Norfolk County Council

Norfolk Health Overview and Scrutiny Committee

Date: **Thursday, 06 December 2018**

Time: **10:00**

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

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

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

Membership

Main Member	Substitute Member	Representing
Mr D Fullman	Mr M Fulton-McAlister	Norwich City Council
Michael Chenery of Horsbrugh	Mr S Eyre/Ms C Bowes	Norfolk County Council
Ms E Corlett	Miss K Clipsham/Mr M Smith-Clare	Norfolk County Council
Mr F Eagle	Mr S Eyre/Ms C Bowes	Norfolk County Council
Ms E Flaxman-Taylor	Mr G Carpenter	Great Yarmouth Borough Council
Mrs S Fraser	Mr T Smith	Borough Council of King's Lynn and West Norfolk
Mr G Middleton	Mr S Eyre/Ms C Bowes	Norfolk County Council
Mr D Harrison	Mr T Adams	Norfolk County Council
Mr F O'Neill	Mr R Foulger	Broadland District Council
Mrs B Jones	Miss K Clipsham/Mr M Smith-Clare	Norfolk County Council
Dr N Legg	Mr C Foulger	South Norfolk District Council
Mr R Price	Mr S Eyre/Ms C Bowes	Norfolk County Council
Mr P Wilkinson	Mr R Richmond	Breckland District Council
Mrs A Claussen-Reynolds	Mr M Knowles	North Norfolk District Council
Mrs S Young	Mr S Eyre/Mrs C Bowes	Norfolk County Council

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

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

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A g e n d a

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

2 **NHOSC minutes of 18 October 2018** **Page 5**

3 **Declarations of Interest**

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

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

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

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

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

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

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

4 **Any items of business the Chairman decides should be considered as a matter of urgency**

5 **Chairman's Announcements**

6 **10.10 - 11.10** **Continuing healthcare** **Page 12**

Examination of the management of continuing

healthcare in Norfolk.

Appendix A (page 25) - Norfolk Continuing Care Partnership report (central and west Norfolk)

Appendix B (page 44) - Great Yarmouth and Waveney CCG report

Appendix C (page 55) - Healthwatch Norfolk report

	11.10 - 11.20	**Break at the Chairman's Discretion**	**Page**
7	**11.20 - 12.00**	**Norfok and Norwich University Hospitals NHS Foundation Trust - response to the Care Quality Commission report**	**Page 61**

Appendix A (page 67) - Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH) report

Appendix B (page 77) - NNUH presentation

8	**12.20 -12.30**	**Forward work programme**	**Page 96**

To agree the committee's forward work programme

Glossary of terms and abbreviations **Page 99**

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Date Agenda Published: 28 November 2018

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Norfolk County Council

NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE
MINUTES OF THE MEETING HELD AT COUNTY HALL, NORWICH
on 18 October 2018

Present:

Michael Chenery of Horsbrugh (Chairman)	Norfolk County Council
Mrs A Claussen-Reynolds	North Norfolk District Council
Ms E Corlett	Norfolk County Council
Mr F Eagle	Norfolk County Council
Mr D Fullman	Norwich City Council
Mrs S Fraser	Borough Council of King's Lynn and West Norfolk
Mr D Harrison	Norfolk County Council
Mr F O'Neill	Broadland District Council
Mrs B Jones	Norfolk County Council
Mr G Middleton	Norfolk County Council
Mr R Price	Norfolk County Council
Mrs S Young	Norfolk County Council

Also Present:

Melanie Craig	Senior Responsible Officer for Palliative and End Life Care Transformation, Norfolk & Waveney STP (& Interim Executive Lead for the STP)
Pam Fenner	Clinical Advisor Palliative and End of Life Care; Chair Norfolk and Waveney Palliative Care Collaborative; NHS Norwich CCG
Becky Cooper	Head of Palliative Care, Norfolk Community Health and Care NHS Trust
Alex Stewart	Healthwatch Norfolk
Krishan Pahwa	Information Analyst, Healthwatch Norfolk
Jenny Beesley	Member of the public (& Chairman of East Coast Hospice Ltd)
Patrick Thompson	Member of the public
Robert May	Member of the public
Sue Vaughan	Member of the public
Jane Shuttles	Member of the public
Grainne Murray	Social Worker, NNUH/NCC
Anna Morgan	Norfolk Community Health and Care NHS Trust
Maureen Orr	Democratic Support and Scrutiny Team Manager
Chris Walton	Head of Democratic Services
Tim Shaw	Committee Officer

1 Apologies for Absence

1.1 Apologies for absence were received from Ms E Flaxman-Taylor, Dr N Legg and Mr P Wilkinson.

2. Minutes

2.1 The minutes of the previous meeting held on 6 September 2018 were confirmed by the Committee and signed by the Chairman.

3. Declarations of Interest

3.1 There were no declarations of interest.

4. Urgent Business

4.1 There were no items of urgent business.

5. Chairman's Announcements

5.1 There were no Chairman's announcements.

6 Access to Palliative and End of Life Care

6.1 The Committee received a suggested approach by Maureen Orr, Democratic Support and Scrutiny Team Manager, to a report from NHS commissioner and provider partners within Norfolk and Waveney Sustainability Transformation Partnership (STP) about the levels of specialist and generalist palliative and end of life care commissioned and provided for adults in Norfolk in comparison with guidance on the levels of care required. The Committee also received a PowerPoint presentation from the NHS speakers on this subject.

6.2 The Committee received evidence from Melanie Craig, Interim Executive Lead for the Norfolk and Waveney STP, Pam Fenner, Clinical Advisor Palliative and End of Life Care, Chair Norfolk and Waveney Palliative Care Collaborative, NHS Norwich CCG and Becky Cooper, Head of Palliative Care, Norfolk Community Health and Care NHS Trust.

6.3 The Committee also heard from Jenny Beesley, member of the public (& Chairman of East Coast Hospice Ltd), Patrick Thompson, member of the public, Sue Vaughan, member of the public and Robert May, member of the public.

6.4 In introducing and welcoming the speakers from the NHS, the Chairman said that they were invited to today's meeting as partners within the Norfolk and Waveney Sustainability Transformation Partnership (STP) to discuss access to palliative and end-of-life care.

6.5 In their introductory remarks, and during the PowerPoint presentation (which can be found at page 59 of the agenda), the speakers referred to the following key challenges facing the Commissioners and Providers of palliative and end-of-life care:

- The outcome of a review of system wide complains.
- Recent developments.
- A patient case study.
- STP collaborative workstreams, including a review of relevant documentation across the STP such as yellow folders.

- Current challenges and next steps including workforce recruitment across the system.
- The speakers were currently working on a *Norfolk and Waveney STP Ambitions for Palliative and End of Life Care Delivery Plan 2017 – 2020* which would be circulated to members when it became available. The outcomes from today's discussions would be addressed as part of that plan, and the plan would include a delivery programme for when action should be taken.
- The speakers said that Great Yarmouth and Waveney CCG was in the final submission phase of a procurement process for NHS community services that would include end-of-life care. Because of the risk of legal challenge, the speakers were unable to discuss the procurement process any further than was set out in the presentation. The procurement process was expected to end by the middle of December 2018 and the service to be in place by April 2019.

6.6 The Chairman then invited to the microphone those members of the public who had indicated their willingness to speak in the meeting.

- Jenny Beesley, Member of the public (and Chairman of East Coast Hospice Ltd), said that more should be done to address issues of patient choice. She said that this was an issue of significant concern to many patients and she was willing to work closely with the speakers to help provide a wider choice of end-of-life care in the Great Yarmouth and Waveney area.
- Dr Patrick Thompson PhD, a member of the public, also spoke about the importance of giving people a real choice of where they could die and said that this issue should be addressed by the STP. In addition, he said that the commissioners should look to do more to address the problem of poor quality care because of ethnic background, sexual orientation, gender identity, disability or social circumstances such as homelessness.
- Sue Vaughan, a member of the public, said that she was a retired GP and wanted to know what the practical effect would be for patients of the NHS moving to a more integrated care system. In reply, the speakers said that the new approach was already helping to link provider specialist groups closer together and providing for a more flexible approach within local neighbourhood areas.
- Robert May, a member of the public, said that his wife has a terminal condition which meant that she is bed bound. She had been assessed as having a 70pc chance of having a heart attack but had not been assessed as having a condition which was 'severe' enough to receive continuing healthcare funding. He added that adults with limited funds and no continuing health care funding found it very difficult to get the right kind of palliative care in the community, especially when this was needed 24/7. The Chief Officer, Great Yarmouth and Waveney CCG, undertook to speak with Mr R May, about specific medical issues which affected his wife's care.

6.7 The Chairman then asked that Members question the speakers within the following subject headings by allowing the whole Committee to ask questions relevant to each heading before moving on to the next heading:

- Strategic and systemic issues
- Specialist palliative care
- Hospice provision
- Generalist palliative care and end of life care
- Equity of service
- Learning from families

6.8 Strategic and systemic issues

The following key points were noted:

- The speakers said that there were some 10,500 deaths in a year in the Norfolk and Waveney area and approximately three-quarters of these were of people who had a palliative/ end-of-life care need.
- To meet NICE guidelines steps were being taken to address issues of variation in service provision, however, there remained at present an unequal provision of hospice and specialist palliative care in-patient facilities across the county and no beds available in the Great Yarmouth and Waveney area.
- The configuration of palliative and end of life care varied significantly from locality to locality. Priscilla Bacon Lodge in Norwich provided 16 specialist NHS in-patient beds for those patients who required focused care. Tapping House, in King's Lynn, provided up to seven NHS beds and NHS beds were also available at St Elizabeth Hospice and St Nicholas Hospice in Suffolk, and in acute hospitals for patients who needed end of life care under the supervision of clinicians.
- In all areas, apart from Great Yarmouth and Waveney, a hospice at home team was in place, offering the care of a hospice but in the community.
- In reply to questions, the speakers said that they recognised that access to end-of-life care outside of normal working hours was a strategic issue of significant concern. People with complex needs, such as cancer, depended heavily on out of hours services to provide advice, treatment and support to manage medical, emotional and practical problems as they emerged.
- The latest procurement process for NHS community services recognised that the needs of those at the end of life and their families and carers could not be met in a standard 9–5 model of service delivery.
- A night-time service was available in the King's Lynn area after 6 pm based on a virtual ward.
- In the central area there were usually 3 night-time nurses on duty.

6.9 Specialist Palliative Care

The following key points were noted:

- A specialist palliative care 24/7 advice line was in place in central and west Norfolk and included in the NHS community services contract for Great Yarmouth and Waveney.
- The speakers assured the Committee that specialist palliative and end-of-life care was provided by multi-disciplinary teams and that members of these teams had undergone recognised specialist palliative care training. The aim of this training included providing patients with physical, psychological, social and spiritual support.
- The speakers said that specialist palliative teams acted as major sources of advice, support and education to others involved in providing care across the NHS, social care and the voluntary sector.
- A specialist service was available to prisoners at Norwich prison and Priscilla Bacon Lodge in Norwich was used on occasions for this purpose.

6.10 Hospice provision

The following key points were noted:

- Members suggested that the shortage of hospice provision was a sign of a lack of patient choice and that aspirant hospices should be fully supported in their attempts to get started.
- In reply, the speakers said that while they were willing to do all that they could to help hospices; hospices should be supported within the context of the NHS and partner organisations putting in place a more integrated community care model and not only for reasons of widening patient choice.
- The speakers said that at a time of increasing pressures on NHS spending, NHS end-of-life care did not necessarily have to be provided in a traditional hospice and going forward might potentially be provided in a more cost-effective way in private care homes or by providing a wider range of hospice care at home, and by other services that provided end-of-life care.
- Members were of the view that it would be helpful for them to see for themselves a range of the palliative and end-of-life services that were available.

6.11 Generalist palliative care and end of life care

- Members said that regardless of where end-of-life care was provided, ensuring staff had appropriate support and training was critical for high-quality care to be consistently delivered.
- In reply to questions about the Marie Curie Delivering Choice Programme, the speakers said that Marie Curie Cancer Care was a charitable organization in the United Kingdom which provided generalist nursing care free of charge to patients and their families. The charity was best known for its network of Marie Curie Nurses who worked in the community to provide end-of-life care for patients with cancer and other life limiting illnesses in their own homes.
- The speakers said that they planned to work more closely with Marie Curie Cancer Care and other partners in the public and voluntary sectors to put in place *a* five-year plan for health and social care.
- Members identified the following issues of importance to the patient:
    - 24/7 access to and availability of community nursing and appropriate drugs and equipment;
    - Quick responses to requests for help with out-of- hours support;
    - Appropriate advice, information and support to patients about their general condition, their medication and future needs; and
    - Knowledge by NHS professionals of the patient's preferred place of care and death.
    - Those identified as important to the dying person should be involved in decisions about treatment and care to the extent that the dying person wanted this to happen.

- As well as choice over their place of care and death, people close to death wanted real choices over other aspects, such as pain control and involvement of family and others close to them.
- It was pointed out that good service provision could help patients stay in their preferred setting, while reducing the strain on overstretched emergency departments and NHS budgets.
- The speakers said that patients with palliative care needs were sometimes admitted to hospital inappropriately when their condition deteriorated.
- The speakers said that end-of-life care teams had a long tradition of delivering services both in acute hospitals and community settings, so they were used to the concept of integrated care and "bridging the gap" and influencing care in both environments.

- Members said that to better understand the progress that was being made in the Norfolk and Waveney area they needed to see a “gap analysis” of current provision compared to the national framework and the STP Delivery Plan.

6.12 Equity of service

- The speakers said that quality palliative and end-of-life care was realised when strong networks existed between palliative care providers, generalist health and social care providers in local communities.
- The speakers said that for this to happen it was essential that there was equity of service provision: a single care specification and single mechanism used for the delivery of quality palliative and end-of-life care throughout the whole of the Norfolk and Waveney area.
- The speakers were aware that they needed to ensure health and social care professionals received the kind of training and support to have the right types of conversations with their patients about their wishes towards the end of their lives, including their preferred place of care and where they wished to die.

6.13 Learning from families

- Members said that in many cases the problems patients and their families experienced in the dying phase of life were longstanding and/or predictable, and the more complex of these needs could have benefited from interventions from access to end-of-life care professionals at an earlier stage.
- Members said that for those approaching the end of their lives, it was vital that they received information about their condition and care in a language that they understood. It was essential for this to be communicated with honesty and sensitivity by professionals who had the expertise to do so.
- Families wanted to see dignity and respect for culture, lifestyles and beliefs of other family members in end of life situations. This was seen by members to be fundamental in achieving high-quality palliative and end-of-life care.

6.14 The Committee agreed:

To note tha*t Norfolk and Waveney (N&W) STP Ambitions for Palliative and End of Life Care Delivery Plan 2017 – 2020* was expected to be made available to Members by December 2018.

That Members should receive the gap analysis for what needed to be done in Norfolk and Waveney to meet the requirements of the *Ambitions for Palliative and End of Life Care: a national framework for local action 2017-2020*.

To ask the Norfolk and Waveney STP representatives to provide written answers to questions in Section 4 of the covering report that were not addressed during the meeting.

Members should be invited to visit existing Palliative and End of Life Care services to get a better understanding of the issues, including hospices, hospice at home, and other services that provided end-of-life care.

To revisit the subject at a future meeting when Members had received the gap analysis against the national framework and the N&W STP Delivery Plan, and when Great Yarmouth and Waveney CCGs’ procurement of NHS community service (including end of life care) was complete.
Issues for that meeting would include (not exclusively):

- **Night time service**
- **Consistency of services**
- **Advocacy for families**
- **Choice of place of care**
- **Input from Norwich Consolidated Charities.**

7 Forward Work Programme

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

7.2 The Committee agreed the Forward Work Programme with the following additions:

For the agenda on 17 January 2019:

- **The Queen Elizabeth Hospital NHS Foundation Trust – action in response to Care Quality Commission report.**
- **Norfolk and Suffolk NHS Foundation Trust – action in response to the Care Quality Commission report**

For the agenda on 28 February 2019:

- **Children's Speech and Language Therapy - to follow up on the action plan from the independent review of the central and west Norfolk service and to address with issues raised during Members visit with the SENsational Families Group.**
- **Notes from the Members visit with SENsational Families Group at Harford Community Centre on 20 September 2018 to be circulated to Members of NHOSC.**

For the agenda on 11 April 2019:

- **Access to NHS dentistry in Norfolk – follow up to the report to NHOSC on 24 May 2018 on access in West Norfolk, and examination of the situation in the rest of Norfolk.**

Chairman

The meeting concluded at 1.10 pm

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Continuing Healthcare

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

A report on the management of NHS continuing healthcare by Norfolk Continuing Care Partnership for the four Clinical Commissioning Groups (CCGs) in central and west Norfolk and by Great Yarmouth and Waveney CCG for its area.

1. Purpose of today's meeting

1.1 The focus areas for today's meeting are:-

(a) An update on the management of continuing healthcare (CHC) in Norfolk.

(b) Norfolk Continuing Care Partnership's (NCCP) progress on issues previously raised by Norfolk Health Overview and Scrutiny Committee. (These related only to the service in the central and west Norfolk area).

(c) Examination of how local systems are changing to take account of the *Revised National Framework for NHS Continuing Healthcare and NHS-Funded Nursing Care, October 2018.*

(d) Examination of how the fast track CHC system operates in Norfolk.

1.2 NCCP and Great Yarmouth & Waveney CCG have been asked to provide the following information for the areas they cover:-

- General contextual information:-
    - Numbers currently receiving CHC (residential and domiciliary).
    - Trend in the numbers of patients eligible to receive CHC in the past 12 months.
    - Compliance against the 28 day assessment target in the past year (showing the trend month by month).
    - Numbers of complaints & themes since Feb 2018.
    - Capacity of the assessment service (caseload numbers and staff capacity, including info on staff vacancy levels).
    - Numbers of people that have had their CHC or Funded Nursing Care withdrawn since NCCP have been completing

the reviews and the numbers where exceptional decisions have been made to continue funding despite no longer being eligible.

- Information about the Discharge to Assess pathways at each of the three acute hospitals in Norfolk (NCCP to provide info for the N&N and QEH; GY&W CCG for the JPH), including:-

  - Description of the pathway at each of the 3 hospitals
  - Numbers accessing the pathway at each hospital
  - Numbers assessed and declined at each hospital
  - Numbers converted to eligible / not eligible for CHC after the Discharge to Assess pathway period.
  - Number of beds used for Discharge to Assess in relation to each of the three hospital areas.

- Fast track:-

  - The number of fast track awards year by year for the past 5 years.
  - The average duration of Fast Track award funding.
  - The proportion of fast track patients placed within 3 days of referral
  - Numbers of fast track patients that plateau and require ongoing care and who this is provided by.

- A breakdown of CHC and fast track considerations and eligibility by CCG area and compared to national benchmarking.

- Numbers of CHC checklists completed.

- Numbers of shared care agreements between CCG and Norfolk County Council, broken down by Older People, Physical Disabilities, Learning Disabilities and Mental Health as a primary category.

- Numbers of reviews of individual CHC packages of care completed in 2018 (i.e. to check the suitability of the CHC package in place, not primarily to re-assess eligibility).

- Changes in the local system to reflect the revised *National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care, October 2018*.

- Update on issues previously raised by NHOSC (**for NCCP only**)

  - Outcome of NCCP's work with Healthwatch Norfolk to improve communication with patients / families

  - Whether it has been possible to introduce real-time feedback from service users

NCCP's report for the central and west Norfolk area is attached at **Appendix A**.

Great Yarmouth and Waveney (GY&W) CCG's report for its area is attached at **Appendix B**.

Representatives from NCCP, GY&W CCG and Norwich CCG (representing central & west Norfolk) will attend NHOSC to answer Members' questions.

1.3 Healthwatch Norfolk has been working with NCCP to improve NHS continuing healthcare communication with patients and families in the central and west Norfolk area. A paper outlining this work is attached at **Appendix C**. A representative from Healthwatch will attend to present the paper and answer any questions that may arise.

2. Background

2.1 The continuing healthcare assessment process

2.1.1 Patients who are assessed as being eligible for continuing healthcare receive healthcare funded by the NHS (i.e. free at the point of use) on an ongoing basis, dependent on subsequent eligibility reviews.

The National Audit Office (NAO) report '*Investigation into NHS continuing healthcare funding*', published on 5 July 2017, included a diagram that clearly and simply illustrated the CHC assessment process (see Diagram 1 overleaf - the numbers shown are for the whole of England in 2015-16).

The full NAO report, which covered issues including the length of the assessment process, access to funding, the cost, variation in access to CHC funding and oversight and monitoring of access, is available on their website:-

https://www.nao.org.uk/wp-content/uploads/2017/07/Investigation-into-NHS-continuing-healthcare-funding-1.pdf

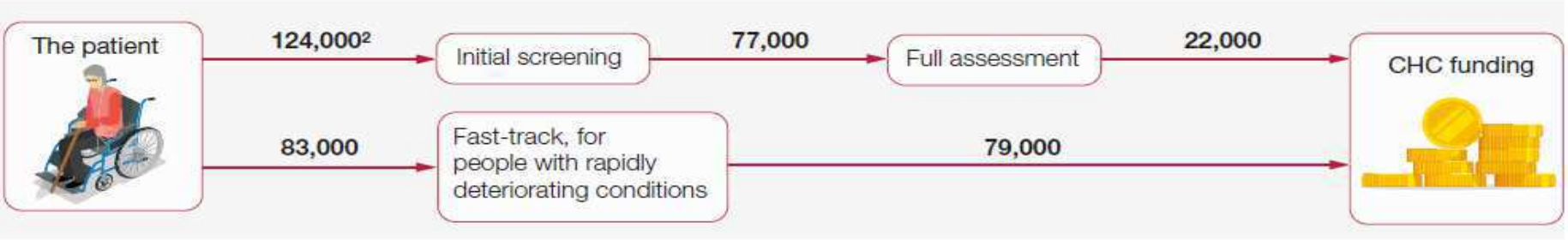
The NAO investigation found that in 2015-16 there was significant variation between CCGs in eligibility for CHC funding that could not be fully explained by the demographics of the population:-

- The number of people that received, or were assessed as eligible for, funding ranged from 28 to 356 people per 50,000 population in different CCG areas.
- The estimated proportion of people that were referred for fast track, or who were identified as needing a full assessment, and subsequently assessed as eligible ranged from 41% to 86%, excluding the 5% of CCGs with the lowest and highest percentages.

Diagram 1 – CHC process, England, 2015-16

The CHC process

For most people the assessment process for CHC funding involves two stages



NHS England recognises that the current assessment process raises people's expectations about whether they will receive funding and does not make best use of assessment staff

Notes

1 All numbers and percentages are for 2015-16 unless stated otherwise. Numbers for the CHC process are rounded to the nearest 1,000.

2 These figures are estimates.

Source: National Audit Office

2.2 The Discharge to Assess (D2A) process

2.2.1 Since 2016 NHS England (NHSE) has encouraged the establishment of Discharge to Assess pathways. In 2017-18 and 2018-19 there have been financial incentives for CCGs to carry out 85% of CHC assessments outside hospital[1].

Discharge to Assess is defined in the Quick Guide on NHSE's website as follows:-

'Where people who are clinically optimised[2] and do not require an acute hospital bed, but may still require care services are provided with short term, funded support to be discharged to their own home (where appropriate) or another community setting. Assessment for longer-term care and support needs is then undertaken in the most appropriate setting and at the right time for the person.

People on the D2A pathway are NHS funded, i.e. care is free to the patient) until:-

(a) they are assessed as eligible for NHS CHC, i.e. care continues in the longer-term, funded by the NHS and free to the patient
(b) or not eligible for NHS CHC, i.e. care continues but is self-funded by the patient or paid for by social care on a limited means tested basis.

The Quick Guide to D2A is available through the following link:-
https://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-discharge-to-access.pdf

2.2.2 The Quick Guide does not specify how a decision on who is eligible for the D2A pathway should be made but it is clearly an important decision, which may affect the longer-term future for the patient and their family.

Each of the three acute hospitals in Norfolk have introduced their own version of a Discharge to Assess pathway and have their own systems for deciding eligibility based on questions about the patient's condition. The decisions are made by both health and social care staff at the hospitals.

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[1] Source - the National Audit Office (NAO) report '*Investigation into NHS continuing healthcare funding*', 5 July 2017. The financial incentive is awarded through the quality premium programme, which rewards CCGs for improvements to the quality of the services that they commission.

[2] Clinically optimised is described as the point at which care and assessment can safely be continued in a non-acute setting. This is also known as 'medically fit for discharge' 'medically optimised.' NHS England (2015).
https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2015/10/mnth-Sitreps-def-dtoc-v1.09.pdf

The reports at Appendix A and B set out the details of the three D2A pathways.

2.3 **Management of CHC in Norfolk**

2.3.1 On 1 November 2017 Norwich, North Norfolk, South Norfolk and West Norfolk CCGs established an in-house partnership, Norfolk Continuing Care Partnership (NCCP), to manage CHC in their areas. Great Yarmouth and Waveney CCG was not part of that arrangement and manages CHC in its own area in-house.

2.3.2 NCCP is hosted by Norwich CCG, which has established an Operational Management Group to oversee its operational activities.

2.3.3 The governance structure for NCCP includes a Strategic Board with director level membership from all five CCGs and Norfolk County Council.

2.4 **Local efficiency savings in NHS CHC**

2.4.1 During the period of financial constraint which has affected all public services in the past decade, the NHS has operated a 'Quality, Innovation, Productivity and Prevention (QIPP)' challenge. This involves setting QIPP targets for savings to be delivered via specific improvements in service or ways of working.

2.4.2 According to figures published in reports to their Governing Bodies, the five local CCGs were planning for QIPP or efficiency savings of approximately £3.7m in in continuing care in 2018-19. The overall budget for the continuing care service across the five is approximately £65.2m. The latest report to the Governing Bodies show that up to October 2018 they have achieved more savings than expected (off-set against some other areas of activity where savings are not being realised at the expected level).

2.5 **Previous reports to NHOSC**

2.5.1 On 28 May 2015 NHOSC received a presentation about proposed changes to CHC local implementation policy in the Norwich, North Norfolk, South Norfolk and West Norfolk CCG areas. At that stage North East London Commissioning Support Unit (CSU) was managing delivery of CHC.

2.5.2 The four CCGs emphasised that they were not proposing and had not made any changes to the National Framework for NHS Continuing Healthcare, which is set at national level and not within the power of local CCGs to change. The National Framework defines, for example:-

- How screening is undertaken to identify people who may be suitable for an assessment of eligibility for NHS CHC –"the Checklist"

- Processes for the assessment of eligibility undertaken through the completion of “the Decision Support Tool”
- Reviews of patients to ensure care continues to meet changing needs and that eligibility is reassessed as appropriate
- How interfaces with joint funding arrangements should be applied.

The four CCGs’ proposals were aimed at achieving an open and transparent approach to delivering NHS CHC with fairness and equity across their area and comprehensive, helpful documents for the patients and public explaining everything there was to know about NHS CHC in central and west Norfolk.

2.5.3 NHOSC was interested in the outcome of the new policy and processes in terms of its impact on patients and the local health and social care system. The committee received update reports from the four CCGs and the CSU on 25 February 2016 and 23 February 2017.

In February 2017 NHOSC made five recommendations to the four CCGs concerning:-

- communication with patients and families regarding the CHC process (including advocacy for those who need it)
- proactive quality monitoring of CHC
- widely accessible surveying of patients & families experience of CHC
- partnership working with relevant agencies to ensure planning for an effective safety-net service for CHC patients on occasions when their usual provider is unable to deliver
- speeding up the process between referral and assessment for CHC eligibility to meet the 28 day standard.

The Healthwatch Norfolk paper at Appendix C shows good progress by NCCP on the communication, quality monitoring and surveying points.

2.5.4 The last report to NHOSC was on 22 February 2018 by which stage NCCP had taken over day-to-day management of CHC from North East London CSU (with a ‘lift and shift’ of staff from the CSU). The report included details of the CCGs’ & NCCP’s responses to the committee’s Feb 2017 recommendations, an update on progress and details of the strategic priorities and development phases for NCCP’s management of the CHC service. The report is available on the County Council website via the following link:-
NHOSC 22 Feb 2018 Continuing Healthcare (see Reports, 7 App B)

2.5.5 On 18 October 2018 NHOSC received a report on ‘Access to palliative and end of life care in Norfolk’ which touched on the CHC fast track process in relation to patients approaching the end of their life. It was noted that the *National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care* says that ‘*Individuals with a rapidly deteriorating condition that may be entering a terminal phase may*

require 'fast tracking' for immediate provision of NHS continuing healthcare' (page 63, paragraph 217*)*.

However, the terms 'rapidly deteriorating' and 'terminal phase' were open to interpretation. A patient with a prognosis of six weeks to live, but who was currently stable and not presently 'rapidly deteriorating' could be considered ineligible for a fast-track decision on NHS continuing healthcare. Such a patient could be discharged to a nursing home on a social care or self-funded basis with the understanding that a fast-track assessment for NHS continuing healthcare could happen when the patient was 'rapidly deteriorating' and 'entering a terminal phase'. In practice such assessments rarely happened.

The committee received Graph 1[3] below, which showed that significantly fewer people per 50,000 population are assessed as eligible for fast track continuing healthcare in Norfolk than is the case in England as a whole, or in the NHS England Midlands and East (East) region.

Graph 1 – Eligibility for Fast Track CHC in Norfolk

NHOSC Members asked for further information about the management of fast track CHC across the whole county.

2.6 **The national framework**

2.6.1 A revised *National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care* was introduced in October 2018 and is available via the following link:- https://www.events.england.nhs.uk/upload/entity/30215/national-framework-for-chc-and-fnc-october-2018-revised.pdf

[3] Graph 1 is based on data extracted from NHS England's *NHS Continuing Healthcare and NHS-Funded Nursing Care* statistics https://www.england.nhs.uk/statistics/statistical-work-areas/nhs-chc-fnc/2018-19/

NHS Continuing Healthcare (CHC) aims to meet the cost of a patient's care in full. NHS Funded Nursing Care (FNC) makes a contribution towards care provided by a registered nurse for people who live in a nursing care home. FNC is intended to acknowledge the fact that the cost of an NHS District Nurse is not required as the patient's nursing needs are met by the nurse in the home rather than a District Nurse attending as they would if the patient was in their own home or a residential home.

2.6.2 Beacon, an independent social enterprise company with profits donated to charity to fund older people's services, has summarised the main differences between the new framework and the previous version as follows:-

- The Framework has been updated to reflect the implementation of the Care Act 2014**.** As such, it makes clear that **the eligibility criteria must be applied to everyone equally, regardless of where they receive their care**. This removes the opportunity for interpreting the criteria differently for people who receive care at home. The Framework's new wording removes this double standard, which is welcome news for patients whose needs can be met in their own home.

- **The definition of a social care need has been updated** in alignment with the Care Act 2014, making it clearer and narrower. This should make it easier to make the important distinction of when a care need is 'social' or 'health', and to judge whether the health needs of the patient are more than incidental or ancillary to their social care needs and therefore count as 'primary health needs'.

- Guidance on **the nature of annual CHC reviews has been significantly improved**, which is excellent news for patients and their families. There is now a clear focus on reviews being primarily to check that the patient's care package is working well, not on reviewing eligibility. Eligibility should only be reviewed if the CCG can demonstrate that the needs have substantially changed. Where eligibility reviews are carried out, they must – like the first full assessment – involve a multidisciplinary team and use the Decision Support Tool.

- There is now welcome **clarity on top-ups** (when the CCG does not meet the full cost of care so the patient or their family pays the excess). The update makes it clear that it is the responsibility of CCGs to meet assessed health and wellbeing needs in full. It also provides guidance around the very limited circumstances in which patients can legitimately pay a top-up, i.e. for non-needs-based services such as hairdressing.

- The **make-up of the multidisciplinary team has been clarified**, with very helpful guidance clarifying that the assessment co-

ordinator (often referred to as the 'nurse assessor') must not dominate proceedings. Instead the whole process must be multidisciplinary throughout.

- The **description of the remit of CCG verification of eligibility decisions has been improved,** reiterating that **'**Only in exceptional circumstances, and for clearly articulated reasons, should the multidisciplinary team's recommendation not be followed' and that verification should not replace proper multidisciplinary panel assessment.

- The Framework **strengthens the guidance around CCGs' commissioning responsibilities** in an attempt to deal with the spread of worrying 'settings of care' policies. These policies cap funding for people who want to live in their own home, and can have the effect of forcing people to move into a care home or live with inadequate care provision. The Framework outlines the rights of individuals to have their assessed health and social care needs fully met by the CCG, taking into account the person's preferences and without unreasonable restrictions being in place.

- It has been made clear that where CHC processes are outsourced to Commissioning Support Units, **CCGs remain responsible for all decisions of eligibility**.

- The obligations on CCGs in respect of **local resolution of appeals** have been improved. For example, the introduction of a two-step process whereby a first attempt at bespoke, collaborative and genuine resolution should be made by the CCG. If that does not answer the individual's concerns, the decision can be reconsidered by a panel.

More information is available on Beacon's website:-
http://www.beaconchc.co.uk/our-commentary-on-key-updates-to-the-nhs-chc-framework/

3. Suggested approach

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

NCCP and Healthwatch Norfolk's work on communication with patients and families (central & west Norfolk only):-

(a) The Healthwatch Norfolk paper (Appendix C) refers to a workshop to be held on 29 November 2018 (after the publication date of these agenda papers) which will include information and discussion on alternative / respite care provision where appropriate. What were the actions arising from this workshop?

(b) One of the clear messages from the Healthwatch Norfolk paper is that there needs to be a 'communications boost' to raise

awareness and understanding about NHS CHC amongst the general public, and specifically what to expect, the process and where to get information and advice or advocacy. What more can be done in this respect?

Fast track CHC

(c) What is the explanation for Norfolk being significantly below the English and regional average in terms of numbers per 50,000 population assessed as being eligible for CHC fast-track?

(d) The National Framework states that in fast-track cases it is the 'appropriate clinician' who makes the decision on whether an individual who is both rapidly deteriorating and may be entering terminal phase has a primary health need, which denotes eligibility for CHC. An 'appropriate clinician' is defined as a person who is responsible for the diagnosis, treatment or care of the individual and a registered nurse or medical practitioner.

In each of Norfolk's hospitals is it an 'appropriate clinician' from the patient's care team who makes these decisions or is it a CHC nurse assessor who is not part of the patient's multi-disciplinary care team?

(e) In relation to referrals for fast track CHC are NCCP and GY&W CCG following the National Framework which states that 'Only in exceptional circumstances, and for clearly articulated reasons, should the multidisciplinary team's recommendation not be followed'?

Discharge to Assess (D2A)

(f) A relatively small proportion of patients who are referred for consideration for the D2A pathway are deemed eligible for the pathway (9.7% at JPUH; 11.6% at NNUH and 18.8% at QEH). Has the introduction D2A pathways at the three acute hospitals had the effect of reducing the numbers of patients who ultimately receive NHS CHC?

(g) In what proportion of cases do health and social care not agree on whether a patient is eligible for the D2A pathway? What is the longest period that a patient's discharge from hospital has been delayed in these circumstances?

(h) Since the introduction of the D2A pathways, to what extent are CHC initial screenings (checklist) and full assessments (decision support tool) still done in the 3 acute hospitals in Norfolk?

(i) If the decision is not to place a patient on a D2A pathway, is there a right of appeal against that decision?

(j) Where a patient has not been placed on the D2A pathway, how would they later arrange to have an assessment for CHC done in the community after they have been discharged and how long would it take for the assessment to be done?

Strategy, equity and the wider system

(k) The policy changes within the new National Framework would imply that more patients may qualify for NHS CHC. How does this square with local QIPP targets to reduce spending on it?

(l) With the announcement on 5 November 2018 that the five CCGs in Norfolk and Waveney will be moving towards a single management team, are there plans for management of CHC in the GY&W CCG area to be aligned with the rest of Norfolk?

(m) Healthwatch Norfolk's paper confirms the significant work that NCCP has done to improve and tailor NHS CHC literature for central and west Norfolk. Is a similar process needed for the Great Yarmouth and Waveney area?

(n) The NHS England CHC statistics, available to view via the link at paragraph 4.4 of NCCP's report (Appendix A), show that in the current year Great Yarmouth and Waveney CCG area has more than the regional average of patients assessed as eligible for NHS CHC (per 50,000 population) whereas every other CCG area in Norfolk has less than the regional average. How significant is the difference in local implementation of CHC between Great Yarmouth and Waveney and the rest of Norfolk?

(o) Has the Strategic Board (with director level membership from all five CCGs and Norfolk County Council), assessed the economic and practical effects of the new management of CHC in central and west Norfolk and the three Discharge to Assess pathways across the county on patients / families and on Norfolk County Council Adult Social Care?

4. Action

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

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

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

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NHS
Norfolk Continuing Care Partnership

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

Report for Norfolk Health and Scrutiny Committee – 6th December 2018

Continuing Healthcare in Central and West Norfolk

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

1. Introduction and Background

This report provides an update on changes to Continuing Healthcare (CHC) service delivery that have occurred since the Norwich CCG, South Norfolk CCG, North Norfolk CCG and West Norfolk CCG formed the Norfolk Continuing Care Partnership (NCCP) to deliver services in November 2017.

The report includes contextual information regarding the caseload of CHC patients, progress against the 28 day assessment target and an analysis of complaints activity for the period February to October 2018. Information regarding cessation of CHC or Funded Nursing Care (FNC) and Discharge to Assess Pathways has been provided where available to NCCP.

NHOSC previously raised a series of issues in relation to CHC service delivery in May 2017 and progress against each area is outlined in the report.

A brief overview of the changes that have resulted from the publication and implementation of a revised National Framework for Continuing Healthcare and NHS-funded Nursing Care (October, 2018) has also been included to demonstrate how central and West Norfolk has adapted practice to accommodate new requirements.

Information has also been provided on the CHC Fast Track pathway as requested by NHOSC.

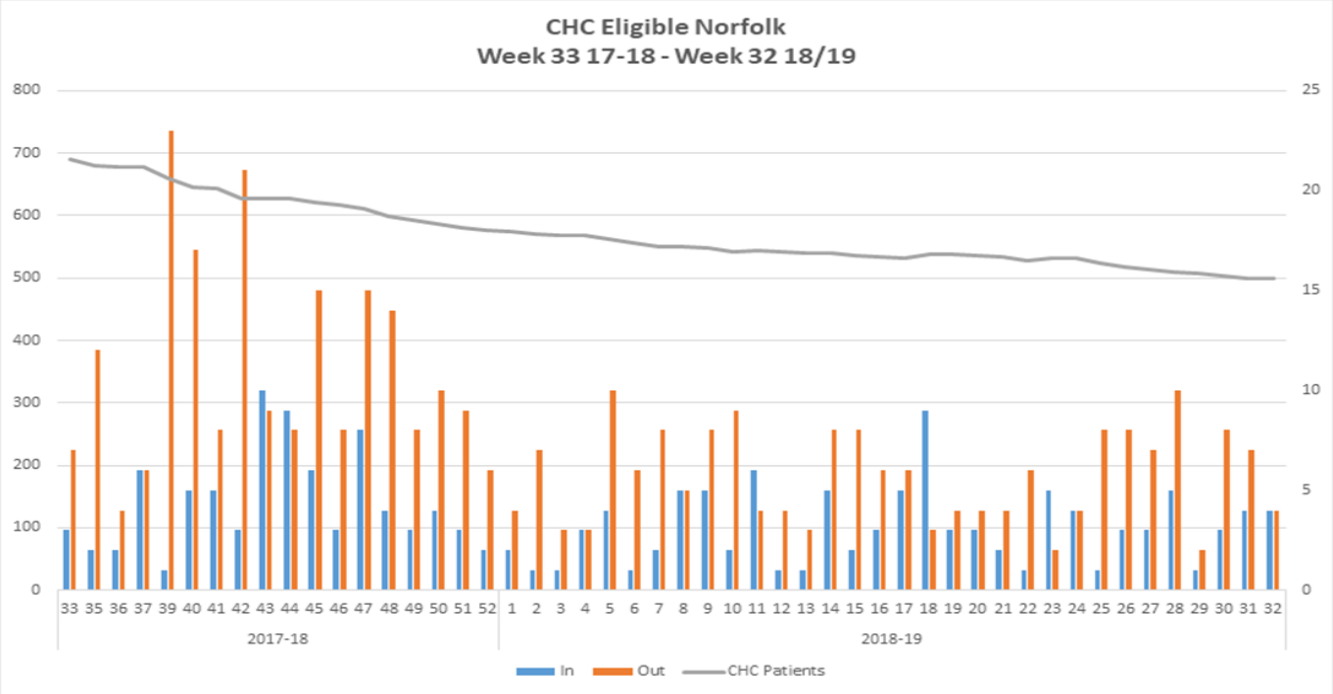
2. General Contextual Information

2.2 Trend in Residential / Domiciliary Care Packages for CHC Patients

	2015/16				2016/17				2017/18				2018/19			
	Q1		Q2		Q1		Q2		Q1		Q2		Q1		Q2	
	Res	Dom	Res	Dom	Res	Dom	Res	Dom	Res	Dom	Res	Dom	RES	DOM	RES	DOM
North Norfolk CCG	75%	25%	75%	25%	73%	27%	71%	29%	62%	38%	68%	32%	66%	34%	67%	33%
Norwich CCG	75%	25%	75%	25%	74%	26%	73%	27%	54%	46%	71%	29%	67%	33%	67%	33%
South Norfolk CCG	68%	32%	69%	31%	66%	34%	66%	34%	63%	37%	72%	28%	63%	37%	62%	38%
West Norfolk CCG	68%	32%	53%	47%	63%	37%	62%	38%	55%	45%	68%	32%	69%	31%	64%	36%
All CCGs	**71%**	**29%**	**68%**	**32%**	**69%**	**31%**	**68%**	**32%**	**59%**	**41%**	**70%**	**30%**	**66%**	**34%**	**65%**	**35%**

The table above indicates the percentage split of location of care provided to CHC patients over the past 4 years. Quarter 1 and 2 data has been presented for consistency. The data indicates that the percentage of patients receiving care in their own home has marginally increased over the 4 year period.

2.3 Trend in the numbers of patients eligible to receive CHC in the past 12 months



The number of patients eligible to receive CHC funded care has decreased over the last 12 months. This is due to a number of factors including additional CCG investment in re-ablement and convalescent pathways which help patients leave hospital earlier and promote recovery prior to assessment for long term care needs, in line with the NHS National Framework for CHC.

2.4 Progress Against the CHC 28 Day Assessment Target During 2018

		Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
All CCGs	No. Referrals completed <=28 days	14	18	49	28	41	30	47	36	43	56
	No. Referrals completed	30	49	56	32	46	31	50	40	43	59
	%	47	37	88	88	89	97	94	90	100	95

		Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
North	No. Referrals completed <=28 days	7	9	13	6	6	8	12	6	12	15
	No. Referrals completed	12	14	14	7	7	8	13	7	12	16
	%	58	64	93	86	86	100	92	86	100	94
Norwich	No. Referrals completed <=28 days	3	3	13	6	9	14	7	13	8	14
	No. Referrals completed	4	12	18	6	9	14	7	15	8	15
	%	75	25	72	100	100	100	100	87	100	93
South	No. Referrals completed <=28 days	4	5	18	10	18	4	21	5	12	16
	No. Referrals completed	9	13	18	12	20	4	21	5	12	17
	%	44	38	100	83	90	100	100	100	100	94
West	No. Referrals completed <=28 days	0	1	5	6	8	4	7	12	11	8
	No. Referrals completed	5	10	6	7	10	5	9	13	11	8
	%	0	10	83	86	80	80	78	92	100	100

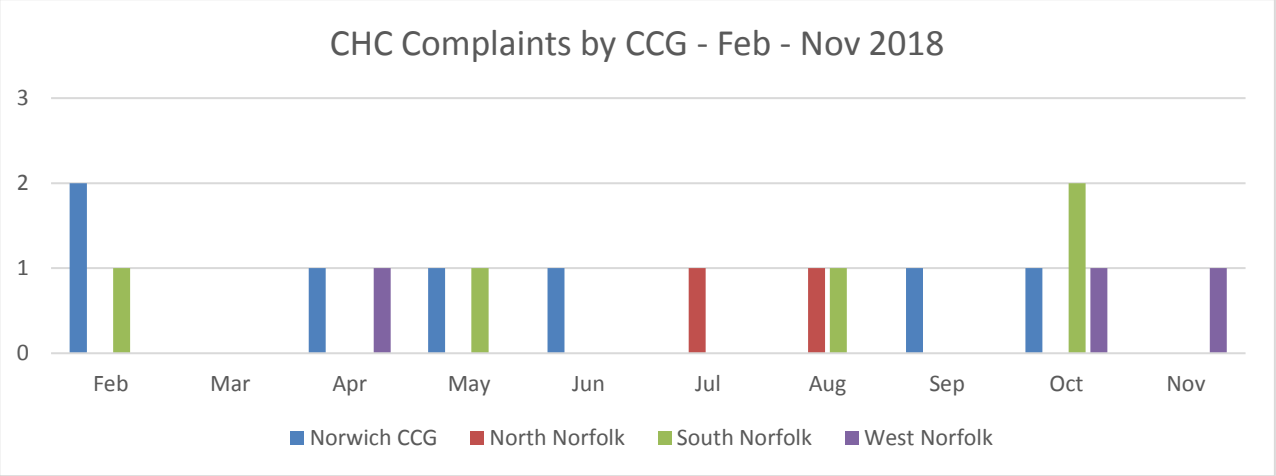
2.5 CHC Complaints Information and Analysis

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

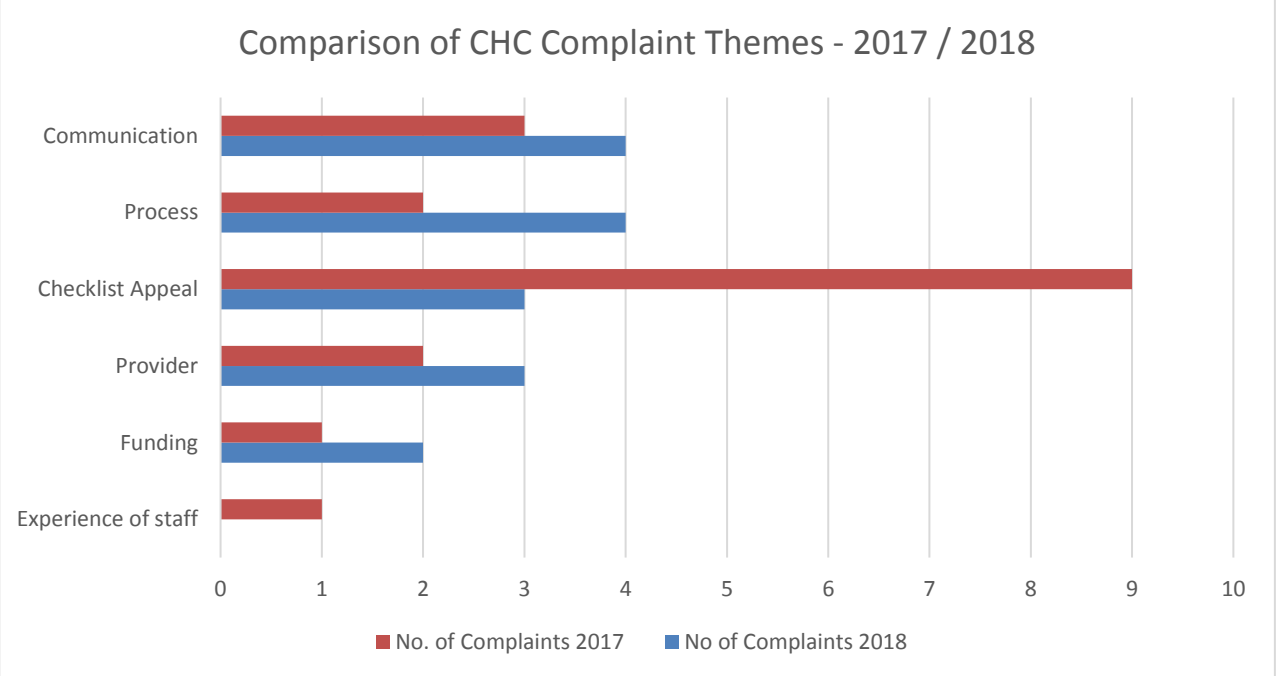
2.5.1 The required timescale for answering complaints is 25 working days from the date the complaint has been received, to the date the final response has been sent. For CHC complaints that were concluded in the nine months from February – November 2018 all except one received a final response within 25 days.

During this period the requirement to acknowledge each complaint within three-working days was met in 94% of cases.

2.5.2 CHC complaints activity has been split by CCG as follows;



2.5.3 Thematic analysis and comparison of complaints



The chart above shows a thematic analysis of complaints received during February and November 2018. Complaints received during 2017 have been included as a baseline.

2.6. Capacity of the Assessment Service

CHC Practitioners are responsible for undertaking CHC assessments for new referrals, undertaking reviews for existing patients and case managing a cohort of patients so capacity for each element is variable depending on demand across the service.

2.6.1 Caseload Numbers

A Case Management model has been introduced. CHC Practitioners have been allocated a caseload of patients including a case mix of individuals receiving care in different care environments. Caseloads have been set to ensure that every patient in receipt of continuing healthcare has a named case manager.

CHC Practitioners have been allocated a caseload of around 30 patients (current average 27 patients per clinician). The specialist Complex Case Managers manage patients with greater variance in their care requirements and have on average 12 cases per clinician. Resilience is provided through a system of Lead and Support clinicians, from supernumerary team leaders and other clinicians within NCCP.

2.6.2 Staff Vacancy Levels – CHC Clinicians

NCCP have 2 whole time clinical vacancies but have been highly successful in recent recruitment drives. Both posts have been offered to successful candidates and staff are due to start in post during December 2018 and January 2019.

The senior Clinical Team Lead and Clinical Service Manager positions have substantive members of staff in post and have experienced stability since service transition to NCCP.

3 Norfolk Health and Overview Scrutiny Committee (NHOSC) – NCCP Progress Update Since Feb 2018

	NHOSC Recommendation	CCG Progress Update (see also the HealthWatch Norfolk Report)
1.	a) The CCGs address the findings in the Healthwatch Norfolk survey - Improvement to both verbal and written communication of the different stages of the process, the outcome of each stage, and the notification of	**UPDATE - November 2018** The suite of standard template letters have been amended in conjunction with Healthwatch to ensure the tone and content of written communication reaches a high standard is clear and easily understood. Service Leaflets have been produced to assist with information giving and to support verbal communications. The proposed CCG information giving audit will commence late in 2018 as part of phase 3 of service transition.

	decisions including funding decisions	
1.	b) CCGs to ensure people are well-informed about what they might be eligible for and what services are available, without raising expectations	***People are well informed about what they might be eligible for*** **UPDATE - November 2018** Information regarding Continuing Healthcare is published on each CCGs website with a downloadable information sheet and contact details. CCG websites contain links to a CHC easy read version of the local guidance. Both the easy read and standard versions of the patient guide to CHC services set out the processes for assessment of eligibility for NHS CHC Funding and include details of what may and may not be funded by the NHS. ***People to be well informed of the services available*** **UPDATE – November 2018** General information about services are available from leaflets. More detailed bespoke information is tailored to need by the CHC clinical staff who are undertaking that patient's assessment. Healthwatch Norfolk are assisting in reviewing service leaflets using the expertise of their volunteers. A revised program of integrated training is due to commence in November 2018 to raise professionals' awareness about Continuing Healthcare funding and referral routes. Training will be aimed at social care, community healthcare and mental health teams to improve knowledge and assist with signposting to appropriate services. ***Expectations to be managed*** **UPDATE – November 2018** The NCCP senior management team have linked with Healthwatch to explore mechanisms to seek patient / relatives feedback with regard to how processes were explained. A draft patient feedback questionnaire has been developed in conjunction with Healthwatch. The process for distribution, collection, recording and analysis is being finalised and a pilot is due to commence shortly. Complaints have been monitored formally on a monthly basis with a written paper being submitted to the NCCP Operational Management Group and to the CCG Directors of Nursing and Quality via the Clinical Quality review Group. All complaints are reviewed by the senior management team within the NCCP. This senior involvement enables the organisation to actively learn from processing complaints and to implement service adaptations in response to feedback where necessary.
	c) CCGs to consider whether to commission more advocacy	**UPDATE – November 2018** Patients undergoing CHC assessment have access to an independent mental capacity advocate (IMCA) where required, in accordance with the Mental Capacity

	services for people involved in the CHC assessment process and those in receipt of CHC so that their views are fully expressed and understood	Act (2005). Independent advice is freely available via Beacon and NCCP signpost patients and their representatives to this service in every written communication. Where a patient with capacity has an assessment for CHC, every effort is made by nursing and social care staff to support the patient and their family to understand the proceedings and their options at each stage. This is part of the role of every member of health and social care staff. NCCP have implemented a model of case management which allocates each patient a named CHC Practitioner. The CHC Practitioner will work with the patient and their representatives throughout the assessment process to provide continuity and ensure personalisation of the process. Following award of CHC funding this relationship continues, to ensure care provision is tailored to clinical need and provided in a way which respects individual circumstances and preferences.
2.	CCGs to undertake more proactive quality monitoring to check that CHC patients are receiving a service that meets their needs	**UPDATE – November 2018** NCCP has designated Quality Assurance Leads. These members of staff maintain close links with the Norfolk County Council Quality team and share information about care providers. Where issues arise, the Quality Assurance Leads work with care providers to implement action plans to address care deficits and improve quality. All CQC reports for Nursing, Residential and Domiciliary care providers with CHC funded patients are closely monitored and shared with NCCP team members and CCG recipients to promote an awareness of quality issues across the care providers in Norfolk. The Quality Assurance Leads attend briefing sessions with the CHC clinical teams to promote the exchange of information and to gather soft intelligence from nursing staff that can be used to identify trends. Where a care provider may be identified as having issues with care quality a proactive set of welfare checks is undertaken for all NHS funded patients receiving care from that provider. A case management approach has been established to provide a named CHC Practitioner for each CHC patient. The purpose of the case management approach is to provide a personalised care package for each patient with support from a senior registered nurse who is knowledgeable about their case. Each CHC Practitioner is also aligned to specific care providers to develop positive relationships and provide consistent support and oversight to commissioned care packages.
3.	CCGs to arrange for a more widely accessible survey of the experiences of CHC patients and families / carers, i.e. using a wider variety of methods than the previous survey, which was on-line, internet based	**UPDATE – November 2018** Healthwatch Norfolk have provided advice on the appraisal and selection of suitable methods for gathering patient and families CHC experiences. A draft patient feedback questionnaire has been developed in conjunction with Healthwatch. The process for distribution, collection, recording and analysis is being finalised and a pilot is due to commence shortly. NCCP have ensured that there are a variety of accessible alternative feedback mechanisms including generic feedback email addresses which are checked several times each day and a manned Single Point of Access telephone service.
4.	CCGs to work in close partnership with social care	**UPDATE – November 2018**

	and other relevant agencies including service user groups to ensure planning for an effective safety-net service for CHC patients on occasions when their usual provider is unable to deliver	Care plans should be in place for all patients in receipt of Continuing Healthcare in line with the CQC requirements and the National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care (2018). Care plans should record both the care required and patients' preferences, to provide guidance and direction for care givers. These documents enable continuity of care provision for patients that may require an episode of care from an alternative care giver. NCCP review the quality and availability of care plans as part of our case management approach and will work with providers to ensure the effectiveness of these documents. Specific contingency plans are built into care plans for those patients in receipt of Personal Health Budgets to enable patients to plan for and mitigate potential problems associated with short term care breakdown. The Continuing Healthcare Brokerage team is available Mon-Friday to support with longer term disruption in care delivery and to offer alternative options via commissioned care where necessary. Better links and relationships with providers is helping to identify issues with care delivery much earlier so that alternative arrangements can be put in place proactively where care disruption is anticipated. During the severe weather experienced in March 2018, NCCP enacted its own Business Continuity Plan. Key services were maintained throughout the period and care disruption was minimal. Links via the Emergency Resilience and Preparedness personnel, Winter Planning and Silver Call systems enabled close contact with providers, identification of areas of concern and enabled private providers to access wider NHS resources to maintain care provision e.g. the voluntary 4x4 Service. The learning from the major incident debrief was used at a Provider Forum event in late spring 2018 to assist Providers in development of their own business continuity plans. NCCP have actively participated in ongoing resilience planning for winter 2018 and have put additional resource in place to support care sourcing. Part of NCCPs remit is to identify and escalate commissioning gaps to CCG partners to improve provision of health services in Norfolk. Close links with the CCGs ensures up to date knowledge of mainstream commissioned NHS services, such as Hospice at Home and Virtual Wards, and increases in social care provision such as additional capacity for the Swifts / Night Owls service.
5.	CCGs work to speed up the process between referral and assessment for CHC eligibility so that the average waiting time in each of the 4 CCG areas reduces to meet the 28 day standard	**UPDATE – November 2018** A significant amount of work has taken place to improve performance in this area. Additional enhanced leadership within NCCP has enabled Clinical Service Managers to have a smaller span of control and better oversight of staff. They are able to utilise data to monitor flow of cases, identify delays and backlogs and support administrators and clinicians to progress cases more efficiently. The CCGs have delegated responsibility for verification of cases to NCCP and Eligibility Verification Meetings are run 4 times each week. Very senior clinicians provide quality assurance and peer review recommendations ensuring they have been made based on relevant evidence and in accordance with the National Framework. A single central process eradicates unnecessary stages in the process, reduces variability across CCGs and contributes to improving the standard of assessments. Where it is necessary to defer a decision these are quickly and robustly followed up by a named member of staff.

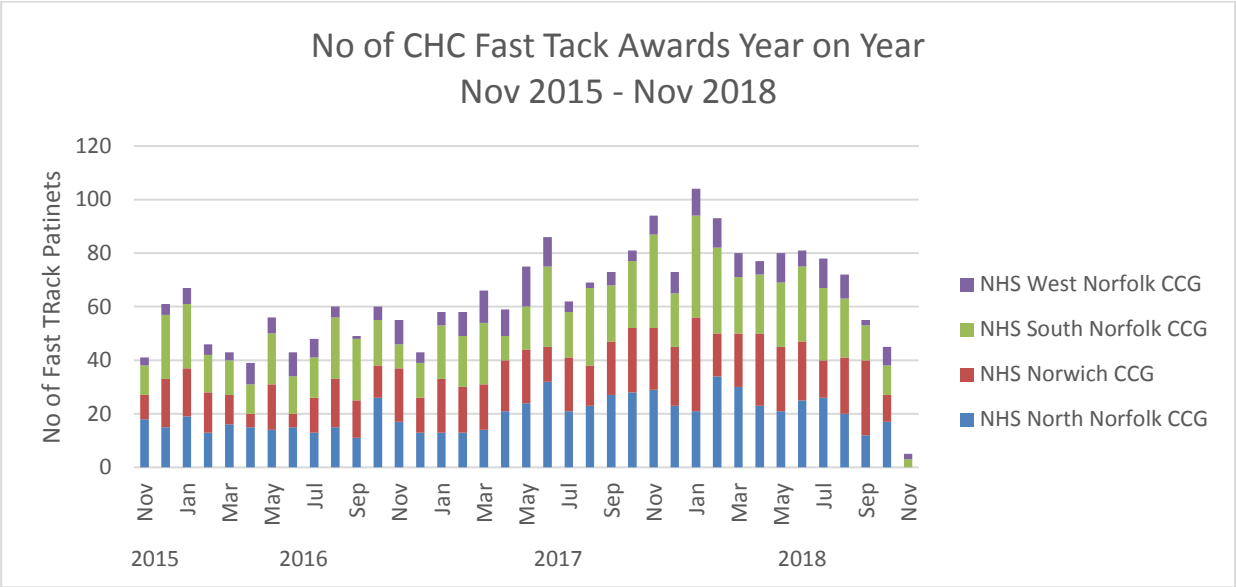
		NCCP and NCC are working cooperatively to address issues related to staff availability to undertake assessments within the required timescale. CCGs have consistently achieved 80% compliance against the 28 day assessment target since April 2018.

4. Additional Information Requested by NHOSC

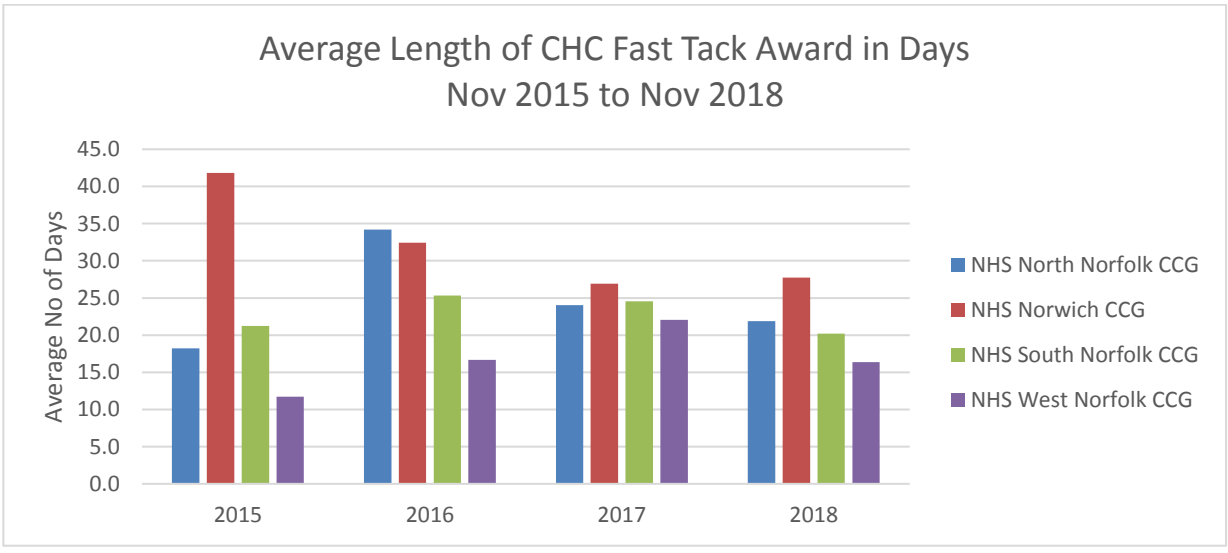
4.1 CHC Fast Track

CHC Fast Track referrals are managed by a small team within central and West Norfolk. These nurses follow each patient from referral, through the assessment and care sourcing process and support their care delivery through the end of life period. They provide continuity and support for patients with oversight of care packages and have the ability to adjust care provision in a timely manner to respond to changes in patient need.

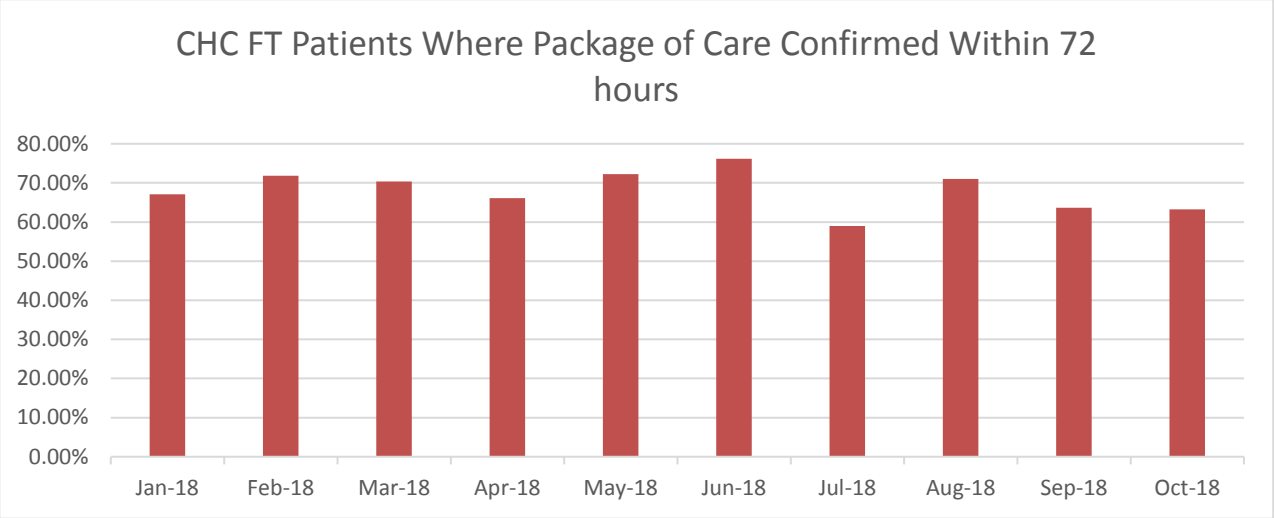
4.1.1 CHC Fast Track Awards by CCG



4.1.2 Average duration (in days) of CHC Fast Track funding over the last 3 years.



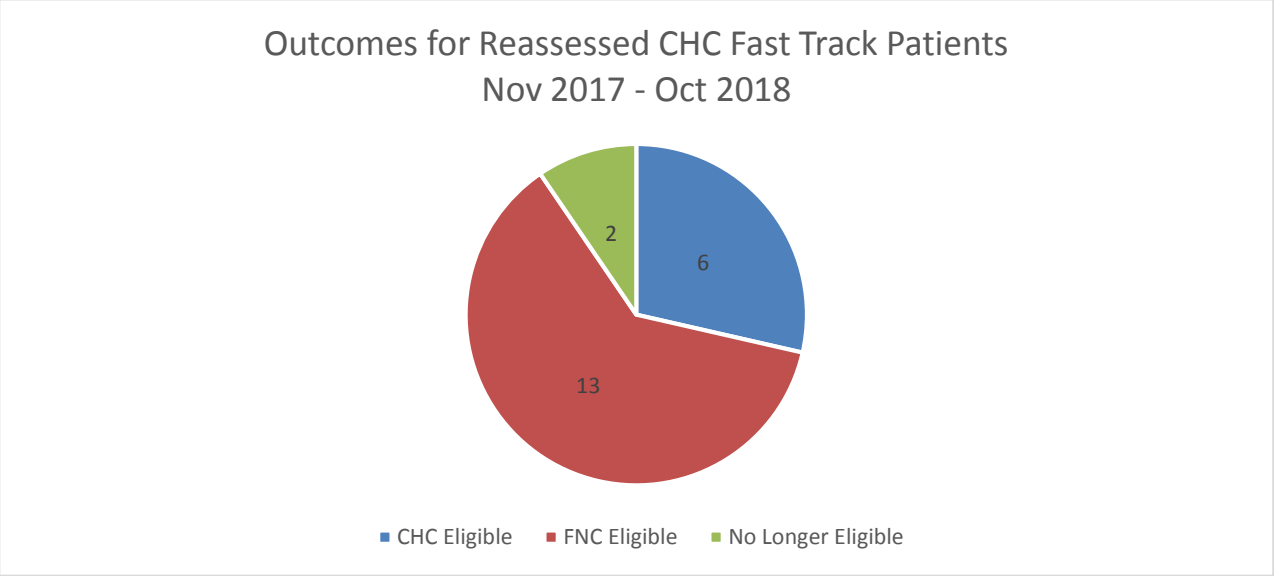
4.1.3 The proportion of CHC Fast Track patients placed within 3 days of referral



Provider capacity remains a nationwide concern and these concerns are mirrored within Norfolk. NCCP are currently working to implement an electronic bed management system to facilitate rapid sourcing of nursing home placements. From 1st October 2018 the National Framework care arranging guidance for patients eligible for CHC Fast Track placement has reduced to 48 hours.

NCCP are exploring alternative mechanisms of sourcing care to provide reliable access to services over the peak winter months and will commission blocks of domiciliary and nursing home care provision from January 2019. NCCP work closely with mainstream NHS commissioned services such as the local Hospice at Home team to ensure we can support timely discharge from hospital and provide the best collaborative service possible to the people of Norfolk.

4.1.4 Number of CHC Fast Track patients that plateau and require ongoing care and who this is provided by



Where a patient who is in receipt of CHC Fast Track experiences a plateau in their condition they may undergo a reassessment of eligibility for CHC. In the cases where this has occurred between November 2017 and October 2018, 90.5% of patients have remained eligible for some form of

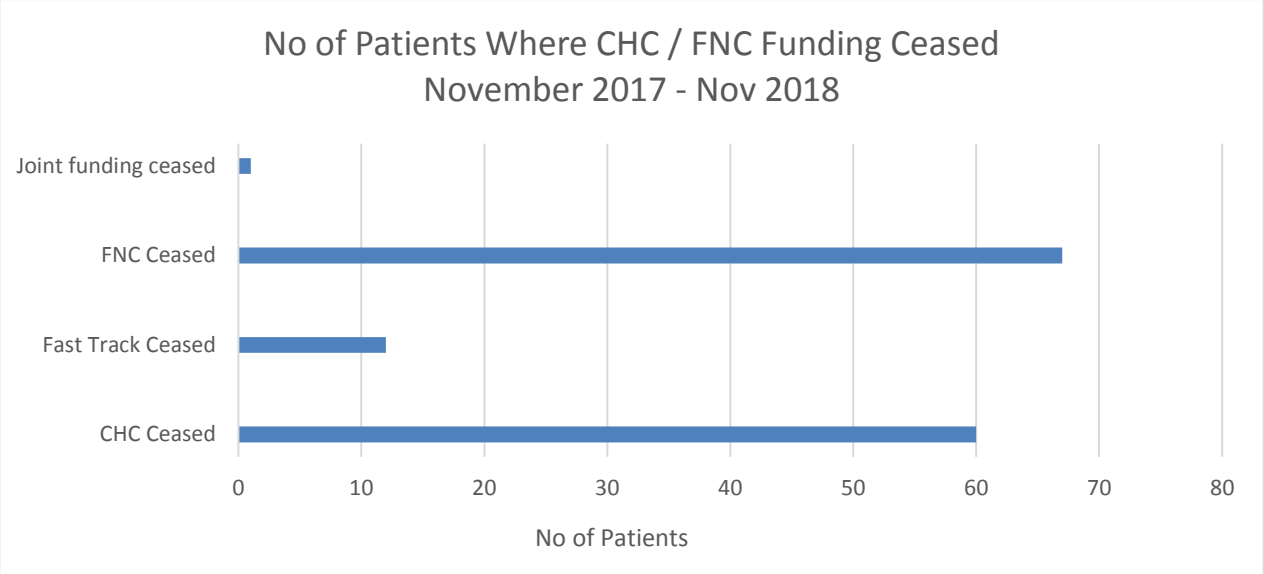
NHS funded care. For the remaining two patients who were not eligible, this was because their assessed health needs could be met through mainstream NHS services such as district nursing and specialist palliative care services.

4.2 Cessation of FNC / CHC Funding

All patients that are no longer eligible for full CHC or Fast Track CHC are referred to Norfolk County Council (NCC) Adult Social Services for assessment of eligibility for social care support in line with the requirements of the Care Act (2014). The NHS National Framework for Continuing Healthcare (2018) clearly sets out that 'no services or funding should be unilaterally withdrawn unless a full joint health and social care assessment has been carried out and alternative funding arrangements have been put in place'.

NCCP uphold this element of the Framework vigorously and work closely with NCC to ensure social care representation within the assessing multidisciplinary team wherever possible. When responsibility for a patient moves between one funding body and another, clear processes have been put in place, agreed notice periods are observed and information on the changes are provided to the patient in a timely way.

4.2.1 Number of patients where CHC / FNC funding has ceased



4.2.2 Number of patients where exceptional decisions have been made to continue funding despite no longer being eligible

Under the National Health Service Commissioning Board and Clinical Groups Regulations (2012) and NHS National Framework for Continuing Healthcare (2012, 2018) the CCG remains responsible for contributing to identified health needs regardless of eligibility for Continuing Health Care. Where patients are no longer eligible for CHC or FNC, the CCG ensures that patients are considered for alternative funding, either by mainstream NHS commissioned services such as community nursing, or by part funding an individual package of support as a joint package of care.

4.3 Discharge to Assess (D2A) Pathways

The 2018 version of the National Framework for Continuing Healthcare and NHS-funded Nursing Care sets out a requirement for CCGs to ensure that eligibility for NHS Continuing Healthcare is considered after discharge from hospital wherever possible. This enables a period of recovery and optimisation of health potential and enables assessment to take place in care environment where the person's ongoing needs should be clearer.

NCCP provide an oversight function to the central Norfolk D2A pathway but have limited involvement in the West Norfolk D2A Pathway from the Queen Elizabeth Hospital (QEH).

4.3.1 Discharge to Assess (D2A) Pathway at the Norfolk and Norwich University Hospital (NNUH)

The D2A Pathway at the NNUH has undergone a 12 month pilot and is in the process of transition to a business as usual model. Norwich, North Norfolk and South Norfolk CCGs have collaborated with Norfolk County Council and the NNUH to establish and deliver the pathway.

Patients with complex health needs may be considered for the D2A Pathway using a screening tool. This enables a multiprofessional approach to select the most appropriate discharge pathway for each individual patient. Where a patient has ongoing care needs that require consideration for CHC they will enter the D2A pathway and be supported to leave hospital into an NHS funded care placement either in their own home with a package of care, or to a nursing home environment.

A team of nurses and therapists visit regularly to provide support to enable each patient to reach their health optimum.

A full CHC assessment is undertaken with the patient and their representatives at the most appropriate point. Designated social workers are assigned to support the pathway, participate in all assessments and provide social care expertise and onward support to those patients that may not be eligible for CHC.

4.3.2 Discharge to Assess (D2A) Pathway at the Queen Elizabeth Hospital, Kings Lynn (QEH)

The Discharge to Assess Pathway from the QEH has been running since 2016 as a collaboration between QEH, NCC, and West Norfolk CCG. The pathway is currently under review with overarching leadership and management provided by West Norfolk CCG.

Patients are selected for the D2A pathway by specialist Discharge Coordinators at the QEH hospital and offered a supported placement in their own home or a care home environment. Patients are reviewed by a D2A case manager and referred to NCCP for assessment for CHC when they have reached their health optimum. As with central Norfolk, designated social workers are assigned to support the pathway, participate in all assessments and provide social care expertise and onward support to those patients that may not be eligible for CHC.

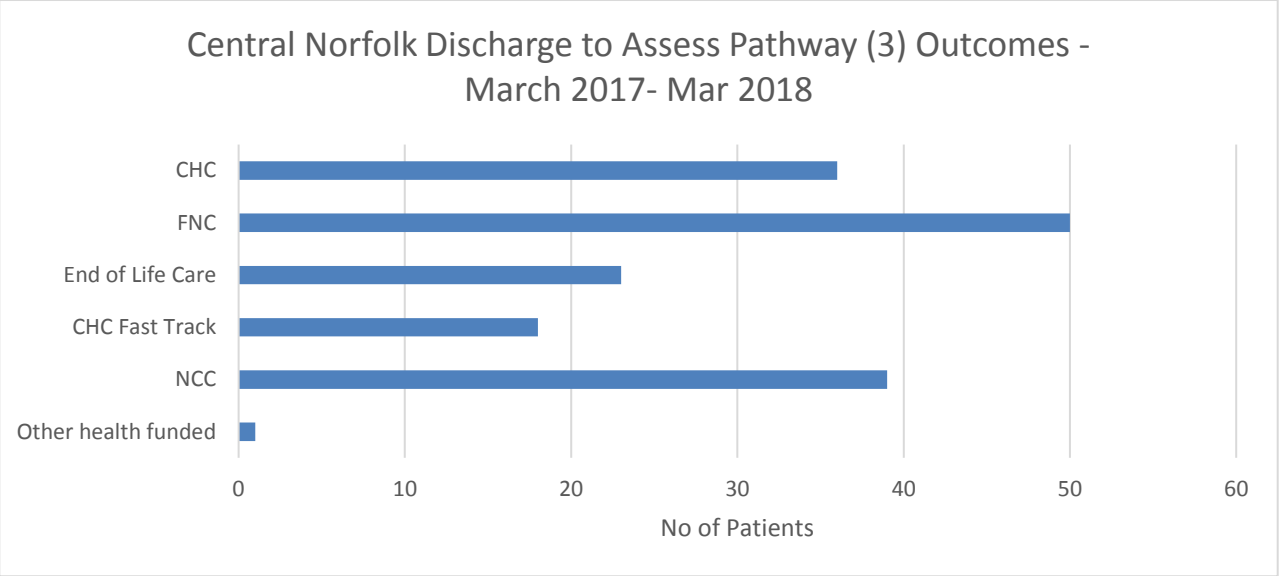
4.3.3 Number of patients assessed and declined at each hospital

For central Norfolk, the D2A end of year report (March 2017 - March 2018) stated that 1442 Discharge to Assess referrals were received by the discharge team at the Norfolk and Norwich University Hospital. Of these, 167 patients were identified as appropriate for the pathway. This equates to 11.6% of all 5Q Care Test's (D2A screening tool) completed.

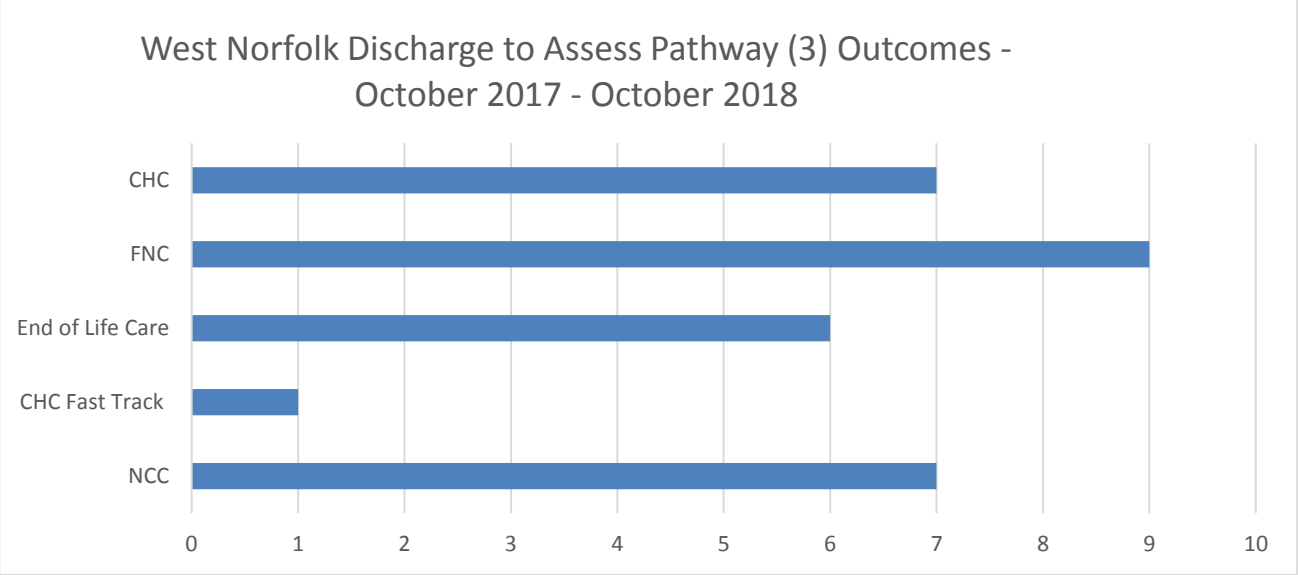
During the 12 month period from March 2017 – March 2018 on the QEH D2A pathway 482 5Q D2A referrals were received. Of these, 91 were identified as appropriate for the pathway which equates to 18.88%.

4.3.4 Number of patients eligible / not eligible for CHC after D2A pathway

Of the 167 patients placed on the D2A pathway in 17/18, 62% (no. 104) received some form of ongoing health funding with 22% (no. 36) of patients becoming eligible for CHC funding.



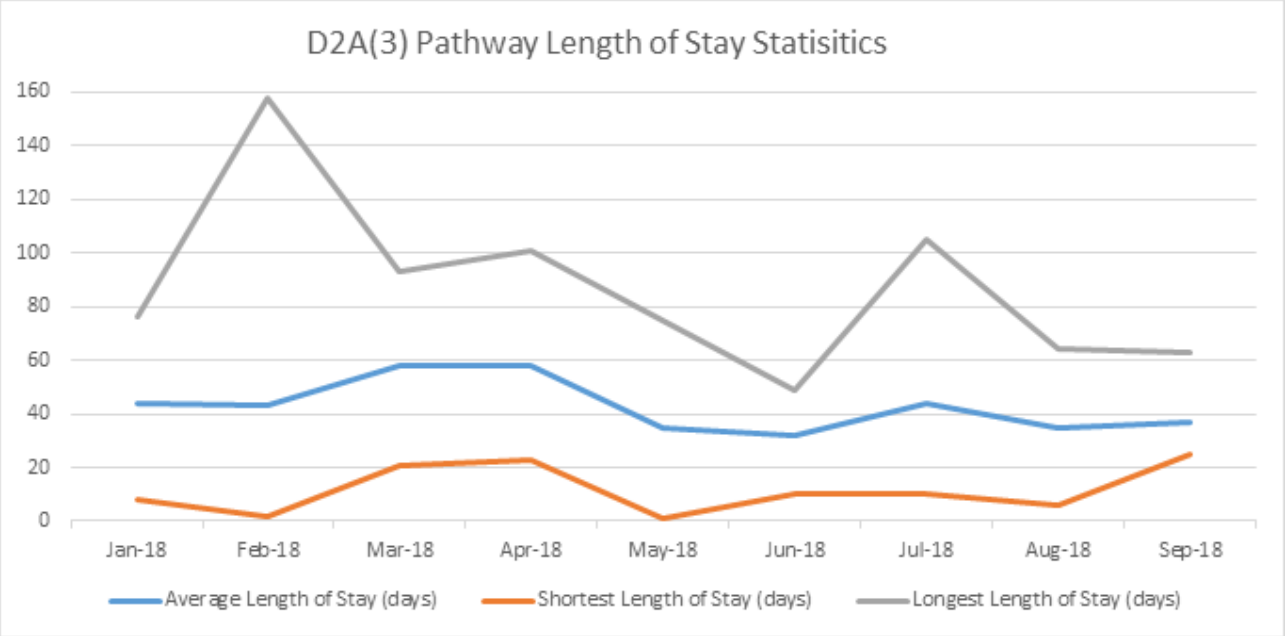
NCCP have provided information regarding the outcome of D2A patients who were referred to NCCP for assessment however this is not representative of the whole cohort of patients that accessed this pathway.



4.3.5 Number of beds used for D2A in relation to each of the 3 hospital areas

Beds are commissioned on a spot purchase basis for the central and West Norfolk D2A pathways and bed usage is variable. Concurrent usage has decreased over time as the average length of stay has stabilised. Employment of social workers specifically to support the D2A pathways has had a

significant impact in reducing bottle necks in the assessment process in central Norfolk since February 2018.



D2A Pathway Length of Stay Statistics for the central Norfolk D2A pathway.

4.4 Statistical Benchmarking of CHC and FT Consideration and Eligibility by CCG Area

CHC data is collated and submitted to NHS England on a quarterly basis of behalf of the CCG Partners. This enables NHS England to provide benchmarking data regarding individual CCG variance and national averages. The full statistical data sets can be accessed via the following link;

https://www.england.nhs.uk/statistics/statistical-work-areas/nhs-chc-fnc/.

5.4.1 Quarter 1 and 2 CHC Data for Central and West Norfolk CCGs, With National, Regional and Sub-regional Comparative Rates

To determine the eligibility rate per 50K population, the GP patient list size for patients aged 18 or above at the end of each quarter, is used. National, regional and sub-regional comparative rates are included within the tables but a more sophisticated 'cluster' based methodology has been developed by NHSE for benchmarking purposes.

Comparison of the Quarter 1 and 2 data sets indicates that the central and West Norfolk CCGs experience variability in conversion rates despite centralised processes. The numbers assessed as eligible are becoming more consistent locally, but remain lower than regional and national levels.

Quarter 1 Data for NCCP CCGs

NHS Continuing Healthcare Quarterly Figures
CCG Q1 2018-19 Data Collection
09 August 2018
NHS CHC Data Team
england.chcdata@nhs.net

	Number of new referrals (not including PUPoCs)				Number of referrals completed (including discounted referrals)		Number assessed as eligible		Assessment Conversion Rate (% newly eligible cases of total cases assessed)	
	Standard NHS CHC (non Fast Track)		Fast Track		Within 28 Days (Standard NHS	% within 28 Days (Standard NHS CHC)	Standard NHS CHC (non Fast Track)	Fast Track	Standard NHS CHC (non Fast Track)	Fast Track
Organisation	**Total**	**Per 50k**	**Total**	**Per 50k**	**Per 50k**	**Total**	**Per 50k**	**Per 50k**	**Total**	**Total**
ENGLAND - 195 CCGs	**18,853**	**20.10**	**23,575**	**25.13**	**14.15**	**67%**	**4.76**	**23.25**	**27%**	**100%**
MIDLANDS AND EAST OF ENGLAND REGION - 59 CCGs	**6,059**	**21.40**	**7,436**	**26.27**	**15.69**	**69%**	**6.01**	**24.68**	**30%**	**100%**
NHS ENGLAND MIDLANDS AND EAST (EAST) - 14 CCGs	**1,152**	**16.86**	**1,588**	**23.24**	**11.80**	**72%**	**3.76**	**21.37**	**26%**	**100%**
NHS NORTH NORFOLK CCG	33	11.36	84	28.90	6.88	91%	0.69	24.09	10%	100%
NHS NORWICH CCG	43	11.11	88	22.74	7.75	100%	1.29	19.90	17%	100%
NHS SOUTH NORFOLK CCG	50	13.56	93	25.21	8.68	89%	2.17	21.69	22%	100%
NHS WEST NORFOLK CCG	33	11.42	25	8.65	6.58	83%	3.11	7.96	39%	100%

Quarter 2 Data for NCCP CCGs

NHS Continuing Healthcare Quarterly Figures
CCG Q2 2018-19 Data Collection
08 November 2018
NHS CHC Data Team
england.chcdata@nhs.net

	Number of new referrals (not including PUPoCs)				Number of referrals completed (including discounted referrals)		Number assessed as eligible		Assessment Conversion Rate (% newly eligible cases of total cases assessed)	
	Standard NHS CHC (non Fast Track)		Fast Track		Within 28 Days (Standard NHS CHC)	% within 28 Days (Standard NHS	Standard NHS CHC (non Fast Track)	Fast Track	Standard NHS CHC (non Fast Track)	Fast Track
Organisation	**Total**	**Per 50k**	**Total**	**Per 50k**	**Per 50k**	**Total**	**Per 50k**	**Per 50k**	**Total**	**Total**
ENGLAND - 195 CCGs	**18,763**	**19.84**	**23,748**	**25.12**	**14.72**	**71%**	**4.28**	**23.94**	**25%**	**100%**
MIDLANDS AND EAST OF ENGLAND REGION - 59 CCGs	**6,106**	**21.49**	**7,452**	**26.23**	**16.76**	**76%**	**4.86**	**24.88**	**26%**	**100%**
NHS ENGLAND MIDLANDS AND EAST (EAST) - 14 CCGs	**1,154**	**16.85**	**1,552**	**22.66**	**12.06**	**63%**	**4.40**	**21.81**	**26%**	**100%**
NHS NORTH NORFOLK CCG	47	16.14	73	25.06	9.96	91%	1.72	22.66	16%	100%
NHS NORWICH CCG	37	9.49	85	21.80	8.72	92%	2.82	20.01	31%	100%
NHS SOUTH NORFOLK CCG	45	12.16	78	21.07	12.43	100%	2.16	19.45	19%	100%
NHS WEST NORFOLK CCG	45	15.55	26	8.99	12.79	90%	2.42	8.99	17%	100%

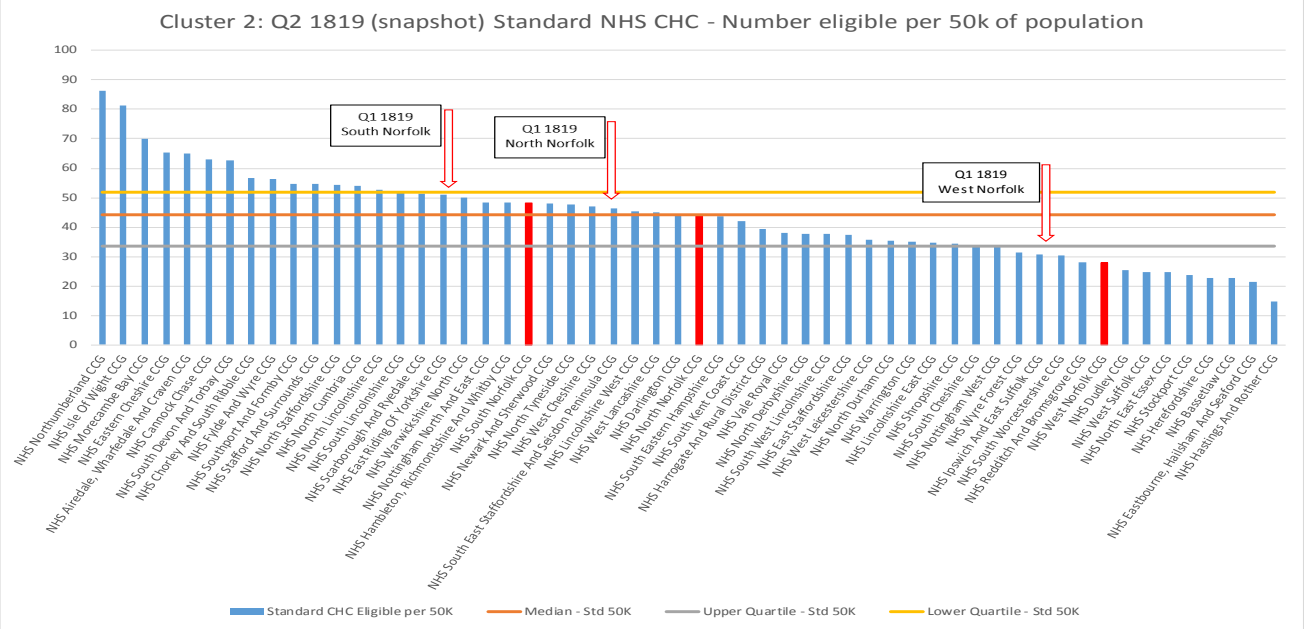
It is believed that the significantly lower number of CHC Fast Track referrals in West Norfolk is due to the existence of other commissioned End of Life services which can be accessed without the need for completion of a Fast Track referral.

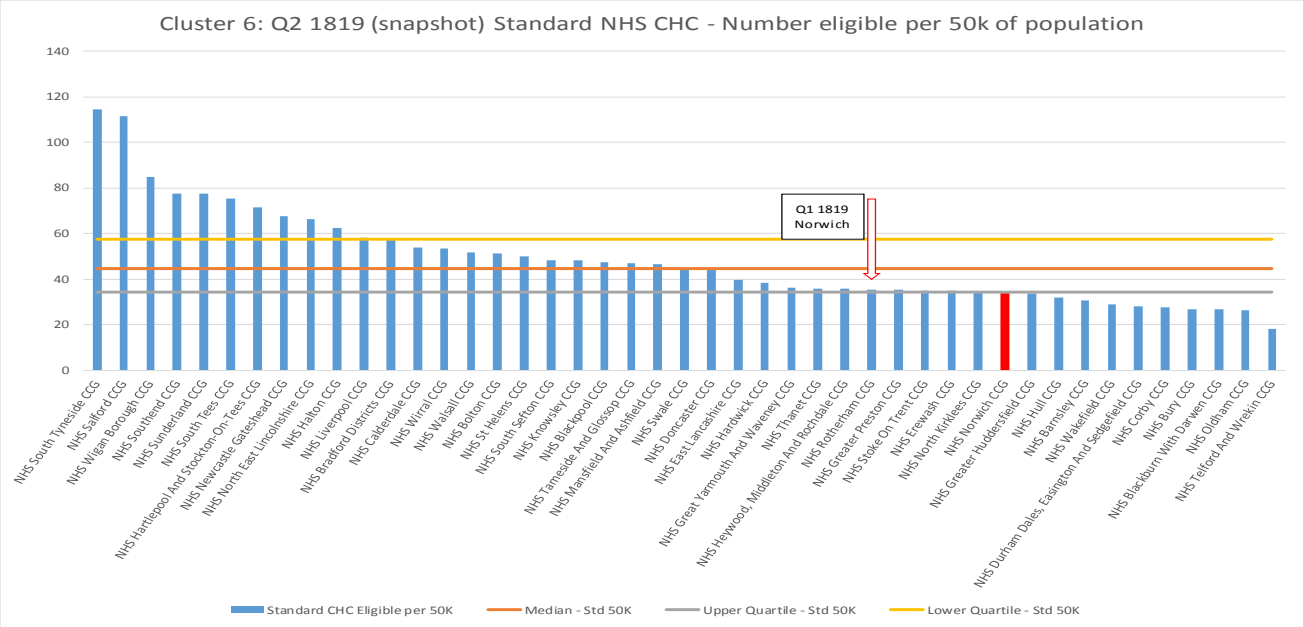
4.4.2 NHS England Cluster Benchmarking

In 2017/18, NHSE developed a 'cluster' benchmarking methodology to interrogate CHC data. NHSE identified comparable CCGs based on a number of factors including, rural population; deprivation; proportion of population aged over 65; ethnic diversity and various disease prevalence. North Norfolk CCG, South Norfolk CCG and West Norfolk CCG are included within Cluster 2, while Norwich CCG is included within Cluster 6.

This methodology was developed further for 2018/19 and is now used by NHS England as part of individual CCG assurance by identifying CCGs, with comparable populations, who have either a high or low incidence of CHC eligibility.

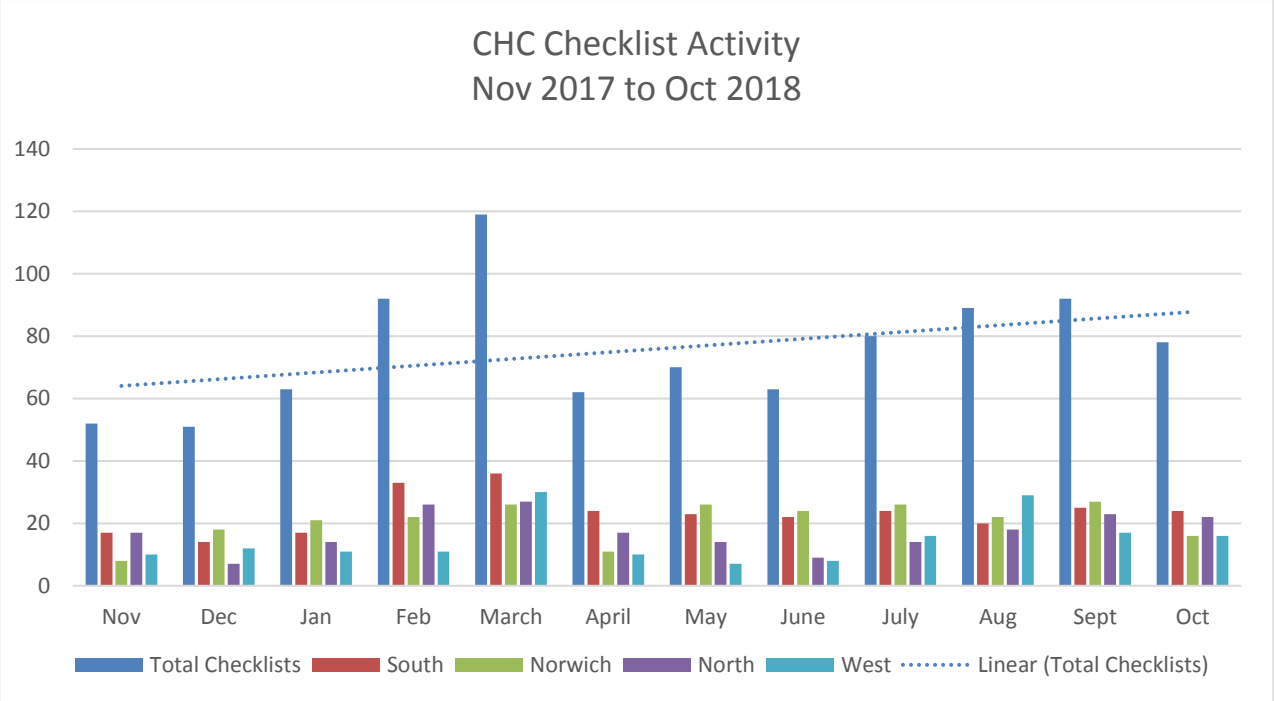
As at the end of Q2 2018/19, the position of the Norfolk CCGs within these cluster groupings was as set out in the chart on the following page. The charts identify how each CCG's CHC eligibility numbers compare with similar CCGs, and how their position in the cluster group has changed between Q1 2018/19 (end of June) and Q2 2018/19 (end of Sept).





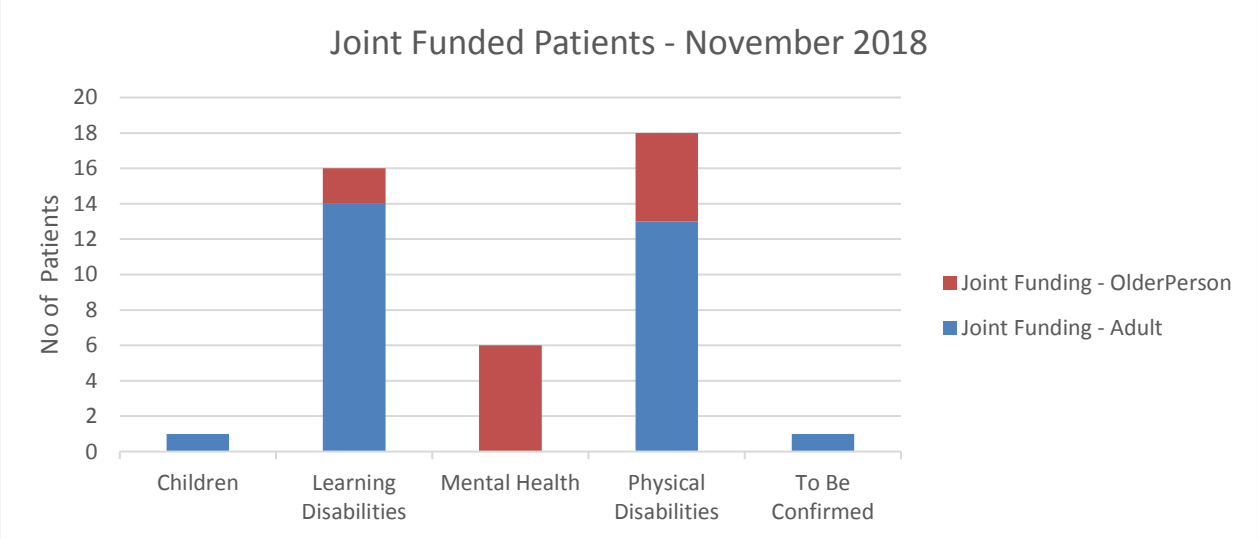
4.5 No of CHC Checklists Completed

The graph below shows the number of CHC Checklist referrals received by NCCP for the 12 months from service commencement in November 2017. The trend line indicates an overall increase in referrals.



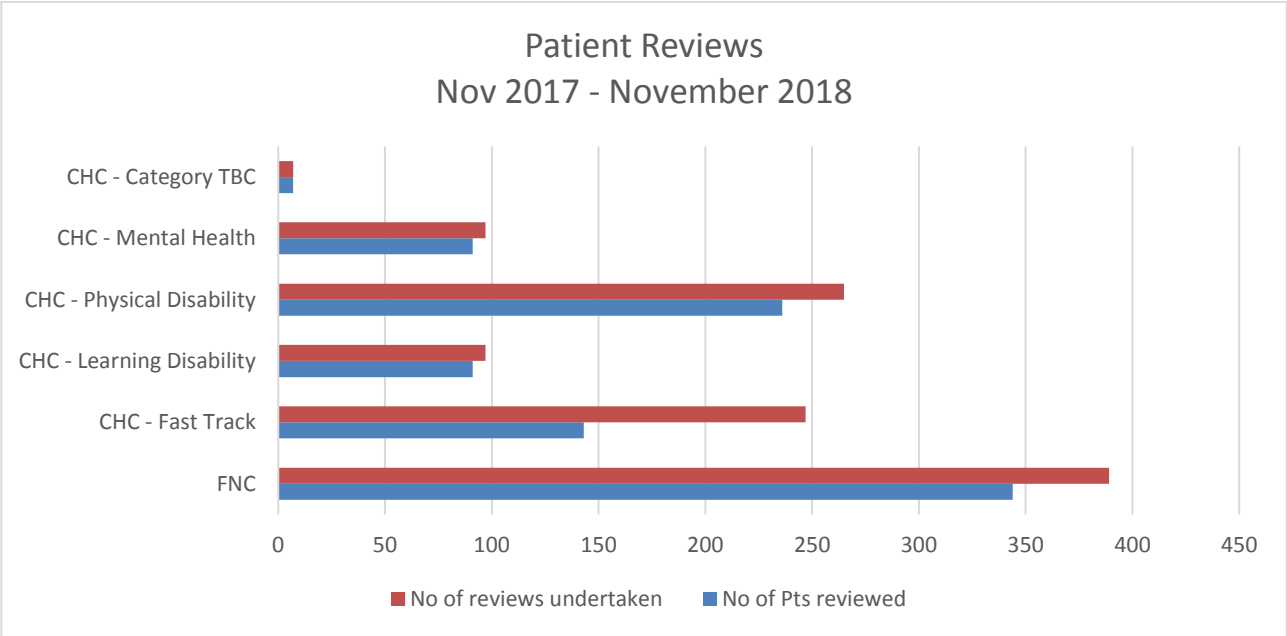
4.6 Shared Care Agreements

The current number of Joint Funded packages of care are indicated in the table below broken down into 'primary categories' as requested.



4.7 Reviews of Individual Packages of Care in 2018

The review activity undertaken by NCCP in the last 12 months is represented below according to patient category. The recording system used does not differentiate between eligibility and package of care reviews, but in practice every review will involve a package of care review to ensure patients clinically assessed needs are being met through the care provided.



4.8 Local System Changes to Reflect the Requirements of the Revised National Framework for Continuing Healthcare and NHS-funded Nursing Care (2018)

The Norfolk Continuing Care Partnership have undertaken significant preparation for the implementation of the new National Framework for Continuing Healthcare and NHS-funded Nursing Care (2018). The entire senior management team have attended training from a legal firm that specialises in CHC, to ensure that the nuance of the changes are well understood and accommodated at all levels within the organisation. A detailed action plan has been developed and implemented by key members of staff with activity carefully coordinated via a weekly steering group. The following measures have been put in place;

- All CHC clinical staff and specialist CHC Social Workers have attended NHSE training events, workshops and local updates to ensure readiness for practice.
- A series of additional role specific training sessions have been held for all staff within NCCP to facilitate an understanding of the changes to the National Framework and new ways of working.
- A case management model has been implemented and all patients have a named case manager allocated from 01.10. 2018.
- Websites and communication materials have been updated for all partner CCGs.
- The NCCP service KPIs have been updated to reflect new requirements (Fast Track patients placed within 48 hours).
- All mandated CHC documentation (CHC Checklist, Fast Track Tool, Decision Support Tool) has been updated and disseminated to stakeholders for use.

- The change in focus to undertake ‘care reviews’ rather than ‘eligibility reviews’ has been implemented and supported by a change in terminology, supporting documentation and reference points throughout the IT systems used by NCCP.

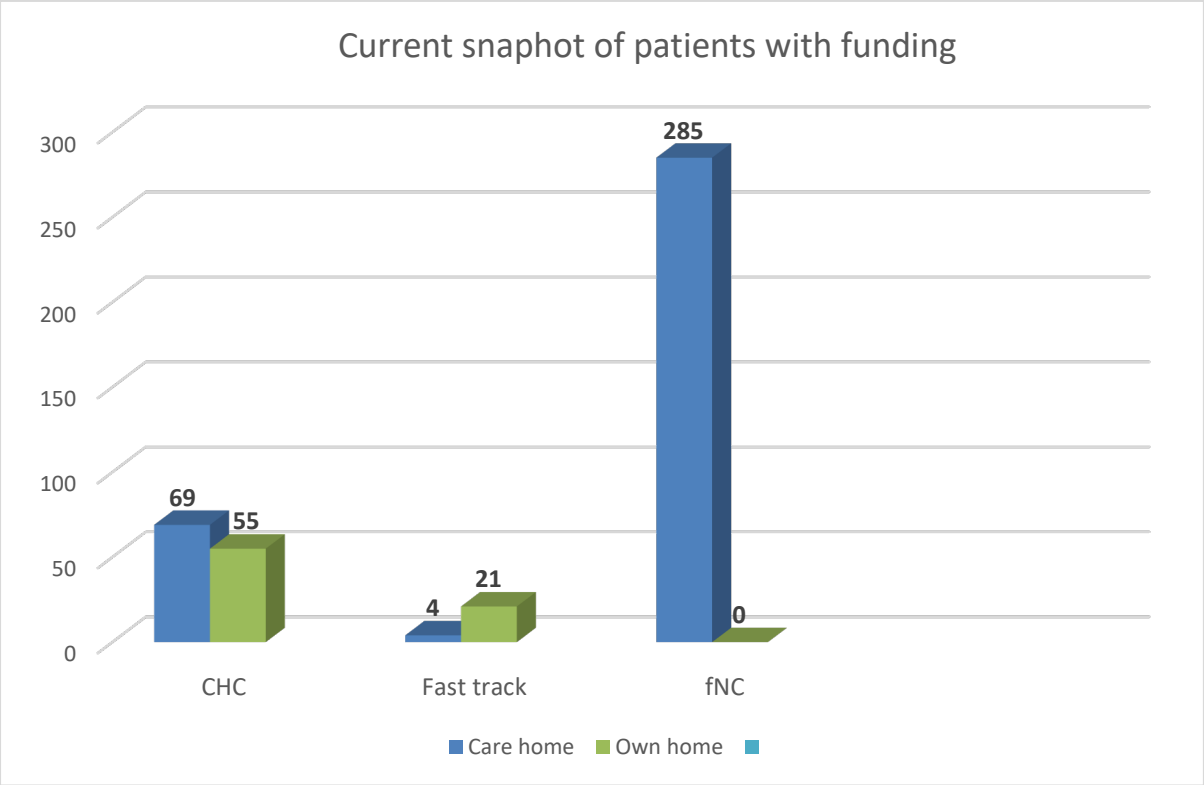
- An integrated training plan has been developed in collaboration with NCC colleagues and a joint CHC training programme is due to commence on a monthly basis from January 2019.

- The NCCP Appeals process is already in place with system for local resolution that is fully compliant with the new National Framework.

Great Yarmouth and Waveney Clinical Commissioning Group

Norfolk Health Overview and Scrutiny Committee
NHS Continuing Healthcare
Appendix B – NHS Great Yarmouth and Waveney Clinical Commissioning Group

General contextual information:
Numbers currently receiving NHS Continuing Healthcare CHC (residential and domiciliary) as at 09 November 2018:
NHS Great Yarmouth and Waveney Clinical Commissioning Group (NHS GYW CCG)



Trend in the numbers of patients eligible to receive CHC in the past 12 months NHS GYW CCG:

Month	Newly eligible for CHC in month	Individuals in month eligible for CHC
November 2017	6	183
December 2017	5	183
January 2018	3	175
February 2018	2	170
March 2018	3	161
April 2018	6	156
May 2018	5	161
June 2018	5	152
July 2018	7	145
August 2018	0	141
September 2018	3	134
October 2018	4	129

Compliance against the 28 day assessment target in the past year (showing the trend month by month).

NHS GYW CCG has been compliant with the minimum data set of 80% of new full considerations for CHC being completed within 28 days:

October 2017	96%
November 2017	100%
December 2017	100%
January 2018	95%
February 2018	95%
March 2018	91%
April 2018	81%
May 2018	91%
June 2018	100%
July 2018	100%
August 2018	89%
September 2018	100%
October 2018	95%

There has been a strong commitment by both Norfolk and Suffolk County Councils and NHS GYW CCG to complete all new full considerations for CHC within 28 days of referral date. In the months whereby 100% has not been achieved this has been because of individual/representative choice or social worker/CHC Nurse availability (including staff sickness, inclement weather etc.). Consistently achieving the 28 day assessment target is a priority for NHS GYW CCG as it lends itself to timely, quality assessments that lead to an improved individual/representative experience of the service that we deliver.

Numbers of complaints and themes since Feb 2018.

Complaints relating to Previously Unassessed Periods of Care: On 21 January 2018, NHS GYW CCG received 25 cases back from North East London Commissioning Support Unit (NEL CSU). These were retrospectively assessed by NEL CSU. Letters of complaint to NHS GYW CCG were in relation to lack of progress and lack of communication associated with furthering the appeals process. Five complaints since February 2018 have been received – all from Claims companies.

Complaints related to assessment process: Since February 2018, NHS GYW CCG has received two complaints about the assessment process – one from an individual and one from their MP. The complainant was dissatisfied that a Decision Support Tool (DST) would be held without separating the roles of Lead Co-ordinator and health Multidisciplinary Team Member. The complainants were informed that the National Framework for NHS Continuing Healthcare permits this arrangement.

Complaints related to commissioning of care: Since February 2018, three complaints have been received by NHS GYW CCG about CHC commissioning. Two complaints were from a representative dissatisfied with the care commissioned for a CHC eligible individual. This complaint was resolved by commissioning a new provider for the individual. Third complaint was from a jointly funded individual and their representatives about their commissioned care; a meeting was held with senior NHS GYW CCG staff to discuss the issues arising.

Capacity of the assessment service (caseload numbers and staff capacity, including info on staff vacancy levels).
The team model is an end to end service. This means that a CHC Nurse will commence and complete the CHC journey with an individual from Checklist through to DST and then case management and review, if the individual is eligible to receive CHC. Therefore caseloads reflect this model of working and are deliberately low (currently up to 20 CHC eligible cases per CHC nurse) to allow for a good standard of case management (care planning, evaluation and review). In addition to this, each CHC nurse is responsible for a geographical area centred round a care home with nursing.

The CHC nurse will also be responsible for all NHS-funded Nursing Care (NHS-fNC) activity associated with this care home (up to 60 beds) and will also be allocated all Checklists associated with other care homes and residential addresses that are received within their geographical area. Relationship building to support care homes and care home quality reviews are all the responsibility of caseload holders. Currently the team employs seven CHC nurses (one of whom is currently on maternity leave) in this function of the team. An additional nurse has been recruited to commence in post January 2019. There are currently no active vacancies within the team. Staff retention is good.

Numbers of people that have had their CHC or Funded Nursing Care withdrawn since NCCP have been completing the reviews and the numbers where exceptional decisions have been made to continue funding despite no longer being eligible.

Since October 2017, 12 individuals have been found to be no longer eligible to receive CHC. No exceptional decisions have been made to continue funding after CHC has been withdrawn.

Since October 2017, 0 individuals have been found to no longer be eligible for NHS-fNC.

It is the expectation of NHS England that as numbers of individuals in nursing home beds receiving CHC level off, the numbers of residents in these care homes receiving NHS-fNC will increase. This has been the reality for NHS GYW CCG since 2014-15 and demonstrates responsiveness to changing needs of individuals and partnership working with social care colleagues.

Information about the Discharge to Assess pathways at each of the three acute hospitals in Norfolk (NCCP to provide info for the NNUH and QEH; GYW CCG for the JPUH), including:-

In January 2018, NHS GYW CCG introduced Discharge to Assess (D2A) for individuals assessed to require complex discharge planning – also known locally across the health and social care system as Pathway 3.

Two NHS GYW CCG CHC nurses in-reach permanently into JPUH and are co-located with their social care colleagues.

The D2A model was developed to focus upon the maturity of the relationships between CCG and social care colleagues. It was judged by health and social care leaders that there is sufficient level of trust and mutual respect for professionals to have a 'conversation' about the best pathway for an individual patient on leaving hospital. The conversation model puts the person at the centre, aims to discharge the individual to a location in which they will be able to remain, does not falsely raise public expectations of on-going health funding post discharge and aims to ensure that the care commissioned on discharge will meet needs.

The pathway was designed to continue to reflect health/social care discharges that took place prior to the commencement of the D2A model.

If patients are assessed to require the health pathway on discharge, NHS GYW CCG will fund the individual's care on discharge for 28 days. Within the 28 days a full DST will be completed. If the individual is eligible to receive CHC health funding continues. If the individual is not eligible to receive CHC funding, health funding ceases on day 28 post discharge.

All pathway 3 individuals are followed up post-discharge:

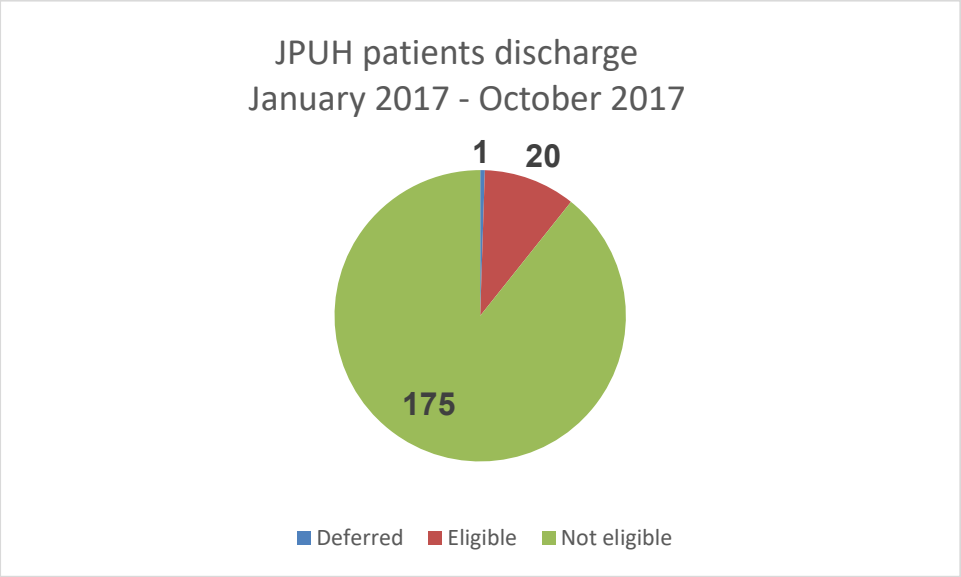
CCG follow-up post discharge	**Local Authority follow up post discharge**
Discharged on health pathway	Individuals discharged with social care funding
Discharged as a self-funder (alerted by social care colleagues)	
Discharged to a care home with nursing	

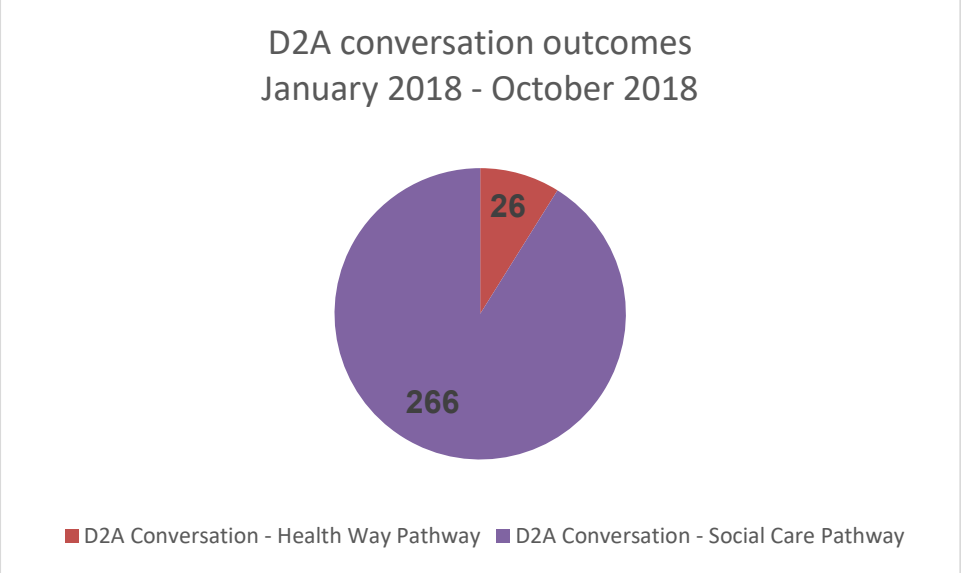
There is no financial risk to social care/individual as any individual followed up after discharge from hospital who is found at review to be eligible for CHC will be reimbursed back to the date of discharge from hospital – thus far this has applied to four individuals (Norfolk = 3).

There have been no complaints associated with the D2A pathway since it was implemented. The model has proved popular with health and social care professionals and has since been adapted for use at Norfolk and Norwich University Hospital.

Numbers accessing the pathway at each hospital
James Paget University Hospital (JPUH)

In order to put current data into context, the numbers accessing the full CHC process (that is Checklist and DST) in JPUH in the same period in 2017 are illustrated below:





Breakdown by County Council:

LA	Health pathway	Local Authority pathway
Norfolk	12 (46%)	147 (55%)
Suffolk	14 (54%)	119 (45%)

Numbers converted to eligible / not eligible for CHC after the Discharge to Assess pathway period.

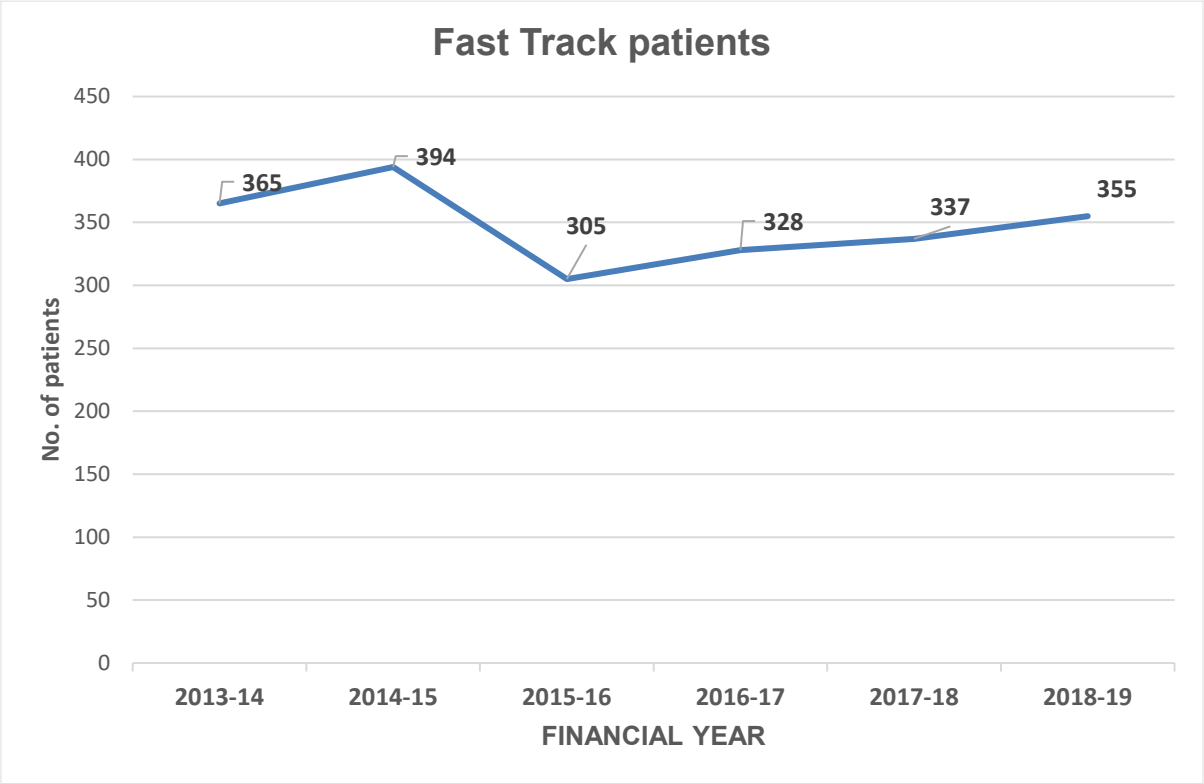
NHS GYW CCG health pathway status after 28 days:

Status	**Number of individuals (N = Norfolk)**
Health funding continues (CHC eligible)	7 N = 2
Health funding ceases (not CHC eligible)	12 N = 7
Joint care	1 N = 0
Patient deceased	6 N = 3

Number of beds used for Discharge to Assess in relation to each of the three hospital areas.
Of the 26 individuals accessing health funding on discharge from JPUH, 24 transferred to a care home bed on discharge from hospital.

Of the 266 individuals discharged from JPUH without health funding, 240 transferred to a care home bed on discharge from hospital, (10% returned home).

Fast Track:-
The number of Fast Track awards year by year for the past five years.



The average duration of Fast Track award funding
The average duration of Fast Track award funding 12 month period November 2017 to October 2018 = 22 days

The proportion of fast track patients placed within three days of referral
This information is not currently an NHS England data set for collection. However NHS GYW CCG recognises the value of having this data readily available; this will be collected moving forward.

On receipt of a properly completed Fast Track referral the dedicated NHS GYW CCG Fast Track Nurse will begin to commission care. In most cases placements are currently exceeding three days due to individual/representative choice/the desire to view care homes when a care bed is required or lack of market capacity, especially in difficult rural areas for individuals requiring home care. When there is a lack of market capacity the Out of Hospital Team provided by East Coast Community Healthcare are engaged to provide care as an interim measure when capacity is available. Every effort to discharge the individual in a timely way is made whilst also maximising individual choice.

Numbers of Fast Track patients that plateau and require ongoing care and who this is provided by

Financial Year	Fast Track patient plateaus – DST – Eligible for CHC	Fast Track patient plateaus – DST – Not Eligible for CHC – referred to relevant local authority for on-going care
2015/2016	4	10
2016/2017	4	7
2017/2018	0	3
2017 to date	1	8

NHS GYW CCG are currently in the process of up-skilling JPUH ward staff to Fast Track patients who have a rapidly deteriorating condition that may be entering a terminal phase. Therefore it is expected that there may be a slight raise in the number of patients that plateau that go on to have a 'not eligible' decision for CHC. This is under continuous review and remedial steps are being taken when necessary regarding education and training.

A breakdown of CHC and Fast Track considerations and eligibility by CCG area and compared to national benchmarking

Data taken from published statistics Q2 2018-19 Year to Date			CHC	FAST TRACK	fNC
CCG Code	Organisation	Organisation Type	Per 50k	Per 50k	Per 50k
Q79	NHS England Midlands and East (East)	Regional Team	56.32	55.68	69.33
06M	NHS Great Yarmouth and Waveney CCG	CCG	59.00	55.16	102.67

Numbers of CHC checklists completed

Period - January 2018 to October 2018

Checklist Outcome	Norfolk	Suffolk
Negative	82	122
Positive	96	141
Grand Total	178	263

Numbers of shared care agreements between CCG and Norfolk County Council, broken down by Older People, Physical Disabilities, Learning Disabilities and Mental Health as a primary category

As at 26 November 2018, NHS GYW CCG jointly fund with Norfolk County Council the following care packages:

Category	CHC	Adult MH/LD	Total
Older People	0	0	0
Physical Disabilities	7		7
Learning Disability	1	12	14
Mental Health	1	42	43

Numbers of reviews of individual CHC packages of care completed in 2018 (i.e. to check the suitability of the CHC package in place, not primarily to re-assess eligibility).

In October 2018 the revised version of the National Framework for NHS Continuing Healthcare was implemented. For the first time reviews should primarily focus on whether the care plan or arrangements remain appropriate to meet the individual's needs. It is expected that in the majority of cases there will be no need to reassess for eligibility.

Since October 2018, NHS Great Yarmouth & Waveney Clinical Commissioning Group has changed the way that data is collected about reviews undertaken. This data will be available to access early in 2019.

Changes in the local system to reflect the revised National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care, October 2018

In order to prepare for the implementation of the revised National Framework for NHS Continuing Healthcare, October 2018 the following has been undertaken:

- NHS GYW CCG Local Resolution Policy has been agreed by the CCG's Clinical Executive Committee and is published on NHS GYW CCG's website - as per the National Framework for NHS Continuing Healthcare 2018 revised.
- Training programme for health and social care professionals – as of 24 November 2018 74 Norfolk and Suffolk health and social care staff have been trained regarding the changes to the Framework with more training sessions booked
- Revised CHC Tools have been shared with system partners

- NHS GYW CCG has developed commissioning care plans and review paperwork in order to comprehensively capture the quality and quantity of care required by an individual and how their needs will be met. This commissioning paperwork will be pivotal to demonstrate significant changes in an individual's presentation that result in a need to complete a further DST to individuals, their representatives and local authority colleagues. This paperwork has been positively received and is being adopted by NHS England as examples of on-going records that can be used when an individual is eligible to receive CHC
- The Disputes Policy currently in use by NHS GYW CCG, Suffolk CCGs and Suffolk County Council is being considered by Norfolk Continuing Care Partnership and Norfolk County Council to consider if it can be adapted for use across the entirety of Suffolk and Norfolk health and social care system
- Other changes, such as the verification of recommendations regarding CHC within 2 days of receipt by NHS GYW CCG, were already standard practice

Dawn Newman,
Head of Quality in Care,
NHS Great Yarmouth and Waveney Clinical Commissioning Group

Improving NHS Continuing Healthcare Communication

A report by Healthwatch Norfolk to the Health Overview & Scrutiny Committee on activities and progress June – November 2018

1. Background

This report provides the committee with a summary of the outcomes of collaborative work between Healthwatch Norfolk and Norfolk Continuing Care Partnership (NCCP) to improve NHS continuing healthcare (NHS CHC) communication with patients and families (next-of-kin). The work focused upon:

- Improving verbal and written communication in the suite of existing (i.e. inherited) template letters including:
    - Stages of the process
    - Outcome of each stage
    - Notification of decisions (including funding decision)
    - Appeals
- Improving verbal and written information provided to patients and families such as information leaflets and signposting to further sources
- Ways of capturing real-time feedback from patients and families, on how well they understood the CHC process and how well they were explained to them

2. Activity July to November 2018

2.1 Four half-day workshops were held between July and November 2018, organised by Healthwatch Norfolk. The content of the workshops was designed to cover each of the actions proposed by NCCP to HOSC, allowing time for discussion, feedback and agreeing changes and /or actions. Healthwatch Norfolk asked volunteers and partners from carers support organisations with lived experience of the NHS CHC process and service to help with this work.

2.2 The volunteers who participated each had varied, lived experience as a spouse, family carer or parent of a person who had either; been assessed for NHS CHC and found not eligible, been assessed for NHS CHC, found eligible and receiving continuing healthcare and experience of providing information and advice to others in a similar position.

2.3 NCCP were actively involved in the workshop planning, preparation and follow-up in a variety of ways. The service director attended every workshop alongside a Clinical Lead for each speciality plus staff holding roles involving frequent contact with families and patients. NCCP provided digital and print versions of original template letters and information leaflets and subsequently amended versions.

2.4 The following is a summary of specific feedback, with subsequent action taken by NCCP.

Content / activity	**Feedback leading to a change by NCCP:**
Workshop 1: Introduction to NHS CHC in Norfolk & Review of Letter Templates	
Reviewing the 10 most frequently used letter templates (out of 40) communicating with patients and families • Checklist CHC Not Eligible • Checklist Appeal for Next of Kin • CHC Combined Eligibility and 3 Month Review • Full Process Not Eligible for CHC • Remains Eligible Letter • Funded Nursing Care (FNC) Eligible and For Full Process • FNC Eligible No for Full Process • Not Eligible for FNC or Full Process • Letter for Next of Kin for a person who died whilst on the waiting list • Letter for Next of Kin for a person who died with Assessment Not Completed • Personal Health Budget invitation letter	• Adding extra 'fields' to the templates so letters can be better tailored/personalised to the recipients • Several changes the tone of the letters e.g. replacing specific words to improve clarity and understanding and avoid complexity • Removing superfluous information that could lead to confusion or misunderstanding and to keep letters succinct where appropriate • Removal of long hyperlinks in print/paper • Adding organisation names, website addresses and contact telephone numbers • Clear instructions on how to contact NCCP (and who to contact) with any questions • Sending accompanying information leaflet where appropriate
Workshop 2: Care Coordinators, Redrafted Letter Templates, Information leaflets and Real-Time Feedback	
Gathering evidence for the NHS CHC assessment What counts as evidence and what can families and carers do?	• During the process of assessment, suggest to families / carers they could record how their loved one is coping day to day, health and support needs, mood and behaviour, taking medication
Review of redrafted letter templates (as detailed above)	• All changes proposed had been implemented <u>Exception</u>:- • The entire Decision Support Tool document is sent to a person (and/or next of kin) following an assessment. It is a 52 page document and record of the assessment at a specific point in time. Volunteers suggested providing only a summary of the completed Decision Support Tool for patients /families however *this is not possible because the national guidance does not allow it*.

Content / activity	Feedback leading to a change by NCCP:
Workshop 2 (cont): Care Coordinators, Redrafted Letter Templates, Information leaflets and Real-Time Feedback	
Information booklet: Central & West Norfolk guide to NHS CHC for patients	• This in-house, locally tailored guide to be available on the NCCP website with an option to request a print copy • Addition of the InTran logo & information on accessible formats and language etc.
Capturing real-time feedback Appraisal of existing, in-house patient feedback pro-forma and channels Comparison against examples from elsewhere • CHC Patient Satisfaction Survey • Funded Nursing Care (FNC) Patient Satisfaction Survey • Easy Read Patient Satisfaction Survey • Personal Health Budgets (PHB) Customer Satisfaction Survey • Personal Health Budget Quarterly Review Satisfaction Survey • Personal Health Budget Annual Review Satisfaction Survey	• Using size 12 font as a standard • Answer options for patients and/or families • Confine the feedback survey to no more than 2 sides of A4 paper, for speedy completion • Questions to have multiple choice options and tick boxes for ease of use • Include one free text /comment box • Explain there are other ways to give more detailed feedback e.g. via telephone • Include brief description of how feedback is used to improve the service On an ongoing basis: • The patient feedback survey will be trialled with 100 people and collated to review themes and trends • There is now a generic email address for giving feedback which is being added to all letters • NCCP already have mechanisms to review complaints and feedback via the Clinical Governance Forum • Healthwatch Norfolk can provide NCCP with comments relating to NHS CHC on a bespoke basis • Healthwatch Norfolk volunteers are willing to assist NCCP in auditing anonymised complaints, the complaints process and correspondence

Content / activity	Feedback leading to a change by NCCP:
Workshop 3: Reviewing communication on Personal Health Budgets, Information for Parents & Young People, Appeals & Previously Unassessed Periods of Care (PUPoC)	
• Personal Health Budgets leaflet	• Promote the benefits of having a PHB, using real case examples with testimonials from a variety of service users and families • Include a reference to wellbeing as part of having health needs met • Explain what support is available to those who might want or need it, including when things go wrong
• Department of Health (DoH) leaflet 'Information for Parents and Young People'	• Re-design two in-house versions: one for the parents of young children and the other for young people i.e. teenagers preparing for transition to adult services in a few years • Include key sections such as: What is NHS CHC? Who might be eligible? What is the assessment like? What happens next? • Remove information about the DoH and CCGs responsibility as this is not helpful to parents • Including brief information on the availability of a mediation service with the option to get more information if required
• Draft Appeals leaflet	• Retain this is a good example of format and layout for an in-house leaflet • The Frequently Answered Questions section is very informative and could be included in many other information leaflets • Substitute the location of the Local Resolution Panel meeting from 'Lakeside 400' to Norwich for simplicity
• Draft Previously Unassessed Periods of Care (PUPoC) leaflet	• Consider whether it is prudent to mention the possibility of a financial refund or payment in this particular leaflet as this might falsely raise a person's expectation prior to the outcome of the process being known • Include the term 'Executor' alongside next-of-fin as some individuals may be the Executor of the deceased person's will as opposed to next-of-kind

• For all services, replace nationally produced leaflets with NCCP in-house leaflets, since these can be bespoke, are much more user-friendly and locally tailored • Add a date and version number, page numbers and the InTran to each • Where information on how to make a complaint is included, include a description of the options for making a complaint e.g. in writing by email or post, or by calling a number, to ensure equity for people who aren't able to write	
Content / activity	**Feedback leading to a change by NCCP:**
Workshop 4: Case Management, Funded Nursing Care, Alternative Care Provision	
Reviewing Role of the CHC Practitioner leaflet	Workshop 4 held 29th November 2018 Outcomes to be confirmed
Reviewing Funded Nursing Care leaflet	
Information and discussion on alternative / respite care provision if appropriate	

3. Feedback from volunteers with lived experience as carers and next-of-kin contributing to this work.

- *Jill Shattock and her team explain issues so clearly and professionally, which was extremely informative and could be valuable to other families. Along with the patient information leaflet, could there be some kind of audio recording or short film giving a brief explain of NHS continuing healthcare, personal health budgets, funded nursing care and so on, on the Norfolk Continuing Care Partnership website?*
- *Norfolk Continuing Care Partnership have been really cooperative. They've brought the most appropriate people to the meeting- those from the frontline where good communication is most effective - to make the meetings as productive as possible. We've also learnt a huge amount from them so we're now in a better position to give other people, such as the North Norfolk Community Engagement Panel, better quality information about continuing care.*
- *A very positive experience. We've worked in a collaborative manner.*

4. Further points noted during this work

In the course of the discussions, people with lived experience raised a number of additional queries and concerns which are described below. These are for Healthwatch Norfolk, NCCP, CCGs, Norfolk County Council and other partners to address in future.

Awareness raising and accurate information for the general public in Norfolk:

- There is a need to a **communications boost** about NHS CHC: there is more to do to raise awareness and understanding of NHS CHC, what to expect, the process and where to get information and advice (or advocacy).

- Many carers and families are **not aware there can be expenses** associated with care provided through Norfolk County Council's adult social care services e.g. for administration costs for closing down an account, or for interest that has accumulated on payments pending.

Variation between Norfolk's Clinical Commissioning Groups:

- Norfolk has five Clinical Commissioning Groups and we understand as that four of the five commission NHS CHC collaboratively. Unless all CCGs are aligning their NHS CHC policies and commissioning specifications, patients in Norfolk could experience variable service provision.

Training and support for those referring:

- Who ensures there is **training and support** for those individuals who will be making referrals whether that be GPs, Community Nurses, Practice Nurses, Occupational Therapists and especially those in supporting roles e.g. Healthcare Practitioners, care home staff etc?
- Healthwatch Norfolk could ask staff about their knowledge, training and confidence on making an NHS CHC referral during **Enter & View** visits in care homes.

Integrated budgets for integrated care:

- Can we voice our support for integrated commissioning and i**ntegrated** budgets / funds for NHS CHC as means to avoid patients and families becoming immobilised in the process whilst health and social care cannot agree on who should pay?

'Top-Up' fees:

- Some families are asked to pay 'top-up fees' (over and above Funded Nursing Care or CHC) to a care or nursing home; can we encourage people to query what these fees are for, before paying them and how they can get advice on 'top-up fees'?
- Healthwatch Norfolk could ask family members and carers about 'additional charges' for lifestyle and wellbeing expenditure e.g. toiletries, hairdressing, chiropody and access to activities and entertainment etc during **Enter & View** visits in care homes.

Good care in the community:

- Many people are not eligible for NHS CHC however this does not mean they cannot get great care in the community. Community services can provide good ongoing care and support but need to be sufficiently funded to do so.

Norfolk and Norwich University Hospitals NHS Foundation Trust – response to the Care Quality Commission report

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

Examination of the Norfolk and Norwich University Hospitals NHS Foundation Trust's (NNUH) response to the report of the Care Quality Commission's (CQC) inspection between 10 October 2017 and 28 March 2018, published on 19 June 2018.

1.0 Purpose of today's meeting

1.1 To receive and examine the NNUH's action plan to address the issues raised by the CQC inspection report.

The key focus areas are:-

(a) The NNUH's progress in addressing the CQC's requirements for improvement.

(b) Capacity of the NNUH to manage current and future demand for services.

(c) The commissioners' and wider health and care system's role in supporting the NNUH to improve.

1.2 The NNUH was asked to provide the following information:-

(a) Details of its progress against the 'must do' and 'should do' actions set out by the CQC. (These are wide-ranging and include staffing, staff training, staff relationships and culture, functionality of the Board, bed and site management to increase capacity, risk assessment, safety of services and equipment,

(b) Details of its capacity planning for this year and for the future.

Full details of progress against the 'must do' and 'should do' actions is available in the **N&N Quality Improvement Programme** document (141 pages) on the committee pages of Norfolk County Council's website in the via the following link :-
http://norfolkcc.cmis.uk.com/norfolkcc/Meetings/tabid/128/ctl/ViewMeetingPublic/mid/496/Meeting/1414/Committee/22/Default.aspx

The NNUH has also provided:-

- A report summarising progress with the Quality Improvement Programme and details of its capacity planning for this year and the future - attached at **Appendix A**

- A slide presentation for today's meeting - attached at **Appendix B**

1.3 Representatives from the NNUH, North Norfolk Clinical Commissioning Group (lead commissioner for the NNUH's services) and Norfolk and Waveney Sustainability Transformation Partnership (STP) will attend to answer the committee's questions.

2.0 Background

2.1 The CQC report

2.1.1 The CQC inspected specific services at the Norfolk and Norwich Hospital (N&N) between 10 October 2017 and 28 March 2018. Services inspected were:-

- Urgent and emergency care
- Surgery
- End of life care
- Outpatients
- Diagnostic imaging services

Medical care (including older people's care), critical care, maternity and services for children and young people were not inspected. The NNUH's Cromer hospital site was not inspected.

2.1.2 The report was published on 19 June 2018 and is available on the CQC website:-

https://www.cqc.org.uk/sites/default/files/new_reports/AAAH0781.pdf

The CQC's Chief Inspector of Hospitals recommended that the Norfolk and Norwich University Hospitals NHS Foundation Trust be placed into special measures. This means:-

- An improvement director can be appointed to provide assurance of the trust's approach to performance
- NHS Improvement review the capability of the trust's leadership
- A 'buddy' trust may be chosen to offer support in the areas where improvement is needed
- Progress against action plans is published monthly on the trust's website and the NHS website.

NHS Improvement assigned Philippa Slinger as the improvement director with the NNUH. Ms Slinger is also the improvement director with Norfolk and

Suffolk NHS Foundation Trust and the Queen Elizabeth Hospital NHS Foundation Trust, who are also in special measures.

Collaboration with a designated 'buddy' trust is yet to be confirmed.

2.1.3 The ratings for the whole Trust were as follows:-

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Inadequate ↓ Jun 2018	Requires improvement →← Jun 2018	Good →← Jun 2018	Requires improvement →← Jun 2018	Inadequate ↓ Jun 2018	Inadequate ↓ Jun 2018

Ratings for specific services now stand as follows:-

Ratings for Norfolk and Norwich hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate ↓ Jun 2018	Requires improvement ↓↓ Jun 2018	Good ↓ Jun 2018	Requires improvement ↓ Jun 2018	Inadequate ↓↓ Jun 2018	Inadequate ↓↓ Jun 2018
Medical care (including older people's care)	Requires improvement Aug 2017	Good Mar 2016	Good Mar 2016	Requires improvement Aug 2017	Requires improvement Aug 2017	Requires improvement Aug 2017
Surgery	Inadequate ↓ Jun 2018	Good →← Jun 2018	Good →← Jun 2018	Requires improvement →← Jun 2018	Inadequate ↓ Jun 2018	Inadequate ↓ Jun 2018
Critical care	Requires improvement Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016
Maternity	Requires improvement Aug 2017	Requires improvement Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Requires improvement Aug 2017
Services for children and young people	Requires improvement Aug 2017	Good Mar 2016	Good Mar 2016	Good Aug 2017	Good Aug 2017	Good Aug 2017
End of life care	Requires improvement →← Jun 2018	Requires improvement →← Jun 2018	Good →← Jun 2018	Requires improvement →← Jun 2018	Requires improvement →← Jun 2018	Requires improvement →← Jun 2018
Outpatients	Requires improvement Jun 2018	Not rated	Good Jun 2018	Requires improvement Jun 2018	Requires improvement Jun 2018	Requires improvement Jun 2018
Diagnostic imaging	Requires improvement Jun 2018	Not rated	Good Jun 2018	Requires improvement Jun 2018	Requires improvement Jun 2018	Requires improvement Jun 2018
Overall*	Inadequate ↓ Jun 2018	Requires improvement →← Jun 2018	Good →← Jun 2018	Requires improvement →← Jun 2018	Inadequate ↓ Jun 2018	Inadequate ↓ Jun 2018

The CQC made 82 recommendations for improvements at the NNUH ('must do' and 'should do' actions).

2.2 **The wider local health and care system**

2.2.1 The current CQC overall ratings for the NHS trusts serving Norfolk (and the independent Community Interest Company (CIC) providing NHS community services) are as follows:-

NHS Trust / Community Interest Company	CQC overall rating
The Queen Elizabeth NHS Foundation Trust	Inadequate (Sept 2018)
Norfolk and Suffolk NHS Foundation Trust	Inadequate (Aug 2018)
East of England Ambulance Service NHS Trust	Requires improvement (July 2018)
Norfolk and Norwich University Hospitals NHS Foundation Trust	Inadequate (June 2018)
Norfolk Community Health and Care NHS Trust	Outstanding (June 2018)
East Coast Community Health and Care CIC	Good (March 2017)
James Paget University Hospitals NHS Foundation Trust	Good (Nov 2015)

2.2.2 In 'The state of health care and adult social care in England 2017/18[1]' the CQC reported that just 3% of NHS acute hospital core services across the country and only 1% of NHS mental health trust core services were rated 'inadequate' in 2018.

With three NHS trusts rated 'Inadequate' in Norfolk, there is clearly a need to consider issues in the county's wider health and care system as well as the individual responsibilities of the trusts involved.

2.2.3 In a report to the NNUH Board in July 2018[2], the Chief Executive Officer said,

"*the Trust anticipates that demand will continue to rise significantly in excess of the national growth assumptions in some areas. We are working with system partners toward agreement of common activity assumptions and plans for how all the relevant services can be funded but this is a difficult 'square to circle*''.

The NNUH had a £23.7m (approx.) deficit at the end of 2017-18 and in 2018-19 the Norfolk & Waveney health system is facing a deficit in the order of £66m on a combined turnover for all organisations of £2.8 billion (not including social care).

2.2.4 The Norfolk and Waveney STP's Interim Executive Lead's response to the CQC's report on the NNUH included the assurance,

[1] https://www.cqc.org.uk/sites/default/files/20171011_stateofcare1718_report.pdf

[2] NNUH Board papers July 2018 file:///C:/Users/dcaor/Downloads/Trust-Board-Papers-July-2018.pdf

"This is very much a report about the health of our whole system, rather than just one organisation.

We are already taking actions which will alleviate some of the pressure on the NNUH and our system, such as creating one Norfolk and Waveney wide A&E Delivery Board, appointing a Winter Director and having one plan for winter. This all runs alongside the work we are doing to strengthen primary care and more effectively integrate with social care and community services. Our challenge is to be bolder, to do more and to act faster, which I know we can do working in partnership together."

2.2.5 The central Norfolk CCGs have been reporting to NHOSC since March 2013 (during 'Ambulance response and turnaround times' scrutiny) on their system-wide measures to manage demand for the N&N's urgent and emergency services by admission avoidance initiatives, provision of more NHS services in the community and integrated working across the NHS and with social care. Despite the work that has been done, demand for the NNUH's emergency and elective services has continued to rise.

3.0 Suggested approach

3.1 After the NNUH representatives have presented the action plan, the committee may wish to discuss the following areas with them and the Sustainability Transformation Partnership / commissioner representatives:-

For discussion with NNUH

(a) With 69% of the required quality improvement actions in the Urgent and Emergency Care workstream either at risk of delivery (61%) or overdue or not on track (8%) at the start of the winter period, is there likely to be enough capacity in the busiest months to make the necessary progress?

(b) 18% of the required quality improvement actions in the Diagnostic Imaging workstream are overdue or not on track. Given the importance of diagnostic services to patient flow through the acute hospital, what can be done speed up improvement in this area?

(c) What effect does being rated 'inadequate' overall and placed in special measures have on the N&N as a teaching hospital?

(d) The commissioners have been looking to agree 'block contracts' with the with acute hospitals. This means the hospital receives a fixed amount of funding regardless of how many patients it serves. Has the NNUH agreed to a block contract and, given the rise in demand in recent years, is the block contract a sustainable funding basis for the hospital?

(e) The NNUH's report (Appendix A) mentions a third party provider who has been engaged to provide a 30 bed virtual ward for patients

living within a 15 mile radius of the hospital. Who is the provider and how does this service fit in with the CCG-commissioned community health services?

(f) Given the staffing challenges that have been experienced at the Queen Elizabeth Hospital, King's Lynn, and the pressures on its A&E department, does the NNUH's winter planning build in capacity for the possibility of more patients coming from the west of the county?

For discussion with commissioners

(g) NHOSC has heard from commissioners over many years that they are working to shift the NHS emphasis towards primary and community services so that more people can be cared for outside of the acute hospital. How are the STP partners planning 'to be bolder, to do more and to act faster'? (see paragraph 2.2.3 above).

(h) Even if the measures that the commissioners are planning for prevention of ill health and primary and community services are very successful, will it still necessary for the NNUH to expand its bed numbers (summer and winter) because of overall population growth in Norfolk and particularly the growth in the older population?

(i) With the health organisations in Norfolk and Waveney facing a combined £66m deficit in 2018-19 and the NNUH approximately £27.3m in deficit at the end of 2017-18, (with the Queen Elizabeth Hospital approximately £18.9m in deficit and the James Paget Hospital approximately £8.9m in deficit) where is the scope for reallocation of resources away from acute care and towards preventative, primary and community services?

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Our Vision
To provide every patient with the care we want for those we love the most

Norfolk and Norwich University Hospitals NHS
NHS Foundation Trust

REPORT TO THE NORFOLK HEALTH OVERVIEW& SCRUTINY COMMITTEE	
Date	6th December 2018
Title	Quality Improvement Programme (QIP) status update
Author(s)	Professor Nancy Fontaine, Chief Nurse Rosemary Raeburn-Smith, Programme Director for Quality Improvement Jane Robey, Head of Improvement
Purpose	To provide Norfolk Health Overview & Scrutiny Committee with an update on progress to achieve the Quality Improvement Plan
Summary including **Key Performance Issues/Risks**	To update on the improvement actions being taken, under the leadership of the Chief Nurse, to progress the Quality Improvement Programme. **Progress towards delivery of the 82 CQC Recommendations.** In October, of the 82 Must do & Should do actions, we have : • 5 (7%) Blue (Evidence reviewed and action completed) • 4 (6%) Red (Overdue action not on track) • 28 (42%) Amber (At risk of delivery) • 25 (37%) Green (On track to deliver) **The Performance Dashboard** The Performance Dashboard is in its last stages of development, and almost fifty discrete metrics are now included within it. Some metrics relate to multiple recommendations. **Routine Provider information Return (RPIR) request** The CQC Routine Provider information Return (RPIR) request was received by the Trust on 16th October; the deadline for submission of the completed return was 6th November. Our submission was returned within this deadline. **Safety Week and External Reviews** • During the week commencing 10th December the Trust will be holding a Quality Week. An external company, Enable East, will undertake the peer review across the Trust. • During the weeks of 10th & 17th December, a team from NHSi will meet with the Divisional Triumvirates and Board Members to undertake interviews in preparation for the CQC Well Led assessment.

Unannounced Clinical reviews

In preparation for a CQC visit in Quarter 4 we have arranged a series of Unannounced Clinical reviews. These have been arranged across the Trust to take place in November & December.

Communications

At the beginning of November we launched a newsletter, 'Sharing The Learning', which informs staff about the quality improvement programme. A variety of communication channels are being employed, to ensure that we reach as many staff and service users as possible.

Key Indicator Progress

During October 2018 progress has been made in the following areas:

Area of focus	Baseline period and value	Latest period and value
Hospital Standardised Mortality Ratio (HSMR) *This ratio indicates a better result if the value is low*	April 2016 - **113.7**	July 2018 – **94.9**
Incident Reporting *The larger value indicates a Safe learning organisation.*	August 2016 – **1,366**	Sept 2018 - **1,668**
Mandatory Training	August 2016 - **73.8%**	Sept 2018 - **83.6%**
Non-medical appraisals	August 2016 - **59.3%**	Sept 2018 - **76.6%**
Deprivation of Liberty standards (DOLS) training	April 2018 - **40%**	Sept 2018 – **82.9%**
Mental Capacity Act (MCA) training	April 2018 - **52.2%**	Sept 2018 - **83.0%**

Capacity Planning

In the short term, we have prepared our winter plan for 2018/19 based upon learning from prior years and from reviewing national best practice guidance. The winter plan was developed in conjunction with the wider Norfolk system.

In the medium term, we have several schemes already underway to increase capacity; these include:

- Positron Emission Tomography PET CT – opens March 2019
- Quadram Institute – opens December 2018
- Interventional Radiology Unit & 4th Cath Lab – opens November 2019
- Cromer Development – opens summer 2020

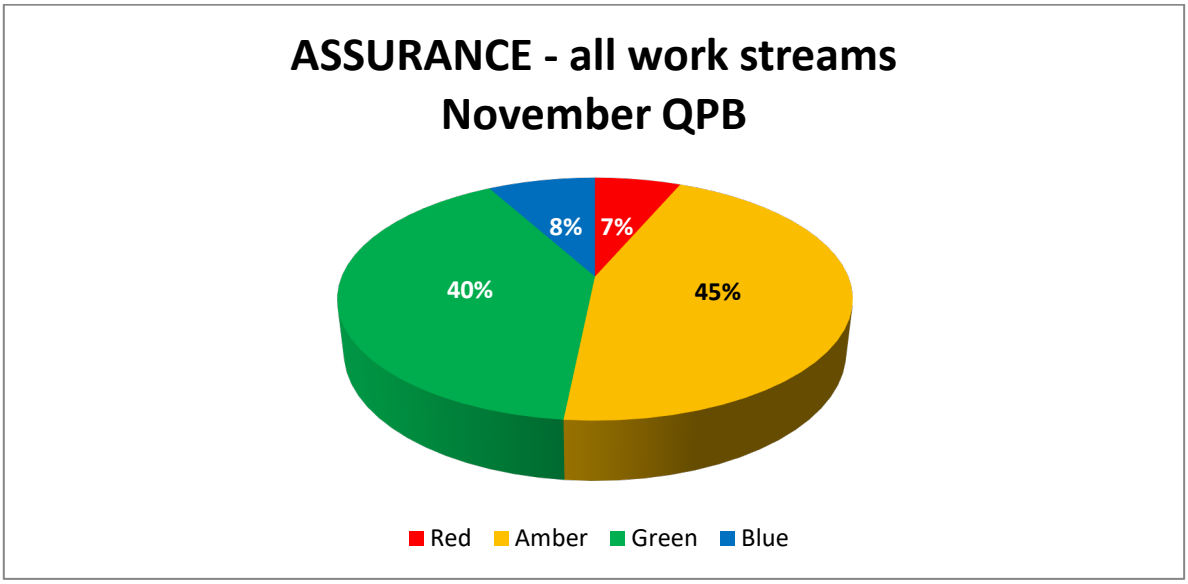
Further schemes are in development.

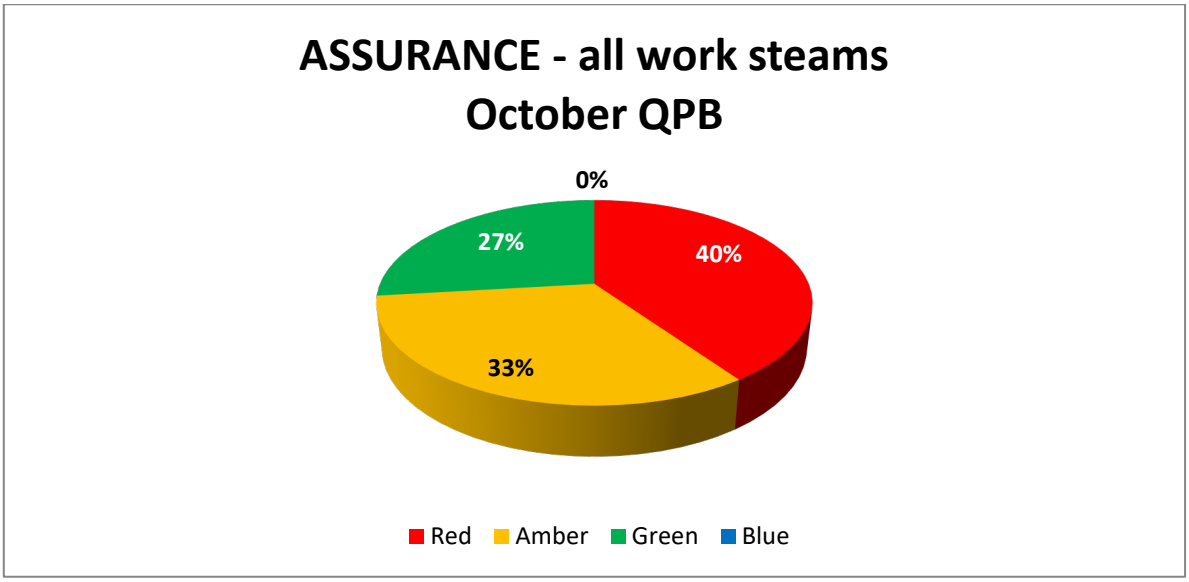
Action Required (✓)	FOR DISCUSSION

1. **Progress towards delivery of the 82 CQC Recommendations.**

The pie charts below show the level of current assurance in respect to achieving the 82 recommendations and embedding sustainable improvement.

Current Status of Action Plan and first level assurance





BLUE	The recommended sustainable improvement has been delivered and clearly evidenced, and 'signed off' by the Evidence Group
RED	Limited progress has been made towards delivering the recommendation, and there is a significant risk that we may not achieve a sustained improvement by our desired deadline.
AMBER	Some progress has been made and evidenced towards achieving the recommendation, but there is a risk that we may not achieve a sustained improvement by our desired deadline.
GREEN	Substantial progress has been made and evidenced towards achieving the recommendation, and we are on track to achieve the sustained improvement by our desired deadline.

2. Performance Dashboard

Our Performance Dashboard is in its last stages of development, and almost fifty discrete metrics are now included within it. Some metrics relate to multiple recommendations.

An automated data collection process is in place. This went well for November QPB (the inaugural collection), which was very encouraging. A supplementary process will be launched shortly to collect narrative commentary.

3. Routine Provider information Return (RPIR) request

The CQC Routine Provider information Return (RPIR) request was received by the Trust on 16th October; the deadline for submission of the completed return was 6th November. Our submission was returned within this deadline, and included our self-assessment against the five CQC domains of Safe, Effective, Caring, Responsive and Well Led for all core services.

4. Safety Week and External Reviews

During the week commencing 10th December the Trust will be holding a Quality Week. An external company, Enable East, will undertake a peer review across the Trust. They will review Emergency Department, Medicine, Surgery (including critical care), Maternity and also look at some cross cutting themes including, Governance structures, Safeguarding/MCA/DoLS, Mental health/learning disability, equipment checks and medicines management (including medicines storage checks), uniform compliance and infection control.

Feedback from this review will take place in The Gooch Lecture Theatre at NNUH from 10:00 to 12:00 on Friday 14th December 2018.

During the weeks of 10th & 17th December, a team from NHSi will meet with the Divisional Triumvirates and Board Members to undertake interviews in preparation for the CQC Well Led assessment.

5. Unannounced Clinical reviews

In preparation for a CQC visit in Quarter 4 we have arranged a series of Unannounced Clinical reviews. These have been arranged across the Trust to take place in November & December. We will visit Wards and Departments across the Trust and will also visit some off site clinical areas. Feedback will be given to the clinical areas and Divisions on actions required. In the meantime, six internal unannounced visits will take place in the weeks leading up to Safety Week. The first of these unannounced inspections took place on November 6th in Critical Care. The inspection was overwhelmingly positive, and feedback and learning/action points were shared immediately with the ward team.

6. Communication Plan

In order to highlight the importance of the quality improvement programme to staff, patients and visitors, we have utilised various communication routes and approaches, including the following:

- An all staff email was sent from the Chief Nurse and Medical Director announcing the launch of our new improvement newsletter “Sharing the Learning”
- A banner on the intranet homepage promotes the Sharing the Learning newsletter
- Laminated posters promoting the newsletter are in every lift, ward and department, and printed copies are available in every ward and department
- Large A1 posters in the Exec cut-out frames are positioned at key entrances

- A Sharing the Learning screensaver is in place
- There are promotional table toppers in the main restaurant
- Numerous posts have been made via social media
- Large displays are positioned at three key locations (including the two main atria)

The “Sharing the learning” newsletter includes the latest progress updates on our Quality Improvement Plan and improvement project case studies. A screenshot of the inaugural edition is shown on the following page.

Sharingthelearning

Online Poll

How do you prefer to access online information?

- On my mobile
- On my Desktop
- On my Laptop or Tablet
- All of the above

Vote

Welcome to Sharing the learning

Dear Colleagues,

Welcome to our first Sharing the learning newsletter where you will find the latest progress updates on our Quality Improvement Plan and improvement project case studies some of which may be useful for your own area .

You will see that the logo for our improvement work is urging us all to be improvers, to work together and be collaborative so that we can deliver the Quality Improvement Plan and achieve an outstanding quality standard. We believe that in five years that the cultural and clinical transformation work which is underway will achieve this goal and we need as many people as possible to be involved in our #JourneyToOutstanding to make this happen.

We have a consolidated Quality Improvement Programme (QIP) and associated action plan which includes the recommendations made by the CQC from the June report, and those from the King's Fund 'Organisational Diagnostic Review' report. We are committed to embedding a continuous quality improvement culture and capability at the Trust to enable the achievement of the QIP in full.

If you are not already involved in an improvement project at NNUH please email BeOutstanding@NNUH.nhs.uk to find out how your team can take part.

Professor Erika Denton, Medical Director and Professor Nancy Fontaine, Chief Nurse

Further Information

See here for the latest information on the CQC approach to inspections.

Social Media

Prof Nancy Fontaine
@DrNancyFontaine

Reduce variation, learn from mistakes & #shareleaming through improved communication #Safetyhuddles

NNUH_i @NNUH_i

FollowingFollowing @NNUH_i

So proud of @Norwichowl @ipswichgrove @NedAldus @sepsismaggie presenting the huge progress made to mental health care in our acute environment over the last 10 months at today's @NNUH OAG with external partners. Their positivity, honesty, buzz and drive for the future is amazing!

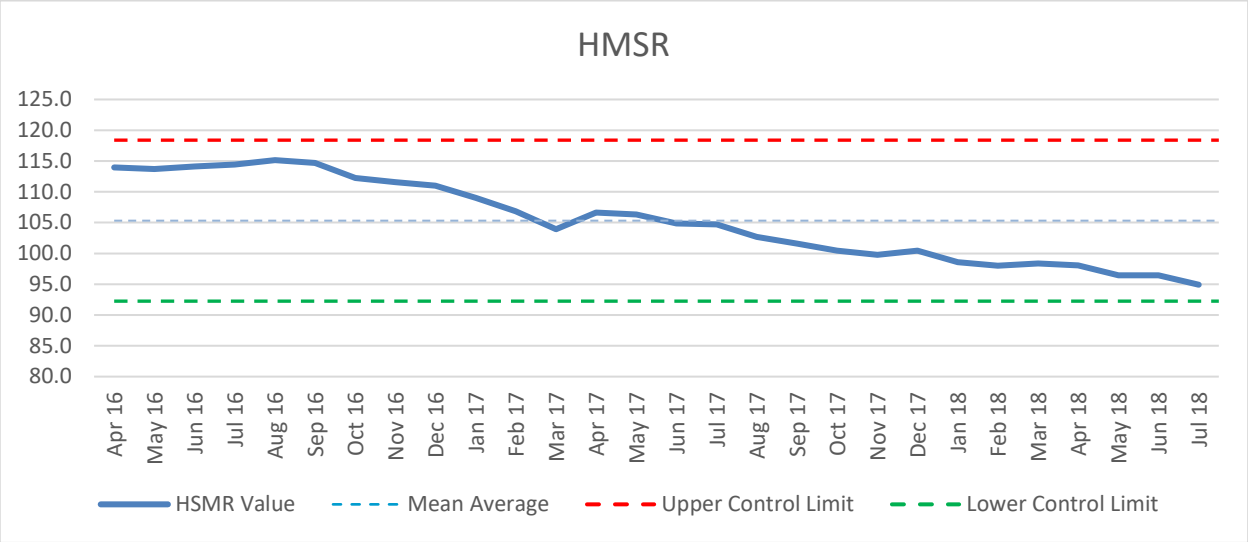
Jrobey18 @jrobey_

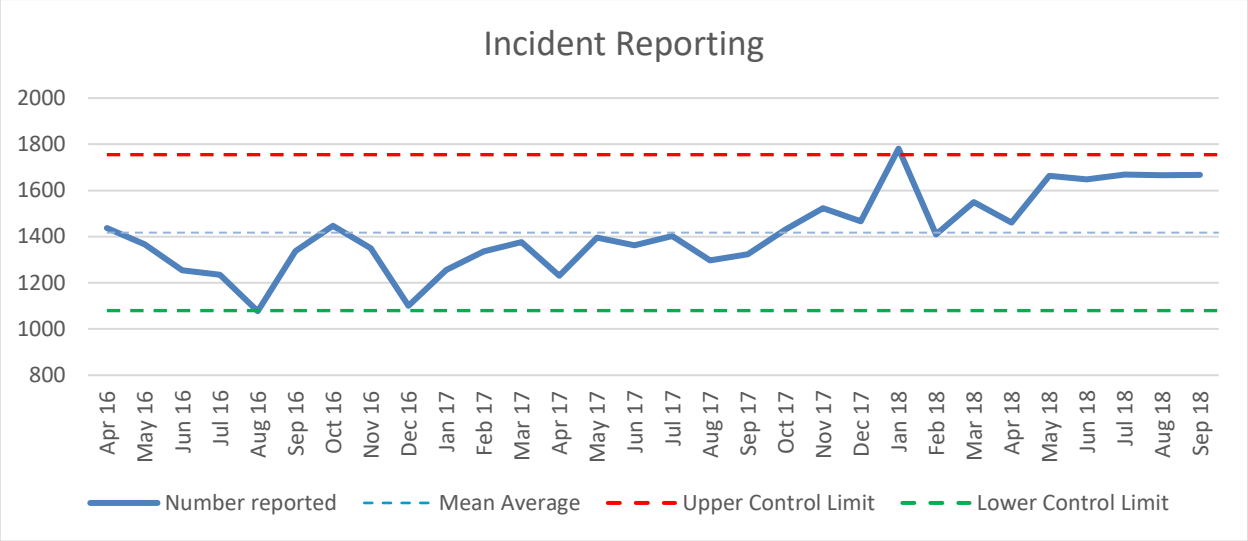
@jrobey_

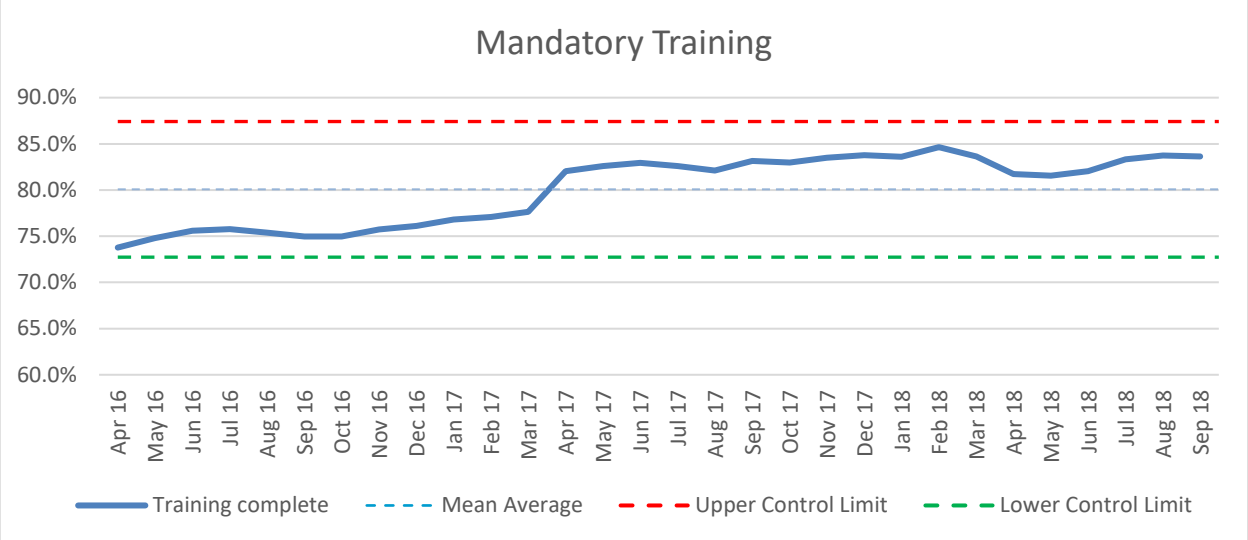
I really enjoyed yesterday's @NNUH Clinical Leaders Forum. It's exciting to be part of the #J2O, and to be taking small but mighty improvement steps. I never tire of hearing the great work that's being done by our fab palliative care team to deliver outstanding End of Life Care.

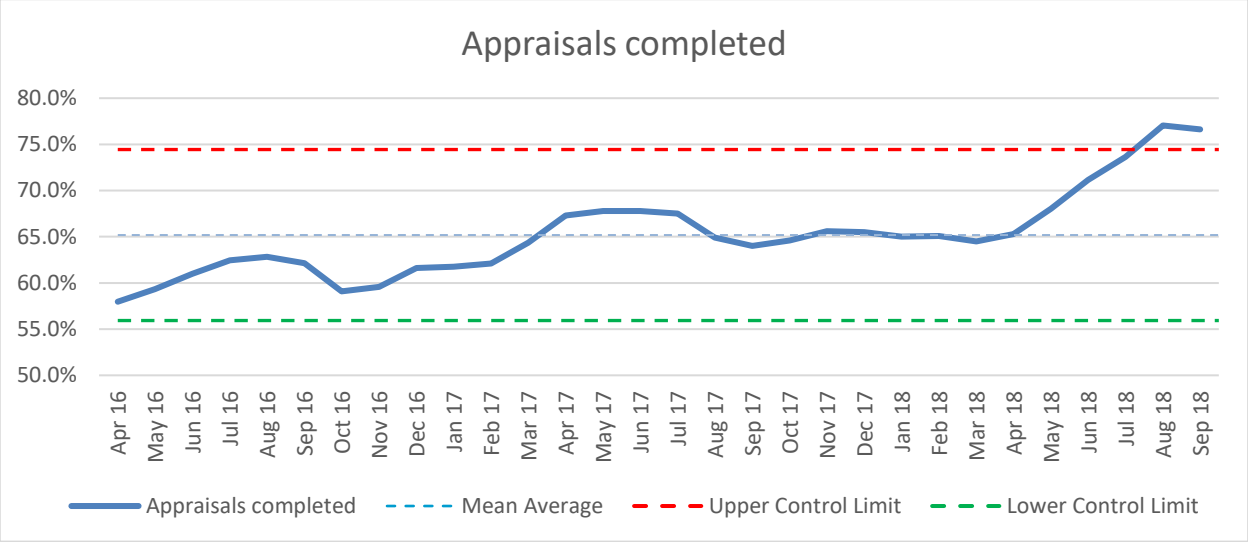
7. Key Indicator Progress

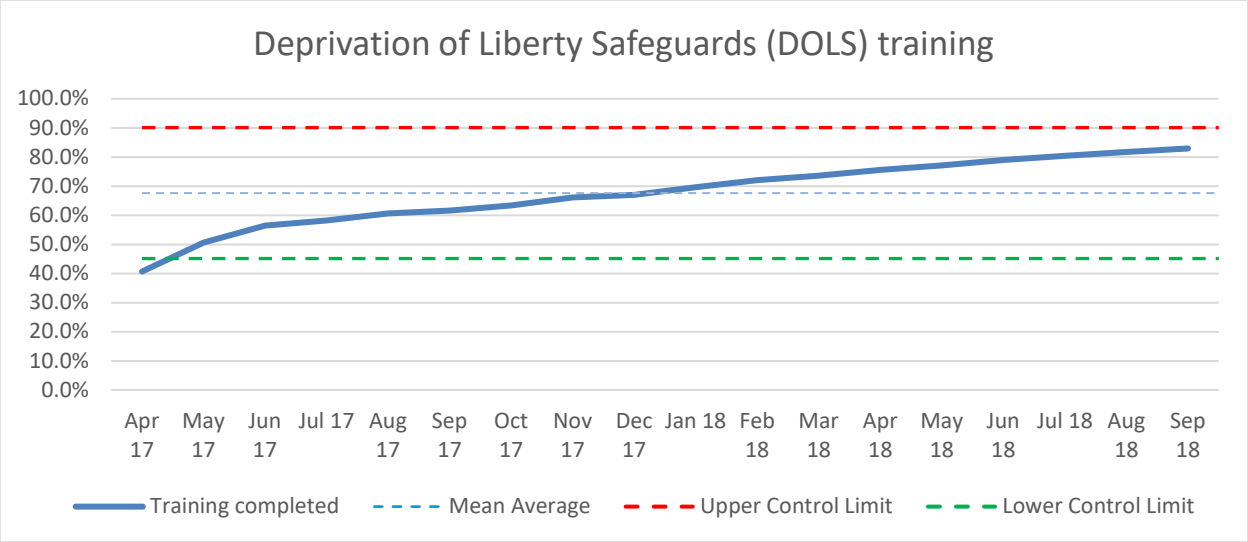
Some of the areas where measurable progress is being made are shown in the following charts.

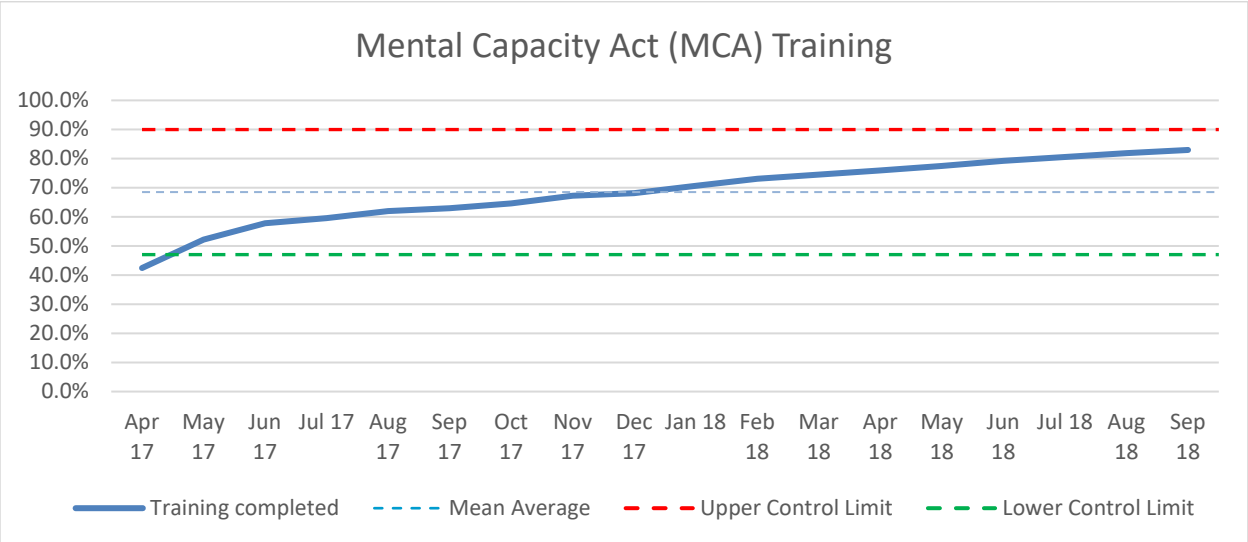












8. Capacity Planning – short term winter planning 2018/19

In the short term, we have prepared our winter plan for 2018/19 based upon learning from prior years and from reviewing national best practice guidance. The winter plan was developed in conjunction with the wider Norfolk system.

- **Additional Beds**
    - Installation is underway for a temporary Modular Ward, which will provide an additional 8 beds. The target date for completion is December 2018
    - We plan to also open existing escalation space, by opening and establishing currently closed beds and beds that are currently being used for research or as non-clinical space across medicine and surgery. This should release a further 45 beds.

- **Discharge Suite and Discharge Processes**
    - Space for 20 seated patients plus 8 bed / stretch patients awaiting ambulance transport
    - On track for completion in mid-December
    - We are working to reduce the length of stay for 'Super Stranded' patients (over 21-days in hospital) in accordance with latest national guidance
    - We are focusing our clinical & operational processes to enable discharges to occur earlier in the day

- **Additional ED cubicles**
    - Plans are in place to expand the Rapid Assessment and Treatment (RATs) area to 8 spaces, allowing a maximum ambulance off-load capacity of 32-patients / hour
    - The capital costs (circa £1.2m) have been funded by NHSE
    - We are on track for completion by 14th December 2018

- **Virtual Ward Trial 'NNUH @ Home'**
    - We have engaged a third party provider to establish a 30-bed virtual ward for patients living in a 15-mile radius of NNUH
    - The proposed 9-month trial would allow NNUH and system partners to assess what a sustainable model could look like in future – either to be run in house or in partnership
    - The principle underpinning the trial is that patients requiring sub-acute care but occupying a bed (e.g. long term antibiotic therapy, complex wound dressings, multiple insulin dose administration etc.) would remain the responsibility of their NNUH consultant but would receive this care at home
    - This is a relatively common model across the NHS.
    - The pilot has a 12-week mobilisation timescale.

- **Older Person's Emergency Department (OPED) extension**
    - OPED opened in December 2017; despite a challenging winter, fewer patients over 80yrs of age were admitted to NNUH
    - The service currently runs until 5pm. This scheme looks to extend it until 8pm weekdays and at the weekend, linked to demand
    - Recruitment of staff has commenced

9. Capacity Planning – medium term

In the medium term, we have several schemes already underway to increase capacity; these include:

- Quadram Institute – opens December 2018
- PET CT – opens March 2019
- IRU & 4th Cath Lab – opens November 2019
- Cromer Development – opens summer 2020

Further schemes are in development include:

- A Diagnostic and Assessment Centre. This is part of a £69m STP priority capital bid, in association with JPUH and QEHKL.
- Turnstone court, which involves the development of two day-case theatres at Norwich Community Hospital
- Renal Dialysis to be provided in the community (with car parking)
- Multi-storey Car Park (funded through charitable funds)
- Nuclear Medicine (£2m) – expansion of key cancer service
- Breast Imaging expansion – to enhance one stop clinics for suspected cancers

10. Conclusion & Recommendations

The Norfolk Health Overview & Scrutiny Committee are asked to note these actions.

Presentation to the Norfolk Health Overview and Scrutiny Committee

6th December 2018

Five Year QI Vision

	Y0 2018	Y1 2019	Y2 2020	Y3 2021	Y4 2022
CQC rating	Special Measures Focus: 'must/should do' actions		Getting to 'GOOD' Transforming services		Journey to OUTSTANDING Becoming the best & leading the way
Change vehicle	Project Management Transactional; compliance led		Deliver QI Strategy led by QI Director Transformational; vision led		
Strategic goals	We will be: A provider of high quality healthcare to our local population The centre for complex & specialist medicine for Norfolk & the Anglia region A recognised centre for excellence in research, education and innovation A leader in the redesign & delivery of health & social care services in Norfolk				Set goals for next five years
QI journey	➢ Strategic Intent for QI ➢ Leadership for QI ➢ Building improvement skills ➢ Building a culture of improvement ➢ Putting patients at the centre of QI ➢ Applying systems thinking in QI				

Delivering outstanding:
♦Efficiency ♦Engagement ♦Experience ♦Improvement

CQC Domains

All 82 of the CQC ‘must do’ and ‘should do’ recommendations have been assigned to one of the five CQC domains:

Outcome statements

All 82 of the 'must do' and 'should do' recommendations has an 'outcome statement that can be articulated in the format: **"We will have achieved GOOD when…."**

E.g. Recommendation 4a: The trust must ensure that there is an effective process for quality improvement and risk management in all departments.

We will have achieved GOOD when:

- We have a Trust Wide QI Strategy with an implementation plan in place, communicated to all staff
- A QI faculty is in place to provide support & facilitation to teams to deliver QI projects
- A Central record of QI projects mapped to department / division & strategic objectives is available and maintained
- A reporting system is in place and being utilised by teams to clearly demonstrate improvements

Evidence Repository

Our approach is rigorously evidence based. We will only categorise a recommendation as ‘complete’ when there is clear documentary evidence filed in the central evidence repository that the outcome statement has been sustainably achieved.

We have established a two-stage assurance process to independently evaluate the evidence:

- **Stage 1** evaluation is carried out by the Improvement Team
- **Stage 2** evaluation is carried out by the Evidence Group, which comprises internal and external assessors, including 3 staff members and a patient representative.

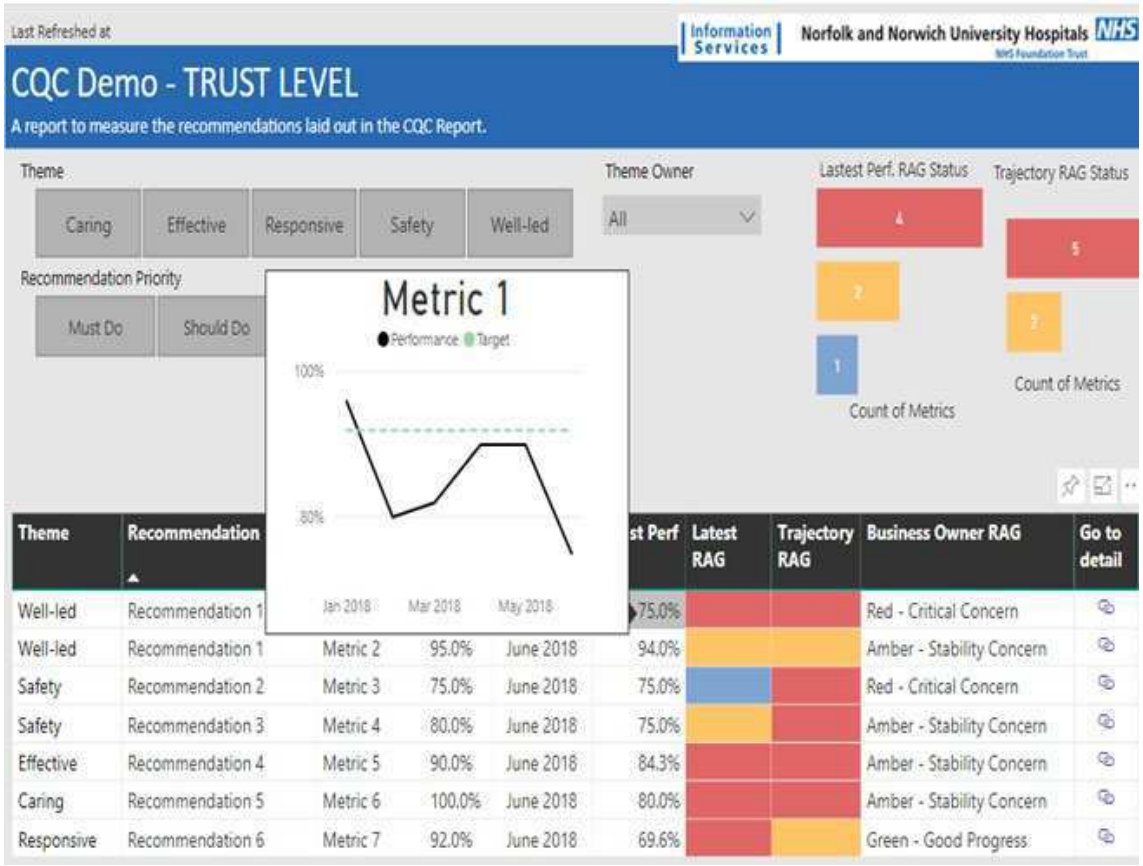
The Quality Programme Board is the only body that can ‘sign off’ a recommendation as being ‘complete and evidenced’.

Monthly reporting

Each month a highlight report is produced for each of the 82 recommendations. These reports are discussed at the internal Quality Programme Board and the external Oversight Assurance Group.

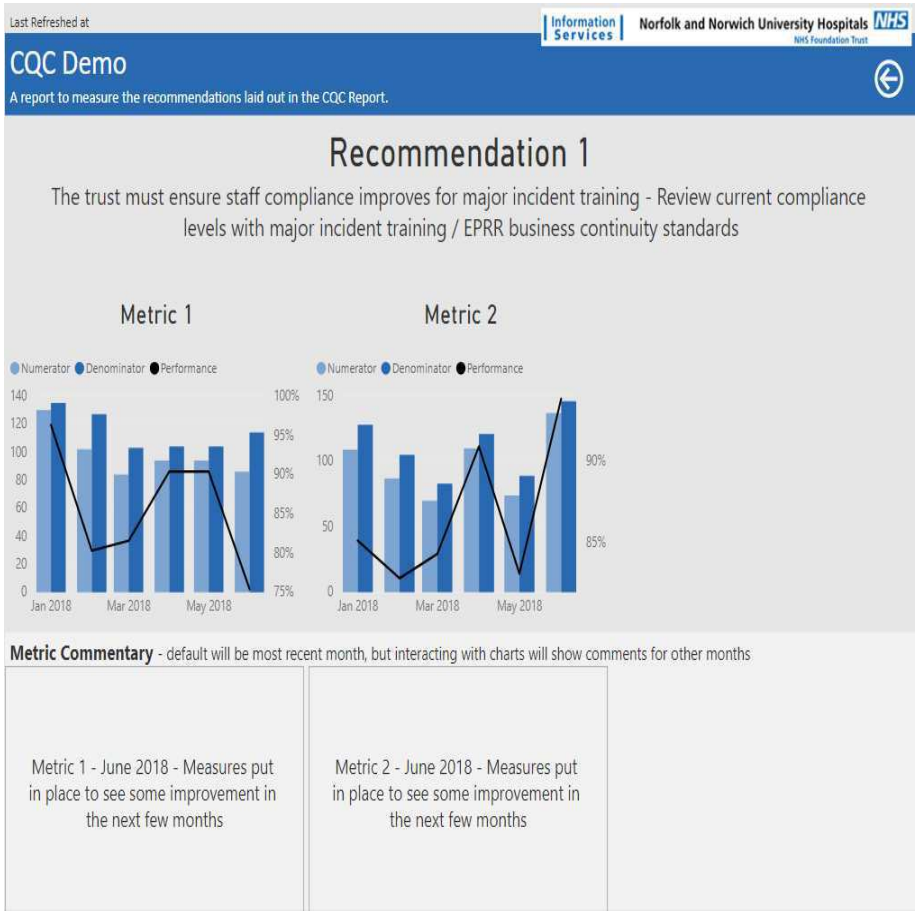
A performance dashboard has also been created. Screenshots from the dashboard are shown on the following two slides:

Dashboard screenshot



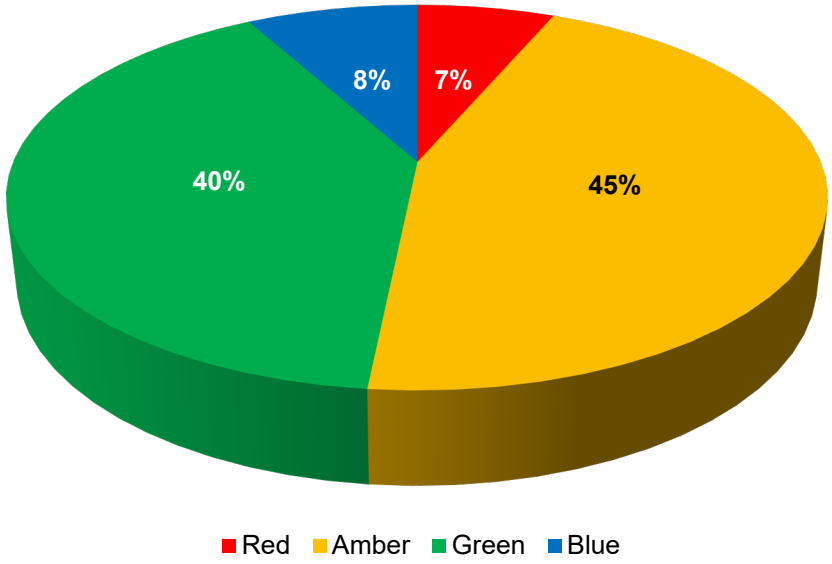
Theme	Recommendation				st Perf	Latest RAG	Trajectory RAG	Business Owner RAG	Go to detail
Well-led	Recommendation 1				75.0%			Red - Critical Concern	
Well-led	Recommendation 1	Metric 2	95.0%	June 2018	94.0%			Amber - Stability Concern	
Safety	Recommendation 2	Metric 3	75.0%	June 2018	75.0%			Red - Critical Concern	
Safety	Recommendation 3	Metric 4	80.0%	June 2018	75.0%			Amber - Stability Concern	
Effective	Recommendation 4	Metric 5	90.0%	June 2018	84.3%			Amber - Stability Concern	
Caring	Recommendation 5	Metric 6	100.0%	June 2018	80.0%			Amber - Stability Concern	
Responsive	Recommendation 6	Metric 7	92.0%	June 2018	69.6%			Green - Good Progress	

Dashboard screenshot

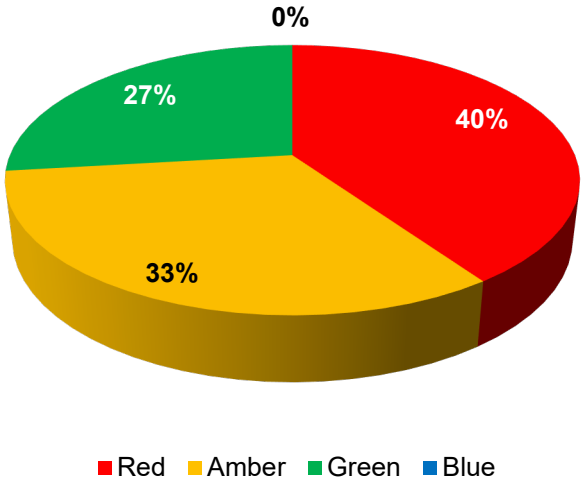


NOVEMBER 2018 ASSURANCE
All work streams

ASSURANCE - all work streams November QPB



ASSURANCE - all work steams October QPB



Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Quality and Safety Improvement Strategy

"Supporting our Journey to Outstanding"

Our quality and safety improvement strategy describes our strategic intent for QI and sets an ambition to build a culture of improvement at all levels.

- Our patients will be at the centre of QI and will be involved as true and equal partners
- We will build the capacity and capability for quality improvement so that everyone from the Board to the frontline has the ability to contribute.
- Our staff will feel empowered to be creative and innovative, always looking for ways to improve their services and the care provided.
- Our leaders create the conditions and commitment to QI and shared across the organisation
- We will see improved patient experience and patient safety metrics
- The focus on quality first will be a consistent part of our culture, from ward to Board.

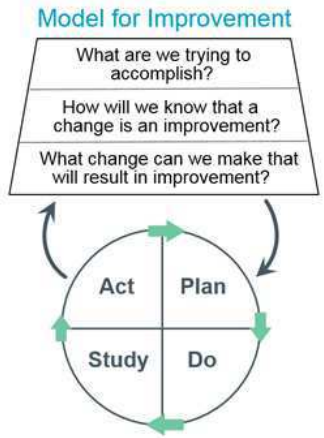
Fig2: Quality Improvement in Hospital Trusts CQC Sept 2018

QI Faculty

Building capacity and capability for improvement

We will build improvement skills in the following key areas:

- QI methodology and tools
- Human Factors
- Patient and Public Involvement in QI.
- Safety Culture



We will strengthen our approach to recognising and sharing quality by building a network of staff throughout the organisation based on the Health Foundation's Q initiative.
'Q' aims to connect people with improvement expertise across the UK, fostering continuous sustainable improvement in health and care.

We will use the **Life QI** electronic platform to help create and deliver improvement projects at every level and in every setting. It is a simple system to access, provides overview of all QI activity and encourages sharing of learning.

Capacity - Winter 2018/19

- Based upon learning from prior year and National best practice guidance and developed in conjunction with the wider Norfolk system
- 3 themes overarching an '8-Point Plan'
- Delivery risks mitigated by assuming a 'belt and braces', planned over-provision set of solutions

Capacity

- Additional beds – Modular Ward Facility plus all beds open (CDU, Gastro, Cringleford, Earsham & Denton)
- Creating a discharge suite to free up ward space earlier in the day
- Additional ED cubicles to eliminate ambulance congestion and delay
- Open an 'NNUH @ Home' Virtual Ward for sub-acute patients
- Extend OPED Opening hours

Leadership

- Senior Nurse, Doctor and Manager to 'Project Manage' winter plus seconded support / senior EEAST staff member to the NNUH Winter Team

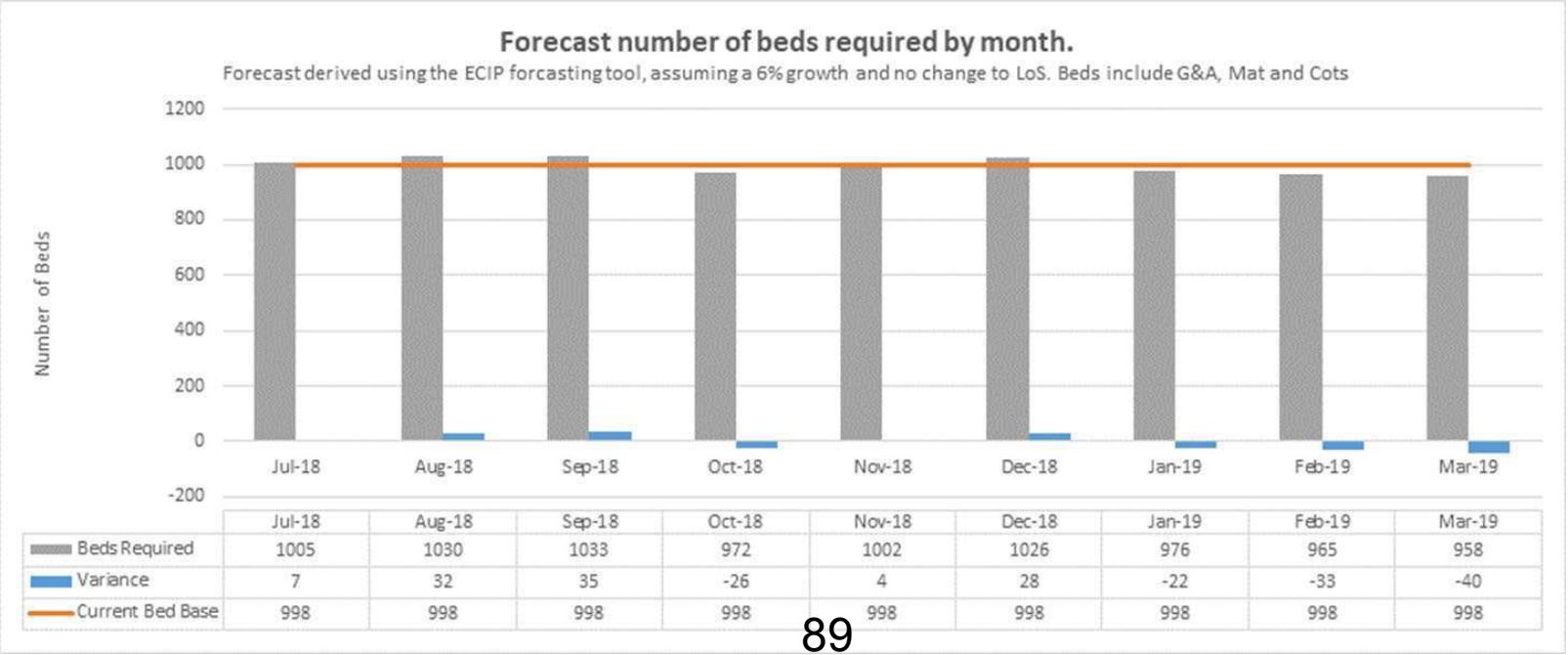
Process

- Reduce the length of stay for 'Super Stranded' patients (over 21-days in hospital) in accordance with latest national guidance
- Focus clinical & operational processes relating to discharge earlier in the day

Capacity

• No. 1 - Additional beds

- Bed capacity requirement modelled using recognised tool
- Relative worst-case scenario used – assumes **6% growth on 2017/18 & no improvements in length of stay and 92% occupancy**
- 22 – 40 additional beds required



	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Beds Required	1005	1030	1033	972	1002	1026	976	965	958
Variance	7	32	35	-26	4	28	-22	-33	-40
Current Bed Base	998	998	998	998	998	998	998	998	998

Capacity

• No 1 - Additional beds cont'd

- Working assumption is to 'over-deliver' against the 40 - bed scenario on the basis that 92% occupancy is relatively high and the experience in Q1 has been of significant non-elective pressure, over and above contract plan levels.

Schemes in progress are:

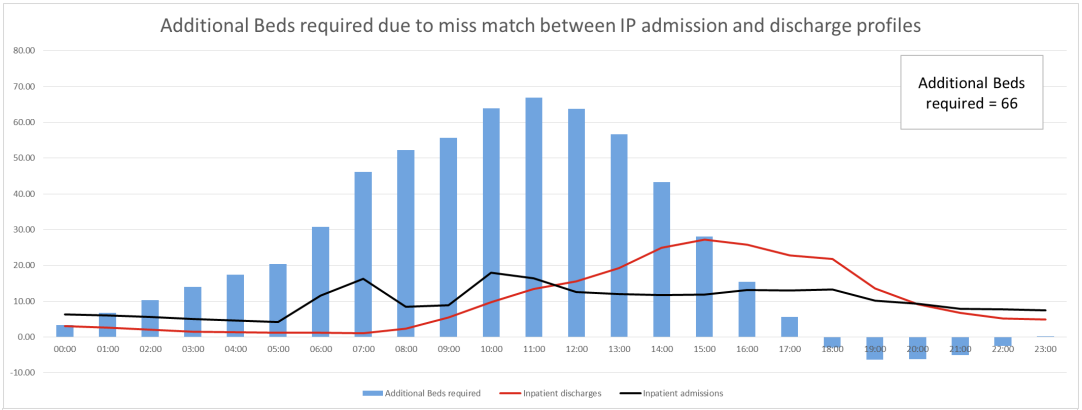
Scheme	Timescale (& indicative cost)	Beds
Temporary Modular Ward – Installation underway	Target date – December 2018	12 elective
Opening Existing Escalation space – Opening and establishing currently closed & / or beds being used for research / non-clinical space across medicine and surgery	Target w/c 24 September 2018. Recruitment commenced. (£505k revenue – recovery through activity over-performance).	45
	Total	**57**

Capacity

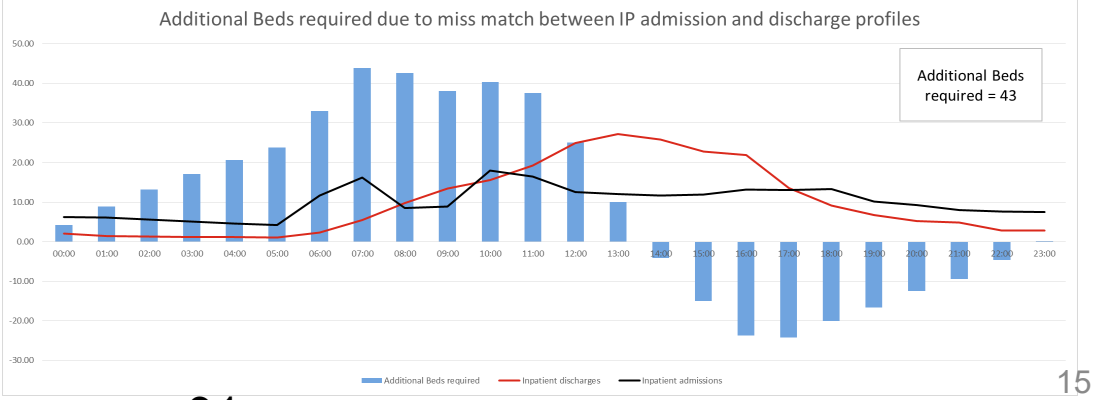
• No. 2 – Discharge Suite

- Review of the time-of-day of discharges suggests a 'late-profile' drives the use of overnight escalation
- **Delivering 30% of discharges by 12md offers the opportunity to reduce the admission / demand mismatch by circa 23 beds**

Current Discharge Time Profile



Discharge Time Profile brought forward by 2-hrs (=30% by midday)



Capacity

• No. 2 – Discharge Facility

- Task & Finish group well-established – overseen by Senior Ops and Nursing & includes patient co-design
- Space for 20 seated patients plus 8 bed / stretch patients awaiting ambulance transport
- On track for **Mid December 2018**

Capacity

• No. 3 – Additional ED cubicles

- Plans are in place to expand the Rapid Assessment and Treatment area to 8 spaces, allowing a maximum ambulance off-load capacity of 32-patients / hour
- Capital costs (circa £1.2m) funded by NHSE
- On track for **14 December 2018**

Capacity

• No. 4 – Virtual Ward Trial 'NNUH @ Home'

- 3rd Party Provider engaged to establish a **30-bed** virtual ward for patients living in a 15-mile radius of NNUH
- 9-month Trial would allow NNUH and system partners to assess what a sustainable model could look like in future – either to be run in house or in partnership
- Principle is that patients requiring sub-acute care but occupying a bed e.g. long term antibiotic therapy, complex wound dressings, multiple insulin dose administration etc. would remain the responsibility of their NNUH consultant but would receive this care at home
- This is a relatively common model across the NHS.
- The pilot has a 12-week mobilisation timescale

Capacity

• No. 5 – OPED extension

- OPED opened in December 2017 and despite a challenging winter fewer patients over 80yrs of age were admitted to NNUH
- The service currently runs until 5pm. This scheme looks to extend it until 8pm weekdays and at the weekend linked to demand
- Recruitment of staff has commenced

Winter Plan Summary

	Scheme	Gain	Bed No's
Capacity	1. Additional Beds	• Modular ward for use as escalation at times of peak pressure • Establishing and opening all / any closed areas (Inc. Gastro) • Specifically to limit or eliminate the use of Day Procedure areas for in-patients	57
Capacity	2. Discharge Suite	• Earlier flow to limit out-of-hours escalation	23 *
Capacity	3. Additional ED cubicles	• Additional 8 spaces focussed on Rapid Assessment & Treatment (RATS) • Designed to cope with high and variable ambulance arrivals	0
Capacity	4. NNUH @ Home	• Virtual Ward to care for patients at home with sub-acute clinical needs	30
Capacity	5. OPED hours increase	• Enhances the delivery of a known and effective service • 7-day working, 12-hrs per day	0
Leadership	6. Winter Team	• Enhanced capacity to deliver all other associated Winter Schemes • Additional capacity to oversee day-to-day performance during winter • Link to system and national structures	0
Process	7. Super - Stranded	• Delivery of a suite of actions to comply with the national initiative to reduce super-stranded numbers	23*
Process	8. Early Discharge processes	• Improve systems and processes to support the discharge lounge and reduce out-of-hours escalation	(supports No. 2)
		Totals	**133** (Actual 87 + 46* Transformational)

Medium term investment in capacity

Current agreed NNUH schemes include:

- PET CT – opens March 2019
- Quadram Institute – opens December 2018
- IRU & 4th Cathlab – opens November 2019
- Cromer Development – opens summer 2020

Current NNUH schemes in development:

- Diagnostic and Assessment Centre - part of a £69m STP priority capital bid with JPUH and the QE hospitals
- Turnstone court – development of two daycase theatres at Norwich Community Hospital
- Renal Dialysis to be provided in the community (with car parking)
- Multi-storey Car Park (charitable funded)
- Nuclear Medicine (£2m) – expansion of key cancer service
- Breast Imaging expansion – to enhance one stop clinics for suspected cancers

Norfolk Health Overview and Scrutiny Committee

ACTION REQUIRED
Members are asked to suggest issues for the forward work programme that they would like to bring to the committee's attention. Members are also asked to consider the current forward work programme:-

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

Proposed Forward Work Programme 2018-19

Meeting dates	*Briefings/Main scrutiny topic/initial review of topics/follow-ups*	*Administrative business*
17 Jan 2019	The Queen Elizabeth Hospital NHS Foundation Trust – action in response to Care Quality Commission report. Norfolk and Suffolk NHS Foundation Trust – action in response to the Care Quality Commission report	
28 Feb 2019	Ambulance response times and turnaround times – report on progress since May 2018 (when EEAST, NNUH and NNCCG attended). QEH to be invited to attend also. Children's Speech and Language Therapy - to follow up the action plan from the independent review of the central and west Norfolk service and to address with issues raised during Members visit with the SENsational Families Group, 20 September 2018.	
11 Apr 2019	Access to NHS dentistry in Norfolk – follow up to the report to NHOSC on 24 May 2018 on access in West Norfolk, and examination of the situation in the rest of Norfolk.	

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

Provisional dates for report to the Committee / items in the Briefing 2018-19

Sept 2019	-	**Physical health checks for adults with learning disabilities** – update since Sept 2018
To be scheduled	-	**Access to palliative and end of life care** – follow-up from the meeting on 18 October 2018

Other activities

Visits to hospice, hospice at home and other services providing end of life care (as requested by NHOSC 18 Oct 2018)	-	Priscilla Bacon Centre, Norwich – 10.00am, 28 Nov 2018
	-	The Norfolk Hospice, Tapping House – 11.30am, 5 Dec 2018
	-	East Coast Hospice, Gorleston (i.e. visit with the charity that is planning a hospice in the Great Yarmouth and Waveney area) – date to be arranged.
Visit to be arranged	-	Follow-up visit to the Older People's Emergency Department (OPED), Norfolk and Norwich hospital to be arranged after expansion works are completed in 2019-20.

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

Clinical Commissioning Groups

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

Norfolk and Waveney Joint Strategic Commissioning Committee

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

NHS Provider Trusts

Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust	-	Mrs S Young (substitute M Chenery of Horsbrugh)
Norfolk and Suffolk NHS Foundation Trust (mental health trust)	-	M Chenery of Horsbrugh (substitute Ms B Jones)
Norfolk and Norwich University Hospitals NHS Foundation Trust	-	Dr N Legg (substitute Mr D Harrison)
James Paget University Hospitals NHS Foundation Trust	-	Ms E Flaxman-Taylor (substitute Mr M Smith-Clare)
Norfolk Community Health and Care NHS Trust	-	Mr G Middleton (substitute Mr D Fullman)

IN TRAN communication for all	If you need this document in large print, audio, Braille, alternative format or in a different language please contact Customer Services on 0344 800 8020 or Text Relay on 18001 0344 800 8020 (textphone) and we will do our best to help.

Glossary of Terms and Abbreviations

5Q Care Test	A Discharge to Assess patient screening tool consisting of 5 questions:- (1) Could the patient's care be given by a competent relative at home, with some instruction and support? (2) Could the patient's care be provided in a residential care home with community nursing support? (3) Is intervention from a nurse needed because the care required by the patient involves making judgements and decisions based on clinical knowledge that a carer could not be expected to have? (4) Is close supervision by a nurse needed due to the risk of patient harm if not provided? (This includes severe mental distress and extreme behaviour.) (5) Is a nurse is required to supervise, train and delegate the care of a patient, whilst maintaining accountability for the delivery of that care by a person they deem competent?
A&E	Accident and emergency
Cath lab	Catheterisation lab – an examination room with diagnostic imaging equipment
CCG	Clinical Commissioning Group
CDU	Clinical Decision Unit
CHC	Continuing Healthcare
CIC	Community Interest Company
CQC	Care Quality Commission – the independent regulator of health and social care in England. Its purpose is to make sure health and social care services provide people with safe, effective, high quality care and encourage care services to improve.
CSU	Commissioning Support Unit
CT	Computerised Tomography Scan – Uses X Rays And A Computer To Make Images Of The Inside Of The Body
D2A	Discharge to Assess – patients in hospital are identified as being suitable for a pathway which involved discharge to a suitable care setting and assessment for NHS Continuing Healthcare at a later date. The patient's care is funded by the NHS until the CHC assessment is carried out. NHS funding after that point is dependent on the outcome of the CHC assessment.
Divisional Triumverates	The Management Teams that run the four Divisions at the Norfolk and Norwich University Hospital NHS Foundation Trust. The three members of each Team are the Chair of Division (Medical), Deputy Divisional Nurse Director or Deputy

	Divisional Support Director (Nurse or Profession Allied to Medicine) and the Operations Director (Manager)
DNACPR	Do not attempt cardiopulmonary resuscitation
DoH	Department of Health and Social Care
DOLS	Deprivation of Liberty Safeguards
DST	Decision support tool
ED	Emergency Department
EEAST	East of England Ambulance Service NHS Trust
FNC	Funded nursing care - NHS Funded Nursing Care (FNC) makes a contribution towards care provided by a registered nurse for people who live in a nursing care home. FNC is intended to acknowledge the fact that the cost of an NHS District Nurse is not required as the patient's nursing needs are met by the nurse in the home rather than a District Nurse attending as they would if the patient was in their own home or a residential home.
FOAMed	Free Open Access Medical education
GY&W	Great Yarmouth And Waveney
GY&WCCG	Great Yarmouth And Waveney clinical commissioning group
HSMR	Hospital Standardised Mortality Ratio – a scoring system that works by taking a hospital's crude mortality rate and adjusting it for a variety of factors, e.g. population size, age profile, level of poverty, range of treatments and operations provided, etc. By taking these factors into account for each hospital, it is possible to calculate two scores – the mortality rate that would be expected for any given hospital and its actual observed rate. Nationally the expected HSMR score is 100. The scores are not percentages but an indicator to help managers and clinicians understand how their services are performing. A score of less than 100 *may* indicate better performance and a score of more than 100 *may* indicate worse performance. A score above 100 does not necessarily indicate that a *real* problem exists but it indicates the need for investigation of the causes.
IRU	Interventional radiology unit
JPUH/JPH/JP	James Paget University Hospital
LD	Learning disabilities
MCA	Mental Capacity Act
MH	Mental health
MRI	Magnetic Resonance Imaging – a scan that produces multiple cross sectional pictures of parts of the body.
NAO	National Audit Office
NCCP	Norfolk Continuing Care Partnership
NEL CSU	North East London Commissioning Support Unit
NHOSC	Norfolk Health Overview and Scrutiny Committee
NNCCG	North Norfolk Clinical Commissioning Group

NHSE	NHS England
NHSI	NHS Improvement – the provider trust regulator
NNUH (N&N, NNUHFT)	Norfolk and Norwich University Hospitals NHS Foundation Trust
N&W STP	Norfolk and Waveney Sustainability & Transformation Plan
OAG	Oversight and Assurance Group
OPED	Older People's Emergency Department
OSC	Overview and Scrutiny Committee
PET CT	Positron Emission Tomography – Computerised Tomography
PHB	Personal Health Budget
PRIDE	'Leading with PRIDE' – an approach to management developed by the Virginia Mason Institute, a non profit organisation specialising in health care transformation. Based on the principles of the Toyota Production System. Patient first, respect for people, continuous incremental improvements
PUPoC	Previously unassessed periods of care
Quadram Institute	A centre for research and training in food science, gut biology and health
QEH / QEHKL	Queen Elizabeth Hospital, King's Lynn
QI	Quality improvement
QIP	Quality Improvement Programme
QIPP	Quality, Innovation, Productivity and Prevention: A DoH agenda, looking at health economy solutions to meet local financial challenges
RAG	Red, amber, green – rating system
RAT	Rapid assessment and treatment
SEN	Special Educational Needs
SMART	Specific, measurable, achievable, realistic, time-bound (or timely)
STP	Sustainability & transformation partnership
RPIR	Routine provider information return (to the Care Quality Commission) – a self-assessment by the service provider of their current performance in the CQC inspection domains; Safe; Effective; Responsive; Caring; Well-led