Norfolk County Council

Norfolk Health Overview and Scrutiny Committee

Date: **Thursday 8 September 2016**

Time: **10.00am**

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

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

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

Membership

MAIN MEMBER	SUBSTITUTE MEMBER	REPRESENTING
Mr C Aldred	Mr P Gilmour	Norfolk County Council
Mr R Bearman	Mr A Dearnley	Norfolk County Council
Mr M Carttiss	Mr N Dixon / Mrs S Gurney/ Mrs A Thomas/ Miss J Virgo	Norfolk County Council
Mrs J Chamberlin	Mr N Dixon / Mrs S Gurney/ Mrs A Thomas/ Miss J Virgo	Norfolk County Council
Michael Chenery of Horsbrugh	Mr N Dixon / Mrs S Gurney/ Mrs A Thomas/ Miss J Virgo	Norfolk County Council
Mr G Williams	*Vacancy*	North Norfolk District Council
Ms E Corlett	Ms S Whitaker	Norfolk County Council
Mr D Harrison	Mr B Hannah	Norfolk County Council
Mrs L Hempsall	Mr J Emsell	Broadland District Council
Dr N Legg	Mr C Foulger	South Norfolk District Council
Dr K Maguire	Ms L Grahame	Norwich City Council
Mrs M Stone	Mr N Dixon / Mrs S Gurney/ Mrs A Thomas/ Miss J Virgo	Norfolk County Council
Mrs S Weymouth	Mrs M Fairhead	Great Yarmouth Borough Council
Mr P Wilkinson	Mr R Richmond	Breckland District Council

Mrs S Young Mr T Smith King's Lynn and West Norfolk Borough Council

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

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

2. Minutes

To confirm the minutes of the meeting of the Norfolk Health Overview and Scrutiny Committee held on 26 May 2016. (Page 5)

3. Members to declare any Interests

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

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

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

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

- your well being or financial position
- that of your family or close friends
- that of a club or society in which you have a management role

- that of another public body of which you are a member to a greater extent than others in your ward.

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

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

5. **Chairman's announcements**

6. **10.10 – 10.55** **Norfolk and Suffolk NHS FoundationTrust – unexpected deaths** (Page 11)

A report on the outcome of the Verita review and resulting actions

Appendix A – Verita review terms of reference (Page 14)
Appendix B – Verita review summary & recommendations NHS England audit recommendations (Page 17)
Appendix C – NSFT response and action plan (Page 31)
Appendix D – Campaign to Save Mental Health Services in Norfolk and Suffolk – rolling average number of unexpected deaths June '15 – May '16 (Page 64)

7. **10.55 – 11.40** **Children's mental health services in Norfolk** (Page 65)

Scrutiny of the implementation of the Local Transformation Plan

Appendix A – Mental Health Assessments for Looked After Children - Norfolk Community Health and Care NHS Trust (Page 70)
Appendix B – CAMHS commissioners report for Norwich, North Norfolk, South Norfolk and West Norfolk (Page 71)
Appendix C – CAMHS commissioner report for Great Yarmouth and Waveney (Page 84)

11.40 – 11.50 **Break at Chairman's discretion**

8. **11.50 – 12.45** **End of life care** (Page 91)

Reports from NHS acute and community care providers

Appendix A – CQC ratings for end of life care in Norfolk (Page 95)
Appendix B – Norfolk and Norwich University Hospitals NHS Foundation Trust. (Page 99)

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Head of Democratic Services

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Date Agenda Published: 31 August 2016

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Norfolk County Council

NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE
MINUTES OF THE MEETING HELD AT COUNTY HALL, NORWICH
On 26 May 2016

Present:

Mr R Bearman	Norfolk County Council
Mr M Carttiss (Chairman)	Norfolk County Council
Mrs J Chamberlin	Norfolk County Council
Michael Chenery of Horsbrugh	Norfolk County Council
Mrs A Claussen-Reynolds	North Norfolk District Council
Ms E Corlett	Norfolk County Council
Mrs L Hempsall	Broadland District Council
Dr N Legg	South Norfolk District Council
Mrs M Stone	Norfolk County Council
Mrs S Weymouth	Great Yarmouth Borough Council
Mr P Wilkinson	Breckland District Council

Substitute Member Present:

Ms L Grahame for Ms S Bogelein, Norwich City Council

Also Present:

Ross Collett	Head of Norfolk and Suffolk Workforce Partnership and representative for Health Education East of England
Brian Watkins	County Councillor
Patrick Thompson	Shadow Public Governor- Great Yarmouth, Norfolk Community Health and Care NHS Trust
Maureen Orr	Democratic Support and Scrutiny Team Manager
Tim Shaw	Committee Officer

1(a) Election of Chairman

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

(Mr M R H Carttiss in the Chair)

1(b) Election of Vice-Chairman

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

2 Apologies for Absence

Apologies for absence were received from Mr C Aldred, Ms S Bogelein, Mr D Harrison and Mrs S Young. Apologies for absence were also received from Mr C Walton, Head of Democratic Services.

3. Minutes

The minutes of the previous meeting held on 14 April 2016 were confirmed by the Committee and signed by the Chairman.

4. **Declarations of Interest**

Ms E Corlett declared an "other interest" in item 8 in that she was the local authority shadow governor (Children's) to the NCH&C.

5. **Urgent Business**

There were no items of urgent business.

6. Chairman's Announcements

6.1 **Welcome to Ms Emma Corlett and Mr Peter Wilkinson**

The Chairman welcomed to the Committee Ms Emma Corlett, who had replaced Mr Bert Bremner. Ms Corlett was the Norfolk County Council Member Champion for Mental Health and had until recently worked for Norfolk and Suffolk NHS Foundation Trust.

The Chairman also welcomed Mr Peter Wilkinson who had replaced Mrs Shirley Matthews as the Breckland Council representative on the Committee.

7 **Initiatives to Address NHS Workforce Issues in Norfolk**

7.1 The Committee received a suggested approach from the Democratic Support and Scrutiny Team Manager to an update report from Norfolk and Suffolk Workforce Partnership/Health Education East of England (HEE) on local initiatives to address NHS workforce Issues in Norfolk that had been reported to the Committee in July and October 2015.

7.2 The Committee received evidence from Ross Collett, Head of Norfolk and Suffolk Workforce Partnership and a representative for Health Education East of England (HEE).

7.4 The Chairman reminded Members that as neither HEE nor its regional or local branches were commissioners or providers of local NHS services, they were outside the scope of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013, which meant that their engagement with the Committee was on a voluntary basis.

7.3 The following key points were noted:

- Ross Collett gave Members a PowerPoint presentation about the vision that the Norfolk and Suffolk Workforce Partnership and Health Education East of England (HEE) had for a more targeted, responsive and collaborative approach to workforce planning in Norfolk.

- The presentation explained the workforce hotspots in Norfolk, the workforce vacancy rates, the workforce supply by Norfolk locality, the numbers of patients per FTE staff member, plans to address supply gaps, how the initiatives of the Workforce Partnership would be measured, the implications of self-funding for new students in health and care training in Norfolk and details as to workforce sustainability and transformation plans. (*Note*: *A copy of the presentation from Health Education England / Norfolk and Suffolk Workforce Partnership can be found on the County Council website alongside the NHOSC agenda papers and minutes for this meeting).*
- In answering Members questions, Mr Collett said that there was a reliance on international recruitment to meet many of the NHS workforce commitments.
- Overall, there was sufficient workforce capacity in Norfolk but it was not always in the right places.
- There was an aging workforce and a reduced pool of potential employees to call upon.
- The retention of experienced NHS staff was seen as an important issue.
- Marketing Norfolk to those seeking health care related work was seen as a particularly important issue but outside of the role of the HEE.
- The HEE took care to ensure that its local and national plans were aligned with the service planning processes of NHS providers and commissioners so that it was able to turn the service strategies and visions of its key partners into a reality.
- The HEE had set its targets on critical areas such as planning for more doctors, dentists and physician's associates and providing new training opportunities for adult and mental health nurses, therapists and paramedics.
- With the introduction of self- funding for non-medical students announced as part of the comprehensive spending review the HEE would no longer be commissioning non-medical education from 2017.The HEE would, however, still have a statutory requirement to protect NHS workforce supply.
- Some of the key decision-making points for workforce planning were more driven by the length of time that it took for students to complete health and care training courses (and the academic cycle of universities in general) than they were by the financial annual planning round of the NHS.
- Initiatives were being developed locally with the Workforce Partnership Board to address workforce gaps and meet future service needs in terms of education.
- The balance in the relationship between the Universities and the employer organisations was changing. With the change to self-funding for student nurses from 2017 onwards, providers would be able to negotiate to provide placements to universities. Student numbers would be limited by provider trusts' capacity to provide adequate supervision rather than HEE's capacity to commission places.
- The HEE had been working for some time with recognised experts to commission a wider range of medical courses than it had in the past that would result in increased activity in General Practice by 2020.
- The "fall out" rate for students failing to complete health and care training courses at the UEA had declined for several years. The attrition rate for these kind of courses was now estimated at approximately 8%.
- Those UEA health and care training students who were failing to complete their courses were leaving university earlier in the academic year than was the case in the past.

7.4 Ross Collett **agreed** to provide further information for Members about:-

1. The rates of attrition of students in health and care training in Norfolk.
2. Where students went to work after they had graduated from training in Norfolk.
3. The UEA evaluation of the Collaborative Learning in Practice (CLP) pilot (referred to in the presentation).

7.5 Patrick Thompson, Shadow Public Governor- Great Yarmouth, Norfolk Community Health and Care NHS Trust, spoke about the importance of evaluating the success or otherwise of changes in the NHS workforce in the context of the impact those changes had on patient experiences of the NHS.

7.6 The Committee was grateful to Ross Collett, Head of Norfolk and Suffolk Workforce Partnership, and a representative for Health Education East of England (HEE), for attending the meeting.

8. Forward Work Programme

8.1 The Committee received a report from Maureen Orr, Democratic Support and Scrutiny Team Manager, that set out a proposed forward work programme for the remainder of 2016.

8.1 The Committee:

1. A**greed** its forward work programme as set out in the report.

2. **Agreed** to fill a vacancy for a formal link member with the Norwich CCG (following the departure from the Committee of Mr Bert Bremner). The names of Mrs Margaret Stone and Mrs Emma Corlett were put forward to fill this vacancy. On being put to the vote there were 7 votes in favour of Mrs Margaret Stone and 2 votes in favour of Mrs Emma Corlett whereupon **Mrs Margaret Stone was appointed as NHOSC link member with Norwich CCG and Ms Emma Corlett was appointed as substitute**.

3. **Agreed** to take up an offer of an informal meeting with Mr Ian Newton, Department of Health, on the issue of development of a primary care education and training tariff. This informal meeting would be arranged separately from the NHOSC timetable of meetings and open to all committee Members who wished to attend. Dr Wendy Thomson, Managing Director of Norfolk County Council, would also be invited to attend.

4. **Noted** that at the next meeting Members would be able to consider how they wished to receive feedback from the Children's Services Committee Task and Finish Review Group (of which Margaret Stone was a Member) that was undertaking a review of access to support and interventions for children's emotional wellbeing and mental health.

5. **Noted** that a representative of Norse had been invited to attend a Committee meeting of North Norfolk District Council to discuss the issue of Cranmer House, Fakenham and the establishment of Supported Care Service community-based teams. Feedback would be given to NHOSC Members through the Member briefing note.

6. Members who had any other items which they wished to have considered for inclusion in the forward work programme were asked to contact Maureen Orr, Democratic Support and Scrutiny Team Manager, in the first instance.

Chairman

The meeting concluded at 12.05 pm

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Norfolk and Suffolk NHS Foundation Trust – unexpected deaths

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

This report updates the committee on the outcome of the Verita independent review of unexpected deaths April 2012 to December 2015 and Norfolk and Suffolk NHS Foundation Trust's response to the recommendations of the review and of NHS England's governance audit in April 2016.

1. Introduction

1.1 On 25 February 2016 Norfolk Health Overview and Scrutiny Committee (NHOSC) added 'Norfolk and Suffolk NHS Foundation Trust (NSFT) – unexpected deaths' to its forward work programme for scrutiny. This followed press reports about information released by NHS England that appeared to show the Trust had the highest number of unexpected deaths of any mental health trust in England.

1.2 NSFT had commissioned consultants Verita to review the Trust's systems and processes for reporting unexpected deaths and the quality of its investigations in cases between April 2012 and December 2015. NHOSC agreed that following the publication of the Verita report NSFT should be invited to report on the outcomes of the review and progress with implementing any recommendations.

1.3 The terms of reference for the Verita review are attached at **Appendix A**. The full 137 page Verita report 'Independent review of unexpected deaths, April 2012 – December 2015' was circulated to NHOSC members by email on 26 May 2016 and is available on NSFT's website:- http://www.nsft.nhs.uk/About-us/Pages/Independent-Review.aspx The executive summary and 13 recommendations are included in **Appendix B** attached.

The NHS Serious Incident Framework (March 2015) referred to in the Verita report is available on NHS England's website:- https://www.england.nhs.uk/patientsafety/serious-incident/

1.4 NHS England wrote to NSFT on 26 April 2016 setting out the findings of a governance audit in relation to reporting and investigation of unexpected and expected deaths. A copy of the letter was circulated to NHOSC members by email on 26 May 2016; it is also included in the Verita report (i.e. Appendix K to Appendix B).

NHS England asked NSFT to view the audit findings in conjunction with Verita's report.

NHS England's 3 recommendations following the governance audit are included in **Appendix B** attached.

1.5 Verita highlighted a lack of national data on unexpected deaths on which to base analysis and comparison of NSFT's position compared to other mental health trusts. Within the constraints of the available data Verita concluded that the number of unexpected deaths recorded by NSFT is likely to be determined by the fact that the trust adopts an early Serious Incident (SI) reporting culture and reports incidents at a rate that is substantially higher than the national average for health trusts.

2.0 Purpose of today's meeting

2.1 Representatives from NSFT have been invited to today's meeting to discuss the Trust's response to the Verita review and NHS England's governance audit, and in particular the implementation of recommendations for improvement. NSFT has submitted the paper at **Appendix C**, which includes its action plan for addressing the recommendations.

2.2 The Campaign to Save Mental Health Services in Norfolk and Suffolk has submitted the graph at **Appendix D** in July 2016. It shows the NSFT three month rolling average of unexpected deaths reported as serious incidents from June 2015 to May 2016. Some unexpected deaths over the most recent period, March – May 2016, may not yet have been fully investigated. Some may be due to natural causes, in which case they would be subsequently reclassified, which would alter the figures.

3.0 Suggested approach

3.1 After the representatives from NSFT have presented their paper, Members may wish to discuss the following areas with them:-

(a) Has NSFT fully accepted all of the recommendations of the Verita review and NHS England governance audit?

(b) Is the implementation of the recommendations proceeding in line with the target dates on NSFT's action plan?

(c) Given the rise in unexpected deaths reported as serious incidents shown by the rolling 3 month average figures since October 2015 (Appendix D) does NSFT expect that delivery of the action plan will contribute towards reducing the numbers in future months? (It is acknowledged that cases in the months from March – May 2016 may not yet have been subject to full investigation and could be reclassified if deaths are found to be due to natural causes).

(d) NSFT planned to create a training session by 31 August 2016 to give staff confidence in their contact with families during the incident investigation process. When would the Trust expect that all relevant staff will have received that training?

(e) Verita highlighted the lack of national data on unexpected deaths, which made it difficult to properly compare NSFT with other mental health trusts in this respect. The Trust was asked to write to NHS England on this matter. What was the response?

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Norfolk and Suffolk NHS
NHS Foundation Trust

Independent Review of Unexpected Deaths, April 2012-December 2015

Terms of Reference, 23rd February 2016

Background

There is a rise in unexpected deaths locally and nationally and that is a concern for us all. The data released by NHS England in January 2016 in response to an FOI highlighted a discrepancy in numbers between Trusts, and an increase generally that we were aware of in our own reporting. The Trust Board, and specifically the Quality Governance Committee have been analysing this data for some time, and responding to obvious trends. This is an issue that has been raised by local campaigners and by relatives, and the Terms of Reference have been developed to include many of the specific questions put to the Trust, including those from families who have been bereaved by suicide. However this is not an investigation into individual incidents/deaths but rather an examination of the relevant data and trust systems and processes.

It is the Trust's position that the data released by NHS England is not comparable for the following reasons:

- It is not standardised for the size of trust, NSFT is one of the largest trusts in the country and would be expected to record more deaths.
- It does not cover comparable services for instance the majority of trusts do not offer drug and alcohol services as NSFT does
- There are differences in reporting and investigation thresholds, as evidenced in the Mazars report into Southern Health.

The Trust has a number of actions are already in progress, including:

- Regular analysis of our data, and testing for trends and actions that would prevent future deaths
- A comparative analysis where this is possible, for instance the National Confidential Inquiry into Suicides demonstrates that our suicide rate is entirely comparable for 13/14 the latest year where comparable data is available
- Clinical review exercises on a case by case basis for any learning
- Leading a multi-agency suicide prevention group

- Development of an internal suicide prevention strategy with an ambition of zero suicides

In addition to these actions, the Trust Board is commissioning this independent review of data, process and actions, specifically to focus on the following issues:

a) To examine how consistent the Trust's internal process of investigation are and if they are sufficiently rigorous for lessons to be learnt
    - That there is consistency is the process of investigation, with involvement of relevant and objective staff
    - That the process for review of RCA reports is rigorous, and that report authors are challenged when appropriate
    - That families and carers have the opportunity to contribute to the terms of reference and process of investigation
b) To examine the depth of the Trust's analysis of data in identification of themes and priorities for action*
    - That there is sufficient overview and identification of themes arising from incidents
    - That there is frequent overview of data by the Trust Board of Directors, and appropriate actions taken and monitored, including sharing of learning internally and externally
c) To compare the Trust's rates of unexpected deaths with national trends and determine (as far as possible according to the constraints of data) if the Trust is an outlier in terms of numbers, patterns or trends in unexpected deaths
d) To examine how the Trust has progressed with the latest national requirements for mortality review
    - That the Trust is responding to national guidance on establishing mortality review procedures
e) To appraise whether the Trust's priorities for suicide prevention internally and system-wide are the correct ones
    - That the Trust has sufficiently strong links with Public Health and system partners to take action across populations
    - That the Trust's internal suicide prevention strategy has sufficient focus on priority areas for action.

*****To include consideration of the following:
- Were levels of care and supervision adequate?
- Are there any trends in relation to availability of community or in-patient treatment, discharge arrangements, and issues for people with dual diagnosis?
- To consider whether there were specific themes or trends in the profiles of patients and their families.
- Are there trends that indicate concerns in specific localities or services?

In addition, the Trust will receive a report from NHS England (East DCO team): **t**o offer a consideration of the governance arrangements of investigating deaths within NSFT against consideration of the new NHS SI Framework to outline:

- whether deaths are reported in line with the new SI framework and investigated within a timely manner
- that there is a rigorous and standardised process for determination of unexpected deaths requiring serio us incident investigation

This will be completed by examining a random sample of deaths from April 2015 – December 2015) – covering expected deaths, and unexpected deaths across Learning Disability and Mental Health specialities.

Timescale

The review will be commissioned in February 2016, and undertaken by Verita and NHS England with a view to reporting back to the Trust Board in May 2016. The report will be released to the public at a Board of Directors meeting, and required actions will be monitored by the Board of Directors. Any immediate issues identified by the investigation team will be communicated to the Trust in advance of the Trust receiving the final report.

Jane Sayer
Director of Nursing, Quality and Patient Safety
February 2016

Extract from Verita report 'Independent review of unexpected deaths, April 2012 - December 2015', 25 May 2016

3. Executive summary and recommendations

3.1 Norfolk and Suffolk NHS Foundation Trust (NSFT) commissioned Verita in February 2016 to undertake an independent review of unexpected deaths at the trust between April 2012 and December 2015.

3.2 NHS England released data in January 2016 in response to a freedom of information (FOI) request by Rt Hon Norman Lamb, MP for North Norfolk. This data identified the trust as being the highest reporter of unexpected deaths in England between April 2012 and September 2015. The trust knew about an increase in the number of unexpected deaths both locally and nationally. As a result, the trust board commissioned this review to examine its systems and processes for SI reporting and the quality of its individual investigations. It also sought to compare trust rates of unexpected deaths against national trends; a review of its progress with the latest national requirements for mortality review; and an appraisal of the trust suicide prevention strategy.

Trust RCA investigation process

3.3 We reviewed the trust's internal investigation process to consider if it was sufficiently rigorous and whether lessons were being learnt from the reports. We reviewed 126 RCA reports of unexpected deaths in the community and inpatient settings against a framework we created based on National Patient Safety Agency (NPSA) and NHS England guidance. Our framework covered a number of factors including the terms of reference, investigation team, analysis, recommendations and engagement with families.

3.4 Overall we found that the trust's RCA investigation process meets trust and national requirements but improvements can be made in following it. The trust's RCA investigation reports we reviewed followed the trust policy but their analysis or wider exploration of service and care management problems could be improved. We found that the quality of RCA reports was inconsistent. The reports typically contained generic terms of reference that did not always include additional terms of reference required in certain circumstances. The reports contained reasonable chronologies but the principles of RCA were not consistently demonstrated in them. National benchmarks were rarely used to evaluate trust practice. Local benchmarks e.g. trust policies were used more readily but we found that they were often not applied as part of analysis. The reports tended to set out local policy

(what should have been done) but failed to say whether what happened was in line with trust policy and practice. In many cases the report authors were unable to identify the root cause of the patient's death, although sometimes this could have been a reasonable conclusion.

3.5 We could not draw out many common themes in relation to patient factors and service level issues, e.g. dual diagnosis or discharge from services, from the reports we sampled because these themes do not readily emerge. Furthermore the majority of the reports we reviewed featured recommendations that were not SMART[2]. Both of these factors are likely to have implications for the trust in terms of missed opportunities for organisational learning. RCA reports that do not produce themes that are easily identifiable or recommendations that convert to learning limit thematic analysis. Across the reports we sampled the quality of analysis was not sufficiently rigorous but the trust's recruitment of RCA facilitators, the first of which was appointed in September 2014, has improved this. The RCA facilitators were appointed after the trust recognised its weakness in this area. A further two RCA facilitators, to be renamed investigation and improvement managers (IIMs), will be appointed by the trust following this review.

3.6 In terms of a national context we note the recently published report[3] (May 2016) from the Department of Health's Healthcare Safety Investigation Branch. The report comments on a range of shortcomings that exist in current incident investigation practices across the healthcare system. The report describes specific problems such as investigations being delayed, protracted and of variable or poor quality. The report also details that, within healthcare organisations, safety investigation is often poorly resourced with limited access to the required expertise and insufficient allocation of time being key problems.

3.7 We reviewed how far the trust engaged with bereaved relatives during RCA investigations. The trust aims to do this by sending a letter of condolence from the chief executive within three days of knowledge about the service user's death. It includes an invitation to be involved in any investigation. However, often the trust does not know of a death until later and in some instances the trust needs to spend time identifying contact details for next of kin. In such cases contact is made at the earliest opportunity. The RCA investigation lead usually follows this initial contact shortly afterwards, with a second letter to make an introduction and establish a point of contact for the duration of the

[2] Specific, Measurable, Achievable, Realistic, Time-bound
[3] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/522785/hsibreport.pdf

investigation. Whether this second letter is sent depends on circumstances - for example, whether the next of kin has expressed an interested in being involved. The trust translates letters if the family does not speak English. The trust sends a final letter at the end of the investigation to offer to share the report with the family.

3.8 We found that the trust's level of engagement with families had improved after the introduction of duty of candour. Complete lack of engagement, according to evidence in the individual RCAs that we reviewed, dropped from nearly 40 per cent to nearly 16 per cent. Despite this improvement, engagement beyond a letter of condolence remained at less than 40 per cent both before and after the introduction of the regulation. However our findings are based only on whether engagement with the family is documented in the individual RCA reports. The trust should seek confirmation of engagement beyond a letter of condolence in these cases.

3.9 We have concerns about the trust's current process of engaging and supporting families. It would be more constructive if the trust were to meet families to offer condolences and outline any investigation to be undertaken, rather than doing this by written correspondence. We accept that engaging with bereaved families is a challenge all trusts face and for which there is no simple solution. However, we recommend that the trust try in the first instance to arrange a face-to-face meeting with families both to offer condolences and explain any investigation to be undertaken. We raised this with the trust during our review. The trust responded by initiating the appointment of two additional IIMs, formerly known as RCA facilitators, to enable better family liaison, increase the central investigation resource and improve the quality of RCA reports.

Board level oversight

Reporting to the board

3.10 We reviewed the trust board minutes (private and public) from 2012 to 2015 to see the extent to which the board had overview of unexpected deaths and whether appropriate action was taken and monitored, including the sharing of learning internally and externally.

3.11 Between 2012 and 2015 the trust board regularly received a *Patient safety report* that provided information about unexpected deaths in the community. The report detailed statistics, trends and pertinent information from recent RCAs.

3.12 Our opinion is that the trust board holds a monitoring role in relation to unexpected deaths in the community. We have seen evidence that unexpected deaths are routinely reported to the board but little evidence in board minutes of action beyond this to explore themes or learn lessons. However this work is conducted by the executive committee, on a weekly basis, and the quality governance committee (QGC), on a monthly basis. Both of these groups have executive representation and the latter has non-executive representation. The QGC also has governors in attendance. We recommend that there is more detailed discussion at board meetings about unexpected deaths to ensure that learning is being applied across the trust.

Learning lessons

3.13 The trust has taken positive steps in relation to learning lessons at a local level. Thematic reviews into unexpected deaths in the community – commissioned internally and externally – were reported to the board in 2013, 2014 and 2015. We found evidence of questions or actions being generated at board level, but not necessarily at board meetings, as a result of information from these reports being shared.

3.14 An internal review led by a trust non-executive was presented to the board in December 2013. The report found that the level of unexpected deaths at the trust was lower than the national average. The board minutes note that some lessons were learned. The QGC's predecessor was the service governance committee (SGC). It held a meeting in July 2014 where a discussion took place about the implementation of the action plan from this report. The implementation plan document is included in the SGC minutes and lists recommendations, actions, timeframes, responsible leads and evidence of action taken. All recommendations had been acted on either partially or completely.

3.15 The public board noted in August 2014 that the trust had commissioned an independent review of SIs in the Norfolk Recovery Partnership (NRP), for which learning lessons was a key part. However, we found no evidence in the board minutes that the findings of this review were shared or explored by the board as a whole. The report was

presented to the SGC, which had board level representation (both executive and non-executive) in September 2014.

3.16 West Norfolk CCG commissioned an external review of deaths across mental health services in 2014. The trust commented on the terms of reference. The review was briefly referenced at board meetings and the board minutes say the findings were never reported to the board. A draft version of the report was referenced at the July 2014 SGC meeting and an update on actions taken was sought by the SGC at the October 2014 meeting.

3.17 Board members sometimes raised concerns about unexpected deaths but they appear not to have been substantially explored. The trust's *Patient safety reports* are noted and numbers reported (particularly in the public board minutes) but the board minutes contain little evidence that issues were followed in board meetings. However, the activity of the QGC and the executive committee shows that some board members are involved with following up on learning from unexpected deaths.

3.18 The QGC was overhauled in 2015 and is now chaired by the trust chair. It is the trust's primary channel for monitoring and exploring learning from unexpected deaths in the community. A detailed *Patient safety report* is routinely submitted to the QGC. The committee has a work plan for the year ahead and intends to investigate fully any new concerns.

3.19 The QGC annual report (2015) found some patterns across the unexpected deaths reviewed, in general relating to the breakdown of incidents per service line. An increase in deaths of patients in liaison services was recognised by the trust which set up a learning event to discuss it. A report was subsequently submitted to the QGC in January 2016.

3.20 The trust has a number of channels for monitoring unexpected deaths and undertaking thematic analysis but the themes and learning do not readily emerge from individual RCA reports.

3.21 The trust undertakes reviews of unexpected deaths but there are some missed opportunities for learning lessons.

3.22 We found some good practice, such as learning events and working groups. These encouraged learning.

Working groups

3.23 The trust has taken positive steps in relation to learning lessons at a local level. A learning from SIs (serious incidents) working group was piloted in Suffolk in 2015. This work is locally driven and aims to improve learning from SIs with a view to sharing themes and good practice. Early signs suggest that this work had a positive impact. We saw examples of the group's work and it emphasises learning lessons. The director of operations for Norfolk recently set up a similar group to review SIs in Norfolk and Waveney with input from the Suffolk group.

3.24 It is too soon to know if any learning derived from these groups has become embedded in clinical practice. The Norfolk working group had met only twice at time of writing and the success of the group is yet to be proven. We recommend that the trust set itself a schedule to progress and align the work of the two groups and to agree a date to evaluate their work.

Data analysis

3.25 In considering the data on unexpected deaths we noted the lack of national data on which to base analysis. This is outside the trust's control and is a national issue. National data about unexpected deaths in mental health trusts offers limited means for making meaningful comparisons between mental health trusts. NHS England report this in their December 2015 FOI response. Many datasets are produced only for non-specialist acute trusts or provide only 'counts' (absolute values) rather than 'rates' (relative values), making it difficult to draw concrete trust-level comparisons. Furthermore it is difficult to be certain that investigating/reporting practices relating to unexpected deaths are consistent across trusts. The classification of incidents is a local decision made in accordance with NHS England's SI Framework. This again makes trust level comparisons difficult. We strongly recommend that the trust tell NHS England about the lack of meaningful, comparative data in this area to avoid potential misrepresentation and misinformation.

3.26 We provide a contextual view of the trust's numbers of unexpected deaths according to the FOI data among national trends to identify (as far as possible according to constraints of data) if the trust could be an outlier.

3.27 We analysed variables that can reasonably be considered to account for a mental health trust in a particular area recording high levels of unexpected deaths. We considered national and regional data on:

- populations served by mental health trusts in England;
- suicide rates;
- demographics (age, gender and unemployment);
- indices of deprivation;
- levels of mental health and illness;
- investigation thresholds;
- the risk profiles of mental health trusts in England, in terms of whether they offer a substance misuse service; and
- reporting practices.

3.28 Using the FOI data, the size of population served does not explain the differences in reported rates of unexpected death. This is contrary to our expectation and suggests that the data could be misleading.

3.29 We compared numbers of suicides at the local authority level for 2013 with the national average. Most local authorities in Norfolk and Suffolk are at or below the national average.

3.30 We conclude that the number of suicides in Norfolk and Suffolk is not higher than the national average.

3.31 The percentage of 30-59 year-old males, a demographic known to be at high-risk of suicide, in the East of England for 2012, 2013 and 2014 has remained between 23-24 per cent in line with the national average.

3.32 We made comparisons at the local authority level on the rate of admissions to hospital for alcohol related conditions (2013) against the national average (645 per 100,000 population). Norwich (960 per 100,000 population) and King's Lynn and West Norfolk (744 per 100,000 population) are the only two local authorities in Norfolk and Suffolk that had a significantly higher rate. All other local authorities in Norfolk and Suffolk are at or below the national average.

3.33 We cannot conclude from PHE data that there is a greater need for alcohol services in Norfolk and Suffolk, relative to the national average. We were not permitted access to PHE's National Drug Treatment Monitoring System so cannot comment on the regional prevalence of drug use.

3.34 Norwich CCG (286 per 100,000 population) and Great Yarmouth and Waveney CCG (243 per 100,000 population) had a significantly higher than the national average (191 per 100,000 population) number of emergency admissions for self-harm per 100,000 population. These are the only CCGs in the closest geographical range of NSFT that have a significantly higher rate than the national average.

3.35 Other than Norwich CCG and Great Yarmouth and Waveney CCG, the CCGs closest to NSFT did not have significantly more than the national average number of emergency admissions for self-harm.

3.36 The level of unemployment in Norfolk and Suffolk is in line with the national average.

3.37 The Department for Communities and Local Government's (DCLG) *Index of multiple deprivation* does not reveal regional imbalances in deprivation that could account for a high number of unexpected deaths being recorded at the trust.

3.38 The CCGs closest to NSFT did not record more than the national average number of bed days in secondary mental health care hospitals.

3.39 The presence of a substance misuse service in a trust's services may cause trusts' to record a high number of unexpected deaths but because substance misuse services are not homogenous it is difficult to reach a definitive conclusion here.

3.40 The number of unexpected deaths the trust recorded, according to the FOI data, is likely to be determined by the fact that the trust adopts an early SI reporting culture and reports incidents at a rate that is substantially higher than the national average for mental health trusts.

Mortality review

3.41 NHS England launched a programme of mortality review, *The national retrospective case record review (RCRR)*, the pilot for which was scheduled to start in the first quarter of 2016.

3.42 The trust formed a mortality group which first met in March 2016. The trust medical director (the group's chair) wrote to NHS England to ask for guidance about undertaking the work in a mental health setting. At time of writing the medical director has not received a reply. The trust has set up a database – which went live in April 2016 – to capture information about its mortality work.

Suicide prevention

3.43 The trust's suicide prevention work takes place across three streams:

1) the trust-wide suicide prevention strategy;
2) the Norfolk multi-agency suicide prevention group; and
3) the Suffolk multi-agency suicide prevention group.

3.44 The trust is drafting a suicide prevention strategy, the final copy of which was unavailable for review at time of writing but is due to be in place by September 2016. The previous version covered 2013-15.

3.45 Suicide prevention work in both Norfolk and Suffolk is multi-agency and is led by PHE. The two groups are at different stages of development.

3.46 The trust is engaged with PHE and system partners through the Norfolk and Suffolk multi-agency suicide prevention groups.

3.47 The trust demonstrated multi-agency work in Norfolk on suicide prevention but lacked an overall strategy. Such strategy is PHE's responsibility and is out of the trust's direct control. Work on this is in its infancy and continues.

3.48 The Norfolk suicide prevention group had a number of meetings and had a relatively strong multi-agency membership that included the police, NHS England, Healthwatch, Norfolk county council, and the Norfolk coroner. However the group lacks an overall strategy. Notable practice from the group included a pilot with Norfolk police that placed trust staff in police control rooms. The director of nursing said that feedback about this work had been positive and helped prevent unnecessary 136[4] sections. She added that the suicide prevention group was constructive in information-sharing and networking.

3.49 We acknowledge that PHE is tasked with leading suicide prevention work but the trust and county council co-chair this multi-agency group. We cannot say from the evidence who was driving the work of the Norfolk group. Trust representatives at this group felt the group was uncoordinated and told us they were working on the trust internal strategy with a view to asking PHE to use it as a template for a county strategy.

3.50 The trust showed a strategic approach to developing its Suffolk suicide strategy (led by PHE). The Suffolk suicide prevention group was smaller than the one in Norfolk but it had undertaken more strategic work and had a draft suicide prevention strategy. It also had a pilot project with the Samaritans and at a trust level a group called the learning from SIs (unexpected deaths and near misses) group.

3.51 The trust could show that it had taken positive steps in relation to its own suicide prevention work (independent of the multi-agency groups) in Suffolk, particularly in the work of the lead clinician for East Suffolk. PHE is tasked with leading multi-agency suicide prevention work in the county. However, the trust could take a more prominent role in this work in light of the positive pilot work they are undertaking. We note examples of good work by the trust in this area, such as a workshop in 2014 at Lynford Hall that sparked interest in the multi-agency groups.

3.52 The trust lead clinician for East Suffolk played an instrumental and positive role in developing the Suffolk suicide prevention work.

3.53 The trust showed areas of good practice in multi-agency work with the police (Norfolk) and the Samaritans (Suffolk).

[4] The police use section 136 of the Mental Health Act to take patients to a 'place of safety' from a public place, if they feel there is a mental health issue.

3.54 We found evidence in the trust board minutes to indicate that the board monitors suicide prevention. The results of suicide audits were presented to the public board in 2013, 2014 and 2015.

Next steps

3.55 We were struck by the enthusiasm and drive among staff we interviewed. They wanted to improve the way the trust managed unexpected deaths. We were shown a number of examples of innovative approaches to collaborative working and suicide prevention. Our review did not extend to interviewing frontline trust staff therefore we cannot comment as to whether this sentiment is replicated in the localities. Ultimately any change in culture should be set by the leadership team. We think that, subject to addressing the recommendations set out above, the trust is well positioned to improve its systems and processes for managing unexpected deaths.

Recommendations

R1 We recommend that the patient safety team carries out an audit to assure itself that every investigation has specific TOR relevant to the case that allow for the capture of:

- how far back the investigation goes;
- who commissioned the investigation;
- who is on the investigation team;
- the key lines of enquiry;
- clear RCA and use of appropriate benchmarks; and
- SMART recommendations.

This should take place **within three months** of the board formally accepting this report.

R2 The patient safety team should ensure that all unexpected deaths are treated like any other SI in respect of applying the statutory requirements of duty of candour. This should take place **within three months** of the board formally accepting this report.

R3 The patient safety team should continue to ensure that frontline staff have training and support to enable them to constructively engage and work with bereaved families. The

training needs of frontline staff should be reviewed **within three months** of the trust board formally accepting this report.

R4 The patient safety team should review its process of involving bereaved families with a view to developing a more engaged, communicative and face-to-face approach. Any changes in practice should be evaluated **within six months** of implementation.

R5 The patient safety team should build on progress already made by ensuring that each investigation team is sufficiently independent and has the correct skills and knowledge.

R6 The patient safety team should develop as a priority a quality assurance checklist/toolkit for all RCAs to promote a consistent approach to quality assurance. The quality of the RCA investigation reports should be evaluated **six months** after this checklist is introduced.

R7 The trust board should develop its role beyond monitoring unexpected deaths. These include:

- learning sessions e.g. localised trust pilot work;
- exploration of (anonymised) case studies;
- exploration of the results from thematic reviews;
- design and implement a programme of sharing learning from thematic reviews with measurable outcomes across the trust; and
- seeking assurance that learning flows from 'ward to board' and back.

R8 The trust should prioritise an aligned programme of work for the two SI working groups and undertake a review of progress **within nine months** of its implementation.

R9 The trust should tell NHS England about the shortage of meaningful, comparative data relating to unexpected deaths across mental health trusts to avoid potential misrepresentation and misinformation.

R10 The trust board should take a more active role in developing and promoting the trust-wide suicide prevention strategy. This should include officially identifying a board-level champion for the work, contributing to the draft strategy, agreeing a programme of

implementation and protecting time at board level for review and evaluation of the strategy.

R11 The trust should ensure that the intention to increase the funding of the lead clinician for East Suffolk to facilitate work in Norfolk is realised.

R12 The trust should ensure as a priority that multi-agency best practice and learning are shared between the two suicide prevention groups with a view to developing a uniform approach under its trust-wide suicide prevention strategy.

R13 The trust should as a priority develop a timeline of implementation of its suicide prevention work and strategy and undertake a follow-up review of progress made in **six to nine months**.

Extract from NHS England's letter to Norfolk and Suffolk NHS Foundation Trust, 26 April 2016
(Appendix K to Appendix B of the Verita report)

Interim report for Norfolk and Suffolk Mental Health Foundation Trust Regarding Governance Audit Undertaken to Focus on Reporting and Investigation of Unexpected and Expected Deaths

Recommendations

- Review incident reporting policies and consider how to embed an updated policy and understanding of the new serious incident framework as current staff training requirements does not require any update of the e-learning training package.

- NSFT may wish to consider the appropriateness of closing an investigation when the cause of death remains unknown and although there may not be implications for the trust regarding the cause of death, understanding the cause of death could be important in ensuring safeguarding of vulnerable people in other settings where rigorous investigation of deaths is not contractually required. Alternatively, if it is felt due to timeliness that it is more appropriate that the investigation is completed prior to the coroner's verdict, it may be helpful for NSFT to consider a process of following-up and adding to an addendum to the Serious Incident Report.

- As part of the ongoing proactive developments of the trust to strengthen governance and transparency into the decision to investigate a death, the trust is encouraged to be interrogative when considering physical health deaths and whether NSFT staff had acted in line with expectations to escalate any concerns about the management of that person's physical health needs.

Independent Review of Unexpected Deaths

Verita / NHS England (Local Office) Reports April 2012 – December 2015

Jane Sayer

26 May, 2016

Overview

- Our approach to unexpected deaths
- Why the Board commissioned the reviews
- Scope of Verita Review and how they conducted this
- Scope of NHS England (Local Office) Review and how they conducted this
- Key findings
- Recommendations
- Actions taken and next steps

Our approach

- One death is one death too many
- We want to learn, to improve and prevent further deaths
- We intend to be more open and consistent in how we support families and carers
- We intend to be more consistent in how we conduct investigations
- We will continue to improve our services and to support our staff

Note: ‘Unexpected death’ does not mean lack of care, or fault within a service

Feedback on our approach

Verita

"During our review we were struck by the enthusiasm and drive among staff we interviewed, wanting to make changes and improvements at the Trust, in relation to its management of unexpected deaths." (3.59)

"The Trust is well positioned to improve its systems and processes for managing unexpected deaths…" (3.55)

NHS England

"It is commendable that the Trust was open, enthusiastic and proactive about engaging with both this audit and the commissioning of their own independent review... Duty of candour was well-evidenced throughout…"

Verita's key comments (1)

The number of unexpected deaths recorded by NSFT is:

"…likely to be determined by the fact the Trust adopts an early SI reporting culture and reports incidents at a rate that is substantially higher than the national average for mental health trusts…" (3.40)

"We conclude that the number of suicides in Norfolk and Suffolk is not higher than the national average…" (3.30)

In its report Verita also noted that there is a:

"… lack of national data... This is outside of the Trust's control and is a national issue. National data about unexpected deaths in mental health trusts offers limited means for making meaningful comparison…" (3.25)

Verita's key comments (2)

"We found that the Trust's level of engagement with families had improved after the introduction of duty of candour…" (3.8)

"We have concerns about the Trust's current process of engaging and supporting families [during RCA investigations]… The Trust responded by… appointment of two additional IIMs to enable better family liaison, increase central investigation resource and improve quality of RCA reports…" (3.9)

"Overall we found that the Trust's RCA investigation process meets Trust and national requirements... but their analysis or wider exploration of service and care management problems could be improved… the quality of reports were inconsistent…" (3.4)

Why we commissioned these reviews

Local context

- Patient safety and quality of care is our priority
- Unexpected deaths increased at NSFT; Board wanted to fully examine in context, ie, more high-risk service users, increase in service users
- Board wanted external experts to bring an independent opinion

National context

- Publication of raw unstandardised national data on unexpected deaths appeared to put NSFT as outlier – data not appropriately adjusted for trust size, patient numbers, reporting differences

How Verita carried out the review

- Covering a period of April 2012 to December 2015
- Verita did not reinvestigate cases

Interviews

- Staff and stakeholders – including MPs, GPs, Coroner, CCGs, NHSE
  Met with two families at their request

Reviewed documents

- 126 Root Cause Analysis (RCA) reviews
- Trust / national data on unexpected deaths
- Trust's reports and minutes of meetings
- Trust's suicide prevention and mortality review work

Reviewed national / policy guidance

- National best practice / standards

NHS England's Review: Reasons and methods

- NHS England reviewed all unexpected deaths and serious incident investigations from April to December 2015
- They did not re-investigate any cases

- To provide assurance to Trusts and commissioners that unexpected deaths of people with mental health problems, including older people and those also with learning disabilities, are being appropriately investigated

Specifically to outline…

- Whether deaths are reported in line with the new Serious Incident Framework and investigated in a timely manner
- Whether there is a rigorous and standardised process for determination of unexpected deaths requiring serious incident investigation

Verita's findings: RCA Process

- Trust's processes meet national requirements but areas for improvement
- Family engagement was weak, is much improved, and to be further developed
- Quality of RCA reports was weak - Trust recognised this and appointed dedicated specialist staff

"… current RCA investigation process meets Trust and national requirements but improvements can be made in following it." (3.4)

"The quality of analysis was not sufficiently rigorous, but the recruitment of RCA facilitators since September 2014 has improved this." (3.5)

"The Trust has made progress in engaging and supporting families. (5.19) *We have some concerns in relation to the Trust's current process of engaging and supporting families* (3.8) *We think that Trust can improve on this process."* (5.19)

Verita's findings: Board oversight

- Good oversight of unexpected deaths by the Quality Governance Committee which reports to the Board and Executive Team
- Board receives regular unexpected deaths reports & monitors suicide prevention
- The Board needs to evidence more clearly how it is assured that lessons are learned and actions taken in relation to unexpected deaths

"The Executive Committee and the QGC are the forums for exploring [unexpected deaths] and this system work well." (F2)

"..Trust Board regularly received a patient safety report that provided information about unexpected deaths in the community..." (3.11) *"…But Board minutes contain little evidence that issue were followed in Board meetings."* (3.17)

"The [patient safety board] reports are detailed, eg, Serious Incident trends, incident reporting, but we cannot ascertain from the minutes the extent of the discussion and exploration they generated." (6.28)

"We found evidence in Trust Board minutes to indicate that the Board monitors suicide prevention. The results of suicide audits were presented to public board in 2013, 2014 & 2015." (3.54)

Verita's findings: Learning lessons

- Trust demonstrated strong track record of wanting to learn from unexpected deaths
- Good follow-up of learning via the QGC and Executive Team
- Opportunities to learn have been diluted by uneven quality of analysis in RCAs
- Appointment of RCA investigators in September 2014 led to improvements in quality of reporting
- More work to be done on improving quality of analysis and on reporting quality improvements to the Board

"Thematic reviews into unexpected deaths in the community – commissioned internally and externally – were reported to the Board in 2013, 2014 and 2015." (3.13)

"The activity of the QGC and the executive committee shows that some Board members are involved with following up on learning from unexpected deaths." (3.17)

"We found that reports completed by the Trust RCA facilitator were of a good standard." (5.26)

"Trust to recruit to two extra RCA facilitators to strengthen this resource." (5.28)

Verita's findings: Data analysis

- Lack of national data on which to base meaningful analysis - the review considered 8 variables
- Trust's provision of substance misuse services may lead to higher reporting
- Trust's culture of early reporting – substantially higher than other MH trusts – may account for a higher level of reported unexpected deaths

"The national data about unexpected deaths in mental health trusts offers limited means for making meaningful comparisons…." (3.25)

"It is reasonable to conclude that the presence of a substance misuse service in the profile of a trust's services causes trusts to record a high number of unexpected deaths." (7.73)

"…likely to be determined by the fact the Trust adopts an early SI (serious incident) reporting culture and reports incidents at a rate that is substantially higher than the national average for mental health trusts…" (3.40)

Verita's findings: Suicide prevention

- Trust has taken an innovative approach to working with partners
- NSFT has adopted innovative suicide prevention initiatives piloted in Suffolk and now being rolled out across the Trust
- There is a need for clearer strategic leadership on suicide prevention in Norfolk to drive change

"Suicide prevention work in both Norfolk and Suffolk is multi-agency and is being led by PHE. (3.45) The Norfolk Suicide Prevention Group had a number of meetings and has a relatively strong multi-agency membership… (3.48) but has yet to produce a strategy…We cannot say from the evidence we have seen who was driving the work of the Norfolk group and whether the group had the power to implement real change" (3.49)

"Notable practice includes a pilot that has taken place with Norfolk police that placed Trust staff in police control rooms." (3.48) "We were shown a number of examples of innovative approaches to collaborative working and suicide prevention." (3.55)

"The Trust could show taken positive steps in relation to its own suicide prevention work (independent of the multi-agency groups) in Suffolk…" (3.51)

"The Trust is drafting a suicide prevention strategy... Due to be in place September 2016." (3.44)

NHS England findings (1)

- Trust's policies have appropriate tone but require urgent updating in line with latest Serious Incident guidance *(Now complete)*
- The Trust applies criteria correctly in identifying where an RCA review is needed and there is a clear audit trail for decision making
- Reporting and investigations were carried out in a timely way

"The Trust manages to have an appropriate tone throughout the policy that embraces the NHS' attitude to learning from incidents not being about apportioning blame…staff members."

"Of 38 case files reviewed …17 were investigated as Serious Incidents and had RCAs completed (or investigations were still ongoing). The remaining 21 were identified as 'expected deaths' where an investigation…was not required. It's of the opinion of the author of the report that for all ...21 deaths this was an appropriate decision to have been made and that there was no evidence that there was an act or omission occurring as part of the NHS funded care received from NSFT."

"All were notified within the timescale expected… investigations were completed in a timely manner… The Trust was able to provide an audit trail for its rationale for considering whether an incident should be explored and reported as a Serious Incident."

"[Trust] policies require urgent updating to bring them in line with the new SI Framework."

NHS England findings (2)

- Quality of reports examined was variable and more inquisitiveness would have been helpful in one report, but they were generally of a good quality
- Duty of candour was well-evidenced
- Trust examines it own processes and seeks to strengthen governance
- Trust is proactive in engaging with improvement initiatives

"An exploration of one particular death as part of the audit (an older adult in a residential home, cause of death sepsis) highlighted that more inquisitiveness into examining the role that all NSFT staff have to ensure the safety of service users could have been helpful."

"It is of the opinion of the author that the Trust is appropriately examining its own processes and understanding how to strengthen governance in this area. It is commendable that the Trust was open, enthusiastic and proactive about engaging with both this audit and the commissioning of their own independent review."

"… in terms of face validity, the reports were generally of a good quality."

"Duty of candour was well-evidenced throughout."

Verita's recommendations (1)

	Trust actions
Patient Safety Team carries out an audit to assure that every investigation has specific TOR relevant to the case within three months of this report	Will be completed by 31.08.16
Patient Safety Team should ensure that all unexpected deaths are treated like any other SI in respect of applying the statutory requirements of duty of candour within three months of this report	Agreed and implemented
Patient Safety Team should continue to ensure frontline staff have training and support to enable them to constructively engage and work with bereaved families / carers Staff training needs should be reviewed within three months of this report	This will be supported through the appointment of two additional RCA (IIM) facilitators. Training needs review to be completed by 31.08.16

Verita's recommendations (2)

	Trust actions
Patient Safety Team should review its process of involving bereaved families / carers with a view to developing a more engaged, communicative and face-to-face approach. Changes in practice should be evaluated within six months of implementation	Review to be completed by 31.08.16
Patient Safety Team should build on progress already made by ensuring that each investigation team is sufficiently independent and has the correct skills and knowledge	Agreed and implemented
Patient Safety Team should develop as a priority a quality assurance checklist / toolkit for all RCAs to promote consistent approach to quality assurance. The quality of the RCA investigation reports should be evaluated six months after this checklist is introduced	Checklist to be in place by 30.06.17 Evaluation to report to Board Jan 2017

Verita's recommendations (3)

	Trust's actions
Trust Board should develop its role beyond monitoring unexpected deaths. To include: learning sessions; exploration of (anonymised) case studies; exploration of results from thematic reviews; design and implement programme of sharing learning from reviews with measurable outcomes across Trust; seeking assurance learning flows from 'ward to Board' and back	Agreed. Development plan signed off by Board by 31.07.16
Trust should prioritise aligned programme of work for two SI working groups and undertake review of progress within nine months of its implementation	Agreed. Report to QGC by Nov 2017
Trust should inform NHS England about shortage of meaningful, comparative data relating to unexpected deaths in MH trusts to avoid potential misrepresentation and misinformation	Agreed and implemented.

Verita's recommendations (4)

	Trust's actions
Trust Board should take more active role in developing and promoting the Trust-wide suicide prevention strategy. To include identifying a Board-level champion; contributing to the draft strategy; agreeing programme of implementation; protecting time at Board level for review & evaluation of strategy	Board level champion identified Workplan for strategy to be approved by 31.07.16
Trust should ensure that intention to increase the funding of the lead clinician for East Suffolk to facilitate work in Norfolk is realised	Funding to be approved
Trust should ensure as a priority that multi-agency best practice and learning is shared between two suicide prevention groups, with a view to developing uniform approach under a trust-wide suicide prevention strategy	Will form part of strategy workplan

Verita's recommendations (5)

	Trust actions
Trust should develop a timeline of implementation of its suicide prevention work and strategy and undertake follow-up review of progress in six to nine months	Agreed. Timeline to be shown in strategy workplan.

NHS England's recommendations (1)

	Trust's actions
Review incident reporting policies and consider how to embed updated policy and understanding of new SI Framework as current staff training does not require update of the e-learning training package.	Agreed. Training plan prepared for Organisational Development & Workforce Committee by 02.09.16
NSFT may wish to consider appropriateness of closing an investigation when cause of death remains unknown. Although there may not be implications for the Trust regarding the cause of death, understanding this could be important in ensuring safeguarding of vulnerable people …. Alternatively, if it is felt, due to timeliness, that it is more appropriate that the investigation is completed prior to the Coroner's verdict, it may be helpful for NSFT to consider process of following-up and adding an addendum to the Serious Incident report.	Policy to be updated to reflect this by 31.07.16

NHS England's recommendations (2)

	Trust's actions
As part of the ongoing proactive developments of the Trust to strengthen governance and transparency into the decision to investigate a death, the Trust is encouraged to be interrogative when considering physical health deaths and whether NSFT staff had acted in line with expectations to escalate any concerns about the management of that person's physical health needs.	To be completed by 31.07.16

Our next steps (1)

Recruiting additional two IIMs to support rigorous investigation of incidents	IIMs to oversee contact with bereaved families (telephone and face to face) with clinical support as required
Revised process of contact with family / carers in place following a bereavement offering a meeting in all cases	Staff training to include clear instruction on analysis within RCAs, and an analysis is appended to completed reports
Additional support from NHS England secured regarding analysis	RCA reports start with a pen portrait of the individual

Our next steps (2)

Locality Managers sign off RCA reports before return to Patient Safety Team	Patient Safety Team applies a quality checklist to completed SI reports
Framework on consultation on Trust Suicide Prevention Strategy to Board May 2016, for ratification in September 2016	Trust implementing NHS England's recommendations. Revised policy agreed, and includes consideration of timeliness of investigation with respect to Coroner's hearings
Trend reporting on SIs includes recommendations at local and Trust level; demographic and service trends continue to be reported (monthly to Executive Team, quarterly to QGC and Board). Patient Safety Team now analysing incidents by service line and based on 1,000 bed days to make accurate comparisons	

Conclusions & Commitments

- Review found no evidence that NSFT is an outlier in unexpected deaths; and higher reporting possibly due to types of services provided and our culture of early reporting
- We recognise need to improve bereaved family / carer engagement - appointing two more RCA / IIM facilitators to help
- We correctly identify incidents needing investigation & investigate promptly
- We will improve quality of our RCA reports so themes can be more clearly identified and lessons learned
- We will improve the way in which we demonstrate Board oversight of unexpected deaths
- We will press NHS England to assist future learning by developing better benchmarking data
- We will continue to develop our suicide prevention initiatives

Working together
for better mental health

Action Plan following Verita Independent Investigation

	Recommendation	Proposed action	By whom	Target date
1	Patient Safety Team carries out an audit to assure itself that every investigation has specific Terms of Reference relevant to the case within three months of this report.	Action taken to ensure facilitators establish clear terms of reference relevant to the case. The implementation of this will be monitored through a series of three audits in October 2016, January and April 2017.	Patient Safety Team	April 2017
2	Patient Safety Team should ensure that all unexpected deaths are treated like any other SI in respect of applying the statutory requirements of Duty of Candour within three months of this report.	The Trust currently sends a condolence letter to the family following an unexpected death reported as an SI. This invites the family to ask questions for the review to consider and provides a named contact link. As the independent report stated the facilitators may also attempt contact with the family and a further action is taken on completion of the report to try and share it. The independent report identified the Trust should strengthen its action in applying Duty of Candour by explicitly offering to meet with the family at the early stage. The Trust has adapted the condolence letter to make explicit statement wishing to meet with the family. Further the Trust has added to its SI database a check that the facilitator has made their attempt to contact the family. Through recording on the database it can be measured and monitored.	Patient Safety Team	31 August 2016 Complete- 7 June 2016

3	Patient Safety Team should continue to ensure frontline staff have training and support to enable them to constructively engage and work with bereaved families/carers. Staff training needs should be reviewed within three months of this report.	The Patient Safety Team will create a training session on the role of the named contact to provide staff with confidence in their contact with families during the incident investigation process.	Patient Safety Team	31 August 2016
4	Patient Safety Team should review its process of involving bereaved families/carers with a view to developing a more engaged, communicative and face to face approach. Changes in practice should be evaluated within six months of implementation.	See actions 2 and 3.	Patient Safety Team	31 August 2016
5	Patient Safety Team should build on progress already made by ensuring that each investigation team is sufficiently independent and has the correct skills and knowledge.	This will be audited as part of action 1 (three audits in October 2016, January and April 2017).	Patient Safety Team	April 2017
6	Patient Safety Team should develop as a priority a quality assurance checklist/toolkit for all RCAs to promote consistent approach to quality assurance. The quality of the RCA investigation reports should be evaluated six months after this checklist is introduced.	The Trust has a quality check process to which a checklist/prompt list will be added to ensure all parties are clear on the expectations of what is included in a report. An evaluation of its effectiveness in supporting consistency of reports will be completed in December 2016.	Patient Safety Team	30 December 2016
7	Trust board should develop its role beyond monitoring unexpected deaths. To include: learning sessions; exploration of anonymised case studies; exploration of results from thematic reviews; design and implement	A programme will be developed that includes the recommendations made. The first development session that will take place will be in July 2016 on unexpected death trends.	Director of Nursing and Quality	30 September 2016

	programme of sharing learning from reviews with measurable outcomes across Trust; seeking assurance learning flows from 'ward to board' and back.			
8	Trust should prioritise aligned programme of work for two SI working groups and undertake review of progress within nine months of its implementation.	This work is being undertaken within the Trust's Mortality Review work led by the Medical Director. A review of its implementation will be completed in March 2017.	Medical Director	March 2017
9	Trust should inform NHS England about shortage of meaningful, comparative data relating to unexpected deaths in MH Trusts to avoid potential misrepresentation and misinformation.	The Trust will communicate the findings of the report to NHS England.	Chief Executive	30 June 2016 Complete
10	Trust board should take more active role in developing and promoting Trust wide suicide prevention strategy. To include identifying a board level champion; contributing to the draft strategy; agreeing programme of implementation; protecting time at board level for review and evaluation of strategy.	The Trust board has a nominated champion in the Director of Nursing and Quality. The board received an update on the draft Suicide Strategy in May 2016 meeting. The strategy is due to be presented to Trust board in September 2016 which will include a structure for monitoring implementation.	Director of Nursing and Quality supported by the Patient Safety Team	30 September 2016 for the strategy
11	Trust should ensure that intention to increase the funding of the lead clinician for East Suffolk to facilitate work in Norfolk is realised.	Funding agreed, and agreement on terms of secondment to be finalised.	Chief Executive	Agreed
12	Trust should ensure as a priority that multi agency best practice and learning is shared between two suicide prevention groups, with a view to	This recommendation refers to the county Suicide Prevention Strategies led by Public Health. Therefore, as practised in whole system models in Mersey and		Complete

	developing uniform approach under a Trust wide suicide prevention strategy.	South West, the preference would be that the county strategies are completed first to which individual organisations then align theirs to. The schedules for completing county strategies are not aligned nor have definitive dates. This is out of the trust's direct control. Therefore the Trust is likely to produce its strategy ahead of these (September 2016). The Trust will be sharing its strategy with both groups and will have consistent attendance on both by the Patient Safety Lead, alongside other local Trust clinical leaders i.e. Lead Clinician. This attendance will support best practice being shared between the two groups.		
13	Trust should develop a timeline of implementation of its suicide prevention work and strategy and undertake follow up review of progress in six to nine months.	See action 10		
14	Review incident reporting policies and consider how to embed updated policy and understanding of new SI framework as current staff training does not require update of the e learning training package.	Q11 Serious Incidents requiring Investigation policy was updated in May 2016. This update confirms changes that had already been applied in practice i.e. change to 60 working days. Therefore key operational staff are already aware of the changes. The e learning package for incidents is provided for staff at induction. The Patient Safety Team will consider and apply which is the most effective suit of	Patient Safety Team	31 August 2016- complete

		actions to highlight across the Trust the policy and its application.		
15	NSFT may wish to consider appropriateness of closing an investigation when cause of death remains unknown. Although there may not be implications for the Trust regarding cause of death, understanding this could be important in ensuring safeguarding of vulnerable people. Alternatively, if it is felt, due to timeliness, that it is more appropriate that the investigation is completed prior to the Coroner's verdict, it may be helpful for NSFT to consider process of following up and adding an addendum to the Serious Incident report.	The case reviewed was an exception to the normal process. The general process is as follows: 1. On receipt of information that a service user has died the Patient Safety Team checks with the Coroner the cause of death. 2. If the post mortem is conclusive the Trust can review information as to whether incident meets SI threshold. 3. If the post mortem is inconclusive and pending toxicology (8-12 weeks) the Trust will generally report the incident as an SI and only commence the investigation upon receipt of the cause of death. 4. RCA investigation proceeds and final report is produced. 5. The final RCA report is provided to the Coroner giving detail that the Trust has examined its contact with the service user seeking to learn lessons. 6. If there are further matters to consider following the inquest additional work may be undertaken. If the Coroner identifies actions the Trust may take they have a duty to write a prevention of future deaths report which the Trust must respond to within 56 days.	Patient Safety Team	Complete 7 June 2016
16	As part of the ongoing proactive developments of the Trust to strengthen governance and transparency into the decision to investigate a death, the Trust	The Trust has created a Mortality Database in order to support the Trust monitor physical health deaths and		

	is encouraged to be interrogative when considering physical health deaths and whether NSFT staff had acted in line with expectations to escalate any concerns about the management of that person's physical health needs.	whether there is learning that may be applied. The Trust's Mortality review programme, led by the Medical Director, will be the key mechanism for this monitoring. Review of the Mortality Review is referenced in action 8. The second aspect is in respect of cases as they become known to the Trust and whether there were concerns (with other elements of the system of care provided to the service user) that could be considered through Safeguarding channels. The Patient Safety Team will review current process to identify if further actions may be considered.	Patient Safety Team	31 August 2016- complete

Update 29 June 2016

This action plan is going to form the basis of a quality improvement project which will be managed within the Trust's Project Management programme. This programme has established links and processes to support its full implementation and provide clear audit trail of evidence to the Trust board. This does not delay the commencement of actions.

Update- 30 August 2016

Further actions planned into schedule for actions 1 and 5. Actions 14 and 16 complete.

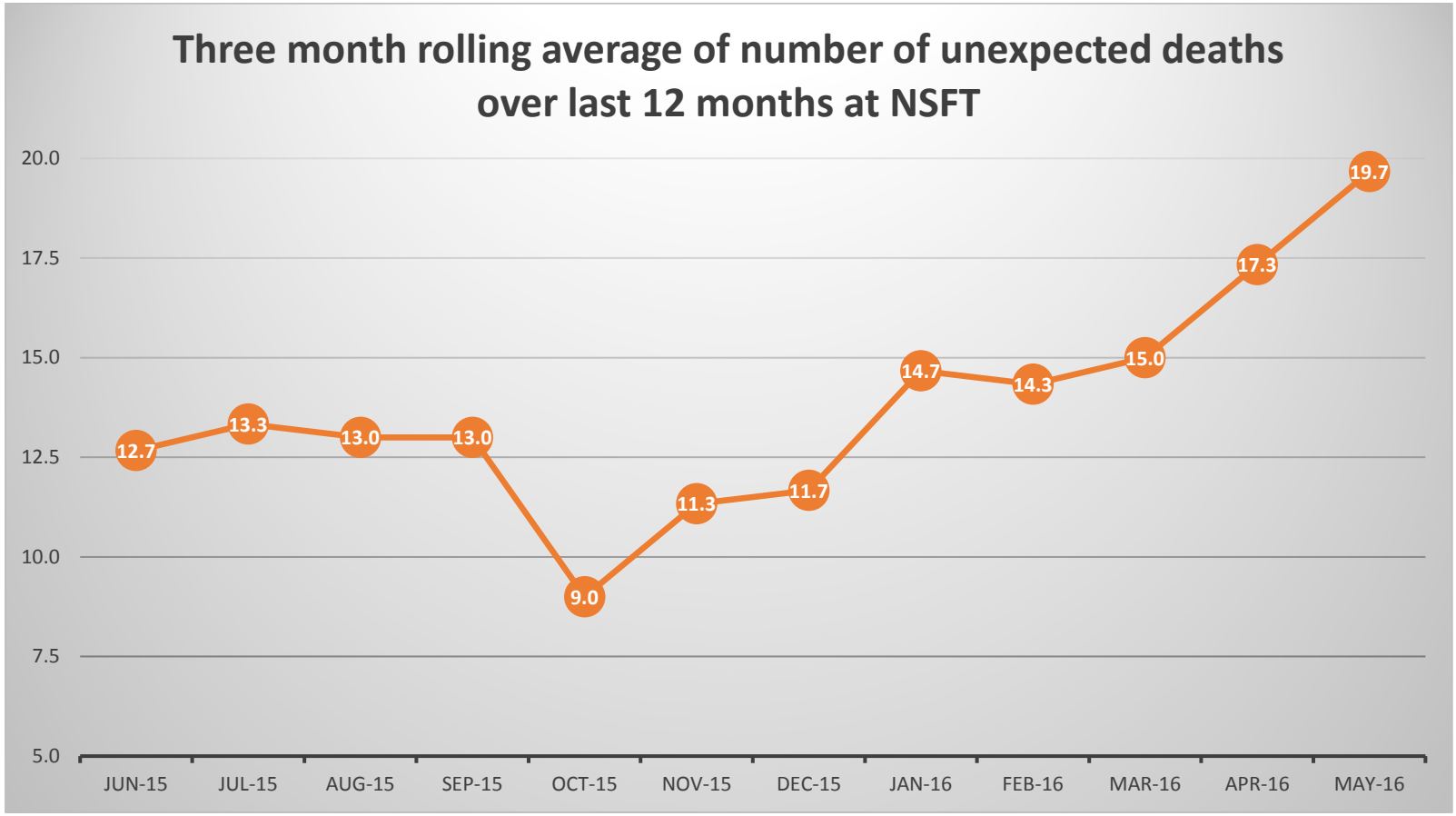
Michael Lozano

Patient Safety Lead

UNEXPECTED DEATHS REPORTED AS SERIOUS INCIDENTS

FIGURES AND GRAPH PROVIDED BY THE CAMPAIGN TO SAVE MENTAL HEALTH SERVICES IN NOROFLK & SUFFOLK

Graph shows 3 month rolling average figures in the months from June 2015 – May 2016



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16
Unexpected deaths reported as SIs	15	9	14	17	8	14	5	15	15	14	14	17	21	21
Rolling 3 month average			12.7	13.3	13.0	13.0	9.0	11.3	11.7	14.7	14.3	15.0	17.3	19.7

NOTE – THE FIGURES OF UNEXPECTED DEATHS REPORTED AS SERIOUS INCIDENTS IN THE MONTHS MARCH TO MAY 2016 MAY INCLUDE CASES WHICH UPON COMPLETION OF INQUEST OR INVESTIGATION PROVE TO BE DUE TO NATURAL CAUSES.

Children's Mental Health Services in Norfolk

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

This report addresses the areas of children's mental health services identified for further scrutiny by Norfolk Health Overview and Scrutiny Committee (NHOSC) on 26 February 2016 following reports to the committee on 3 December 2015.

1. Background

1.1 On 3 December 2015 NHOSC received a report from Child and Adolescent Mental Health Services (CAMHS) commissioners addressing issues and concerns that were set out in scrutiny terms of reference agreed by the committee on 3 September 2015. NHOSC also received Norfolk and Waveney's Local Transformation Plan, which had recently attracted £1.9m per annum additional recurrent funding for CAMHS in Norfolk; background information from Public Health on levels of need; information from NHS England Specialised Commissioning about Tier 4 services and a paper from Healthwatch Norfolk about research it had commissioned on young people's experience of the services in Norfolk. The reports are available on the County Council website:- http://norfolkcc.cmis.uk.com/norfolkcc/Meetings/tabid/70/ctl/ViewMeetingPublic/mid/397/Meeting/389/Committee/22/Default.aspx

1.2 On 3 December 2015 NHOSC decided that it would to return to the subject of Children's Mental Health Services in Norfolk at a future meeting. On 26 February 2016 the committee agreed a two stage approach with implementation of the Local Transformation Plan (LTP) to be examined at today's meeting and early outcomes / further development of the services to be examined in April 2017.

2.0 Results of other research / examination of CAMHS since December 2015

2.1 The results of research on young people's experience of tier 3 services, commissioned by Healthwatch Norfolk and delivered by MAP (Mancroft Advice Project), were received by the Healthwatch Norfolk Board in March 2016. The report is available on Healthwatch Norfolk's website:- http://www.healthwatchnorfolk.co.uk/reports-and-papers/board-papers/ (item 6). Healthwatch circulated the report to stakeholders and has received responses to its recommendations all of the Norfolk CAMHS

commissioners. It will monitor the actions taken in response to the recommendations.

Healthwatch also commissioned UEA and Norfolk and Suffolk NHS Foundation Trust (NSFT) to undertake a research project on mental health literacy and access to CAMHS Tiers 1 and 2 in young people aged 14 – 25 years. The results of this work are now expected in autumn 2016.

2.2 On 15 March 2016 Children's Services Committee (CSC) approved a scoping document for a task and finish group to examine people's access to support and interventions for children's emotional wellbeing and mental health. CSC invited a County Council member of NHOSC to serve on the task and finish group and NHOSC nominated Mrs Margaret Stone to this role on 14 April 2016. The task and finish group is progressing. The scoping document is available with the NHOSC papers of 14 April 2016 (main agenda, page 58):- http://norfolkcc.cmis.uk.com/norfolkcc/Meetings/tabid/70/ctl/ViewMeetingPublic/mid/397/Meeting/514/Committee/22/Default.aspx

2.3 In February 2016, at the request of several Members of the Committee, an information briefing on Health Assessments (physical and mental health) for Looked After Children (LAC) was included in the NHOSC Briefing. This included full details of the arrangements for Health Assessments, for children and young people aged 0 – 19 across the county. Norfolk Community Health and Care NHS Trust (NCH&C), which carries out the initial assessments for children aged 0 -19 and review assessments for children aged 5 – 19, addressed the questions on mental health assessment that NHOSC had agreed on 26 February 2016 (see paragraph 3.1 (10) below) for today's meeting. NCH&C's responses are attached at **Appendix A**. The questions are also addressed in CAMHS commissioners' reports at Appendices B and C.

3.0 Purpose of today's meeting

3.1 NHOSC agreed to focus on the following areas at today's meeting:-

Implementation of the LTP

1. Has the £1.9 million additional funding promised for implementation of the LPT been received in full by the Clinical Commissioning Groups and fully allocated to services for children and adolescents' mental health?

2. Details of progress with recruitment of the additional staff identified in the LTP and skills training for others involved with mental health issues in universal settings:-
    a. How many and which type of staff have been employed using the transformation funding?
    b. What specific training is delivered to front line staff in schools and GP surgeries?

3. What is the LTP expected to deliver in terms of improved mental health support in schools and educating children in mental wellbeing?

4. Have the results of Healthwatch Norfolk's research on user experiences of tier 1-2 and tier 3 services (published in early 2016) been taken into account in the implementation of the LTP? *(Note – the tier 1-2 research has not yet been published – see paragraph 2.1 above).*

5. What was the outcome of the evaluation of Department for Education (DfE) funded work by the Benjamin Foundation linked to Compass Outreach / Compass Schools (this was raised at 3 December 2015 NHOSC meeting in the context of Looked After Children) and how does this affect implementation of the LTP?

6. How do drug and alcohol services (Matthew Project for under 18s; Norfolk Recovery Partnership for over 18s) link with CAMHS services as they develop in the LTP?

7. What are the current waiting times (at all tiers) for children's mental health services?

8. The LTP said that a range of key performance indicators (KPIs) would be developed. What KPIs are now in place, and what still needs to be agreed?

9. Self-harm - an area of special concern:-

    a. What services are available now (before full implementation of the LTP) to help children who have begun to self-harm and what additional service will the LTP put in place?
    b. What are the benchmarks regarding self-harm at the start of LTP implementation against which success of the Plan can be measured; e.g. numbers of children self-harming and types of self-harm (e.g. cutting, burning, overdose); numbers of attempted or successful suicide attempts; numbers of children attending A&E for self-harm on more than one occasion. Members have asked to see numbers 'before' implementation of the LTP.

10. Looked After Children – an area of special concern:-

    a. Is an assessment of mental health included in the initial health assessment for Looked After Children (LAC) and in subsequent annual assessments?
    b. Is there a process for linking the annual Strengths and Difficulties Questionnaire (SDQ) completed for each Looked After Child to the annual health assessments, so that mental health needs identified in the SDQ are picked up?

c. If an annual health assessment or SDQ identifies a mental health need, does it automatically trigger action to meet the child's needs?
d. How are mental health needs recorded through the annual health assessment and SDQ?
e. Does the County Council, as corporate parent, oversee that the mental health needs of LAC are treated appropriately and at pace?

3.2 The following representatives will be in attendance to answer Members' questions:-

- CAMHS Strategic Commissioner - representing Norfolk County Council and Norwich, North Norfolk, South Norfolk and West Norfolk CCGs
- Assistant Director of Commissioning Mental Health and Learning Disabilities – representing the four CCGs listed above and Norfolk County Council
- Head of Joint Commissioning, Norfolk County Council
- Director of Commissioning and Engagement – representing Great Yarmouth & Waveney CCG

Great Yarmouth and Waveney CCG is represented separately because the CCG is handling the LTP funding and implementation process itself whereas the process for the other 4 CCGs is being managed by the CAMHS Strategic Commissioner.

3.3 The questions set out in paragraph 3.1 are addressed in the attached reports:-

- **Appendix B** – covering the Norwich, North Norfolk, South Norfolk and West Norfolk CCG areas

- **Appendix C** – covering the Great Yarmouth and Waveney CCG area.

4.0 Suggested approach

4.1 After the commissioners have presented their reports, Members may wish to discuss the areas set out in paragraph 3.1.

5. Action

5.1 On 26 February NHOSC agreed that the next stage of its scrutiny of Children's Mental Health Services in Norfolk, in April 2017, would cover the development of the service and the early outcomes achieved by the LTP. In summary, the committee agreed to look at waiting times, performance against LTP KPIs, the staffing situation, and the situation regarding NHOSC's two areas of special interest: self harm and Looked After Children.

5.2 In light of the discussions at today's meeting, Members are asked to identify any other areas that they wish to discuss with commissioners or providers of the service in April 2017.

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

Extract from Norfolk Community Health & Care NHS Trust's (NCH&C) information briefing for NHOSC, February 2016

NCH&C's response to NHOSC enquiries about mental health assessment for Looked After Children:

1. Is an assessment of mental health included in the initial health assessment for Looked After Children (LAC) and in subsequent annual assessments?

- The Initial Health Assessment (IHA) does include assessment of mental health and in response to this assessment a referral to the CAMHS LAC team will be made. IHAs are completed on the BAAF (British Association for Adoption and Fostering) form which is a national document from the Department of Health. During the Review Health Assessments (RHAs) emotional health is reviewed on an annual basis for over 5 year olds.

2. Is there a process for linking the annual Strengths and Difficulties Questionnaire (SDQ) completed for each Looked After Child to the annual health assessments, so that mental health needs identified in the SDQ are picked up?

- SDQs are undertaken by foster carers/residential home and the social worker for the young person follows this up. NCH&C get the score of the SDQ and this is recorded in the health record on our patient records system. A copy of the questionnaire is also attached. However, we have identified that the timeliness of sending the SDQs does not always meet with the RHA calendar for the individual. We will be working with NCC (Norfolk County Council) to improve this as part of the redesign of LAC Norfolk.

3. If an annual health assessment or SDQ identifies a mental health need, does it automatically trigger action to meet the child's needs?

- The social worker follows up the SDQ.

4. How are mental health needs recorded through the annual health assessment and SDQ?

- Mental health needs are captured during the IHA and RHAs (annual for over five year olds) and documented in the BAAF form and on our patient records system, as outlined in (1).

5. Does the County Council, as corporate parent, oversee that the mental health needs of LAC are treated appropriately and at pace?

- The social worker follows up the assessment outcomes for mental health via the SDQ and NCH&C would make a referral to the CAMHS LAC team as appropriate.

Norwich CCG

South Norfolk CCG

North Norfolk CCG

West Norfolk CCG

Children's Mental Health Services in Norfolk – Norfolk HOSC 21st July 2016

Update regarding the Implementation of the Norfolk & Waveney Local Transformation Plan (LTP)

Purpose of Report

The Committee's ongoing interest in mental health provision commissioned for children and young people is welcome. Via the LTP process central government allocated in 2015/16 £1.9m of additional funding to the 5 CCGs in Norfolk & Waveney to deliver the joint Plan they had successfully submitted in October 2015. From 2016/17 onwards, the CCGs were expected to uplift this spending by £0.25m (12%) to make a grand total of £2.15m. However, there was no additional central funding made available and CCGs were expected to meet the entirety of this commitment from core baseline funding. The 5 CCGs have therefore committed to continue to allocate the total of £1.9m identified in the LTP process, but are unable to commit any further funding to meet the notional £0.25m uplift.

Since the HOSC's last session on this subject, the CAMHS joint commissioning team spent a large proportion of its time scenario planning for variations to the LTP based on local decision making that temporarily reduced the partnership to four CCGs. The four CCG partnership was working to a joint budget of £1.4m. This had implications for the number, size and scope of the agreed service developments in the published LTP – which are in the process of being resolved now that the partnership is operating with all 5 CCGs.

All 5 CCGs remain fully committed to improving provision for the children and young people of Norfolk & Waveney. As one might expect, at this early stage of what is a 5 year Plan, some service developments have begun to be implemented and others remain at varying stages of planning and implementation. This paper responds to the questions and issues set out in section 3 of the covering report by Maureen Orr.

Each of the issues raised in the covering report are now addressed in turn. These answers relate to the 4 CCG partnership.

> ***Question 1:*** *Has the £1.9 million additional funding promised for implementation of the LTP been received in full by the Clinical Commissioning Groups and fully allocated to services for children and adolescents' mental health?*

The full allocation was received by each of the 5 CCGs in December 2015. The Plan as published allocated the full £1.9m (5 CCG total) against a range of service developments. The total allocation to the 4 CCGs this paper is written on behalf of amounted to £1,437,217. Due to late receipt of the 2015/16 allocation (which arrived in November/December 2015) it was impossible to spend the full year's funding on additional activity. A total of £975,383 or 68% of the allocation was spent by 4 CCG Partnership on recurrent and non-recurrent CAMHS work, some of which took place during 2015/16, with the remainder continuing into 2016/17. A full breakdown by CCG showing how the 2015/16 allocation was spent is set out at Appendix One. The unspent funds from 2015/16 remained with CCGs. Spend against the allocation and the LTP is reported to NHS England on a quarterly basis.

Finance advice from CCGs indicates that since submitting the LTP and committing to supporting its implementation, CCGs have been informed that in 2016/17 and subsequent years they will not receive any specific funding to support this work. However, the CCGs have committed to maintain annual spending at the level of £1.9m, despite this now needing to come from CCG baseline allocations. This has clearly added to the significant financial pressure being experienced by all local CCGs.

> ***Question 2:*** *Details of progress with recruitment of the additional staff identified in the LTP and skills training for others involved with mental health issues in universal settings:-*
>
> a. *How many and which type of staff have been employed using the transformation funding?*

The NHS England assured LTP contains 12 agreed recurrent developments. A brief update relating to each now follows:

1. **CAMHS Eating Disorders increased capacity** – £410k of recurrent LTP funding allocated – fully recruited to 8.7 FTE posts (including psychologists, nurse therapists, other therapists and support posts) with one part time dietician post currently out for recruitment.
2. **Point 1 increased capacity** - £183k of recurrent LTP funding allocated – fully recruited to all 6 posts as per the CAMHS LTP.
3. **Link work function for schools and universal settings** - £151k of recurrent funding allocated – options appraisal almost completed. Implementation will take place during 2016/17 once the preferred option is selected.
4. **Online developments** - £75k of recurrent funding allocated – working group producing options.
5. **ADHD increased capacity** - £21k of recurrent funding allocated – the initial option was rejected by the Project Board. Revised options are to be put to the Project Board.
6. **Increased CAMHS support for CYP affected by domestic abuse and sexually inappropriate/harmful behaviour** - £113k of recurrent funding allocated. Revised options are to be put to the Project Board.

7. **Extended opening hours of NSFT CAMHS** - £171k of recurrent funding allocated. Details currently being negotiated as a Contract Variation to the NSFT contract, with the extended opening hours due to be introduced during 2016/17.
8. **Increased capacity of NSFT's IST workforce** - £37k of recurrent funding allocated. Details currently being negotiated as a Contract Variation to the NSFT contract, with with the extra capacity due to commence during 2016/17.
9. **Out of hours crisis assessments** - £113k of recurrent funding allocated. Details currently being negotiated as a Contract Variation to the NSFT contract, with the new function being introduced during 2016/17.
10. **Training/advice for 'first responders' to crisis presentations** - £23k of recurrent funding allocated. Details currently being negotiated as a Contract Variation to the NSFT contract, with the new function being introduced during 2016/17.
11. **Crisis Bank staff** - £117k – options appraisal being conducted to identify the most effective and safe way to deliver this new function. Preferred option to be agreed and implemented during 2016/17.
12. **Police Control Room Integrated MH Team** - £23k – Operating as business as usual.

The signed CAMHS LTP included assumed financial contributions from all CCGs for a countywide approach with some elements of local emphasis.

> ***Question 2 (contd.):*** *Details of progress with recruitment of the additional staff identified in the LTP and skills training for others involved with mental health issues in universal settings:-*
>
> *b. What specific training is delivered to front line staff in schools and GP surgeries?*

The LTP funded developments in this area are yet to be fully implemented.

The extra capacity added to CAMHS Eating Disorders provision and Point 1 are operational. Both of these include provision of advice, consultation and some training to schools, GP surgeries and other universal settings.

The more limited progress that has been made is described in the responses above regarding the Link Work function and Training/advice for first responders.

> ***Question 3:*** *What is the LTP expected to deliver in terms of improved mental health support in schools and educating children in mental wellbeing?*

It is anticipated that the LTP funded Link Workers will be able to offer an enhanced level of support to schools. Schools will have a named Link Worker who will provide advice and training to key staff groups from school clusters. The aim of this work will be to ensure that school staff know how best to support and develop positive emotional wellbeing in all pupils and to know when and how to seek specialist mental health input for those pupils who need it. The Link Workers will work to develop an enhanced level of support for named emotional wellbeing leads in each school.

Question 4: *Have the results of Healthwatch Norfolk's research on user experiences of tier 1-2 and tier 3 services (published in early 2016) been taken into account in the implementation of the LTP?*

We are not aware that the report of user experiences of tier 1-2 has been published yet. However, the HealthWatch report of tier 3 CAMHS has been received and a joint response on behalf of the 4 CCGs has been submitted to HealthWatch. A copy of the response is available to members upon request. There are a number of points raised by the HealthWatch report that are being addressed through developments in the published LTP. We would therefore expect to see improvements in those areas. The report will be used as a helpful reference point when designing or re-commissioning services.

Question 5: *What was the outcome of the evaluation of Department for Education (DfE) funded work by the Benjamin Foundation linked to Compass Outreach / Compass Schools (this was raised at 3 December 2015 NHOSC meeting in the context of Looked After Children) and how does this affect implementation of the LTP?*

This question relates to the Compass Outreach in particular. The Compass Outreach is delivered as an extension to the Compass Schools. It is a partnership between NSFT, the Benjamin Foundation and Norfolk County Council. The Compass Outreach provides intensive support and treatment for looked after children and those on the edge of care. Following a two year DfE funded pilot, Norfolk County Council agreed to pick up the ongoing recurrent cost of the service as the evaluation indicated positive outcomes were being delivered for key groups of vulnerable children. We see this as an important complementary development to the LTP.

Question 6: *How do drug and alcohol services (Matthew Project for under 18s; Norfolk Recovery Partnership for over 18s) link with CAMHS services as they develop in the LTP?*

The LTP was developed by our CAMHS Strategic Partnership. Our Partnership has representatives of substance misuse services and Public Health who lead the commissioning of substance misuse services.

Question 7: *What are the current waiting times (at all tiers) for children's mental health services?*

The NHS waiting time standard is that patients should wait no longer than 18 weeks between being referred to a service and the start of treatment.

Currently tier 1 provision is delivered by primary care, schools and social work. No waiting time standard applies to this sector.

Tier 2 is currently provided by the Point 1 service in Norfolk who operate a two part waiting time standard that consists of:

- Referral being received to first face to face assessment – no more than 28 days (4 weeks) to be achieved for a minimum of 95% of clients. Current performance is that this standard is met for 93% of clients.
- First face to face assessment and first treatment session – no more than 28 days (4 weeks) to be achieved for a minimum of 95% of clients. Current performance is that this standard is met for 92% of clients

Tier 3 is currently provided by Norfolk & Suffolk Foundation Trust (NSFT) who operate a waiting time standard that consists of:

- Referral being received to first face to face assessment appointment – no more than 8 weeks to be achieved for a minimum of 80% of patients. Current performance is that this standard is met for 85% of patients in the Central area (Norwich, South Norfolk and North Norfolk), and 95% for West Norfolk.

It should be noted that demand (number of referrals) for both services has risen significantly in recent years – a key factor that affects how quickly clients/patients can be seen.

> ***Question 8:*** *The LTP said that a range of key performance indicators (KPIs) would be developed. What KPIs are now in place, and what still needs to be agreed?*

Please see Appendix Two to view a table showing the KPIs that relate to the LTP. The KPIs that have been agreed and signed off as part of providers' contracts are highlighted in grey. In response to Question 2, we set out the progress made/being made to implement each of the recurrent developments in the LTP. Some are listed as being subject to further negotiation. The negotiations will include agreement of KPIs and reporting arrangements.

> ***Question 9:*** *Self-harm - an area of special concern:-*
>
> a. *What services are available now (before full implementation of the LTP) to help children who have begun to self-harm and what additional service will the LTP put in place?*

Point 1 works with children with mild-moderate levels of mental ill-health, including self-harm. Point 1 provides individual and group interventions to children who self-harm, including talking therapies, psycho social provision and consultations for families and professionals supporting children and young people.

NSFT works with children with moderate-severe levels of mental ill-health, including self-harm. NSFT provides individual and group treatment to children who self-harm, delivered by a multi-disciplinary team including nurse therapists, psychologists and psychiatrists. NSFT attends acute general hospitals to assess children admitted in crisis – some of whom will have harmed themselves intentionally.

Question 9 contd: *Self-harm - an area of special concern:-*

b. What are the benchmarks regarding self-harm at the start of LTP implementation against which success of the Plan can be measured; e.g. numbers of children self-harming and types of self-harm (e.g. cutting, burning, overdose); numbers of attempted or successful suicide attempts; numbers of children attending A&E for self-harm on more than one occasion. Members have asked to see numbers 'before' implementation of the LTP.

Based on national figures, we know that only 1 in 4 children with a diagnosable mental health problem access targeted and specialist mental health services. When fully implemented the new funding supplied via the LTP will enable that figure to move to around 1 in 3 children. Through the extra capacity funded by the LTP we want to increase the number of children who are able to access support and treatment as well as undertaking activity to help reduce the stigma associated with so doing. Therefore, success to us would include a higher number of children asking for support and treatment to address their self-harm issues.

Via a number of the priorities from the LTP additional targeted and specialist support will be put in place to address the needs of children affected by self-harm – such as the Crisis Bank function and increased staffing for Point 1.

Question 10: *Looked After Children – an area of special concern (see Appendix A for NCH&C's responses to these questions in February 2016):-*

a. Is an assessment of mental health included in the initial health assessment for Looked After Children (LAC) and in subsequent annual assessments?

Yes. The Audit findings undertaken in June identified some shortfalls in the quality of Health Plans for children and young people who are looked after and addressing specifically emotional and mental health need. For example where a child has recently been accommodated, the Initial Health Assessment given the young person's or child's early accommodation is not always able to pick up on such needs as it is early on in the child's care episode. His or her foster carer/carer is getting to know that young person which can inform subsequent review health assessments. Any needs identified subsequent to the Health assessment are the responsibility of the social worker to address through the appropriate referral route.

b. Is there a process for linking the annual Strengths and Difficulties Questionnaire (SDQ) completed for each Looked After Child to the annual health assessments, so that mental health needs identified in the SDQ are picked up?

SDQ's are provided to the providers although at present these are undertaken yearly and do not fall within the review period. A

mechanism for completion of SDQ's in readiness for the initial/review health assessment are being implemented.

c. ***If an annual health assessment or SDQ identifies a mental health need, does it automatically trigger action to meet the child's needs?***

   The Annual Health Assessment and Review Health Assessment once complete triggers a Health Plan which includes all health needs of the child/young person. This Health Plan is forwarded by the clinician to Children's Services and is passed onto both the Child's Social Worker and Independent Reviewing Officer whose role it is to then consider those needs, how they are to be met and whether services provided are allocated in a timely way. There has been an increase in the numbers of children and young people whose mental health needs, including therapy (talking and play) are not able to be provided by CAMH services and as a consequence Children's Services have seen a rise in the number of independent requests for commissioned services for children to receive therapy at the expense of Children's Services.

d. ***How are mental health needs recorded through the annual health assessment and SDQ?***

   The Health Plan should include any mental health needs identified and how such need is to be met. The Health Plan is incorporated into the Child/Young Person's Care Plan that is overseen by the child/young person's Independent Reviewing Officer.

e. ***Does the County Council, as corporate parent, oversee that the mental health needs of LAC are treated appropriately and at pace?***

   Independent Statutory Services review the Care Plan for the child/young person and hold the County Council to account for addressing the mental health needs of LAC where these are not met.

Children's Services Committee has oversight of this performance as part of the post Ofsted improvement work. Particular attention has been paid to ensuring health assessments and reviews are happening within timescales. Further work is being done to ensure the health assessments inform care planning and collaborative work with health partners.

The annual health assessments of Looked After Children (LAC), incorporating reference to the mental health needs of LAC has rightly been the subject of attention. In June 2016 an audit report examining the quality of Health Assessments for LAC was published, which made the following recommendations in relation to the mental health needs of LAC and use of the SDQ (copied directly from the audit report):

- All LACYP should have and Strengths and Difficulties Questionnaire (SDQ) completed to inform the health assessment

- Where appropriate, SDQ assessments are carried out within xxxx weeks before the HA (timeframe yet to be agreed)

- Where an SDQ is undertaken, all scores(s) are referenced in the HA summary

- Where an SDQ or other emotional health assessment is undertaken, the findings inform documented health recommendations

- An interpretation/ contextual consideration of the SDQ/ specialist assessment is clearly communicated in the HA summary

Partners are currently working to implement the recommended actions. However, it is recognised there are significant steps to be taken to ensure the mental health of LAC and children coming into care is assessed, recognised and (when needed) responded to promptly.

Appendix One:

Local Transformation Plan- Budget for 2015/16 allocation (Slippage)

		CCG Breakdown			
	Total	**North Norfolk**	**West Norfolk**	**South Norfolk**	**Norwich**
Full Year Allocation 15/16	**£ 1,437,217**	**£ 328,377**	**£ 349,611**	**£ 397,830**	**£ 361,399**
LTP Priority					
Early Help	**£ 113,497**	£ 25,932	£ 27,609	£ 31,416	£ 28,540
Accessibility	**£ 170,076**	£ 38,859	£ 41,372	£ 47,078	£ 42,767
Eating Disorders	**£ 337,901**	£ 95,034	£ 42,282	£ 102,162	£ 98,424
Crisis Pathway	**£ 353,909**	£ 71,941	£ 76,595	£ 87,156	£ 118,217
Total Spend for NHS England Tracker	**£ 975,383**	**£ 231,766**	**£ 187,858**	**£ 267,812**	**£ 287,947**
%	68%	71%	54%	67%	80%

Notes:

- Each CCG spent 52% of its allocation on joint proposals. The difference between this and the final percent of spend per each CCG is local spend on eating disorders and crisis pathways.
- 2015/16 allocation was received in December 2015
- In future years, all spend is planned to be based on an equal proportionate basis.

Appendix Two: CAMHS LTP KPIs

The KPIs that have been agreed and signed off as part of providers' contracts are highlighted in grey.

Pathway/Description	KPI
Accessibility	• A Single Point of Contact is implemented • Experience of Service Questionnaire indicate clients/patients finding services more accessible • % of complaints about difficulty accessing services reduces • A min % of routine appointments take place on line • a min % of clients make use of apps, self-help, etc • Usage of the online platform increases year on year for 3 successive years • An increased number of children and young people are seen by our services – numbers to be proportionate to the additional funding allocated to each service • Workforce remodelled to include 'junior' posts with dedicated training attached • Audit schedule produced, implemented and improvements made to pathways based on findings
Eating Disorders	
Year 1	Wait to Treatment: Routine CAMHS ED referrals seen within standard (4 weeks) 75% (indicative target to be monitored monthly with final target agreed alongside new CAMHS ED specification developed in-year) Wait to Treatment: Urgent CAMHS ED referrals seen within standard (1 week) 80% (indicative target to be monitored monthly with final target agreed alongside new CAMHS ED specification developed in-year) Wait to Treatment: Emergency CAMHS ED referrals seen within standard (24 hours) 100% (indicative target to be monitored monthly with final target agreed alongside new CAMHS ED specification developed in-year)

Year 2	80% of all cases accepted will start NICE-concordant treatment within 4 weeks from first contact with a designated healthcare professional. 100% of urgent cases accepted will start NICE-concordant treatment within 1 week from first contact with a designated healthcare professional.
Year 3	95% of all cases accepted will start NICE-concordant treatment within 4 weeks from first contact with a designated healthcare professional. 100% of urgent cases accepted will start NICE-concordant treatment within 1 week from first contact with a designated healthcare professional.
Year 4	95% of all cases accepted will start NICE-concordant treatment within 4 weeks from first contact with a designated healthcare professional. 100% of urgent cases accepted will start NICE-concordant treatment within 1 week from first contact with a designated healthcare professional.
Year 5	95% of all cases accepted will start NICE-concordant treatment within 4 weeks from first contact with a designated healthcare professional. 100% of urgent cases accepted will start NICE-concordant treatment within 1 week from first contact with a designated healthcare professional.
Crisis Pathway	
An evaluation of the key aims and intended outcomes for the IST in order to establish its place on the CAMHS pathway.	A minimum of 10% of routine treatment sessions to be delivered outside of these hours/days.
Provision of specialist out of hours CAMHS face to face assessment of crisis cases in the community and Acute General Hospitals (including weekends and bank holidays), in addition and complementary to the current Crisis Team functions. Access to the service to be available to Acute General Hospitals, the Police, Primary Care and other first responders via the existing published NSFT Out of Hours phone number. The offer to include advice and support to those professionals providing ongoing treatment and care to crisis cases.	A specialist CAMHS practitioner to attend 90% of calls for an assessment of a patient in crisis within 1 hour of the request being received and 100% within 2 hours (5% tolerance for exceptional circumstances) Annual audit re. the awareness levels of the Out of Hours pathway among first responders

Delivery of a rolling programme of training and consultation to 'first responders,' General Hospital ward staff and others who respond to cases that present in crisis – to include acute hospital staff, police, social care, ambulance staff, community/voluntary agencies, Primary Care	a minimum of 10 training sessions per year in West Norfolk, 10 sessions per year in Gt Yarmouth and Waveney and 15 per year in Central Norfolk a minimum of 10 group case consultation sessions per Acute General Hospital per year, including those wards providing support to Eating Disorders patients needing re-feeding delivery of induction and ongoing training, group consultation and supervision to staff recruited to the new Bank – a minimum of x sessions per month
Establishment of a Bank of staff who can be deployed at short notice by either specialist CAMHS or specialist LD CAMHS staff following an assessment (as at 2 above). The staff to provide intensive community or Acute General Hospital based support for the most complex, risky cases while specialist teams complete assessments and put in place the next stage of the child's treatment and care (which may include de-escalation and admission avoidance or keeping a child safe while sourcing a specialist CAMHS or LD CAMHS inpatient bed). A minimum dedicated budget to be established and held for 'approved' staff with delegated authority to purchase Bank staff for up to 24 hours on a weekday and up to 3 days on a Bank Holiday weekend. During that period, if further use of the Bank is recommended, the relevant responsible body will need to agree continuing funding (acute hospital, CCG, Local Authority, or other body). The staff on the Bank to receive a rolling programme of training and supervision to develop a team of staff able to competently and confidently work across existing specialisms and organisational boundaries (mental health, learning disabilities, social care). Norfolk County Council is supportive in principle of joining the effort to develop the Bank and to incorporate existing relevant bank/on call staff into this scheme.	Bank staff to be mobilised and providing intensive support within 2 hours of a request being received by the Bank Bank staff are paid to receive (at least monthly) specialist training and group supervision from a combination of mental health, learning disability and local authority from existing services (delivered 'free')
Revising transition protocols in Norfolk to ensure that arrangements are planned in advance for those clients/patients approaching 18 for whom it is predicted there may be ongoing concerns and potential further crises. Establishing a process/system to be embedded in day to day practice, whereby a modified Care Programme Approach (CPA) is used for all young	Percentage of those who meet the criteria for CPA who receive a multi-disciplinary and social care assessment and care plan, including: • psychiatric, psychological family relationships and social functioning

people who are supported Norfolk's intensive provision for those with CAMHS and LD CAMHS needs – including those in crisis and those considered to be at risk of tipping into crisis. The CPA approach to be applied most rigorously to those aged 16/17 as it is relevant for all young people in transition. Using CPA will ensure that improved information sharing between agencies is facilitated and that personalised care to the young person is provided through partnership with the young person and their family, with thorough assessment and care planning within a whole systems approach. A cost neutral development.	• impact of medication • risk to individual and others • crisis and contingency planning. • clear information for adult services including information about education, training, Social Services and other agencies • clear agreed time scales for transition Minimum percentage (To be Agreed locally) of those who are 16 & 17 who receive CPA whose details are shared and successfully added to the Norfolk County Council Adult Services held register of cases 'at risk,' identified for joint transition planning. • Joint audit of an agreed percentage of such cases to review quality and effectiveness of CPA for this population and to make recommendations to improve pathways
Early Help and Prevention	
	• Number of settings that have a named lead • Requests for support are dealt with in a timely manner • A minimum volume or % of intervention/treatment sessions are delivered in universal settings • Annual audit/evaluation activity to assess impact of training, consultation and support • A minimum no of training/group consultation sessions attended by range (and minimum number) of practitioners • Increased positive perception of emotional wellbeing and mental health by children and young people • Increase in the number of practitioners feeling equipped to support children's and young people's emotional well-being • Reduction in the number or percentage of inappropriate referrals made to specialist and targeted CAMH Services

NHS
Great Yarmouth and Waveney Clinical Commissioning Group

HealthEast

Briefing for Norfolk Health Overview and Scrutiny Committee 8th September 2016.

Great Yarmouth and Waveney Clinical Commissioning Group's (GYWCCG)Approach to Delivering Services the Norfolk and Waveney CAMHS Transformation Plan (LTP).

The approach of Great Yarmouth and Waveney Clinical Commissioning Group (GYW CCG) to delivering services to children with emotional and wellbeing issues has been conducted against a backdrop of recent significant national initiatives. These include the Future In Mind document, 1001 critical days, Healthwatch feedback and information received from children and young people themselves.

GYWCCG has a history of collaborative working CCG colleagues, the local mental health provider, Norfolk and Suffolk Foundation Trust (NSFT) and with third sector providers to lead and implement innovative service developments. We have examples of great working in our patch, e.g. the Great Yarmouth and Waveney youth service works with young people aged 0-25 years and has been nationally recognized, and the perinatal mental health group at The Priory, which has been in place since 2009, formed the basis of the Norfolk Infant Attachment project (NIAP).

The following is the response to the health questions raised by the committee.

1. **Has the £1.9 million additional funding promised for implementation of the LPT been received in full by the Clinical Commissioning Groups and fully allocated to services for children and adolescents' mental health?**

The funding for the CAMHS transformation plan was included in the baseline allocation to the CCG from NHS England. GYWCCG were allocated £466,752 for 2016/17.

A paper was approved by the GYWCCG Governing Body in February 2016 approving the full allocated funding to CAMHS according to four key areas which are currently under development .These include:

- early help and prevention
- accessibility
- eating disorders
- crisis pathways

GYWCCG will continue to work collaboratively with the 4 Norfolk CCGs and their allocation will be included to work on the assured plan as it is a Norfolk and Waveney plan.

As part of the 2016/17 planning process GYWCCG allocated a total of £467k in the baseline as recurrent funding for the CAMHS Transformation Plan (LTP). The CCG was expected to uplift this spending by 12% to make a total spend of £524k in 2016/17. However, there was no additional central funding made available and the CCG was expected to meet the entirety of this commitment from core baseline funding. However, the CCG has committed to continue to plan for the total of £467k identified in the LTP process but are unable to commit any further funding to the LTP. The use of any slippage against the planned £467k LTP spend will need to be agreed through the CCG and NHSE

It should be noted the CCG has planned for additional CAMHS spend outside of the LTP in 2016/17 .This gives an overall increase in the level of planned funding above the level of funding expected to made in this financial year; £527k vs £524k.

GYWCCG currently have a service development plan with NSFT to deliver the CAMHS LTP over the next five years.

2. **Details of progress with recruitment of the additional staff identified in the LTP and skills training for others involved with mental health issues in universal settings:-**
    a. **How many and which type of staff have been employed using the transformation funding?**
    b. **What specific training is delivered to front line staff in schools and GP surgeries?**

1)Early help and prevention.

Link worker function for schools and universal settings.

For the Waveney area, in September 2016 there will be some specific training delivered by Suffolk MIND for all staff working with children and young people including schools and GPs.
As part of the Norfolk and Waveney LTP, GYWCCG held a multi-agency workshop on 6 July 2016 to explore what training schools would like and the best way to support and provide this.
GYWCCG have allocated £49,000 re-current funding as agreed on the assured plan to developing this link worker function along with the 4 Norfolk CCG 's funding.

2)Eating Disorders.

a) GYWCCG have recruited to the 2.8 WTE (as identified on the assured LTP) for eating disorders and are in the process of agreeing a service specification. This will continue to be an all age service.

3) Accessibility.

Point One service.
This service is only currently commissioned to cover the Great Yarmouth area and GYWCCG therefore have inequity of provision in the Waveney area, for this reason GYWCCG are currently looking to have discussions with the service to see if a service can be offered to the Waveney area also.GYWCCG have in 2015/16 contributed to the Point One data base and funded some additional support over the festive period to increase their capacity.

Online developments.
GYWCCG have allocated £24,500 of recurrent funding (as agreed in the assured Norfolk and Waveney Plan) to support this and will await the working groups options paper.

ADHD services.
GYWCCG are currently undertaking a community paediatric review looking at having integrated pathways within the current funding levels.

Increased CAMHS support for young people affected by sexual abuse.

GYWCCG currently commission a voluntary sector to support young people who have been victims of abuse in the Waveney area and will be exploring possibilities of this service extending to the Great Yarmouth area.

4) Crisis.

Extended hours of NSFT CAMHS.

GYWCCG have allocated £36,750 of recurrent funding as agreed in the assured LTP and is included as part of a service development plan with in the NSFT contract and once services in place a contract variation will be undertaken.

Out of hours crisis assessments.

GYWCCG have allocated £38,750 as agreed on the assured plan and are working with the 4 Norfolk CCGs looking to have anew function introduced during 2016/17.

Training advice for first responders.

GYWCCG have allocated £7,350 recurrent funding as agreed in the assured plan working with the 4 Norfolk CCGs looking to have a new function in 2016/17

Crisis bank staff.
GYWCCG have allocated £31,000 of the recurrent funding as agreed on the assured plan, working with the other 4 Norfolk CCGs looking to have an option introduced in 2016/17.

Police control room.

GYWCCG have allocated £7,350 of recurrent funding as agreed on the assured plan and is operating as business as usual.

b) Within the GYWCCG area there has been two protected time for learning events that almost all local GPs attended in May 2016. At these events, the CAMHS practitioners delivered presentations on the LTP and referral pathways. GYWCCG has a retained GP for children and young people who is already working closely with NSFT on developing pathways for CAMHS.

It is not known fully what staffing mix is required at this stage, but as the LTP develops this will be identified. GYWCCG also recognise that there are other providers and the voluntary sector who may be able to also improve outcomes for young people.

3 What is the LTP expected to deliver in terms of improved mental health support in schools and educating children in mental wellbeing?

The assured Norfolk and Waveney LTP over the next four to five years will be exploring the possibility of every school having access to a 'link worker' and training that maybe required to staff as well as on line support and developing a single point of access**.**

Agreed outcomes within the assured Norfolk and Waveney LTP include:

1) More people will have good mental health
2) More people with mental health problems will recover
3) More people with mental health problems will have good physical health
4) More people will have a positive experience of care and support
5) Fewer people will suffer avoidable harm
6) Fewer people will experience stigma and discrimination
7) More infants, children and young people will be able to remain at home for the long term with their parents/carers in safe, stable and nurturing circumstances
8) More vulnerable parents/carers who receive targeted and/or specialist support will be confident in their parenting abilities
9) More people will be able to make and maintain positive, supportive relationships
10) More people will be able to be engaged with and achieving in education, training and employment

These outcomes are taken from our existing Norfolk CAMHS Strategy (2015-17), which adopted the six shared outcomes from the existing National Mental Health Strategy (No health without mental health). Outcomes 7-10 were added by Norfolk's CAMHS Strategic Partnership.

4 Have the results of Healthwatch Norfolk's research on user experiences of tier 1-2 and tier 3 services (published in early 2016) been taken into account in the implementation of the LTP?

GYWCCG is fully aware of the tier 3 report work and our engagement team is working closely with the Head of Children, Young People and Maternity in GYWCCG to ensure that these findings are fully embedded in the implementation of the LTP across Great Yarmouth and Waveney.GYWCCG have provided a response to healthwatch and a copy of this letter can be made available if required.

5 What was the outcome of the evaluation of Department for Education (DfE) funded work by the Benjamin Foundation linked to Compass Outreach / Compass Schools (this was raised at 3 December 2015 NHOSC meeting in the context of Looked After Children) and how does this affect implementation of the LTP?

GYWCCG is unable to comment on the Compass outreach service because the lead commissioner is Norfolk County Council. With regard to Compass specifically, GYWCCG has funded a block contract for Compass in Belton near Great Yarmouth since 2009.

6. How do drug and alcohol services (Matthew Project for under 18s; Norfolk Recovery Partnership for over 18s) link with CAMHS services as they develop in the LTP?

Young people accessing these services will benefit from any new developments such as extended working hours of CAMHS, on line development etc. and will be co-opted into any working groups as required.

7 What are the current waiting times (at all tiers) for children's mental health services?

Tier 1 no waiting time standard applies as provision is delivered by universal services.
Tier 2 in the Great Yarmouth area only is provided by point one and Norfolk County Council lead on this contract.

GYWCCG CAMHS youth (0-25 years) referral to treatment (standard 56 days) is 90%. Eating disorders is 100% and CAMHS access to assessment (standard 56 days) is 100%

8. The LTP said that a range of key performance indicators (KPIs) would be developed. What KPIs are now in place, and what still needs to be agreed?

There is a new national CAMHS dataset which NSFT is currently working to implement. There are also national waiting time standards for eating disorders which the CCG is looking to implement. The Compass service is having new KPIs developed. As new services come on line, the KPIs and outcomes will be agreed as part of contractual discussions.

9. Self-harm - an area of special concern:-

a. **What services are available now (before full implementation of the LTP) to help children who have begun to self-harm and what additional service will the LTP put in place?**
b. **What are the benchmarks regarding self-harm at the start of LTP implementation against which success of the Plan can be measured; e.g. numbers of children self-harming and types of self-harm (e.g. cutting, burning, overdose); numbers of attempted or successful suicide attempts; numbers of children attending A&E for self-harm on more than one occasion. Members have asked to see numbers 'before' implementation of the LTP.**

A) Point one services are currently commissioned to cover the Great Yarmouth area only.

Currently within the GYWCCG area the local acute trust, NSFT and a local voluntary sector provider have been working very closely with young people who attend the hospital due to self-harm issues. They have an agreed joint pathway, have been sharing training and risk assessment processes developing a shared care plan and there is a CAMHS practitioner who attends the ward on a Saturday and Sunday morning so that young people don't have to stay in over the weekend. GYWCCG is also currently negotiating with a voluntary sector provider on supporting young people who attend with self-harm where bereavement has been identified as an issue.

Additional services as part of the LTP will include exploring the possibility of the crisis team with further investment being able to come to the acute hospitals and assess young people after normal working hours.

b) There was some work undertaken by the local safeguarding board on self-harm and public health did a profile of self-harm in Norfolk in August 2015.This information can be provided if required.

10 Looked After Children – an area of special concern:-

c. **Is an assessment of mental health included in the initial health assessment for Looked After Children (LAC) and in subsequent annual assessments?**

GYWCCG commission East Coast Community Healthcare and the local acute trust to undertake the initial health assessments and as part of these the strengths and difficulties questionnaire are used. Community paediatricians who undertake the assessments will always consider the holistic needs of the young person including mental health. The Designated doctor for safeguarding recently undertook some quality assessments of the initial health assessments in the Great Yarmouth and Waveney area and was happy with their quality and all health assessments are being completed within the statutory timeframe.

GYWCCG also commission a CAMHS LAC service which offers mental health support to this vulnerable group of children.

Current risks:

- NSFT will be recruiting from the national pool of staff where all CCGs will be looking to recruit from.
- GYWCCG is committed to work collaboratively, and has to ensure that every GYWCCG equity for our residents in terms of commissioning spend. We are keen to enhance the focus of the LTP on the Waveney elements of service provision in our area and are working closely with colleagues across the Norfolk CCGs to achieve this.

Conclusion

GYWCCG remain committed to working collaboratively on the LTP and are keen now to start to deliver improved services for children and young people which will ultimately improve outcomes for children and young people.

The emotional wellbeing of young people is everyone's business if we are to achieve real transformation .Real transformation is not necessarily about funding but how we as a system can work together within the resources that we have to make a real difference to young people. This involves schools, public health, and police safeguarding board, childrens services, voluntary sector and health.

Patricia Hagan
Head of Children, Young People and Maternity
NHS Great Yarmouth and Waveney CCG
June 2016

End of life care

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

A report on the response of local health and care providers to National Institute for Health and Care Excellence (NICE) guidance on the care of dying adults published in December 2015 and the Care Quality Commission's (CQC) 'A different ending' report published in May 2016.

1.0 Background

1.1 In 2004 Norfolk Health Overview and Scrutiny Committee (NHOSC) commissioned research into local experiences of death and dying in Norfolk, which led to the 'How We Manage Death and Dying in Norfolk and Waveney' report to the committee in September 2005. The report made 45 recommendations and was well received by NHS organisations and Adult Social Care.

1.2 NHOSC monitored the implementation of the 2005 recommendations at regular intervals over the subsequent years to April 2010 and received a final update via the NHOSC Briefing in April 2011. It appeared that good progress had and would continue to be made.

1.3 During its initial review and in the years that followed NHOSC was aware of the drive to introduce the Liverpool Care Pathway (LCP) in healthcare settings across the county. The LCP was welcomed as one of the ways by which the care of terminally ill patients could be improved regardless of the setting in which they reached the end of their life. However, mounting national concerns about the implementation of the LCP, particularly in acute settings, during 2012 prompted NHOSC to review its use in Norfolk's acute and community hospitals in April 2013.

1.4 Following the meeting in April 2013 members of NHOSC visited the newly opened Louise Hamilton Centre in the grounds of the James Paget Hospital. The centre provided information and support for patients with progressive or life limiting conditions and their carers / families in the catchment area of the James Paget hospital and support for staff providing palliative care in care homes. The centre was integrated with the NHS hospital services but the running costs were paid by fund raising.

1.5 Following a national decision to phase out the LCP by 2014, NHOSC invited local acute and community hospitals to report on 29 May 2014 on how they

intended to manage end of life care in future. The report is available on our website (item 8, page 114):- http://norfolkcc.cmis.uk.com/norfolkcc/Meetings/tabid/70/ctl/ViewMeetingPublic/mid/397/Meeting/39/Committee/22/Default.aspx

1.6 After hearing a 'Patient Voice' item at Norfolk Community Health and Care NHS Trust's (NCH&C) Board meeting in April 2016, which highlighted examples of system-wide issues for end of life care, NHOSC's link member with NCH&C proposed that NHOSC should return to the subject. The committee agreed to take the approach of examining the local response to NICE guidance issued in December 2015 and the recommendations from 'A Different Ending', the report of the CQC's review of end of life care in England, published in May 2016.

2.0 Recent guidance and reports

2.1 NICE Guideline NG31 'Care of dying adults in the last days of life', published in December 2015, is available on the NICE website:- https://www.nice.org.uk/guidance/ng31

The guideline provides recommendations on:-

- recognising when people are entering the last few days of life
- communicating and shared decision-making
- clinically assisted hydration
- medicines for managing pain, breathlessness, nausea and vomiting, anxiety, delirium, agitation, and noisy respiratory secretions
- anticipatory prescribing

It is aimed at:-

- Health and social care professionals caring for people who are dying, including those working in primary care, care homes, hospices, hospitals and community care settings such as people's own homes
- Commissioners and providers of care for people in the last days of life
- People who are dying, their families, carers and other people important to them

2.2 The CQC's 'A Different Ending' report is available on its website:- http://www.cqc.org.uk/content/different-ending-end-life-care-review

The specific actions identified by the CQC to ensure that each person gets fair access to care at the end of life, and which the CQC recommended should be addressed as a priority in the NHS in England were summarised as follows:-

1. **Leaders of local health and care systems** to work together to develop a plan for delivering good quality, equitable end of life care for everyone in their community.

2. **Commissioners and providers** to fulfil their duties under the NHS Constitution, the Health and Social Care Act 2012 and the Equality Act 2010 to reduce inequalities, eliminate discrimination and advance equality when developing, arranging or delivering end of life care.
3. **Commissioners and providers** to ensure that staff who care for people who may be approaching the end of life, including care home staff, have the knowledge, skills and support they need.
4. **Hospices** to champion an equality-led approach, engage communities, deliver equitable end of life care, and support others to do the same.
5. **GPs** to ensure that everyone with a life-limiting progressive condition has the opportunity to have early an ongoing conversations about end of life care, and is given a named care co-ordinator.

In services that receive a rating for end of life care, including hospitals, community health services and hospices, the CQC undertook to reflect the importance of end of life care meeting the needs of people from different groups and strengthen its assessment of whether the services were meeting the needs of these groups.

In services that provide end of life care but do not currently receive a specific rating, including adult social care services and GPs, the CQC undertook to include an assessment of the quality of end of life care and whether it is meeting the needs of different groups. In GP assessments the CQC would assess whether the service was ensuring early conversations and coordinated end of life care for people from different groups.

2.3 The most recent CQC ratings for end of life care by local acute and community providers, and the CQC's summaries of their findings, are attached at **Appendix A**.

2.4 Healthwatch Norfolk hosted 'The Big Conversation', a Dying Matters event, at the Forum in Norwich on 12 May 2016. At this event, working with Norfolk and Suffolk Palliative Care Academy, Healthwatch drew on the findings of its 'Thinking Ahead' research report into the barriers to advanced care planning for end of life. It highlighted the importance of people being able to talk about the issues and concerns they may have about the end of life.

3.0 Purpose of today's meeting

3.1 NHOSC has agreed to examine the local NHS acute and community health care providers' responses to the recommendations of the CQC's 'A Different Ending' report and NICE's Guideline NG31 'Care of dying adults in the last days of life' at today's meeting. Representatives from the acute and community providers have been invited to provide information and to attend today's meeting to answer members' questions. Their reports are attached at:-

Appendix B – Norfolk and Norwich University Hospitals NHS Foundation Trust
Appendix C – James Paget University Hospitals NHS Foundation Trust

Appendix D – The Queen Elizabeth Hospital NHS Foundation Trust
Appendix E– Norfolk Community Health and Care NHS Trust
Appendix F – East Coast Community Healthcare (Community Interest Company)

3.4 Healthwatch Norfolk has been invited to present the findings of its 'Thinking Ahead' report (see paragraph 2.4). The presentation is attached at **Appendix G**.

3.5 The committee will also hear from the relative of a patient whose story at NCH&C's Board meeting in April 2016 prompted NHOSC to add this subject to today's agenda.

4.0 Suggested approach

4.1 After the provider representatives have presented their reports and other speakers have made their presentations, you may wish to explore the following areas:-

(a) How have the providers changed their practices in response the NICE's NG31 'Care of dying adults in the last days of life'?

(b) What have NNUH, JPUH and QEH done specifically to address the issues raised by the CQC inspection reports? (See Appendix A)

(c) What do the providers see as the greatest obstacles to providing the highest standard of end of life care in Norfolk?

(d) One of the recommendations from the CQC's 'A Different Ending' report is for 'leaders of local health and care systems to work together to develop a plan for delivering good quality, equitable end of life care for everyone in their community'. Are providers taking this forward across organisational boundaries within the Sustainability Transformation Plan process?

5.0 Action

5.1 Depending on discussions at today's meeting, NHOSC may wish to consider whether there are issues to raise with commissioners of end of life services at a future meeting.

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Care Quality Commission inspections of end of life care by acute and community health care providers in Norfolk

These are the most recent CQC inspection dates for each organisation.

Provider	**CQC overall rating for end of life care and summary of findings** (Note – the detail given in CQC summaries varies greatly between inspections)
Norfolk & Norwich Hospital NHS Foundation Trust	**Requires improvement** (16 March 2016) (For 'safety', 'effectiveness', 'responsiveness' and 'well-led'[1]) • Do not attempt cardio-pulmonary resuscitation (DNACPR) forms not always completed fully or accurately • DNACPR forms did not conform to national standards • No standardised documentation pathway had replaced the LCP • The incident reporting system did not specifically capture incidents concerning patients at the end of their lives • No systems in place to make effective assessment of the quality of end of life care • Scored significantly worse than the national average in the latest national care of the dying audit, meeting only 47% of the key performance indicators (KPIs). • No on-site seven-day specialist palliative care. • Out-of-hours staff unsure who to contact should advice be needed. • The specialist palliative care team (SPCT) had the vision to create a seven-day service however the current staffing was not sufficient to support this. • Patients at the end of life and their relatives were cared for with respect and compassion in a way that considered their dignity.
Queen Elizabeth Hospital NHS Foundation Trust	**Requires improvement** (30 July 2015) (for 'responsiveness' and 'well-led'):- • A plan needed for specialist consultant input in the event of continued recruitment difficulties • Complaints and significant events were not being appropriately coded for end of life care so information was not being used to improve services • Mortality meetings that were not focusing on the end of life care journey

[1] The five key questions the CQC asks when it inspects a service are 'Are they safe? Are they effective? Are they caring? Are they responsive to people's needs? Are they well-led?'

	• Not routinely surveying patients regarding end of life care • Audits to evaluate the quality of care provided not being routinely carried out.
James Paget University Hospitals NHS Foundation Trust	**Requires improvement** (12 November 2015) (for 'safety', 'effectiveness' and 'well-led'):- • Staff were caring and responsive • Patients DNACPR forms were sometimes incomplete • Patients did not have a clear care plan which specified their wishes regarding end of life care • Introduction of the end of life care pathway to replace the LCP was slow and lacked oversight at board level • Staff knew how to report concerns but these reports were not analysed and used to improve the service • The trust had scored much worse than the national average in the care of the dying audit. • The trust did not monitor the quality of the service effectively, e.g. no audits carried out to check if there were any obstacles to a patient's discharge and to ensure patients died in their preferred location. • Proactive in developing links with local providers of end of life care and tried to influence how the services were delivered to the local population. • Patients complaints had been responded to and appropriate actions were taken in response. • No routine audit of palliative care teams response times so CQC was unable to fully assess if the team was always responsive. • Specialist palliative care team was poorly represented in the elective division • No non-executive director could provide representation of end of life care at board level • Limited capacity to develop the service and undertake research due to recruitment issues. • Staff across the hospital were respectful and maintained patients' dignity, there was a person centred culture. • Specialist palliative care team members felt supported in their work and worked well as a team. • Staff were clear about their roles and their involvement in decision making. • Patients said staff were caring and compassionate • Patients had appropriate access to pain relief and said they were happy with food and drink offered. • Palliative and end of life teams were competent and knowledgeable • There were examples of good multidisciplinary team working • The palliative care team was visible on all wards and nursing staff knew how to contact them.

Norfolk Community Health and Care NHS Trust	**Good** (19 December 2014) (for 'safe', 'effective', 'caring', 'responsive', 'well-led') • Staff were aware and had access to the trust's on-line incident reporting system • There was evidence of learning from incidents to improve practice • Standards of cleanliness and hygiene were good • Staff demonstrated good knowledge of procedures for the management of clinical waste • Procedures were in place to ensure equipment was regularly maintained and fit for purpose • Appropriate systems in place to protect patients against the risks associated with unsafe use and management of medicines • Effective safeguarding policies and procedures which were understood and implemented by staff • Staff were aware of the trust's whistleblowing procedures and what action to take • The trust could not be assured that all faith leaders who visited had been subject to a DBS check • There was a trust-wide safe staffing reporting mechanism in place, reported to the Quality Risk and Audit Committee on a monthly basis • Most staff the CQC spoke to demonstrated little or no knowledge of their responsibilities under the Mental Capacity Act 2005 and did not know what to do when patients were unable to give consent • Patients were triaged and assessed effectively so that safe treatment and care was provided to guard against risks associated with their condition. • Risk assessments in areas such as falls, pressure care and nutrition were complete and updated • The Trust had removed the use of the LCP and implemented interim guidance called 'Caring for people in the last days and hours of life'. Training was still being undertaken. • Patients within end of life services had pain control reviewed daily. Regular and 'as and when' medication was prescribed. • Care records showed staff supported and advised patients who were identified as being at nutritional risk. • Patients received support from a multi-disciplinary end of life care team, including specialist palliative care, consultants, GPs and district nurses, and a full time social worker at Priscilla Bacon Lodge. • In accordance with the Gold Standards Framework, multi-disciplinary team meetings took place weekly to ensure any changes to patients' needs could be addressed promptly. • End of life services monitored the performance of their treatment and care. Records were completed to a good standard and contained a clear pathway of care.

	• Community end of life services were caring, with patients treated with compassion and empathy and with mutual respect amongst staff. • Patients and relatives told the CQC that care was good and they felt involved in their care and treatment. • The specialist palliative care team had received training to support people emotionally. They also delivered training to community staff. • Through advanced care planning patients were able to able to dictate both their preferred place of care and preferred place of death. • Staff were aware of the trust's policy for handling complaints and had received training in this area. Staff said there was active reflective practice and learning following complaints, which resulted in improvements being made. • Most staff were aware of the Trust's vision to improve and develop high-quality end of life care, however the vision and strategy was not fully embedded amongst all staff. • There was good leadership and support from local managers and a positive culture in the service. • Risk management and quality assurance processes were in place at a local level.
East Coast Community Healthcare (Community Interest Company)	The CQC has not undertaken overall inspection of end of life service by this provider.

Paper submitted by Norfolk and Norwich University Hospitals NHS Foundation Trust

NHOSC 8/9/16 – End of Life Care

Response to request

Health and care providers response to the new NICE guidance (December 2015) Care of Dying Adults in the last Days of Life and the CQC's A Different Ending report (May 2016)

End of Life Care – Everyone's Business

End of life care is the responsibility of all the health and social care staff involved with a patient's care. CQC recognise End of Life Care as an integral part of good health care. The Government's ambition (July 2016) *"is for everyone approaching the end of life to receive high quality care that reflects their individual needs, choices and preferences".*

The 2015 NICE guidance responds to the need for an evidence-based guideline for the clinical care of the dying adult. This guidance is focused on the care needed when a person is judged by the multiprofessional clinical team to be within a few days of death. This is different from other important NHS initiatives labelled 'end of life care' which are aimed at improving care for people in the last year of life. The NICE guidance is a guide for all staff caring for the patient who is in the last 2 – 3 days of life – and includes specialist and non-specialist staff. With this in mind the Norfolk & Norwich University NHS Foundation Trust has embraced the principles and guidance of the NICE document Care of Dying Adults in the Last Days of Life which includes:

- Recognising dying
- Communication around dying with both the patient and those important to the patient
- Shared decision making
- Maintaining hydration
- Pharmacological interventions and anticipatory prescribing
- How to implement these principles of care
- Recommendations for research

"*However, the real challenge will be how this guidance is put into practice. There can never be 'a tick-list approach' towards caring for the dying and this guidance must be underpinned by greater investment in training and education for all staff involved in end of life care. This is crucial if we are to avoid the failings of how the Liverpool Care Pathway was implemented."* Commenting on the new guidance, The Rt. Hon. Lord Howard of Lympne, Chair of Hospice UK.

The Care Quality Commission published "*A Different Ending, Addressing Inequalities in End of Life Care*" in May this year. This document very much focusses on ensuring the highest quality of care and support for everyone who is approaching the end of life regardless of diagnosis, ethnicity, gender, sexuality, age, religious beliefs: this includes people with learning disabilities, mental health conditions, people who are homeless, people in secure or detained settings, gypsies and travellers. This document looks at the longer term for people who are likely to die within the next 12 months, and focusses on:

- identification of those who may otherwise be marginalised and not get an equitable access to appropriate end of life care
- the communication with these people and those important to them
- co-ordination of their care
- ensuring timely and equitable access to good care and 24/7 support
- care in the last days and hours of life that delivers the five priorities of care for the dying person

End of life care within the Norfolk and Norwich is based upon the overarching themes found in both documents (which also draw their approaches from other National publications aimed at end of life care):

- The 5 Priorities of Care
- The 6 Ambitions for end of life and palliative care
- Ensuring mental capacity has been assessed
- That all end of life care is appropriate to the individual needs of the patient at the time and meets choices made by the patient – this includes discharge planning and Preferred Place of Care/Death
- That care is the best it can be and addresses comfort and dignity for the patient
- Appropriate information is available for all patients and those important to them at this vital time
- Timely access to the right services and care within the Trust and upon discharge when they are needed regardless of any circumstances the patient may have
- Staff are adequately prepared to undertake the care of patients who at facing the end of life. That education is offered to ensure the delivery of high quality care. This includes physical care, symptom control and communication skills

The above themes have been addressed in the below sections

- Background to palliative care, specialist palliative care and end of life care in NNUH
- Discharge Planning and Preferred Place of Care
- Choice and Advance Care Planning
- Appropriate Information
- Staff Education – prepared to care for end of life patients
- 5 Priorities of Care
- Liaising with community and social care services

Background

NNUH provides a service to the central Norfolk population of 750,000 as well as patients who attend the Trust from other areas. The Trust experiences in excess of 200 deaths per month. Of these deaths the specialist palliative care team sees approximately 20% of those who die within the Trust (this excludes sudden deaths and deaths of those under 16 years old).

The Specialist Palliative Care Team at present consists of 1.3WTE consultants and 4.29 WTE nurses. The service operates a 9-5 Mon-Fri service and delivers care to inpatients and outpatients (regardless of diagnosis) and the Acute Oncology Service. The team offers a breathlessness service on an outpatient basis. There is an OOH telephone advice line consisting of a first on call (a NCH+C specialist nurse or the senior nurse on duty based at Priscilla Bacon Lodge) and a second on call (consultant) . The OOH service operates weekends, bank holidays and after 5pm until 9am the following morning during the normal working week. The NNUH switchboard is aware of the number for any HCP wishing to access the number. It is also available on posters in all ward areas. All patients seen by the SPC team have a yellow sticker with details of this number put into their notes at least once during the time of contact with the SPC team.

A business case to expand the NNUH SPC service to develop the outpatient clinics and a seven dayface to face service, as well as a dedicated end of life educator who will work with generalist staff to ensure a skilled and educated workforce who are adequately equipped to provide the highest standard of end of life care to all the patients who are facing end of life within the Trust, has been approved by the Trust Board.

There is access to a Macmillan funded social worker and social worker practitioner for complex social needs. These posts are fixed term and will cease in October 2017.

Palliative and end of life care is available for all patients who are in the Norfolk & Norwich University NHS Foundation Trust regardless of their circumstances. Patients have access to interpreters and IMCA's as required. The learning disability CNS's see all patients with LD who are admitted and are facing end of life and work with the ward staff and SPC team to ensure choice and provision of care is appropriate to the patients and family's needs. The Trust has a policy for staff to follow for homeless patients. Patients are encouraged to have their families involved in care decisions to the extent they wish.

All end of life patients have a named senior Dr and ward nurse responsible for their care. These are made obvious to the patient and their family and can be accessed for further information and updates as required. All patients seen by the SPC team are given contact details for their named SPC practitioner and where it is feasible their

relatives are seen or contacted and also given contact details. All end of life patients with cancer and their families have access to support and benefits advice from the Big C centre. OPM patients can access advice and support from Age Concern UK.

Discharge Planning and Preferred Place of Care

The Trust has developed a post for an end of life discharge facilitator who will commence at the end of August 2016. This post will further support and build on the work already happening to ensure prompt and efficient rapid discharges and generally support all end of life rapid discharges especially to usual place of residence.

The Trust is also looking at developing a discharge hub so all referrals for discharge can be sent to a central point and appropriate pathways including end of life discharges can be identified. The Discharge team are redesigning the rapid/end of life discharge pathway for those patients who are approaching end of life.

There is a recognition that care and place of care has to be tailored to the individuals needs and that thorough assessment and communication with the patient and family is paramount to successful discharge planning. Flow charts are available for ward staff to follow to ensure correct pathway is followed for a smooth discharge.

The fast track process needs to ensure it is responsive to patients' needs, at present it can be slow to respond as patients wait indefinite times for care packages and even for an acceptance to their fast track application. This does not ensure rapid discharge. There can are also be long waits for community palliative care beds, including transfer to PBL. It is to be hoped that the new discharge co-ordinator will be able to streamline and facilitate this service so it can be more appropriately responsive to the patient group's needs.

As part of the Trust's CQUINN programme we are participating in the CQUINN which looks at Preferred Place of Death (PPoD). This focusses on the patient's documented preferred place of death to ensure it has been recorded and appropriate referrals to meet this choice have been made in a timely manner. The patients "wellness" to be transferred and availability of resources can limit success of any planned PPoD.

All patients discharged from NNUH who are facing their end of life are discharged with anticipatory medications, these and if there is a syringe driver, are all prescribed on a community drug chart to ensure a smooth transition of care. Information is given verbally to the GP regarding any rapid discharge and electronic letters generated at ward level are sent to the GP and a copy given to the patient. The letters should prompt the inclusion of the patient on the GSF register if they are not already so registered. The SPC team also send a summary care record to the GP and offer a copy to the patient. All patients who are discharged home for end of life care are referred to the district nursing service. On average NNUH sends home one – two

patients who are at end of life every day; other patients are discharged to palliative beds, including PBL.

Choice and Advance Care Planning

Norfolk & Norwich University NHS Foundation Trust has adopted Norfolk's county wide Advance Care Plan (ACP) – the Thinking Ahead Document. Staff are encouraged to look out for patients bringing their ACP into hospital to inform care choices. However the NNUH is not seeing many patients attending hospital with an Advance Care Plans or even being in possession of one. Further education is required to embed this into practice in all clinical areas and an educator post is being looked at through the Palliative Redesign Group. However it has been noticed that many patients offered the opportunity to complete the document in the acute setting state they would prefer to do so in their own home once they have been discharged.

To roll out Advance Care Planning in the Trust is a big project to ensure it is embedded and accepted into practice by all specialities and all clinicians. However it is recognised, it is the right of people to make choices about their own end of life care and the responsibility of the health and social care teams to respect these choices as far as possible. This will be a challenge for the acute and community Trust to ensure the success of ACP.

Appropriate Information

Facing dying is unfamiliar to many people in this day and age, therefore written information is beneficial to ensure they have something to refer to that is easily understood and specifically written. Macmillan has produced a booklet End of Life a Guide and The NCPC, Hospice UK and Sue Ryder have produced a leaflet for the very end of life, What to Expect When Someone Important to You is Dying. Both booklets are available in the Trust to give to patients and their families. The Macmillan booklet is free but the NCPC leaflet (which is nationally accepted as the gold standard for information) has a cost attached and sourcing funding is on-going.

The Big C centre offers a wealth of information to patients with cancer and their families. Other departments offer information regarding their speciality such as the renal, cardiac and respiratory teams. These leaflets offer information re: how to live with their diseases and details of support groups.

Staff Education

As a Trust the SPC team and the End of Life & Bereavement Steering Group have recognised the need for staff education so staff are confident they can provide the necessary care for each person who is facing end of life.

Monthly sessions on end of life care are available for all staff (regardless of grade, role, speciality) to attend and are run by the SPC team.

The SPC nurses offer ward based teaching sessions, particularly during ward meetings. A link nurse system is in place where ward based link nurses champion end of life and palliative care, attend study afternoons and an annual conference and take developments and initiatives back to their clinical area for dissemination. They are responsible for updating the ward's Pink Folder which is a hard copy of all the relevant palliative and end of life information wards may require.

The SPC team organise an annual Palliative Conference which is well attended by health and social care staff from throughout Norfolk and Suffolk and although hosted by the SPC team speakers come from all over the country to speak.

Teaching is given to HCPs at the UEA both pre and post registration in a variety of subjects associated with end of life care (including medical, nursing and HCP's).

The Palliative Medicine consultants run GP trainee courses, courses for SpRs, and newly qualified Drs in end of life care.

Communications skills are an identified area of need to ensure good end of life care is delivered with appropriate and sensitive conversations. 3 members of the SPC team are advanced communication skills facilitators and many members of oncology related MDTs have attended an ACS course.

Macmillan funded 3 people (2 CNS's and one chaplain) to become facilitators for Sage and Thyme, which is a communications skills course aimed at all grades of staff to allow them to deal with and recognise distress in patients and carers. The facilitators have successfully run three courses and have to complete 2 more by March 2017. Macmillan have extended the licence so the Trust can run courses until 2018.

eELCA on line modules are available for all staff via the Trust's ESR system. These modules aim to provide basic education in end of life care. The modules are also available via http://www.e-lfh.org.uk/home/ The Health education England website. Registered staff need their NMC or GMC number to register.

All trust staff attend or complete an on line equity and diversity training on an annual basis which ensures all patients and those important to them are cared for in the manner in which they would wish to be cared for. The Trust respects religious beliefs and has a multi-faith approach from the chaplaincy department and there is access to

representatives from many faiths locally who can support patients facing thei end of life and those important to them when required. Information is available to ensure respect is maintained when a patient has died to ensure their needs are still addressed regardless of religious beliefs.

All staff attend mandatory training around Mental Capacity and safeguarding and UEA has also run courses more recently for all NNUH staff looking at safeguarding, mental capacity, and frailty in more depth.

Five Priorities of Care

Both the NICE (2016) End of Life Guidance and the CQC's A Different Ending Report (2016) documents adopt the approach of the 5 Priorities of Care.

The Trust's guidance document for End of Life care is based on these 5 Priorities and provides clear detailed guidance for all staff how to care for patients in the last days of life using these priorities as the guiding principles – recognition of dying, communication, including uncertainty in communication and ensuring documentation is completed, involving patient and family/carers in all decision making, supporting those important to the patient and planning and doing – which includes all hygiene, nutritional and hydration needs, anticipatory prescribing and ensuring symptoms are well controlled.

Guidance on recognition of dying, with the uncertainty around this, and encouragement of open communication and shared decision making are really emphasised in the Trust's end of Life guidance.

All patients have a named senior Dr and ward nurse for each shift who the family and patient can access for information and updates.

The SPC team have developed and are in the process of piloting an individualised care plan which encompasses these priorities. It very much focusses on holistic assessment, communication, choice, symptom control, spiritual support throughout the dying phase, into care after death and into the bereavement. The patient is very much respected as an individual and their choices and wishes influence care and clinical decisions made. The care plan is not a tick box exercise.

The Trust has adopted a palliative care rounding tool which the nurses use to ensure that their patients who are at the end of their life are comfortable and all their needs are being addressed – physically, spiritually, psychologically and that those important to the patient are also appropriately cared for including their spiritual needs, any other concerns, including information and general information about the hospital are addressed. This is more of a prompting tool and is a natural continuation for nursing staff leading on from the Intentional Rounding document.

To ensure good symptom control the SPC have written clear guidance for anticipatory prescribing. These guidelines are available on all wards attached to drug trolleys as a laminated document, is available in the wards pink folders (which is an end of life information folder each ward holds as a resource) and on the Trust intranet. The anticipatory prescribing is supported by EMPA (the Trust's electronic prescribing system) as it recognises the anticipatory medications and offers options to support this prescribing to ensure all relevant medications are prescribed. However the emphasis on individualised prescribing for current and anticipated symptoms, avoiding undue sedation or other side effects, cannot be over emphasised.

The SPC team have also devised nursing guidance sheets to help ward nurses care for patients with the major symptoms at end of life including pain, breathlessness, distress/agitation, nausea and vomiting and secretions. These guidance documents guide nurses on pharmacological treatments and non- pharmacological interventions for all these symptoms. They have also been involved with developing Trustwide guidance for mouth care – which is a vital part of end of life care which should not be neglected.

To ensure easy access to all end of life information the SPC team have produced an icon which can be located on the desk top of all Trust computers. This ensures staff can readily access any information they require that pertains to Trust guidance and National documents for end of life care.

Support for patients and those important to them

A volunteer service for volunteers who will be specially trained to sit with patients who are at the end of life and who will support patients and those important to them within the limits of their role, is being developed with the volunteer co-ordinator.

The chaplains offer support to patients and their families and also provide volunteers who can provide support particularly in different faiths.

Monitoring Standards

1. 3 monthly retrospective audit of patient notes. Audit is based on the National End of Life Standards. Results are fed back to the End of Life Steering Group, CAPE, Trust Board, Matrons meetings.
2. Daily ward audits which although are general audit, end of life care is also looked at during these audits. Wards get feedback on the day and all feedback is collated and disseminated monthly.
3. Participation in the CQUINN for Preferred Place of death – which involves auditing of patient's notes regarding discharge planning.
4. The Change Management Team are developing a dashboard for end of life care to monitor end of life care throughout the Trust.

Liaising with community and social care services

- Macmillan funded social worker and assistant practitioner (funded until Oct 2017).
- Close ties with Priscilla Bacon Lodge. The SPC team “gate keep” the waiting list to PBL by assessing patients who wish to be transferred to Priscilla Bacon Lodge and by liaising with staff at Priscilla Bacon Lodge to manage the waiting list for beds there.
- Referrals are made for SPC community follow up for patients discharged out of the Trust who have on going complex needs.
- All patients are discharged with a discharge letter.
- Patients being discharged for end of life care are given community contacts in case of any problems/concerns.
- Patients at the end of life are all referred to the district nurse for ongoing assessment and palliative review.

In Summary

As a Trust there have been many developments big and small regarding end of life care. There have been the overarching policy developments and service developments that impact directly on patient care.

As a Trust we respect individuality and the right to choice and do all we can within the resources available to us to meet patients’ choice. There is a commitment to always providing individual care as agreed with our patients and their families. Education for all remains key to ensuring staff understand National developments and commitments in end of life care as well as ensuring the best possible care for patients who are facing end of life, and those important to them; also that individual needs are met and supported at this very crucial time. After all we only have one chance to get it right and we aim to ensure where possible we do get it right!

James Paget University Hospitals NHS Foundation Trust

Report to the Norfolk Health Overview and Scrutiny Committee

August 2016

The Trust Board and staff teams were encouraged by the positive findings within the 2015 CQC Inspection report and were reassured that the areas of weakness were aligned to our internal assessments. Using an improvement plan approach we have used the findings to identify and make further improvements to the services which contribute to the delivery of end of life care.

We were re-inspected on 16th and 17th August 2016 and there were no areas for immediate action at that time. We are awaiting the draft report and have provided evidence that we had met the requirement to improve by:

- Publishing an End of Life Care Strategy
- Completing the baseline assessment against the NICE Guidance[i] meeting 69/72 standards in the NICE guidance assessment and so scored 96%
- Completing the roll out and training for use of the Plan of Care for the last days of life
- Improving on the results in the National Care of the Dying Audit 2015
- Appointing a non executive director as Board level lead
- Appointing medical and nursing leads who are responsible for day to day design and monitoring of the systems which deliver safe and quality care to people who require support because they are nearing the end of their lives
- Strengthening our monitoring by ensuring that audits are undertaken against the standards required.

Progress to plan is regularly monitored by the End of Life Care Strategic Group which reports to the Carer and Patient Experience Committee and this is a sub-committee of the Board.

Care Quality Commission's (CQC) 'A different ending' report published in May 2016

Our response is as follows:

1. **Leaders of local health and care systems** to work together to develop a plan for delivering good quality, equitable end of life care for everyone in their community.

   End of Life Care within the Great Yarmouth and Waveney system is supported by the End of Life Care Programme Board. All relevant stakeholders in primary and secondary care, commissioning, community care, and the voluntary sector are invited. The Programme Board has a strategy and is developing a Dashboard. It responds to National reports such as NICE and CQC and also individual patient stories.

2. **Commissioners and providers** to fulfil their duties under the NHS Constitution, the Health and Social Care Act 2012 and the Equality Act 2010 to reduce inequalities, eliminate discrimination and advance equality when developing, arranging or delivering end of life care.

   The End of Life Care Board is aware of its duties to reduce discrimination and inequalities. Our local population has specific issues relating to demographics, with a preponderance of elderly. We are also challenged by local geography and limited transportation infrastructure that poses challenges in such a rural area.

3. **Commissioners and providers** to ensure that staff who care for people who may be approaching the end of life, including care home staff, have the knowledge, skills and support they need.

   The End of Life Care Board are conscious of the education needs across the staff groups involved with this group of patients. A good example of the integrated approach achieved locally is the education and supporting documentation relating to a change in National recommendations for syringe drivers that has been rolled out to all sectors. The JPUH specialist palliative care team, while based on site in the Louise Hamilton Centre, deliver the majority of their care in the community and thus have close links. They are supportive of the GSF network in primary care.

4. **Hospices** to champion an equality-led approach, engage communities, deliver equitable end of life care, and support others to do the same.

   The voluntary sector is included in the End of Life Care Board and has been part of several elements of service delivery. They are a vital source of patient feedback and are enthusiastically engaged in local fund raising to improve local facilities. As a trust, we have recently developed a partnership with Marie Curie to review our services and help develop our strategy for the future.

5. **GPs** to ensure that everyone with a life limiting progressive condition has the opportunity to have early ongoing conversations about end of life care, and are given a named care co-ordinator.

   Through the GSF forums, which are linked by the SPCT, primary care are able to highlight appropriate patients and monitor their progress, assessing their needs at regular intervals to deliver the most appropriate support.

<u>NICE NG31</u>

We assessed ourselves against the baseline assessment tool for care of the dying adults in the last days of life (NICE clinical guideline NG31). The document contains 72 relevant recommendations under the following headings:

- recognising when people are entering the last few days of life
- communicating and shared decision-making
- clinically assisted hydration
- medicines for managing pain, breathlessness, nausea and vomiting, anxiety, delirium, agitation, and noisy respiratory secretions

- anticipatory prescribing.

We have taken the following action regarding recognising last few days of life:

- Implemented new documentation, supported by education across the Trust
- The medical lead for end of life care and palliative care educator have provided training and education to medical and nursing staff using a mixed approach including training sessions, grand round and communications
- Ensured that clinically assisted hydration is highlighted through the last days of life documentation with clear instructions to staff on introduction, communication, involvement of carers and regular reassessment
- Ensured that we have clear arrangements for anticipatory medicines prescribing is supported by documentation available through the intranet within the JPUH.

Current Issues/ Risks

The specialist palliative care team is undergoing change currently because of recent resignations however, we are advertising these vacancies and we will consider flexible solutions should these prove hard to recruit to.

Implementing recommendations from national audits and reports

We have encountered some barriers to the use of national tools and frameworks because the national strategy is very complex to navigate but we continue to identify ways of adopting these and we seek to learn from others who face similar challenges.

Next steps

Using the framework Ambitions for Palliative and End of Life Care 2016[ii] we will strive to broaden our vision to ensure that patients' experience a seamless transition through providers across the system and we continue to work in partnership to achieve this.

We will continue to train and educate our staff on the use of the revised care planning tool because the transitional nature of our trainee and student workforce makes this necessary. We are also reviewing the awareness of our most senior medical workforce to ensure that the model is implemented using a consistent approach.

We will use the NICE NG31 baseline audit information to build continuous compliance assessment into our service delivery and performance plans. We envisage an audit focussed approach to measuring the effectiveness of our arrangements and we will triangulate this with policy development and patient and staff feedback.

Areas for improvement are:

- Establishing communication needs and expectations of people who may be entering the last days of life
- Identifying the most appropriate available team member to explain the dying persons' prognosis.
- Identifying a named lead healthcare professional who is responsible for encouraging shared decision making in the person's last days of life.

- The implementation of safe, effective processes for receiving and sharing information from and to our external partners and other agencies.

We have undertaken a baseline assessment to the Chaplaincy Guideline[iii] and have identified the actions we need to take in order to align our chaplaincy service to modern standards and ways of working. This will support us in addressing the national audit performance in the area of spiritual care.

Julia Hunt
Acting Director of Nursing

Sarah Downey
Clinical Lead for End of Life Care

[i] NG31 Care of the dying, adults in the last days of life
[ii] Ambitions for Palliative and End of Life Care –a national framework for local action 2015-2020
[iii] NHS Chaplaincy Guidelines 2015

Report for the Health Overview and Scrutiny Committee, Sept 2016 from The Queen Elizabeth Hospital Kings Lynn

Introduction

In July 2015, a CQC inspection of the Trust's End of Life (EoL) services was rated as 'requires improvement' with the following recommendations and action updates:

1. A plan needed for specialist consultant input in the event of continued recruitment difficulties
   Specialist consultant advice is available to the Macmillan specialist palliative care team and the Trust's own specialty doctor by telephone. The Community Trust (supported by QEH) continue with their efforts to recruit to the vacant posts.

2. Complaints and significant events were not being appropriately coded for end of life care so information was not being used to improve services
   Complaints, compliments and incidents are coded for EoL issues and reviewed at the EoL Group meetings. A number of actions have arisen from these – detailed in the report below.

3. Mortality meetings that were not focusing on the end of life care journey
   Mortality reviews focussing on EoL issues have been undertaken in a number of specialities.

This brief paper summarises the Trust's response to the following 2 reports, published since the last Trust CQC inspection:

- NICE Guideline 'Care of dying adults in the last days of life' Dec 2015, and
- CQC report 'A Different Ending' May 2016

2015 NICE Guideline - 'Care of dying adults in the last days of life'

This guideline recognises the reasons for withdrawal of the LCP in 2014 and provides guidance for health and care staff for care of patients recognised as being in the *last days of life*. This includes recognition of the dying phase, communication with patient and those important to them, shared decision making, providing individualised care, hydration and feeding and managing end of life symptoms.

The Guideline is similar to the approach contained within the Leadership Alliance for the Care of Dying People's report 'One Chance to Get it Right' published in 2014 and on which the QEH has based its End of Life education program.

QEH Strategy

The Trust launched its first End of Life (EoL) Care Strategy in January 2015 with the aim of making excellent EoL care 'everyone's business'. The Trust employed its first full time EoL care facilitator commencing in October 2015, and launched a series of education and training events.

Support for Staff:

See appendix 1 for services available to support QEH clinical staff with EoL care.

The Integrated Palliative Care Service is nurse-led and owned by the community Trust, NCH&C. This service in-reaches to the hospital and integrates with the part-time palliative care speciality doctor and the Fast-track discharge service which aims to transfer EoL patients to their preferred place of death whenever possible.

There are 2 vacant posts but currently no consultant service in specialist palliative care locally despite efforts on the part of both the acute and community trusts to appoint.

General education and training:

Teaching about End of Life Care at QEH is based on the '5 priorities of care' for the dying person outlined in 'One Chance to Get it Right' and these are echoed in the newer NICE guideline.

The 5 priorities are:

1. Recognise the possibility that someone may be dying
2. Communicate sensitively with the patient and their friends and family
3. Involve the dying person and those important to them in decisions about their care
4. Support the needs of the family and others identified as important to the dying patient
5. Plan and do an individualised plan of care and ensure it is co-ordinated and delivered with compassion

Teaching is provided on induction for clinical staff and at annual mandatory training refreshers. This program has been backed up by a series of presentations to surgical and medical teams during the last 18 months, specifically introducing the 5 priorities. In addition, there have been a number of medical 'grand round' presentations concerned with EoL decision making, and in particular DNA-CPR decisions.
The team delivering the education includes:

- the palliative care team (especially around symptom control),
- the EoL care co-ordinator (recognition of death and referred place of care),
- Fast-Track liaison nurse,
- the medicolegal services manager (especially around DNA-CPR decisions) and
- the Lead Chaplain (spiritual aspects of care).

Additional 'Basics of EoL Care' short (2 hour) courses were provided for nursing staff at all levels by the palliative care team during 2015.

The general training also introduces the 'Thinking Ahead' initiative, also known as the 'Yellow Folder' advance care planning scheme. The folder contains information for patient around DNA-CPR decisions, and planning for EoL care. The Folders may be initiated in the community or in the acute setting. This was a regional initiative which appears to have had some impact so far but there is potential for further use.

Communication

In addition to the general training described above, further support is offered with EoL communication from the EoL Care Facilitator – see appendix 1.

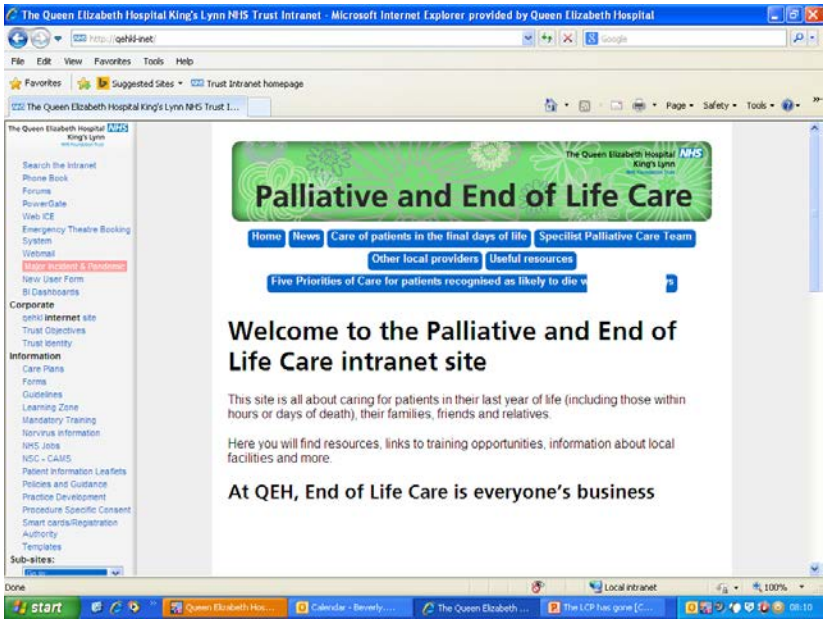
There are 2 further initiatives underway:

1. As part of our Cancer Services Transformation Program, there will be a training needs analysis undertaken for staff who manage patents on cancer pathways. This is likely to highlight the need for additional 'breaking bad news' and EoL communications skills training and this will be undertaken as part of the overarching 2-year Program

2. The Trust is also in the process of commissioning communication skills training for a significant proportion of the workforce to reinforce the internally developed values and behaviours and improve customer service. Whilst not specifically around EoL issues, staff with improved communications skills are likely to positively impact on EoL patients and their families too.

Symptom Control and Anticipatory Prescribing

This forms part of the general training outlined above and is backed up through an intranet site which provides guidelines for anticipatory prescribing for patients with and without renal impairment. The EoL Care Facilitator is exploring how to make this more responsive to the needs of clinicians eg use of a mobile phone app.



Supporting those important to the Dying Person:

A focus group for bereaved relatives in May 2015 and work with an 'expert by experience' since that time to collect the views of bereaved family and friends about their experience have contributed to:

- Free car parking for visitors to patients at EoL
- Written information on eating and drinking at EoL
- A maximum time standard for transfer of patients to the mortuary after death
- Increased hours of provision for the bereaved relatives support office
- Registrar of births, marriages and deaths on site for 3 days a week negates the need to attend the hospital to collect the death certificate and then go to the registrar's office in town
- The communications initiatives detailed above

Further Ambitions:

The Trust has yet to replace the LCP with a specific 'pathway' approach to care. A decision on how to move forward with this, bearing in mind what initiatives have been effective at other local Trusts, is expected in the near future.

CQC Report

A Different Ending – Addressing Inequalities in End of Life Care

This report from the CQC about EoL care experienced by a variety of different patient groups produced recommendation concentrated on ensuring that commissioners and providers were able to meet the needs of everyone in their local community.

The emphasis is on collaboration across provider boundaries and engagement with local communities and 'end of life' in this report refers to the last year of life rather than the final days.

QEH response:

The Report and good practice case studies were discussed at the EoL Steering Group in June 2016.

Cross boundary work

The Trust has been working with the local commissioners (WNCCG) and community Trust (NCH&C) to drive better provision of care out of the acute hospital so that more EoL patients achieve their preferred place of death (PPoD).
Since Q2 2015/16, the proportion of patients referred for Fast-Track discharge (considered to be within 6 weeks of the end of their lives) from the hospital and who died in their PPoD has risen from 57 to 72%. Over the same time period, the number of inpatients identified as within the last 6 weeks of life and referred for Fast-track discharge has almost doubled from 55 to 95 per quarter.
The main reason for patients *not* achieving their PPoD is insufficient community resources (care at home or nursing home bed) for the patient to be discharged to.

The Trust has also engaged with NCH&C in the development of their Integrated Palliative Care Service, which provides a single point of contact for hospice at home, end of life and palliative care referrals from the hospital and community. There is access to palliative care support 7 days a week during daytime hours.

Addressing inequalities – specific patient groups

Prior to the CQC publication and since, the Trust has also focussed on some internal work, reviewing and improving EoL services for patients and their families from the following groups:

- **Elderly and frail patient:** The Trust's has a vision, 'Aiming for Excellence', and is focussing on elderly care by developing comprehensive geriatric assessment, with acute geriatric and frailty pathways. This will provide improved early senior decision making for elderly patients including those at end of life.

- **Patients with Learning Disability (LD):** 8 patients with LD died whilst in the hospital during 2015/16. A review of the care received by these patients was commissioned by the Mortality Committee and completed in August 2016. This showed excellent support for patients and their families from the QEH LD Liaison nursing team, and the Trust will continue to monitor EoL care for this group.

- **Patients who have no next of kin, family or friends to support them**: the Trust has a ward companion volunteer project. These volunteers receive training to allow them to sit with patients who are at EoL and support them and those who care for them. The aim is to link with the Hospice volunteer group so that support can be continued if these patients are discharged out of the acute Trust.

- **Patients with drug and alcohol-related disorders**: this patient group often have specific EoL needs which may arise from poor or no permanent housing, family breakdown or mental health disorders. A senior clinician is currently reviewing deaths in this group to ensure that they received skilled, compassionate and appropriate end of life care.

Improvement in post-mortem care to support family and friends of the deceased.

- **Parents of babies who are stillborn or suffer neonatal death**: 'cool cots' were charitably donated to the Trust and allow parents to keep their babies with them for longer after death before transfer to the mortuary. This also allows the midwives and chaplaincy more time to support them

- **Bariatric patients**: the Trust has invested in equipment for bariatric patients whilst in hospital, and purchased a system for rapidly post-mortem cooling of

bariatric patients who are too large to be stored in bariatric mortuary fridge spaces. This maintains the dignity of the deceased and ensures that viewing is still available for family and friends

Further ambitions:

1. **Improved advance care planning and primary care oversight of patients in nursing homes**
   Most local nursing homes are not supervised by a single general practice. Many nursing home residents do not have EoL care plans in place and patient are admitted to the acute Trust without reference to their GP, particularly out of hours. This group would benefit from improved advance care planning and primary care oversight.

2. **More EoL beds in the community and nursing support for patients wishing to die at home**
   Too many patients are still dying in hospital locally when their PPoD is at home or in a nursing home. There is a shortage of nursing home facilities or community nursing at home to take EoL patients and this is more marked in Lincs and Cambs than in West Norfolk although it exists in all three areas. The Trust will work with the CCG and Community Trust to drive increased provision.

3. **Local specialist palliative care beds**
   There are no consultant-led specialist palliative care hospice beds in West Norfolk. The local hospice (The Norfolk Hospice Tapping House) delivers out-patients services. However, WNCCG plan to commission some beds at the hospice, most likely under a nurse-led model of care. These will be for step-up/step down care in addition to EoL care. It will be vital that these are in addition to rather than instead of, existing facilities in the community.

4. **Better integration of care models across providers**
   Further work is required to better integrate facilities between acute and community care and to ensure that primary, community, ambulance Trust and secondary care staff are all 'on the same page' regarding the patients prognosis and wishes.
   This will include increased sharing of advance care plans, ideally electronically, in for Trust patients across all 3 CCGs (West Norfolk, Cambridge and Peterborough and Lincolnshire)

- In West Norfolk and Cambs, use of SystmOne allows QEH staff to view NCH&C Palliative Care Service records, and records from GP practices that use this system (around 2/3 of local practices).
- In Lincs, the palliative care service use 'My Right Care', and the viewer will be made available to QEH staff

Appendix 1

QEH End-of-Life and Palliative Care Help and Support Services – August 2016

It's important for the patient's owning team to decide what help is required (ie symptom control or discharge planning) then access the right support.

Specialist Palliative Care

There are Macmillan Specialist Palliative Care (SPC) Nurses available to all QEH patients, irrespective of where they live, 7 days a week, 9am -5pm.

This service is to help you with symptom management in both cancer and non-cancer patients eg pain control, management of nausea and agitation

- For telephone advice from these nurses, contact them through the QEH switchboard – this is called the Specialist Palliative Care Advice Line
- To make a new referral to these nurses, telephone 01553 668526. You will be asked to fax a referral to 01485 601702, or email it to ipcs.westnorfolk@nhs.net
  You can also arrange for community support after discharge via this route.

Palliative Care Specialty Doctor

Dr Bassam is available Mondays (8.30-2.30), Wednesdays (9-5) and Thursdays (8.30 - 2.30) for urgent medical advice.

- Medical staff only can bleep Dr Biddy Bassam on 3417

Fast Track Discharge

This is a service to facilitate rapid discharge of patients whose life expectancy is less than 6 weeks, and is available Monday to Friday only.

Medical teams should document the patient's prognosis and the conversations that have already taken place with patient and family members. A DNA-CPR form should be correctly completed and in place.

- Bleep Lisa Moxham on 2472

Norfolk Health Overview and Scrutiny Committee –
End of Life Care, 8 September 2016

Norfolk Community Health and Care provide palliative and end of life care for patients and their families in the community setting (including patients' own home and care homes) and also within eight community hospitals. The numbers of palliative care patients being cared for within these community hospitals is rising – in 2015/16 this was equivalent to 12% of all capacity (average length of stay 18.7 days; total of 6421 occupied bed days).

The Trust also provides specialist palliative care services for patients and families with more complex needs – this includes our Community Specialist Palliative Care Team, the Rowan Centre Specialist Palliative Care Day Unit and the sixteen specialist palliative care inpatient beds at Priscilla Bacon Lodge.

This paper summarises how NCHC are addressing End of Life Care in the light of recent NICE Guidance (December 2015) and the CQC's 'A Different Ending' report (May 2016).

NICE Guideline NG31 – Care of Dying Adults in the Last Days of Life, 16 December 2015

This guideline is focused on the care needed in the last few (two to three) days of life and responds to a need for evidence-based guidelines throughout the NHS. It is specifically aimed at non-specialists, but also provides a baseline for standards of care in settings that specialise in caring for people who are dying, such as our specialist palliative care unit at Priscilla Bacon Lodge.

<u>Actions and Responses</u>

- Baseline assessment within specialist palliative care services, completed April 2016 – all standards met.

- Baseline assessment within other areas due to be completed in September 2016.

- Within Priscilla Bacon Lodge and the community hospitals, we are using individualised end of life care documentation which was developed following the publication of "One Chance to Get it Right" in 2014. This documentation has been regularly reviewed and audited over the last couple of years. An audit in Summer 2015 highlighted that improvements were needed in our documentation around family support needs and psycho-spiritual needs - this was primarily thought to be due to design of the documentation. The documentation has therefore been reviewed significantly in the last six months. The revised care plan was re-audited at Priscilla Bacon Lodge in May 2016.

This audit showed the care plan was used in 75% of appropriate patients. In 100% of cases, there was evidence of regular review of symptoms and comfort measures, documentation around carer needs. Documentation of carer's needs as well as spiritual and psychological needs had improved significantly and was now evident in two-thirds of cases. This audit shows further work is needed and the care plan has now been further revised and continues to be piloted at Priscilla Bacon Lodge, and now on the palliative care beds at Kelling Hospital. The team have implemented a number of actions around improving use and efficacy of the care plan which are ongoing. Once this new pilot has been completed, the plan will be to roll out the revised care plan to all community units in Norfolk.

- Within patients' own homes, NCHC have been working with other local providers to design an electronic care plan. The Integrated Palliative Care Service in West Norfolk has led on this and have developed a new SystmOne Palliative Core template. This incorporates a response needs assessment tool (based on the Gold Standards Framework) and an individualised end of life plan of care (based on the Five Priorities of Care guidance from the Leadership Alliance). This template and associated care plans are currently being piloted for three months in West Norfolk.

- The specialist palliative care team actively seek feedback from patients and carers around the quality of their service. In 2015, Priscilla Bacon Lodge and the specialist community palliative care team took part in a national survey measuring bereaved relatives satisfaction with end of life care. The survey, organised by the Association for Palliative Medicine of Great Britain and Ireland, measured satisfaction across a range of domains including the patient's comfort, communication and involvement of family. The care provided by our teams scored higher than the national average in most areas (15/17) and we were able to demonstrate improvement from a previous survey in 2013.

- The specialist palliative care service continues to prioritise education and training for other healthcare professionals locally to address some of the key areas highlighted in the guidelines, such as recognising dying, communication skills, advance care planning, shared decision-making and symptom control at the end of life.

CQC – A Different Ending, May 2016

NCHC is committed to addressing inequalities in end of life care and continues to build on partnership work to meet the needs of all patients. Here are some examples of work we are committed to:

- People with dementia – the Trust run 6 Dementia workshops annually for a wide audience including Care Home staff, NCHC staff, Social Services and Domiciliary Care agencies. These are always over subscribed and highly evaluated.

- People with learning disabilities – the Trust are currently trialling a resource pack for carer support put together by the Learning Disability community nurses and the Palliative Care Team. This will be evaluated before roll out more widely.

- People with mental health conditions – we are keen to work jointly with the mental Health Trust and are looking at pathways of care.

- People in secure and detained settings – our Specialist Palliative Care Team have previously won an award for partnership working within Norwich Prison to meet the needs of patients at the end of life. We continue to attend GSF meetings within the prison setting and are keen to develop further education programmes to support this work.

- Care homes – our Palliative Care Team continue to support the Six Steps programme for Norfolk. They have successfully accrediated 34 homes with 4 re-accredited. The team have 2 cohorts currently completing with a further 2 cohorts booked over the next 6 months.

The Trust acknowledges that achieving good quality end of life care for everyone must be a responsibility of the health and care system jointly, together with the wider community. We support the vision outlined in the '*Ambitions for Palliative and End of Life Care'* document from last year and are currently completing a gap analysis against this. We are working with commissioners and other providers locally to ensure a joined up approach.

End of Life Care is central part of our services at East Coast Community Healthcare (ECCH). Working in partnership with our colleagues across the health economy we have been and are continuing to develop integrated systems and processes to support people at the end of their lives and provide those in our care with the highest levels of quality care. Since December 2015 the pace of development in palliative care integration and improved outcomes for patients and families has increased. This has been through a combination of shared education, collaborative development of end of life tools and pathways and improved function of the palliative care meetings. The strategic Palliative Care Board hosted by the Commissioning team involves representatives from secondary, primary and community care, informatics development, third sector colleagues and patient representatives. The operational meeting, currently chaired by ECCH, has a wider stakeholder attendance including links to all strategic attendees and representation from Patient Flow Team, Out of Hospital care teams, Specialist Respiratory and Neurology Nurses, Community Matrons, Paramedics and Pharmacists. This provides a multi-professional and multi-dimensional approach to End of Life care. Below is a table detailing the actions ECCH has taken to improve End of Life Care and how these align with the recommendations from both the NICE guidelines Care of dying adults in the last days of life December 2015 and following the CQC thematic review and publication of A different ending - Addressing inequalities in end of life care.

National Institute for Health and Care Excellence Recommendation (ng31) Dec 2015	East Coast Community Healthcare Response	CQC A different ending - Addressing inequalities in end of life care Recommendations
Recognising when a person may be in the last days of life	• A continuation of an integrated programme of education with the specialist palliative care team based in the acute hospital to widen understanding and assessment of individuals at end of life. The training programme includes clinical assessment skills, advanced communication skills and difficult conversation training.	1 – working together 2 – eliminate discrimination, 3 – provide knowledge and skills

	• Dissemination to community nursing teams of essential reports including 'One chance to get it right' from the Leadership Alliance and the Royal College of Nursing's 'Getting it right every time' to provide staff with the appropriate ethos by which to manage patients and their families / carers at end of life. • All patients identified as at end of life have a minimum of daily contact with a member of the Community Nursing team. • An enhanced Hospice at Home, integral with the Community Nursing team, has been developed and full implementation has been in place since July 1st 2016 . This service offers patients and their families a consistent, individualised and supportive approach during the last few days of life with high level interaction. • All patients recognised as end of life are required to have evidence that a preferred place of death has been discussed and recorded as a quality measure. • Regular communication, directly or within Gold Standard Framework (GSF) meeting with patient's GP / practice is maintained and recorded.	5 – GP co-ordination
Communication	• As above access to advanced communication skills and difficult conversation training has been made available for all registered community nursing staff. More recently staff from all disciplines and bands have been encouraged to attend level 1 communication workshops (SAGE&THYME) in collaboration with acute provider. This programmes has been supported by Commissioners. • Learning from complaints and incidents is shared with all teams in promote the use of effective communication skills.	1 – working together 2 – eliminate discrimination 3 – provide knowledge and skills 5 – GP co-ordination

	• Case load management provides patient with a named registered nurse identified to manage and coordinate their care. • Extensive assessment of physical, psychological, social, spiritual and cultural needs are conducted and care plans made at initial and all subsequent contacts with the opportunity discuss wishes and values and involve family / carers as appropriate. • All residential homes in Great Yarmouth and Waveney have a named Community nurse identified to provide information, guidance and care to support home staff to provide good quality end of Life care • Part of pilot of Electronic Palliative Care Coordination Systems (EPaCCS) across Great Yarmouth and Waveney	
Shared decision making	• Staff are well informed regarding advance decisions through Mental Capacity training and the principles of capacity in decision making including advanced decisions and enduring and lasting power of attorney. • Advice and guidance available to all staff on religious and cultural preferences • Attendance by Community Nursing case load at the GSF meetings led by GPs to contribute as the patient's key worker	1 – working together 3 – provide knowledge and skills 5 – GP co-ordination
Providing Individualised Care	• Case load management provides patient with a named registered nurse identified to manage and coordinate their care. • A single point of access provides patients and care colleagues access to this individual with electronic tasking	1 – working together 2 – eliminate discrimination 3 – provide knowledge and skills 5 – GP co-ordination

	and a deputy system to provide access to care when named nurse is off duty. • Development of an integrated end of life care plan to be used through patient's period of care. Care plan will provide a structure on which to build a plan of care to meet physical and physiological needs while upholding the patient's own wishes and values and those.	
Maintaining hydration	• Issues surrounding delivery of hydration are discussed within integrated end of life care plan and explored with patients on an individual basis. • Speech and Language therapists are involved to ensure options for oral hydration are fully understood and managed. • Mouth care is an identified competency for all community staff, registered and non-registered, and skills are part of education suite delivered to residential and nursing homes.	1 – working together 2 – eliminate discrimination 3 – provide knowledge and skills
Pharmacological interventions	• Liaison with GP through GSF meetings or joint visiting to review medication and involvement with patient regarding ceasing prescribed medicines that are not contributing to symptom control. • Medicines management training exists for all registered nurses with an enhancement for the use of syringe drivers, appropriate drug usage, dosage and contraindication. • Integrated bedside pack for syringe driver use is shared across secondary and community care • Agreed formulary is in place for all primary care prescribing • Community prescription chart is used across Great Yarmouth and Waveney to ensure safety and parity in prescribing practice	1 – working together 2 – eliminate discrimination, 3 – provide knowledge and skills 5 – GP co-ordination

Managing pain	• Agreed formulary received input from specialist palliative care lead regarding evidenced based pain management advice. • Advice on positioning and equipment to reduce pain and discomfort • Awareness of therapeutic benefit of talking therapy and expectation management in reducing pain.	1 – working together 2 – eliminate discrimination, 3 – provide knowledge and skills 5 – GP co-ordination
Managing nausea and vomiting	• Agreed formulary received input from specialist palliative care lead regarding evidenced based management of nausea and vomiting. • Advice regarding oral intake, type and amount of food or drink to minimise nausea and vomiting.	1 – working together 2 – eliminate discrimination 3 – provide knowledge and skills 5 – GP co-ordination
Managing anxiety, delirium and agitation	• Agreed formulary received input from specialist palliative care lead regarding evidenced based advice on pharmacological management of anxiety, delirium and agitation. • Environmental management to reduce anxiety and agitation • Dementia awareness training received by all ECCH Community nursing staff	1 – working together 2 – eliminate discrimination 3 – provide knowledge and skills 5 – GP co-ordination
Anticipatory prescribing	• Caseload management requires awareness of potential needs and anticipatory prescribing	1 – working together, 3 – provide knowledge and skills 5 – GP co-ordination

ECCH are embedding the recommendations from both the Nice guidelines and the CQC review as part of an integrated approach with commissioners, other providers, third sector organisations and patient groups.

healthwatch Norfolk

Research Report
'THINKING AHEAD'
ADVANCE CARE PLANNING

Presentation to
Health Overview and Scrutiny Committee

Norfolk County Council

September 2016

Sue Spooner

Why we did this research

- In Norfolk over 9,000 of us die each year
- There will be a surge in the older age groups in the next 10 years:
  - our 75-84 year olds are projected to increase by 32.9%
  - our 85+ will increase by 39.7%
- 1:4 of us will suffer from some form of dementia
- Many of us will be living alone
- Research for HOSC in 2005 '*How we Manage Death and Dying in Norfolk*' showed that we want to die at home, but only if well supported.
- We know Advance Care Planning helps us to achieve what we want.

What wanted to find out

- What are the barriers to Advance Care Planning?

- What are the prompts to encourage people to '*think ahead*' so we can provide better services

There is *Only One Chance to get it Right*

What is Advance Care Planning

- It can include legally binding documents, such as:
  - Lasting Power of Attorney for Property and Financial Affairs
  - Lasting Power of Attorney for Health and Welfare
  - Advance Decision to Refuse Treatment ('Living Will')
  - Do Not Attempt Cardio-Pulmonary Resuscitation (DNAR)

Or it can include simply recording your wishes:

Yellow Folder ‘Thinking Ahead’

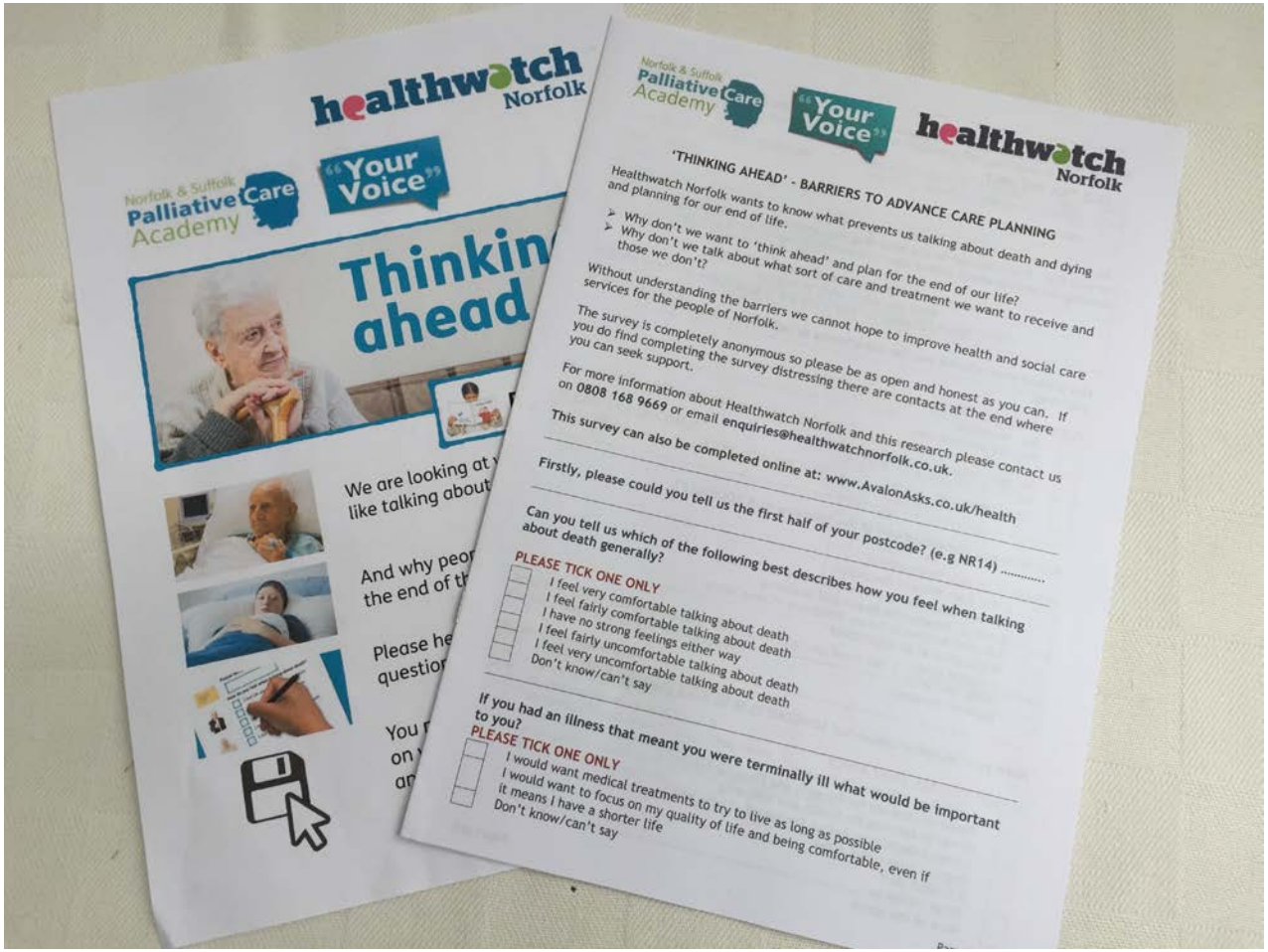
Joint NHS and Norfolk and Suffolk County Councils documentation

What we did

- Comprehensive Literature Review
- 37 indepth interviews
  - health and social care professionals
  - under-represented groups
- 15 focus group discussions with general public and under-represented groups
- Large scale survey across Norfolk

Survey of members of the public

1,613 responses



Who replied?

- More females (56%) than males(44%)
- Respondents tended to be in the older age group, (50% of respondents were aged 65 or over)
- Almost 400 (or 25%) of the respondents cared for a spouse/partner or another family member
- 3.5% of respondents from non-white British backgrounds (reflects the 2011 census of the population in the County)

What we found

- We say we are comfortable talking about death (74%) but we don't tell anyone our wishes (46% had told no-one)
- We want care to focus on quality of life and being comfortable, rather than prolonged medical treatment (72%)
- We have little knowledge of formal advance care planning
- Even when we do ACP for others, eg helping a relative into a care home or planning retirement, we do not want to think about ACP for ourselves.

- We say our two major prompts would be:
  - fear of losing capacity through dementia (62%)
  - diagnosis of a life-limiting illness (51%)
- 78% had a Will, but this is not a prompt to do more
  - Only 11% had a Power of Attorney for Health and Wellbeing
  - 5% had completed an Advance Decision to Refuse Treatment ('Living Will')
- We are more likely to do our own ACP if we have adult children with learning disabilities

- 44% don’t know if wishes will be respected
- 29% worry if they wrote down their wishes, doctors would stop treatment too soon
- We would like our GPs to approach the subject for us, and before we need to have the difficult conversation

We want ….

- …honesty from health and social care professionals and to be able to trust them
- …to be assured that our wishes are properly recorded in a way that medical and care staff have access to them
- …clear and timely information and an acknowledgement that carers are a valuable member of the health care team.

Recommendation

Raise public awareness of the benefit of advance care planning

- Norfolk County Council, Public Health

Recommendation

Ensure all workforce, including care home staff, have the knowledge, skills and support they need to communicate the benefits of ACP effectively – eg adopting a person-centred approach to ACP training

- Health Education East of England
- Norfolk and Suffolk Carer Support

Recommendation

Address inequalities in end of life care for BAME communities, people with disabilities and LGBT groups by monitoring access to end of life care services and outcomes for people from different groups

Local Clinical Commissioning Groups

Recommendation

Assure people that their wishes will be recorded and shared appropriately.

All local health and social care providers

Sustainability and Transformation Plans will need to show

- Significant increase in patient access to and use of the electronic health records.
- Measurable reduction in age standardised emergency admission rates and emergency inpatient bed-day rates.
- Significant measurable progress in health/social care integration, urgent and emergency care (single point of contact), and electronic health record sharing.
- Achieve accelerated implementation of health/social care integration, by sharing electronic health records and making measurable progress towards integrated assessment and provision.

www.healthwatchnorfolk.co.uk

www.bereadyforit.org.uk

Sue Spooner
suespooner51@btinternet.com

Forward work programme and nomination of a substitute link member with Norfolk and Suffolk NHS Foundation Trust

Report by Maureen Orr, Democratic Support and Scrutiny Team Manager

The Committee is asked to:-

(a) Nominate a substitute link member with Norfolk and Suffolk NHS Foundation Trust (NSFT)
(b) Consider the current forward work programme and suggest issues for future scrutiny.

1. Substitute link member with Norfolk and Suffolk NHS Foundation Trust

1.1 There is a vacancy for a substitute Norfolk Health Overview and Scrutiny Committee (NHOSC) link member with Norfolk and Suffolk NHS Foundation Trust (NSFT). Ms Sandra Bogelein previously served in this role.

1.2 Michael Chenery of Horsbrugh is the nominated NHOSC link member with NSFT. The role is to attend the Trust's meetings held in public to keep abreast of developments and highlight any issues which may require NHOSC's attention. The NHOSC link member has no formal position with the Trust.

2. Forward work programme

2.1 The current NHOSC forward work programme is attached at **Appendix A**.

3. Action

3.1 NHOSC is asked to:-

(a) Nominate a substitute link member with NSFT

(b) Consider the current forward work programme (Appendix A):-

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

	If you need this report in large print, audio, Braille, alternative format or in a different language please contact Customer Services on 0344 800 8020 or 0344 800 8011 (Textphone) and we will do our best to help.

Norfolk Health Overview and Scrutiny Committee

Proposed Forward Work Programme 2016 - 17

Meeting dates	*Briefings/Main scrutiny topic/initial review of topics/follow-ups*	*Administrative business*
13 Oct 2016	Community pharmacy – reports from NHS England Midlands and East (East) and Norfolk Local Pharmaceutical Committee on forthcoming changes to local pharmacy services. Ambulance response times and turnaround times in Norfolk – an update from East of England Ambulance Service NHS Trust, Norfolk and Norwich University Hospitals NHS Foundation Trust and North Norfolk CCG (follow up to the reports in October 2015) Stroke Services in Norfolk – an update on progress with the 2014 NHOSC recommendations and the outcome of the Review of Stroke Rehabilitation in the Community, November 2015	
8 Dec 2016	*Supported Care, North Norfolk and Rural Broadland – consultation by North Norfolk CCG*	*Provisional – depending on agreement by NHOSC and progress of the CCG's review.*
12 Jan 2017		

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

Provisional dates for report to the Committee / items in the Briefing in 2017

23 Feb 2017 – Continuing healthcare in Norfolk – an update on the implementation and evaluation of the new policy introduced by North Norfolk, South Norfolk, Norwich and West Norfolk CCGs (following on from the report to NHOSC on 25 February 2016)

6 April 2017 – Children's mental health services in Norfolk – scrutiny of the service after a full year of operation following the Local Transformation Plan changes.

6 April 2017 – IC24's NHS 111 and GP Out of Hours Service in Central and West Norfolk – an update from IC24 and Norwich CCG (further to the meeting on 14 April 2016)

Members serving on Task & Finish Groups

Task & finish group	**Membership**	**Progress**
Children's Services Committee Task & Finish Group Review Review of access to support and interventions for children's emotional wellbeing and mental health	**From NHOSC** Mrs M Stone	The T&F group has met three times with the last meeting on 20 July 2016. Due to reconvene in Sept. The group expects to report to CS committee in January 2017.

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

Clinical Commissioning Groups

North Norfolk	-	M Chenery of Horsbrugh (substitute Mr David Harrison)
South Norfolk	-	Dr N Legg (substitute Mrs M Stone)
Gt Yarmouth and Waveney	-	Mrs M Stone (substitute Mrs M Fairhead)
West Norfolk	-	M Chenery of Horsbrugh (substitute Mrs S Young)
Norwich	-	Mrs M Stone (substitute Ms E Corlett)

NHS Provider Trusts

Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust	-	M Chenery of Horsbrugh (substitute Mrs S Young)
Norfolk and Suffolk NHS Foundation Trust (mental health trust)	-	M Chenery of Horsbrugh (substitute *Vacancy)*
Norfolk and Norwich University Hospitals NHS Foundation Trust	-	Dr N Legg (substitute Mrs M Stone)

James Paget University Hospitals NHS Foundation Trust	-	Mr C Aldred (substitute Mrs M Stone
Norfolk Community Health and Care NHS Trust	-	Mrs J Chamberlin (substitute Mrs M Stone)

Glossary of Terms and Abbreviations

ACP	Advance care planning
ADHD	Attention deficit hyperactivity disorder
A&E	Accident and emergency
BAAF	British Association for Adoption and Fostering
BAME	Black, Asian and minority ethnic
BMJ	British Medical Journal
CAMHS	Child And Adolescent Mental Health Services
CAPE	The Caring and Patient Experience Sub Board
CCG	Clinical commissioning group
CNS	Cancer Nurse Specialist
CPA	Care Programme Approach
CQC	Care Quality Commission
CQUINN	Commissioning for Quality and Innovation
CRHT	Crisis Resolution Home Treatment
CSC	Children's Services Committee
CYP	Children and young people
DCLG	Department For Communities And Local Government
DCO	Directors of Commissioning Operations
DfE	Department for Education
DICES	The DICES risk assessment and management system is a training course accredited by the Association for Psychological Therapies
DNA-CPR	Do not attempt cardiopulmonary resuscitation
ED	Eating disorder
eELCA	An e-learning programme for end of life care
EMPA	Electronic Prescribing and Medicines Administration
EoL	End of life
EPaCCS	Electronic Palliative Care Coordinations Systems
ESR	Electronic staff record
FOI	Freedom of Information
GMC	General Medical Council
GORs	Government Office Regions
GP	General Practitioner
GSF	Gold Standard Framework – a model that enables good practice to be available to all people nearing the end of their lives, irrespective of diagnosis. It provides a framework for a planned system of care in consultation with the patient and family. It promotes better coordination and collaboration between healthcare professionals and helps to optimise out-of-hours care to prevent crises and inappropriate hospital admissions

GYWCCG	Great Yarmouth and Waveney Clinical Commissioning Group
HA	Health assessment
HCP	Health care professional
HES	Hospital Episode Statistics
HMP	Her Majesty's Prison
HOSC (OSC)	Health Overview And Scrutiny Committee
HPFT	Hertfordshire Partnership University NHS Foundation Trust
HQ	Head quarters
HQIP	Healthcare Quality Improvement Partnership
HSCIC	Health & Social Care Information Centre
IAPT	Improving Access To Psychological Therapies
IHA	Initial health assessment
IIM	Incident information management
IMCA	Independent Mental Capacity Advocate
IMD	Indicies of multiple deprivation
IRC	Immigration removal centre
IST	Intensive support team
KPI	Key Performance Indicator
KPMG	A global network of professional service firms providing audit, tax and advisory services
LAC	Looked After Children
LCP	Liverpool Care Pathway
LD	Learning Difficulties / Disability
LGBT	Lesbian, gay, bisexual, transgender
Lorenzo	An electronic patient record management system used by Norfolk & Suffolk NHS Foundation Trust
LSOAs	Loser Super Output Areas
LTP	Local Transformation Plan
MAP	Mancroft Advice Project – a charity providing advisers, counsellors and youth workers from centres in Norwich and Great Yarmouth and working in schools, health centres, youth centres etc. around Norfolk and Suffolk
Matthew Project	A charity based in Norfolk and Suffolk working with adults, young people and communities affected by drugs and alcohol. Providing professional advice, information, support, counselling, support, care and education.
MDT	Multi disciplinary team
MH	Mental Health
MHMDS	Mental health minimum dataset
MHT	Mental health trust
NCH&C (NCHC)	Norfolk Community Health and Care NHS Trust
NCPC	National Council for Palliative Care
NHOSC	Norfolk Health Overview and Scrutiny Committee
NHSE	NHS England

NIAP	Norfolk Infant Attachment Project
NICE	National Institute for Health and Care Excellence
NMC	Nursing & Midwifery Council
NNUH	Norfolk and Norwich University Hospitals NHS Foundation Trust
NPSA	National Patient Safety Agency
NRLS	National Reporting and Learning System
NRP	Norfolk recovery partnership
NSFT	Norfolk and Suffolk NHS Foundation Trust (the mental health trust)
ONS	Office of National Statistics
OOH	Out of hours
OPM	Older people's medicine
PBL	Priscilla Bacon Lodge
PHE	Public Health England
Point 1	A consortium of 3 organisations – Ormiston Families (the consortium's lead agency), Mancroft Advice Project (MAP) and Norfolk and Suffolk Foundation Trust (NSFT) providing Norfolk's county wide targeted mental health service (2015)
PPoD	Preferred place of death
QGC	Quality governance committee
QOF	Quality outcomes framework
RAP	Referrals assessments and packages of care
RCA	Root cause analysis
RCRR	National retrospective case record review
RHA	Review health assessments
SAGE & THYME	A three hour workshop that teaches people how to use a structured approach to getting into and out of a conversation with someone who is upset or has concerns, whilst providing basic psychological support.
SDQ	Strengths and difficulties questionnaire
SGC	Service Governance Committee
SI	Serious incident
SMART	Specific, measurable, achievable, realistic, time-bound
SOB	Survivors of bereavement
SPC	Specialist palliative care
SPCT	Specialist palliative care team
SpRs	Specialist Registrars
STAR-Pus	Specific therapeutic group age-gender weightings-related prescribing units
StEIS	Strategic Executive Information System
SUI	Serious Untoward Incident
ToR	Terms of reference
TSS	Trust Service Strategy (Norfolk and Suffolk NHS Foundation Trust's Service Strategy 2012-16)

UEA	University of East Anglia
WNCCG	West Norfolk Clinical Commissioning Group
WTE	Whole time equivalent
YOI	Youth offenders institute