Health & Wellbeing Board

Date: **Wednesday 8 January 2014**

Time: **9:30am to 1pm (*Note earlier start time and new venue)***

Venue: **Room 16, Abbey Conference Centre, Norwich**

Membership	Substitute	Representing
William Armstrong	Alex Stewart	Chair, Healthwatch Norfolk
Cllr Brenda Arthur		Norwich City Council
Cllr Yvonne Bendle (Vice-Chairman)	Cllr Lisa Neal	South Norfolk Council
Stephen Bett	Jenny McKibben	Norfolk's Police and Crime Commissioner
Harold Bodmer	Catherine Underwood	Director Community Services
Dr Jon Bryson	Ann Donkin	South Norfolk Clinical Commissioning Group
Pip Coker	Dan Mobbs	Voluntary Sector Representative
T/ACC Nick Dean	C/Sup Jo Shiner	Norfolk Constabulary
Dr Anoop Dhesi	Mark Taylor	North Norfolk Clinical Commissioning Group
Tracy Dowling		Director of Operations & Delivery, NHS England, East Anglia Team
Richard Draper	Dan Mobbs	Voluntary Sector Representative
Andy Evans	Kate Gill	Great Yarmouth & Waveney Clinical Commissioning Group
Cllr Angie Fitch-Tillet	Mark Taylor	North Norfolk District Council
Anne Gibson		Chief Executive (Acting), Norfolk County Council
Joyce Hopwood	Dan Mobbs	Voluntary Sector Representative
Cllr James Joyce		Cabinet Member, Safeguarding Children, Norfolk County Council
Cllr Penny Linden	Cllr Marlene Fairhead	Great Yarmouth Borough Council
Sheila Lock	Michael Rosen	Director Children's Services
Dr Ian Mack (Vice-Chairman)	Sue Crossman	West Norfolk Clinical Commissioning Group
Lucy Macleod		Interim Director of Public Health
Cllr Elizabeth Nockolds		King's Lynn and West Norfolk Borough Council
Dr Chris Price	Jonathon Fagge	Norwich Clinical Commissioning Group
Cllr Andrew Proctor	Cllr Roger Foulger	Broadland District Council
Cllr Daniel Roper **(Chairman)**		Cabinet Member, Public Protection, Public Health, Trading Standards, Fire & Rescue, Norfolk County Council
Cllr Lynda Turner		Breckland District Council
Cllr Sue Whitaker		Cabinet Member, Adult Social Services, Norfolk County Council

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

For further details and general enquiries about this Agenda please contact the Committee Administrator:
Julie Mortimer on 01603 223055
or email committees@norfolk.gov.uk

1	**Apologies**	Chair	
2	**Minutes** To confirm the minutes of the meeting held on 23 October 2013.	Chair	**(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.	Chair	
4	**To receive any items of business which the Chairman decides should be considered as a matter of urgency**	Chair	
Items for Business			
5	**Norfolk Joint Health and Wellbeing Strategy 2014-17** Report of the Interim Director of Public Health, NCC	Lucy Macleod	**(Page 11)**
6	**Clinical Commissioning Groups - Commissioning intentions** Reports of the 5 x Norfolk Clinical Commissioning Groups	CCGs	**(Page 32)**
7	**Integration and the Better Care Fund** Report of the Director of Community Services, NCC	Harold Bodmer	**To follow**
8	**Support for Parents and Carers of Children & Young People accessing Mental Health Services** Report of the Chief Officer, North Norfolk Clinical Commissioning Group	Mark Taylor	**(Page 88)**

9	**Pharmaceutical Needs Assessment (PNA)** Report of the Interim Director of Public Health, NCC	Lucy Macleod	**(Page 92)**
10	**Autism Self-Assessment Framework** Report of the Director of Community Services, NCC	Harold Bodmer	**(Page 96)**
11	**Report of the Cambridgeshire, Norfolk and Suffolk Joint Health Scrutiny Committee on Proposals for Liver Resection Services.** Report of the Head of Planning, Performance & Partnerships, NCC.	Debbie Bartlett	**To follow**
	Standing Items		
12	**Healthwatch Norfolk** • Minutes of the meeting held on 16 September 2013	William Armstrong	**(Page 152)**
13	**NHS England** • Verbal update including feedback from the Local Quality Surveillance Group (QSG)	Tracy Dowling, NHS England	
14	**Norfolk Health & Overview Scrutiny Committee** • Minutes of the meetings held on 10 October and 28 November 2013	Chair	**(Page 157)**

Close

Future Board meetings dates - all are on Wednesdays:

Venues to be confirmed

- 16 April 2014
- 16 July 2014
- 22 October 2014

Norfolk County Council
at your service

Health and Wellbeing Board
Minutes of the meeting held on Wednesday 23 October 2013
at 10am in the Green Room, Archive Centre, County Hall

Present:

Cllr Yvonne Bendle	South Norfolk Council
Pip Coker	Voluntary Sector representative
T/ACC Nick Dean	Norfolk Constabulary
Ann Donkin	South Norfolk Clinical Commissioning Group
Tracy Dowling	Director of Operations & Delivery, NHS England, East Anglia Team
Richard Draper	Voluntary Sector Representative
Joyce Hopwood	Voluntary Sector Representative
Cllr James Joyce	Norfolk County Council
Cllr Penny Linden	Great Yarmouth Borough Council
Dr Ian Mack	West Norfolk Clinical Commissioning Group
Lucy Macleod	Acting Director of Public Health
Jenny McKibben	Deputy Police and Crime Commissioner
Elizabeth Nockolds	Kings Lyn & West Norfolk Borough Council
Dr Chris Price	Norwich Clinical Commissioning Group
Cllr Andrew Proctor	Broadland District Council
Cllr Dan Roper	Cabinet Member for Public Protection, NCC
Michael Rosen	Assistant Director Early Help, NCC
Riana Rudland	Breckland District Council
Dr John Stammers	Great Yarmouth & Waveney Clinical Commissioning Group
Alex Stewart	Healthwatch Norfolk
Mark Taylor	North Norfolk Clinical Commissioning Group
Catherine Underwood	Director of Integrated Commissioning, Community Services, NCC

Others present:

Debbie Bartlett, Head of Planning, Performance and Partnerships, NCC

1 Apologies

Apologies were received from William Armstrong, Healthwatch (Alex Stewart substituting), Cllr Brenda Arthur, Norwich City Council; Stephen Bett, Norfolk Police & Crime Commissioner (Jenny McKibben substituting); Harold Bodmer, Director Community Services (Catherine Underwood substituting); Dr Jon Bryson South Norfolk Clinical Commissioning Group (Ann Donkin substituting), Dr Anoop Dhesi North Norfolk Clinical Commissioning Group (Mark Taylor substituting); Cllr Angie Fitch-Tillet, North Norfolk District Council; Sheila Locke, Interim Director Children's Services (Michael Rosen substituting); Anne Gibson, Norfolk County Council; Cllr Lynda Turner, Breckland District Council (Riana Rudland substituting) and Cllr Sue Whitaker, Norfolk County Council.

2 Welcome New Attendees

The Chairman welcomed Cllr James Joyce, NCC Cabinet Member for Safeguarding to his first meeting of this Board and Riana Rudland, attending from Breckland Council.

3 Minutes of the Health and Wellbeing Board meeting held on 10 July 2013.

The minutes of the Health and Wellbeing Board (H&WB) meeting held on 10 July 2013 were agreed as a correct record and signed by the Chairman.

4 Declarations of Interest

There were no declarations of interest.

5 To receive any items of business

There were no items of urgent business.

6 Norfolk County Council Budget Consultation

6.1 The Board received and noted a verbal report from the Head of Planning, Performance and Partnerships (PPP) on the Council's Putting People First public consultation on the budget proposals for 2014-17.

6.2 The following key points were highlighted during the discussion which followed:

- Debbie explained that talks were underway with organisations but she urged Board members to look at the proposals and to make submissions direct to the Council, bringing to bear their knowledge and expertise.
- The point was made that the Board should consider the impact of any cuts alongside the priorities of the Board.
- Members welcomed the briefing and that the information was for noting only as several confirmed their responses would be submitted once the input from their governing bodies had been sought.
- The role for input from the Board would arise once the outcome from the consultation was identified.

7 Early Help (Intervention) Strategy

7.1 The Board received a presentation from Sandra Dineen, Chair, Norfolk Early Help Programme, which set out a strategy for "Raising our Game on Early Help", following on from an informal workshop on the subject held in April.

7.2 The following key points were highlighted, following the presentation:

- There needed to be a serious commissioning intent, in order to meet the challenges raised.
- What work had been undertaken to deliver solutions issues locally, below district level, and involving the third sector level, rather than at a statutory level? In reply, it was confirmed that there was a role for community level engagement and that much was going on through the voluntary sector, without wider knowledge. It was also noted that information sharing was key to ensuring that, in practical terms, there was an opportunity to do so. It was **noted** that Tom Baker, Norfolk County Council's Head of ICT and Information Management would be invited to attend the January Board meeting to explain how the Council was working to develop the concept of an Information Hub for Norfolk.
- One of the key areas was support for young people at 10/11 years of age and emotional well-being and mental health issues. However, there were as yet no visible signs of service delivery to support them, and their families; the need for Early Help was vital to safeguarding them. Mark Taylor **agreed** to explore and bring back information in support of this point to the next meeting.

- It was noted that the Early Health Programme Board sat within a good governance structure. The Board considered that dialogue at H&WB level was vital to ensure a shared approach. Further thought was needed on the issues raised and what the role of the Board might be. It was, therefore, **agreed** that for a workshop on Early Help to be held on this issue, ideally before the January meeting. (Later in the meeting it was agreed to broaden this workshop out and to include Child Poverty).

- The Board recognised the need to think about identifying other underlying factors such as poor housing, lack of employment, and abuse, and how these factors affected young people. More work was needed to evidence these assumptions but it was clear that there was a need for this essential intelligence gathering, for example, to support Distinct Councils in ensuring the correct provision of housing.
- The Board **agreed** that resourcing was an issue and this should form part of the discussions on the subject at the next Board meeting in January. The need for a coherent strategy at a district level structure to support the delivery of early help initiatives was also identified for further discussion.

RESOLVED that the presentation be received.

8 Integration of Health and Social Care Services in Norfolk – An Update

8.1 The Board received a report, presented by the Director of Integrated Commissioning, which gave information on the progress from the Task & Finish Group, which had been charged with enabling an assessment to be made of integration in Norfolk. The report also provided an update on the three Norfolk bids which were submitted to the Department of Health to become Integration Pioneers (North Norfolk, Great Yarmouth & Waveney, and West Norfolk).

8.2 The following points and actions were noted during the discussion:

- Comment was made that more work was needed to ensure a customer approach as communication was an important element to good integration and the method of doing so.
- The Board **agreed** that the Terms of Reference for the task and finish group should be amended to give it more 'teeth'; to focus in on the key aspects of the task; include offender health and communication (as a key driver of integration).

- It was noted that this was phase 1 of the process
- Members **agreed** that work was needed to increase the pace and move to making recommendations for what actions needed to be taken in the near future to support longer term integration
- It was recognised that it was the role of the Health & Wellbeing Board to sign off the Integration Transformation Fund Plan which the County Council and Clinical Commissioning Groups are required to submit to NHS England and Local Government Association in February 2014. It was **agreed** that a report on this would be brought to the Board's meeting in January 2014.
- Suggestion was made that at the next meeting in January the Board should consider setting up a specific task group, to include representatives from the main providers, to oversee the detailed planning for the implementation in Norfolk of the Integration Transformation Fund.
- It was **agreed** that a paper be presented to the January meeting which reviews the processes/plans in place to support longer term integration, with a focus on

implementation of Integration Transformation funding and the risks that this poses to health/social care.

- Lastly, it was **agreed** that CCGs bring their commissioning intentions to the January meeting together with an update from all on progress on integration across Norfolk, including the West Norfolk Integration Pioneer and the other non-shortlisted Pioneer bids.

RESOLVED to receive to report and for a further report to be presented to the January meeting.

9 Developing a Norfolk Joint Health and Well-Being Strategy 2014-17 (JH&WBS)

9.1 The Board received a progress report, presented by the Head of PPP and the Acting Director of Public Health, NCC, who outlined the outcomes from the recent meeting of the JH&WB Strategy Group on the 3 development of the Board's 3 priorities. It was noted that work was now underway on the different approaches needed for each of the priorities including developing a breakdown of actions at different levels, including those targeted at key organisations, individuals/residents, front-line workers, etc.

9.2 The following points were noted during the discussion:

- Members reviewed the progress being made and **agreed** the need to see some concrete actions as it was felt that there had been limited progress to date
- It was recognised that these were challenging and complex areas to tackle and there were not instant solutions – and that the Board was learning as it worked through them
- There was some discussion about the Board's role and aspiration in developing a JH&WBS and it was acknowledged that, amongst other things, the Board was testing out models and potential roles for itself as it took this work forward.
- The Board asked the Strategy Group to narrow the focus to a set of more precise objectives and to make proposals for actions for the next meeting
- It was suggested that there was a need to bring in the 'voice of the people' and that workshops might be used to support this process

RESOLVED that action be taken by the Strategy Group to progress the development, with a further paper presented to the January meeting.

10a Community-led Health Improvement Work Programme - Update

10a.1 The Board received a progress report presented by the Acting Director of Public Health, NCC. The programme included the Healthy Communities project which had been set up to help local people identify the health and wellbeing issues that matter most to them.

10a.2

Members considered the progress being made and achievements to date with its community led health improvement work programme, which had been set up in 2012. RESOLVED to receive to report.

10b Funding allocation to Community-Led health Improvement 2013-14

The Board received a briefing note, presented by the Head of Planning, Performance and Partnerships (PPP).

Members noted the arrangements for the Board's funding allocation to locally-led health improvement for 2013/14. The funding would be used to support activities that would result in a demonstrable improvement in either, the agreed goals and priorities in the Board's

developing JH&WB Strategy 2014-17, or the existing priorities in the 2013-14 Strategy. The funding would be allocated to city, district and borough councils to work with their local partners to commission activities in line with the aims and outcomes identified in the briefing note. A further report from all 7 local authorities would be presented to the Board in July 2014.

RESOLVED to receive the report

11. Services for Adults with a Learning Disability: Outcomes of the Winterbourne View Enquiry

The Board received a report, presented by the Director of Integrated Commissioning.

RESOLVED that the report be noted and the terms of reference for the multi-agency Steering Group be approved.

12 Public Health Outcomes Framework

12.1 The Board received a presentation by the Acting Director of Public Health. She confirmed that this gave a reference point for the Board on its Strategy.

The following points were noted during the discussion:

- It was confirmed that the data presented was the lowest geographic level which could be obtained but that, depending on the method of data collection, it could be distilled further.

- The Board was advised that there was an ongoing watching brief on welfare reforms and a basket of indicators were monitored but it would be better to have more timely, monthly data to hand rather than the current annual information, for it to be in any way an effective monitoring tool.

- The Board discussed the possibility using some of this as a framework for monitoring the JH&WB Strategy and/or for developing the JSNA. It was agreed that further thought would be needed to develop this and take it forward.

RESOLVED that the Board note the presentation.

13 Healthwatch Norfolk

The H&WB received and noted the Healthwatch minutes of the meetings held on 8 July 2013.

14 NHS England

14.1 The Board received a verbal update from Tracy Dowling, Director of Operations and Delivery, NHS England East Anglia Team and noted feedback on key points from the latest CCG Checkpoint visits and the local Quality Surveillance Group meeting on 10 October 2013.

The Chairman thanked the Director of Operations and Delivery, NHS England East Anglia Team, for the update.

15 Norfolk Health Overview and Scrutiny Committee

The Board received and noted the minutes from the Norfolk Health Overview and Scrutiny Committee meeting held on 20 June and 5 September 2013.

The next meeting would take place on **Wednesday 8 January 2014** at 10am. The venue is to be confirmed.

The meeting closed at 12.14pm

Chairman

Report to Norfolk Health and Wellbeing Board
8 January 2014
Item 5

Cover Sheet

Developing a Norfolk Joint Health and Wellbeing Strategy 2014-17

What is the role of the HWB in relation to this paper?

The Health and Social Care Act 2012 sets out a number of legal responsibilities for the Health and Wellbeing Board, including a duty to prepare a Joint Health and Wellbeing Strategy

The Health & Wellbeing Board is currently developing a Joint Health and Wellbeing Strategy 2014-17 with a view to sign off of the Strategy in April 2014.

Key questions for discussion

What are your views on the:

- Overall direction of the draft Strategy?
- Proposals for “what do we need to do” and for who needs to take the lead?
- Key outcome measures and the proposal for pilot projects for each of the 3 x priorities?

Actions/Decisions needed

The Board needs to:

- Consider the report and give views on the direction, format and content of the draft strategy

Report to Norfolk Health and Wellbeing Board
8 January 2014
Item 5

Developing a Norfolk Joint Health and Wellbeing Strategy 2014-17

Report by the Interim Director of Public Health

Summary

This report provides an outline draft Joint Health & Wellbeing Strategy 2014-17 for consideration by the Health & Wellbeing Board, with a view to it being amended and presented in its final form to the Board at its meeting in April 2014.

Action

The Board is asked to

- Consider the report and provide views on the direction, format and content of the draft strategy

1. Background

1.1 Joint health and wellbeing strategies (JHWSs) are strategies to meet local population's health and wellbeing needs identified in Joint Strategic Needs Assessments (JSNAs).

1.2 They are not one-off documents but are a live, continuous process of strategic assessment and planning, which in a two-way relationship will build on and inform other local assessments and strategies.

1.3 Local authorities and clinical commissioning groups (CCGs) have equal and joint duties to prepare JSNAs and JHWSs, through the health and wellbeing board. The responsibility falls on the health and wellbeing board as a whole and so success will depend upon all members working together throughout the process.

1.4 JHWSs should translate JSNA findings into clear outcomes the board wants to achieve, which will inform local commissioning – leading to locally led initiatives that meet those outcomes and address the needs.

2. Progress to date

2.1 At its meeting on 13 July 2013, the Health &Wellbeing Board agreed the approach for the development of the Joint Health & Wellbeing Strategy 2014-17, including the set of principles which would underpin it. The report can be found at this link.

2.2 The Board also agreed to set up a sub-group (Strategy Group) to progress the development outside of formal Board meetings and to draft a strategy for the Board's consideration. At its meeting on 23 October, the Board received an update on progress with development of its agreed priorities and the report can be found at this link.

2.3 The Health and Wellbeing Strategy Group has progressed this work and an outline Strategy is now attached at Appendix A. The Strategy Group asked the Norfolk Older People's Partnership to look at what was needed in relation to the Dementia priority and their submission is attached at Appendix B.

3. Proposed delivery of the Strategy

3.1 The Strategy proposes a number of high level actions which are largely drawn from evidenced based guidelines. A more detailed workplan with clear responsibilities, milestones, outcomes and targets will be required to sit beneath the Strategy. This will be developed by the Strategy Group when the overall direction of the Strategy has been approved.

4. Discussion and next steps

4.1 At this stage of the development it would be useful for the Strategy Group to have views from the Health & Wellbeing Board on the:

- Overall direction of the draft Strategy
- Draft content - including the proposals for "what do we need to do" and for which partners who need to take the lead?
- Key outcome measures and the proposal for pilot projects for each of the 3 x priorities
- Format, presentation, etc

4.2 Following the discussion today the Strategy Group will reconvene and take this work forward with a view to presenting the Strategy in its final form to the Board at its meeting in April 2014.

5. Action

5.1 The Board is asked to:

- Consider the report and provide views on the direction, format and content of the draft strategy,

Introduction

Our vision is that in Norfolk people will say:

- That those who need them experience safe, integrated, care and support that is personalised and coordinated
- That health and wellbeing resources are used in a way that encourages healthy life styles, prevents problems developing and reduces health and wellbeing inequalities

The Norfolk Health and Wellbeing Board has been operational since 1 April 2013. It has a broad membership encompassing representatives of the District and County Councils, Health and Social Care Services, the Police and Crime Commissioner, the Third Sector and Healthwatch. The Board is intended to build strong and effective partnerships, which improve the commissioning and delivery of services across NHS and local government, leading in turn to improved health and wellbeing for local people.

In pursuance of this the Board has agreed its strategic priorities for 2014-17. Although there are many priorities for health and wellbeing in Norfolk, the Board has agreed to focus its strategic direction on a very limited number of areas. This is not because other issues are not considered important, but because there is a real ambition to make a difference to the lives of people in Norfolk and it is felt that effort dissipated too widely achieves less. The areas agreed are those where the Board feels that more can be achieved by a joint approach than by the work of any individual partner and where all those around the table have a part to play in achieving outcomes.

The Purpose of the Strategy

- To provide a focus for working together on goals that can help organisations deliver the best possible outcomes in a context of limited resources
- To inform the budget decisions and commissioning plans of partners and thereby aligning resources with priorities
- To provide a way that the board and its members can be held to account by the public and other stakeholders

Ways of Working

The Board has agreed three overarching goals that all activity must be measured against. These are;

- Integration – of activity and outcomes, making services more joined up for those receiving them
- Prevention – moving intervention much further upstream and making a difference before problems become acute
- Reducing Inequalities in health and wellbeing outcomes

Strategic Priorities

Priority 1	**Giving Every Child the Best Start in Life**	**Lead Partner(s)**
What does this mean?	Ensuring that children under the age of 5 and their families are enabled to grow up safely and happily with the social and emotional support they need.	
Why have we chosen this?	Social and emotional wellbeing is important in its own right, but it also provides the basis for future health and life chances. The first years of a child's life are key in influencing their future health, school performance and ultimately employability. Poor social and emotional capabilities increase the likelihood of antisocial behaviour and mental health problems, substance misuse, teenage pregnancy, poor educational attainment and involvement in criminal activity. In the most recent Public Health Outcomes Framework Norfolk is significantly worse than the national average for many of the indicators relating to young people including • Breastfeeding initiation • mothers smoking during pregnancy • childhood obesity • pupil absence • first time entrants to the youth justice system • young people not in employment, education or training • MMR vaccination School attainment at all stages is also poorer than the average. All of these factors are relatively worse in more deprived areas.	
What do we need to do?	1. Ensure the social and emotional wellbeing of under-5s is assessed as part of the JSNA. This includes vulnerable children and their families. Population-based models (such as PREview, a set of planning tools published by the Child and Maternity Health Observatory) can be considered as a way of determining need and ensuring resources and services are effectively distributed. 2. Develop arrangements for integrated commissioning of universal and targeted services for children aged under 5. This includes services offered by general practice, maternity, health visiting, school nursing and all early years'	Public Health Children's Services, NHS England, Public Health, CCG

	providers. The aim is to ensure: • vulnerable children at risk of developing (or who are already showing signs of) social and emotional and behavioural problems are identified as early as possible by universal children and family services • targeted, evidence-based and structured interventions are available to help vulnerable children and their families – these should be monitored against outcomes • children and families with multiple needs have access to specialist services, including child safeguarding and mental health services. 3 Ensure that procedures are in place for professionals: • to make referrals to specialist services, based on an assessment of need • to collect, consistently record and share information as part of the common assessment framework (relevant child and adult datasets should be linked) • for integrated team working • for continuity of care • to avoid multiple assessments. 4 Put in place training to ensure that the range of organisations which have contact with families of young children are able to recognise, address and make appropriate referrals in relation to signs of domestic abuse 5. Support the development of programmes which promote the inclusion of fathers in early child care. 6. Identify and address barriers for more vulnerable families to access affordable childcare and early learning 7. Promote programmes which improve work readiness of parents in vulnerable families 8. Ensure that maternal mental health is assessed at an early stage and any issues addressed	As Above Police Third Sector District Council

	9. Support and encourage development of parental literacy 10. Improve contact between substance misusing parents and treatment services 11. Develop and pilot a single programme which addresses empowerment and self-esteem in relation to domestic abuse, relationships and risk taking behaviour in teenagers. 12 Review and target the availability of parenting support for vulnerable families 13. Promote projects addressing child safety in the home 14 Improve the promotion of and opportunities for healthier diets, physical activity and toothbrushing in preschool children	NHS England/Public Health Public Health/NDAP Children's Services/Public Health/Third Sector NHS England/Public Health
Pilot Project	Asset based community model in two wards of Great Yarmouth to be developed	
Key Outcome Measures	• Foundation Stage Attainment • CAHMS Referrals • A&E data - accidents • Domestic Abuse Stats • Public Health Drug and Alcohol Data • Reception Year Childhood Obesity Data • Breastfeeding initiation and continuation at 6-8 weeks • mothers smoking during pregnancy • pupil absence • first time entrants to the youth justice system • young people not in employment, education or training • MMR vaccination	
Priority 2	**Reducing the Prevalence of Obesity**	**Lead Partners**
What does this mean?	Halting the rise in obesity in adults and children, improving levels of physical activity and supporting healthy dietary habits.	
Why have we chosen this?	Evidence has shown that obesity is a common risk factor for diabetes, other metabolic diseases, heart disease, stroke, liver disease, many cancers, injuries,	

	arthritis, and depression, causing death and disability, and posing a huge burden to health and social care sector. The UK has the highest obesity rates in Europe[1], and Norfolk has obesity rates higher than England average. Severely obese individuals are likely to die on average 11 years earlier than those with a healthy weight, comparable to the reduction in life expectancy from smoking. Obesity is associated with an increased risk of a number of conditions such as: • 10% of all cancer deaths among non-smokers are related to obesity • The risk of Coronary Artery Disease increases 3.6 times for each unit increase in BMI • 85% of high blood pressure is associated with a BMI greater than 25 • The risk of developing type 2 diabetes is about 20 times greater for people who are very obese (BMI over 35), compared to individuals with a BMI of between 18 and 25 • Up to 90% of people who are obese have fatty liver. Non-alcoholic fatty liver disease is projected to be the leading cause of cirrhosis in the next generation. • The health effects of excess weight are increasingly apparent even in children; the incidence of both type 2 diabetes and non-alcoholic fatty liver disease used to be rare in children, but is now increasing • Obesity in pregnancy is associated with increased risks of complications for both mother and baby such as miscarriage, gestational diabetes, thromboembolism, birth defects, stillbirth, shoulder dystonia of foetus, etc. • Social stigmatisation and bullying are common and can, in some cases, lead to depression and other mental health conditions	
What do we need to do?	1. Develop a comprehensive Countywide obesity strategy 2. Put in place an individual to co-ordinate activity on obesity 3. Provide advice and information support to District Councils, CCGs and other partners	Public Health Public Health Public Health

	4. Promote Active Travel	NCC ETD
	5. Ensure that Norfolk people have the widest possible opportunities to be physically active. This includes identifying and addressing barriers to activity	All Partners
	6. Making the most of the potential for the planning system to create a healthier built environment	District Councils
	7. Working with local businesses and partners to increase access to healthy food choices	NCC, District Councils
	8. Linking activities on healthy weight to initiatives relating to the environment and sustainability – allotments and food growing projects can, for example, support environmental objectives and at the same time provide opportunities for people to be more active and eat more healthily.	
	9. Leading by example –partners providing leadership in their local area by ensuring that there is healthier catering provision in the settings and services that they run and in schools under local authority control, or by promoting a switch from driving to cycling among their own staff.	All partners
	10. Making the most of key opportunities to engage with communities and promote behaviour change,	Third Sector, CCGs, Districts, Public Health
	11. Work with partners to embed physical activity and healthy eating support within existing social care pathways. Provide a wide range of appropriate physical activity and healthy eating opportunities across a range of settings. Provide necessary adaptations and carer support for severely obese people to help improve their quality of life and avert the need for emergency service intervention (as a result of falls, for example).	CCGs, NCC Community Services
	12. Work with social landlords to implement the practical action plan led by CABE (now referred to as the Design Council) and the National Housing Federation, that sets out ten priorities for change to provide more opportunities for people	District Councils

	of all ages to be more active and enjoy the space outside their homes.	
	13 Ensure that obese people in social housing or in adapted homes have the opportunity to be physically active through home or community based physical activity programmes. Improve availability of unstructured opportunities for physical activity, such as access to parks and open spaces and safe play areas.	District Councils
	14 Encourage local workplaces and businesses to sign up to the Responsibility Deal and put into place effective actions to support employees and customers to make healthier choices, for example, introduce policies to prevent, support and manage obesity. This could include ensuring the availability of healthy food choices and the provision and promotion of physical activity physical activity, for example, by introducing walking meetings or non-working lunch times. The effectiveness of such policies is dependent on the support and ongoing commitment of senior members of staff.	NCC, District Councils
	15 Provide ongoing training and awareness-raising to combat prejudice and discrimination against obese people in the workplace.	
	16 Ensure elected members and all management and staff working with local communities, both within and across partner organisations, are aware of the importance of preventing and managing obesity and that they advocate for action on obesity.	All partners
	17 Agree a local “obesity branding” such as Change4Life which enables partners to have shared vision, speak with 'a common voice' and be clearly identifiable to the community.	All partners
	18 Undertake engagement activity to better understand perceptions of obesity in high prevalence areas and what messages and services will be effective.	NCC Public Health
Pilot Project	Asset based community approach in high prevalence areas of Norwich	
Key Outcome Measures	Childhood obesity measures GP Recorded Obesity	

	Evidence from engagement exercises GP recorded physical activity Health Trainer records	
Priority 3	**Improved Quality of Life for People with Dementia and their Carers**	
What Does this Mean?	Ensuring that Norfolk is a place where people with dementia and their carers receive high quality, compassionate care, whether at home, in hospital or in a care home. We want communities to understand, accept and support people with dementia enabling them to lead more fulfilling lives.	
Why have we chosen this?	Dementia is an isolating, disabling and frequently misunderstood condition. A recent survey by the Alzheimers Society found that less than half of respondents felt part of their community and they listed a number of activities which they had had to give up, often because of a loss of confidence or a fear of becoming lost or confused. Many felt unable to go out or try new things and most felt unable to contribute to their community. Nationally it is estimated that; • 4/5 of people in residential care have dementia • 2/3 of people with dementia live in the community • 1/3 of acute inpatients have dementia • ¼ of Home Care Staff lack knowledge or skills on dementia • Only 31% of GPs believe they have received sufficient basic and post-qualification training to diagnose and manage dementia. On average people currently wait up to three years before reporting symptoms of dementia to their doctor and most carers report being unaware of the symptoms of dementia before diagnosis. Many carers report being in denial about their relative having the illness and over half believe the symptoms to be just part of ageing. The prevalence of dementia is rising both nationally and in Norfolk. Dementia is principally a disease of older people and Norfolk has a higher proportion of people over 65 than the England average. It is estimated that nearly two thirds of people with dementia in Norfolk have not had a formal diagnosis of their condition.	
What do we need to do?	This section is covered in a separate report – see Appendix B	

Key Outcome Measures	• Diagnosis rates, observed vs expected • Service user and carer feedback • Community awareness measures • Medication prescribing • Community activities involving people with dementia and carers • Availability of advice • Training uptake	
Pilot Project	Developing dementia friendly community activity in North Norfolk through the Healthy Communities team.	

Norfolk Older People's View of What Needs to be Done

During 2013 the Norfolk Older People's Strategic Partnership devoted two meetings from 10.0 am – 2.0 pm to the subject of Dementia as well as including it further in the recent Awayday. This is because we saw and continue to see the huge significance of the subject to Norfolk and wanted to be as informed as possible on two particular aspects. Firstly, the importance of early diagnosis and secondly, the importance of removing the stigma, these two major aspects cover most of the things that cause concern for people with dementia and their carers.

Four clear priorities emerged from these meetings and from work undertaken during the year:

1. **Integration**, everyone wants to have a smooth seamless service with a clear pathway that is easy to understand and enables safe sharing of relevant information. It is not possible to overestimate the importance of integration in everyone's mind. When you are dealing with an issue as complex and as devastating as dementia you need processes to be as simple as possible, so that artificial barriers between services such as health and social care but also including housing and transport and the voluntary and private sectors, need to disappear, at least as far as the patient and their family is concerned. Can we learn from the West Norfolk Alliance model of partner agencies with a pooled budget safe sharing of relevant information, and from the North Norfolk's integrated GP hubs?

2. **Transport**, all the difficulties reported in other places about transport are hugely exacerbated and need urgent attention for people with dementia and their carers,

3. **GP practices as a crucial** first point in the pathway. GP practice staff need to have a much clearer focus on their patients with dementia and their carers, and be able to provide the assessment, integrated care/key worker and information about the pathway/community support that their patients and carers desperately need.

4. **Advice and information** in a properly accessible form is essential for everyone and underpins everything else.

If the following issues are achieved for people with dementia and their carers, they will be valuable to all older people and their carers in Norfolk.

1. Needs Assessment, Strategy and Commissioning

1.1 Process

a. Older people with dementia and carers of people with dementia must be included from the start and through the whole process to implementation and monitoring (co-production)

b. Norfolk's 2009 - 2014 Dementia Strategy should be revisited first – what worked, what didn't and what is sustainable?

c. The Joint Strategic Needs Assessment (JSNA) needs to precede a full Strategy/Action Plan

d. The Strategy/Action Plan should then be revisited regularly and agencies held to account at 12 monthly intervals i.e. it should be a working document

1.2 Commissioning

a. Integration must underpin all work

b. There should be a refocusing from acute to community funding, alongside the removal of perverse incentives for acute hospitals whereby they receive funding for the number of patients they treat

c. Small and large flexible grants for three to five years to support people in the community should be used more (avoid time-wasting/expensive tendering processes unless legally obliged to under EU law) – enable: ask people what support they need and what outcomes should be measured

d. Pilot & evaluate new services including measures of satisfaction of the older people with dementia and their carers who receive the services (monitor outcomes not just outputs) and, if effective, fund long-term

2. Changing the Culture

2.1 Carry out a county wide information campaign

a. Involve people with dementia and their carers throughout – use people's stories to promote understanding

b. Work with community leaders – it must be a 'bottom up' campaign

c. Focus on raising awareness and understanding, and the importance of early diagnosis and follow-up

d. Encourage and enable carers, including older carers, to recognise they are carers. GPs have a crucial role to play here.

2.2 Provide general & specialist information on paper, internet & face-to-face

a. Provide an annual 'Older People's Handbook' along the model of the 'Carers' Handbook' linked to an internet database with general information about all the support that is available including a section on dementia and on transport developed with older people and carers

b. Clinical Commissioning Groups and Norfolk County Council must better support their partner voluntary agencies providing Information and advice services. Commissioners should only put out to tender services whose cost meets the Part B threshold under EU regulations, and should use more 3-5 year grants – be more flexible and save the money/time of commissioners and of voluntary agencies who fail to win tenders.

2.3 Enable communities to develop activities and support

a. Make more use of flexible grants to support small and larger projects and volunteers in communities ('enable'). Make it easier to apply for these grants and put fewer conditions on - be more flexible / less tight about the outcomes required - ask them what they need to achieve. If community development isn't 'bottom up' and what local people need and ask for, it won't work.

b. Extend the Norfolk Village/Community Agents pilots to ensure proper time to pilot this service which has been tried and fully evaluated in Gloucestershire, and is now established in 10+ other local authorities. If effective, fund for 3 years to 5 years, and establish Community Agents in areas of high deprivation & low community capacity.

2.4 Promote and support dementia friendly communities

a. Evaluate the Age UK Norfolk Dementia Friendly Communities Manager and Dementia Lead posts promoting dementia friendly communities and, if effective and value for money, provide three/five years funding from April 2014 including realistic support costs
- it's a ten year piece of work, as existing dementia communities continue to need on-going support
- must be bottom-up community led

b. Learn from the examples of dementia friendly communities outside Norfolk such as Debenham in Suffolk

2.5 Provide transport to enable older people and their carers to access health and wellbeing services

- Transport services (public and community) don't reflect the needs of older people and their carers in Norfolk
- Of the £45 million spent on providing transport in Norfolk each year, the county council spends £32 million, health £8 million and other funders £5 million; proper coordination could ensure this funding was used much more effectively
- Social isolation has a huge impact on access to the health care and wellbeing activities that sustain good mental health

a. Be radical – Norfolk County Council should take the lead in working in all localities to audit all transport funding going in (public, subsidised, community, voluntary agency), map need and consider how it could be used most effectively

b. Commissioners of the call centre which decides eligibility for non-urgent patient transport services (PTS) must make sure the national 2007 flexible criteria are properly followed so that carers of people with dementia and people who can't walk far are included

2. Fund low level generic preventative services which help all older people remain living independently are funded

- funding for prevention should be integrated and ring-fenced

a. Agree health and social care funding to maintain Swifts and Reablement across all districts

b. Fund the Norfolk Handyperson scheme which provides simple practical help in the house

2.7 District councils should identify in their local development plans how homes for meeting the aspirations and needs of older people, including those with dementia and their carers, can be provided

- housing needs to be warm, appropriate, affordable and safe, and there isn't sufficient housing with care

a. Councils should consult older people and their carers and, through planning for housing, make sure that/lobby for housing developments accommodate the requirements of older people in all aspects of housing number, design (accessibility, low heating costs etc) and location.

3. Timely Diagnosis, Information and Support in GP practices

3.1 The 'Family GP' model is the best for patient-centred care

3.2 Make dementia awareness training available to practice staff

– 'the knowledge of GPs and practice nurses is invaluable'; 'sympathetic support is vital at GP/surgery staff level'

3.3 Identify a staff member who would like to volunteer as Dementia Champion

- Champions are most effective where they must have a real personal motivation to opt for this

3.4 GP Practice should support patients and their carers who can't access transport

a. GP Practice staff should mark patients' and carers' notes if they don't have access to transport

b. GP Practice receptionists should have the local knowledge to advise patients on local transport, and book it for patients where appropriate

3.5 Diagnose in a timely way and explain why this matters to people with dementia and their carers

3.6 Identify a key worker from any of the relevant agencies to co-ordinate support for older people with dementia and their carers

a. For older people with dementia who come very regularly to the GP Practice

b. Co-locate key workers with other partner staff for at least some of the time

c. Explain the Care Pathway and provide information (paper and/or internet, including about benefits and transport)

d. Co-produce a Care Plan with the person who has been diagnosed and with their carer

e. Include contingency funding into personal support budget/plans so carers can have an urgent break they can initiate themselves through Norfolk County Council's Customer Services or directly if they have a direct payment

f. Include the transport costs of accessing health and wellbeing services in social care and health personal budgets / care plans

g. After the key worker has set up and reviewed the care plan, make it possible for older people with dementia and their carers to re-refer directly back into their Adult Social Care locality team, rather than starting again though Norfolk County Council Customer Services / the Social Care Centre of Excellence

3.7 Identify and assess the health and wellbeing needs of carers of people with dementia

a. Offer a separate assessment to all carers who may want to talk apart from the person they care for about their needs

b. Co-produce a care plan with the carer

c. Explain the pathway and provide information (paper and/or internet, including about transport)

3.8 Provide a paper-based booklet about specialist support available for people with dementia, linked to an internet database
- develop this with older people with dementia and their carers

3.9 Have available in the GP practice on a sessional basis someone who can provide face-to-face information about support that is available

a. Research all the models that have been / are being used in Norfolk GP practices to date
- GP Practices should identify the model that will suit them and their patients/carers best
- CCGs must provide some funding/support

b. Use GP Practice receptionists to book appointments

c. Signpost people with dementia and their carers to local general and specialist support e.g. on self-management, practical help, exercise, activities, befriending, Pabulum Cafes, benefits including non-means tested Attendance Allowance

4. Provide Appropriate Support in the Community after Diagnosis

4.1 Provide specialist outreach into communities from acute hospitals

4.2 Evaluate and fund the specialist Admiral Nurses

- they provide expert support for carers in particularly difficult and complex situations

a. Evaluate the Admiral Nurse pilot funded until the end of March 2014 see how this model fits as part of post diagnostic support in Norfolk for people with dementia and their families/ carers. If effective and appropriate, continue funding for three – five years as one of the more specialist parts of the range of support services

4.3 Evaluate and fund paid Dementia Advisers

- these are **invaluable** once the key worker has agreed a care plan with services and handed over to the Dementia Adviser
- they can be accessed directly, and are there for carers to talk through problems and to provide advice and support

a. Fund Dementia Advisers to cover the whole county for three – five years as part of a range of support, so every person with dementia and their carer has easy access. Immediate action is needed as the current funding ends in March 2014.

4.4 Ensure independent sector home care staff have dementia training

- most people with dementia are living in the community with support

a. Work with Norfolk Independent Care & share existing good practice, e.g. a home care agency opening the dementia training for its staff to the unpaid carers of people with dementia they are supporting

b. Campaign to raise awareness of the value of care work
- create more apprenticeships; emphasise job satisfaction using case examples; promote accessible, on-going training

c. Promote and encourage flexible working in the home care sector for people aged 67+ who have a great deal of experience to offer

4.5 Make it easier & simpler for people to complain if they are unhappy with their homecare service

a. Norfolk County Council (NCC) must ensure that the independent home care & care home agencies they commission have transparent complaints procedures, and if people are not satisfied following complaint to their service provider they must know that they can expect NCC to help. Develop the model of continuous improvement.

4.6 Fund activities and support for people with dementia and their carers

a. Fund and develop across Norfolk **Pabulum cafes** which support both the person with dementia and their carer at the same time but in separate rooms so the carer has peace of mind and can get support including IAA – these are a lifeline for carers

b. Support the development of exercise such as chair-based Extend, Tai Chi and Zumba across Norfolk

c. Grant fund the extension of dementia choirs across Norfolk

5. Support in Acute Hospitals

5.1 Appoint a Dementia Lead

5.2 Produce a Dementia Strategy with people with dementia and their carers
e.g. Doncaster and Bassetlaw Hospitals NHS Foundation Trust Draft Dementia Strategy 2013-15

5.3 Have a holistic view of the care of people with dementia and other long-term conditions, and co-ordinate treatment provided by different specialists

5.4 Promote training in dementia care for all staff
- older people are on most wards

5.5 Acute hospitals should ensure that older people's wards are adequately staffed

a. Wards need the right mix of registered nursing staff to health care support workers (HCSWs), & the minimum number of patients per nurse (Royal College of Nursing policy briefing on Mandatory Nurse Staffing Levels, March 2012), particularly at weekends, evenings & bank holidays.

5.6 Provide information, advice and advocacy for older people with dementia and their carers on hospital wards and in outpatient clinics

a. Subject to positive evaluation, identify funding to extend the IAA pilot on NNUH hospital wards & extend to Queen Elizabeth and James Paget Hospitals

5.7 Recruit Health Care Assistants and Registered Nurses with the right values as well as the technical skills

5.8 Create dementia friendly care environments

5.9 Make it simpler and easier for people to complain

a. Make the process transparent

b. Handle complaints so that staff understand they will be used positively to improve the service

c. Develop a culture where everyone is responsible (rather than: 'that's not my job/problem') and a model of continuous improvement

5.10 Audit care for people with dementia/their carers

5.11 Provide specialist outreach into communities
- people with dementia often have other long-term conditions

a. Acute hospital consultants should go out into communities to provide support and reduce risk of hospital admission

6. Support in Residential and Nursing Care

- it is estimated that over 8,000 people aged 65+ are living in Norfolk residential care and nursing homes, and that 80% of these will have dementia

6.1 Identify a staff member who would like to volunteer as Dementia Champion
- Champions are most effective where they have a real personal motivation to opt for this

6.2 Fund Admiral Nurses to provide outreach into these homes

- specialist input and skill-sharing has been evidenced to reduce admissions to acute hospitals and improve care for residents

6.3 Work with Norfolk Independent Care and other partners to agree ways to provide training for staff in caring for people with dementia

6.4 Work with Norfolk Independent Care and other partners to agree ways to provide exercise and activities in care homes
- residents must have the opportunity to keep fit, have an interest in life, learn new skills and laugh.

a. Norfolk County Council should have in its contracts with independent care homes a requirement that there should be a

minimum of one hour a week exercise and one hour a week of other activities. This would be a place for the use of volunteers.

6.5 Make it simpler and easier for people to complain

- without the fear of repercussions for people who are particularly vulnerable

a. Make the process transparent

b. Handle complaints so that staff understand they will be used positively to improve the service

c. Develop a culture where everyone is responsible (rather than: 'that's not my job/problem')

d. Norfolk County Council must include in its contract with care homes the requirement to display details of an independent advocate e.g. Norfolk Alzheimer's Society's Advocacy Manager

7. End of Life Care

This is very important issue but not yet tackled by us.

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Report to Norfolk Health and Wellbeing Board
8 January 2014
Item 6

Clinical Commissioning Groups – Commissioning Intentions

What is the role of the HWBB in relation to this paper?

The Health and Social Care Act 2012 sets out a number of legal responsibilities for the Health and Wellbeing Board, as below:

- Duty to prepare a Joint Strategic Needs Assessment, a Pharmaceutical Needs Assessment, and a Joint Health and Wellbeing Strategy
- Duty to encourage integrated working between commissioners of health and social care services
- Duty to provide an opinion as to whether the CCG commissioning plan has taken proper account of the Health and Wellbeing Strategy and what contribution has been made to the achievement of it
- Duty to assess how well the CCG has discharged its duties to have regard to the JSNA and JHWS.

Key questions for discussion

Q.1 How do the CCGs commissioning intentions relate to the overarching goals and priorities in the Joint Health and Wellbeing Strategy 2014-17, as based on the JSNA?

Q.2 What will be the overall contribution towards delivering the priorities of the Joint Health and Wellbeing Strategy 2014-17?

Actions/Decisions needed

The Board is asked to:

- Note the information provided by the CCGs

- Consider the engagement with and contribution towards delivering the priorities of the Joint Health and Wellbeing Strategy 2014-17

Clinical Commissioning Groups – Commissioning Intentions

Report by Norfolk's Clinical Commissioning Groups

Summary

This report provides information about the commissioning intentions of Norfolk's Clinical Commissioning Groups (CCGs) for the period 2014/15. It brings together the submissions from each of the CCGs at this stage in the annual planning process. In addition, each of the CCGs have been invited to give a presentation at the Board meeting to highlight key areas for the Health & Wellbeing Board.

Action

The Board is asked to:

- Note the information provided by the CCGs
- Consider the contribution to delivering the priorities of the Joint Health and Wellbeing Strategy 2014-17

1. Background

1.1 At its meeting in April 2013, the Health & Wellbeing Board agreed a Forward Work Programme for the year. The Forward Plan includes an item for the Board to consider at this meeting the commissioning priorities of CCGs to see how they contribute to the priorities of the Joint Health and Wellbeing Strategy (see item 5 on this agenda).

1.2 In setting priorities for Norfolk as a whole, through the development of the Joint Health and Wellbeing Strategy, it is acknowledged that there are local variations in the levels of need and there will be differences in focus in local areas.

1.3 This report provides the commissioning intentions for Norfolk's Clinical Commissioning Groups (CCGs) for the period 2014/15. It brings together the submissions from the CCGs at this stage in the annual planning process.

2. Annual Planning process and CCGs Commissioning intentions

2.1 As part of this year's annual planning round, in accordance with national guidance, all CCGs are asked to submit a 2-year operational plan by 4 April 2014, with the 2014/15 element requiring to be 'signed off' by 28 February 2014.

2.2 In addition, as part of the process all CCGs are asked to submit a draft 5-year strategic plan by 4 April 2014 and, for the purposes of that plan, to confirm their strategic planning 'unit'.

2.3 For the purposes of today's discussion, the CCGs were invited to submit their commissioning intentions, as they currently stand, for 2014/15. The submissions are attached in the appendices as follows:

- West Norfolk CCG - Appendix A
- North Norfolk, Norwich and South Norfolk CCGs – Appendix B
- Great Yarmouth & Waveney CCG – Appendix C

2.4 In addition, each of the CCGs have been invited to give a presentation at the Board meeting to highlight key areas for the Health & Wellbeing Board.

3. Action

3.1 The Board is asked to:

- Note the information provided by the CCGs

- Consider the engagement with and contribution towards delivering the priorities of the Joint Health and Wellbeing Strategy 2014-17

Officer Contact

If you have any questions about matters contained in this paper please get in touch with:

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West Norfolk Clinical Commissioning Group

WEST NORFOLK

CLINICAL COMMISSIONING GROUP

COMMISSIONING INTENTIONS 2014/15

Purpose

The purpose of this document is to appraise the Norfolk Health and Wellbeing Board of West Norfolk Clinical Commissioning Group's (WNCCG) commissioning intentions for the period 2014/15 and beyond.

Specifically it is to:

1.
   a. Demonstrate the WNCCG response to the recent 'Call to Action' and 'Closing the Gap' reports issued by NHS England and Monitor respectively, warning of substantial impending challenges to health and care delivery driven by an ageing population, increase in long-term conditions, rising costs and growing public expectations within a financially constrained environment[1]
   b. Highlight the particular challenges faced by the West Norfolk health system in terms of ensuring long term 'system sustainability, alongside the opportunities presented by a track record of innovation, system collaboration and integration

And in so doing highlight the context within which,

2.
   a. WNCCG proposes it's 'unit of planning' in line with national guidance
   b. WNCCG will meet nationally required timescales to support one year planning for 2014/15, two and five year planning by end June 2014
   c. WNCCG proposes commissioning intentions for 2014/15; the process of generation of these and the high level content

1. WNCCG context: national and local drivers

The national challenge

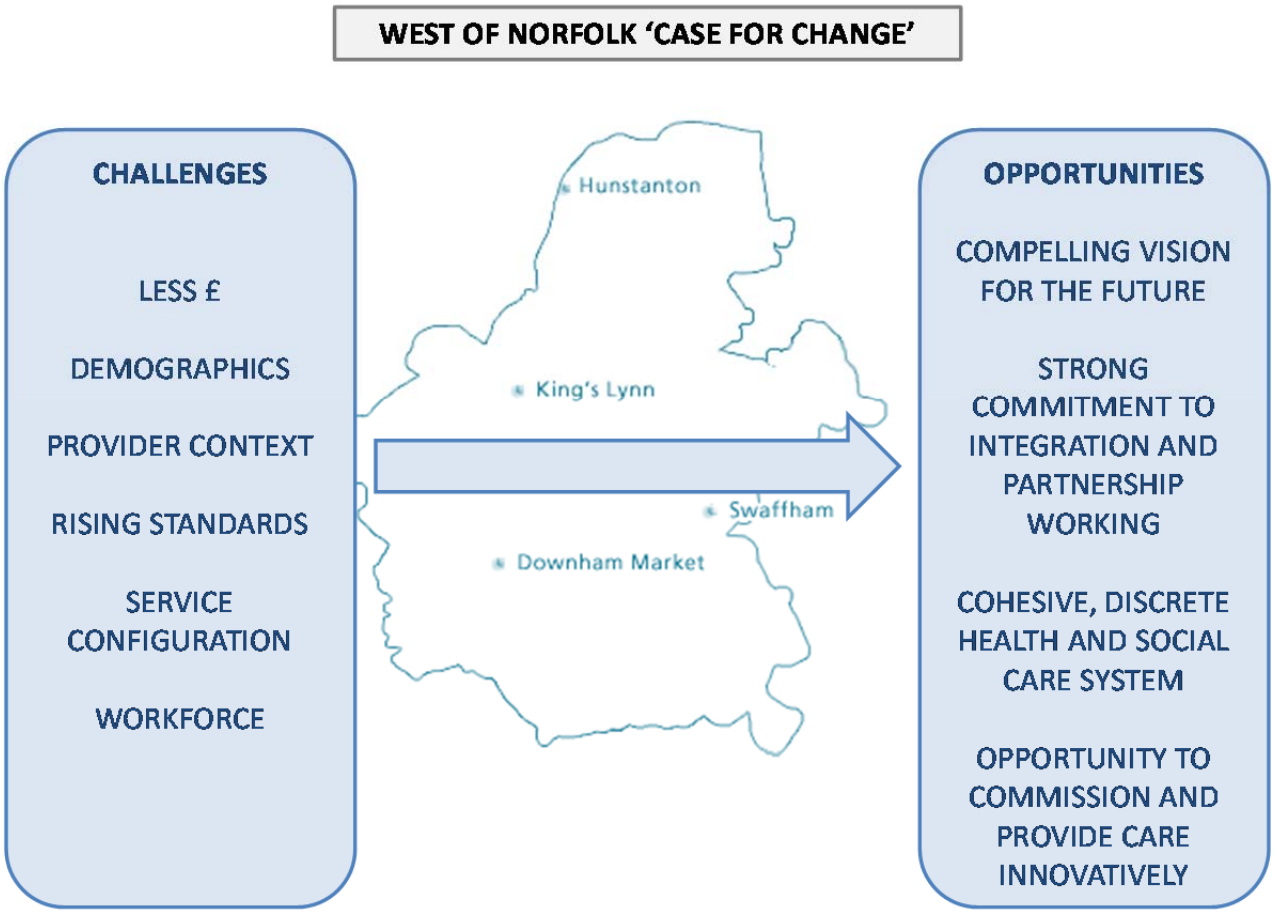
In 'The NHS Belongs to the people: a call to action', a compelling call for engagement in service delivery and redesign is set out. The document outlines a number of future pressures that the NHS will experience. An ageing population with increase in people with long term conditions – heart disease, diabetes and hypertension – will increase demand on healthcare services. This growing demand, coupled with increasing costs of provision serves to put further pressure on financial stability and sustainability of the NHS. To respond to these challenges the national 'call to action' suggests our solution is to find ways of 'doing things differently', 'harnessing technology', 'improving productivity', increasing patient choice and control in their care, and of health and care integration.

[1] Publications Gateway Reference No: 00658, 'Strategic and operational planning in the NHS', 4th November 2013; Local Government Association, Trust Development Authority, Monitor and NHS England

The local challenge

In response to this national vision, Clinical Commissioning Groups are called on to lead local delivery. West Norfolk Clinical Commissioning Group has considered this national 'call to action', and can identify local parallels which offer a compelling 'case for change'. This is set out below, where both challenges to service delivery, and opportunities for creation of a vision for change are identified.

Figure 1: West Norfolk 'Case for change'



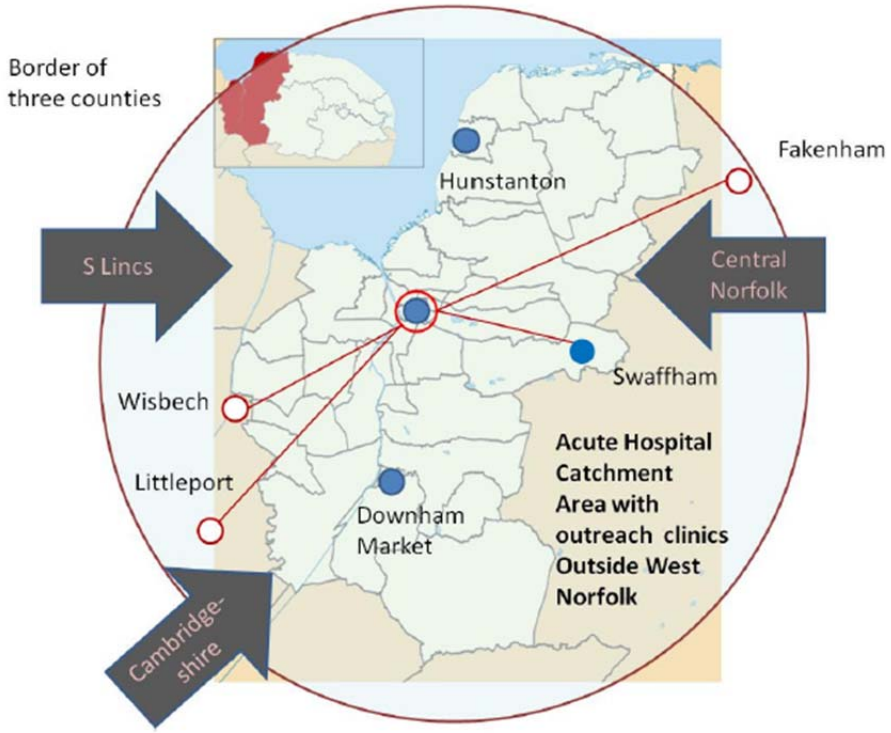
2.

a. WNCCG proposed 'unit of planning'

As per national guidance (see above footnote), Clinical Commissioning Groups have been asked to confirm their strategic planning 'unit', to meet set criteria, including that which is locally agreed, clinically led, reflective of patient flow, centred on significant local NHS Trusts with Local Authority support. In line with this, and demonstrative of a significant track record in West Norfolk of integrated partnership working, across health, social care, borough council,

independent and voluntary sectors, West Norfolk Clinical Commissioning Group proposes the 'unit of planning' be that of the 'West Norfolk' population, as depicted overleaf:

Figure 2: West Norfolk 'unit of planning'



b. Adherence to nationally specified planning timescales

In accordance with nationally specified timescales, West Norfolk Clinical Commissioning Group intends to produce the following for timely submission to NHS England:

Key deliverable	By When
1st submission of 2 year operational plan	Mid Feb 2014
Contract 'sign off' for 2014/15	28th Feb
Submission of final 2 year plans and draft 5 year plan	4th Apr
Submission of final 5 year plans	End June 2014

c. WNCCG commissioning intentions for 2014/15

As a Clinical Commissioning Group our overarching commissioning focus is on the achievement of four main aims:

- Commissioning integrated services for the patient population in order to improve quality of care
- Improving the health and wellbeing of the people of West Norfolk
- Preventing disease and premature death
- Decreasing hospital admissions for long-term conditions

Process for development of 2014/15 commissioning intentions

In developing commissioning intentions for 2014/15 WNCCG developed a robust methodology for collation and prioritization over the previous several months, which comprised:

- Collation of feedback from stakeholder engagement events over summer 2013
- A 'stock take' of the progress of implementation of the CCG's Integrated Commissioning Strategy (ICS) 2013/14 – 2014/15
- A review of the 'NHS Commissioning for Value Benchmarking set', identifying unwarranted variation requiring further analysis
- A distillation of WNCCG Members External Peer Review Summary, highlighting opportunities for improved commissioning spend as part of NHS England Quality and Outcomes Framework (QOF) requirements
- A synthesis of performance and quality issues identified during 2013/14
- Alignment with Public Health priorities for 2014/15
- Alignment with national guidance, and political imperatives
- Consideration of 'fit' with longer term strategy for West Norfolk system sustainability

The above synthesis of 'inputs' to derive WNCCG commissioning intentions demonstrates development of commissioning intentions based on robust evidence base, practical experience and local population and clinical engagement.

Content

Every provider from which WNCCG commissions has been asked to:

- Adhere to nationally mandated requirements as set out in forthcoming contractual and planning obligations by NHS England
- Adhere to national efficiency requirements, ensuring transparency of proposals to deliver these efficiencies and quality impact assessment and monitoring of their implementation
- Work in collaboration with WNCCG to fully participate in system redesign and integration, to ensure long term sustainability of the West Norfolk system

The proposed pathway areas for WNCCG focus, derived from a composite of the above, requiring further clinical dialogue with NHS provider organisations over the coming months are as follows. To note, these will be further prioritised and distilled by WNCCG via contractual and clinical dialogue with provider organisations and wider stakeholders:

- Ambulatory Care Sensitive conditions: increased treatment in community settings where clinically appropriate, and improved hospital treatment pathways
- Dementia: improved early diagnosis, assessment and referral

- Cancer: improved early diagnosis and intervention
- Urology: pathway review and consideration of community interventions
- Gastro-intestinal: review of pathway interventions
- Pain management: review of community 'work up' and Acute Trust provision
- Neurology: review of opportunity for change
- Ophthalmology: review of cross system provision
- Cardiology: review of local activity and clinical networks, with 'linkage' to tertiary services
- Paediatric urgent care: review of local sustainability and community/acute pathway interface
- GP education: opportunity for heightened education to improve referral behaviour
- Continuing health care: review of CHC systems and processes to improve care for patients
- Mental health and well being: review of West Norfolk access and assessment to Mental Health and Wellbeing services
- Integration of frail and elderly pathway: integration across 'frail and elderly' pathway, across health, social care, voluntary and independent sector
- Integrated Transformation Fund delivery: clarity on usage of funding of monies transferred to 'Social Care', for the delivery of mutual benefit for the population of West Norfolk
- Prescribing improvements: improvements in line with best practice guidance regarding prescribing and benchmarking data, to ensure WNCCG performance is aligned with national standards

3. Next steps

WNCCG will work with NHS providers over the coming weeks to ensure full implementation of nationally mandated contractual and planning requirements.

Through clinical dialogue WNCCG will translate opportunities for pathway redesign in the areas aforementioned into contractual plans and improvements for 2014/15. A programme of work, in line with contractual negotiation with providers will ensure that pathway by pathway, clinical dialogue, evidence base and provider performance informs future contracting for 2014/15.

WNCCG is confident that the approach set out in this paper for the commissioning of services for 2014/15 will be aligned with local need, and congruent with longer term commissioning planning requirements for the coming 2-5 years.

North Norfolk, Norwich and South Norfolk Clinical Commissioning Groups (CCGs) – Commissioning Intentions 2014/15

1. Background and Purpose

1.1 The Health and Well Being Board has asked to be briefed on CCG commissioning intentions for the new financial year starting in April 2014. This paper therefore, with the appended Commissioning Intention Letters, sets out the key priorities identified to the main NHS providers for the new financial year.

1.2 As Members will see, the letters are drafted on a collaborative basis through the CCG Collaborative Commissioning Boards, covering Acute Care, Mental Health, and Out of Hospital Care.

1.3 West Norfolk CCG are included in the letters covering mental health, and Out of Hospital Care, though the CCG has developed separate CCG wide Commissioning Intentions which are reported separately (see Appendix A).

2. Purpose of Commissioning Intentions

2.1 NHS Commissioners have routinely issued formal commissioning intentions to their main providers by the end of September each year for the following contractual and financial year, due to the fact that contracts for the most part are re-negotiated annually. In the new world of a more diverse provider market, with longer term commercial contracts, including those with the Foundation Trust sector, it could be argued that this process is less important than in the past. However for 2014/15 at least CCGs decided to issue commissioning intentions as a way of signalling desired changes and priorities to their main providers for 2014/15.

2.2 The letters attached are heavily caveated in respect of 2 issues:

- CCGs are still awaiting the publication of planning guidance, known as the Operating Framework, from NHS England for 2014/15, which is expected in mid-December

- And CCGs are awaiting final confirmation of their resource allocations for 2014/15 and 2015/16.

3 Main Priorities for 2014/15

3.1 It is fair to say that in the main the attached commissioning letters focus on largely short term priorities and contractual conditions rather than setting out the broader strategic aims of commissioners, though clearly the latter influences the former. Each of the CCGs have extant Commissioning Strategies which have been consulted on and can be accessed on individual CCG websites.

3.2 In the near future, these commissioning plans will be refreshed in the light of the requirement to have integrated health and care plans covering the next 2 and 5 years, which set out the planned use of the Integrated Transformation Fund which will require oversight and sign off by this Board.

3.3 However there are a number of common themes and priorities for 2014/15 which CCGs have identified to providers in the attached letters:

- A clear focus on enhancing the safety and quality of service delivery through a financial incentive for Trusts known as Contracting for Quality and Innovation (CQUIN), as well as contractual sanctions where standards fall below acceptable levels.
- An onus on Providers to demonstrate that patient opinion is both sought and acted upon in service delivery
- A commitment to integrated care across the NHS, social care and Children's Services.
- A focus on better palliative care through a programme of education and support

3.4 There is also a wide range of service specific priorities for each provider, examples include:

- Norfolk and Norwich University Hospital Foundation Trust:
    - Delivering further improvement in Acute Stroke Care.
- Norfolk and Suffolk Foundation Trust:
    - Safe transition to and embedding of the new service model set out in the Trust's service strategy.
- Norfolk Community Health and Care NHS Trust:
    - Enhancing the integration of community nursing and adult social care teams.

4. Conclusions and Recommendations

4.1 The attached commissioning intentions represent a coherent set of largely short term, incremental changes commissioners are seeking to achieve in 2014/15 through the main NHS providers in Norfolk. It is likely that these will require some amendment in the light of the issue of the national planning guidance, which is likely to be available by the time of the meeting. More significantly the advent of the Integrated Transformation Fund and the attendant pressures on NHS and local authority finances is likely to see much more fundamental and transformative changes to service delivery set out for 2014/15 and beyond.

4.2 The Board is asked to note this report.

Mark Taylor
Chief Officer, North Norfolk CCG

Attachments:

Annex 1: Letter to Roy Clarke, NCH&C, from Central Norfolk CCGs, dated 30 September 2013
Annex 2: Letter to Julie Cave, Director of Resources, NNUH, dated 30 September 2013
Annex 3: Letter to Andrew Hopkins, Acting Chief Executive, N&SFT, dated 30 September 2013
Annex 4: Child Health & Maternity Commissioning Intentions, dated 19 August 2013

South Norfolk Clinical Commissioning Group

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Old Chapel Way
Broadland Business Park
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Email: Ann.Donkin@nhs.net

Date 30th September 2013

Roy Clarke
Director of Finance
Norfolk Community Health and Care NHS Trust
Elliot House
130 Ber Street
Norwich
NR1 3FR

Dear Roy,

Clinical Commissioning Group (CCGs) Commissioning Intentions 2014/15

This letter sets out headline commissioning intentions specific to your organisation on behalf of South Norfolk, North Norfolk, Norwich, and West Norfolk CCGs ("the Commissioners") for the contract year 1st April 2014 to 31st March 2015.

Unless otherwise stated all the intentions and related negotiating positions span all of the CCGs listed. In addition some or all of the CCGs have further requirements which are also outlined here.

This list is not exhaustive. It is intended to give NCHC an understanding of the areas CCGs wish to discuss as part of contract negotiation. However CCGs reserve the right to amend or add to the areas listed

For clarity, both NHS England East Anglia and Public Health Norfolk intend to be party to a single CCG contract with yourselves for 2014/15. Both commissioners will be writing to you seperately with their commissioning intentions.

We will use the months from October 2013 to March 2014 to discuss and agree contractual issues with an anticipated completion date for negotiations of w/c 3rd March 2014, and a signed contract w/c 24th March 2014.

National contract
We will contract using the electronic version of the NHS Standard Contract for 2014/2015. Whilst it is not available yet, we do not envisage any significant changes to the format, structure and content of the 2013/14 NHS Standard Contract.

Financial context
At the time of writing CCGs do not know the detail of the 2014/15 financial allocations. The commissioning intentions as listed may need to be revisited in the light of any changes arising from the resource allocation process. The contract negotiation timeline as outlined will allow for a full and frank discussion with yourselves regarding funding.

The medium and longer term present the health system, both locally and nationally, with a challenging financial scenario. Unless specifically stated we anticipate no additional funding in 2014/15. Any decision to invest in services will need to be matched by disinvestment or a reconfiguration of existing provision.

Cost pressures already identified include inflationary and other increases in prescribing and drugs costs, continuing healthcare, and the impact of tariff and other acute cost pressures. These include non PBR/local prices being subject to the same percentage change as national PBR pricing.

Again in 2014/15 the CCG will be asked to set aside 2% of our recurrent funding to spend non-recurrently. This non recurrent fund will be used to enable the local health system to transform services and in doing so increase quality and reduce inefficiency. Commitments against this fund will need to be agreed by the NHS England East Anglia Area Team and will need to demonstrate savings and efficiencies as an outcome.

CCG's Quality Innovation Productivity and Prevention (QIPP) savings targets for 2014/15 reflect the financial environment; it also reflects commissioning intentions highlighting the areas where together we can increase quality through joint working and smarter working. It is essential that QIPP is delivered on a system wide basis as well as within individual organisations and we expect the full engagement of service providers in QIPP initiatives.

We will actively encourage collaborative ventures between providers of care to reduce transaction costs and share infrastructure investments, building services along integrated care pathways, minimising disruption to patient access and continuity of care.

<u>CIP</u>
Comissioners require ongoing assurance throughout the 2014/15 financial year regarding NCHC's internal CIP. The impact of any cost improvement on workforce and front line delivery is of particular importance to CCGs. Commissioners would want to understand the principles of any cost improvement plans and the impact/risk stratification of proposed workforce redesign on patient care and safety and on agreed service outcomes

"NHS planning guidance for 2013/14, 'Everyone Counts', dictates that:

"To be contracted to receive NHS services, all commissioners will operate on the basis that any cost improvement programmes must be agreed by the Medical and Nursing Directors of the provider as having been assured as clinically safe. In addition, the clinical leaders of clinical commissioning groups must make their own assessment of cost improvements and be satisfied that services are safe for patients with no reduction in quality. To support decision making they should use the National Quality Board's "how to" guides, the potential impact on local and nationally accredited tools, such as the National Quality Dashboard, the NHS Safety Thermometer and any likely impact on staff and patient surveys, including the Friends and Family Test."

To support this CCGs require that each provider organisation shares detailed information determining:

- Assurance process for initiation, development and sign off of CIP plans, including QIAs that triangulate quality, staff, patient and carer feedback. Whether a current or aspirant FT, CCGs expect NHS providers to demonstrate compliance against Monitor's

'Delivering sustainable cost improvement programmes' guidance as an indicator of good practice
- Content of individual CIP plans, detailing proposed impact on staffing (e.g. total headcount and staffing mix) and activity assumptions (e.g. bed reduction, outpatient activity, caseload size) linked to QIAs
- Proposed process for monitoring QIA of CIP plan implementation, providing appropriate assurance to commissioners of impact throughout the year on key performance targets. This may appropriately include discrete, locally developed KPIs to provide assurance to individual CCGs of no reduced quality and provision of service by locality. Monitoring against QIA targets will be required on a regular basis.

Supply of the above information will be required prior to contract sign-off.

Prior Approval & Individual Funding Requests
Clinical Commissioning Groups will continue with the prior approval process, with future phases being data driven and evidence based. Implementation of future phases in 2014/2015 will be subject to the agreed consultation process as set out in the Prior Approval Policy, as contained within the current contract.

Any revisions to the Individual Funding Requests (IFR) policy will be implemented following due process where required.

Please see also 'Equipment'.

Sharing and Processing Patient and other Information
Later this year, the Anglia Commissioning Support Unit will obtain Safehaven status and will be working closely with a Data Management Information Centre (DMIC) to manage information flows between Providers and Commissioners. It will mean some changes to our existing data-sharing arrangements and as more information emerges it will be shared with Providers. The success of this will be dependent on collaborative work between the DMIC, Commissioners and Providers.

Operating Framework
We will commission in a way that is consistent with the 2014/15 National Operating Framework and associated guidance. We would look to NCHC to take remedial action where performance is below the national expected level.

NHS Outcomes Framework
We will expect providers to report against the agreed outcomes in the NHS Outcomes Framework and take remedial action where performance is below the national expected level.

Other key guidance and documents relied on
The provider will be expected to comply fully with guidance issued by the Department of Health, the National Institute for Clinical Excellence (NICE) and other competent bodies. This includes a requirement to deliver services in the appropriate settings as prescribed in any such guidance.

Timely and responsive action in accordance with other key documentation includes, but is not limited to:
- The Castlebeck Inquiry
- The Francis Report
- SEND legislation (due Sept 2014)

Integration across health and social care
CCGs remain committed to aligning health and social care to deliver services in an integrated way. We will work throughout the course of 2014/15 and beyond to deliver this aim.

Project Domino
Project Domino remains a key priority area and focus for commissioners and providers going into 2014 and beyond. We will use all mechanisms available to encourage and foster partnership working. Specifically we would seek formal commitment to the roll out of 'Domino 2', inclusive of continued attendance at specific meetings; Central Planning Group, Urgent Care Network.

The Central Norfolk Urgent Care system has expressed a desire to identify and quantify common measures of the "health of the system" against which all partners in the system should be held to account for. This will be developed with a view to inclusion as a standard measure across all contracts for 2014/15.

In relation to NCHC and the 'green workstream' we will look for continued engagement and assurance over delivery/implementation throughout the 2014/15 contractual year.
Any potential and/or new business cases would need to evidence their contribution to the ethos of Domino in order to be prioritised in the first instance.

Patient Experience, Safety and Quality
In accordance with the CCG's aim of placing the quality of the patient experience at the heart of all we do, and in line with central policy, we will work with, and support, providers to understand and address their quality challenges. This work will be underpinned and supported by the CQUIN framework.

We also believe that there are certain outcomes that represent care of a sufficiently unacceptable quality that we will not pay for the associated spell.

In 2014/15 we will apply this to the following:

- Inpatient falls – we will not pay for spells where inpatients sustain falls resulting in the 3 most severe NPSA grades of harm – Moderate, Severe or Death.
- Pressure ulcers – we will not pay for spells of care where patients develop a new pressure sore of grade 2 or above; or where a pre-existent pressure ulcer deteriorates into grades 3 or 4, or from 3 to 4. (Patient level data will be required on notification of a pressure ulcer via the Serious Incident (SI) process).
- Hospital Acquired Infections – we will not pay for spells where inpatients develop MRSA or MSSA bacteraemia, excluding admissions where this is the primary cause of admission (i.e. acquired elsewhere).
- We will not pay for spells where an inpatient develops Invasive Group A Streptococcus.
- We will not pay for spells where an inpatient is involved in an outbreak of C Difficile – i.e. where 2 or more cases of confirmed C Difficile infection occur within 24 hours of each other in the same clinical area; we will not pay for the second inpatient's nor any subsequent cases until the outbreak is formally declared closed.
- Never Events – we will not pay for spells where a patient suffers an unacceptable and eminently preventable Never Event, as defined by the Department of Health.
- Inpatient suicide – we will not pay for spells where an inpatient commits suicide whilst under the care of the provider.

We will work with you on the continued delivery of the Pressure Ulcer Ambition and we wish to see a similar approach to Catheter Acquired Urinary Infections (CAUTI)

Quality Reporting
We will continue to implement the QIR, SI and NE process and to work with you to use learning and trends to inform quality and safety improvement.

We will further develop and use the Quality Schedule developed during 2013/14 to manage performance via the formal monthly Clinical Quality Review Meetings. This includes, but is not limited to, a review of the current Quality Requirements as outined in Schedule 4.

Where applicable NCHC is required to work with Commissioners in the implementation and achievement of their Quality Premium initiatives.

Prescribing and Medicines management
We expect compliance with the relevant NICE and RPS guidance for Hospital Pharmacy Services, and to use agreed formularies.

CQUIN
We will seek assurance from yourselves that appropriate CQUIN schemes implemented over 2012/13 are mainstreamed into core delivery. This is inclusive of the 1% system-wide initiatives aimed at reducing emergency admissions.

We will develop the annual CQUIN schemes for 2014/15 which will include nationally mandated and local CQUIN indicators. We are still committed to a system-wide approach to tackling admission and flow through the acute settings and will, again, be ring-fencing a percentage of CQUIN monies for this purpose.

Where pre-qualification criteria applies NCHC will need to evidence compliance.

Please see also ‘Palliative / End of Life Care’.
Please see also ‘CCG specific initiatives’.

KPIs
Using the 2012/13 work undertaken in collaboration with yourselves we wish to agree an amended set of KPIs for the 2014/15 contract. It is our intention to ensure that, where specifications are developed as part of the 2012/13 SDIP KPIs are agreed and reported on.

To date these include, but are not limited to:
Adult Speech and Language Therapy.
Continence – all age
Lymphoedema
Care at Home Team
Childrens Community Nursing Team, inclusive of DASH

Please see also ‘Community Nursing and Therapies’, ‘Community Beds’, ‘Looked After Children’ and ‘Orthopaedic Triage’ for additional commissioning intentions in relation to KPIs.

Community Nursing and Therapies (CNT)
We do not intend to move CNT to a cost and volume arrangement for 2014/15. We will continue to commission the service on a block arrangement.

Based on recent meetings between NCHC, the CSU and CCGs we do not believe it is realistic to move to an alternative currency for CNT during 2014/15. This is contra to intial discussions with yourselves. We also feel the transformation project currently underway within NCHC could inform future contract currency.
We are still committed to finding a suitable and alternative currency for commissioning district/community nursing. We are hopeful that continueing to work with you throughout 2014 may allow for an alternative currency to inform the 2015/16 contracting round.

The 2013/14 CNT block was commissioned based on 2012/13 actual contacts. We recognise that activity has increased in 2013/14 and are prepared to re-negotiate the CN&T block accordingly. This will take into account the increased activity but will not be a straight percentage uplift, as the revised figure will need to take into account the fixed cost element of the service, demographic growth and tariff deflation.

We require any change in the recording of CNT activity over 2014/15 be subject to the Data Quality Improvement Plan.

We will review the current CNT KPIs as part of the contract negotiation process. Where appropriate we will look to agree CCG specific KPIs for elements of the CNT service.

We will continue to refine the CNT specification to link more closely with Intermediate Care aims (and beds, including procured beds), reablement, case management, primary care and social care.

Please see also: Continuing Health Care.

MSK Physiotherapy
We no longer wish to move to a tariff-based model for MSK Physiotherapy in 2014/15. We will retain existing contract currency. We will therefore discontinue ‘shadow’ cost and volume arrangements for 2014/15.

Community Beds
There has been good joint working throughout 2013/14 in relation to the development of a specification and related pricing structure. We intend to use the contract negotation process and further in-year joint working to decide if a move away from a block contract is still desirable.

We are committed to implementing the recommendations of the system-wide bed review as and when they are published, including further development of shorter average lengths of stay and a wider move towards maximising independence closer to home. This should allow for further discussions about the future of Ogden Court.

We will consider an overall ‘community intermediate care’ approach, including multi-disciplinary team approach with acute input and integration across all areas, including CNT, reablement, procured beds and care homes.

Placement without prejudice. Work during 2013/14 is in place to understand how community hospital beds might provide ‘without prejudice’ placements prior to a continuing healthcare assessment. The outcome of this work may result in further discussions as part of 2014/15 contract negotiation.

Delayed Transfers of Care. We wish to contract specific minimum standards in discharge planning and transparent reporting of all delays and reasons for delay building on the agreed KPIs developed in the current specification.

Orthopaedic Triage
We wish to agree an amended and alternative set of KPIs for Orthopaedic Triage.

We intend to undertake a full review of the Orthopaedic Triage service within the context of a wider system-wide Orthopaedic review. The outcome of this review may impact on in-year provision or may affect 2015/16 commissioning intentions.

Equipment
We will be implementing a set of criteria and thresholds for the prescribing of community equipment. All prescribers across all providers will be required to work to the same set of criteria which may include a revised product range. It may also identify specific items where prior approval will apply and/or internal audit.

Continuing Health Care
As a part of the Norfolk system-wide integrated commissioning project CCGs wish to review the current market for continuing health care, both through nursing home and domiciliary care. We will re-specify the Norfolk NHS CHC care home provision using best practice, incorporating appropriate KPIs with a banded approach to pricing to allow individual care packages to be set up within a central contracts framework. The intention is to undertake a programme of market negotiation to implement the contract during 2013/14 with a wider procurement approach to consolidate the position 2014/15.

For domiciliary provision CCGs will implement a consistent specification detailing the full range of 'standard' tasks to be undertaken by a domiciliary care provider within someone's home. Additional, more specialised, tasks may also be identified. A standard hourly rate utilised with a tariff for specific tasks deemed specialist.

CCGs expect that all patients requiring general nursing care will be managed under the current block arrangements with the main providers of community/mental health care.

The commissioners expect that all practice registered patients will receive an appropriate level of care through our contracts with all our providers. This will include all patients including those who have been assessed as being eligible for Continuing Health Care funding.

Where NHS providers are delivering care to patients before a CHC assessment we expect this care provision to be continued after an assessment irrespective of outcome.

All checklists and assessments are to be completed by an assessing clinician before it will be accepted by the Commissioners/CSU as a referral and the referral will not be considered without a checklist having been completed.

The commissioners expect that all providers will attend and participate in all MDTs in relation to CHC eligibility for their patients and will organise placement of those patients in their care through collaboration with the NHS Anglia CSU CHC and contracts team.

The commissioners expect that all providers will ensure that all MCA and best interest reviews are undertaken where required and in a timely manner and communicate the outcomes to all relevant parties.

See also 'Community Beds'; namely Placement without prejudice.

Palliative / End of Life Care
Commissioners wish to see palliative care education supporting service transformation through the implementation of a palliative care education service specification – supported by a CQUIN indicator.

It is the intention to review the content and delivery of the patient held 'yellow folder', and to implement an electronic palliative care record to ensure safe and effective governance and information transfer processes are in place.
This will support the movement of palliative patients between care settings so that their care needs are met and their decisions respected.

Timely information sharing will also support delivery of an Urgent Care Plan and will enable commissioners to monitor key performance indicators such as agreement of an Advanced Care Plan, reduced admissions at end of life to the acute setting, and meeting patients preferred place for care and death.

Looked After Children
We are committed to implementing any changes resulting from the 2013/14 review of the Look After Children service.
We seek to address the lack of support LAC have when leaving care.
We will review the current KPIs for LAC and agreeing revisions where appropriate.

Autistic Spectrum Disorder
Whilst this is part of the DASH service specification, new NICE guidance requires CCGs to review the current ASD pathway. The provider is asked to engage fully in this piece of work.

Other
Still to be confirmed is:

- A review of current wheelchair provision for children.

CCG specific initiatives
North Norfolk CCG

- Integrating health and social care delivery – ensuring that health and social care deliver integrated teams with a single assessment process and a risk stratification tool, taking account of any reablement monies available.
- Community Nursing IV service – to provide IV therapy to patients (see South Norfolk CCG)
- Review effectiveness of Community Liaison team in light of the outputs from Project Domino
- Community service support to care homes (as established in mid-Norfolk, and using the resources previously identified as 'case management/FOPP). Case management of patients in care homes, e.g. review of care plans by community matrons, work with care home staff – nutition, tissue viability, continence and mobility assessments. Nursing (and other specialis) support and education into nursing and residential homes, including dementia and end of life. (See also South Norfolk CCG)

Norwich CCG

- The CCG will continue to work as a key partner in the Healthy Norwich programme, influencing specific health improvement and lifestyle programmes across the city. The CCG encourages all Providers to engage in these work streams.
- NHS Norwich CCG (NCCG) has four Clinical Action Teams (CATs)– Mental Health, Children & Families, Planned Care and Older People. The CATs are currently working up a prioritised 2014/15 work programme.Specific clinical areas include;
  - Review the focus/remit of case management including risk stratification.
  - Review of the dermatology, respiratory and pulmonary rehabilitation community service provision.
  - Commission IUCD (gynaecology) fitting in the community.
  - Review of IV CQUIN with view to roll out across the City. (See also South Norfolk CCG and North Norfolk CCG)
  - Patient Opinion; In line with national focus and Norwich CCG's commitment to patient engagement and involvement, the CCGs intend to include a requirement for Patient Opinion to be included across all provider contracts with local quality reporting and performance standards.

South Norfolk CCG

- Specialist Epilepsy Service. To increase the scope of epilepsy care in the community and ensure alignment with best practice models of care.
- Community and Primary Care Diabetes Service: to increase the scope of diabetic care that could be provided outside the acute setting.
- Community service support to care homes (as established in mid-Norfolk, and using the resources previously identified as 'case management/FOPP). Case management of patients in care homes, e.g. review of care plans by community matrons, work with care home staff – nutition, tissue viability, continence and mobility assessments. Nursing (and other specialis) support and education into nursing and residential homes, including dementia and end of life. (See also North Norfolk CCG)
- Community Nursing IV service. Roll out of CQUIN / IV therapy in all localities. (See North Norfolk CCG and Norwich CCG).
- End of life services: to improve end of life services with the aim of reducing acute admissions towards the very end of life and increasing the proportion of people dying in their preferred place of care.

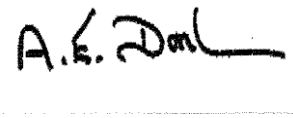
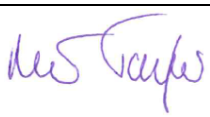
West Norfolk CCG

- These intentions are to be considered alongside the overarching commissioning intentions letter, issued to all providers by West Norfolk CCG as an addendum to this letter. This overarching document has been developed to reflect the system wide partnership work already commenced in West Norfolk – the SWIFT programme, to which existing partners including NCH&C have expressed their commitment. This complex programme of commissioning redesign, instigated by both system challenge and opportunity and supported by NHS England and Monitor, will necessarily continue to shape commissioning intentions for 2014/15 as it develops over the coming months. West Norfolk CCG expects partner providers to continue to work proactively and in collaboration to develop the provision of integrated services in the West of Norfolk. West Norfolk CCG reserves the right to amend or add to the areas listed in light of future SWIFT programme developments.
- West Norfolk CCG expects the Trust to participate fully, as other members of the Urgent Care Board in the West of Norfolk for the benefit of urgent care provision across the health and care system. This will include full participation in the Urgent Care Board, fielding of appropriate representation of sufficient seniority to this, and sub-

group meetings, and active engagement in the development of robust Urgent Care, and system wide escalation plans.

- West Norfolk CCG expects the Trust work collaboratively, to ensure inpatient bed, intermediate care and community nursing and therapy provision are aligned to best meet the needs of the urgent care pathway, and the frail and elderly population of West Norfolk. This will include active exploration of further integrated working, alignment of KPIs and incentives to drive system improvement.
- West Norfolk CCG expects the Trust to continue collaborative work to further implement the Hospice at Home model of provision in the West, working with partners to demonstrate the efficacy of the service model and improved outcomes for patients
- To develop and report against West Norfolk CCG specific KPIs/targets within agreed KPIs.

Yours sincerely,

			To follow.
Ann Donkin	Mark Taylor	Jonathon Fagge	Sue Crossman
Chief Officer South Norfolk CCG	Chief Officer North Norfolk CCG	Chief Officer Norwich CCG	Chief Officer West Norfolk CCG

Copies:
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Anglia CSU

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Commissioning_Intentions_2014-2015 ISSUED

30th September 2013

Julie Cave
Director of Resources
Trust Management
Level 4
Norfolk & Norwich University Hospitals NHS Foundation Trust
Colney Lane
Norwich
NR4 7UY

Dear Julie,

Clinical Commissioning Groups (CCG) Commissioning Intentions for 2014/2015
This letter sets out the collective commissioning intentions for North Norfolk, Norwich and South Norfolk CCGs ("the Commissioners") for the contract year 1st April 2014 to 31st March 2015. The sections below set out an outline of the key areas for service delivery and development, and are designed to enable the Norfolk & Norwich University Hospitals NHS Foundation Trust ("the Provider") plan for capacity and activity changes and opportunities that the changes present.

We intend to engage with the Provider from late September or early October 2013 to ensure we capture all the issues needed to discuss for the 2014/2015 contract. We will discuss and agree the contractual issues from November 2013 onwards with an anticipated completion date for negotiations by 28th February 2014 with a signed contract by 28th March 2014.

Unless explicitly stated, the contracting, prescribing and information intentions apply to all Commissioners party to the 2014/2015 contract. Specific Commissioning Intentions for each of the Central Norfolk CCGs are included in the Appendices to this letter.

The timing and issue of this letter does not in any way limit opportunities for Commissioners to refine or initiate new Service Improvements or Clinical Pathways during contract year 2014/2015.

Financial context
The medium and longer term present the health system, both locally and nationally, with a challenging financial scenario. In 2014/2015 there will be no recurring financial resources available for investment into new services unless some commissioning decisions are made around disinvestment from clinical services.

Cost pressures already identified include inflationary and other increases in prescribing and drugs costs, continuing healthcare, and the impact of tariff and other acute cost pressures. These include non PbR/local prices being subject to the same percentage change as national PbR pricing.

In 2014/2015, Commissioners will be asked to set aside 2% of recurrent funding to spend non-recurrently. This non-recurrent funding will be used to enable the local health system to transform services and in doing so increase quality and reduce waste. Commitments against this fund will need to be agreed by the NHS England East Anglia Area Team and will need to demonstrate savings and efficiencies as an outcome.

The CCGs Quality Innovation Productivity and Prevention (QIPP) savings target for 2014/2015 reflects the financial environment; it also reflects our commissioning intentions highlighting the areas where together we can increase quality through joint and smarter working. It is essential that QIPP is delivered on a system-wide basis as well as within individual organisations and we expect the full engagement of service s in QIPP initiatives.

We will actively encourage collaborative ventures between Providers of care to reduce transaction costs and share infrastructure investments, building services along integrated care pathways, minimising disruption to patient access and continuity of care.

At the time of writing Commissioners do not know the detail of the 2014/2015 financial allocations. The commissioning intentions as listed may need to be revisited in the light of any changes arising from the resource allocation process. The contract negotiation timeline will allow for a full and frank discussion with Providers regarding funding.

Comissioners require ongoing assurance throughout the 2014/2015 financial year regarding the Provider's internal Cost Improvement Plan (CIP). The impact of any cost improvement on workforce and front line delivery is of particular importance to Commissioners. Commissioners will want to understand the principles of any cost improvement plans and the impact/risk stratification of proposed workforce redesign on patient care and safety and on agreed service outcomes.

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Operating Framework

We will commission in a way that is consistent with the 2014/2015 National Operating Framework and associated guidance. The Provider will be expected to comply fully with guidance issued by the Department of Health, the National Institute for Clinical Excellence (NICE) and other competent bodies. This includes a requirement to deliver services in the appropriate settings as prescribed in any such guidance.

National contract

We will contract using the electronic version of the NHS Standard Contract for 2014/2015 and, while recognising that it is not available yet, we do not envisage any significant changes to the format, structure and content of the 2013/2014 NHS Standard Contract.

Payment by Results (PbR)

The Department of Health is currently preparing the PbR package for 2014/2015.
We will contract based on the 2014/2015 PbR guidance, and update commissioning intentions as necessary on publication.

Unless otherwise stated explicitly for 2014/2015, we believe that the tariff structure for 2014/2015 will include the requirement for Providers to deliver all of the NICE Quality Standards within the tariff costs.

Providers must notify Commissioners of any planned changes to coding of services observing the good practice behaviour set out in the PbR Code of Conduct. Providers should give notification of changes planned for 2014/2015 no later than 30th September 2013. Changes notified after this date will be accepted for consideration and implementation at the discretion of the Commissioners.

We will expect the Provider to report against the agreed outcomes in the NHS Outcomes Framework and take remedial action where intelligence indicates a level of performance below the national expected level.

Activity and Finance

Commissioners wish to enter into discussions with the Provider to contract for services in 2014/2015 based on 2013/2014 actual outturn figures.

Patient Experience, Safety and Quality
In accordance with the CCG's aim of placing the quality of patient experience at the heart of all we do, and in line with central policy, we will work with, and support, Providers to understand and address their quality challenges. This work will be underpinned and supported by the CQUIN framework. However, we also believe that there are certain outcomes which represent care of a sufficiently unacceptable quality that we will not pay for the associated spell.

In 2014/2015 we will apply this to the following:

- Inpatient falls – we will not pay for spells where moderate harm, serious harm or death is the result of an inpatient fall
- Pressure ulcers – we will not pay for spells where patients develop a new pressure ulcer of Grade 3 or 4 or where a pre-existent Grade 2 pressure ulcer deteriorates into a Grade 3 or 4 or from a Grade 3 to 4.
- Hospital Acquired Infections – we will not pay for spells where inpatients develop MRSA or MSSA bacteraemia, excluding admissions where this is the primary cause of admission e.g. acquired elsewhere
- We will not pay for spells where an inpatient develops Invasive Group A Streptococcus, excluding admissions where this is the primary cause of admission e.g. acquired elsewhere
- We will not pay for spells where an inpatient is involved in an outbreak of C. Diff - where 2 or more cases of confirmed C. Diff occur within 24 hours of each other in the same clinical area and there is a proven causal link between patients e.g. same strain isolated; we will not pay for the second inpatient's nor any subsequent cases until the outbreak is formally declared closed.
- Never Events – we will not pay for spells where a patient suffers an unacceptable and eminently preventable Never Event, as defined by the Department of Health.
- Inpatient suicide – we will not pay for spells where an inpatient commits suicide whilst under the care of the Provider.

The Commissioners also expect the Provider to work in collaboration with other Providers to ensure that ambulance turnarounds meet the national quality targets and we will continue to apply National consequences of breach where handover and turnaround performance is not achieved.

In line with national focus and the Commissioner's commitment to patient engagement and involvement, we intend to include a requirement for Patient Opinion to be included across all contracts with local quality reporting and performance standards.

Preventing falls in older people during a hospital stay (NICE CG161)
We expect the Provider to regard the following groups of inpatients as being at risk of falling in hospital and manage their care according to recommendations in sections 1.2.2.1 to 1.2.3.2 of CG161:

- all patients aged 65 years or older
- patients aged 50 to 64 years who are judged by a clinician to be at higher risk of falling because of an underlying condition.

Patients with Learning Disabilities or Autism
We expect the Provider to work to improve the quality of care offered to patients with a Learning Disability and patients with Autism, referring to the NHS Midlands and East *'Improving Acute Hospital Care for Adults with a Learning Disability and Adults with Autism in the East of England: A Review of the Acute Hospital Self Assessments and Improvement Plans'* (September 2012) and to provide us with assurance about the quality of care delivered across the Trust.

Mid-Staffordshire Hospitals Public Enquiry
We expect the Provider to respond to the recommendations of the Mid-Staffordshire Hospitals Public Inquiry and continue to demonstrate how they are assured about the quality and safety of patient care across their organisation. This includes agreed schedules for both Quality and Contract Meetings, for external visits to Provider organisations as well as unannounced visits by Commissioners and other visitors as required.

Commissioning for Quality and Innovation (CQUIN)
We will develop the annual CQUIN scheme which will include nationally mandated and local indicators. This will enable us to reward excellence by linking a proportion of the Provider's income to the achievement of quality improvement goals. We will apply this framework to embed quality within our discussions with Providers to create a culture of continuous quality improvement.

The Provider will need to evidence compliance with the High Impact innovations set out in the Health and Wealth Document (December 2011) which is required as pre-qualification criteria for 2014/2015 CQUINs. We will not release payment until we are satisfied that all the relevant elements have been met.

There is an expectation that the Provider will continue to achieve the desired outcomes for current System-wide indicators and carry on membership of, and development work within, project Domino II.

We also expect the Provider to continue their current work with the three dementia indicators:

- Supporting Carers
- Clinical Leadership and
- Find, Assess, Investigate and Refer

The remaining national indicators VTE risk assessment and Root Cause Analysis, NHS Safety Thermometer and Patient Experience – Net Promoter Score should now become 'business as usual' in 2014/2015 in the context of the CQUIN ethos.

NICE do not do list
We expect Providers to comply with the NICE 'Do not Do' list, as set out at **http://www.nice.org.uk/usingguidance/donotdorecommendations/index.jsp ,** and therefore not undertake any procedures, treatments or interventions which appear on this list. This list is subject to constant revision and Providers are expected to ensure that internal practices are therefore also continually revised.

Service Changes

Provision of services in a community setting
We intend to commission further services in a community setting during 2014/2015 and some of these initiatives are included in the attached Appendices.

Over the next 3 months we will work with Providers to assess the activity and financial impacts of these initiatives and rationalise the Commissioning Intentions set out in the Appendices to this letter.

In addition, specifications for the services listed below will remain on Supply to Health in 2014/2015. Should applications for these services be received, additional Providers may enter the market.

- Upper GI Endoscopy - http://www.supply2health.nhs.uk/5PQ/Lists/Advertisements/DispForm.aspx?ID=5
- Lower GI Endoscopy http://www.supply2health.nhs.uk/5PQ/Lists/Advertisements/DispForm.aspx?ID=5
- Carpal Tunnel - http://www.supply2health.nhs.uk/5PQ/Lists/Advertisements/DispForm.aspx?ID=19
- Cataracts – http://www.supply2health.nhs.uk/5PQ/Lists/Advertisements/DispForm.aspx?ID=17

- Adult Hearing Services
  https://www.supply2health.nhs.uk/CPI/Lists/AQPOffers/DispForm.aspx?ID=29

Paediatrics and Midwifery
In line with National initiatives, we will develop integrated community health pathways for children with specialist needs which are cost-effective and responsive to the needs of this vulnerable group of young people, including providing more care in the community.

We expect the Provider to achieve the Birthrate Plus ratios for midwives consistently during 2014/2015.

Palliative / End of Life Care
It is the intention to ensure palliative care education supports service transformation through the implementation of a palliative care education service specification – supported by a CQUIN indicator.

We also intend to implement a patient held ' yellow folder', and electronic palliative care record and resuscitation documentation to ensure safe and effective governance and information transfer processes are in place to support the movement of palliative patients between care settings so that their care needs are met and their decisions respected. Timely information sharing will also support delivery of the Urgent Care Plan and will enable Commissioners to monitor key performance indicators such as agreement of an Advanced Care Plan, reduced admissions at end of life to the acute setting and meeting patients preferred place for care and death.

Speciality reviews
The following areas will be the focus of service and pathway redesign initiatives:

Trauma & Orthopaedics (T&O)
A review of T&O was undertaken by the Royal College of Surgeons (RCS) during 2013. Although the review was limited in clear points of action, the Commissioners recognise the need to review and simplify the primary care pathway for orthopaedics. In particular the Commissioners will review the current orthopaedic triage service and MSK Physiotherapy services.

Following recommendations from the RCS review, and those awaited from Central Acute Commissioning Board-led working group, the Commissioners expect:

- Choose and Book to be fully utilised for patients requiring secondary care referrals for T&O
- Redesign of pathways for patients presenting to primary care with hip, knee or spinal pain

Clinical Decision Making Preadmission Service
We intend to commission an acute clinical decision making pre-admission service aimed at ensuring that suitable patients are clinically and diagnostically assessed prior to admission in line with National guidance and recommendations made in the 2012 Department of Health Emergency Care Intensive Support Team report (Schedule 14).

It is envisaged that an agreed number of AMU beds will be re-commissioned to operate in an emergency clinic-type system relying more on trolleys and point of care testing than is currently the case.

In terms of rationalising and achieving this approach, the Commissioners seek to systematically apply the Institute of Innovation's 2010 Directory of Emergency Ambulatory Care and Implementation of Emergency Ambulatory Care documents (Schedule 14).

Stroke Service
In 2014/2015 we will close the gap between the currently commissioned stroke service and the Midlands and East Best Practice Service Specification. No additional funding will be provided. The Provider is expected to deliver a clinically safe Stroke Service within the Best Practice Tariff structure. Given the lack of progress to date with stroke performance, the Commissioner will seek to implement a series of financial penalties beyond the non-awarding of the best practice tariff.

Prior Approval & Individual Funding Requests
The prior approval process will continue in 2014/2015 with future phases being data driven and evidence-based. Implementation of future phases in 2014/2015 will be subject to the agreed consultation process as set out in the Prior Approval Policy, and contained within the current contract.

This agreement is for all activity, for all Commissioners party to the 2014/2015 NHS Standard Contract, and applies to elective care only. As per the Prior Approval process, referrals via the 2 week wait pathway are exempt.

Any revisions to the Individual Funding Requests (IFR) policy will be implemented following due process where required.

Local Audits and Policy Reviews
In addition to specialty reviews, we will review adherence to the Consultant-to-Consultant and other local policies in 2014/2015, as necessary.

Commissioners reserve the right to conduct Local Audits throughout 2014/2015 to confirm adherence to pathways and policies and where coding or other anomalies are identified.

Commissioners will not accept any Provider-enforced limits to the number and scope of any such Audits or Reviews.

Where anomalies are identified via audits and case notes reviews, the findings will be applied to the entire sample. If the sample is for a full year, the findings will be applied retrospectively to the whole year. For example, if 1 in 3 procedures in a sample reviewed could have been carried out in an outpatient setting and would have attracted an outpatient tariff, then this will be applicable to 30% of all those procedures in the sample year.

Review of day case and outpatient activity
The Commissioners will continue to review activity which is clinically appropriate for either a day case or an outpatient setting and seek to embed clinical conditions to ensure patients are managed in the most appropriate setting for their condition. For example, we will no longer commission a daycase service for such conditions as wet AMD except in exceptional circumstances.

Clinical audits and discussion will take place during 2014/2015 to review activity that has both a day case and outpatient procedure tariffs. It is the intention of Commissioners to pay for procedures in line with the level of care provided and also in line with national guidance.

Activity will be benchmarked against expected rates of day case and outpatient procedures and clinically audited. Where a HRG is found to be an outlier in terms of the proportion of day case activity, the results of the audit will be extrapolated across all actual activity for that HRG and a financial deduction made.

Information Provision of Backing data for High Cost Drugs
Data provided for validation of invoices must conform to the minimum dataset as defined in the High Cost Drugs Schedule. This means that data must contain:

- indication for treatment
- unique patient identifier in accordance with national guidelines
- date of administration
- GP Practice code
- individual GP Name
- individual GP code
- drug name and formulation
- quantity issued
- acquisition cost

- associated activity code
- Consultant name or Directorate

Data must be provided in a consistent and standard format and where requested, proformas must be provided, in accordance with the High Cost Drug Commissioning Principles.

Invoicing & Backing Data
Invoicing and Backing Data for high cost drugs must be received no later than one month from the end of the month of issue. Invoicing will not exceed a maximum of one month's cost of supply per patient, at acquisition cost, except where delivered by Homecare, outreach and outpatients where the drug supply may be linked to 8 or 12 week appointments. The rationale for this is to reduce waste incurred through over supply. For the exceptions noted above, no charges will be paid where the supply exceeds three months.

To reduce waste and allow good financial planning, a maximum of 13 month's supply of individual high cost drugs at usual doses must be invoiced in any one year. Invoices reflecting supply exceeding this amount will not be paid by the Commissioners. Prior Approval via proforma is required for those patients requiring higher than usual amounts of drugs.

Invoices for clinical trial treatments will not be paid unless the excess treatment costs (drug and activity) of the clinical trial have been agreed beforehand with the Commissioners. This also includes the ongoing treatment of patients when clinical trials come to an end. The Commissioners should be informed of all clinical trials taking place.
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Treatments and associated activity costs designated as managed by NHS England must not be invoiced to the Commissioners.

Prior agreements regarding outstanding sums owed to Commissioners, where in some cases amounts were written off in lieu of other arrangements, will not hold in 2014/2015.

Out-patient, Outreach, Homecare & A&E Prescribing & Medicines Management
The Provider must implement Royal Pharmaceutical Society (RPS) guidance for Hospital Pharmacy Services.

Patients seen in outpatients, A&E, through outreach or Homecare must receive an appropriate prescription from the consulting clinician at the time of treatment as clinically necessary conforming to agreed formulary, treatment pathways and guidelines.

Where prompt treatment is deemed required by the consulting clinician as a result of the outpatient consultation, a prescription for that treatment must be provided by the Trust, covering the treatment course or 14 days, whichever is shorter. Prompt treatment is understood to be that required within the following 48 hours (or 72 hours where a longer holiday period immediately follows the appointment). If treatment is not deemed 'prompt' at the time of consultation, the patient must be made aware that treatment will be delayed until written clinician-to-clinician communication is received by the GP.

A letter must be sent to the patient's GP (by post/fax/e-mail) in a timely manner describing the consultation and including the treatment plan (see "Communications" below). The letter must be received at the GP surgery within the time allowed to issue a follow on prescription (usually 48 hours) if required to allow ongoing supply and to minimise patient harm.

Patients must not be left at risk of harm or major inconvenience through lack of supply of medication caused by the Trust not issuing a required prescription as defined above. Due care must be given to patient access to medication supply e.g. distance to travel to obtain supplies and opening hours of pharmacies.

Supplies of high cost drugs issued from outpatients must be limited as for inpatient high cost drugs as described in "Invoicing" above, to avoid waste from over supply. Data is required as described above for all high cost drugs issued on form FP10 (HP) as for drugs charged on invoices above. Drugs

issued through FP10 (HP) are subject to the same principles of Prescribing & Medicines Management as high cost drugs charged via invoice, as outlined above and below.

To facilitate good patient care and make best use of clinical time, the following definition of immediately necessary drug treatment is:

- Medicines which clinically require the first course to be prescribed by a specialist e.g. shared care
- Medicines which are required immediately to relieve patient suffering & symptom control e.g. pain relief, steroids, antibiotics, antihistamines
- Medicines should be prescribed generically where possible and 14 days supply or a course (whichever is shorter) should be given.

In-patient & Day Case Prescribing & Medicines Management
The Provider must implement RPS guidance for Hospital Pharmacy Services.

In-Patients & Day Case patients must receive an appropriate prescription at the time of discharge conforming to agreed formulary, treatment pathways and guidelines.

Discharge supplies for inpatients are expected to allow for a minimum of 14 days treatment for the patient, as clinically appropriate, and treatment choices must conform to local formularies, treatment pathways and guidelines.

Where prompt treatment is deemed required by the consulting clinician as a result of the day case or inpatient procedure, a prescription for that treatment must be provided by the Trust, covering the treatment course or 14 days, whichever is shorter. Prompt treatment is understood to be that required within the following 48 hours (or 72 hours where a longer holiday period immediately follows the appointment). If treatment is not deemed 'prompt' at the time of prompt, the patient must be made aware that treatment will be delayed until written clinician-to-clinician communication is received by the GP.

A letter must be sent to the patient's GP (by post/fax/e-mail) in a timely manner describing the consultation and including the treatment plan (see communications below). The letter must be received at the GP surgery within the time allowed to issue a follow on prescription if required to allow ongoing supply and to minimise patient harm.

Patients must not be left at risk of harm or major inconvenience through lack of supply of medication caused by the Trust not issuing a required prescription as defined above. Due care must be given to patient access to medication supply e.g. distance to travel to obtain supplies and opening hours of pharmacies

Supplies of high cost drugs issued to day-case and inpatients must be limited as described in "Invoicing" above, to avoid waste from over supply.

Communications regarding treatments
To facilitate accurate transfer of information about a patient's treatment, Providers must implement the guidance and principles issued by NICE & RPS:

- Health care professionals transferring a patient must ensure that all necessary information about the patient's medicines is accurately recorded and transferred with the patient, and that responsibility for ongoing prescribing is clear. In particular, any changes to medications must be made clear e.g. stopping/starting/dose changes
- When taking over the care of a patient, the healthcare professional responsible must check that information about the patient's medicines has been accurately received, recorded and acted upon
- Patients (or their parents, carers or advocates) must be encouraged to be active partners in managing their medicines when they move, and know in plain terms why, when and what medicines they are taking

- Information about patients' medicines must be communicated in a way which is timely, clear, unambiguous and legible; ideally generated and/or transferred electronically.

Therefore:

- Trust clinician-to-clinician written communications must include, but not be limited to, patient details, consulting clinician contact details, diagnosis, details of consultation including any allergies, investigations or examinations, medications, treatment plan, prescribing changes and/or recommendations where appropriate, symptoms requiring re-referral, other service referrals made, required GP action plan and information given to the patient
- Trust clinician-to-clinician written communications detailing prescriptions must include a complete description of the medicines regime
- Trust clinician-to-clinician written communications must clearly state which clinician(s) have prescribing responsibility e.g. 'Red' drugs prescribed by Trust clinicians only
- Patients must be made aware by the consulting clinician that where recommended treatments are outside of local agreed guidelines, treatment pathways or formularies, the treatment will not automatically be continued in primary care. Where such treatments are considered necessary, clinician to clinician agreement is required beforehand
- Local shared care arrangements and pathways on drug treatments must be followed where available, and referred to in agreeing patient treatment plans with fellow clinicians
- Trust clinician-to-clinician written communications must include investigation results from each patient encounter where required for safe GP prescribing
- Patients must have the risks and/or benefits of treatments clearly explained to them in plain terms in language that they can easily understand.

Promoting Prescribing & Medicines Management QIPP

The Provider must implement regional and local QIPP guidance in relation to aspects that cover Trust responsibilities.

Lower acquisition cost generics and biosimilars must be used in preference to higher cost brands where available. Higher cost brands will not be reimbursed where a lower cost product is available, without prior approval.

In particular, the cost of growth hormone issued is expected to be no more than the average cost for the brands available.

As new developments in biosimilars, generics and drug administration methods leading to lower costs become available in 2014/2015 it is expected that they will be used in place of higher cost existing products e.g. biosimilar anti TNF, SC version where previously an infusion was required.

The Provider must utilise the regionally agreed discounts where available.

The Provider is expected to obtain medicines at the lowest possible cost to the health economy, taking into account national and locally agreed contracts. Where Trusts invoice different prices for the same drug in the same strength and formulation, the lower price will be used as the reference cost for reimbursement, unless representation is made to the Commissioners explaining the reasons for the higher cost.

NICE 'Do Not Do' drug treatment recommendations must be followed.

Trusts should work collaboratively with local community pharmacists to facilitate good patient care and make the best use of NHS resource through the use of targeted Medicine Use Reviews and New Medicines Service

Formularies, Treatment Pathways, Guidelines & Horizon Scanning

Local and CCG formularies & agreed local, national and regional commissioned treatment pathways and guidelines must be followed. Use of formularies, treatment pathways and guidelines will be

monitored and performance managed. Where drug treatment is outside of formulary, agreed pathway or guidelines, Commissioners will withhold payment.

The Provider must demonstrate effective internal financial and clinical management of adherence to formularies, treatment pathways and guidelines, through (but not limited to) minimum 6 monthly audits.

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The Provider must publish formularies and treatment pathways to confirm implementation of NICE technology appraisals. Published formularies must be electronic and available for access by 31st March 2014.

The Provider must contribute to the local Horizon Scanning process in identifying future treatments that may be required for the local population, and producing business cases for consideration
Where NICE estimate expenditure as the result of a Technology Appraisal, the Provider must make Commissioners aware of any variation from the NICE estimate within three months of the NICE TA publication.

Patient Access Schemes (PAS)
The Provider must implement PAS where available as a result of NICE guidelines. Where a drug treatment is free of charge, this must be recorded on invoices as zero cost. Where a drug treatment is discounted, this must be recorded on invoices as the discounted cost. Where a drug treatment is rebated, this must be recorded on invoices as the rebated cost.

Homecare
The Provider must increase patient choice by offering therapies delivered via Homecare (i.e. direct to patient's home) where clinically appropriate. Where Homecare treatments are subject to PAS, then PAS discount arrangements will apply. Homecare contracts must comply with the regional framework agreements to ensure standard of service, governance and cost. Homecare contracts must be approved by the Commissioners before sign off.

VAT will not be charged (therefore will not apply to patients not having supplies delivered to their own home, or patients in care homes or institutions).

MRSA Decolonisation packs
The Commissioners expect the Provider to continue sending decolonisation packs to GPs, at no cost to the GPs, where a patient is found to be MRSA-positive following a pre-elective screening.

Local pricing
The Commissioners plan to undertake a full review of local prices during 2013/2014 to ensure consistency and appropriate pricing within contracts, and accurate distribution of costs across Clinical Commissioning Groups. This review may be conducted by an external organisation.

To inform this review, the Commissioners require details of the Provider's costings for those areas currently covered by local arrangements. This detail is required no later than 31st December 2013.

In addition to the above, the Commissioners will include the following clauses and payment terms in 2014/2015 contract:

- Non PbR/local prices will be subject to the same percentage change as national PbR pricing;
- We will consider introducing further procedures and restrictions under our 'Excluded and non-routine procedures policy' and will not fund procedures undertaken by Providers outside the policy
- We will not pay for service developments, new technology and/or associated cost pressures unless approved in advance during the commissioning cycle
- We will only pay a critical care rate for those patient receiving critical care and not those awaiting a bed to return to ward if this triggers a daily charge and
- Commissioners will withhold payment where NHS numbers are missing from CDS records, subject to defined exceptions where it is accepted that it may not be possible or practical to source the NHS number

- Commissioners will only pay for the Lucentis (Eyelea or other similar drugs) Wet AMD service to be delivered in an outpatient setting unless in exceptional circumstances
- Information in 2013/2014 from the Provider showed a number of admissions at the Children's Admissions Unit where length of stay was less than 12 hours. The Commissioners would like clinical discussion with the Provider on admissions with a shorter length of stay, to understand reasons for attendance and to agree alternative pricing to reflect the level of care provided. Discussion might also identify potential for a service outside of the acute setting.

Services funded 100% by Commissioners
The Provider is expected to:

a) identify services currently charged wholly to Commissioners which are shared with other Commissioners and
b) to agree with Commissioners an appropriate apportionment of these going forward taking into account the outcome of a)

Information requirements
The Commissioners will review the Information Requirements for the 2014/2015 contract and amendments may be required to reflect any contract revisions, and to ensure that local information requirements are adequately incorporated. As for 2013/2014 all activity will need to be reported on at GP Practice level in 2014/2015.

Providers are required to complete all CDS datafields and in addition, to provide regular data on the indicators of good stroke care and to comply with the cancer dataset, and the supporting mental health dataset.

The Commissioners expect that SUS may become the main dataset used for the validation and payment of acute trust invoices in 2014/2015.

In order to support the Commissioners' ongoing needs assessment and capacity planning, the Provider will be required to provide monthly information about patient referrals into the Trust.

The Commissioners expect the Provider to submit activity data according to an agreed Minimum Data Set for all cost-per-case /cost & volume Non-PbR activity in 2014/2015.

Specific information requirements from 1st April 2014 are:

- a monthly report, delivered within 10 working days of month-end, providing a brief snapshot of performance (albeit unvalidated) against Contractual KPIs followed by the Trust Board Report once signed off by the Trust Board
- weekly waiting list information, for each CCG, detailing:
    - numbers waiting, by speciality, split by elective inpatient, daycase and outpatient first attendance.
    - numbers waiting, split down by week in the pathway, by speciality, split by elective inpatient, daycase and outpatient first attendance
    - where patients are unlikely to be seen and treated within 18 weeks, a weekly update to confirm what alternative arrangements have been made to ensure compliance with the NHS Constitution and Patient Charter
    - a monthly KPI activity report covering
        - conversion rates and case-mix
        - A&E attendances and short stay vs. long stay mix
        - New-to-follow up conversion rates
        - Outpatient first appointments to DTA

The speciality split will be at a more detailed level than those currently included within the UNIFY2 submission. Where waiting list information is already produced internally, the Commissioners will work with the Provider to determine if this can be used and adapted, avoiding duplication of processes.

Healthcare Acquired Infections:

- Completed data sets and root analysis for MRSA/CDIFF/MSSA and E-coli, to be provided on the existing template to aid in creation of a system-wide HCAI surveillance database.
- Standard reporting template and timeframe for outbreaks of infectious disease, to enable greater coordination of system wide responses.

Breastfeeding data for infants completed at discharge from hospital, at 5 days of age and at handover to Health Visiting Services.

We require the Provider to submit patient level data for Stroke Best Practice Tariff. Payments will be triggered by direct admission from the Emergency Department to a stroke specialist ward (Heydon) as well as 90% Length of Stay.

Child Health and Maternity Services are required to collect all items in the Maternity Services Secondary Uses Data Set as detailed in this spread sheet from the Information Centre:

http://www.ic.nhs.uk

The maternity services data will be collected monthly and the child health datasets will be collected quarterly. These will be uploads directly from local systems PAS/Maternity systems and Child Health system into a system in the same way as Hospital Episode Statistics is currently collected.

Further information about Maternity Services and Child Health Dataset phase 1 can be found at:

http://www.ic.nhs.uk

In addition the following items have been nominated by Department of Health for collection in Maternity Services and Child Health Dataset phase 2 (date to be confirmed) and should be planned for accordingly in data collection systems.

In Maternity Services

- Breastfeeding status at new born screen test (blood spot) (5 to 7 days after birth)

Child Health Datasets

- Breastfeeding status at new birth visit by Health Visitor (10 to 15 days)
- Breastfeeding status at 16 week immunisations / vaccinations

The Provider will be required to comply with other requests for information in a timely manner throughout the year as necessary.

Sharing and Processing Patient and other Information

Later this year, the Anglia Commissioning Support Unit will obtain Safehaven status and will be working closely with a Data Services for Commissioning Regional Office (DSCRO) to manage information flows between Providers and Commissioners. This will mean some changes to our existing data-sharing arrangements, including movement of the existing timetable towards the national SUS timetable but as yet, we can't quantify them. As more information emerges it will be shared with Providers.

Wider commissioning intentions

Collaborative Working

Subject to guidance on lead Commissioner and other arrangements in 2014/2015,NHS Great Yarmouth & Waveney CCG intends to work with their Norfolk CCG counterparts to contract services from the Norfolk & Norwich University Hospital and will issue its own commissioning intentions covering all areas of care for their local system.

Continuing Healthcare

We wish to avoid patients having to automatically change their Provider as a result of receiving “fast track” Continuing Care eligibility at the end of life stage. We will be piloting a different approach to this in South Norfolk in 2014/2015 and intend to roll this out if successful.

We want most patients who are identified as potentially eligible for NHS Continuing Care whilst in an acute hospital to be formally assessed after they have moved home or into a more appropriate intermediate care bed in the community. We therefore want to agree arrangements with you to enable this to happen.

Yours sincerely,

Jonathon Fagge
Chief Officer
Norwich CCG

Mark Taylor
Chief Officer
North Norfolk CCG

Ann Donkin
Chief Officer
South Norfolk CCG

Copy:

Sue Crossman	NHS West Norfolk CCG	
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Jocelyn Pike	NHS South Norfolk CCG	
Steve Ham	NHS South Norfolk CCG	
Jim Barker	NHS South Norfolk CCG	
Keeva Rogers	NHS South Norfolk CCG	
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Chris Humphris	NHS Cambridgeshire and Peterborough CCG	
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Sheila Budd	Norfolk & Norwich University Hospitals NHS Foundation Trust	
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Tim Shayes	Norfolk & Norwich University Hospitals NHS Foundation Trust	

Appendix 1

NHS North Norfolk-specific Commissioning Intentions for 2014/2015

Planned Care

Endoscopy
Commission community service for North Norfolk and work with other CCGs to ensure NICE guidelines are met by NNUH service.

Improved access to wellbeing service for patients with spinal pain
Commissioning a Pain Management Service to devise training programme for Wellbeing staff to improve their ability to manage patients with chronic musculoskeletal pain at an early stage of presentation.

Appendix 2

NHS Norwich-specific Commissioning Intentions for 2014/2015

NHS Norwich CCG has identified the following Clinical Action Teams (CAT) as a working programme for development. It is proposed that these are prioritised and set out against a simple template.

Children & Families CAT work programme

Reducing emergency admissions
Norwich CCG would like to contract for provision of Monday morning paediatric epilepsy clinics

Reducing admissions and outpatient attendances
Norwich CCG would like to work with NNUH to develop a structured education programme for paediatric diabetes

Increased patient choice / improved outcomes
Norwich CCG would like to work with NNUH to enable diabetes transitional care (19-24 years) in a community setting

Continuation of work on paediatric asthma service/pathway: Targeted management or out of hours/improved outcomes
Norwich CCG would like to work with NNUH and the Norfolk Recovery Partnership (NRP) to understand if there is a case for alcohol prevention / support nurse roles in NNUH out of hours

Paediatric urgent care pathway re-design
Norwich CCG would like to work with the NNUH in a clinical review of paediatric urgent care pathways to ensure effectiveness and value for money

Appliances
Norwich CCG would like to work with NNUH to review the pathway for appliances such as boots/shoes/hernia belts etc.

Shift of acute care to community
Norwich CCG would like to work in partnership with NCH&C and NNUH to develop the case for phase 2 of Children's Community Nursing and Therapy

Reducing NNUH admissions
Norwich CCG would like to work with Norfolk and Suffolk NHS Trust (NSFT) and NNUH to develop a pathway for those that self-harm to prevent future admissions

To reduce childhood and adult obesity
Norwich CCG would like to work in partnership with all stakeholders providing tiers 1 to 4.

Allergy Pathway
As a result of paediatric peer review, the Children and & Families CAT would like to review the allergy pathway to understand effectiveness, coverage (gap analysis) and value for money.

Planned Care CAT work programme

Elective Admissions
To undertake clinical audit / review of criteria / pathway for specialties (tbc) where elective admissions have increased in recent years

To review the effectiveness and VFM of dermatology, pulmonary rehabilitation and respiratory community clinics to inform future commissioning

Aural Care (ENT)
To explore community provision of aural care (ENT).

Carpel Tunnel
Support for direct access to carpel tunnel investigations.

IUCD fitting
Support for IUCD (gynaecology) fitting in the community.

TELEDerm
Norwich CCG intends to evaluate the TELEDerm pilot and if successful roll out to other GP Practices.

Peer Review
To undertake clinical audit for specialties that have been part of the peer review process if referral numbers increase; and if necessary further adapt the pathway to ensure referral levels decrease or remain at status quo.

Older People CAT work programme

To work with stakeholders in reducing winter deaths

To work with the voluntary sector to upstream projects focusing on maintaining independence of our older population

To review, in partnership with stakeholders, the pathway for falls

To work with stakeholders to review the complete pathway for Heart Failure

Appendix 3

NHS South Norfolk-specific Commissioning Intentions for 2014/2015

Emergency and Urgent Care

Same day and next day clinics
To increase the availability of telephone advice and same day and next day clinic appointments for patients requiring urgent consultant opinion

(Emergency) Ambulatory Care Sensitive Conditions
Implementation of emergency outpatient tariff at NNUHFT for EACS and improvement of community management of ACS conditions through improved community diagnostics and access to NNUHFT diagnostics prior to or place of admission

Length of Stay Reduction
To review and redesign current discharge protocols to ensure maximum integration and ensure the most efficient process

Direct access to emergency x-rays for suspected small fractures
To enable GPs to directly refer to x-ray when they suspect a small fracture

Urgent Care / Walk in service for South Norfolk
Improved access to urgent care services for the South Norfolk population

Signposting from A&E to urgent outpatient clinics
To avoid duplicate charges for same day A&E attendance and outpatient attendance

Planned care and tackling variation

Review Orthopaedic Pathways
Best practice pathway for Orthopaedic services

Glaucoma
To provide glaucoma services in the community

One Stop Cataract service
To remove unnecessary steps and costs from the cataract pathway

Age-related macular degeneration and other eye conditions
To provide injections for eye conditions in the community

Community Dermatology Service
To increase the scope of dermatology services provided in the community

Community Rheumatology
Review the current rheumatology service to ensure compliance with best practice models of care. Seek to provide rheumatology services in the community, including the transfer of new drug infusions.

Community injections service
To provide services in the community at equal quality but better value

Choose & Book
To ensure a full menu of services on C&B is published and available

Discharge Planning
To contract specific minimum standards in discharge planning and transparent reporting of all delays and reasons for delay

To ensure practices have typed discharge letters within 48 hours of discharge to enable the correct clinical care

Daily consultant ward round for all patients in an acute bed and inter Consultant discharges
To improve clinical care of patients while admitted to an acute hospital and to standardise discharge processes across the week

Clinical effectiveness and prior approval
To ensure the latest best practice is in place for clinical effectiveness and prior approval policies

Admission ratio from A&E
To maintain the rates of admission from A&E to expected levels and not allow process or targets to distort admission need

Out of Hospital Care / Frail and Older People

Community Geriatric Service
Extension and development of the community geriatrician role across SNCCG practice areas (subject to findings of review scheduled October 2013)

End Of Life
End of Life service(s): continue to explore ways to improve these services, with a focus on reducing avoidable admissions and increasing the PPOC.
Better care for end of life reducing referrals

Intermediate Care Beds
Change to the nature of Intermediate Care to allow an increased provision as an alternative to acute admissions and to facilitate better discharge from the acute

LTC Self-Management and review of existing services
Long-term conditions priorities: Dementia, Diabetes, COPD, CHD. Consider improvements, more support to allow people to manage their own conditions

Community IV service
Provision of IV therapy in the community

Orthopaedic triage
NNUH to provide feedback regarding the appropriateness of NCH&C Ortho Triage referrals, both at an individual level by being copied in to the letters from consultants to GPs, but also on a service wide basis in terms of conversion rates.

Women & Children

Same day telephone advice and assessment service for children
To provide immediate advice to GPs and/or outpatient assessment for children at NNUH

Weekend Early Pregnancy Service
To extend the Early Pregnancy Assessment Unit to a 7 day service (subject to EPAU review) in order to mitigate differential tariff rate currently charged

Sexual Health
To reduce teenage and other unplanned pregnancies To provide a service closer to users – closest family planning is in Norwich. Potentially to reduce the termination rate particularly in younger people

Contraception
There is increasing difficulty in obtaining specialist contraception including IUCD

Long Term Conditions - high admission pathways
To consider the outcomes of the review of the high admission pathways for childrens' long term conditions identifying and implementing pathway improvements and/or potential avoidance options

ASD Pathway
To review and ensure compliance with new NICE guidance for ASD due November 2013

Mental Health

Frequently Admitted Patients (FAP) Service
To monitor outcomes of FAP and ensure mainstreaming in 2014/15

Primary Care

Irritable Bowel and Dyspepsia screening test
To implement an Irritable Bowel/Dyspepsia screening test for use in Primary Care

Referral Management
To provide a consistent level of referral management services across SNCCG

NHS

North Norfolk Clinical Commissioning Group

North Norfolk Clinical Commissioning Group
1 Mill Close
Aylsham
Norfolk
NR11 6LZ

Tel: 01263 738100

E-mail: mark.taylor25@nhs.net

Andrew Hopkins
Acting Chief Executive
Norfolk and Suffolk NHS Foundation Trust
Hellesdon Hospital
Drayton Road
Norwich
NR6 5BE

30 September 2013

Dear Andrew,

Mental Health Commissioning Intentions for North Norfolk, Norwich, West Norfolk and South Norfolk Clinical Commissioning Groups for 2014/15

This letter sets out the collective commissioning intentions for North Norfolk, Norwich, South Norfolk and West Norfolk CCGs ("the Commissioners") for the contract year 1st April 2014 to 31st March 2015. As you will be aware Great Yarmouth and Waveney CCG will be issuing separate commissioning intentions in order to inform a separate contract for 2014/15.

The sections below set out an outline of the key areas for service delivery and development, and are designed to enable the Norfolk & Suffolk NHS Foundation Trust ("the Provider") to plan for capacity and activity changes and opportunities that the changes present.

Unless otherwise stated the intentions and related negotiating positions span all of the CCGs listed. In addition, some or all of the CCGs have further requirements which are also outlined here.

This list is not exhaustive and it is intended to give the Provider an understanding of the areas CCGs wish to discuss as part of contract negotiation. However, CCGs reserve the right to amend or add to the areas listed and the issue of this letter does not in any way limit opportunities for Commissioners to refine or initiate new Service Improvements or Clinical Pathways during the contract year 2014/2015.

We will use the months from October 2013 to March 2014 to discuss and agree contractual issues with an anticipated completion date for negotiations of w/c 3rd March 2014. It is our intention to have a signed contract by 31st March 2014 at the latest.

Patient Experience, Safety and Quality

We are fully aware that the Provider is currently part way through a major programme of change in how it delivers its services in a period of significant financial constraint. Commissioners' main priority for 2014/15 therefore is to continue to work closely with the Provider to ensure that the new service models are safe and deliver high quality care for patients, and where risks are identified ensure that

the Provider takes prompt action to resolve these. In particular, we will wish to focus on ensuring that the agreed timeframes for assessment through the Access and Assesssment Team are complied with in order to minimise the risk to patients.

We believe that there are certain outcomes which represent care of a sufficiently unacceptable quality that we will not pay for the associated episode and we will seek to discuss this in the contract negotiation round.

In 2014/15 we will apply this to the following:-

- Inpatient suicide – we will not pay for episodes where an inpatient commits suicide whilst under the care of the provider.
- Inpatient falls – we will not pay for episodes where inpatients sustain falls resulting in the 3 most severe NPSA grades of harm – Moderate, Severe or Death.
- Pressure ulcers – we will not pay for episodes of care where patients develop a new pressure sore of grade 2 or above;,or where a pre-existent pressure ulcer deteriorates into grades 3 or 4, or from 3 to 4. (Patient level data will be required on notification of a pressure ulcer via the Serious Incident (SI) process).
- Hospital Acquired Infections – we will not pay for episodes where inpatients develop MRSA or MSSA bacteraemia, excluding admissions where this is the primary cause of admission (i.e. acquired elsewhere).
- We will not pay for episodes where an inpatient develops Invasive Group A Streptococcus.
- We will not pay for episodes where an inpatient is involved in an outbreak of C Difficile – i.e. where 2 or more cases of confirmed C Difficile infection occur within 24 hours of each other in the same clinical area; we will not pay for the second inpatient's nor any subsequent cases until the outbreak is formally declared closed.
- Never Events – we will not pay for episodes where a patient suffers an unacceptable and preventable Never Event, as defined by the Department of Health insofar as they apply in a mental health context.

Patient Opinion
In line with national focus and the CCGs' commitment to patient engagement and involvement, we intend to include a requirement for Patient Opinion to be sought by all providers under contract with local quality reporting and performance standards.

Commissioning for Quality and Innovation (CQUIN)
We will seek assurance from yourselves that appropriate CQUIN schemes implemented over 2013/14 are mainstreamed into core delivery.

We will develop the annual CQUIN scheme with the Provider which will include nationally mandated and local indicators. This will enable us to reward excellence by linking a proportion of the Provider's income to the achievement of quality improvement goals. We will apply this framework to embed quality within our discussions with Providers and to create a culture of continuous quality improvement.

In addtion to using CQUIN to incentivise the delivery of improved mental health services we continue to be committed to a system-wide approach to tackling admission and flow through unplanned care settings and will, again, be ring-fencing a percentage of CQUIN monies for this purpose. We expect the Provider to contribute to this work and a proportionate amount of the CQUIN scheme will be dedicated to this as was the case in 2013/14.

Where pre-qualification criteria apply the Provider will need to evidence compliance.

Financial context

At the time of writing CCGs do not know the detail of the 2014/15 financial allocations. The commissioning intentions as listed may need to be revisited in the light of any changes arising from the resource allocation process. Unless specifically stated we anticipate no additional funding in 2014/15. Any decision to invest in services will need to be matched by divestment or a reconfiguration of existing provision.

Assurance on Quality
Commissioners require ongoing assurance throughout the 2014/15 financial year regarding the Provider's internal CIP. The impact of any cost improvement on workforce and front line delivery is of particular importance to CCGs. Commissioners would want to understand the principles of any cost improvement plans and the impact/risk stratification of proposed workforce redesign on patient care and safety and on agreed service outcomes

Though we have yet to see the Operating Framework for 2014/15, the NHS planning guidance for 2013/14, 'Everyone Counts', directed that:-

> *"To be contracted to receive NHS services, all commissioners will operate on the basis that any cost improvement programmes must be agreed by the Medical and Nursing Directors of the provider as having been assured as clinically safe.*
>
> *In addition, the clinical leaders of clinical commissioning groups must make their own assessment of cost improvements and be satisfied that services are safe for patients with no reduction in quality. To support decision making they should use the National Quality Board's "how to" guides, the potential impact on local and nationally accredited tools, such as the National Quality Dashboard, the NHS Safety Thermometer and any likely impact on staff and patient surveys, including the Friends and Family Test."*

CCGs will therefore continue to follow this guidance.

Service Specific Issues

Access and Assessment Team and Primary Care Communication

- Commissioners require the Provider to achieve the following compliance with the agreed times for assessment within the Access and Assessment Team:
    - 4 hour, 100% compliance
    - 72 hour, 95% compliance
    - 28 days, 95% compliance
- During 2014/15 we will also wish to establish similar standards for ongoing treatment along the pathways beyond the Access and Assessment Team.
- Where necessary, the Commissioners will seek to use the available contractual levels to ensure the required Provider performance is achieved.
- If not already implemented by 1st April 2014, Commissioners wish NSFT to pilot an electronic GP feedback form (template to be agreed between Provider and Commissioner) to be issued following referral and assessment.

Dementia

- We expect the Provider to meet the national dementia diagnosis trajectory to meet national calculator uplift between 2% - 5% per annum – requirement for additional resource to meet the early/ timely diagnosis of patients. This is currently being mapped as a part of an additional 600 case capacity for 2013/14.

- We will work with the Provider to ensure the pathway for patients assessed and referred under the FAIR scheme (Dementia CQUIN into the Acute Trusts 2012/13/14) is opened to direct referrals from Acute Trusts to Memory Services and to ensure that the current low level waiting times are not compromised by this change of pathway. We also wish to ensure that timely communication with GPs is in place to confirm that a direct referral has been made.
- An evaluation of the current system for Dementia Diagnosis is taking place in 2013/14 with the outcome of this being potentially taken forward in 2014/15.

Adult ADHD
There are new care pathways that have to be agreed for the 2014/15 contract, with agreement to be sought on certain care pathways to understand where they align to Care Clusters i.e. Adult ADHD.

Improving Access to Psychological Therapies (IAPT)
The Improving Access to Psychological Therapies service across all the CCGs in Norfolk including Great Yarmouth and Waveney CCG will be re-commissioned in 2015. An options appraisal will be undertaken leading to the tendering and procurement in 2014/15.

CAMHS
Commissioners will support the establishment of a CAMHS Network so that commissioners and providers of the four tiers meet regularly to ensure a clear and seamless pathway to support children with mental health issues.

Commissioners wish to maintain the maximum waiting time for treatment of children and families CAMHS Tier 3 services of 8 weeks.

Section 136 Suites
Commissioners wish to see staffed Section 136 suites in place throughout Norfolk. This is in line with recent CQC and HMIC report recommendations.

Patient Transport
Commissioners seek to adopt, in Norfolk, the pilot and standards set in the North Essex agreement for the conveyancing of Mental Health patients by EEAST.

Discharge
Commissioners seek to aid the early discharge of patients from acute hospitals through the use of non-acute care facilities, including mental health settings for "without prejudice" placements prior to continuing healthcare assessment provision. We specifically wish to explore opportunities for patients with dementia in this regard.

Gender Dysphoria
Commissioners seek to commission Gender Dysphoria local psychiatric assessments from mainstream provision in line with the NHS England guidelines prior to possible referral to Charing Cross services.

Mental Health Liaison Worker Service
Commissioners wish to review the role and function of the Mental Health Liaison Worker service.

111
Commissioners wish to ensure that the front of house system of referral into NSFT services via AAT or CRHT is linked to the 111 service.

Placement without prejudice
Work during 2013/14 is in place to understand how community beds might provide 'without prejudice' placements prior to a continuing healthcare assessment. The outcome of this work may result in further discussions as part of 2014/15 contract negotiations.

Autistic Spectrum Disorder
New NICE guidance requires CCGs to review the current ASD pathway. The provider is asked to engage fully in this piece of work.

Palliative Care

- It is the intention of Commissioners to ensure palliative care education supports service transformation through the implementation of a palliative care education service specification – supported by a CQUIN indicator.
- It is the intention to implement a patient held 'yellow folder', an electronic palliative care record and resuscitation documentation to ensure safe and effective governance and information transfer processes are in place to support the movement of palliative patients between care settings so that their care needs are met and their decisions respected. Timely information sharing will also support delivery of the Urgent Care Plan and will enable commissioners to monitor key performance indicators such as agreement of an Advanced Care Plan, reduced admissions at end of life to the acute setting and meeting patients preferred place for care and death.

Whole System Working

Commissioners recognise the important role played by mental health services in effective whole system working, especially as it impacts unplanned care. Therefore commissioners require the Provider to engage in the following work streams with commissioners and other providers:

Common KPIs
The Central Norfolk Urgent Care system has expressed a desire to identify and quantify common measures of the "health of the system" against which all partners in the system should be held to account for. This will be developed with a view to inclusion as a standard measure across all contracts for 2014/15.

Project Domino
Project Domino remains a key priority area and focus for commissioners going into 2014 and beyond. We will use all mechanisms available to encourage and foster partnership working. Specifically we would seek formal commitment to the roll out of 'Domino 2', inclusive of continued attendance at the Central Planning Group, and Urgent Care Network and ensure that linkage to Project Domino is incorporated into all services commissioned where relevant. Any potential and/or new business cases would need to evidence their contribution to the ethos of Domino in order to be prioritised in the first instance.

Frequently Admitted Patient Schemes
The Commissioners wish to evaluate the effectiveness of the Frequently Admitted Patient (FAP) schemes in West Norfolk and Central Norfolk. Based on the outcome of the evaluation, Commissioners wish to consider sustainment or potential expansion of the FAP services in 2014/15 and ensure that it plays an active contribution to improve efficiencies and effectiveness of the urgent care system.

Other Issues

Operating Framework
We will commission in a way that is consistent with the 2014/15 National Operating Framework and associated guidance. The Provider will be expected to comply fully with guidance issued by the Department of Health, the National Institute for Clinical Excellence (NICE) and other competent bodies. This includes a requirement to deliver services in the appropriate settings as prescribed in any such guidance and the Commissioners intend to undertake the financial instruction (deflator) as

outlined in Operating Framework for the NHS for all Mental Health and Learning Disability contracts with health funding streams.

Payment and Pricing System

- At present we believe that the system of activity and currency is changing in 2014/15 for mental health contracts to shadow Payment and Pricing system as opposed to the current Block contract arrangements. This change will need to translate into the 2014/15 main contract with double running of the current system and the new Payment and Pricing system. Commissioners will wish to ensure that neither they nor the Provider are materially financially destabilised by these changes.
- The restructuring of Mental Health services under the Provider's Service strategy and the Payment by Results Care Clusters requires new clinical specifications to be agreed and costed. Commissioners wish to focus considerable effort on agreeing clear specifications with the Provider to include in the 2014/15 contract.

NHS Outcomes Framework
We will expect providers to report against the agreed outcomes in the NHS and Social Care Outcomes Framework and take remedial action where performance is below the national expected level.

National contract
We will contract using the electronic version of the NHS Standard Contract for 2014/15 and, whilst recognising that it is not available yet, we do not envisage any significant changes to the format, structure and content of the 2013/14 NHS Standard Contract.

Sharing and Processing Patient and other Information
Later this year, the Anglia Commissioning Support Unit will obtain Safehaven status and will be working closely with a Data Management Information Centre (DMIC) to manage information flows between Providers and Commissioners. It will mean some changes to our existing data-sharing arrangements and as more information emerges this will be shared with Providers. The success of this will be dependent on collaborative work between the DMIC, Commissioners and Providers.

Commissioning Intentions – CCG specific initiatives

South Norfolk CCG

- The development of South Norfolk locality level KPIs/SNCCG targets within the overall agreed KPIs to monitor the impact of the NSFT service strategy West Plus model on SNCCG patients.
- SNCCG wishes to increase access to psychological therapies with provision being closer to primary care. It is intended that this will include a redesign of IAPT and clusters 1 to 4 as part of the redesign model.
- Review and potential roll out of mindfulness pilot.

North Norfolk CCG

- Improved access to wellbeing service for patients with spinal pain – commissioning Pain Management Service to devise training programme for Wellbeing staff to improve their ability to manage patients with chronic musculoskeletal pain at an early stage of presentation.
- DIST and link workers – reviewing and where appropriate re-commissioning the service to provide specific care packages to frequent A&E attenders with mental health conditions.

West Norfolk CCG

- These intentions are to be considered alongside the overarching commissioning intentions letter, issued to all providers by West Norfolk CCG as an addendum to this letter. This overarching document has been developed to reflect the system wide partnership work already commenced in West Norfolk – the SWIFT programme, to which existing partners including NSFT have expressed their commitment. This complex programme of commissioning redesign, instigated by both system challenge and opportunity and supported by both NHS England and Monitor, will necessarily continue to shape commissioning intentions for 2014/15 as it develops over the coming months. West Norfolk CCG expects partner providers to continue to work proactively and in collaboration to develop the provision of integrated services in the West of Norfolk. West Norfolk CCG reserves the right to amend or add to the areas listed in light of future SWIFT programme developments.

- As an inherent part of commissioning intentions for 2013/14, and a commissioner document referred to in the Provider's contract (dated 18th December 2012), West Norfolk CCG, along with other Norfolk commissioners, have consistently requested further detail of planned Radical Redesign plans. To date this has not been received, and further, inconsistent messages have been received from frontline NSFT staff, and shared Trust documents regarding proposed changes. West Norfolk CCG requires transparency of proposed Radical Redesign plans for 2013/14 and 2014/15. This should include a breakdown of working assumptions regarding demand and capacity modelling, expected bed provision (numbers and occupancy assumptions), expected caseload size and future plans. West Norfolk CCG recognises the need for the Provider to make efficiency savings, and would wish to work collaboratively with the Provider to agree these with full knowledge of any local implications for West Norfolk patients.
- Specific work is being undertaken for the design and modelling of the Psychiatric Liaison Service at QEH. West Norfolk CCG is of the position that this service was withdrawn, and its' function is commissioned within the baseline of provision in the West of Norfolk. From additional non recurrent Winter funding a service is being redesigned to meet current needs and to extend that into patient pathway areas requiring Mental Health expertise in A&E, In-patients and in other relevant settings in the hospital. The sustainability of this provision is core to the delivery of mental Health services in West Norfolk and the effective and efficient functioning of the Accident and Emergency Department at QEH.
- To ensure that the development of the Psychiatric Liaison Services at QEH is a component part of an integrated approach to patient care.
- To continue the provision and implementation of the DIST team, and system-wide Joint Assessment Team commissioned as part of the System Wide 1% CQUIN scheme in previous years.
- To ensure that the availability of a single point of access, via AAT, is sufficient to meet the demands of the West Norfolk population, to agreed KPI response times. This should ensure all patients receive timely access to services in line with their need.
- To develop and report against West Norfolk CCG specific KPIs/targets within agreed KPIs.
- To have staffed Section 136 suites in place in West Norfolk, as other parts of Norfolk. This is in line with recent CQC and HMIC report recommendations.

- West Norfolk CCG expects the Provider to participate fully, as other members of the Urgent Care Board in the West of Norfolk for the benefit of urgent care provision across the health and care system. This will include full participation in the Urgent Care Board, fielding of approrpiate representation of sufficient seniority to this, and sub-group meetings, and active engagement in the development of robust Urgent Care, and system wide escalation plans.

Norwich CCG

- NHS Norwich CCG wishes to develop, in conjunction with our clinical leads and local people, a model of primary care mental health service specific to meet the particular needs of an urban/suburban population. It is intended that this will include a redesign of IAPT and clusters 1 to 4 as part of the redesign model.
- The CCG would like to work in partnership with NSFT and NNUH to develop a pathway for those that self-harm to prevent future unplanned admission.
- NHS Norwich CCG has four Clinical Action Teams (CATs) – Mental Health, Children & Families, Planned Care and Older People. The CATs are currently working up a prioritised 2014/15 work programme. Specific clinical areas of interest to NSFT are:-
    - The Mental Health Needs Assessment presented to the Mental Health Clinical Action Team in August highlighted that in February 2012, there were 2,505 people claiming incapacity benefit across Norwich due to mental illness, 57.5% of all claimants and a rate of 2.8% of working age adults - the highest in the county. Norwich CCG would like to work with NSFT to understand the issues further and produce a joint action plan to address.
    - Norwich CCG, Norwich City Council and Public Health specialists along with a wide range of stakeholders have developed a Norwich Alcohol strategy. Norwich CCG wishes NSFT to play an active role in the partnership action required to achieve the goals of the strategy.
    - The CCG will work with other CCGs – supported by the Child Health & Maternity Commissioning Team (Anglia CSU) to review the current pathway for providing health assessments to Looked After Children and to address the lack of support Looked After Children have when leaving care.
        - The CCG will continue to work as a key partner in the Healthy Norwich programme, influencing specific health improvement and lifestyle programmes across the city. The CCG encourages all Providers to engage these work streams.

We hope that this letter is helpful to the Provider in setting out Commissioners main priorities for 2014/15 and we look forward to working with you to a successful conclusion.

Mark Taylor	**Ann Donkin**	**Jonathon Fagge**	**Sue Crossman**
Chief Officer	**Chief Officer**	**Chief Officer**	**Chief Officer**
North Norfolk CCG	**South Norfolk CCG**	**Norwich CCG**	**West Norfolk CCG**

Copied to
Andy Evans, NHS Great Yarmouth & Waveney CCG
Clive Rennie, NHS North Norfolk CCG
Jennie Starling, NHS Anglia CSU
Kathy Chapman, Norfolk & Suffolk NHS Foundation Trust
Karen Rix, Norfolk & Suffolk NHS Foundation Trust
Maria Short, Norfolk & Suffolk NHS Foundation Trust

Norfolk & Waveney Child Health and Maternity Commissioning Board

Introduction

In accordance with the Terms of Reference for the Child Health and Maternity Commissioning Board (CHMCB) the following principles apply to sharing information with all commissioning boards in order to inform and support the development of commissioning intentions with all providers.

1. To develop child health and maternity commissioning intentions across its functional remit, clinically led, aligned to the contracting cycles and appropriately aligned to commissioning led by Norfolk County Council's (NCC) Children's Services.
2. To facilitate and agree joint Clinical Commissioning Group (CCG) commissioning and where appropriate joint CCG and NCC commissioning. Commissioners should bring all relevant (ie where there is impact beyond the proposing CCG) commissioning proposals to the Board to enable participation by other CCGs and joint commissioning wherever appropriate. However, the Board should not be considered an approval gateway for individual CCGs, unless a commissioning intention by one represents a significant risk to services in other CCG areas.
3. To ensure that services commissioned/commissioning intentions deliver compliance with the statutory framework for safeguarding children, Looked After Children (LAC) and children with Special Educational Needs (SEN) and other relevant statutory guidance.
4. To act as an escalation point for exceptional issues in clinical quality and patient safety, contract negotiation, contract and financial performance, and contract dispute. Escalation to the Board ensures that all CCGs are aware, and a coordinated commissioner response determined.

The CHMCB has developed the enclosed composite of expressed CCG commissioning intentions, grouped according to CCGs with common priorities. If it would be helpful to group them differently, in relation to provider contract, please let me know.

We have included Public Health and NHS England information for completeness although these are obviously not within our commissioning remit.

I hope this information is helpful to your Board. Please let me know if the CHMCB can provide anything further.

Sue Crossman

Norfolk & Waveney CCGs Commissioning Intentions 2014/15

CCGs (all 5 Norfolk & Waveney CCGs) Norwich North Norfolk South Norfolk West Norfolk GY&W	Service	
	1	Health Assessments for Looked After Children
	2	**CAMHS** • Developing further a common CAMHS offer for children and young people (for targeted and specialist CAMHS) • Strengthening support and advice for Primary Care and other staff working in universal settings • Improving access to joint/integrated CAMHS pathways of care and treatment (for targeted and specialist CAMHS) • Systematic implementation and reporting of approved routine outcome measures across targeted and specialist CAMHS • Moving to a single contract and performance monitoring/ management process across Norfolk & Suffolk specialist CAMHS • Future of IST

CCGs (4 Norfolk) Norwich North Norfolk South Norfolk West Norfolk	Service	
	1	Children & Families Bill (SEND legislation) Expected to be implemented from September 2014 • New birth to 25 health education and care plans. Statutory duty on health to contribute to these. Reviewed annually. Resource implication. • All children with an EHCP will have the right to ask for a personal health budget. This will have implications for the community block contract.
	2	ASD Pathway NICE guidance on Interventions due November 2013
	3	Community Healthcare Services for Children with a Disability and/or Additional Healthcare needs (DASH Service Specification)
	4	Long Term Conditions (in relation to high levels of emergency admissions including coding issues): • Asthma • Epilepsy • Diabetes • LRTIs (lower respiratory tract infections)
	5	Community Continence Service
	6	Wheelchairs, including appliances
	7	CFS/ME pathway for under 18s
	8	Model for commissioning Children's Continuing Care provision including therapies (complex cases, tripartite funded)

CCGs (3 Central)	Service	
Norwich North Norfolk South Norfolk	1	Children's Community Nursing Team Further development of CCNT re "aspirational" services to be provided in the future as per original business case.

CCG	Service
Norwich	• Provision of Monday morning Epilepsy clinics (NNUH) – Project has commenced • Diabetes Structured Education Programme (NNUH) – Project has commenced • Diabetes Transitional Care – Community Settings (NNUH) – Project has commenced • Alcohol prevention/support Nurses (out of hours) (NNUH) – project has commenced • Self Harm Pathway (NSFT) – project has commenced • IAPT Re-commissioning (NSFT) • Urgent Care Pathway Redesign (NNUH) – to commence Sept 2013 • Asthma Pathway Review (NNUH) – project has commenced • Childhood Obesity • Exploration of local Bariatric Surgery Provision (NNUH) • Allergy pathway
South Norfolk	• Obesity and childhood physical activity • Healthy weight strategy • Early Pregnancy Assessment Unit • Review of the maternity payment by results pathway
West Norfolk	• Children's Community Nursing Team
North Norfolk	(None submitted)
HealthEast (GY&W)	• Integration • Teenage Pregnancy

Public Health	• Re-specification of Healthy Child Programme 5 – 19, including School Nursing Service
NHS England	• Intention to work collaboratively to ensure the immunisation status of all children at independent schools is recorded and vaccination offered and ensure they are registered with a GP and child health to ensure they are known to health services and to ensure safeguarding. • Ensure vaccination status of all University entrants and offer vaccination. • To continue with the Increase in Health Visitor training and recruitment trajectories as per national plans. • To ensure all transfers in /New births /deaths are notified to child health in a timely manner by GPs to ensure access to all appropriate services Health Visiting ,immunisation screening • To ensure all suspensions on child health systems due to DNA for vaccinations are notified to safeguarding. • To ensure appropriate provision of Forensic medical examination and paediatrician cover and appropriate forensic facilities to gather evidence for children following rape and sexual assault . • To work with National teams to improve access and distribution of Healthy Start vitamins and ensure licences are in place. • To ensure BCG is administered in maternity unit prior to discharge For all eligible children as per Health Child Programme. • Implementation of paediatric influenza vaccine

SC/19.08.13

NHS
Great Yarmouth and Waveney
Clinical Commissioning Group

HealthEast

Commissioning intentions 2014/15 and beyond

Andrew Evans
Chief Executive

January 2014

Better Health, Better Care, Better Value

Aiming to achieve

NHS
Great Yarmouth and Waveney
Clinical Commissioning Group

HealthEast

- Focus on our whole population
- Integration across the public sector
- Best use of total resources
- Well-being not health alone
- Care at home and in the community
- Removal of perverse incentives
- Vertical integration effects
- Prevention and early treatment
- Sharing care, resources, risks and benefits with partners

Contracting actions

NHS
Great Yarmouth and Waveney Clinical Commissioning Group

HealthEast

- Single operational management arrangements across pathways/disease areas required
- Respiratory care pilot- whole care approach
- Some movement from *Payment By Results*
- Out of hospital team
- 7 day working requirements
- Investing in primary care
- Virtual pooling of budgets with partners – CCs, D/BCs, NHS England
- Scrutiny of value for money of all contracts

Support for Parents & Carers of children & young people accessing mental health services

Cover Sheet

What is the role of the H&WB in relation to this paper?

For information and discussion

Key questions for discussion

Q. In what ways could partners help improve the accessibility of mental health services?

Actions/Decisions needed

The Board needs to:

- Discuss the report and consider the ways in which partners could help improve the accessibility of mental health services.

Support for Parents & Carers of children & young people accessing mental health services

Report of the Chief Officer of NHS North Norfolk Clinical Commissioning Group

Summary

This report sets out how parents/carers of children & young people accessing mental health services are routinely involved in their treatment and care. It also describes the mechanisms through which parents/carers in need of separate or additional targeted or specialist mental health support are enabled to access adult mental health services.

Action
The Health and Wellbeing Board is asked to:

- Discuss the report and consider the ways in which partners could help improve the accessibility of mental health services

1. Background

1.1 At the October Board meeting members received a presentation from Sandra Dinneen which made reference to how Suffolk had successfully reduced the numbers of young people requiring high levels of intervention through improved inter agency working. One of the points discussed was the importance of good access for children, young people and their parents/carers to mental health services. It was agreed that Mark Taylor would review what the current picture is in terms of support for parents/carers of children and young people accessing mental health services.

2. Current picture

2.1 **Systemic approaches** - Child & Adolescent Mental Health Services (CAMHS) in Norfolk routinely work 'systemically' – i.e. with the referred child and their family (particularly their parents/carers). This is because frequently, interpersonal issues within a family system are significant factors that either cause or exacerbate the presenting mental health needs of the child or young person. Norfolk's Targeted and Specialist CAMHS use systemic approaches to support children to be able to function better within the systems (not exclusively families) that they sit within. Systemic or Family Therapists form one of the core professions employed by our main Specialist Mental Health Service provided by the Norfolk & Suffolk Mental Health Foundation Trust (NSFT). NSFT also has two discreet teams with a remit to support looked after and adopted children in Norfolk – primarily by working with and through the main carers, social workers and others who have a role to support the children. Norfolk's Targeted CAMH Service – Point 1 – also routinely adopts

systemic approaches which, while child focused, include interventions and support for parents, carers and siblings.

2.2 Adult services catering for more mild/moderate mental health problems are designed to treat people 16 years and older. The 16-25 years age-group are seen as a vulnerable population and are specifically targeted by services. This is done through the main contract function and also the CQUIN scheme that is designed to improve quality. The provider, NSFT, is therefore required to increase access among 16-25 year olds and to make services more attractive for young people to come forward for help.

2.3 The service available, e.g. Improving Access to Psychological Therapies (IAPT), offers a range of talking therapies from the lower intensive psycho-educational workshops to more intensive face to face therapy sessions. A young people's specific service is offered, which includes young people's specialist workers, and works in a systemic way with CAMHS services and other pathways for young people.

2.4 **Referral rights** – Parents and carers do not have automatic rights to refer their child to Specialist CAMHS, although there are some exceptions (in emergencies, for example). Referrals typically are made to Specialist CAMHS by GPs or other health related professions. Parents/carers can refer their child to Point 1 and are encouraged to seek advice and consultation via the service's Single Point of Contact (parents/carers generated 6% of referrals in the last quarter). The parts of the 'menu' offered by Point 1 that proactively involve parents/carers include:

- Advice and consultation about how they can provide effective support to their child/young person
- Parenting courses – 3 evidence based programmes are provided: Incredible Years, Strengthening Families and Triple P
- Parent Infant Mental Health (PIMH) provision – attachment based interventions directed at the primary care giver (usually the mother) aimed at improving the care giver/infant bond and relationship form a core part of the service. The PIMH part of Point 1 also provides training, advice and consultation to staff working with parents/carers and infants across Norfolk (including Health Visitors and Children's Centre staff)

Norfolk's Wellbeing Service encourages and accepts self-referrals of adults to its talking therapy service as well as GP referrals.

2.5 **Supporting and/or referring on parents/carers with mental health problems** – when working with the parents/carers of a child receiving a CAMH Service, providers sometimes identify that some parents/carers may require targeted or specialist mental health support themselves (over and above the level of support available through the CAMH Service). In such cases, dependent on the specific presenting needs of the parent/carer and the access criteria of the relevant Adult Mental Health team, the CAMH Service will routinely advise and support the parent/carer to seek and obtain a referral.

2.6 The Norfolk Wellbeing Service is open access and is designed to serve the Norfolk and Waveney population. The self-referral option has improved the number of people accessing the service and makes it far easier for other professionals to encourage their clients to refer themselves. NSFT are also actively expected to improve the numbers of people accessing the service through the contract but also

through CQUIN measures that reward improved quality. One of these measures in specifically around improving access to the service from young people.

3. Discussion

3.1 Members are asked to discuss the report and consider the ways in which partners could help improve the accessibility of mental health services.

4. Action

4.1 The Health and Wellbeing Board is asked to:

- Discuss the report and consider the ways in which partners could help improve the accessibility of mental health services

Officer Contact

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Pharmaceutical Needs Assessment

Cover Sheet

What is the role of the HWBB in relation to this paper?

The Health and Social Care Act 2012 transferred responsibility for developing and updating Pharmaceutical Needs Assessments (PNAs) to Health and Wellbeing Boards (HWBs). The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 set out the legislative basis for developing and updating PNAs.

Each Health and Wellbeing Board (HWB) must assess needs for pharmaceutical services in its area, and publish a statement of its first assessment and of any revised version. The Regulations require each HWB to publish its first PNA by 1 April 2015.

A 60 day period must be allowed for consultation with a range of stakeholders

Actions/Decisions needed

The Board needs to:

- Note this report. The PNA will be brought to a future meeting of the Board for approval.

Report to Norfolk Health and Wellbeing Board

8 January 2014
Item 9

Pharmaceutical Needs Assessment

Report by the Interim Director of Public Health, NCC

Summary
This report outlines the purpose of a Pharmaceutical Needs Assessment (PNA), the responsibilities of the Health & Wellbeing Board in relation to production of this needs assessment and the timelines for production of a new PNA for Norfolk to come into effect in April 2015.

Action
The Board is asked to:

- Note this report. The PNA will be brought to a future meeting of the Board for approval.

1. Background

1.1 From 1 April 2013 Health and Wellbeing Boards (HWBs) became responsible for the pharmaceutical needs assessments (PNAs) published by primary care trusts (PCTs). The NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013, require each HWB to publish its first PNA by 1 April 2015.

1.2 The PNA will then be used by NHS England when making decisions on applications to open new pharmacies and dispensing appliance contractor premises. Such decisions are appealable and decisions made on appeal can be challenged through the courts. In order that NHS England can make robust decisions it is vitally important that the PNA is robust and kept up to date. The PNA will also form the basis for the commissioning of services from pharmacies by the local authority.

1.3 Failure to comply with the regulatory duties may lead to a legal challenge, for example where a party believes that they have been disadvantaged following the refusal by NHS England of their application to open new premises.

2. The duties on the H&WB

2.1 In addition to publishing a PNA, HWBs need to put systems in place that allow them to:

- Identify changes to the need for pharmaceutical services within their area
- Assess whether the changes are significant and
- Decide whether producing a new PNA is a disproportionate response.

2.2 HWBs need to ensure that there is a good flow of information with regards to the provision of pharmaceutical services by pharmacies, dispensing appliance contractors and dispensing doctors. HWBs will also need to ensure they are aware of any changes to the commissioning of public health services by the local authority and the commissioning of services by clinical commissioning groups as these may affect the need for pharmaceutical services.

2.3 HWBs will be required to undertake a consultation on their first PNA for a minimum of 60 days and the regulations list those persons and organisations that must be consulted.

3. Purpose of PNAs

3.1 PNAs will be key documents for NHS England as they will inform its decisions on applications to open new pharmacies and dispensing appliance contractor premises. PNAs will also inform the commissioning of enhanced services from pharmacies by NHS England. Enhanced services are services such as anti-coagulation monitoring, the provision of advice and support to residents and staff in care homes in connection with drugs and appliances, on demand availability of specialist drugs, and out of hours services.

3.2 The preparation and consultation on the PNA should take account of the Joint Strategic Need Assessment (JSNA) and other relevant strategies, such as children and young people's plan, the local housing plan and the crime and disorder strategy in order to prevent duplication of work and multiple consultations with health groups, patients and the public. The development of PNAs is a separate duty to that of developing JSNAs as PNAs will inform commissioning decisions by local authorities (public health services from community pharmacies) and by NHS England and clinical commissioning groups (CCGs). PNAs, as a separate statutory requirement, cannot be subsumed as part of these other documents but can be annexed to them.

3.3 Having assessed local needs and the current provision of services, the PNA must identify any gaps that need to be filled. Such needs might comprise a pharmacy providing a minimum of "essential services" in a deprived area, or pharmaceutical services of a specified type. The PNA may also identify a gap in provision that will need to be provided in future circumstances, for example, a new housing development is being planned in the HWB area.

3.4 Gaps in provision are not just gaps in pharmaceutical health needs but also gaps by service type. For example, a locality may have adequate provision of essential services to meet the needs of the population, but have a need for more specialist services, such as the management of a long-term condition. Examples of gaps that HWB's may identify, include:

- inadequate provision of essential services at certain times of day or week leading to patients attending the GP-led health centres being unable to have their prescription dispensed;
- opening hours that do not reflect the needs of the local population;
- areas with little or no access to pharmaceutical services; and
- adequate provision of dispensing services (by those GPs who dispense), but patients unable to access the wider range of essential services.

3.5 The PNA includes a statement outlining any gaps.

4. Risks to HWBs

4.1 Decisions on applications to open new premises may be appealed by certain persons and may also be challenged via the courts. The use of PNAs for the purpose of determining applications for new premises is relatively new. It is therefore expected that many decisions made by NHS England will be appealed. It is therefore vitally important that PNAs comply with the requirements of the regulations, due process is followed in their development and that they are kept up-to-date.

5. Timescale

5.1 Preparation of the PNA will begin in January 2014. The aim is to consult on the PNA during the summer and to bring the document to the HWB for approval in the autumn, ensuring that the legal duty to publish before April 2015 can be met.

6. Action

6.1 The Board is asked to:

- Note this report. The PNA will be brought to a future meeting of the Board for approval.

Officer Contact

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Autism Self Assessment Framework

Cover Sheet

What is the role of the H&WB in relation to this paper?

In order to comply fully with the terms of the Autism Act of 2009 and the strategy Fulfilling and Rewarding Lives (2010), the County Council together with the CCGs are required to assess progress in implementing the 2010 Adult Autism Strategy.

In a letter to all Directors of Adults Social Services, the Minister of State for Care and Support, confirmed the requirement for the completed Autism Self-Assessment Framework (SAF) to be presented to the HWBB by the end of January 2014. It is the role of the Health & Wellbeing Board to be aware of, discuss and endorse the Norfolk SAF.

Key questions for discussion

Q1. What are the key challenges faced in addressing the areas identified for improvement?

Q.2 What are the barriers and what can partners on the H&WB do, either individually or collectively, to help overcome them?

Actions/Decisions needed

The Board needs to:

- Consider and the areas where improvement is necessary
- Endorse the Norfolk Autism Self Assessment Framework (SAF)

Autism Self Assessment Framework

Report of the Director of Community Services, NCC

Summary
This report outlines the Government's strategy 'Fulfilling and Rewarding Lives', which sets out the long term vision for transforming the lives of and outcomes for adults with autism, with an emphasis placed on the requirement for local, specialised services.

The report also outlines the requirement for completion of an Autism Self Assessment in all areas which would reflect position of Norfolk services in relation the needs of people with Autistic Spectrum Conditions. It also highlights the requirement that the completed Self Assessment Framework be presented to the relevant Health & Wellbeing Board by the end of January 2014.

Action
The Health and Wellbeing Board are asked to:

- Consider and discuss the areas where improvement is necessary
- Endorse the Norfolk Autism Self Assessment Framework (SAF)

1. Background

1.1 The passing of the Autism Act (2009) and the subsequent strategy (Fulfilling and Rewarding Lives, 2010)[1] emphasised the requirement for local, specialised Autism services. The government's vision for service delivery was set out in the strategy where 'all adults with autism are able to live fulfilling and rewarding lives within a society that accepts and understands them. (They are also able) to get a diagnosis and access support if they need it, and they can depend on mainstream public services to treat them fairly as individuals, helping them make the most of their talents.'[2]

1.2 The strategy focuses on five core areas of activity:

- Increasing awareness and understanding of autism among frontline professionals
- Developing a clear, consistent pathway for diagnosis followed by the offer of a personalised needs assessment
- Improving access to the services and support which adults with autism need to live independently within the community
- Helping adults with autism into work
- Enabling local partners to plan and develop appropriate services for adults with autism to meet identified needs and priorities.

[1] http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_113405.pdf
[2] The 2010 Adult Autism Strategy Fulfilling and Rewarding Lives: Evaluating Progress – the second national exercise.(letter from N. Lamb)

1.3 Autism is a developmental condition which affects the function of the brain. It affects the way that someone interacts with and relates to other people, and for someone with Autism the world can be a confusing, unpredictable and sometimes scary place. Principally, people with Autism have difficulty with communicating and interacting with others, find change to their environment very difficult to cope with and find processing information and recognising social signals troubling.

1.4 Under the new Diagnostic and Statistical Manual of Mental Disorders (DSM-5) criteria, individuals with ASC must show symptoms from early childhood, even if those symptoms are not recognised until later. This criteria change encourages earlier diagnosis of ASC but also allows people whose symptoms may not be fully recognised until social demands exceed their capacity to receive the diagnosis. It is an important change from DSM-4 criteria, which was geared toward identifying school-aged children with autism-related disorders, but not as useful in diagnosing younger children.

1.5 Two of the four symptoms related to restricted and repetitive behaviour need now to be present for a diagnosis of ASC:

- Stereotyped or repetitive speech, motor movements or use of objects.
- Excessive adherence to routines, ritualized patters of verbal or nonverbal behaviour, or excessive resistance to change.
- Highly restricted interests that are abnormal in intensity or focus.
- Hyper or hypo reactivity to sensory input or unusual interest in sensory aspects of the environment.

1.6 The Adult Autism Strategy Fulfilling and Rewarding Lives is an essential step towards realising the Government's long term vision for transforming the lives of and outcomes for adults with autism. The Department of Health is the lead policy department for the Strategy but with delivery shared across a range of government departments and agencies, and local health and social service providers. The Strategy is not just about putting in place autism services but about enabling equal access to mainstream services, support and opportunities through reasonable adjustments, training and raising awareness

1.7 In August 2013, the Minister of State for Care and Support, Norman lamb MP, wrote to all Directors of all Adults Social Services, asking for a completed Autism Self-Assessment Framework to be returned to Public Health England by Monday 30 September 2013. This would reflect position of Norfolk services in relation the needs of people with Autistic Spectrum Conditions. It was required as part of the requirement for the completion of the SAF that it be presented to the HWBB by the end of January 2014.

2. Autism Self-Assessment Framework (SAF)

2.1 The SAF is the formal review of progress against the Strategy will give the Government an opportunity to assess whether the objectives of the Strategy remain fundamentally the right ones, and be assured of the progress that is being achieved by Local Authorities and the NHS. There is also a need to consider what should happen to continue to make progress and what barriers need to be resolved. The investigative stage of the Review will last until the end of October and the Strategy will be revised as necessary by March 2014. The purpose of the review was to:

- Assist Local Authorities and their partners in assessing progress in implementing the 2010 Adult Autism Strategy;

- Demonstrate how much progress has been made since the baseline survey, as at February 2012;

- Provide evidence of examples of good progress made that can be shared and of remaining challenges.

2.2 In his speech at the Adult Autism Strategy Conference on 9th October, Norman Lamb, Care Minister, posed questions for commissioners, local authorities and service user and their carers

- How to make more people in society aware of Autism and raise awareness across the health and care profession by introducing extended training for GPs
- How can we make diagnosis more straightforward? Currently waits are too long
- More adults with autism should receive the right support. What is currently stopping people from getting access? Are the services there; what's the block; what's the difficulties; and why are the services coming from the voluntary sector and not the local authority
- Adults with autism should be helped into work. Employers have a lack of understanding. What are the challenges and issues that restrict people with autism accessing employment?
- How can employers have the benefits of employing people with autism demonstrated to them?
- How to improve organisational reasonable adjustment

2.3 The completed Norfolk SAF (see appendix 1), was used as part of the Round Table discussion that took place on 24th October, where the Minister, playing an active role in the Review of the Strategy, launched the Review's listening stage. As well as sharing ideas for local development and for the Review to consider, the discussion offered a chance for the Minister (and those attending) to better understand the reality of implementation and the challenges being faced, of the needs and wants of people with autism.

3. Adult Autism Steering Group

3.1 The Adult Autism Steering Group was established in 2012 with a range of stakeholder from statutory services, health services, voluntary sector and carers and service users. This group has met on a number of occasions, most recently on 28th November where elements of the SAF was reviewed.

3.2 At a previous meeting the Public Health assessment of the prevalence of Autism in Norfolk was discussed (See Appendix 2). It was however, noted by the group, that although prevalence was a useful tool as a starting point to assess the county wide need, clearer data is required. The group was updated with the information on the general picture for Norfolk, where it was observed that some work in addressing the specific needs of people with Autistic Spectrum Conditions, eg Job Centre was required.

3.3 The Autism SAF was recognised as being a reflection of the services that available to people with Autism in Norfolk, but it was also observed that there were examples of good and poor practice that could be reported by different members and this was an area that needed to be reflected in the actions for future meetings. The Group agreed to use the SAF as a framework for addressing specific issues as part of an Action Plan Strategy and would meet again in the new year.

4. Action

4.1 The Health and Wellbeing Board is asked to:

- Endorse the Autism Self Assessment Framework (SAF)

Officer Contact

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Autism SAF: Collation of responses to the 37 Questions

Link to PH questions
http://www.improvinghealthandlives.org.uk/uploads/doc/vid_18893_20130832%20AutSAF2013%20Questions%20with%20RAG%20rating%20definitions.pdf

Number	Question	Responses	Q-type	Red	Red/ Amber	Amber	Amber / Green	Green
1	How many Clinical Commissioning Groups do you need to work with to implement the Adult Autism Strategy in your local authority area?	**Derek Holesworth** North Norfolk CCG South Norfolk CCG West Norfolk CCG Norwich CCG Great Yarmouth and Waveney CCG (Health East)	5					
2	Are you working with other local authorities to implement part or all of the priorities of the strategy?	Yes, through integrated commissioning provision on behalf of the Local Authority and Norfolk CCGs. This is enacted through a formal Section 75 arrangement						
3	Do you have a named joint commissioner/senior manager responsible for services for adults with	Derek Holesworth, Integrated Commissioner for the Norfolk CCGs and Norfolk County Council						

	autism?							
4	Is Autism included in the local JSNA?	Yes See http://www.norfolkinsight.org.uk/resource/view?resourceId=820						
5	Have you started to collect data on people with a diagnosis of autism?	Norfolk Community Health and Care diagnostic LD service records Autism Acute hospitals - An autism patient administration system (PAS) alert is recorded and data gathered (with patient consent) Data is recorded by a dedicated commissioned service for people with high functioning Autism (Asperger's Syndrome)						
6	Do you collect data on the number of people with a diagnosis of autism meeting eligibility criteria for social care (irrespective of whether they receive any) If so, what is 1. the total number of these people? 2. the number who are also identified as having a learning disability, and 3. the number who are identified as also having	1) No 2) No 3) No Data is collected and recorded on all people with LD though not able to sort by Autism. Autism detail is held within case notes						

	mental health problems?							
7	Does your commissioning plan reflect local data and needs of people with autism?	No - An Action Plan drawn up to address the elements of the Autism Act is progressing within the Adult Autism Steering Group. For future commissioning intentions we will be relying on the data and assessment in the Public Health JSNA to address the needs of people in Norfolk with Autism						
8	What data collection sources do you use?	This is formation to follow						
9	Is local CCGs engaged in the planning and implementation of the strategy for local area	Yes, There exist a cross social care and health Adult Autism Steering Group that meets to look into the issues that are required to be addressed to implement the strategy, which meets quarterly						
10	How are people with Autism and their carers engaged in the planning of services	Adult Autism Steering Group has Carers and service users listed as part of the ,membership and are invited to attend the meetings Engagement / stakeholder event have Norfolk Family Services coordinator from Autism Anglia attending						
11	Have reasonable adjustments been made to everyday services to improve access and support for people with autism?	**NNUH** Patient information regarding a diagnosis of Autism is recorded on the PAS system and in the patient's notes. NNUH have an Acute Liaison Nurse for people with learning disabilities and autism. This individual supports staff in making reasonable adjustments based on the individual's specific needs. Furthermore, the NNUH has structured training programmes for staff that care for patients with autism in addition to the basic autism awareness sessions that all clinical staff completes on induction. Autism link practitioners and a wealth of electronic resource are available on NNUH staff Intranet **Queen Elizabeth Hospital,** Kings Lynn, Examples of reasonable adjustments regularly made •Side room to reduce impact of ward sounds, smells, light and to give						

		patient control of their environment and who enters. •First on theatre list to reduce waiting time and subsequent anxiety, and also to reduce risk of delay / cancellation •Where in patients best interest, tests can be done under anaesthetic / sedation e.g. blood samples taken when otherwise not possible due to distress caused •Hospital Passport, where details of a patients specific needs go with them into hospital and remain with their notes •Individualised care planning / timetabling with Liaison Nurse (myself) •Direct admission to ward rather than going to pre-assessment and/or using Admission ward **GP Practices** are making reasonable adjustments for patients with Autism						
12	Do you have a Transition process in place from Children's social services to Adult social services?	NCC has a robust system, with Multi agency Transition Protocols, a clear Transition pathway. A clear referral to adult care that can be triggered by schools, voluntary sectors, parents/carers/professionals. Transition workers specifically assigned to complex cases and well defined partnerships across agencies. We also Collate date of cohorts coming through to predict need and collate what services are being used by young people when transferring over at 18. The experience of organisations working with AS clients in transition is reported as an issue that needs to be review in light of the action plan. The issue is one of clients not meeting NCC adult service criteria when referred. This will be examined and clarified						
13	Does your planning consider the particular needs of older people with Autism?	Autism Self Assessment Framewo The Adult Steering Group takes into consideration of the needs of older people when considering the Action Plan against the Autism Act "The commissioning assumption for all services for older people is to						

		start from the premise that most people experiencing increasing problems as a result of the aging process share common needs regardless of any underlying or long-standing conditions. There is therefore a commissioning expectation that both "universal" and mainstream services will make any necessary adjustments to be in a position to meet these needs. The commissioning of specialism services would therefore only be consider where it could be demonstrated that needs – including those associated with autism – could not be met by the universal/mainstream services."						
14	Have you got a multi-agency autism training plan?	We are not aware of any multi-agency autism training plan						
15	Is autism awareness training being/been made available to all staff working in health and social care?	**NCC** provides Autism training to Children's Services staff and foster carers. They will be working with Autism Anglia in 2013-14 to deliver further training . **NNUH** has structured training programmes for staff that care for patients with autism in addition to the basic autism awareness sessions that all clinical staff completes on induction. Autism link practitioners and a wealth of electronic resource are also available, via staff Intranet **QEH** Autism Awareness forms part of my LDAA (LD and Autism Awareness) training. This includes a short video - Nick`s story. Nick is a gentleman with Autism who has a variety of reasonable adjustments made so that he is able to go into hospital and have his operation. The 30minute training programme is delivered 3 times a month and clinical staff from all over the hospital attends yearly. Bespoke sessions from 10mins to 1 day in length are delivered on request to departments throughout the hospital. Autism information would be in the patient's health record if QEH have been made aware of the issue by the GP or the patient and their family. They are looking to try and flag these issues on the actual							

		patient's PAS record so that it can be flagged to others who may be booking appointments etc. without the convenience of having the patient's health records to hand. Updating PAS is part of a current project being undertaken and has started. QEH are trying to work with the Learning Disability Partnership Trust to access the information in the community as to individuals' diagnoses so that PAS can be as live and relevant as possible. At the moment much of this information sits on registers within the GP practice or with other trusts and we are not always aware of the person's underlying condition. Our LD policy and procedures do include making reasonable adjustments. **NCH&C** training delivered to the NCHC staff (mainly nursing in the Community hospitals) **GP Practices.** NCH&C also provided Autism training to the GPs and so far we have trained about 89% practices. Asperger East Anglia has been contracted to supply Autism awareness training to NHS staff, we are currently delivering to staff at Little Plumstead hospital						
16	Is specific training being/been provided to staff that carry out statutory assessments on how to make adjustments in their approach and communication?	See Q15 regarding training and appropriate adjustment training for people with Autism						
17	Have CCGs been involved in the development of workforce planning and are GPs and primary care practitioners engaged	See Q15. Yes there has been some involvement of GP in the training agenda but not system wide						

	included in the training agenda?							
18	Have local Criminal Justice services engaged in the training agenda?	Yes, training covers Autism •Within the student officer training autism is made mention of •it has also been discussed at Operational Partnership Team MH & LD networking days where Autism Anglia has delivered awareness training. •The lead for MH and LD has participated in SENCO training days around Autism together with the lead for Safer Schools Partnerships. •As an organisation NPC are signed up to the Autism Alert card run by Autism Anglia						
19	Have you got an established local diagnostic pathway?	Yes for people with high functioning Autism, Asperger's Service Norfolk is part of the pathway For lower functioning Autism LD services is part of the pathway						
20	When was the pathway put in place?	Asperger's Service Norfolk was piloted in 2010 started 2011. NCH&C LD service has a long term arrangement						
21	How long is the average wait for referral to diagnostic services?	Asperger's Service Norfolk. Initial screening 2 – 6 weeks, Prioritised referrals 2 – 6 weeks, Non-priority referrals can wait up to over a year						
22	How many people have completed the pathway in the last year?	Asperger's Service Norfolk - August 2012 - August 2013 from screening to diagnostic assessment (71) August 2012 - Dec 2012 (25) January 2012 - August 2013 (following service review) (46)						

23	Has local CCG / support Services taken the lead in developing the pathway	As part of the integrated commissioning function, Derek Holesworth chairs an Adult Autism Steering Group to look at issues that need to be addressing as part of the National Autism Strategy						
24	Local diagnosis pathway for Autism	Asperger's Service Norfolk is made up of Asperger's East Anglia which delivers the assessments, NCH&C which delivers the diagnosis and NCC that delivers Social Worker support. The pathway is available to GPs through the Commissioning Support Anglia, Knowledge Management resource Lower functioning Autism is assessed through NCH&C community paediatric services						
25	In your local diagnostic path does a diagnosis of autism automatically trigger an offer of a Community Care Assessment?	Not automatically, initial screening for diagnostic pathway includes prioritisation based on Autism Act and FAC criteria. Those identified with additional social care needs are offered a community care assessment						
26	What post-diagnostic support (in a wider personalisation perspective, not just assuming statutory services), is available to people diagnosed?	Each case for personal budgets is reviewed on merits. Those involved in reviewing are LD nurses and have had training to work with those with Autism. Personal budgets are adapted to personal needs of Autism						
27	Of those adults who were assessed as being eligible for adult social care services and are in receipt	This is poorly recorded, however, there is an action plan from 2014/15 when it will be mandatory to report Reported Health Conditions of service users to the Department of Health and two of these will be Autism (excluding Asperger's Syndrome/High Functioning Autism) and Asperger's Syndrome/High Functioning Autism.						

	of a personal budget, how many people have a diagnosis of Autism both with a co-occurring learning disability and without?							
28	Do you have a single identifiable contact point where people with autism whether or not in receipt of statutory services can get information signposting autism-friendly entry points for a wide range of local services?	Norfolk Care Connect is the main entry point for NCC social care referrals and provides information and signposting, Plus the contract with Asperger's East Anglia provides specific information and assessments for people with Asperger's.						
29	Do you have a recognised pathway for people with autism but without a learning disability to access a community care assessment and other support?	Yes the Asperger's Service Norfolk for the higher functioning Autistic person Eligibility is dependent on Fair Access to Care to move onto community care assessment						
30	Do you have a programme in place to ensure that all advocates working with people with	Advocates from ASN have the training in place in order to meet the requirements however there is no formal program						

	autism have training in their specific requirements?							
31	Do adults with autism who could not otherwise meaningfully participate in needs assessments, care and support planning, appeals, reviews, or safeguarding processes have access to an advocate?	Yes, IAA services for people with autism but yes IAA services for people with mental health problems, disabilities and learning difficulties regularly support people with autism including advocate. This is an area that requires on-going monitoring and is subject to improvement support in many of these areas.						
32	Can people with autism access support if they are non Fair Access Criteria eligible or not eligible for statutory services?	Yes there are generic services which are appropriate for many people with autism whose support needs are not substantial and FACS eligible. These include Information, Advice and Advocacy services and countywide floating support.						
33	How would you assess the level of information about local support in your area being accessible to people with autism?	Information about local support though ASN is positive. Asperger Service Norfolk: provides post diagnostic support including specialist information for the following types of interventions: • Person Centred Planning • Navigating the benefits system • Attending JCP appeals, tribunals, supporting at ATOS medicals • Education support						

		• Housing support • Carers advice and support NCC provide information and signposting for people with Autism to voluntary service provision Asperger East Anglia provides social groups, skills groups and therapeutic and carers support groups Service user response: For those who had received help from Asperger service Norfolk post diagnosis the response was positive.						
34	Does your local housing strategy specifically identify Autism?	LD assessments include those with Autism as part of housing strategy Asperger Service Norfolk have supported people with high functioning Autism in partnership with Stonham Housing. Service user comment that the help received for housing issues the response was positive.						
35	How have you promoted in your area the employment of people on the Autistic Spectrum?	Norfolk statutory Employment providers (contracted by the Jobcentre plus): The programmes provided are the Work Choice work programme. The programmes give limited support and do not offer the individual tailor made support & understanding that is required to help those with Autistic Spectrum Condition (ASC) to access meaningful activity, work experience and employment. Service user agreed that the employment providers were not effective for those with Asperger syndrome						
36	Do transition processes to adult services have an employment focus?	This is an area where development ids required and will be part of the adult Steering Group Action Plan						
37	Are the CJS engaging with you as a key partner in	Voluntary sector: Asperger East Anglia receives very little requests from the Norfolk based teams. AEA act as appropriate adults at the request of the police and solicitors and have in the past accompanied						

	your planning for adults with autism?	people to court hearings. AEA represent people with AS on the Norfolk Police Disability Advisory Forum which has been useful in strengthening relations with the police. NPC are looking into what the police need in the way of training and also how they can ensure that what is delivered is what is expected of Police as part of the Autism Act.						
38	Self-advocate stories. Up to 5 stories may be added. These need to be less than 2000 characters. In the first box, indicate the Question Number(s) of the points they illustrate (may be more than one. In the comment box provide the story.	"I have diagnosis of Asperger syndrome and was advised to contact Asperger East Anglia for support. My ambitions have always been to have a job where I would be accepted for who I was and one which I enjoyed. I have had a succession of jobs in the past which only lasted for short periods of time as the people I worked for considered me too slow or not productive enough. I found this hard to accept and it caused me to have very low self-esteem. I wanted to do something meaningful and not feel useless but the people I worked for had little understanding of my difficulties and I found it hard to explain. With support from the Asperger East Anglia I visited the local Jobcentre to see a Disability Employment Advisor to discuss various options that might suit me and my disability. The support worker form Asperger East Anglia helped me to understand the various options available to me and the procedures and likely outcomes. I decided to explore the possibility of Horticultural training as this was an area that had interested me for some time since a work experience placement when I was at school. I was thrilled to hear that the training would increase my chances of gaining employment especially as the training program would be able to assist me to find work after the completion of the course. I received help filling in various forms, phone calls were made on my and the whole process was less stressful than I ever imagined. After many years of feeling despondent I was very excited to learn a few weeks later that I had been accepted on the training course. This raised my self-esteem and I feel I am embarking on a more hopefully						

		and positive chapter in my life. Without the kind support and encouragement I received form Asperger East Anglia I would never have achieved this I am enjoying the course very much and after only a short time I already feel more positive about life"		
39	Self-advocate stories. Up to 5 stories may be added. These need to be less than 2000 characters. In the first box, indicate the Question Number(s) of the points they illustrate (may be more than one. In the comment box provide the story.	"We attended our first meeting carers group at Asperger East Anglia . Following 20 years of struggling in ignorance we found a knowledgeable, friendly and helpful group of people. Initially we took comfort from sharing information with others and did learn some techniques for dealing with our daughter's behaviour. Then, mainly through the efforts of the support workers at Asperger East Anglia a plan of action was developed. The plan was discussed and agreed with our daughter and targets were set for her to work towards more independent living. We are delighted to report that the target has been achieved some months before her 21st birthday and she is now sharing a supported living flat with another girl. The journey has been stressful at times but the route was set out by Asperger East Anglia and included involvement by Social Services. Along the way we have met many wonderful people, triage nurses, occupational therapists, psychologists and doctors and some five weeks after living independent of us she is settling down quite well. One of the most satisfying results is that our relationship with her has already improved and we are able to talk quietly without her rushing off in It has been difficult to reduce our input into our daughter's life and wellbeing but we are now content knowing she has some independent living skills that will help her lead a meaningful life as a independent young woman. From attending the carers group it seems that there are many parents looking after their adult children, we always felt isolated until we found the group. It appears we are one of many cares experiencing very stressful lives taking care of our children, hope is not something we have had before and thankfully that is now very different."		
40	Self-advocate stories. Up	"This is to acknowledge, the value of support provided by Asperger East Anglia. Ruth has supported both myself and my son since 2007.		

	to 5 stories may be added. These need to be less than 2000 characters. In the first box, indicate the Question Number(s) of the points they illustrate (may be more than one. In the comment box provide the story.	Ruth and the advice and support received, has been invaluable. I know from past research that there is no other organisation that can provide the necessary home visits my son needs".		

Adults with Autism Spectrum Conditions (ASC)

Public Health Needs Assessment

July 2012

Public Health data and information to contribute to a "Needs Assessment" exercise for NHS Norfolk and Waveney

Dr Kadhim Alabady Principal Epidemiologist
Linda Hillman, Public Health Consultant
Steve McCormack, Commissioning Manager Mental Health and Learning Disabilities

Table of content

Adults with Autism Spectrum Conditions (ASC)

1. Background[1]

- Autism Spectrum Conditions (ASC) is the collective term for Autism, Asperger Syndrome, Atypical Autism and Pervasive Developmental Disorder – Not Otherwise Specified. Autism Spectrum Conditions are lifelong neuro-developmental disorders that affect how a person is able to learn and make sense of the world, process information and relate to other people. Consequently people with Autism Spectrum Conditions experience the world in a way that is different to those without the condition (Lawson 1998), and this often affects how they function in society, require services and respond to therapies.

- Autism Spectrum Conditions exist on a spectrum of severity affecting people in many different ways and to varying degrees. Current thinking suggests that people with ASC typically demonstrate pervasive, qualitative differences compared to non-autistic people across three broad areas of social functioning – the hypothesised triad of impairment, affecting:

  - social interaction;
  - social communication;
  - social imagination.

  Alongside a tendency towards restricted interests and repetitive behaviour and unusual reactivity to sensory input.

- The autism spectrum is commonly subdivided into two main sub-groups:
  - Autism;
  - Asperger Syndrome.

- Those who have a learning disability and an autism spectrum condition usually receive a diagnosis of autism, and those who have normal developmental milestones and are of normal general intelligence usually receive a diagnosis of Asperger Syndrome. However the boundary between these two sub-groups is not a clear one. In this paper, autism will generally be used to refer to adults with ASC and learning disabilities and Asperger Syndrome to refer to adults with ASC without learning disabilities.

[1] *South West Regional Oversight Group for Adults with Autism Spectrum Conditions (Commissioning Guidance), Adult Autism Spectrum Conditions Services.*

- Autism Spectrum Conditions are believed to affect around one in every hundred people (Brugha et al, 2009). While little is known about the experience of adults with Autism Spectrum Conditions, the outcomes are thought to be generally poor, with many experiencing high levels of unemployment, mental and physical ill-health, discrimination and social exclusion.

- People with Autism Spectrum Conditions are a highly heterogeneous group, and therefore a range of provision is required. The nature of the spectrum means that most will need at least some level of understanding and support at some stage in their lives, and some will require more intensive services. For many people, obtaining a diagnosis represents an identification and acknowledgement of their difficulties, and was reported as being of paramount importance to many people interviewed (see Appendix 1). Although diagnosis is a crucial first step, what helps one person will not necessarily help another, so a formal community care assessment of need alongside a diagnosis is essential. Diagnosis should therefore be seen as a process leading to helpful action, and not merely acquiring a label (Mills and Francis, 2010).

- Unfortunately, one of the most serious issues affecting the lives of adults with Autism Spectrum Conditions is the absence in many areas of diagnostic/identification services, which means that in reality, the majority of adults in the UK will not be able to receive even a rudimentary diagnostic assessment, let alone access appropriate support.

- Across the country, the people with Autism Spectrum Conditions and learning disabilities are usually assessed, supported, and psychologically treated by specialist learning disability services, for whom autism forms a substantial part of their work.

- The complex needs of people with Autism Spectrum Conditions without learning disabilities, such as those with a diagnosis of Asperger Syndrome, are overall poorly met by mainstream health and social care providers. One of the issues is that ASC is not in itself a mental health condition, which means that typically mental health NHS Trusts will refuse to accept referrals to work with people with Asperger Syndrome, unless they also present with significant levels of psychiatric co-morbidity.

- Learning disability services usually exclude people with an IQ over 70, and do not have expertise in helping this more able group. Since individuals with Asperger Syndrome have an IQ above this, learning disability services are unable to assist, thus leaving the individual with Asperger Syndrome with no service to turn to. Consequently, this separation between mental health and learning disability leaves a gap which has a serious impact on many people with Asperger Syndrome, who are typically unable to access an appropriate range of support from health and social care agencies.

- Furthermore, the current structure of adult social services is a key barrier for people with Autism Spectrum Conditions as they try to access support, due to the fact that services tend to be provided by teams on the basis of categorised client groups.

- In 2006, the Department of Health published a document "*Better services for people with an autistic spectrum disorder: A note clarifying current Government policy and describing good practice*", stating that the current position whereby some adults with autism fall through local services in particular between mental health and learning disability is unacceptable and contrary to the intention of government policy.

  Often the „hidden" needs of adults with autism and Asperger Syndrome are not identified during the community care assessment process, the result of which is that people are denied appropriate support from services. Where a person with ASC has neither a learning disability nor a mental health condition it should be Adult Social Care who should retain the care management function.

- Another obstacle people with ASC face when attempting to access an appropriate range of mainstream services is the presence of a significant competency gap amongst front-line health and social care staff with regard to how to work effectively with people with autism. The general lack of awareness of the needs of people with Autism Spectrum Conditions amongst health providers was highlighted in a survey by the National Autistic Society, where it was also reported that many General Practitioners felt unprepared to treat patients with autism as published by National Autistic Society in 2002.

- Whilst this document is aimed at provision of adult services the transition from children and young people"s services to adult services is very problematic and has been compared to "falling off a cliff" (Austin 2009).

- As identification rates of children with Autism Spectrum Conditions are significantly higher than they are for adults, there is an emerging situation where many more young people with a diagnosis of ASC, having had statements of special educational needs, specialist placements and support from Child and Adolescent Mental Health Service teams, are reaching the age of 18-19 years with an expectation, backed by legislation that services and support for them will continue.

- However many are finding no available services or support, and with rising numbers the previously hidden problem is becoming far more apparent. Many parents feel disregarded when their children reach the age of 16, leaving them feeling anxious whilst the young person is unprotected, vulnerable and in need of support.

- In addition, some young people with Asperger Syndrome have been excluded or have self-excluded from education at some point prior to the age of 16, and have been home

educated. For these young people to re-enter formal education they will need support in order to reintegrate.

- The remit of Tier 4 specialised services for Asperger Syndrome and Autism Spectrum Conditions currently resides with the South West Specialist Services Commissioning Group and is within the National Specialised Services Definition Set (3rd Edition). Examples of those requiring assessment and care by under these circumstances include:

  - High risk offenders;
  - Those hard to engage with, showing evidence of additional personality pathology;
  - Clients with significant psychiatric and neurological co-morbidity meaning that effective diagnosis/treatment is beyond the expertise of local team
  - People with challenging behaviours and/or complexity that would typically require an out-of-area placement.

- Whilst thought will need to be given around access to these services and appropriate linkages made to any future provision by the Specialised Commissioning Group, Tier 4 is not within the remit of this commissioning specification.

- Autism presents a significant challenge for commissioners due to the increasing numbers of people being identified and the wide range of presenting need. There is a major gap in knowledge as stated by the former Care Services Minister - „We have insufficient epidemiological information reliably to estimate the prevalence of adult neuro-developmental disorders in the UK population" (Schneider 2007).

- Few local authorities know how many adults with an Autism Spectrum Conditions are in their area, and this lack of comprehensive data on people with ASC has made it difficult to plan and commission services effectively. However the Autism Act (2009) for the first time places a statutory obligation on NHS Bodies and Local Authorities to provide appropriate services for this client group.

2. Abbreviations

ASC	Autism Spectrum Conditions	**LSOA**	Lower Supper Output Area
BME	Black and Minority Ethnic	**MSOA**	Middle Supper Output Area
CCG	Clinical Commissioning Group	**NHS**	National Health Service
DH	Department of Health	**NICE**	National Institute for Health and Clinical Excellence
EoE	East of England	**NSF**	National Service Framework
ERPHO	East Region Public Health Observatory	**ONS**	Office of National Statistics
GMS	General Medical Services	**PBC**	Practice-based commissioning
GP	General Practitioner	**PANSI**	Projecting Adult Needs and Service Information
IC	Information Centre	**QOF**	Quality and Outcomes Framework
IMD	Index of Multiple Deprivation	**QMAS**	Quality Management and Analysis System
ICD	International Classification of Disease	**SHA**	Strategic Health Authority
JSNA	Joint Strategic Needs Assessment	**UL**	Upper Limit of confidence interval
LA	Local Authority		
LL	Lower Limit of confidence interval		

3. Executive Summary

The South West Regional Oversight Group recently provided a stark summary of likely numbers of adults with ASD and the issues facing them, based on results of recent research studies.

This paper simply applies the predictions to Norfolk populations, without any adjustment for local conditions. It is intended to help stakeholders discuss the scale of issue locally. Key findings are summarised.

As we go forward to implement the national strategy to improve the lives of adults with Autism, 'Fulfilling and Rewarding Lives', the strategy for adults with autism in England, this data will help us to plan for staff training, services, transition support, abilities to include services users and their carers within service planning, and employment support.

Further information is needed on people placed in the area by other local authorities and further data may be collected for diagnostic services, job centres, third sector organisations etc.

The work was undertaken within short time scale to inform planning workshop in spring 2012.

4. Key findings

- Assuming 1% adults have ASC, there were 5173 adults between the ages of 18 and 64 with this condition in Norfolk in 2011. This total was built up from predicted numbers by age group and by district council area.

- Numbers are expected to rise slightly up to 2030, in line with general population increases, such that there will be 5691 adults aged 18 – 64 by this time.

- Based on the 2011 estimates of 5173 cases, 4138 were expected to be men and 1035, women.

- If it is assumed that 40% of people with ASD have psychiatric morbidity, 2069 people with ASD in Norfolk in 2011 had psychiatric morbidity.

- Data from the National Audit Office Survey of 2009, showed 80% GPs reporting a need for additional guidance and training.

- Applying research findings of Rosenblatt, 2008, we might expect that of the 5173 adults predicted to have ASD in 2011, only 1397 had a care plan, and using data from Reid (2006), only 776 might have been employed.

5. Data sources

Where possible, this document has used sources of data that are routinely available nationally, either as published material such as the Projecting Adult Needs and Service Information (PANSI)[2], or form published guidance such as:

- The South West Regional Oversight Group for Adults with Autism Spectrum Conditions (Commissioning Guidance), Adult Autism Spectrum Conditions Services.

- Estimating the Prevalence of Autism Spectrum Conditions in Adults, Extending the 2007 Adult Psychiatric Morbidity Survey which is published at Information Centre (IC), department of Health (DH)[3].

Elsewhere we have used Norfolk population data that are obtainable from Office of National Statistics (ONS), mid year estimates of from General Practice registry (Exeter database).

Recent data from Practice-based Commissioning (PBC) is used to provide the information on Clinical Commissioning Groups (CCG), and GP practices.

The Autism document showed the most up-to-date data available. Not all the data relate to the same time period. Different sets of data are published at different times of the year and the most recent data may not yet be published, or if the numbers of events are very low, the data for several years are combined to obtain a more reliable picture.

[2] http://www.pansi.org.uk/

[3] http://www.ic.nhs.uk/webfiles/publications/005_Mental_Health/Est_Prev_Autism_Spectrum/Est_Prev_Autism_Spec_Cond_in_Adults_Report.pdf

6. ASC Prevalence

Data on adults in UK private households (Brugha et al, 2009) suggest an overall ASC prevalence of 1%, with early data suggesting that 1.8% of males and 0.2% of females meet the diagnostic criteria, and that Autism Spectrum Conditions affect 8% of single men in sheltered housing.

Based on the above figures Projecting Adult Needs and Service Information (PANSI), estimated the expected prevalence in Norfolk for people with Autism as seen in **Tables 1-5. Table 6 and 7** provide information of the number of people with ASC by gender applying the (1.8% men, 0.2 women) rates.

There is however some evidence that women may be being under-diagnosed in childhood and adulthood. The experience of the Somerset Asperger Team over two years from 1 April 2008 to 1 April 2010, albeit using a small sample of positive diagnoses of 40 people, is that approximately 33% of these diagnoses have been of women. There is currently a dearth of evidence with regard to hypothesised differences in presentation between men and women with ASC.

Table 1: Expected number of people aged 18-64 with Autism by district and age band in Norfolk, 2011

2011	18-24	25-34	35-44	45-54	55-64	18-64
Breckland	99	150	170	176	181	777
Broadland	81	120	170	188	171	731
Great Yarmouth	83	108	122	132	133	579
King's Lynn and West Norfolk	104	136	177	199	202	818
North Norfolk	63	80	103	137	163	547
Norwich	258	307	187	152	127	1,031
South Norfolk	79	108	155	177	171	690
Norfolk	**767**	**1009**	**1084**	**1161**	**1148**	**5173**

Source: Projecting Adult Needs and Service Information (PANSI database)

Figure 1: Expected number of people aged 18-64 with Autism by district in Norfolk, 2011 - 2030

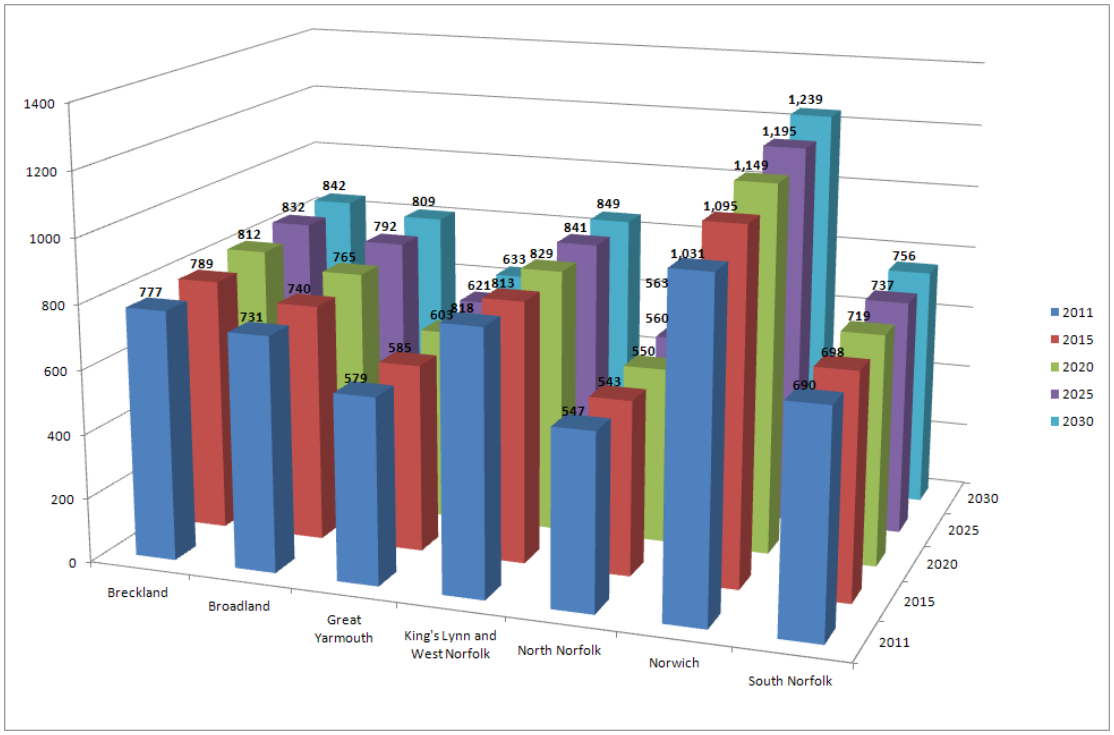

Figure 2: Expected number of people aged 18-64 with Autism by age band in Norfolk, 2011 - 2030

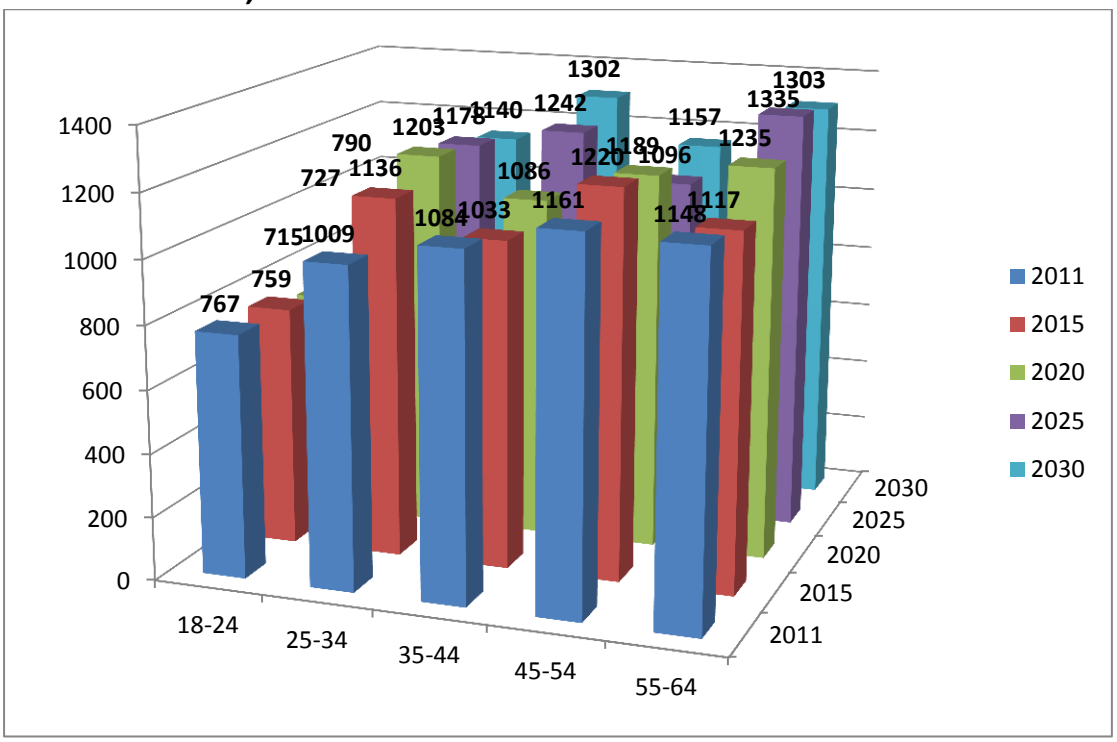

Figure 3: Total Expected number of people aged 18-64 with Autism in Norfolk, 2011 - 2030

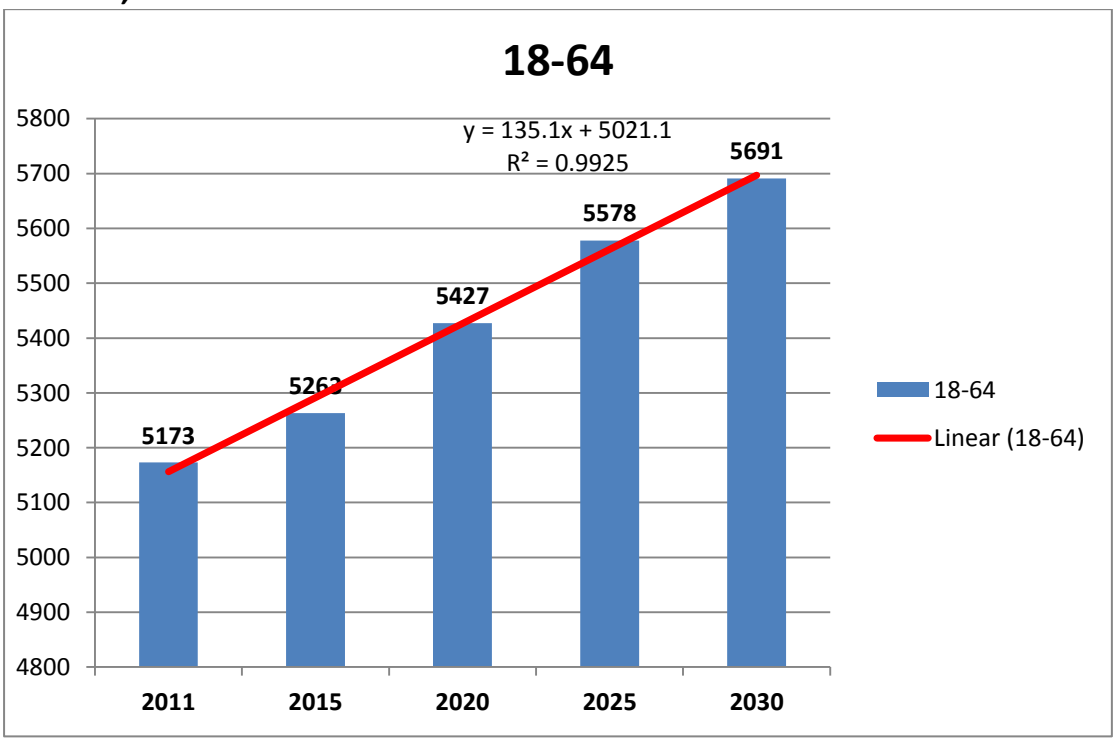

Table 2: Expected number of people aged 18-64 with Autism by district and age band in Norfolk, 2015

2015	18-24	25-34	35-44	45-54	55-64	18-64
Breckland	99	164	164	187	175	789
Broadland	81	136	158	198	167	740
Great Yarmouth	80	124	115	139	129	585
King's Lynn and West Norfolk	101	148	159	209	196	813
North Norfolk	63	88	95	139	158	543
Norwich	254	354	197	163	127	1,095
South Norfolk	81	122	145	185	165	698
Norfolk	**759**	**1136**	**1033**	**1220**	**1117**	**5263**

Source: Projecting Adult Needs and Service Information (PANSI database)

Table 3: Expected number of people aged 18-64 with Autism by district and age band in Norfolk, 2020

2020	18-24	25-34	35-44	45-54	55-64	18-64
Breckland	95	172	169	183	193	812
Broadland	75	146	165	190	188	765
Great Yarmouth	74	131	120	137	141	603
King's Lynn and West Norfolk	97	156	159	198	220	829
North Norfolk	57	92	98	131	171	550
Norwich	242	374	226	169	139	1,149
South Norfolk	75	132	149	181	183	719
Norfolk	**715**	**1203**	**1086**	**1189**	**1235**	**5427**

Source: Projecting Adult Needs and Service Information (PANSI database)

Table 4: Expected number of people aged 18-64 with Autism by district and age band in Norfolk, 2025

2025	18-24	25-34	35-44	45-54	55-64	18-64
Breckland	95	170	189	169	209	832
Broadland	77	144	193	175	202	792
Great Yarmouth	74	128	140	126	153	621
King's Lynn and West Norfolk	101	150	176	176	238	841
North Norfolk	59	90	112	117	182	560
Norwich	246	368	261	166	154	1,195
South Norfolk	75	128	171	167	197	737
Norfolk	**727**	**1178**	**1242**	**1096**	**1335**	**5578**

Source: Projecting Adult Needs and Service Information (PANSI database)

Table 5: Expected number of people aged 18-64 with Autism by district and age band in Norfolk, 2030

2030	18-24	25-34	35-44	45-54	55-64	18-64
Breckland	103	164	197	174	204	842
Broadland	83	138	203	187	198	809
Great Yarmouth	82	122	146	132	151	633
King's Lynn and West Norfolk	109	148	184	179	229	849
North Norfolk	63	88	116	123	174	563
Norwich	268	356	273	186	156	1,239
South Norfolk	82	124	183	176	191	756
Norfolk	**790**	**1140**	**1302**	**1157**	**1303**	**5691**

Source: Projecting Adult Needs and Service Information (PANSI database)

Table 6: Expected number of men aged 18-64 with Autism by district in Norfolk, 2011 - 2030

	Number of men with ASD 18-64				
	2011	2015	2020	2025	2030
Breckland	622	631	666	650	674
Broadland	585	592	634	612	647
Great Yarmouth	463	468	497	482	506
King's Lynn and West Norfolk	654	650	673	663	679
North Norfolk	438	434	448	440	450
Norwich	825	876	956	919	991
South Norfolk	552	558	590	575	605
Norfolk	**4138**	**4210**	**4462**	**4342**	**4553**

Note: Brugha, 2009 (1.8% men, 0.2% women)

Table 7: Expected number of women aged 18-64 with Autism by district in Norfolk, 2011 - 2030

	Number of women with ASD 18-64				
	2011	2015	2020	2025	2030
Breckland	155	158	166	162	168
Broadland	146	148	158	153	162
Great Yarmouth	116	117	124	121	127
King's Lynn and West Norfolk	164	163	168	166	170
North Norfolk	109	109	112	110	113
Norwich	206	219	239	230	248
South Norfolk	138	140	147	144	151
Norfolk	**1035**	**1053**	**1116**	**1085**	**1138**

Note: Brugha, 2009 (1.8% men, 0.2% women)

7. ASC and psychiatric conditions

Many people with ASC will require accurate mental health diagnostic assessments for the correct identification and treatment of co-morbid psychiatric conditions. Many also need sensory profiling to assess sensory perceptual differences and difficulties that may be affecting their lives.

As a lifelong neuro-developmental condition, the need for reassessment and review is important. Research by Ghaziuddin (2002) suggests that 40% of people with autism show evidence of psychiatric co-morbidity. However, the lack of knowledge and competency with regard to ASC in mainstream services means that common co-morbid conditions, such as: depression, anxiety, OCD, transient episodes of psychosis, or physical health conditions are seldom correctly recognised or effectively managed.

Table 6 provides information on the expected number of people with ASD that have psychiatric morbidity. The Ghaziuddin 40% estimate was applied using the PANSI estimation.

Table 8: Expected number of people aged 18-64 with Autism have psychiatric morbidity (40%)

	Expected number of people aged 18-64 with Autism have psychiatric morbidity (40%)				
	2011	**2015**	**2020**	**2025**	**2030**
Breckland	311	316	333	325	337
Broadland	292	296	317	306	324
Great Yarmouth	232	234	248	241	253
King's Lynn and West Norfolk	327	325	336	332	340
North Norfolk	219	217	224	220	225
Norwich	412	438	478	460	496
South Norfolk	276	279	295	288	302
Norfolk	**2069**	**2105**	**2231**	**2171**	**2276**

Note: Ghaziuddin 2002

8. ASC and GP required additional training

Few healthcare professionals have expertise in working with adults with Asperger Syndrome. For example, at the time of publishing the (**South West Regional Oversight Group for Adults with Autism Spectrum Conditions**) guidance there were only 14 NHS teams in England who diagnose adults with Asperger Syndrome, and 80% of General Practitioners responding to the National Audit Office survey (2009) said they required additional guidance and training in order to provide a good service to this client group.

Table 9 gives information of number of GP practices within NHS Norfolk that require training by Clinical Commissioning Group (CCG).

Table 9: Expected number of GP practices required additional guidance and training to give good service to this client group by Clinical Commissioning Group (CCG)

Consortia name	No of GP practices	Number of GP practices required additional guidance and training to give good service to this client group
Dereham	5	4
Great Yarmouth & Waveney	27	21
North Norfolk	20	16
Norwich	23	18
West Norfolk	23	18
South	21	17
Total	**119**	**94**

Note: NAO 2009

9. Personal and individual budget

Although individual and personal budgets are becoming increasingly common within social care, only 27% of adults with Autism Spectrum Conditions currently have a person-centred plan or care plan (Rosenblatt 2008). Historically, learning disability services have better developed skills in these areas as a result of government guidance (Valuing People, 2001; Valuing People Now, 2009, 2011). To better enable positive outcomes in people with ASC, it would be helpful if these skills were shared with teams across the care pathway.

Table 10 shows the expected numbers of Adult with ASD have a person cantered care plan.

Table 10: Expected numbers of Adult with ASD have a person cantered care plan

Expected numbers of Adult with ASD have a person cantered care plan (27%)					
	2011	**2015**	**2020**	**2025**	**2030**
Breckland	210	213	225	219	227
Broadland	197	200	214	207	218
Great Yarmouth	156	158	168	163	171
King's Lynn and West Norfolk	221	220	227	224	229
North Norfolk	148	147	151	149	152
Norwich	278	296	323	310	335
South Norfolk	186	188	199	194	204
Norfolk	**1397**	**1421**	**1506**	**1465**	**1537**

Note: Rosenblatt 2008

10. Employment

Accessing work for many people interviewed has been highly problematic, with statistics suggesting only 15% of people regarded as having Asperger Syndrome are in paid employment (Reid 2006). Whilst employment is not an option for all, many more could be able to work if they received better support (Barnard et al, 2001). However, there is very little offered in terms of specialist ASC employment support across the country, with the majority of provision targeting people with mental health or learning disabilities.

Table 11 provides the estimated numbers of adults with ASD are in paid employment.

Table 11: Expected numbers of Adult with ASD are in paid employment

Expected numbers of Adult with ASD are in paid employment (15%)					
	2011	**2015**	**2020**	**2025**	**2030**
Breckland	117	118	125	122	126
Broadland	110	111	119	115	121
Great Yarmouth	87	88	93	90	95
King's Lynn and West Norfolk	123	122	126	124	127
North Norfolk	82	81	84	83	84
Norwich	155	164	179	172	186
South Norfolk	104	105	111	108	113
Norfolk	**776**	**789**	**837**	**814**	**854**

Note: Reid 2006

11. Benefits Realisation

Quality, Innovation, Productivity and Prevention

Opportunities for benefits realisation identified by Knapp et al (2007) indicates that earlier intervention for people with Asperger Syndrome would achieve benefits in line with health service principles of quality, innovation, productivity and prevention.

It has been estimated by a recent study by researchers at Kings College London (Knapp et al 2007) that the yearly cost to society of each adult with Autism Spectrum Conditions in Great Britain is £90,000 and with the cost to the UK economy around £28.2 billion per year (£25.5 billion for adults and £2.7 billion for children). Of the cost for adults, 59% is accounted for by services, 36% through lost employment and the remainder by family expenses.

Table 12 gives overall cost estimation based on the £90,000 per adult individual, while **table 13, and 14** show the break down of this cost for services accounted, and lost of employment.

Table 12: Annual society cost estimation for people aged 18-64 with ASD

	Estimated society cost for people aged 18-64 with ASD (£90K)				
	2011	2015	2020	2025	2030
Breckland	£69,930,000	£71,010,000	£74,880,000	£73,080,000	£75,780,000
Broadland	£65,790,000	£66,600,000	£71,280,000	£68,850,000	£72,810,000
Great Yarmouth	£52,110,000	£52,650,000	£55,890,000	£54,270,000	£56,970,000
King's Lynn and West Norfolk	£73,620,000	£73,170,000	£75,690,000	£74,610,000	£76,410,000
North Norfolk	£49,230,000	£48,870,000	£50,400,000	£49,500,000	£50,670,000
Norwich	£92,790,000	£98,550,000	£107,550,000	£103,410,000	£111,510,000
South Norfolk	£62,100,000	£62,820,000	£66,330,000	£64,710,000	£68,040,000
Norfolk	**£465,570,000**	**£473,670,000**	**£502,020,000**	**£488,430,000**	**£512,190,000**

Note: Knapp et al 2007

Table 13: Estimated service cost for people aged 18-64 with ASD

	Estimated services cost for people aged 18-64 with ASD (59%)				
	2011	2015	2020	2025	2030
Breckland	£41,258,700	£41,895,900	£44,179,200	£43,117,200	£44,710,200
Broadland	£38,816,100	£39,294,000	£42,055,200	£40,621,500	£42,957,900
Great Yarmouth	£30,744,900	£31,063,500	£32,975,100	£32,019,300	£33,612,300
King's Lynn and West Norfolk	£43,435,800	£43,170,300	£44,657,100	£44,019,900	£45,081,900
North Norfolk	£29,045,700	£28,833,300	£29,736,000	£29,205,000	£29,895,300
Norwich	£54,746,100	£58,144,500	£63,454,500	£61,011,900	£65,790,900
South Norfolk	£36,639,000	£37,063,800	£39,134,700	£38,178,900	£40,143,600
Norfolk	**£274,686,300**	**£279,465,300**	**£296,191,800**	**£288,173,700**	**£302,192,100**

Note: Knapp et al 2007

Table 14: Estimated cost due to lost employment for people aged 18-64 with ASD

	Estimated cost due to lost of employment for people aged 18-64 with ASD (36%)				
	2011	2015	2020	2025	2030
Breckland	£25,174,800	£25,563,600	£26,956,800	£26,308,800	£27,280,800
Broadland	£23,684,400	£23,976,000	£25,660,800	£24,786,000	£26,211,600
Great Yarmouth	£18,759,600	£18,954,000	£20,120,400	£19,537,200	£20,509,200
King's Lynn and West Norfolk	£26,503,200	£26,341,200	£27,248,400	£26,859,600	£27,507,600
North Norfolk	£17,722,800	£17,593,200	£18,144,000	£17,820,000	£18,241,200
Norwich	£33,404,400	£35,478,000	£38,718,000	£37,227,600	£40,143,600
South Norfolk	£22,356,000	£22,615,200	£23,878,800	£23,295,600	£24,494,400
Norfolk	**£167,605,200**	**£170,521,200**	**£180,727,200**	**£175,834,800**	**£184,388,400**

Note: Knapp et al 2007

The guidance report also considered the impact of identifying more adults with Asperger Syndrome through a Probabilistic Sensitivity Analysis and highlighted cost benefits.

The analysis suggested that if a new service identified 4% of adults with Asperger Syndrome in their catchment, the service would be cost neutral.

Identification rates of 6% would achieve a £38m cost benefit per annum, and a realistically achievable identification rate of 8% would lead to a cost benefit of £67m. With regard to the likelihood of this, it is worth noting that the longest established specialist team within England – the Liverpool Asperger team - reports identification rates of 14%, with projected cost benefit of £159m per annum.

Tables 15, 16, and 17 show the estimated number of people with ASC need to be identified at 4%, 6%, and 8%.

Table 15: Estimated number of people with ASC Norfolk, needs to identify in order to achieve 4% diagnoses and neutral cost

	4%				
	2011	**2015**	**2020**	**2025**	**2030**
Breckland	31	32	33	32	34
Broadland	29	30	32	31	32
Great Yarmouth	23	23	25	24	25
King's Lynn and West Norfolk	33	33	34	33	34
North Norfolk	22	22	22	22	23
Norwich	41	44	48	46	50
South Norfolk	28	28	29	29	30
Norfolk	**207**	**211**	**223**	**217**	**228**

Table 16: Estimated number of people with ASC, Norfolk needs to identify in order to achieve 6% diagnoses and £38m cost benefit per annum

	6%				
	2011	**2015**	**2020**	**2025**	**2030**
Breckland	47	47	50	49	51
Broadland	44	44	48	46	49
Great Yarmouth	35	35	37	36	38
King's Lynn and West Norfolk	49	49	50	50	51
North Norfolk	33	33	34	33	34
Norwich	62	66	72	69	74
South Norfolk	41	42	44	43	45
Norfolk	**310**	**316**	**335**	**326**	**341**

Table 17: Estimated number of people with ASC, Norfolk needs to identify in order to achieve 8% diagnoses and cost benefit of £67m per annum

	8%				
	2011	**2015**	**2020**	**2025**	**2030**
Breckland	62	63	67	65	67
Broadland	58	59	63	61	65
Great Yarmouth	46	47	50	48	51
King's Lynn and West Norfolk	65	65	67	66	68
North Norfolk	44	43	45	44	45
Norwich	82	88	96	92	99
South Norfolk	55	56	59	58	60
Norfolk	**414**	**421**	**446**	**434**	**455**

12. Commissioning

Evidence from existing specialist ASC services that both train and support other services to provide effective help for people with autism, and provide assessment and liaison support for those who are not eligible to access secondary health services, suggests two main outcomes:

- Reduction in hospital admissions and use of crisis intervention services;
- Greater likelihood of people with autism spectrum being able to live in more independent, cost-effective housing:

    - Without specialist teams, 7% lived in residential services;
    - With a specialist team, this figure fell to less than 1%.

The **Table** below illustrates the ASC cost categories involved in the provision of three currently established specialist Autism Spectrum Conditions services - and these show overall costs of services based on an estimated cost per 1,000 of working age adult which vary from £564 - £1,536

Cost categories
Consultant Psychiatrist
Clinical Psychologist
Occupational Therapist
Community Psychiatric Nurse/Social W
Admin/Secretary
Team Manager
Assistant Psychologist
Estimated Cost (£)
Estimated cost per 1,000
Working age adult population (£)

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14. Appendices

Appendix 1

People in Norfolk and Waveney with Autistic Spectrum Disorder

Linda Hillman
Public Health Consultant,
March 2011

The national strategy to improve the lives of adults with Autism, *'Fulfilling and Rewarding Lives: the strategy for adults with Autism in England'* was strengthened by statutory guidance for Local Authorities and the NHS (17th December 2010), *'Implementing Fulfilling and Rewarding Lives: the strategy for adults with Autism in England'*), the guidance intended to cover all services.

The four key themes of the strategy are to

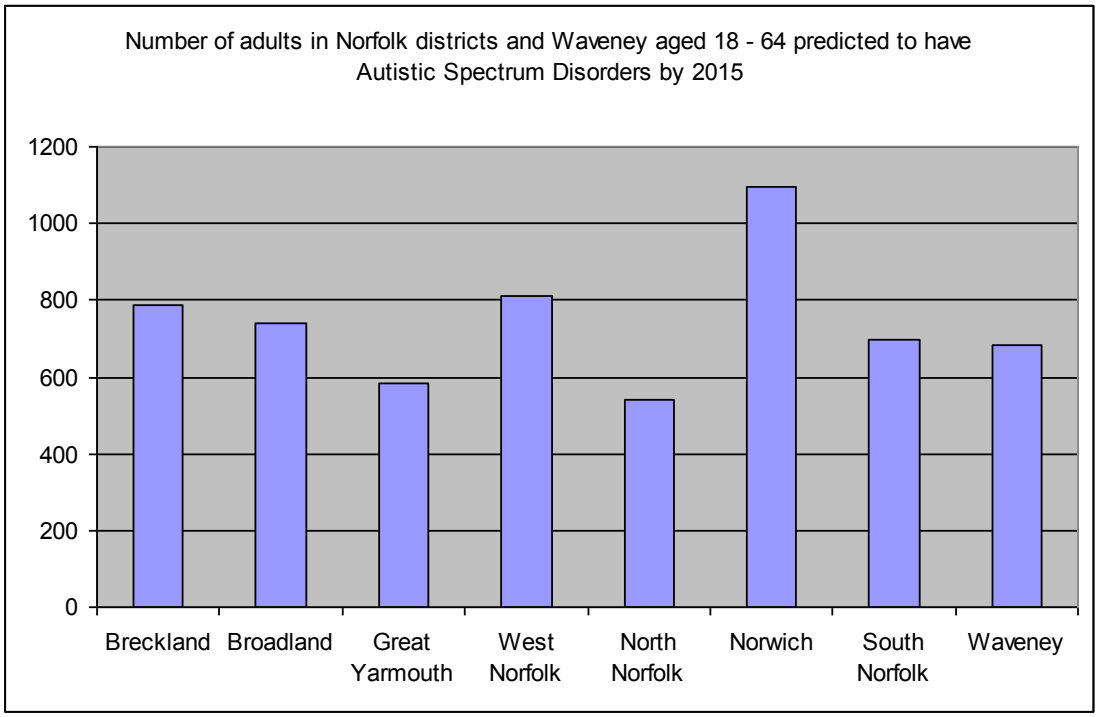
- increase understanding amongst staff,
- strengthen diagnosis (including for Asperger Syndrome) and needs assessments (for individuals)
- improve transition support
- ensure adults are included within service planning.

The Equality Act 2010 makes it a duty that reasonable adjustments are made, for example premises need to take account of hypersensitivities, processes need to be in place to allow good access, for example with appointments at quiet times and communication needs to improve, for example through having accessible information and documentation. Having reasonable adjustments is now in the standard contract, and this requires service specifications and providers to demonstrate how reasonable adjustments can be made. Planning should also take account that people will increasingly have personal budgets.

A shared understanding of needs and priorities at the population level should be established through the local Joint Strategic Needs Assessment (JSNA) showing numbers of adults with autism as part of the core dataset.

For Norfolk and Waveney, the core dataset (source: www.pansi.org.uk version 4.0), is attached at appendix 1. This data shows that by 2015, 5260 18 - 64 year olds in Norfolk are predicted to have Autistic Spectrum Disorder, with a further 684 in Waveney. The breakdown by district is shown in Figure 1. Note, there is no national prediction on numbers aged 65 and over.

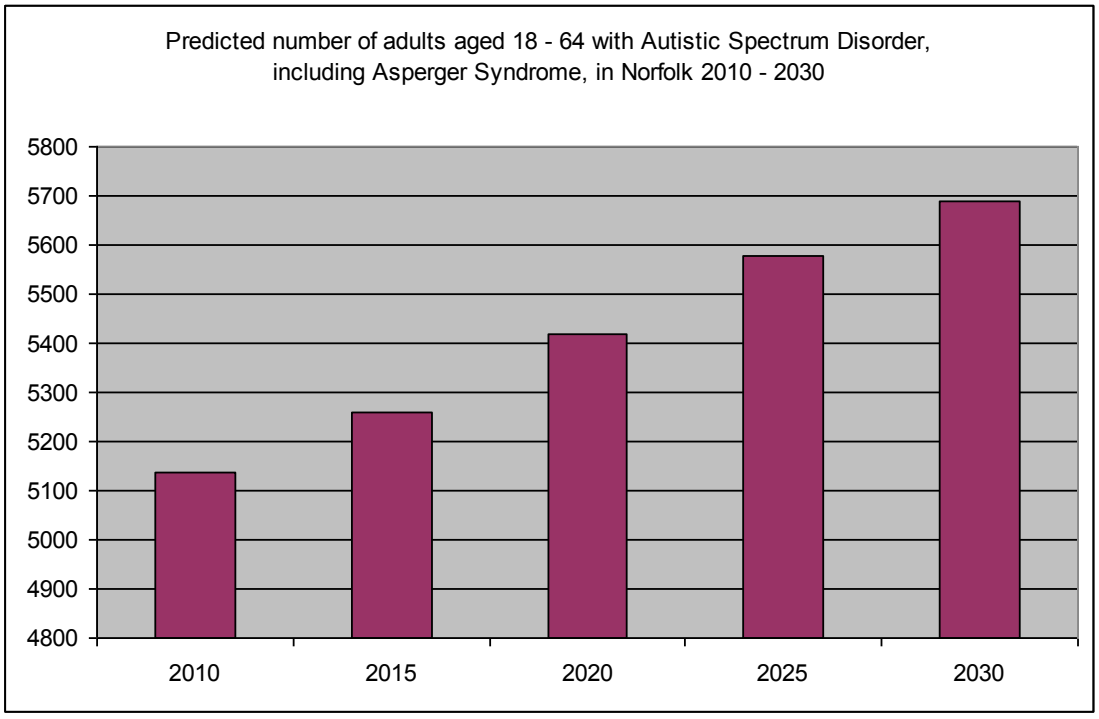
Figure 1: Number of adults in Norfolk districts and Waveney aged 18 – 64 predicted to have Autistic Spectrum Disorders by 2015



Source: Pansi database

The increasing numbers between 2010 and 2030 are shown in Figure 2, for Norfolk.

Figure 2: Number of adults in Norfolk aged 18 – 64 predicted to have Autistic Spectrum disorders, 2010 – 2030.



The statutory guidance requires an appointed lead in the local authority to commission for adults with autism, who recognises that services and support dedicated to adults with autism can be pivotal in enabling them to use mainstream services effectively and services to have a preventive, supportive approach. This commissioner is expected to work closely with a local specialised commissioning group and organisations, linking to the Health and Wellbeing Board. Information on local health and social care services that improve health and outcomes are to be published online shortly as 'good practice' examples, and include for example, care and support and travel training.

There is a requirement to establish the actual number and age profile of adults, plus the range of need for support to live independently. This information is needed also by local authorities in fulfilling their Disability Equality Duty. Information should be supplemented by data on ethnicity, gender, religion or belief and sexual orientation of adults with autism so that local authorities, NHS bodies and NHS Foundation Trusts can understand the numbers of people from different backgrounds with autism.

Preliminary enquiries have been made, but further specific local information is not readily available in from local databases to establish numbers in the areas the statutory guidance identifies, namely

- in employment in the area
- likely to need employment support in order to work
- placed in the area (and funded by) other local authorities
- placed out of area by local authorities
- in hospital or living in other NHS-funded accommodation
- resettled from long-stay beds or NHS residential campuses to community provision
- living at home on their own, or with family members, and not receiving health or social care services, or living with older family carers.

The information below summarises findings from preliminary discussion with some commissioners and providers in Norfolk and it is noted that expectations are much higher among younger people and families and that these expections will increase as awareness across the community grows.

Finding and keeping work: For those with pronounced ASD, the likelihood of finding work is low, but people with milder forms of the condition, including those undiagnosed, may or may not have work with arrangements that may or may not be satisfactory. Job Centre Plus has a Disability Employment Adviser who helps people with job searching.

Work must continue to support workplaces in making reasonable adjustments to enable people to access jobs, including the use of schemes such as that implemented at the acute hospital in Norwich (Project Search) to prepare and employ people with learning disabilities.

There is a large number of agencies, many third sector, approved by the Local Authority as 'preferred providers' who have contracts to provide varying degrees of support to clients in accessing alternatives such as voluntary work.

Advocacy support to clients is extremely helpful in assisting clients and work places, to enable establishment and integration into the workplace.

Requiring specific health or social care services: It is of note that in its response to the government's consultation on the autism strategy, the Royal College of Psychiatrists expressed concern that adults with autism who also have learning disability may be under estimated by assuming that everyone has been diagnosed. For clients who receive a diagnosis later in life there are frequently difficulties in finding ways into services. They also warn that assumptions on support costs for this group may be underestimated unless allowance for the greater complexity is made.

Commissioners locally note that funding may eventually come via the NHS or Local Authority, and for people receiving their first diagnosis as adults (ie not picked up as children) may have difficulty establishing which body would fund their needs.

Much work has been done in recent years to enable Norfolk residents who had lived a hospital setting to move to a community setting, so the few people placed in hospitals reside out of the area. Residents in the community may live alone or in groups, with varying amounts of support, funded through a range of ways including via Supporting People or Social Services. This can include the support described in the section above, on finding work, in addition to helping with other needs. Many people do not receive state support as they are cared for entirely by their families or support networks, but for others, it remains difficult for support networks to grow and remain. Many third sector organisations have an important role in providing social support, including links tobefriending, eg through BUILD or self advocacy (Open Door). There are other community settings such as church groups that play a valuable role.

Getting a diagnosis of Asperger Syndrome:
A service was established last year with Aspergers East Anglia to help people to get a diagnosis and hence access to a wider range of support. A person can self refer to this service, although referral via a GP is preferred. The service offers screening, but if an urgent or critical need is identified, the social worker within the team will go ahead in drawing up a 'care plan' that would include advocacy support or signposting to other services. Usually, the screening identifies needs before the full diagnosis is made and the service doesn't delay further work with the client. Where the screening identifies a likelihood of Asperger Syndrome, the person is referred to a psychologist in Norwich, Great Yarmouth or Kings Lynn for a definitive diagnosis. Over the past year there have been just over 200 referrals to the Aspergers East Anglia service (including self referrals) , around sixty of which have been older

people who missed getting a diagnosis whilst at school, the setting where this condition currently is most frequently picked up for younger cohorts.

A report is expected by the end of March 2011 from the County Psychologist on uptake of diagnostic services for people with Asperger Syndrome and the capacity of the service.

There is a range of issues that support advocacy, a further role which the service provided or signposted to by Asperger East Anglia, provides. This includes help with getting benefits and/or helping the client and others recognise, understand and make allowances for common features of the condition that may include difficulties in decision making, due to over-analysing situations and the range of possibilities. Further areas of support are to assist with socialising and to deal with the consequences of unconventional behaviour for example due to hypersensitivity to stimuli such as smells, sound or light, that makes activities such as using public transport difficult and hence lead to isolation for those who live in rural areas.

There are links to two projects recently established through the psychologist team, including Cognitive Behavioural Therapy for people bereaved and with learning disability, and also an intervention model for first time parents with children who are taken into care or adopted, where contact meetings are arranged. It is recognised that health costs, particularly mental health costs in the context of parent needs in relation to adoption can be high due to grief, separation and psychosis. Work is ongoing to establish the economic benefits of this service to the health system.

People aged 18-64 predicted to have autistic spectrum disorders, by age ,and district, 2010 -2030

Table produced by www.pansi.org.uk version 4.0

	People aged 18-64 predicted to have autistic spectrum disorders, by age and district, projected to 2030				
	2010	**2015**	**2020**	**2025**	**2030**
Breckland					
18-24	99	99	95	95	103
25-34	145	164	172	170	164
35-44	174	164	169	189	197
45-54	172	187	183	169	174
55-64	183	175	193	209	204
Total population aged 18-64	773	789	812	832	842
Broadland					
18-24	83	81	75	77	83
25-34	114	136	146	144	138
35-44	176	158	165	193	203
45-54	184	198	190	175	187
55-64	173	167	188	202	198
Total population aged 18-64	731	740	765	792	809

Great Yarmouth					
18-24	83	80	74	74	82
25-34	104	124	131	128	122
35-44	124	115	120	140	146
45-54	128	139	137	126	132
55-64	135	129	141	153	151
Total population aged 18-64	575	585	603	621	633
King's Lynn and West Norfolk					
18-24	103	101	97	101	109
25-34	132	148	156	150	148
35-44	181	159	159	176	184
45-54	197	209	198	176	179
55-64	202	196	220	238	229
Total population aged 18-64	815	813	829	841	849
North Norfolk					
18-24	63	63	57	59	63
25-34	78	88	92	90	88
35-44	107	95	98	112	116
45-54	133	139	131	117	123
55-64	165	158	171	182	174
Total population aged 18-64 and over	547	543	550	560	563
Norwich					
18-24	254	254	242	246	268
25-34	292	354	374	368	356
35-44	187	197	226	261	273
45-54	148	163	169	166	186
55-64	127	127	139	154	156
Total population aged 18-64	1,009	1,095	1,149	1,195	1,239
South Norfolk					
18-24	77	81	75	75	82
25-34	104	122	132	128	124
35-44	159	145	149	171	183
45-54	173	185	181	167	176
55-64	173	165	183	197	191
Total population aged 18-64	686	698	719	737	756
Waveney					
18-24	95	92	84	84	92
25-34	120	141	151	145	138
35-44	147	130	136	158	167
45-54	155	165	161	147	152
55-64	162	156	173	188	184
Total population aged 18-64	678	684	706	722	732
Norfolk					
18-24	760	758	713	726	788
25-34	972	1,140	1,202	1,174	1,140
35-44	1,112	1,028	1,086	1,242	1,303
45-54	1,134	1,220	1,186	1,103	1,157
55-64	1,158	1,114	1,231	1,331	1,302
Total population aged 18-64	5,136	5,260	5,418	5,576	5,689

The information about ASD is based on *Autism Spectrum Disorders in adults living in households throughout England: Report from the Adult Psychiatric Morbidity Survey 2007* was published by the Health and Social Care Information Centre in September 2009.

The prevalence of ASD was found to be 1.0% of the adult population in England, using the threshold of a score of 10 on the Autism Diagnostic Observation Schedule to indicate a positive case. The rate among men (1.8%) was higher than that among women (0.2%), which fits with the profile found in childhood population studies.

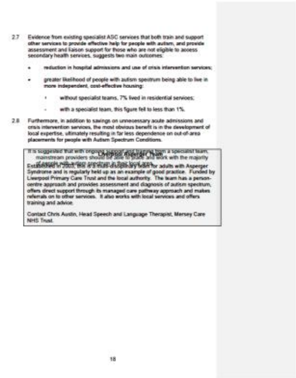
The report *Prevalence of disorders of the autism spectrum in a population cohort of children in South Thames: the Special Needs and Autism Project (SNAP)*, Baird, G. et al, The Lancet, 368 (9531), pp. 210-215, 2006. found that 55% of those with ASD have an IQ below 70%.

The National Autistic Society states that 'estimates of the proportion of people with autism spectrum disorders (ASD) who have a learning disability, (IQ less than 70) vary considerably, and it is not possible to give an accurate figure. Some very able people with ASD may never come to the attention of services as having special needs, because they have learned strategies to overcome any difficulties with communication and social interaction and found fulfilling employment that suits their particular talents. Other people with ASD may be able intellectually, but have need of support from services, because the degree of impairment they have of social interaction hampers their chances of employment and achieving independence.'

The prevalence rates have been applied to ONS population projections of the 18 to 64 population to give estimated numbers predicted to have autistic spectrum disorder to 2030.

Appendix 2

South West Regional Oversight Group for Adults with Autism Spectrum Conditions (Commissioning Guidance), Adult Autism Spectrum Conditions Services.



2.7 Evidence from existing specialist ASC services that both train and support other services to provide effective help for people with autism, and provide assessment and liaison support for those who are not eligible to access secondary health services, suggests two main outcomes:

- reduction in hospital admissions and use of crisis intervention services;
- greater likelihood of people with autism spectrum being able to live in more independent, cost-effective housing:
  - without specialist teams, 7% lived in residential services;
  - with a specialist team, this figure fell to less than 1%.

2.8 Furthermore, in addition to savings on unnecessary acute admissions and crisis intervention services, the most obvious benefit is in the development of local expertise, ultimately resulting in far less dependence on out-of-area placements for people with Autism Spectrum Conditions.

It is suggested that with ongoing ... a specialist team, mainstream providers should ... work with the majority ...

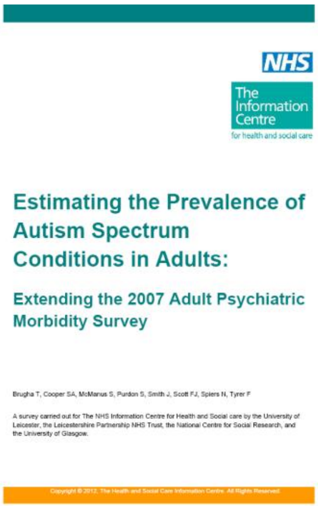
Liverpool Asperger Team

... for adults with Asperger Syndrome and is regularly held up as an example of good practice. Funded by Liverpool Primary Care Trust and the local authority. The team has a person-centre approach and provides assessment and diagnosis of autism spectrum, offers direct support through its managed care pathway approach and makes referrals on to other services. It also works with local services and offers training and advice.

Contact Chris Austin, Head Speech and Language Therapist, Mersey Care NHS Trust.

Appendix 3

Estimating the Prevalence of Autism Spectrum Conditions in Adults, Extending the 2007 Adult Psychiatric Morbidity Survey which is published at Information Centre (IC), department of Health (DH)



NHS
The Information Centre
for health and social care

Estimating the Prevalence of Autism Spectrum Conditions in Adults:

Extending the 2007 Adult Psychiatric Morbidity Survey

Brugha T, Cooper SA, McManus S, Purdon S, Smith J, Scott FJ, Spiers N, Tyrer F

A survey carried out for The NHS Information Centre for Health and Social care by the University of Leicester, the Leicestershire Partnership NHS Trust, the National Centre for Social Research, and the University of Glasgow.

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MINUTES OF THE HEATHWATCH NORFOLK BOARD
HELD ON MONDAY 16 SEPTEMBER
AT 14:00 – ROWAN HOUSE, HETHERSETT

PRESENT	**OFFICERS IN ATTENDANCE**
William Armstrong (Interim Chair)	Alex Stewart
Jon Clemo	Chris Knighton
Diane DeBell	Chris MacDonald
Graham Dunhill	Sam Revill
Roan Dyson	Andy Magem
Mary Ledgard	
Julia Redgrave	

1 APOLOGIES FOR ABSENCE AND INTRODUCTIONS

William Armstrong introduced himself to the board and thanked Healthwatch Norfolk (HWN) for the invitation to chair the September board meeting prior to his formal appointment on 1 October 2013.

Apologies for absence were received from Nick Baker, Mark Ganderton, Moira Goodey, Joanna Hannam, Pa Musa Jobarteh and Fiona Poland.

2. DECLARATIONS OF INTEREST

William Armstrong declared his role as a trustee for Voluntary Norfolk and confirmed Voluntary Norfolk are also aware of his appointment as HWN chair.

3. MINUTES OF THE MEETING HELD ON 08 JULY 2013

The minutes of the HWN board meeting held on 8 July 2013 were confirmed as a correct record of the meeting.

4. MATTERS ARISING

Alex Stewart thanked Julia Redgrave for her support and guidance in production of HWN's Equality Impact Assessments and Safeguarding Children Policy.

The board discussed the pending TUPE claims following a verbal update from Alex Stewart.

RESOLVED

Alex Stewart agreed to summarise discussions in an email to the board. The board agreed it would be appropriate to call an urgent meeting of key stakeholders Norfolk County Council and Voluntary Norfolk with HWN representation from William Armstrong, Alex Stewart and Jon Clemo

Alex Stewart brought Article 39 (relating to the disqualification and removal of directors) to the attention of the board; specifically paragraph 6 which states:

[A director shall cease to hold office if he or she] is absent without permission of the directors from all their meetings held within a period of six consecutive months and the directors resolve that his or her office be vacated.

It was confirmed that Steve Cheshire had been absent from two consecutive board meetings without issuing apologies to the board and had therefore been absent without permission of the directors from all their meetings held within a period of six consecutive months.

RESOLVED

The board resolved that Article 39 should be invoked subject to written confirmation of the articles, giving 7 days notice to account for prior non-attendance.

5. STAFF REPORTS

Staff reports by Chris Knighton, Chris MacDonald, Sam Revill and Andrew Magem were received.

5.3 Research Manager's Report

RESOLVED

The following recommendations received in the report were endorsed by the board:

1. Healthwatch Norfolk should monitor and analyse the ward-level Friends and Family Test scores for inpatient services when at least six months of results have been published.

2. Where ward level trends are low (below +50) further work should be undertaken to investigate what lies beneath, through dialogue with hospital management, ward staff, inpatients and their visitors and families and where appropriate deployment of Enter & View.

3. The Chief Executive should write to the CEO of each of the five Clinical Commissioning Groups (CCGs) offering a presentation by the Research Manger to discuss the findings of The GP Patient Survey results for Norfolk practices. Where the survey results for individual practices indicate poorer patient satisfaction, a request should be made for the lead practitioner of that surgery to join the discussion.

4. For November 2013 Board Meeting, the Research Manager will prepare a summary report of the reaction to the survey's findings, setting out any recommendations that Healthwatch Norfolk would like to see addressed. This report will be for the attention of CCGs and Practice Managers.

With the following additions.

1. The board resolved that Alex Stewart would also inform the CCGs of the report's findings at the Chief Officers' meeting.

2. The board agreed that Alex Stewart would attend the presentation of the GP Patient Survey findings to each CCG by Research Manager Sam Revill.

5.4 Information Officer's Report

RESOLVED

The information officer will report on the nature and quantity of signposting enquiries and comments on local services received from the public.

6. ITEMS FOR DECISION

6.1 Board meetings in public

A summary of the paper (item 6.1) was received by the board.

During the ensuing discussion the following points were made:

Graham Dunhill noted the lack of interest in previous shadow board meetings and highlighted the cost implications of moving to a larger venue.

Jon Clemo emphasised the importance of engagement but expressed reservations that opening board meetings to the public was the most effective approach.

Roan Dyson suggested an engagement plan would mitigate the decision to hold meetings in private and provide clarity as to the aims and objectives of board engagement.

Julia Redgrave made it clear that the decision to hold meetings in private would be kept under review and that specific opportunities for engagement should be developed.

William Armstrong affirmed that there should be a presumption of public meetings.

Mary Ledgard did not object to holding meetings in public but asked that the meetings were made relevant to the public and that relevant governance arrangements were put in place.

RESOLVED

The board agreed to revisit this item at the next board meeting following further consideration.

Chris Knighton offered to present a range of board engagement approaches at the next meeting to help inform and guide discussion.

6.2 Internal Tendering Policy

A summary of the paper (item 6.2) was received by the board.

During the ensuing discussion the following points were made:

Alex Stewart emphasised the operational challenges posed by the current tendering process; specifically the delay in waiting the requisite 4 weeks before opening tenders to bids from outside the consortium.

John Clemo pointed out that any local voluntary organisation can join the consortium.

Roan Dyson asked that a preference for local providers be retained within the policy and suggested that HWN could be more proactive in reaching out to providers and suggested holding a provider event.

Chris MacDonald reiterated the operational challenges faced by HWN to date and highlighted the lack of feedback received from providers to help improve the tender process. It was also noted that a planned event to engage with consortium members had been postponed due to a lack of interest from all provider representatives but would hopefully go ahead before the end of the year.

Julia Redgrave highlighted the absolute pressure on the voluntary sector in the current financial climate and emphasised the knock-on effects for capacity within these organisations to appraise and manage new projects and relationships.

Graham Dunhill urged the board to consider the short time that the policy had been in place, affirming that it was too soon to change the tender policy and advising that the board should wait until the end of year one before amending the policy.

RESOLVED

The board resolved to approve option one as set out in the paper (item 6.2): to continue for a further 6 months using the internal tender approach and review outcome of further tenders at the end of the financial year (March 2014); retain the QC1 and QC2 panels to evaluate bids, award and monitor contracts.

6.3 Young Healthwatch Ambassadors/Apprentices

A summary of the paper (item 6.3) was received by the board.

During the ensuing discussion the following points were made:

Diane DeBell highlighted the scale and variety of work that make up a comprehensive approach to representing the interests of local young people and children in Norfolk, being careful to emphasise that this was not equivalent to the work of one person.

Julia Redgrave described the wide variety of youth engagement projects already in place locally and urged the board to make the most of these options before committing resources.

Jon Clemo added that wider options analysis was required and advised that further, more general research should be carried out before appointing HWN ambassadors or apprentices.

Roan Dyson described the need for a mapping exercise to set-out these options for the board at a future board meeting.

RESOLVED

The board resolved that prior to exploring either apprenticeship or ambassador options detailing expenditure, it is necessary for HWN to review the local opportunities for youth engagement currently in place. Julia Redgrave pledged her support to provide this information to the HWN office.

7.7 Proposed reports for November board meeting

Jon Clemo requested that the board have an opportunity to revisit the HWN objectives as set out on the Plan on a Page and receive an update on the work that has been undertaken in the 1st 6 months of operation.

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NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE
MINUTES OF THE MEETING HELD AT COUNTY HALL, NORWICH
ON 10 OCTOBER 2013

Present:

Mr C Aldred	Norfolk County Council
Mr D Bradford	Norwich City Council
Mrs J Chamberlin	Norfolk County Council
Michael Chenery of Horsbrugh	Norfolk County Council
Mrs A Claussen-Reynolds	North Norfolk District Council
Mrs M Fairhead	Great Yarmouth Borough Council
Mr T Jermy	Norfolk County Council
Miss A Kemp	Norfolk County Council
Mr R Kybird	Breckland District Council
Dr N Legg (Elected Chairman for the Meeting)	South Norfolk District Council
Mrs M Somerville	Norfolk County Council

Substitute Members Present:

Mr P Balcombe for Mr J Bracey
Mrs A Thomas for Mr M Carttiss
Mr A Wright for Mr G Sandell

Also Present:

Dr Sue Crossman	Chief Officer, West Norfolk Clinical Commissioning Group
Chris Coath	Assistant Director, Commissioning (Out of Hospital Care), South Norfolk Clinical Commissioning Group
Yvonne Srinivasan	Supplier Manager, Specialised Mental Health Commissioning, NHS England East Anglia Area Team
Carolyn Young	Programme of Care Manager – Trauma, NHS England (Midlands and East)
Tanya Clarke	Operational Manager for Wheelchair Services, Norfolk Community Health and Care
Nina Melville	Service Manager for Specialist Rehabilitation, Norfolk Community Health and Care
Dr Trevor Wang	Family Voice
Patricia Wright	Chief Executive, Queen Elizabeth Hospital, NHS Foundation Trust
David Stonehouse	Director of Resources, Queen Elizabeth Hospital, NHS Foundation Trust
Andrea Goldsmith	Member of the Public
Hazel Fredericks	Member of the Public
Steve Sheldrick	Member of the Public
Esther Aldred	Member of the Public

1. Apologies for Absence

Apologies for absence were received from Mr J Bracey, Mr M Carttiss, Mr B Hannah and Mr G Sandell.

2. (a) To Elect a Chairman for the Meeting

Resolved

That in the absence of the Chairman and the Vice Chairman (who had both given their apologies for the meeting) Dr N Legg be elected Chairman for this meeting.

(Dr N Legg in the Chair)

(b) Chairman's Comments

The Chairman welcomed onto the Committee Mr T Jermy (Norfolk County Council) who had replaced Mr D Crawford.

3. Minutes

The minutes of the previous meeting held on 5 September 2013 were confirmed by the Committee and signed by the Chairman, subject to the addition of the words "…and an under-spend in West Norfolk" at the end of the first bullet point on page 9.

4. Declarations of Interest

There were no declarations of interest.

5. Urgent Business – Appointment of a NHOSC Link Member with Norfolk and Suffolk NHS Foundation Trust

The Chairman agreed that the Committee should take as urgent business the appointment of a NHOSC Link Member with Norfolk and Suffolk NHS Foundation Trust. This matter was urgent because there was a public meeting of the Norfolk and Suffolk NHS Foundation Trust's Board on 24 October 2013, which was before the next scheduled meeting of this Committee.

It was pointed out that Mr D Crawford had been appointed as NHOSC Link Member with Norfolk and Suffolk NHS Foundation Trust but he was no longer a Member of NHOSC and a new Link Member might therefore be appointed. The role of the NHOSC Link Member was to attend the Trust Board and Governors meetings in public to observe and gain a good understanding of the Trust's work, which could be used to inform NHOSC's scrutiny work. The NHOSC Link Member had no formal position with the Trust. The NSFT Governors met quarterly at locations across Norfolk and Suffolk. The NSFT Board met bi-monthly at locations across Norfolk and Suffolk.

Resolved

That Michael Chenery of Horsbrugh be appointed the NHOSC Link Member with Norfolk and Suffolk NHS Foundation Trust (the vacancy having arisen because Mr D Crawford was no longer a Member of the NHOSC).

6. Wheelchair Provision by the NHS

The Committee received a suggested approach from the Scrutiny Support Manager (Health) to update reports from the South Norfolk CCG, the West Norfolk CCG, Great Yarmouth and Waveney CCG and Family Voice concerning the new commissioning arrangements for NHS wheelchair services and the performances of the wheelchair services across Norfolk.

The Committee received evidence from Dr Sue Crossman, Chief Officer, West Norfolk Clinical Commissioning Group; Chris Coath, Assistant Director, Commissioning (Out of Hospital Care), South Norfolk Clinical Commissioning Group; Yvonne Srinivasan, Supplier Manager, Specialised Mental Health Commissioning, NHS England East Anglia Area Team; Carolyn Young, Programme of Care Manager – Trauma, NHS England (Midlands and East); Tanya Clarke, Operational Manager for Wheelchair Services, Norfolk Community Health and Care; Nina Melville, Service Manager for Specialist Rehabilitation, Norfolk Community Health and Care and Dr Trevor Wang, Family Voice.

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

- From 1 April 2013 NHS England had taken on responsibility for highly complex specialist wheelchair provision. NHS England had a contract worth £1.4m with Norfolk Community Health and Care for wheelchair provision in Norfolk.
- The witnesses said there was no reason why the public should be concerned about changes in the financial arrangements for the wheelchair service.
- Feedback showed that people were generally happy with the wheelchair service that they had received from the NHS and that there was no shortage of available wheelchairs in the county.
- Where there were delays in people having to wait for a wheelchair this could usually be attributed to the design of the wheelchair that was required; there was more work involved in the design and production of specialist wheelchairs.
- Where necessary, a specialist team could provide assessments for people with severe physical disabilities who could not use standard wheelchairs or controls.
- Wheelchairs for adults were often less complex than those for children.
- On average, children did not have to wait as long as adults did for their initial assessment.
- Where children did have to wait, this was usually where they had outgrown an existing wheelchair, rather than having to wait to receive their first wheelchair.
- It was a requirement for all children to have received their first wheelchair within 18 weeks of their initial assessment.
- Parents and carers were usually part of the assessment process, and their opinions and views were valued.
- There was on average a two week wait for an assessment in West Norfolk. The block contract for wheelchair provision in West Norfolk was in shadow form until 2014/15.
- A voucher system was in place to allow wheelchair users to have more choice in relation to the kind of wheelchair they wanted. A voucher was available to the value of the chair the service user would have been offered

after an assessment.

- The wheelchair repair service was usually available between 8am and 4pm, Monday to Friday. The out of hours wheelchair repair service was available for powered wheelchairs only between 4pm and 9pm. Repairs and services were usually carried out at a mutually convenient time and place.
- Where wheelchairs were no longer needed, there was an expectation that they would be returned. Wheelchair parts were then recycled. There was a plate number on all NHS wheelchairs.
- It was uneconomic for the NHS to pursue the return of wheelchairs of the deceased.
- Norfolk Community Health and Care planned to set up and hold the first meeting of a new Wheelchair Services User Group by the end of January 2014.
- Dr Wang commented that the wheelchair services had not made sufficient progress on the issues that Family Voice had raised the last time that they had given evidence to the Committee, particularly round the need for user engagement, so that service managers were better able to identify problems, test ideas and communicate effectively with users.

The Committee asked for a further update from the commissioners of wheelchair services, to provide details of the new service specifications in Central and West Norfolk and an assurance that users' views were being heard and acted upon on an ongoing basis.

Dr Sue Crossman was asked to check with the Queen Elizabeth Hospital Service on whether a multi disciplinary approach was currently being taken to deciding when a child was ready to operate an electric wheelchair. It was agreed that the answer provided by Dr Crossman would be made available to Members in the Internal Member Briefing.

7 Terms of Reference for Scrutiny of Stroke Services in Norfolk

Members received a report from Mrs Margaret Somerville, Chairman of the Task and Finish Group for the Scrutiny of Stroke Services in Norfolk, which asked the Committee to approve the suggested terms of reference for the Group.

The Committee agreed to approve the terms of reference for the Stroke Services Task and Finish Group as set out in the report.

8 Quality of Service at the Queen Elizabeth Hospital, Kings Lynn

The Committee received a suggested approach from the Scrutiny Support Manager (Health), for a report on action taken by the Queen Elizabeth Hospital (QEH) to address concerns raised by the Care Quality Commission (CQC) and Monitor.

The Committee received evidence from Patricia Wright, Chief Executive at the QEH; David Stonehouse, Director of Resources at the QEH and Dr Sue Crossman, Chief Officer at West Norfolk Clinical Commissioning Group.

In the course of discussion, the following key points were noted:

- The QEH was expected to make £10m of year on year efficiency savings in order to make ends meet.
- The QEH had planned to make a £1.6m surplus in 2012/13, but had

delivered a £800,000 deficit.

- The QEH was working with a firm of consultants to identify efficiencies in the operation of the hospital. This did not mean that there were plans to close hospital services. Short term financial support for the QEH was in place.
- A number of other small District hospitals in the country were facing similar problems.
- The QEH was working closely with the Department of Health to achieve a surplus financial position, and was discussing with the West Norfolk CCG the way in which services were configured.
- In West Norfolk, the NHS had a history of working closely with providers of social care and had put in place a memorandum of undertaking with service providers.
- A system-wide review was currently being undertaken.
- The Senior Management Structure at the QEH had been reviewed within the last 12 months and there were now four clinical directors where there had been eight clinical directors.
- The main concern for the hospital was to address a shortage of nursing staff.
- In April 2013, there had been 70 nursing vacancies. There were currently 17 nursing vacancies at the hospital and this number was expected to be reduced to less than 10 nursing vacancies by the end of December 2013.
- Due to difficulties in recruiting nurses in the UK, the hospital recruited 36 nurses from Portugal in June and July 2013 and another 35 nurses were expected to join the hospital in November and December 2013. An additional 40 healthcare assistants had been recruited from the local area and a nurse consultant had been appointed for A & E.
- No nursing posts had been frozen in order to achieve efficiency savings.
- Since 2008, the hospital had taken on over 200 additional staff most of whom were nursing staff.
- The hospital had a staffing ratio of 1 nurse to every 8 patients on a ward during the day, 1 nurse to every 11 patients on a ward at night.
- A number of Band 5 nurses had moved away from the hospital to take up nursing jobs elsewhere, which led Members to question why more was not being done at the hospital to retain more experienced nursing staff.
- In reply it was said that the hospital was working closely with local FE Colleges to provide suitable training for nurses and was looking at ways to retain existing staff.

The Committee noted that a system-wide review was currently underway in West Norfolk (i.e. involving not only the Queen Elizabeth Hospital but all other relevant healthcare providers under a memorandum of agreement with the CCG).

It was agreed to receive an update about the system-wide review and the QEH action plans at the next meeting of the Committee on 28 November 2013.

9 Care Quality Commission – New Approach to Hospital Inspections

The Committee received a report from the Scrutiny Support Manager (Health) which considered the Care Quality Commission's new approach to hospital inspections and asked Members to consider the Committee's involvement.

The Committee agreed the following response to the CQC's new style hospital inspection process:

(a) **Scrutiny Task and Finish Group reports** – continue the current practice of routinely sending copies of detailed scrutiny reports to the CQC whenever they are published.
(b) **Invitation to give views in advance of CQC inspections** – authorise the Chairman to provide the CQC with a summary of the Committee's recent scrutiny activity in relation to the hospital, based on the reports received by the Committee and the minutes of its meeting.
(c) **Public listening events in advance of inspections** – Committee Link Members with the hospital concerned to attend the listening event, if possible, and give views based on the summary provided for (b) above where relevant.
(d) **Quality summit after the inspection** – the Committee's Link Member for the hospital, or another Member of the Committee, to attend the summit where possible.

The NHOSC also agreed that information on a number of complaints and the nature of complaints should be included in reports to the Committee on each of the subjects it examined.

10. Forward Work Programme

The Committee agreed the list of items on the current Forward Work Programme with the addition of an update on the system-wise review in West Norfolk, to be received at the meeting on 28 November 2013.

The Committee asked for information about various issues relating to Access to GP Services to be sought from NHS England East Anglia Area Team and included in NHOSC's internal Member briefing, namely:

- The level of complaints about access to GPs in Norfolk.
- Which GP practices had introduced an appointment triage system?
- Had the practices with a triage system experienced increased complaints about access or other issues?
- What level of engagement or consultation with patients should be undertaken before introducing a triage system?
- Data to show to what extend the workload for GP practices was increasing.
- A summary of the contracts under which Norfolk GPs operate to show what level of access patients could reasonably expect.
- Information on how long patients were waiting to see their GP.
- Would GPs in Norfolk be encouraged to take part in the first wave of pilots for longer opening hours in 2014/15 (7 days a week 8am to 8pm)?

It was agreed that on receipt of the information mentioned above, NHOSC Members would decide whether or not to put "Access to GP Services" on the Committee's Forward Work Programme.

The meeting concluded at 1.20pm

Chairman

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NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE
MINUTES OF THE MEETING HELD AT COUNTY HALL, NORWICH
ON 28 NOVEMBER 2013

Present:

Mr M Carttiss (Chairman)	Norfolk County Council
Mr C Aldred	Norfolk County Council
Mr P Balcombe	Broadland District Council
Mr D Bradford	Norwich City Council
Mrs J Chamberlin	Norfolk County Council
Michael Chenery of Horsbrugh	Norfolk County Council
Mrs A Claussen-Reynolds	North Norfolk District Council
Mrs M Fairhead	Great Yarmouth Borough Council
Mr B Hannah	Norfolk County Council
Miss A Kemp	Norfolk County Council
Mr R Kybird	Breckland District Council
Dr N Legg	South Norfolk District Council
Mrs M Somerville	Norfolk County Council
Mr T Wright	King's Lynn & West Norfolk Borough Council

Also Present:

- Adrian Matthews - Director of Strategy & Business Development, East of England Ambulance Service NHS Trust
- Jon Moore - Interim Sector Lead for Norfolk & Suffolk, East of England Ambulance Service NHS Trust
- Matt Broad - General Manager for Norfolk, East of England Ambulance Service NHS Trust
- Chris Hartley - Associate Director of Communication, East of England Ambulance Service NHS Trust
- Chris Cobb - Director of Medicine and Emergency Services, Norfolk and Norwich Hospital
- Jonathon Fagge - Chief Executive Officer, NHS Norwich CCG
- David Stonehouse – Director of Resources, Queen Elizabeth Hospital NHS Foundation Trust
- Val Newton, Deputy Director of Nursing, Queen Elizabeth Hospital NHS Foundation Trust.

1. Apologies for Absence

Apologies for absence were received from Mr J Bracey, Mr T Jermy and Mr G Sandell.

2. Minutes

The minutes of the meeting held on 10 October 2013 were confirmed and signed by the Chairman.

3. Declarations of Interest

There were no declarations of interest.

4. Urgent Business

The Chairman confirmed there was no urgent business to consider.

5. Ambulance Turnaround Times At The Norfolk And Norwich Hospital

5.1 The Chairman welcomed the following witnesses to the meeting:

Adrian Matthews - Director of Strategy & Business Development, East of England Ambulance Service NHS Trust

Jon Moore - Interim Sector Lead for Norfolk & Suffolk, East of England Ambulance Service NHS Trust

Matt Broad - General Manager for Norfolk, East of England Ambulance Service NHS Trust

Chris Hartley - Associate Director of Communication, East of England Ambulance Service NHS Trust

Chris Cobb - Director of Medicine and Emergency Services, Norfolk and Norwich Hospital

Jonathon Fagge - Chief Executive Officer, NHS Norwich CCG

5.2 Adrian Matthews gave the Committee an overview of the current position regarding turnaround times at the Norfolk And Norwich Hospital (N&N). In doing so he noted that there had been significant improvements seen, arising from recent changes and closer working relations, partnership arrangements between the Norwich CCG and N& N Operations Team. In particular there had been the introduction of the post of Hospital Ambulance Liaison Officer (HALO) which had led to a decrease in delays to turnaround times of 75%.

5.3 Chris Cobb addressed the Committee to highlight that, since March, improved collaborative working built on the impact from initiatives arising from Project Domino, launched in December 2012, many of which were still to reach their potential in delivering effective change. However, one key outcome to date was the introduction of the Immediate Assessment Unit (IAU), created in direct response to the national shortage of Accident and Emergency spaces. This Unit reflected the improved interaction between services in Norwich with statistics showing that only one ambulance had waited over 60 minutes for a patient handover in the previous 6 months. The IAU aim was to ensure all handovers were completed within 15 minutes and that a patient was seen by a senior medical practitioner within 20 minutes. The intention was for this Unit to operate a 7 days per week service from December 2013 but it was already up and operational, ahead of target.

5.4 He also went onto describe the efforts underway to ensure patients were moved

through the doors from A & E by the Clinical Decisions Unit, with speedier diagnostics, thus avoiding lengthy periods of delay for patients on trolleys etc. However, he noted that the efforts to improve turnaround times in this area had been up against an 18% increase in the number of ambulance arrivals since April 2013. He noted that the national handover timescale was 15 minutes. In 2012 the N&N average turnaround time was 25 1/2 minutes and between April and September 2013 this time had reduced to 16.31 minutes. The situation was much improved on the picture seen in March 2013 but he confirmed that now was not the time for complacency.

5.5 Jonathon Fagge addressed the Committee to explain the role of the Norwich CCG and noted that it had been a robust commissioner of services since April 2013 in ensuring there was effective challenge on quality and performance. He stated that he was very heartened to report on the dramatic and genuine news story which was the turnaround in service delivery and quality in this area. He added that the launch of Project Domino, which had arisen from small beginnings, had evolved and its status grown due to the range and scale of successful outcomes which he had seen first hand. He reported that the N & N and Ambulance Trust had shown a real improvement in performance and should be congratulated.

5.6 The Chairman then referred the Committee to a BBC Look East report with Andrew Morgan, Chief Executive of the East of England Ambulance Service NHS Trust and his comments, amongst other points, on the difficulty of recruiting staff.

5.7 In response to questions from the Committee, the following key points were noted:

- The recruitment of paramedic staff was a national problem. The current training programme required paramedics to complete a 3 year university course with on the job training. The Ambulance Trust was working closely with universities running this course to ensure access to suitable qualifying students. There was a recruitment campaign to bring in qualified personnel from other services, such as nursing, but there was a 1 year conversion course which applied for such career change staff. The approach being taken to filling the immediate gap in paramedics now was to make better use of the existing 550 staff employed with the Trust, including supporting ambulance technicians more effectively during their training period. Lastly, work was underway to create a career pathway for advanced paramedics, to encourage staff retention and to bring trained paramedics into the Trust. The rural nature of Norfolk was an added difficulty to recruitment and so a new approach was needed – which is what the Trust was now seeking to address.
- The approach to support for stroke victims was time critical and a separate, specialist approach was in operation for these patients at the N & N. There was an alert sent ahead to the N&N by the ambulance crew, the N & N were primed to keep resuscitation bays free and a dedicated entrance was given to stroke patients who were met by an assessment nurse on arrival, available 24/7. Delays were overcome by the efforts of the new IAUnit, which moved patients swiftly into a dedicated facility in the hospital.

- Work was underway to understand why there had been a 20% turnover of Ambulance Trust staff in the current year to September 2013 (49 paramedics). Of this figure 20% had left due to ill-health but all leavers were being investigated to better identify the underlying issues.
- It was noted that 2 consultants had been recruited by the N&N but one had been previously employed by the QE Hospital, King's Lynn, which is itself experiencing staffing difficulties. However it was confirmed that options open to the consultant might have led the individual to leave the county altogether if a position had not been secured at the N&N.
- The appointment of five Hospital Ambulance Liaison Officers (HALOs) supported the N&N around the clock, 7 days each week in managing some 250-300 more patient arrivals than another other acute Trust in the region. This Team of officers played a key role in capacity planning and managing the flow of patients through to the hospital.
- In addition to the 18% increase in ambulance arrivals during the year, it was noted that walk-ins had increased by 6%, with a peak in July 2013 at 13% over the previous year. The increase in walk-ins had predominantly been due to minor injuries but more importantly it had showed that the processes handling such increased A & E attendances were now being managed much more effectively.
- The Ambulance Trust was making efforts to encourage students and freshers at university to be more aware of the dangers of alcohol and medical emergencies and how to manage them. In addition, a Community Support Team of staff were responsible for attending primary schools to explain how to call for help in an emergency. Further community engagement initiatives underway included the Crucial Crew (an educational campaign) and involvement with the SOS Bus at weekends in Norwich, advising on healthcare and taking a holistic approach to well-being.
- Sanctions for patient time unduly spent waiting on a trolley in A & E amounting to £127,000 had been levied on the East of England Ambulance Service NHS Trust by its commissioners, the Suffolk CCGs (on behalf of all CCGs in the region). It was reported that sanctions were also a necessary part of the contract between the Norwich CCG and N & N, however, it was also reported that any fines levied in relation to ambulance turnaround at the N&N were being reinvested into the urgent care system and that this innovative new approach provided the fuel for the Domino Project's successes. No data was yet available on just how successful Domino was but there was every intention that this information would be available by January 2014.
- Another new initiative to tackle bed delays was the Early Supported Discharge project. The aim was to prevent unnecessary admissions to hospital, especially for more elderly patients, and work was underway to ensure that this was now better managed, by closer work with care homes and others.
- It was recognised that paramedic training was also given to military personnel and the Ambulance Trust used every opportunity to approach the military services and American bases for recruitment purposes. The accredited training needed to become a paramedic was governed by the Health and Care Professional Council but that was not to say that this was the only route; Open University pathways were another route being investigated for in house technicians – all in all every option available was being investigated to build up the workforce.

- Mr David Russell, Interim Chairman of the North Norfolk Older People's Forum asked about a scheme to work with those who were more susceptible to falls and was informed that new money was being accessed which would help deliver a more coordinated service for such people. A report would be presented to the Norfolk Health and Well-being Board in March 2014, setting out how a scheme might operate.
- Councillor Russell Herring, Trowse with Newton Parish Council addressed the Committee in relation to his observations on the N &N and out of hours service, stating that experience was not valued sufficiently, staff had no confidence in management, callbacks delayed admissions and there were insufficient staff and equipment facilities in hospitals. The Chairman noted his comments and thanked him for attending to present his views.
- The Chairman suggested bed delays created a problem, preventing the earlier release of bedspaces. In response it was noted that medically stable patients in the N&N averaged 50 per day. Rarely did the number of people capable of release drop below 35 and this was a matter currently being investigated by the Domino Project. The introduction of a specialist Social Services Team by NCC, had been a positive step forward in helping to address this issue however, much more work was needed.

5.8 In concluding, the Chairman expressed his view that the issue of how to hasten the release of patients no longer in need of hospitalisation, thus releasing beds for others, should be addressed particularly as Norfolk County Council was closely involved in supporting this service improvement. He also confirmed that he wished to invite back the representatives from the N & N and Ambulance Trust in the New Year, to gain an understanding of how both services had performed following the predicted tough winter ahead.

At this point, the Committee took a 10 minute break.

6. Quality of Service at the Queen Elizabeth Hospital, Kings Lynn

6.1 The Chairman welcomed the following witnesses to the meeting:

David Stonehouse – Director of Resources, Queen Elizabeth Hospital NHS Foundation Trust

Val Newton, Deputy Director of Nursing, Queen Elizabeth Hospital NHS Foundation Trust.

6.2 David Stonehouse addressed the Committee and presented the Quality Improvement Plan for the hospital.

6.3 Val Newton addressed the Committee and spoke in relation to the actions taken since the matter was last considered. In particular, she noted that the Children's Safeguarding policy had been updated and the Adult Safeguarding policy had been refreshed. She reported on the programme of work undertaken regarding dementia support in that all staff were now required to undertake mandatory training in this subject and the time allotted for this at induction had also increased. She added that key wards had been targeted and observations were made on practice by the nursing staff. In addition, it was noted that QE had buddied with Guy's and St Thomas' NHS Foundation Trust, who were regarded as displaying best practice in this field, having video training and feedback from dementia

patients on how to work together, smarter.

6.3 Ms Newton spoke of changes taken to ensure appropriate staffing level ratios on wards and the zero tolerance policy which had been introduced to ensure all wards met the 1:8 ratio for registered nurses during daytime and 1:11 at night. During the previous 8 weeks this ratio had been maintained and checks were ongoing. She also spoke on the issue of vacancies in nursing staff to explain that there was a recruitment campaign running with nurses arriving from Portugal and working on wards by Christmas. The recruitment campaign also focussed on encouraging local people and return to work practitioners.

6.4 She continued by confirming that efforts were underway to match skill sets with the wards that nurses worked on. She also noted that compulsory training had been introduced to ensure informal English language was spoken by all nurses from January 2014, to ensure appropriate levels of skill in handling telephone calls and for patient discussions.

6.5 Ms Newton advised the Committee that an external review was underway to determine the reason for the high level of incidents at work which were reported. She also reported that the Complaints process was being reviewed by an external adviser and a plan for the way forward would follow in the New Year. Ms Newton, commented on the patient safety culture and explained that Values and Behaviours Sessions, involving all staff, were being rolled out to ensure staff felt able to challenge practices and to raise concerns freely. Lastly, she noted that work was underway to review specialist areas and staff ratios, with a focus on the move to 80-90% of Ward Sisters taking on a more supervisory role by March 2014.

6.6 In response to questions from the Committee, the following key points were noted:

- A Radio report had suggested that some services might be lost at the hospital, however, reassurance was given that there were no major plans to downgrade the A & E facility, indeed there was increased funding to improve this service provision, with building works having been given the go ahead.
- It was not possible to confirm when the hospital would come out of special measures; it was in significant financial difficulty. A programme of efficiency savings was being delivered and work was ongoing with the CCGs to reshape current services but there were no short term plans to remove services. Special measures was, nevertheless, a supportive process and with that had come the benefits of buddying with Guy's & St Thomas' and a new leadership team.
- It was noted that one issue which had been raised was management being out of ward sightlines. Therefore, it was now the hospital's practice to ensure that management and the executive did go walkabout. Friday was Clinical Leadership Day. Also, to ensure challenge was ongoing, mock CQC visits were carried out. The new Board was taking a lead on challenging best practice.
- Dehydration concerns were an issue for the Tilney Ward, therefore, air conditioning units had been brought in during the hot summer, with closer inspection of fluid charts. In addition, a working group of senior nurses had been set up to oversee developments in patient nutritional needs as a focus for fundamental change. Action had also been taken to recruit 37 auxiliary

nurses with extra training and buddying with external partners, to get the fundamental, focussed approach to the care of patients' right. Blue trays at mealtimes meant help for the patient and a red drug system encouraged intake of fluids. More was being actively undertaken now on the practicalities of care, such as the This Is Me Passport for dementia sufferers.

- The Board was also keen to see Patient Stories. Videos were important in communicating between patient and Board members and a good way of involving patients in improvement.
- Staffing levels were reviewed three times each day to meet the complexity of nursing provision and to ensure a responsive approach to care. Work was currently underway to review the skill mix, based on the needs of the patient and the work was due for completion in December.
- Patient care was safeguarded by establishing that everyone's care from shift to shift will be managed through a handover process, with the registered nurse determining the next steps, dependant on the type of ward.
- The safeguarding of children was a national concern and work was ongoing to determine the best approach, with safeguarding champions in paediatrics a possible way forward.
- There have been improvements to the car parking situation so patients do not miss appointments. One remaining challenge for people leaving the hospital is the work currently underway on the roundabout!
- Overseas nurses were supported to stay, with 60% still in post from recruitment 2/3 years ago. Examples of the support given to Portuguese nurses were in terms of accommodation but more increasingly academic, clinical and pastoral. Thoughts were turning to the next overseas location for nurses and HR were considering all possibilities. Local recruitment was also encouraged and efforts had been made to change shift patterns so more were enticed to apply. The recruitment of medical staff was also ongoing but agency costs for medical staff had increased particularly in the last couple of months. This area too was an issue of concern but mainly in areas such as A & E. Agency nurses were valuable in terms of quality but what was essential were permanent staff over the longer term. There was not so much difficulty in filling doctor posts. However, staff retention was the key and work was in hand to make the QE attractive through development opportunities a fast track to promotion or whatever suited the needs of the QE best.
- Releasing staff to attend mandatory training was essential to securing the long term stability of the QE Hospital. Staff did not need to be on duty to attend mandatory training; however, mandatory training was built in and was a development focus for the individual.
- The clue to keeping a Chief Executive was to have in place a good organisational strategy for the future. Success was a work in progress, it was not however, necessary to keep a Chief Executive long term.
- Work is underway to encourage young children's interest in nursing from an early age and to bring young people into the profession. When the time is right young people are helped to put in a good application. In this way, efforts to "grow our own" nurses continues.
- Work is in hand to help a patient ready to leave hospital with easy assistance to access their discharge medication. A working group is currently investigating how to improve this element of the discharge process as work has shown that the leaving date can be reduced by 2 days if the

various elements of discharge services are joined up.

6.7 The Chairman concluded by noting that Nigeria had a population of 150million and English as their first language, the hospital might consider that country in its future recruitment drive. He then went on to thank the representatives for attending and noted that by their commentary the observations from the Committee indicated that the QE Hospital was on the right path.

7. Forward Work Programme

7.1 The Committee **agreed** the list of items on the current Forward Work Programme with the addition of the items below:

- Mental Wellbeing in Norfolk and Waveney – Shaping the Future' - 16 January 2014 meeting.

- Report of Cambridgeshire, Norfolk and Suffolk Joint Health Scrutiny Committee on the Proposals for Liver Resection Services' – 16 January 2014 meeting.

- Delayed Transfers of Care – 27 February 2014 meeting.

The meeting concluded at 1.05 pm

Chairman

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communication for all

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