had been produced. The GY&W Workforce Forum would focus on primary care this year and intends to offer support to GP practices to implement different staff skill mixes and other innovations.

5.3.5 **Other initiatives which may be of interest to healthcare**

5.3.5.1 We met with adult and social care representatives to discuss their perspectives on staffing, particularly for integrated health and social care.

The integration agenda applies mainly to adult social care, and the initiatives for the integrated services are outlined in paragraph 5.3.2 above. However, our meeting with children's social care gave us an interesting insight into some different initiatives, for instance:-

(a) Public sector apprentice / training course - Norfolk County Council Children's Services told us about this course, which Norfolk County Council and Easton College are looking to put in place. It would be for school leavers who wish to start a career in the public sector but are not sure which area of work would be suitable for them. The aim was to tackle the high dropout rate in some jobs in Norfolk's public sector (e.g. social worker).

(b) Collaborative cross border teams – Children's services has been exploring potential for working in collaboration with neighbouring local authorities to staff cross border teams. It is working on this possibility of establishing a cross border team in the Fens with Cambridgeshire and Lincolnshire.

(c) A limit on agency pay – Children's Services in co-ordination with other social care authorities in the east of England and east Midlands had placed a limit on what it was prepared to pay agency staff.

5.3.5.2 We also received information about a service to manage locum recruitment across nine south west England hospital trusts. They had commissioned a service to manage locum recruitment with the aim of bringing down the cost of locum doctors and dentists by between 15 and 26%. They were also looking to commission a similar service to manage agency nurse recruitment.

In June 2015 it was announced that NHS foundation trusts in England spent £1.8bn in 2014 on agency and contract staff, which was more than twice the planned amount and that action would be taken at national level to curb some of the agencies who are accused of charging 'egregious prices' for supplying staff. This action is in itself a cause for concern in the short term. The Chief Executive of NHS England has said 'There will undoubtedly be occasions where it will be hard in the first several weeks or few months for a hospital to fill a marginal spot while this works its way through the system. We just have to be open about that'. (Health Service Journal 10 June 2015)

6. What more could be done?

We must start this section by acknowledging that a massive amount is already being done locally, regionally and nationally and that we appreciate the hard work of all those engaged in improving and securing the NHS workforce 'pipeline'.

Successful implementation of the national initiatives to improve the supply of GPs and other primary care professionals are vitally important for the

future of the whole NHS system, which will rely increasingly on out of hospital services to meet the needs of an ageing population.

This is especially true in Norfolk which according to mid-2013 estimates in the Joint Strategic Needs Assessment, has a much older population than in England overall (23% of Norfolk population aged 65 or over compared to 17.3% in England). The county also faces the challenge of providing more out of hospital services to patients across a wide rural area. For these reasons we very much hope that the Department of Health and the NHS will respond quickly to the RCGP's blueprint for urgent support to general practice (as outlined in section 5.2.1)

The national shortage of paramedics is another area of particular concern to us. The problems of the East of England Ambulance Service NHS Trust are well known to NHOSC and the Trust has been working hard to ensure front-line resilience by recruiting Student Ambulance Paramedics. We were therefore concerned to read reports in the local press on 3 June 2015 that student paramedic diploma courses at UEA and Anglia Ruskin University have not received approval from the Health and Care Professions Council. We hope that the higher education institutes will be able to achieve the necessary approval very quickly to allow student paramedics to qualify.

The following paragraphs focus on additional areas that we think would repay attention.

6.1 **Local Planning Authority and NHS liaison**

6.1.1 As a Group with four district council members, this was an area of particular interest to us. We knew from Breckland District Council's July 2014 scrutiny report on the situation surrounding de-registering of 1,500 patients from the Watton Medical Practice that liaison between planning authorities and the NHS was a matter of concern.

The difficulties at Watton Medical Practice were caused by the practice being unable to recruit, not by local housing growth, but the scrutiny commission was concerned that lack of consultation could leave NHS service and workforce planning lagging behind local developments, especially in primary care.

6.1.2 Breckland Overview and Scrutiny Commission recommended 'That NHS England, Clinical Commissioning Groups and Local Practices should be consulted with regards to planning applications to assist with future staffing requirements'. NHS bodies are not statutory consultees for planning applications for new development.

6.1.3 We spoke with representatives of South Norfolk and Breckland Councils as we knew for certain that they have been routinely consulting with NHS on planning matters. We also contacted the other Norfolk planning authorities (including the Broads Authority and Norfolk County Council) by

email to check on their experience of consultation with the NHS on local plan development and major planning applications. We did not receive responses from all the planning authorities but from the six we got we saw a mixed picture of consultation and NHS response. All recognise the need for liaison but our impression is that local authorities are unclear about which NHS organisations they should consult. This may be as a result of the major reorganisation of NHS commissioning from 2012 onwards.

We also heard of instances where planning authorities had consulted NHS England, NHS Property Services, CCGs or GP practices and had not received responses. In some cases this left them unsure of whether they had contacted the right body.

NHS England Midlands and East (East) told us that they had, with support from NHS Property Services, been trying establish improved links with the Local Planning Authorities in Norfolk and establish how the CCGs can best be involved in the planning process. A workshops had been held in January 2015 with the central Norfolk CCGs, Broadland, Breckland, South Norfolk and Norwich councils, Norfolk County Council (including the interim Director of Public Health) and the Greater Norwich Partnership. Follow up meetings were also held with Breckland and South Norfolk councils and each of the CCGs. Another workshop was planned for Greater Norwich to develop a more strategic approach to requirements for future health infrastructure required to address growth.

Estimates that one GP is needed to cover a community of 1,800 people, or one care home, emphasise the need for pre-consultation with the NHS on the development of large care homes.

Our discussions with local planners and with doctors strongly suggest to us that it would be better to consult with CCGs rather than with individual GP practices as CCGs are more likely to have the capacity to respond in time.

6.1.4 Local authorities need to know the implications of housing and other developments for the local NHS not least because local people raise the question but also because the Community Infrastructure Levy (CIL) may be spent on health and social care infrastructure.

CIL differs from Section 106 planning obligations income in that it does not need to be used for providing infrastructure on the site it is collected from. Any infrastructure which is directly required as a result of a development continues to be sought through Section 106, as is affordable housing provision. S106 obligations therefore remain alongside CIL but are restricted to that infrastructure required to directly mitigate the impact of a proposal. Regulations restrict the use of planning obligations to ensure that individual developments are not charged for the same items of infrastructure through both S106 and CIL.

District councils may also wish to consider innovative ways in which developers' S106 contributions could be used to support healthcare recruitment in certain circumstances. For instance, in London there have been schemes whereby incoming essential workers have been offered special house buying / renting rates.

6.1.5 Planning authorities need to be clear on how to consult with the NHS and NHS organisations need to be ready to respond to consultation within the statutory timescales. For this they need good evidence to hand on which to base their response.

Norfolk County Council Public Health manages the Norfolk Joint Strategic Needs Assessment (JSNA) which includes demographic, health and housing needs information and has been piloting a specific piece of work in west Norfolk. This was initiated when the Borough of King's Lynn and West Norfolk sought a response from NHS West Norfolk CCG to their consultation on the 'Detailed Policies and Sites Plan' which sets out specific new sites and land areas to accommodate the planned 16,000 new dwellings in the borough up to 2026.

Norfolk County Council Public Health was engaged to work with the CCG on a systematic and evidence based approach. This consisted of

A) Mathematical modelling to calculate health infrastructure needs

The London Healthy Urban Development Unit (HUDU) has developed a comprehensive tool to assess the health service requirements and cost impacts of new residential developments. The mathematical model is being reconfigured with local data variables and is nearing completion for adoption of use in West Norfolk. The model has potential for further adjustment for use in the rest of Norfolk local authorities.

The model calculates:

- The net increase in population resulting from new development
- Health activity levels
- Primary healthcare needs (GPs and community health facilities)
- Hospital beds and floor space requirements
- Other healthcare floor space
- Capital and revenue cost impacts

This information can then be used to influence the planning process via S106 planning negotiations or Community Infrastructure Levy (CIL) and to gain necessary resources for health improvements or expansion. It is likely that provision of additional healthcare requirements will require commissioning of a range of primary, community and secondary health and social care services; hence it could be a useful tool for health planners and commissioners.

B) Mapping of housing locations and health facilities

Strategic Health Asset Planning and Evaluation (SHAPE) tool is a web-enabled, evidence-based application that informs and supports the strategic planning of services and physical assets across a whole health economy.

SHAPE links national datasets for clinical analysis, public health, primary care and demographic data with estates, performance and facilities location. SHAPE uses Geographical Information Systems (GIS) to map the site location of every NHS site and facility, and this includes GP practices, hospitals, care homes, dentists, pharmacies and others. SHAPE has an in-built travel time and 'crow flies' catchment area which can be used to indicate access for use by the future residents of a planned residential development. SHAPE affords visualisation of impact and/or access to healthcare facilities as a result of new housing developments.

The process, so far, has involved regular and ad-hoc engagement with a wide range of key stakeholders drawn from West Norfolk CCG, NHS England Area Team, NHS Estates, Public Health England, planning officials from Norfolk District Councils and Norfolk County Council, and planning strategy groups. This will be extended to include members of Patient Participation Groups (PPGs).

The establishment of an agreed process linking local authority planners with health service commissioners, incorporating the elements described above, is now anticipated to be completed by the autumn of 2015.

6.1.6 We **recommend** that Public Health, Norfolk County Council, takes the lead to co-ordinate liaison between local planning authorities (LPAs) and the local NHS across Norfolk to ensure that the LPAs consult effectively with the NHS and that the NHS has the necessary information to be able to respond, based on evidence of growing needs modelled on the LPA geographic area.

6.2 **Healthcare education and training in west Norfolk**

6.2.1 **Each of the NHS provider organisations that operate in west Norfolk told us that it is the most difficult area in which to recruit staff**. It therefore seems to us that as much healthcare education and training as possible should be delivered in the area so that people who train there might be attracted to stay.

6.2.2 Nursing and paramedicine are both degree level professions but the College of West Anglia (COWA) does not currently offer degree courses. It has in recent years introduced level 3 pre-nursing and pre-paramedic courses.

6.2.3 COWA has a partnership with Anglia Ruskin University (Essex) and has received £6.5 million from the Local Enterprise Partnership for a higher education centre at King's Lynn. Work will start in September 2015 and the building will open in 2016. To run healthcare degree courses COWA would need university status and accreditation by the Royal College of Nursing and Midwifery would be needed before it could offer nursing degrees. Health Education East of England also pointed out to us that if COWA was accredited as a provider of nursing degrees it could only commission places from it by commissioning fewer at other universities in the region.

6.2.4 Given the national shortages, the mandate to HEE to enable more nurses to be trained (see paragraph 5.3.2), the Health Secretary's call for expansion of nurse training programmes (reported in the Health Service Journal 10 June 2015) and vast sums currently being spent on agency and locum staff across the NHS, we consider that provision of degree courses at COWA, including nursing, paramedicine and social work would be a very positive move.

6.2.5 We **recommend** that Health Education East of England and the College of West Anglia work together with all the necessary partners with a view to receiving accreditation and providing health care degree courses in King's Lynn as soon as is practicable.

6.2.6 We recognise that even if our recommendation at 6.2.5 is accepted and all the relevant agencies work towards providing degree courses at COWA with all possible speed, it will take some time to achieve. However, we could start to see student nurses in the west of the county much more quickly if UEA would make placements at the Queen Elizabeth Hospital (QEH), Norfolk Community Health and Care NHS Trust (NCH&C) and Norfolk and Suffolk NHS Foundation Trust in west Norfolk available as part of their degree course. As mentioned in paragraph 5.3.3., we understand that Health Education East of England is in discussions with UEA and the local providers to make this happen.

6.2.7 We **recommend** that Health Education East of England, UEA School of Health Sciences, the Queen Elizabeth Hospital NHS Foundation Trust and Norfolk Community Health and Care NHS Trust urgently reach agreement and make arrangements for UEA nursing students to be offered placements in west Norfolk.

6.3 Resources for GP training in Norfolk

6.3.1 We understand that there is a serious imbalance in the levels of Service Increment for Teaching (SIFT) funding paid to university medical schools in England. Norwich Medical School receives £29,000 per student per annum but some universities receive much more. SIFT is used to support GP training in general practice and UEA could potentially attract more GP practices to provide training if it received a fairer share of the funding, which is distributed from national level. We understand that there is a

programme in place to level out the imbalances but at the current rate it will take 17 years to achieve equal funding.

6.3.2 Bearing in mind the severe difficulties in recruiting GPs in this county and region, we **recommend** that local MPs raise the issue of the Service Increment Funding for Teaching (SIFT) with the Department of Health, with a view to speeding up progress towards a fair share for Norwich Medical School.

6.4 Promoting Norfolk

6.4.1 We know that the problems of NHS workforce supply, especially for GPs, cannot be solved simply by good advertising or by promoting Norfolk as a nice place to study, work and live. Nevertheless, we are certain that it is worth trying to attract as many applicants as possible for healthcare courses and jobs in the county by active promotion and marketing.

6.4.2 West Norfolk Alliance's recruitment portal is a very good example of public sector organisations working together to produce a useful resource for recruitment and other parts of the county may wish to consider a similar initiative.

6.4.3 The fact is that everyone in Norfolk depends on the health service, including the staff of the large private sector employers, and we all have a stake in its success. We **recommend** that the Local Enterprise Partnerships in Norfolk and Cambridgeshire works with local NHS organisations and Higher Education Institutes to explore innovative ways to support attraction and recruitment of healthcare students and workers to Norfolk.

6.5 Healthcare careers advice for young people

6.5.1 All the provider organisations we met are already active in promoting their organisations at careers fairs and special events in the region and several told us about how they work with schools. HEEoE's Health Ambassador roles are also a good initiative to raise awareness of healthcare careers (see paragraph 5.3.2).

6.5.2 We were, however, struck by some comments which suggested to us that more could be done to encourage young people's ambitions towards careers in the health service. One local doctor mentioned that very few local sixth formers have ever asked for work experience at his surgery and yet nearly all applicants to medical schools will have done work experience with a GP practice or nursing home. We also heard about a national survey which has highlighted the inadequacy of careers advice across England in relation to local labour market opportunities.

6.5.3 Certain allied health profession students on university courses leading to registration with the Health and Care Professions Council are eligible for financial help from the NHS. The New Deal 10 point plan for practice also

includes target financial incentives for GP trainees in some areas. These things are worth promoting to local young people.

6.5.4 We realise that dissemination of information depends on the co-operation of individual schools and that their boards of governors are responsible for what happens but we **recommend** that Norfolk County Council Children's Services explores ways in which co-operation between schools, including primary schools, and local NHS organisations, higher education institutes and Health Education East of England can be encouraged to promote early awareness of healthcare roles and career opportunities in the local healthcare system, to achieve 100% coverage of Norfolk's secondary schools and sixth form colleges.

6.6 Information for the public about new roles and new models of primary care

6.6.1 Our scrutiny has left us in no doubt that primary care will have to change and change rapidly. Rising demand and the shortage of GPs make it inevitable. We are concerned that there has been very little information for the public on what this will mean for them.

6.6.2 It is early days for new roles such as Physicians Associate and the new models for provision of care proposed by the Five Year Forward View are still being piloted (and none of the vanguard sites are in Norfolk). However, it will be important that the public understand what the new professional staff are able to do and that they are prepared for change in the way that general practice operates.

6.6.3 We **recommend** that NHS England Midland and East (East) and Norfolk's Clinical Commissioning Groups consider how the public will be engaged and informed as changes to the skill mix and delivery of primary care are introduced.

6.7 Workforce planning process

6.7.1 Health Education East of England and the provider organisations are clearly working very hard to get the workforce planning process as good as it can be. There are just a few aspects of the process that caused us some unease.

6.7.2 Community providers referred to the short term funding of services by CCGs which meant that they could not plan for those staff requirements longer term even though they knew that in all probability the staff would be required. In previous years this had led to them making submissions to HEEoE that were accurate according to the funded position but likely to be an under estimate of future years' requirements. HEEoE assured us that it challenges provider submissions, expects them to take CCG strategic intentions into account and requires their boards to sign off the submissions as accurate. We are not entirely sure that provider boards

would wish to sign off a submission of requirements that goes beyond the funded position.

6.7.3 One community provider told us about the extreme demographics of its workforce with very many staff due to retire in the coming years and felt that HEEoE's five year forecasting template did not take full account of the situation. The mental health trust also told us about the challenges of demographics with an aging workforce. Its retirement projections have led it to implement flexible retirement arrangements, including re-engagement post-retirement to try and retain experienced staff. HEEoE assured us that it takes retirements into account in its planning but we are not completely assured about the depth of the analysis.

6.7.4 We **recommend** that HEEoE checks with the community providers, and other providers if necessary, on the issues of funded services versus probable requirements and the forecast number of front-line staff retirements and involves CCGs in the discussions if necessary.

7. Conclusion

7.1 The recommendations of the Breckland District Council scrutiny in July 2014 were:-

1. That NHS England review the rules and guidelines for becoming a dispensing practice and to consider whether they had an impact on the recruitment and retention of GPs.
2. That NHS England, Clinical Commissioning Groups and Local Practices should be consulted with regards to planning applications to assist with future staffing.

The first recommendation has been subsumed in the New Deal for General Practice work on which NHS England is currently engaged. The aim of the second recommendation we have supported with our recommendation to Norfolk Public Health (see paragraph 6.1.6).

7.2 NHS workforce planning is a complex business and we are currently experiencing the expensive consequences of lack of foresight in the past. We are satisfied that the problems are fully recognised at national, regional and local level. All parts of the local health system, the higher education institutions and Health Education East of England are working hard to deal with the immediate challenges and improve workforce planning for the future.

7.3 Our health scrutiny experience has taught us that the health and social care system is a delicate balance and that seemingly sensible and expedient decisions in one part can have unforeseen and unfortunate effects in another, which then rebound on everyone.

7.4 Co-ordination and co-operation between all the different organisations involved is the key and there are already plenty of forums in the county

where that can happen. We would urge all the organisations, large and small, to make use of the opportunities to meet and we wish them well in securing the future healthcare workforce for Norfolk.

Recommendations		To
1.	That Public Health, Norfolk County Council, takes the lead to co-ordinate liaison between local planning authorities (LPAs) and the local NHS across Norfolk to ensure that the LPAs consult effectively with the NHS and that the NHS has the necessary information to be able to respond, based on evidence of growing needs modelled on the LPA geographic area. (paragraph 6.1.6.)	Interim Director of Public Health
2.	That Health Education East of England and the College of West Anglia work together with all the necessary partners with a view to receiving accreditation and providing health care degree courses in King's Lynn as soon as is practicable. (paragraph 6.2.5)	Health Education East of England College of West Anglia
3.	That Health Education East of England, UEA School of Health Sciences, the Queen Elizabeth Hospital NHS Foundation Trust, Norfolk Community Health and Care NHS Trust and Norfolk and Suffolk NHS Foundation Trust urgently reach agreement and make arrangements for UEA nursing students to be offered placements in west Norfolk (paragraph 6.2.7)	Health Education East of England Queen Elizabeth Hospital NHS Foundation Trust Norfolk Community Health and Care NHS Trust Norfolk and Suffolk NHS Foundation Trust
4.	That local MPs raise the issue of the Service Increment Funding for Teaching (SIFT) with the Department of Health, with a view to speeding up progress towards a fair share for Norwich Medical School. (paragraph 6.3.2)	Norfolk MPs (x 9)
5.	That the Local Enterprise Partnerships in Norfolk and Cambridgeshire work with local NHS organisations and Higher Education Institutes to consider innovative ways to support recruitment of healthcare students and workers to Norfolk (paragraph 6.4.3)	Local Enterprise Partnerships (Norfolk & Cambridgeshire)

Recommendations		To
6.	That Norfolk County Council Children's Services explores ways in which co-operation between schools, including primary schools, and local NHS organisations, higher education institutes and Health Education East of England can be encouraged to promote early awareness of healthcare roles and career opportunities in the local healthcare system, to achieve 100% coverage of Norfolk's secondary schools and sixth form colleges. (paragraph 6.5.4)	Interim Director of Children's Services
7.	That NHS England Midland and East (East) and Norfolk's Clinical Commissioning Groups consider how the public will be engaged and informed as changes to the skill mix and delivery of primary care are introduced (paragraph 6.6.3)	NHS England Midlands & East (East) CCGs x 5
8.	That HEEoE checks with the community providers, and other providers if necessary, on the issues of funded services versus probable requirements and the forecast number of front-line staff retirements and involves CCGs in the discussions if necessary. (paragraph 6.7.4)	Health Education East of England

Appendix 1

Terms of Reference

Norfolk County Council
Norfolk Health Overview and Scrutiny Committee (NHOSC)
Terms of reference for scrutiny of NHS workforce planning in Norfolk
Scrutiny by Task and finish group
Membership of task and finish group 5 Members of NHOSC 1 co-opted Member of Healthwatch Norfolk (non voting)
Reasons for scrutiny NHOSC is aware of instances of clinical staff shortages that have come to its attention in recent years, where despite adequate funding being available NHS providers have been unable to recruit sufficient paramedics, hospital nurses, midwives, mental health professionals, and stroke consultants. The Committee is also aware of major difficulties in recruiting GPs to work at practices in Norfolk. NHOSC is concerned that:- 1. Clinical staff shortages will ultimately have a detrimental effect on the health service delivered to patients 2. The shortage of GPs may cause a severe knock-on effect by increasing urgent demand on secondary health care services, which will ultimately affect their ability to deliver timely elective services.
Purpose and objectives of study 5. To understand the extent of unfilled clinical vacancies due to recruitment difficulties across primary, community and secondary care in Norfolk. 6. To understand the process of NHS workforce planning from national to local level and to understand where responsibilities lie. 7. To discuss action that is already underway, or that could be taken, to ease clinical workforce shortages in the areas identified at 1. 8. To make recommendations, if appropriate, on actions that could be taken to improve workforce planning and recruitment and retention of clinical healthcare staff.

Issues and questions to be addressed

General

1. Do the System Resilience Groups in east, west and central Norfolk have a complete picture of clinical workforce shortages currently affecting services in Norfolk and likely to affect them in future?
2. What is the assessment of risk posed by clinical workforce shortages in the county?
3. What can be done locally to tackle the risks posed by clinical workforce shortages (community and acute) in the short term and longer term?
4. What is the process through which Health Education England (HEE), HEE East of England and Norfolk and Suffolk System Resilience Group gather information on which to plan education of the future workforce, which may need a different mix of skill from the current workforce? Can the process be improved? (e.g. how to include the workforce needs of the private providers and the multidisciplinary needs for integrated health and social care services?)
5. How will current health care education programmes address future workforce requirements?
6. What can councils do to work with the NHS in attracting medical and other clinical staff to live and work in Norfolk?
7. Are there areas of best practice where recruitment has been successful and from which lessons could be learned?
8. What more can be done to improve retention of community and acute medical / clinical workforces and attract people who have left to return to the professions.
9. What would be the best way for local planning authorities to consult with the NHS in respect of major planning applications, planning applications for care and nursing homes, and policy development?
10. Does the group support the recommendation made by Breckland Council:-

    That NHS England, Clinical Commissioning Groups (CCGs) and local practices should be consulted with regards to planning applications to assist with future staffing requirements.

Regarding primary care

11. Why are GPs opting for
    a. locum work in preference to salaried positions
    b. salaried positions in preference to partnership

    and what effect does this have on provision of primary care?
12. Is there an opportunity for CCGs to influence the mix of partners and variety of salaried clinical staff that GP practices seek to recruit to provide better overall cover in primary care?
13. Is there potential for mental health staff, health visitors and social workers to work in practices alongside other clinicians?
14. How can other professions, e.g. pharmacy, be involved in reducing pressure on general practice?
15. What effect do the rules and guidelines for becoming a dispensing practice have on GP recruitment and viability of a practice?

16. Does the group support the recommendation made by Breckland Council:-

    That NHS England reviews the rules and guidelines for becoming a dispensing practice and consider whether they have an impact on the recruitment and retention of GPs.
17. Does the national NHS funding formula disadvantage recruitment of GPs into Norfolk? (e.g. is there sufficient recognition of the needs of older people in the funding formula?)
18. How is NHS England EAAT managing the review of PMS (Personal Medical Services) contracts in Norfolk in view of the GP recruitment difficulties that already exist?
19. Would it be helpful to increase the number of training practices in Norfolk and, if so, what is being done in this respect?
20. What can be done to encourage medical schools to focus more on primary care?
21. What more could be done to encourage postgraduates to take up the available GP training places?
22. What progress has been made following the General Practice Workforce Summit convened by the EAAT on 17 October 2014?
23. What are the issues regarding provision of primary care premises and what could be done to resolve them?

People to speak to

- System Resilience Groups x 3 - Central Norfolk; Great Yarmouth and Waveney; West Norfolk.
- NHS England EAAT
- Norfolk and Waveney Local Medical Committee
- Norfolk and Suffolk Workforce Partnership
- Health Education East of England
- NHS provider organisations x 7
    - East of England Ambulance Service NHS Trust (EEAST)
    - Norfolk and Norwich University Hospital (N&N)
    - The Queen Elizabeth Hospital (QEH)
    - The James Paget University Hospital (JPH)
    - Norfolk and Suffolk NHS Foundation Trust (NSFT)
    - Norfolk Community Health and Care (NCH&C)
    - East Coast Community Healthcare (ECCH)
- University of East Anglia Medical Faculty
- A local planning authority (*suggest the group chooses one of the 7 to talk through the issues)*
- Norfolk County Council:-
    - Interim Lead Human Resources (HR) and Organisational Development (OD) Business Partner for Adult Social Services
    - Lead HR and OD Business Partner for Children's Services
    - Interim Director of Integrated Care

Other sources of information Health Education England The Royal Colleges The British Medical Association
Style and approach • Panel-style meetings with representatives from the organisations listed above. *These may be held at County Hall or at the organisations' premises, as convenient.*
Planned outcomes A report to Norfolk Health Overview and Scrutiny Committee with the Task and Finish Group's findings and recommendations, if appropriate, on what more could be done to improve NHS workforce planning in Norfolk.
Deadlines and timetable It is expected that the task and finish group will report back to Norfolk Health Overview and Scrutiny Committee by July 2015. It is expected that the work can be completed in approximately 6 meetings. Details of the programme will depend on availability of Members, NHS representatives and emerging findings.

Terms of reference agreed by	**Date**
Norfolk Health Overview and Scrutiny Committee	15 January 2015

Appendix 2

Information received by NHS Workforce Planning in Norfolk Scrutiny Task & Finish Group

Include all minutes & notes

1. Norfolk and Waveney Local Medical Committee's report to NHOSC 24 November 2014

2. 'NHS Workforce Planning for Norfolk' extract from NHOSC minutes of 24 November 2014

3. NHS Five Year Forward View, October 2014

4. 'Building the Workforce – the New Deal for General Practice' – Royal College of General Practice, British Medical Association, NHS England and Health Education England, 26 January 2015

5. 'Forward View into Action' – options for new models of care

6. 'Central Strategic Resilience Group – workforce assurance' report presented to NHOSC on 24 November 2014

7. East of England Ambulance Service NHS Trust – report on 20 March 2015

8. Norfolk and Norwich University Hospitals NHS Foundation Trust – report 20 March 2015

9. Queen Elizabeth Hospital NHS Foundation Trust - report on 20 March 2015

10. Norfolk and Suffolk NHS Foundation Trust – report on 20 March 2015

11. East Coast Community Healthcare – report on 31 March 2015

12. Norfolk Community Health and Care NHS Trust – report on 31 March 2015

13. Report to Community Services Overview and Scrutiny Panel, 4 March 2014, item 14 – Section 75 Agreement for a Joint Integrated Management structure between Norfolk County Council and Norfolk Community Health and Care Trust

14. West Norfolk Alliance – Workforce Emerging Challenges – Clinical Reference Group 4 June 2014

15. Operational resilience and capacity planning for 2014/15 – Monitor, Trust Development Authority, Directors of Adult Social Services, NHS England, 13 June 2014

16. Norfolk County Council Children's Services – responses to questions posed by the NHS Workforce Scrutiny Group – 14 May 2015

17. NHS England East Anglia Area Team – Report to Norfolk Health Overview and Scrutiny Committee, 24 November 2015

18. James Paget University Hospitals NHS Foundation Trust – report on 14 May 2014

19. Responses to the Task & Finish Group's questions to the Local Dental Committee – reported on 14 May 2015

20. Great Yarmouth and Waveney Clinical Commissioning Group – Workforce Resilience update – reported on 21 May 2015

21. Health Education East of England – responses to the Task & Finish Group's questions – reported on 21 May 2015

22. Responses to the Task & Finish Group from Local Planning Authorities – Reported 21 May 2015

23. UK Shortage Occupation List 2015

24. Partial Review of the Shortage Occupation Lists for the UK and for Scotland - Migration Advisory Committee – February 2015

25. Royal College of Practitioners – A blueprint for building the new deal for general practice in England – 18 May 2015

26. The King's Fund – Workforce Planning in the NHS – April 2015

27. Information from Norfolk & Suffolk Workforce Partnership on Health Ambassadors – reported 9 June 2015

28. Information from Norfolk County Council Public Health – NHS and Public Health Approach to Local Housing Strategy – an update to Norfolk HOSC 31 May 2015 – reported 9 June 2015

29. Minutes of Task & Finish Group meetings with witnesses:-

10 Feb 2015	-	Norfolk & Waveney Local Medical Committee
	-	Central System Resilience Group
20 Mar 2015	-	East of England Ambulance Service NHS Trust
	-	Norfolk and Norwich University Hospitals NHS Foundation Trust
	-	The Queen Elizabeth Hospital NHS Foundation Trust
	-	Norfolk and Suffolk NHS Foundation Trust
31 Mar 2015	-	East Coast Community Health Care

	-	Norfolk Community Health and Care
	-	Integrated Health and Adult Social Services
	-	Norfolk County Council Public Health
22 Apr 2015	-	Local Planning Authorities – South Norfolk and Breckland
	-	University of East Anglia – Norwich Medical School
12 May 2015	-	West Norfolk System Resilience Group
	-	College of West Anglia
14 May 2015	-	Children's Services – Norfolk County Council
	-	University of East Anglia – School of Health Sciences
	-	NHS England Midlands and East
	-	James Paget University Hospitals NHS Foundation Trust
21 May 2015	-	Great Yarmouth and Waveney System Resilience Group
	-	Health Education England / Norfolk and Suffolk Workforce Partnership

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 act as link members with local NHS provider trusts and Clinical Commissioning Groups

2. NHOSC appointments

2.1 NHOSC appoints members to act as link members with local NHS Trusts and Clinical Commissioning Groups (CCGs). The role is to attend the Trust Board / Council of Governors or CCG Governing Body meetings held in public to keep abreast of developments and to raise with NHOSC any matters which may warrant the committee's attention. NHOSC also appoints substitutes to act in these roles.

2.2 The following vacancies exist for link members (NHOSC appointed Mrs J Chamberlin as link member for Great Yarmouth and Waveney CCG on 28 May 2015 but Mrs Chamberlin has asked to stand down from the role because she will not be able to attend on most of the the Governing Body's meeting dates) :-

Link member vacancies

Trust / CCG	**Programmed meetings**
Norfolk Community Health and Care NHS Trust (former link – Mrs J Chamberlin)	Public Board Meeting (all at 09:30-12:00):- 29 July 2015 (Cromer) 26 August 2015 (Norwich) 30 Sept 2015 (King's Lynn) 28 October 2015 (Norwich) 25 Nov 2015 (Norwich)
Queen Elizabeth Hospital NHS Foundation Trust	Public Board Meetings (all at the Queen Elizabeth Hospital starting at approximately 13:00hrs) :- 28 July 2015 29 September 2015 24 November 2015 26 January 2016 29 March 2016

NHS Great Yarmouth and Waveney CCG (former link Mrs S Weymouth)	Governing Body meetings (all at 13:00-17:00hrs in Beccles):- 23 July 2015 24 September 2015 5 November 2015

2.3 The following vacancies exist for substitute link members:-

Substitute link member vacancies

Trust / CCG	**Programmed meetings**
NHS North Norfolk CCG	Governing Body meetings (all at 14:00- 16:30hrs in Aylsham) 21 July 2015 15 September 2015 17 November 2015
NHS South Norfolk CCG	Governing Body meetings (all at 13:30-15:30hrs in Hethel Engineering Centre) 7 July 2015 8 September 2015 3 November 2015
NHS Great Yarmouth and Waveney CCG (formerly Mrs J Chamberlin)	As above
NHS West Norfolk CCG	Governing Body meetings (all at 09:30hrs in King's Lynn) 30 July 2015 27 August 2015 24 September 2015 29 October 2015 26 November 2015 14 December 2015
Norfolk and Suffolk NHS Foundation Trust	Board of Directors (normally 09:30-12:30hrs) 23 July 2015 (Norwich) 24 September 2015 (Ipswich) 22 October 2015 (Norwich) 26 October 2015 (Ipswich)

2. Action

2.1 The Committee is asked to:-

(a) Appoint members to the link member and substitute link member roles listed at paragraph 2.2 and the substitute link member roles listed at 2.3.

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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 2015

Meeting dates	*Briefings/Main scrutiny topic/initial review of topics/follow-ups*	*Administrative business*
3 Sept 2015	Diabetes Care within Primary Care Services in Norfolk – NHS England Midland and East (East), Central Norfolk Diabetes Network and West Norfolk Clinical Commissioning Group will report on the services delivered in primary care. Continuing Health Care – to receive consultation from North Norfolk, South Norfolk, Norwich and West Norfolk CCGs on proposals for policy changes.	
15 Oct 2015	Policing and Mental Health Services - an update from the Police & Crime Commissioner for Norfolk, Norfolk and Suffolk NHS Foundation Trust and Norfolk Constabulary (further to the presentation given to NHOSC in October 2014). *NHS Workforce Planning in Norfolk – responses to NHOSC's recommendations agreed on 16 July 2015.*	*Subject to approval by NHOSC on 16/7/15*
3 Dec 2015	Stroke Services in Norfolk - update (12 months after the responses to stroke recommendations, presented to NHOSC 27 November 2014)	

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

Provisional dates for reports to the Committee / items in the Briefing 2016

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

Jan 2016 – Continuing Health Care – final consideration of the four CCGs' proposals (depending on confirmation by NHOSC on 3 Sept 2015)

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

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

NHOSC Scrutiny Task and Finish Groups

Task & finish group	**Membership**	**Progress**
NHS Workforce Planning in Norfolk	Cllr Michael Chenery of Horsbrugh Cllr Alexandra Kemp Cllr Nigel Legg Cllr Margaret Somerville (Chairman) Alex Stewart – Healthwatch Norfolk Robert Kybird (co-opted, non voting lay member)	To present a report to NHOSC on 16 July 2015

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

Norwich	-	Mr Bert Bremner (substitute Mrs M Somerville)

NHS Provider Trusts

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

Norfolk Health Overview and Scrutiny Committee 16 July 2015

Glossary of Terms and Abbreviations

A&E	Accident and Emergency
ATA	Alternative to Admission
CCG	Clinical Commissioning Group
CFWI	Centre for Workforce Intelligence
CIL	Community infrastructure levy
CLIP	Collaborative Learning in Practice
COWA	College of West Anglia
CQC	Care Quality Commission
DH / DoH	Department of Health
DIST	Dementia Intensive Support Team
DOM	Duty Operations Manager
EAAT	East Anglia Area Team
ECA	Emergency Care Assistant
ECCH	East Coast Community Healthcare
ECP	Emergency Care Practitioners
EEA	European Economic Area
EEAST	East of England Ambulance Service NHS Trust
EU	European Union
FD	Foundation degree
GIS	Geographic Information System
GMC	General Medical Council
GMS	General Medical Services
GP	General practitioner
HCA	Health Care Assistant
HCRT	Home Crisis Resolution Team
HEEoE	Health Education East of England
HEE	Health Education England
HEFCI	Health Education Funding Council for England
HSCIC	Health and Social Care Information Centre
HUDU	Healthy Urban Development Unit
JPUH & JPH	James Paget University Hospital
JSNA	Joint strategic needs assessment
LAT	Locums Appointed for Training
LETB	Local Education and Training Board
LMC	Local Medical Committee
LPA	Local Planning Authority
MAC	Migration Advisory Committee
MBA	Masters of Business Administration

NCH&C (NCHC)	Norfolk Community Health and Care NHS Trust
NHOSC	Norfolk Health Overview and Scrutiny Committee
NHS E M&E (E)	NHS England Midlands and East (East)
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)
NSWP	Norfolk and Suffolk Workforce Partnership
ONS	Office of National Statistics
PMS	Personal Medical Services
PMO	Programme Management Office
PPG	Patient Participation Group
QEH	Queen Elizabeth Hospital, King's Lynn
QOF	Quality outcomes framework
RCGP	Royal College of General Practitioners
RCN	Royal College of Nursing
RLMT	Resident Labour Market Test
RMN	Registered Mental Nurse
RN	Registered Nurse
S106	Section 106 (of the Town and Country Planning Act 1990 (as amended)) – a mechanism by which a development proposal can be made acceptable in planning terms, that would not otherwise be acceptable
SAP	Student Ambulance Paramedic
SHA	Strategic Health Authority
SHAPE	Strategic Health Asset Planning and Evaluation
SOL	Shortage Occupation List
SRG	System Resilience Group
UEA	University of East Anglia
WTE	Whole time equivalent