Norfolk County Council
at your service

Norfolk Health Overview and Scrutiny Committee

Date: **Thursday 27 November 2014**

Time: **10.00am**

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

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

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

Membership

MAIN MEMBER	SUBSTITUTE MEMBER	REPRESENTING
Mr C Aldred	Mr P Gilmour	Norfolk County Council
Mr J Bracey	Mr P Balcombe	Broadland District Council
Mrs C Woollard	Ms S Bogelein	Norwich City Council
Mr M Carttiss	Mr N Dixon / Miss J Virgo	Norfolk County Council
Mrs J Chamberlin	Mr N Dixon / Miss J Virgo	Norfolk County Council
Michael Chenery of Horsbrugh	Mr N Dixon / Miss J Virgo	Norfolk County Council
Mrs A Claussen-Reynolds	Mr B Jarvis	North Norfolk District Council
Ms D Gihawi	*Vacancy*	Norfolk County Council
Mr D Harrison	Mr T East	Norfolk County Council
Miss A Kemp	Mr R Bird	Norfolk County Council
Mr R Kybird	Mrs M Chapman-Allen	Breckland District Council
Dr N Legg	Mr T Blowfield	South Norfolk District Council
Mrs M Somerville	Mr N Dixon / Miss J Virgo	Norfolk County Council
Mrs S Weymouth	*Vacancy*	Great Yarmouth Borough Council
Mr A Wright	Mrs S Young	King's Lynn and West Norfolk Borough Council

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

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

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

2. Minutes

To confirm the minutes of the meeting of the Norfolk Health Overview and Scrutiny Committee held on16 October 2014. (Page 5)

3. Members to declare any Interests

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

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

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

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

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

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

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

5. Chairman's announcements

6. 10.10 – 11.15 NHS workforce planning for Norfolk

Examination of workforce planning for General Practice and other NHS services (Page 11)

Appendix A – Central Norfolk System Resilience Group (Page 17)
Appendix B – NHS England East Anglia Area Team (Page 19)
Appendix C – Norfolk and Waveney Local Medical Committee (Page 21)
Appendix D – Norfolk and Suffolk Workforce Partnership (Page 24)

7. 11.15 – 11.45 Stroke services in Norfolk

Responses to the recommendations of the scrutiny task & finish group (Page 27)

Appendix A – Responses co-ordinated by Norfolk Stroke Network (Page 29)

11.45 – 11.55 Break at the Chairman's discretion

8. 11.55 – 12.35 Wheelchair provision by the NHS, Central and West Norfolk

Update from commissioners and service providers (Page 42)

Appendix A – Norwich Clinical Commissioning Group for central Norfolk (Page 45)
Appendix B – Queen Elizabeth Hospital for west Norfolk (Page 48)
Appendix C – NHS England specialised commissioning (Page 57)
Appendix D – Family Voice (Page 58)

9. 12.35 – 12.45 Forward Work Programme

To consider and agree the forward work programme (Page 61)

Glossary of Terms and Abbreviations (Page 63)

Chris Walton
Head of Democratic Services

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Date Agenda Published: 19 November 2014

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Norfolk County Council
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NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE
MINUTES OF THE MEETING HELD AT COUNTY HALL, NORWICH
On 16 October 2014

Present:

Mr C Aldred	Norfolk County Council
Mr J Bracey	Broadland District Council
Mr M Carttiss (Chairman)	Norfolk County Council
Mrs J Chamberlin	Norfolk County Council
Michael Chenery of Horsbrugh	Norfolk County Council
Mrs A Claussen-Reynolds	North Norfolk District Council
Ms D Gihawi	Norfolk County Council
Mr D Harrison	Norfolk County Council
Mr R Kybird	Breckland District Council
Dr N Legg	South Norfolk District Council
Mrs S Weymouth	Great Yarmouth Borough Council
Mrs C Woollard	Norwich City Council
Mr A Wright	King's Lynn and West Norfolk Borough Council

Substitute Members Present:
Miss J Virgo for Mrs M Somerville Norfolk County Council

Also Present:

Stephen Bett	Police and Crime Commissioner for Norfolk
Emma Hutchinson	Mental Health Drugs and Alcohol Co-ordinator, Office of the Police and Crime Commissioner
Veno Sunghuttee	Acting Associate Director of Operations Norfolk and Suffolk NHS Foundation Trust
Dan Roper	Chairman of Norfolk Health and Wellbeing Board
Lucy MacLeod	Interim Director of Public Health
Alex Stewart	Chief Executive, Healthwatch Norfolk
Ed Fraser	Healthwatch Norfolk
Kevin James	Norfolk and Suffolk NHS Foundation Trust
Michael Scott	Chief Executive, Norfolk and Suffolk NHS Foundation Trust
Steve Goddard	Norwich City Council
James Joyce	County Councillor
Chris Walton	Head of Democratic Services

Maureen Orr	Democratic Support and Scrutiny Team Manager
Tim Shaw	Committee Officer

1 Apologies for Absence

Apologies for absence were received from Mrs M Somerville.

2. Minutes

The minutes of the previous meeting held on 4 September 2014 were confirmed by the Committee and signed by the Chairman.

3. Declarations of Interest

There were no declarations of interest.

4. Urgent Business

There were no items of urgent business.

5. Chairman's Announcements

There were no Chairman's announcements.

6 Policing and Mental Health Services

6.1 The Committee received a briefing from the Democratic Support and Scrutiny Team Manager on recent developments regarding policing and mental health services in the county.

6.2 The Committee received evidence from Stephen Bett, Police and Crime Commissioner for Norfolk, Emma Hutchinson, Mental Health, Drugs & Alcohol Coordinator from the Office of the Police and Crime Commissioner and Veno Sunghuttee, Acting Associate Director of Operations Norfolk and Suffolk NHS Foundation Trust**.**

6.3 Copies of a joint statement between the organisations in Norfolk that supported the Concordat were laid on the table for Members of the Committee. It was noted that since it had been printed more organisations had signed up to support the statement than were listed in it.

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

- It was estimated that approximately 30 per cent of all police calls concerned people with mental health issues.
- A member of NSFT staff was available (on a rota basis) at the Police Control Room at Wymondham to give advice on mental health issues.
- A means of assessing the outcomes and added value of the support that the NSFT provided to the police was being developed.
- Norfolk County Council was the first County Council in the country to sign up to the Mental Health Crisis Care Concordat which was a national, joint statement published by the Government and signed by senior representatives from organisations committed to improving mental health

care.

- The Concordat was a shared agreed statement which contained a commitment to reduce the use of police stations as places of safety, by setting a fast-track assessment process for individuals whenever police accommodation was used.
- The Concordat provided for the development of a single point of access to a multi-disciplinary mental health team and also took into account the needs of children and young people with mental health conditions.
- The action plan that would accompany the Norfolk Concordat was due to be published in December 2014.
- Members considered it important that people experiencing a mental health crisis got as responsive an emergency service as people needing urgent and emergency care for physical health conditions.
- Members also considered it important that organisations dealing with housing and physical health issues were involved in supporting those tackling mental health issues.
- A wide ranging team of professionals who were dealing on a daily basis with mental health issues had been put together in Norfolk, at a cost of £170,000. The work of this team was 40% funded by the Office of the Police and Crime Commissioner for Norfolk. Members spoke in support of the team's work and hoped that the Office of the Police and Crime Commissioner for Norfolk would continue to provide the same level of financial support in future years.
- The street triage initiative that had been introduced on a trial basis in Suffolk, whereby mental health professionals accompanied the police car in a triage car and provided an initial point of contact for police officers on the beat to receive advice on mental health issues, was considered by Emma Hutchinson to be an excellent initiative that could be trialled in Norwich city centre during the evenings.
- It was pointed out that the advice provided by mental health professionals could include an opinion on a person's condition, or appropriate information sharing about a person's health history. The aim was, where possible, to help police officers make appropriate decisions, based on a clear understanding of the background to these situations. This initiative should lead to people receiving appropriate care more quickly, leading to better outcomes and a reduction in the use of powers under Section 136 of the Mental Health Act.
- The Norfolk Constabulary was putting together a training programme about mental health issues that would be relevant to police officers at all stages in their police career. Emma Hutchinson said that she would let the Democratic Support and Scrutiny Team Manager have the details when this scheme had been put in place.
- Veno Sunghuttee, Acting Associate Director of Operations Norfolk and Suffolk NHS Foundation Trust, suggested that police officers could shadow some of the work that the NSFT undertook at Hellesdon hospital so to increase their level of understanding of mental health issues.

6.4 The office of the Police and Crime Commissioner for Norfolk was asked to let the Democratic Support and Scrutiny Team Manager know the number of adults who remained in police custody under Section 136 of the Mental Health Act for more than 10 hours, as well the numbers of children and those with dementia who were detained in accordance with this Act. This information would then be made available to Members of the Committee.

6.5 It was noted that the Committee might wish to return to this topic in a year's time.

7 Health and Wellbeing Strategy 2014-17

7.1 The Committee received a suggested approach from the Democratic Support and Scrutiny Team Manager to an update on progress with implementation of the Health and Wellbeing Strategy 2014 – 2017 agreed by Norfolk Health and Wellbeing Board on 6 May 2014.

7.2 The Committee received evidence from Cllr Dan Roper, Chairman of Norfolk Health and Wellbeing Board and Lucy MacLeod, Interim Director of Public Health.

7.4 In the course of discussion, the following key points were made:

- The Committee received a detailed PowerPoint presentation from Cllr Dan Roper, Chairman of Norfolk Health and Wellbeing Board, about the Health and Wellbeing Strategy 2014-17. (The presentation can be found on the Committee pages website).
- The three goals for the Strategy were identified as:
  - Integration
  - Prevention
  - Reducing Inequalities.
- It was pointed out that the partners to the strategy were involved in at least one of the Board's three topics which were identified as:
  - Social and emotional development of preschool children
  - Reducing Obesity
  - Making Norfolk a better place for people with dementia and their carers.
- The Board was looking to reduce inequalities for the most disadvantaged 10% of the population.
- The performance indicators were reviewed regularly at a local and national level to see trends over time.
- A member questioned the phrase in the strategy's communications sub-branding "ageing well with dementia" which was seen as sending a mixed message to the public.

7.5 The Interim Director of Public Health agreed to produce a briefing note for Members on the work that was being done to support those with dementia and to put greater emphasis on their wellbeing as part of the Strategy.

7.6 The Committee noted the presentation.

8 NHS complaints handling in Norfolk

8.1 The Committee received a suggested approach from the Democratic Support and Scrutiny Team Manager to a report from Healthwatch Norfolk on NHS complaints handling in Norfolk with recommendations to NHS organisations for improvements to the process.

8.2 The Committee received evidence from Alex Stewart**,** Chief Executive of Healthwatch Norfolk, who drew Members attention to the recommendations that were contained in the report.

8.3 The recommendations from Healthwatch (that were set out on page 21 of the agenda) were endorsed.

9 Delayed Discharge from hospitals in Norfolk

9.1 The Committee received a suggested approach from the Democratic Support and Scrutiny Team Manager to responses to recommendations made by the scrutiny task and finish group on Delayed Discharge from Hospitals in Norfolk.

9.2 Members asked for information to be included in the next Member Briefing about the current position regarding Clinks Care Farm and a similar farm at Acle that were being used by the NHS to improve the well-being and safeguarding of vulnerable patients and to increase their employment prospects.

9.3 The Committee noted the positive responses to the recommendations of the delayed discharge from hospitals in Norfolk report that were attached at Appendix A to the report.

10 Forward work programme

10.1 The Committee agreed the list of items on the current Forward Work Programme subject to the following additions:

- **Policing and Mental Health Services** - an update in one year's time (i.e. October 2015).

- **Progress with integration of health and social care services** – to be added to the programme for 2015.

- **West Norfolk CCG consultation on permanent changes to mental health services** – to be added to the forward work programme after March 2015. Progress with changes to mental health services in central Norfolk to be considered at the same meeting.

10.2 Committee members requested information on the following items (to be included in the NHOSC Briefing):

- The future of elective surgical services at the Queen Elizabeth Hospital
- The handling of day surgery cases at the Norfolk and Norwich hospital.

10.3 The Committee noted the following:

- The proposed task and finish group with Adult Social Care Committee on 'Transition of social workers from NSFT to Norfolk County Council social care' would not proceed as Adult Social Care Committee would be monitoring this subject. The effect of the transfer of mental health social care to Norfolk County Council could be examined by NHOSC in forthcoming scrutiny of mental health service changes in west and central Norfolk.
- The 'NHS workforce planning for Norfolk' item scheduled for 27 November 2014 would include issues regarding GP workforce, which underlined some of the difficulties that people had in getting appointments.

The meeting concluded at 11.50 am

Chairman

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Norfolk Health Overview and Scrutiny Committee
27 November 2014
Item no 6

NHS workforce planning for Norfolk

Report by Maureen Orr, Democratic Support and Scrutiny Team Manager

Examination of regional and local action to address recruitment difficulties in general practice and other areas of the local NHS.

1. Introduction

1.1 Norfolk Health Overview and Scrutiny Committee (NHOSC) added the subject of NHS Workforce Planning for Norfolk to its forward work programme in July 2014. It was prompted to do this primarily by concerns about GP recruitment and the effects on patients in Norfolk. The committee also recalled other examples of clinical staff shortages which have come to its attention in recent years, e.g. paramedics, hospital nurses, midwives, mental health professionals, stroke consultants. NHOSC agreed to look at the wider process of NHS workforce planning for Norfolk.

1.2 Each NHS organisation has responsibility for its own workforce planning, recruitment and training but all are dependent on the supply of suitably educated and qualified individuals.

1.3 **Health Education England** (HEE) is the organisation responsible for healthcare education and workforce planning at national level. It was established by the Health and Social Care Act 2012 and the majority of staff were transferred to the organisation from the workforce and deanery functions of the former Strategic Health Authorities.

HEE has thirteen local education and training boards across England, one of which is **Health Education East of England** (HEEE), which covers our region. Within the HEEE area there are four workforce partnerships, one of which is the **Norfolk and Suffolk Workforce Partnership**. Certain decisions, including the decision about the numbers of doctors required for the future, are taken at HEE national level. Other decisions, including the decision about future requirements for nurses and therapists, are taken regionally and locally based on information from NHS provider organisations (e.g. hospitals; community health services).

In July 2014 the Health Service Journal reported that HEE would be starting a review in October 2014 with the aim of cutting its running costs by 20% by March 2015. There were concerns that the timing and pace of the proposed changes would risk destabilising the new organisation's workforce planning and education commissioning structures and functions before they have become properly embedded or evaluated.

1.4 Particularly in the context of GP recruitment, **NHS England** plays a strategic role as the commissioner of primary care services. Its actions can affect the viability of

general practice and consequently the recruitment and retention of the GPs. **NHS England East Anglia Area Team** (EAAT) is responsible for our region.

NHS England is also currently in the process of a management restructure and reorganisation.

1.5 The recently formed **Central Norfolk System Resilience Group** is a forum where local NHS organisations come together to address perceived shared risks to the resilience of local NHS services. This includes concerns about workforce availability.

2. Background

2.1 Breckland District Council scrutiny report

2.1.1 In June 2014 Breckland District Council Overview and Scrutiny Commission established a task and finish group to review the issues raised by Watton Medical Practice's decision to deregister 1,500 patients. Amongst the task and finish group's findings published in July 2014 were:-

- The number of GP vacancies in Norfolk was around 50 which approximately represented an overall 10% shortfall.
- The cost of GP locum services in Norfolk can be up to £800 per session making such services strategically unaffordable.
- Issues around the provision of GP training posts, with a number of unfilled vacancies in Norfolk.
- Disparity of potential earnings between dispensing and non dispensing GP practices making it more difficult for the latter to recruit.

2.1.2 The Breckland task and finish group commented that NHOSC may wish to examine the issue of NHS workforce planning with particular regard to GP recruitment and retention. It also made two formal recommendations:-

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

2.1.3 Committee members received the Breckland report with their September 2014 NHOSC Briefing. The report was published on Breckland District Council's website for a meeting of their Overview and Scrutiny Commission on 24 July 2014:- http://democracy.breckland.gov.uk/ieListDocuments.aspx?CId=143&MId=3461&Ver=4

2.2 Other information on GPs and primary care

2.2.1 In November 2013 several members of NHOSC and other councillors from district councils met informally with representatives from NHS England EAAT and Norfolk and Waveney Local Medical Committee to discuss residents' concerns about difficulties in getting GP appointments. The Local Medical Committee (LMC) representative

explained the problems that practices were facing with recruitment of GPs nationally and particularly in Norfolk. In the LMC's opinion the recruitment situation was at the root of many of the access issues that councillors were raising.

2.2.2 There are numerous concerns in primary care about factors that could adversely affect recruitment and retention of GPs:-

- The current review of the Personal Medical Services (PMS) contracts which could potentially reduce income in 49 general practices across Norfolk and Waveney.
- Reducing average income for GPs[1].
- Change to pension rules which are encouraging some GPs to retire early.
- More demand for primary care increasing individual GP workloads.
- Location of residential / nursing homes adding disproportionate demand intensity.
- A relative lack of teaching practices, which are often an easier route to recruitment.
- The disparity in income between dispensing and non dispensing practices (and rules which prevent practices from becoming dispensing practices).
- More female GPs who wish to work part time for part of their career.
- The revalidation process for GPs discouraging older or retired GPs from returning to the workforce as locums.
- High rent for PFI funded premises undermining economic viability.
- A reduced share of the overall NHS budget going to primary care.

3. Purpose of today's meeting

3.1 Today's meeting is an opportunity to:-

- Learn more about the process of NHS workforce planning from national to local level and understand where responsibilities lie.
- Explore some of the recruitment issues currently facing local services.
- Discuss with local and sub regional agencies what is being done or could be done in future to avoid the recruitment and retention difficulties that currently affect some NHS services in Norfolk.

3.2 Central Norfolk System Resilience Group has been invited to inform NHOSC about the workforce risks that it has identified (i.e. which services are experiencing significant difficulties with recruitment and retention) and the local action it has taken to address them. Its report is attached at Appendix A.

3.3 NHS England EAAT has been invited to update the committee on the current level of GP vacancies, how many practices in the county are currently experiencing recruitment difficulties, the action being taken by the EAAT to support those practices and the demographics of the GP workforce in Norfolk (i.e. an estimate of the future problems as GPs retire / take maternity leave). The EAAT has also been asked to explain how it takes local development and likely future demand for services into

[1] The Health and Social Care Information Centre, GP Earnings and Expenses 2012-13, published 19 September 2014

account in its strategic regional planning. The EAAT's report is attached at Appendix B.

3.4 Norfolk and Waveney Local Medical Committee (LMC) has also been invited to give NHOSC its perspective on the reasons for the current difficulties in recruiting GPs and any actions that it thinks local or regional organisations could take to improve the situation. The LMCs paper is attached at Appendix C. It includes a request for NHOSC's support to ensure the issues faced by general practice are being considered by local MPs, the Government, UEA Medical School and local training schemes.

3.5 Health Education East of England (HEEE) (i.e. regional level) was invited to inform NHOSC about its role and the system of NHS workforce education and planning from national to local level. It was also invited to inform the committee about health education programmes currently underway that will help to provide sufficient numbers of suitably qualified people in future and how it estimates the likely level of demand for local NHS services. HEEE (regional level) asked the local Norfolk and Suffolk Workforce Partnership (local level) to respond to the request and it has provided the report attached at Appendix D.

4. Suggested approach

4.1 After the Central Norfolk System Resilience Group, NHS England EAAT, LMC and Norfolk and Suffolk Workforce Partnership have presented their reports, NHOSC may wish to explore the following issues:-

4.2 Central Norfolk System Resilience Group (CNSRG)

(a) Does the CNSRG have a complete picture of clinical workforce shortages currently affecting services in central Norfolk?

(b) What has CNSRG done (or can it do) locally to tackle the risk posed by clinical workforce shortfalls?

(c) Is the CNSRG satisfied that regional and local agencies are doing all they can to address the current workforce shortfalls?

(d) Is the CNSRG satisfied that regional and local agencies are doing all they can to plan for future workforce requirements?

(e) Planning is currently underway for Clinical Commissioning Groups (CCGs) to take responsibility for commissioning primary care in 2015. Is this an opportunity for local commissioners to influence the mix of partners and variety of salaried clinical staff that GP practices seek to recruit?

4.3 NHS England EAAT

(f) Breckland Overview and Scrutiny recommended 'That NHS England reviews the rules and guidelines for becoming a dispensing practice and consider

whether they have an impact on the recruitment and retention of GPs'. Has this been done and what were the results of the review?

(g) Breckland's second recommendation was 'That NHS England, Clinical Commissioning Groups (CCGs) and Local Practices should be consulted with regards to planning applications to assist with future staffing requirements.' Can NHS England EAAT offer any advice on what is the most sensible way for local planning authorities to consult with the NHS in respect of major planning applications and policy development?

(h) As the commissioners of primary care, what can NHS England EAAT do to help overcome the difficulties caused by the current shortage of GPs? (given that it takes around 10 years to train a doctor).

(i) How is NHS England EAAT currently supporting GP practices that are experiencing recruitment difficulties?

(j) Does the national NHS funding formula disadvantage recruitment into Norfolk? (e.g. we have a large number of care and nursing homes which are disproportionate to population numbers and represent a significant increased workload for GPs; is the funding formula fair in that respect?).

(k) How is EAAT managing the review of PMS contracts in view of the GP recruitment difficulties that already exist (see paragraph 2.2.2).

(l) What can be done to increase the number of training practices in Norfolk? (see paragraph 2.2.2).

(m) Who has overall responsibility for GP workforce planning?

(n) What kind of initiatives were agreed by the General Practice Workforce Summit convened by the EAAT on 17 October 2014?

4.4. **Norfolk and Waveney Local Medical Committee**

(o) Given that there is no easy answer to the current shortage of GPs, can practices use more nurses / therapists to maintain services.

(p) Can Norfolk practices offer more training places as a way of easing recruitment difficulties?

4.5 **Norfolk and Suffolk Workforce Partnership (NSWP)**

(q) What resources do NSWP and HEEE have to enable them to plan education for future clinical workforce requirements in this region?

(r) How will current health care education programmes address future workforce requirements?

(s) What more could be done to encourage postgraduates to take up the available GP training places?

5. Action

5.1 NHOSC is asked to consider:-

(1) Whether it wishes to support the recommendations made by Breckland Council:-

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

(2) Whether it has received sufficient information on this subject or would like to examine the issues in more detail, in which case the committee may wish to establish a scrutiny task and finish group in 2015 (draft terms of reference could be presented in January 2015).

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NHS
Norwich
Clinical Commissioning Group

Subject:	Central Strategic Resilience Group – workforce assurance
Presented By:	James Elliott, Director of Clinical Transformation
Submitted To:	HOSC 27 November 2014
Purpose of Paper:	Information

1 Purpose

As part of the Norfolk HOSC review of workforce and recruitment difficulties the Strategic Resilience group (SRG) for Central Norfolk has been asked to reflect its position regarding workforce pressures to local resilience.

This report sets out the purpose and key responsibilities of the SRG and how it has identified workforce risks and its assurance of mitigation to manage these.

2 Background

The Central Norfolk "Unplanned Care Clinical network" was established November 2012. Its role was to ensure cross system, commissioners and providers, coordination of the Urgent Care system. The Domino Project was initiated and implemented by the Network.

With revised national guidance, most recently in June 2014, Urgent Care Networks or similar arrangements nationally, were required to evolve into "Strategic Resilience Groups" with a clear remit to oversee the resilience and delivery of their urgent care system. The Terms of Reference of the Unplanned Care Network and name have been amended to reflect this. The organisations represented at the SRG remain the same, providers and 3 Central Norfolk commissioners with senior management and clinical representation from all main health and social care organisations.

3 SRG responsibilities.

The overall purpose of the Central Norfolk System Resilience Group is to be the senior strategic group that addresses the delivery of an effective 24/7 urgent and emergency care system for the health community in response to current system pressures and in line with national guidance and local need. This will require the integration of urgent health and social care services.

The Urgent Care Board will have delegated responsibility from its member organisation to:

- Oversee the performance management and delivery of any system wide Urgent Care recovery plans.
- Oversee recommendations as to the best use of the relevant non-recurrent funding allocations e.g. the marginal rate emergency tariff 70% which is retained by NHS England for breaching the NEL threshold and any seasonal non-recurrent winter pressures money to support the delivery of Urgent Care development.
- Supervise any additional non-recurrent or recurrent resources specifically allocated to the delivery of Urgent Care standards including the recovery of operational performance (including winter pressures monies, winter planning decisions and initiatives, CQuINs).

- Promote the adoption of care pathways across all components of emergency Health and Social Care which deliver best practice and meet national Emergency Care standards and guidance.
- Hold the whole system to account to ensure that productivity and efficiencies are delivered through patients being treated and cared for by evidence based services that meet their needs in the least intensive environment.
- Ensure that individual organisations develop service resilience plans that are reactive to service fluctuations and also support the health economy response to a system wide approach to pressure e/g: winter planning, business continuity planning and emergency planning, including an integrated system wide resilience plan, with stakeholder contribution.
- Ensure local service developments provide support to specific groups of patients who are likely to be at increased risk of needing urgent care services e.g. the frail elderly, children with disabilities or long term illness, vulnerable adults including people with Mental Health problems, learning disabilities and substance misuse problems.
- Ensure that the patient and carer perspective and quality of care are the priorities in planning emergency healthcare in the local Health and Social Care community.
- Ensure that assurance is received that stakeholder organisations are carrying out root cause analysis in relation to breaches and system failures and that these RCA's are resulting in action improvement and that the learning is being shared across the Health and Social Care system.
- Coordinate and manage the Domino programme of work to improve and maintain the urgent care system including full programme management office (PMO) responsibilities including the delegated power to commence, evaluate and close projects at completion or when assessed to be failing to deliver key performance indicators.

4 Implementing 2014/15 risk assessment and management.

In implementing the Domino project and through a programme of allocation of national funding streams the SRG has initiated a range of schemes designed to alleviate the pressure on the urgent care system, and to return to a more resilient and sustainable one.
A critical risk highlighted was workforce pressures, both short term and potentially longer term. These workforce pressures are recognised nationally, and are being experienced across all partners and providers within the system.

Although it is not the responsibility of the SRG to manage these pressures, it is the responsibility of the SRG to ensure resilience across the system. As a part of this assurance process the SRG has;

- Requested Health Education England to outline how workforce planning is coordinated across Central Norfolk and to advise and guide HEE where appropriate. This includes reflecting the 5 strategic year plan in planning assumptions and reflecting the transformational programme of change in training and educational national programmes.
- Agreeing new services only where supplemented by new additional staff, not by reallocating existing staff from "core" services.
- Requiring all new service proposals to have evidenced the utilisation of skill mix across providers and the system where practical and that are linked through clear integrated pathways of care.
- Supported the principle of a Norfolk- wide recruitment fayre, ideally working with the County Council and other local authorities to "sell" the opportunities of moving to Norfolk to live and work.
- Although an NHSE responsibility CCGs are working with their own practices to support integrated working, "wrap around" community services and encouraging practices to develop opportunities to work together, to try and mitigate the current increasing pressures on GP recruitment.

Appendix B

Report to Norfolk Health Scrutiny Committee

NHS England East Anglia Area Team
NHS Workforce Planning for Norfolk

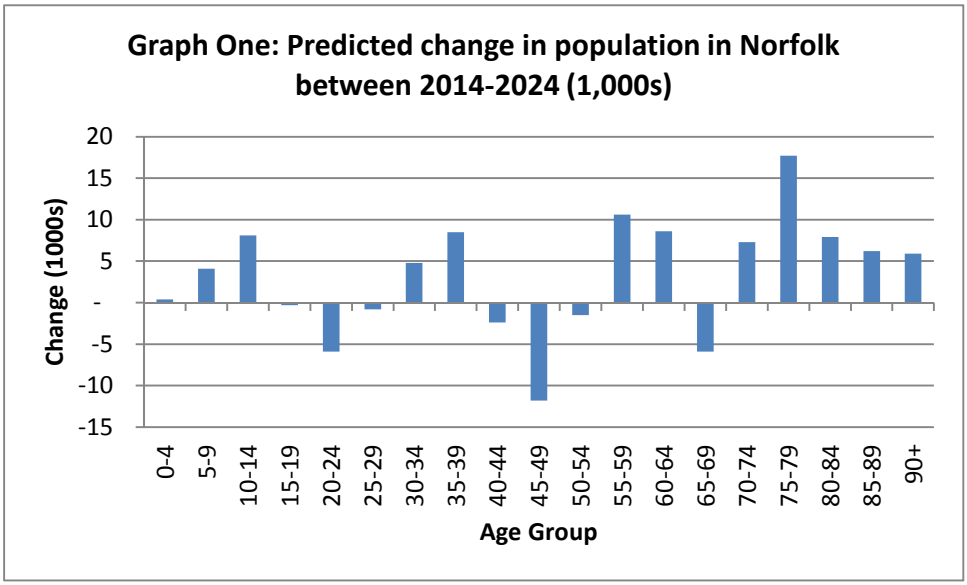
1. Introduction

The NHS England Area Teams must work in partnership with Health Education England, CCGs and provider organisations to ensure effective and appropriate workforce planning. This is particularly relevant in relation to the current responsibilities held by the Area Team in relation to:

- Commissioning primary care and public health services
- Commissioning specialised services and services for individuals within the criminal justice system
- Responsibility for professional revalidation and performance of independent primary care contractors
- System oversight and assurance

2. General Practice Workforce

Between 2014 and 2024 the population in Norfolk is expected to increase by 64,000 people (see Graph One)[1]. If, as the ONS predicts, there are 64,000 more people in Norfolk by 2024 then, based on current ways of working this would suggest the need for 44 additional GPs in Norfolk.



[1] http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-335242

There are, however, very immediate pressures impacting on local practices as a result of the national shortage of general practitioners. As a result we are aware of an increasing number of practices who have been unable to fill GP vacancies both in relation to doctors who wish to join as Partners, or as salaried GPs. Similar issues are also being seen in relation to practice nurses.

While the current impact of this is varied across Practices in Norfolk, the underlying issues are common across East Anglia and beyond. They relate to workload, financial uncertainty, moral, and attractiveness of the current practice model etc.,.

The Area Team convened a General Practice Workforce Summit in partnership with Health Education England on 17th October. As a result of the summit, a number of initiatives are being progressed, with a follow up workshop planned for January.

The representatives from NHSE, Health Education England and the LMC attending the Committee will be able to discuss these in more detail.

NORFOLK & WAVENEY LOCAL MEDICAL COMMITTEE
"representing all General Practitioners in Norfolk and Great Yarmouth & Waveney"

Dr Tim Morton — Chairman
Dr Ian Hume — Medical Secretary
Mrs Naomi Woodhouse — Principal Executive Officer

Norfolk HOSC Meeting Report

The LMC has put together this report to provide the HOSC with context and background to the current workforce crisis which General Practice is facing locally and nationally. Norfolk and other "shire counties" seems particularly affected.

The General Practitioners Committee (GPC) is carrying out a national campaign to raise awareness for these critical issues. We recommend the HOSC familiarises itself with the GPC's 'Your GP Cares' campaign, which includes a short video.

The LMC has carried out lots of work on the issue of workforce and recruitment, raising the key points with local MPs, and feels the main reasons for this reduction are as follows:

WORKLOAD

- NHSE estimates GP appointments have risen from 300 million p.a. (2008) to 340 million p.a (2014)
- The average person visits their GP 6 times a year – double that of 2004.
- The average consultation is 12 minutes, compared with 8 minutes 20 years ago, demonstrating the increased complexity of managing more long term conditions and increased elderly population.
- Locally GPs are working routinely 12 hour days, not the "9-5" that the media falsely portrays.
- The population is growing and getting older, thus requiring greater use of health resources.
- General Practice is being forced to support over stretched hospitals and community providers with earlier discharges and work previously done within hospital out-patients
- The increasing number of new drugs, treatments and services requires GPs to spend extensive time keeping up to date and checking protocols
- CQC regulation has brought increased scrutiny, paperwork and workload.
- GPs now have to be part of CCGs and play a part in commissioning decisions but these are often dictated by budget constraints.
- Increased bureaucracy and form filling on top of clinical work
- Highly rural area makes travel time for home visits longer
- Multiple contractors (NHSE, CCGs, Public Health (Local), Public Health England) increases bureaucracy, and complexity due to multiple different contracts and duplication of requirements and reporting. The Health and Social Care Act by getting rid of Strategic Health Authorities and forming Area Teams left a huge void of "health intelligence and support"
- Poorly commissioned contracts result in services being 'forgotten' or not commissioned to a level an external provider would be able/willing to take on the contract; this results in work defaulting to general practice to pick up at zero cost.

WORKFORCE

- In Norfolk & Waveney we have an average patient:GP ratio of 1,922. When the GP contract was held by individual GPs, rather than a practice, the PCT trigger for another partner being required was when the GP:patient ratio reached 1,800. This shows a large number of practices in the area have an unsustainable GP:Patient ratio with many practices ratios being over 1:2500.

- Locally our Vocational Training Schemes (VTS) for fully qualified doctors to train in General Practice have many vacancies and those in schemes plan to return to bigger cities to work once training completed.
- Medical Schools seem to encourage hospital futures rather than general practice.
- NWLMC offers an advert function on our website. Over the past 3 month period 33% of Norfolk & Waveney practices have advertised for 1 or more vacancy on our site. However it is the time that practices take to fill vacancies which is particularly concerning. An advert in the British Medical Journal a few years ago would produce 20-30 applicants, now practices are lucky to get any interest at all let alone suitable candidates and given that it costs £1000 per week to advertise this probably hides the true extent of practice vacancies.
- According to the Nuffield Trust research, 73% of GPs say their workload is currently unsustainable and unsafe.
- Only a 4% GP increase in 7 years, compared to a 27% increase in Consultant numbers – this is not keeping up with the increase in demand. T*hese figures do not acknowledge full time or part time.*
- Increased numbers of GPs taking early retirement due to workload and changes to the pension scheme
- Majority female workforce, as 60% of medical students are now female, which often results in career breaks, part time working and earlier cessation of medical careers.
- Increasing number of GPs working part time to enable a portfolio career developing other clinical interests such as teaching and training at UEA Medical School.
- According to the GPC survey, 9% of under 50's plan to leave direct patient care in next five years
- The low morale has filtered through to medical students and resulted in a very low uptake to the GP trainee scheme
- Medical Students are choosing to work elsewhere in the world due to the perceived better conditions, those returning find the bureaucracy to re-enter the NHS prohibitive
- Constant abuse and misrepresentation from the media results in General Practice not being an attractive career choice.
- Lack of incentive to become a partner, which underpins the current structure of general practice. Most General Practices are in fact businesses holding "independent contractor status". The removal of this 'family doctor' role to a more commercial, less personalised service undermines the reasons why many GPs trained in this specialty
- Proposed loss of occupational health service support available to GPs could have a detrimental impact on GP health.

DEMAND

- Patient expectations and demand has increased – "clinical wants rather than clinical need"
- Lack of education for patients to self-care where appropriate results in inappropriate expectations
- Patients want a 24/7 service, the shortage of GPs means GPs are required to work even longer days to manage this demand. This same GP workforce also man the Out of Hours services although since 2004 GPs have relinquished the responsibility for organising this service.
- More treatment options and advances in medical technologies has increased the options available to patients and reasons to see their GP
- More elderly patients wanting to receive their care at home
- NHSE is demanding more "efficiencies" from General Practice
- The Government is pushing for 7 day working. The workforce is not sustainable for the current opening hours, neither is the resource applied to this: the increase in working hours would be 60%, however the increase in funding represents a 1.1% increase
- Hospitals and Community Staff are expecting more input from General Practice to co-ordinate the care provision for patients under their care prior to admission and post-admission.
- Increasingly patients and companies expect GP practices to provide medical information and reports, which is not mandated within the GP contract, but GPs feel compelled to provide.

FUNDING

- The proportion of NHS funding supporting general practice in England has fallen from 10.4% in 2005/6 to 7.47% in 2012/13.
- The GP contract is based on the 2004 appointment rate, which now doesn't reflect current workload.
- The recent GP contract changes have resulted in new work being funded from recycled money, so no new money to comes into general practice for these increased services.
- Current contract reviews are resulting in very large funding cuts taking place in General Practice at a time when demand is increasing; many practices will need to reduce the number of GPs they have owing to the imminent funding cuts
- The reduction in funding makes general practice unattractive and risky for young GPs to invest
- The reductions in funding make many services unviable
- The changes to the NHS has resulted in multiple different claiming methods to the different contract holders – there have been multiple delayed and erroneous claims made which causes uncertainty, cashflow difficulties and workload.
- The Health Bill 2010 brought with it a push for contracts to be put out to tender to increase competition – this increases uncertainty for general practice.

As the report lays out, there are a multitude of reasons why General Practice workload is at an unsustainable level and the direct impact this is having on recruitment and retention. The LMC would like to ask for the HOSC's support to ensure these local concerns are being considered by local MPs, the Government, UEA Medical School and local training schemes to support General Practice and ensure our trusted and well respected health service is preserved and enhanced in a manageable and sustainable way. We also ask for the HOSC's support to help promote the area of Norfolk and Waveney to help encourage and attract new recruits to this beautiful area.

Health Education East of England (HEEoE)

TITLE **Role of HEEoE in Workforce Planning and Education Commissioning through local Workforce Partnership structures**

Report of Kirk Lower - Ross Collett, Head of the Norfolk & Suffolk Workforce Partnership

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1 Overview

The Dept of Health published The Education Outcomes Framework[1] in March 2013, which HEE has responsibility to deliver, with the stated aim to "ensure the health workforce has the right skills, behaviours and training, available in the right numbers, to support the delivery of excellent healthcare and health improvement".

The outcomes are delivered by HEE through four key functions:

1. Workforce Planning – each year through a local process of engagement with employers HEE identifies the numbers, skills, values and behaviours that employers tell HEE they need for the future;
2. Attracting and recruiting the right people to education and training programmes that HEE commissions;
3. Commissioning excellent education and training programmes for students to achieve high quality care in a safe environment;
4. Lifelong investment in people – encouraging employers to continue to provide high quality care for patients through on-going training.

In delivering these functions HEE has been given a mandate[2] by the Dept. of Health outlining priority areas to address in the context of the education outcomes framework. The headline priorities are:

1. From pregnancy through to adulthood – ensuring the best start in life for every child and young person;
2. Delivering integrated care that meets the needs of people and their families;
3. Mental Health;
4. Public Health;
5. The right healthcare workforce with the right skills, values and competencies;
6. Value for money, transparency and reforming education and training funding.

[1] Dept of Health. The Education Outcomes Framework, March 2013
[2] Dept of Health. Delivering high quality, effective, compassionate care: Developing the right people with the right skills and the right values. A mandate from the Government to Health Education England: April 2014 to March 2015

2 HEE Structures

HEE is a provider lead organisation and carries out its functions and delivers its mandate through 13 Local Education and Training Boards or LETBs across England. The LETB covering Norfolk is Health Education East of England (HEEoE) which has responsibility for Norfolk, Suffolk, Cambridge & Peterborough, Beds, Herts and Essex. In turn HEEoE has set up 4 local workforce partnerships to cover this geography where providers come together with commissioners to determine local priorities, in line with the national priorities, and engage with the four functions that the LETB has to carry out. In the case of Norfolk this is the Norfolk and Suffolk Workforce Partnership (NSWP).

NSWP has a local advisory Board with provider CEOs, CCG COOs, local authority Directors and University Deans of Health as constituents and is chaired by the CEO of the Norfolk and Norwich University Hospital NHS Trust.

3 Education Commissioning & training process

NSWP is the vehicle by which engagement with local providers takes place.

NSWP as the local partnership organises and runs the process of collecting and challenging workforce plans from our local NHS Providers. This process informs the investment or the commissioning of education locally primarily with our two partner universities and equates to a number of students who will enter undergraduate training for non-medical professions e.g. nursing, therapists and healthcare science. The process of planning and commissioning takes place annually on a rolling 5 year cycle. Non-medical training from a graduate to a qualified professional, ready to enter the workforce, takes anywhere from 3 to 4 years depending upon the profession.

Medical training has two components: undergraduates entering university or medical school; postgraduate training which takes place in service. Postgraduate trainee numbers for all specialties, including GPs, are not determined at a local level but are determined through a national process with the involvement of the various royal colleges and a number of other national stakeholders. HEE, through this national process, then allocates each LETB a number of postgraduate training posts across the specialties that are available to be filled on a competitive basis by trainees. These posts at a regional level are organised into programmes that see trainees progress through the various levels of training, rotating through different organisations towards finally becoming, for example, a fully qualified GP who is able to practice. The training of Doctors varies but in the case of a GP can take 10 years before they are able to practice as a fully qualified GP.

It is important to note that postgraduate medical training posts are filled on a competitive basis. Trainees apply for posts nationally and then go through competitive interview and selection processes run by the LETBs in the regions. Each year this often means that trainees are offered posts that they choose not to accept as they will have made multiple applications; this can result in unfilled training posts across specialties including general practice. NHS Providers will fill these gaps where they cannot attract trainees with locums or other "out of training" doctors or other trained professionals such as advanced practitioners.

4 General Practice

As has been described above HEE is a provider lead organisation and therefore it is providers, through the planning and commissioning process, who inform us of the requirement they have for trainees or undergraduates to enter training. HEE has no responsibility or ability to fill gaps in service where vacancies exist today as in the case of general practice.

HEEoE or NSWP, as is described above, do not control the process of determining the numbers of GP training posts. HEE nationally was given, as part of the mandate, a requirement by 2016 to ensure that 50% of trainees who successfully complete foundation training have the opportunity to enter a GP training programme. HEEoE has already met its share of this requirement.

HEEoE as a result of the mandate and through successful lobbying at a national level has secured an increase in the numbers of GP training posts available but for the first time in a number of years has had difficulty in filling all of these training posts with a significant number of these gaps being in Norfolk and Suffolk.

5 Additional action NSWP is taking to support General Practice

NSWP and the LETB has been working with NHS England, who has the responsibility to commission primary care services, to support the development of alternative models of care that will help address the gaps where GP vacancies remain unfilled. For example these can be initiatives such as the development of new roles where either existing healthcare workers can be retrained or up skilled to take on additional patient facing responsibilities and can be brought in to the primary care workforce at a faster rate than would be required to train a GP.

There are a range of these initiatives currently being developed at a regional and local level.

Stroke Services in Norfolk

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

The Norfolk and Waveney Stroke Network responds to Norfolk Health Overview and Scrutiny Committee's recommendations for stroke services in Norfolk.

1. Background

1.1 On 17 July 2014 Norfolk Health Overview and Scrutiny Committee (NHOSC) approved a report by its Stroke Services in Norfolk Task and Finish group with 21 recommendations for organisations involved in local stroke care.

1.2 One of the recommendations was for Norfolk and Waveney Stroke Network to meet with the Task & Finish Group to discuss the recommendations before responding to NHOSC. A very constructive meeting took place on 19 August 2014 and the Network undertook to co-ordinate responses to the NHOSC from each of the organisations concerned.

2. Suggested approach

2.1 A representative of the Norfolk and Waveney Stroke Network, has been invited to present the responses to NHOSC's recommendations (attached at Appendix A). All the organisations concerned have responded positively.

2.2 NHOSC may wish to discuss the responses with the representative from Norfolk and Waveney Stroke Network, bearing in mind that they cannot personally answer for the 16 organisations involved. They may, however, be able to clarify certain points or undertake to provide information at a later date.

2.3 NHOSC may wish to ask Norfolk and Waveney Stroke Network to report to a future meeting on progress with implementation of the accepted recommendations.

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

Norfolk Health Overview and Scrutiny Committee – Stroke Services in Norfolk (July 2014) – Final response Document

Recommendations		To	Response
Strategic Overview			
1.	That members of the Norfolk and Waveney Stroke Network commit to regular meetings and to working with the Cardiovascular Strategic Clinical Network and the Clinical Senate to drive co-ordinated improvement of stroke services in the county. (Paragraph 2.7)	Norfolk and Waveney Stroke Network	Accepted – The wider strategic clinical network, The Norfolk and Waveney Stroke Network now meets on a regular two month cycle, with dates diarised well in advance. Members of the Norfolk and Waveney Stroke Network already hold key roles within the regional Network. Dr Kneal Metcalf is chair of the East of England Stroke Network and Dr Raj Shekhar is chair of the Telemedicine Subgroup. The standing agenda items for the Norfolk and Waveney Stroke Network will be amended to receive reports from the Strategic Network meetings.
2.	That the NHS England East Anglia Area Team should be involved in the Norfolk and Waveney Stroke Network and that a clinical lead for the Network should be identified. (Paragraph 2.7)	Norfolk and Waveney Stroke Network NHS England East Anglia Area Team	Accepted - NHS England East Anglia Area Team has proposed that the Manager of the NHS England East of England Cardiovascular Strategic Clinical Network represent the Area Team on the Norfolk and Waveney Stroke Network. The role of clinical lead for the network will be shared between the three consultants who are members of the Norfolk and Waveney Stroke Network; Dr Kneale Metcalf, Dr Raj Shekhar and Dr Hilary Wyllie.
Preventative			
3.	That the Norfolk and Waveney Stroke Network takes up the recommendations of the Health Needs Assessment and oversees collective	Norfolk and Waveney Stroke Network	Accepted - The Network will consider the Health Needs Assessment at its meeting on the 9th December 2014 and will also agree with Public Health a process for accessing additional data sources and reporting these back to the

Recommendations		To	Response
	work between CCGs and Public Health to identify additional data sources and further analyse data in relation to stroke. (Paragraph 3.2)		network. Public Health will look for and identify additional data sources and carry out further analysis. Including: • benchmarking acute providers via the royal college of physicians data or Dr Foster or other national tools • highlighting areas of unwarranted variation in secondary prevention at GP practice level • looking at primary prevention services at a GP practice level e.g. stop smoking service provision and take up • looking at local schemes to reduce salt use. These to be reported at Network meetings in March 2015.
4.	That NHS England East Anglia Area Team considers the scope for introducing blood pressure checks at dental surgeries and pharmacies. (Paragraph 3.4)	NHS England East Anglia Area Team	Accepted: The Network will ask for a review of the evidence base for Blood pressure checks in these locations and report on the effectiveness of existing schemes involving community pharmacies. As NHS England is currently restructuring its area teams and is likely to combine East Anglia with Essex and also is developing mechanisms for 'co-commissioning' services with CCG's, it is proposed that collection of evidence and data be completed by February 2015, with agreement on next steps at the Network meeting with NHS England in March 2015. Public Health has a spread-sheet with the practice level offer and take-up of health checks. This will be augmented with quality metrics from the stroke and AF QOF information compared to health check uptake. This will assist in highlighting areas of unwarranted variation.

Recommendations		To	Response
5.	That Norfolk County Council Public Health, who are responsible for commissioning the NHS Health Checks in the county, assess the numbers of people who are eligible for a NHS Health Check and the numbers who actually take up a Health Check and make the information available to the NHS England commissioners and GPs on a practice by practice basis to encourage action in the areas of low take-up (Paragraph 3.4)	Norfolk County Council Public Health	Accepted: The data will be produced by April 2015 and reported back to the new NHS England local team for dissemination to practices and further action under the new co-commissioning process currently being proposed.
Pre hospital			
6.	That EEAST reviews the number and location of ambulance bases in Norfolk in relation to travelling times to the hyper acute stroke units with a view to achieving the Stroke 60 standard in all parts of the county. (Paragraph 4.10)	EEAST	Accepted: Local ambulance stroke 60 audit should be the first step to discuss further reorganisation/pathway variations EEAST has already undertaken a comprehensive review of all its locations across Norfolk and Waveney, both in number and location. Talks are ongoing with Norfolk Fire & Rescue Services to co-locate in some of their premises where this would prove of benefit to improving the responses to all categories of patients, but especially where there is a time factor to definitive treatment. New locations have been identified in line with the recently published Clinical Capacity Review undertaken by ORH (Organising or Optimising Resources for Health) in January 2014. These locations are

Recommendations		To	Response
			in places such as Watton and Hoveton. Travelling times across the county are often challenged by seasonal demands, poor infrastructure, and time of day. There are some parts of Norfolk and Waveney where even if an ambulance was close to a patient, they would not reach a hyper-acute stroke unit within 60 minutes. The map of driving times on page 20 of the report highlights this geographical challenge. It is proposed and being worked on that these new locations are active before the end of financial year 2014/15 (31st March 2015). Staffing challenges prevent these being active sooner than this.
7.	That the Norfolk and Waveney Stroke Network seeks assurance from the three acute hospitals in Norfolk that they report back to EEAST on failures to provide pre-alerts of the arrival of stroke patients so the problem can be quantified and appropriately addressed and that EEAST identifies a lead for stroke with whom the hospitals can liaise consistently. (Paragraph 4.12)	Norfolk and Waveney Stroke Network EEAST	Accepted: EEAST have established a new Stroke lead for Norfolk who will attend the Network meetings. At the meeting of 21st October 2014, process agreed for a robust collection of failures of pre-alerts at hospital using DATIX system. Data will be reported back at all future Stroke Network meetings by EEAST.
8.	That the NNUH, JPUH, QEH and EEAST consider what more could be done to enable the ambulance service and the acute hospitals to work together to shorten the diagnosis time for stroke.	NNUH JPUH QEH EEAST	Accepted - At the Norfolk and Waveney Stroke Network Meeting on 21st October, Network members agreed to hold meetings based around each Hospital system and to then collectively share their work at the Network meetings. This will be on the Agenda for the Network Meetings scheduled for 2015.

Recommendations		To	Response
	(Paragraph 4.13)		
9.	That EEAST focuses on improving its performance by ensuring that double staffed ambulances are first on scene to a higher proportion of suspected stroke patients and that patients are transported to hospital without delay. (Paragraph 4.15)	EEAST	Accepted: EEAST - EEAST remodelled its delivery of service in Norfolk by converting 3 rapid response vehicles (RRVs) to double staffed ambulances (DSAs). These additional hours meant the provision of extra ambulances in Cromer, Fakenham, and Diss. Further DSA hours have also since been put into Kings Lynn. The EEAST stroke lead has also introduced a process of auditing all stroke coded calls highlighting time spent on scene by the crew and completion of the care bundle. This in turn reinforces the need to reduce on scene times for the crew. This is completed monthly by the local manager. It is however a challenge to improve the time taken to get a patient a hyper-acute stroke unit given the locations of these units in relation the rural communities. EEAST will review how other rural areas within the UK manage the challenges and feed this back to the network meetings. Success will see improved DSA provision and a reduction in average response time to stroke patients, and an improvement in the numbers of patients arriving at a hyper-acute stroke unit within 60 minutes.
Hyper acute and acute			
10.	That the stroke team at the NNUH should be a stand alone team, as is recommended in the National Stroke Strategy 2007 and that it should be staffed to the appropriate levels in all the relative disciplines.	NNUH	Accepted: NNUH support this recommendation. This is progressing and they aim to have this in place by December 2014. The staff to support this structure are in place. They now have six stroke consultants and have appointed additional nursing and therapy staff. Manjari Mull to share the report produced by the

Recommendations		To	Response
	(Paragraph 5.3.2)		Strategic Clinical Network.
11.	That the James Paget University Hospitals NHS Trust **urgently** increases the number of stroke specialist consultants in its service. (Paragraph 5.6)	JPUH	Accepted: This is an urgent priority for the Trust. Funding has been identified for several years for a third stroke consultant. They are currently advertising nationally for a stroke specialist consultant, this time with a substantial "golden hello" attached to the post. They also booked a stand at the British Geriatrics Society Autumn meeting to advertise the James Paget Hospital and the current opportunities in stroke and geriatrics. In the last 12 months the Trust has successfully recruited a neurologist with a special interest in stroke, whose main commitment is to the stroke unit. In Sept 2014 an additional middle grade doctor joined the stroke team on a long term locum basis. If the Trust are unsuccessful in recruiting a stroke specialist consultant this year, the Executive team have agreed that they will seek a locum stroke consultant for a period of at least 6 months in 2015. This will give the team better support while exploring other recruitment options, including European recruitment agencies. They are also looking at options for increased out of hours specialist support for stroke via a telemedicine link to another unit.
12.	That the Norfolk and Waveney Stroke Network reviews that number of stroke specialist staff in post (i.e.	Norfolk & Waveney Stroke Network	Accepted: The Network will conduct a review by April 2015.

Recommendations		To	Response
	people actually in post, not the number of posts in the establishment), and the availability of staff in post in supporting disciplines, to assess the clinical safety of the services. (Paragraph 5.6)		
13.	That the Local Education and Training Board explains what is being done to resolve the shortage of stroke specialist consultants, other stroke specialist staff and staff in other disciplines whose expertise is needed in the stroke care pathway. (Paragraph 5.6)	Health Education East of England	HEEoE acknowledges the challenges in filling stroke posts but continues to provide, through a national process, opportunities for trainees to access stroke educational out of programme opportunities as part of a training programme that leads to a Certificate of Completion of Training (CCT). Stroke is a sub specialty post. Trainees who apply for posts must already hold a national training number in another specialty. Often, these are in geriatric medicine. Stroke as a sub specialty has had difficulty recruiting country wide from Aug 2014 and this, it is in part believed, is linked to changes in the way that at a national level the Specialty Advisory Committee for Medicine for the Elderly no longer credits this as an out of programme experience towards a trainees CCT. Prior to Aug 2014 HEEoE has always recruited to between 6-8 posts each year; from Aug 2014 intake only 4 of 8 posts have been filled. This issue is being picked up by HEEoE at a national level. In addition to the issue described above there is already a shortage of trainees choosing to apply for stroke posts. Given that these posts are filled on a competitive basis

Recommendations		To	Response
			trainees appear not to be valuing these out of programme experiences on their training career path towards a CCT. HEEoE continues to create training opportunities for stroke as a sub specialty and pursues several rounds of recruitment in order to fill these posts each year. HEEoE can only offer the opportunity it cannot mandate trainees to take up these opportunities in what is a competitive process but continues to work with service colleagues to make these opportunities as attractive as possible.
14.	That the Norfolk and Waveney Stroke Network undertakes an assessment of how many patients are delayed at acute and community hospitals due to waiting for NHS Continuing Care assessment or funding and establish what the cost is. (Paragraph 5.7)	Norfolk and Waveney Stroke Network	Accepted: NNUH support this recommendation. Data is currently collected. They will look at this for Stroke and bring information to the December meeting. QEH – accepted. Data is being monitored within the organisation and will analysed specifically for Stroke and reported to the Network and West Suffolk SRG. NNCCG - Happy to support CHC assessment delay exercise noting this will cut across both CSU & NNUH as they have their own assessment team. For Central Norfolk the SRG will oversee this piece of work. JPUH support this GY&WCCG - The number of specialist nurse posts at JPUH to undertake CHC has increased. Currently a review of the CHC process at JPUH for all patients is being undertaken with the aim of involving the ward staff in the process. This will be a great benefit to stroke patients as the hospital staff

Recommendations		To	Response
			that have cared for them during their in-patient stay will be involved in making recommendations on eligibility moving forward, although many stroke patients will not be ready for assessment whilst at the hospital or whilst undergoing active rehabilitation. Recent statistics demonstrate that form Checklist to DST there is a mean of 5 working days being achieved. This is minimising delays once in the process however there is further work to do to reduce the wait (at times) for a checklist to be completed. There are no delays at JPUH with agreeing recommended funding as all CHC recommended eligible patients then have their on-going care funded on a 'patient without prejudice' basis. Any delays following eligibility are associated with lack of provider provision.
Rehabilitative			
15.	That the Norfolk and Waveney Stroke Network reviews the staffing of stroke rehabilitative services across Norfolk, including the availability of staff in the necessary supporting disciplines (including psychology) to ensure the appropriate level of support. (Paragraph 6.2.4)	Norfolk and Waveney Stroke Network	Accepted: The Network will request staffing data from NHS providers across Norfolk, including specialist rehabilitation providers. In addition it will request staffing data for generic rehabilitation that follows the period of specialist care. This will be reported to the Stroke Network meeting in March 2015.
16.	That the Norfolk and Waveney Stroke Network assesses the relative merits of the three rehabilitative stroke services in	Norfolk and Waveney Stroke Network	Accepted: The Network agrees that clinical outcomes based assessment be progressed to consider the effectiveness of Stroke Rehabilitation. It requests this is led by Public Health

Recommendations		To	Response
	Norfolk with a view to commissioning services in future that bring the maximum benefit to the greatest number of patients, within the available overall funding limits. (Paragraph 6.2.6)		and a project plan be agreed by the network in February 2015. The outcomes of this work will be reported to the Network and shared with the Commissioners who retain statutory responsibility for Commissioning of Services.
Long term			
17.	That the Local Education and Training Board explains what is being done to improve the availability of trained Psychologists. (Paragraph 7.4)	Health Education East of England	The LETB is currently in the cycle of commissioning regional programmes as part of the annual investment plan and when indicative numbers are known early in the new year we will be in a position to provide a detailed response.
18.	That Norfolk County Council adult social care, Norfolk Independent Care, Norfolk Community Health and Care and East Coast Community Healthcare meet to consider how more training in the long term care of stroke survivors can be delivered to care home staff in private and public sector care homes across Norfolk, how progress with such training can be tracked and how good practice can be shared across the care home	Norfolk County Council Adult Social Care Norfolk Independent Care NCH&C ECCH	Accepted: Norfolk Independent Care has met with Norfolk County Council, NCH&C and ECCH. Information about the current training for new and existing care home workers in relation to the long term care of stroke survivors has been obtained in relation to each organisation. An action plan to drive forward consistency of training has been developed (see attached document). A Task and Finish group will be convened to support and develop a consistent approach to the training of care workers in relation to the long term care of stroke survivors. The Task

Recommendations		To	Response
	spectrum. (Paragraph 7.7)		and Finish group will also review how training is tracked and agree a system for sharing good practice. Notes of the Task and Finish group will be available to all key stakeholders. NNUH support this recommendation. We are supporting training of a number of nurses for Tracheostomy for the Oak Farm Nursing Home. We have provided honorary contract for the Oak Farm staff to come and observe our staff. This model should be transferable to other settings. NCH & C: Our stroke team have been involved in attending the steering group and will be part of the action group chaired by Norfolk Independent Care. The Network also support Integrated training programmes e.g. UEA module which is easily accessible to varied staff groups
19.	That the five Norfolk CCGs should work together to commission an integrated prevention, information, communication and six month stroke review service across Norfolk. (Paragraph 7.8)	North Norfolk CCG South Norfolk CCG Great Yarmouth & Waveney CCG West Norfolk CCG Norwich CCG	Accepted: Great Yarmouth and Waveney CCG will be working with providers to review options regarding stroke follow up pathways, including consultant, nurse, ESD and Stroke association services. This will be included in our commissioning intentions for 2015/16. NHS South Norfolk CCG recognises the value of a collaborative approach to prevention, information and communication, particularly from the point of view of consistency and, to a lesser extent, economies of scale. As six month follow up needs to be delivered at an individual Patient level there may be considerations that preclude a Norfolk County model (i.e. distinct Community Providers), however NHS SNCCG will commit to engaging with the

Recommendations		To	Response
			Norfolk and Waveney Stroke Network, and the Norfolk Stroke Advisory Group on these, and all matters relating to Stroke Care to ensure that patients within its geography receive a service that is at least better than the National average, or meets National standards where average performance is not met Nationally. WNCCG will continue to commission support services in the community for West Norfolk and we would welcome the opportunity to work with the other CCGs to deliver equity of service across Norfolk. The Network will review the Commissioning outcomes of the CCG's in August 2015 and report on the effectiveness of services in place.
The cost of stroke and stroke services			
20.	That Norfolk and Waveney Stroke Network collectively considers whether CCGs and Norfolk County Council could usefully commission research on the overall cost of stroke to the health and social care authorities in the county and robust evaluation of the overall cost effectiveness of the three existing stroke service systems in the county.	Norfolk and Waveney Stroke Network	Partially Accepted – The Network recognises that such a project would be of considerable interest but has concerns that the cost and time of this work represents a significant piece of work, likely to be at PhD level. It will explore this with the UEA and Public Health and receive a report on the feasibility of this progressing at its meeting in February 2015.

Recommendations		To	Response
	(Paragraph 8.2)		
Next steps			
21.	*That representatives of Norfolk and Waveney Stroke Network meet with the Stroke Services Task & Finish Group to discuss the recommendations of this report before responding to Norfolk Health Overview and Scrutiny Committee.* *(Paragraph 10.1)*	Norfolk and Waveney Stroke Network	Accepted – The Network met with HOSC task group on 19th August 2014.

Wheelchair provision by the NHS – central and west Norfolk

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

An update report on NHS wheelchair services in central and west Norfolk.

1. Background

1.1 Norfolk Health Overview and Scrutiny Committee (NHOSC) has received reports from commissioners and providers of NHS wheelchair services on 12 January 2013, 10 October 2013 and 17 April 2014. The subject was first put on the committee's agenda in response to members' concerns about the length of time taken to provide wheelchairs and the suitability of the equipment provided. NHOSC decided that it would focus on the provision of wheelchairs to adults and children rather than on the full range of equipment for independent living for people with disabilities.

1.2 The committee has previously examined the eligibility criteria and assessment processes used by the wheelchair providers and received information on the commissioning arrangements for the service. Currently specialised wheelchairs are commissioned by NHS England and non specialist by the Clinical Commissioning Groups (CCGs) but from April 2015 all NHS wheelchair services will be commissioned by the CCGs.

1.3 At each of the previous meetings NHOSC heard from Family Voice, which is a collective of parent carers within Norfolk representing families of children with special and additional needs. In April 2014 Family Voice commented that there was a need for more service user engagement to identify problems, test ideas and communicate customer needs to the NHS.

1.4 NHOSC agreed that it was imperative that the voice of children, young people and their families should be heard in the planning and provision of wheelchair services and invited the central and west Norfolk service providers to report back in six months' time on what more would be done to hear the views of children, young people and families who use the wheelchair service, in keeping with the spirit of The Children and Families Act 2014.

2. Purpose of today's meeting

2.1 The CCGs for central and west Norfolk were asked to supply the following information for today's meeting:-

- An update on wheelchair service user involvement, with particular emphasis on families, young people, children and the carers of wheelchair users.
- An update on waiting times and key performance indicator results.

The central Norfolk CCGs have also been asked to provide an update on how the new Service Specification for the All-Age Non-Complex Wheelchair Provision, on which NHOSC received details in April 2014, has helped with service delivery.

NHS England has been asked to provide performance information (in terms of waiting times and other key performance indicators) on specialised wheelchair provision.

Reports are attached as follows:-

Appendix A –Norwich CCG for central Norfolk
Appendix B – Queen Elizabeth Hospital, west Norfolk
Appendix C – NHS England specialised commissioning

2.2 Family Voice has been asked to update the Committee with current views about the services. Its paper is attached at Appendix D.

2.3 Representatives of the relevant CCGs (who commission non specialised wheelchairs), NHS England (who currently commission specialised wheelchairs), the central Norfolk service provider Norfolk Community Health and Care (NCH&C) and the west Norfolk provider The Queen Elizabeth Hospital NHS Foundation Trust will be present to answer Members' questions. A representative from Family Voice will also be in attendance to give service users' views.

4. Suggested approach

4.1 Following the presentation of the commissioner, provider and Family Voice reports, Members may wish to raise questions in the following areas:-

(a) How will the central Norfolk service user group change to encourage more involvement?

(b) In April 2014 it was reported to NHOSC that there was no service user group in west Norfolk but that the possibility of establishing two including one for children who required specialist provision, would be examined. Has there been progress with this, or with a virtual user group?

(c) What preparations are being made in preparation for the smooth handover of specialised wheelchair commissioning from NHS England to the CCGs from April 2015, especially with regard to involvement of this group of patients?

(d) Does NHS England have a clear picture of how the specialist wheelchair services are currently operating to assist the CCGs in taking over management of the contracts?

(e) Are wheelchair users who move to Norfolk and Suffolk from other areas able to access repairs and replacement parts through the local services for the chairs that they bring with them?

(f) One of two therapists in the west Norfolk area left the service in May 2014 and at the time of writing had yet to be replaced, which had led to longer waits for hand over of equipment. When is another therapist likely to be appointed?

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

NHS
Norwich
Clinical Commissioning Group

Subject:	Non specialized Wheelchair Services
Presented By:	James Elliott, Director of Clinical Transformation
Submitted To:	HOSC 27 November 2014
Purpose of Paper:	Information

The CCGs in Central Norfolk (Norwich, North Norfolk, and South Norfolk) commission non-complex wheelchair services from Norfolk Community Health & Care (NCH&C). Specialised wheelchair services are commissioned by NHS England.

In March 2014 South Norfolk – as coordinating commissioner – presented a paper to the committee detailing the role of service users in commissioning, a new draft service specification for the service, and an update on service performance in the area of waiting times and access to services.

The committee has requested an update on the following matters:

1. An update on user involvement in Central Norfolk, with particular emphasis on families, young people, children, and carers;
2. An update on waiting times and key performance indicators
3. The impact of the new service specification on service delivery

In July 2014 the role of coordinating commissioner passed from South Norfolk CCG to Norwich CCG.

User Involvement

A service user group was established by NCH&C in January 2014. The group first met on 6th March 2014, attended by 5 users and 3 carers. Further group meetings were arranged for 27th May, 26th July, and 29th September, but each meeting was cancelled due to 'lack of interest from users'.

NCH&C are now conducting further work to identify how the group can be reshaped to improve user involvement, and is planning to relaunch the group in January 2015. As part of this review two consultation events have been planned:

- Consultation event with young wheelchair users at Clare School – 21st November 2014
- Consultation event with a youth wheelchair basketball team – date to be confirmed

NCH&C are also working with Dr Wang (Family Voice) to improve family engagement. Dr Wang has also provided some input into the current service specification.

In October and November 2014 Jonathon Fagge (CEO of Norwich CCG) had discussions with two long-term users of wheelchairs, to obtain feedback on the service and consider

how the user group could generate a higher level of user involvement in service review and development. It has been recommended that commissioners participate in the service user group, and that it has a greater focus on service improvement and development.

ACTION – Norwich CCG commissioner will participate in the wheelchair service user group, and actively engage with that group on the design and development of services.

ACTION – Norwich CCG will work with NCH&C to ensure that the re-launched user group has wider participation from users, including families and young people.

Service Performance

1. Service Usage

Referrals received for Wheelchair Services
Child < 18 years - Adult >= 18 years

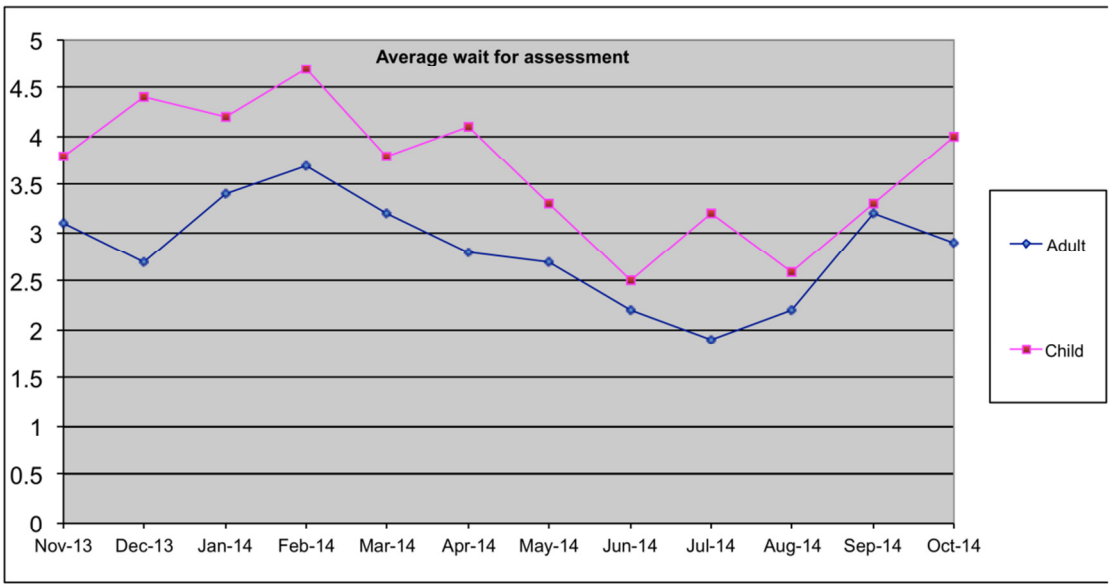
All Ages	237	219	239	207	238	263	263	278	303	237	229	230
Week Ending	**01/11**	**01/12**	**01/01**	**01/02**	**01/03**	**01/04**	**01/05**	**01/06**	**01/07**	**01/08**	**01/09**	**01/10**
Adult	204	199	220	180	214	234	235	249	269	208	194	209
Child	33	20	19	27	24	29	28	29	34	29	35	21

Demand for wheelchair services (measured as new referrals into the service) are broadly static, with an average of 218 adults and 27 children referred into the service each month.

2. Trends in Waits for Assessment & Wheelchair Provision

Average wait for assessment
(referral to first contact)

All Ages	3.2	2.9	3.5	3.8	3.3	3	2.8	2.3	2	2.2	3.2	3.1
Week Ending	**01/11**	**01/12**	**01/01**	**01/02**	**01/03**	**01/04**	**01/05**	**01/06**	**01/07**	**01/08**	**01/09**	**01/10**
Adult	3.1	2.7	3.4	3.7	3.2	2.8	2.7	2.2	1.9	2.2	3.2	2.9
Child	3.8	4.4	4.2	4.7	3.8	4.1	3.3	2.5	3.2	2.6	3.3	4

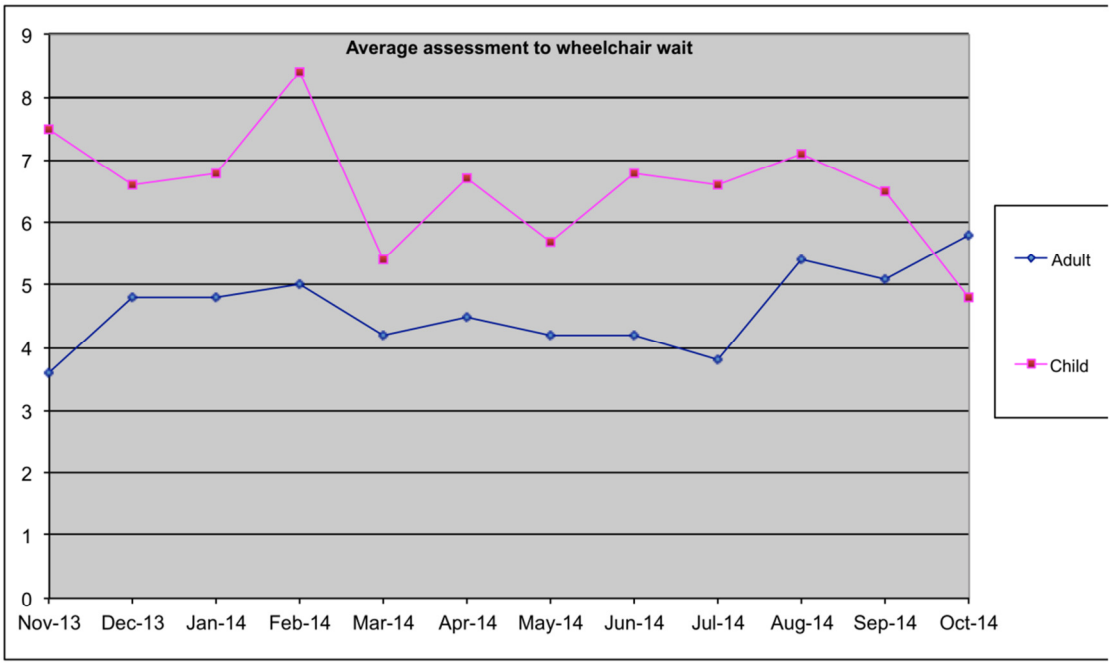


Average waits for assessment for both adults and children improved between February and August 2014, falling to under three weeks, from a peak in February of almost five weeks for adults and four weeks for children. The latest data for October 2014 shows an

increase in waiting times for children. The commissioner has requested further information on this increase from NCH&C.

Average assessment to wheelchair wait
(first contact to discharge)

All Ages	4.2	5	5	5.5	4.4	4.7	4.3	4.4	4.3	5.6	5.3	5.7
Week Ending	**01/11**	**01/12**	**01/01**	**01/02**	**01/03**	**01/04**	**01/05**	**01/06**	**01/07**	**01/08**	**01/09**	**01/10**
Adult	3.6	4.8	4.8	5	4.2	4.5	4.2	4.2	3.8	5.4	5.1	5.8
Child	7.5	6.6	6.8	8.4	5.4	6.7	5.7	6.8	6.6	7.1	6.5	4.8



Post-assessment waits for wheelchair provision show a mixed picture, with waits for children improving slightly over the last year, while waits for adults have increased from 5 weeks to 6 weeks. Again, further information has been requested from NCH&C.

Service Specification

The revised service specification for non-complex wheelchair provision was agreed by the Central CCGs in March 2014, but has not yet been incorporated into the NCH&C contract. The intention was to invite the user group to provide structured feedback on the impact of the new service specification. It is intended that the re-launched group will provide feedback from January 2015, and the specification can then be included in the contract negotiations for 2015-16

Item 8 Appendix B

Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust

Wheelchair Service

Children, Young People and their Families.

Background

In April 2014, the Health Overview and Scrutiny Committee asked us to look at the service we provide for children, young people and their families and to take steps to gather their views on how the service performs and any improvements that could be made.

The Kings Lynn Wheelchair Service has 185 clients who are 19 years or under. This represents approximately 8% of users although this group occupies 15% of all appointments (September 2014).

Waiting Times

All referrals are prioritised and booked into priority or non priority clinics. Children and young people are always treated as priority. At the time of writing the wait for a priority clinic appointment is 9 working days although we can respond to urgent requests more quickly.

Key Performance Indicators

The service aims to hand over equipment within 10 weeks of referral in 95% of cases. At the moment this is 88% for the general population as one of the two therapists left in May and has yet to be replaced.
However, there is no client under 19 who has waited more than 10 weeks.

Gaining the Views of Children, Young People and their Families

The Trust has produced a version of the “Friends and Family” questionnaire which has been modified to reflect issues in a Wheelchair Service. In October this was sent to all clients under 19 with a stamped addressed envelope and a covering letter asking for their evaluation of the service. The letter also asked for their opinions on how the service could be improved and any experiences they have had which might influence the training and information we provide. This information is provided anonymously.

Questionnaire Results

At the time of writing we have had 22`` Questionnaires returned. The results are as follows:-

“How likely are you to recommend our service to your friends or family if they needed similar care or treatment?”

Extremely Likely		20
Likely	1	
Neither likely or unlikely		
Unlikely		1
Extremely unlikely		
Don’t know		

“Were you treated with dignity and respect?” and graded from 1 Not at all to 5 totally.

1	0
2	0
3	0
4	4
5	18

“Did you feel involved enough in decisions made about you?”

1	0
2	0
3	1
4	4
5	17

“Did you receive timely information about your care and treatment?”

1	0
2	0
3	1
4	6
5	15

“Was the location clean?”

1	0
2	0
3	1
4	5
5	16

“Were you treated well by the staff looking after you?”

1	0
2	0

3	0
4	2
5	20

“How satisfied are you with the equipment you have been prescribed?”

1	0
2	1
3	0
4	2
5	19

“Do you feel that there was a full assessment of your equipment needs?

1	0
2	1
3	0
4	4
5	17

“Were you kept up to date on the waiting times to be seen?”

1	0
2	0
3	2
4	5
5	15

<u>Comments</u>

“I got an appointment in two weeks!”

“Good – Nice clinic, friendly staff, appointment quick after referral went in. Being referred to clinic took ages.”

“The staff always listen to what I have to say. They take what I have to say and give advice accordingly. You come out of the appointment feeling positive.”

“Having opportunity to discuss needs. Improvement : only one choice, that doesn’t meet the needs.”

“My sons care has always been without fault, plus sensitive to his needs. As a parent with a young child I would say the waiting area could have some books/toys for children who need them. Plus maybe some grown up magazines for adults.”

"We were treated with respect and well informed."

"Very Good."

"Fast, efficient, friendly service."

"We were really looked after by Nadine. Thank you."

"I have always found the staff in the wheelchair clinic to be kind and helpful and have never had any complaints. The staff go out of their way to help. On this occasion Steve Sheldrake actually went to COWA to see my daughter and Mike set up the new wheelchair when it was ready and took it into COWA for her. Thank you so much. We deal with lots of departments at the hospital, but without doubt the wheelchair clinic is the most helpful."

"How quick and easy it was to change the maclaren buggy to a wheelchair when my child had outgrown the buggy. Also how friendly the wheelchair clinic nurse was as my child has other care needs to be taken into consideration when talking to him, the nurse was able to get him to communicate well."

"Everything was very professional. Very good service."

"xxxxxx was happy deciding on using a wheelchair and needed guards on wheels later which was acted on quickly and when I requested them I was treated very pleasantly and very helpful on phone. Could not ask for more"

"All care from start to finish was excellent."

"You were always helpful."

"Very friendly and listen to what I had to say. A wider range of accessories available"

"The care for my son has been very good. No concerns at all, other than recently the reflectors on his chair have fallen off (did almost from new) which I will arrange to replace with Bartrams. A good team (Nadine who has now left was helpful) as well as Steve Sheldrake."

<u>Action Taken</u>

While we were very pleased with the result of the questionnaire, we have also been discussing issues informally with children and parents as they have attended clinics. Three issues have been raised.

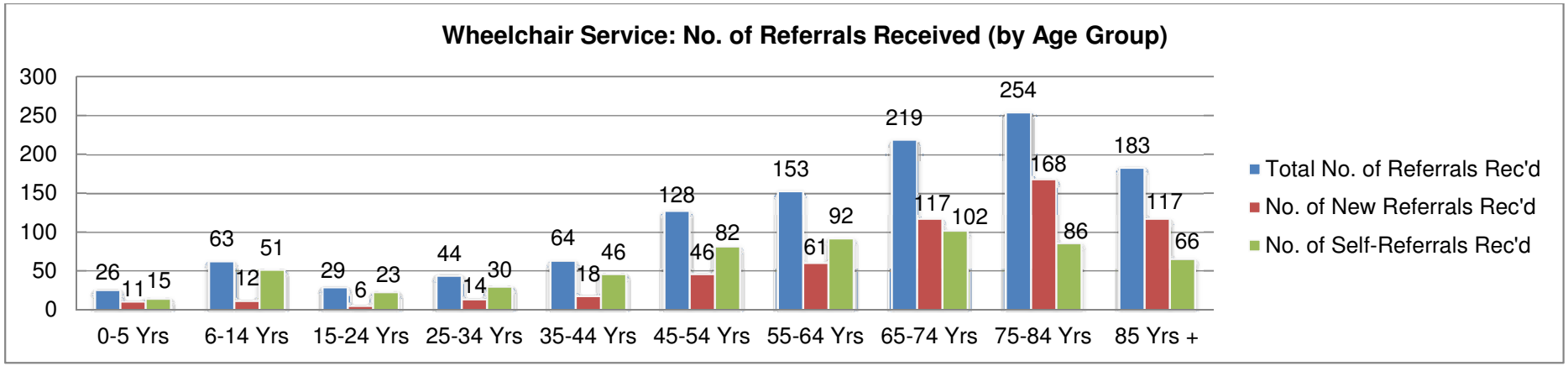
Firstly, parents with children at the local special school would like regular reviews carried out there in conjunction with the school physiotherapist and this will begin in November.

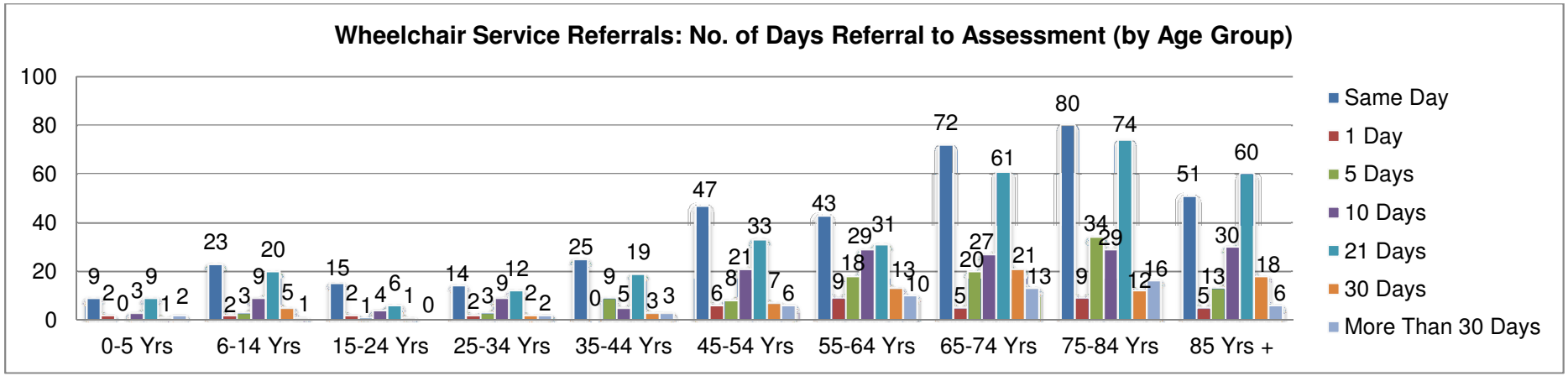
Secondly, parents would like more choice of wheelchairs and buggies on the NHS range. To help address this, we have introduced one new manual wheelchair (Sunrise Medical RX Kidz), one new powered wheelchair (Zippie Salsa) and one new buggy (RMS Clip Buggy).

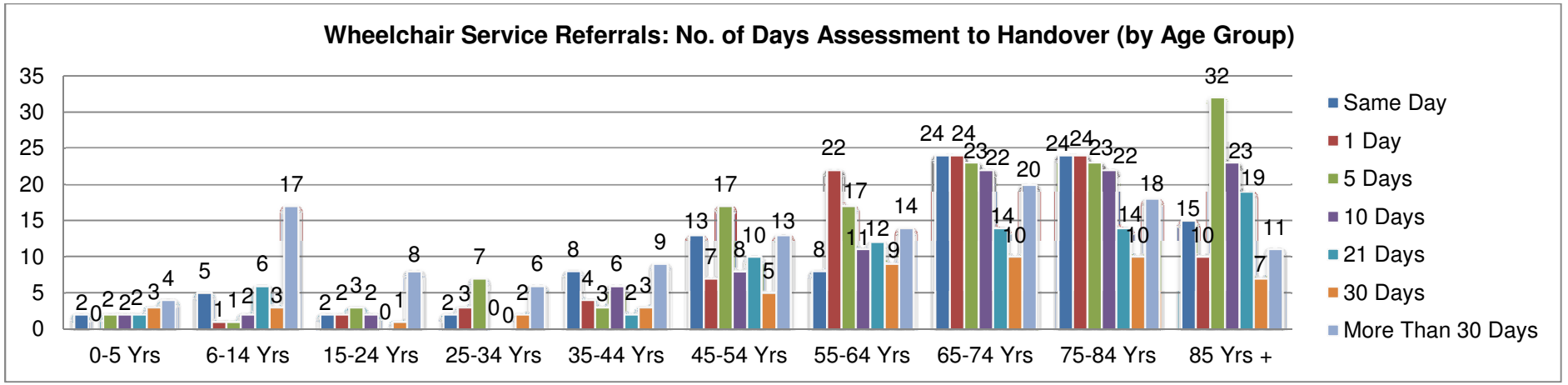
Finally, parents would like more information on which charities would be more likely to help towards funding of non NHS equipment and so we have collated a hand out with a range of charitable sources.

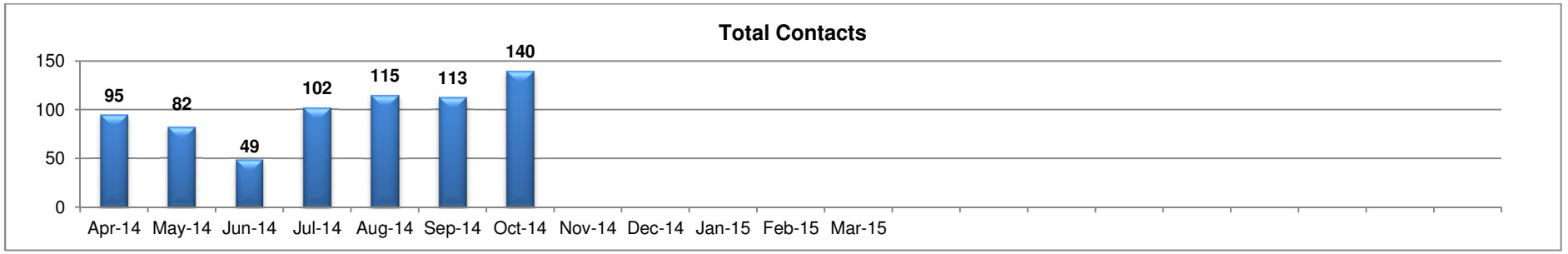
We are also looking at the option of a virtual user group with people providing feedback on issues electronically. We ran a user group in the past but people often found it difficult to travel to the hospital and were concerned about parking and issues of access.

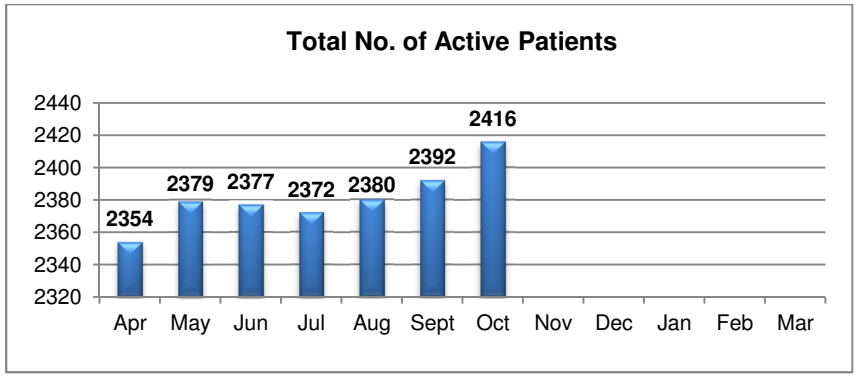
Item 8 Appendix B 1 Queen Elizabeth Hospital (west Norfolk) – wheelchair data

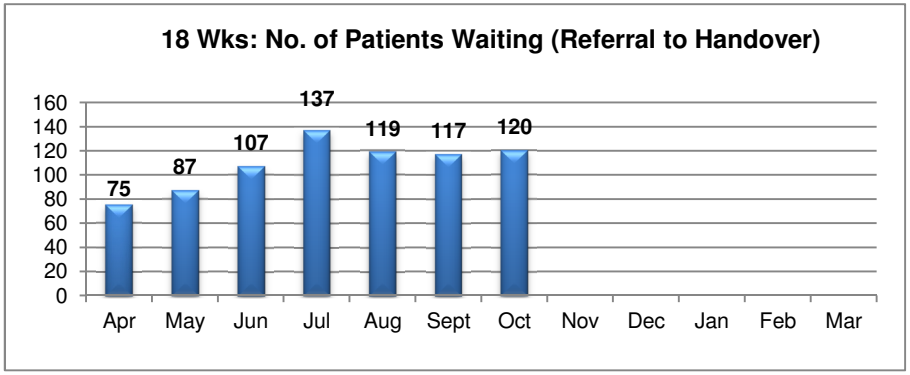


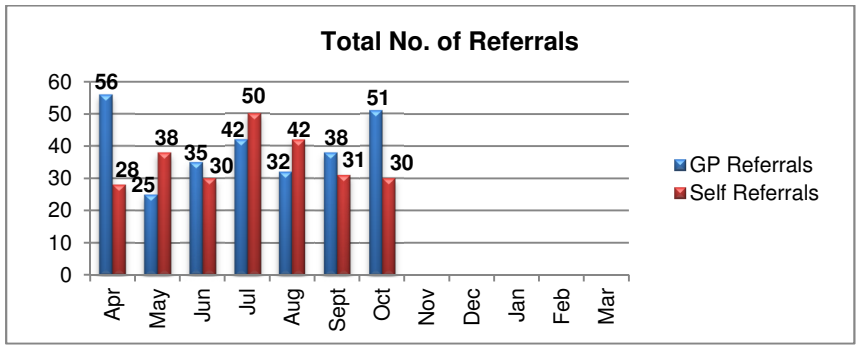


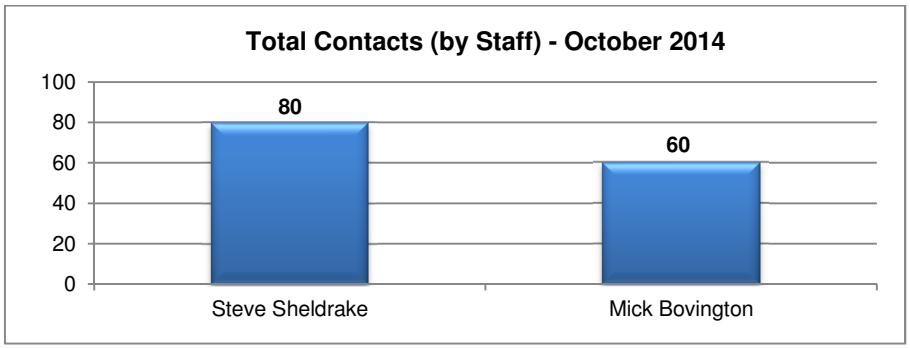

Wheelchair Service Referrals: No. of Days Assessment to Handover (by Age Group)
35
30
25
20
15
10
5
0
0-5 Yrs
6-14 Yrs
15-24 Yrs
25-34 Yrs
35-44 Yrs
45-54 Yrs
55-64 Yrs
65-74 Yrs
75-84 Yrs
85 Yrs +
Same Day
1 Day
5 Days
10 Days
21 Days
30 Days
More Than 30 Days

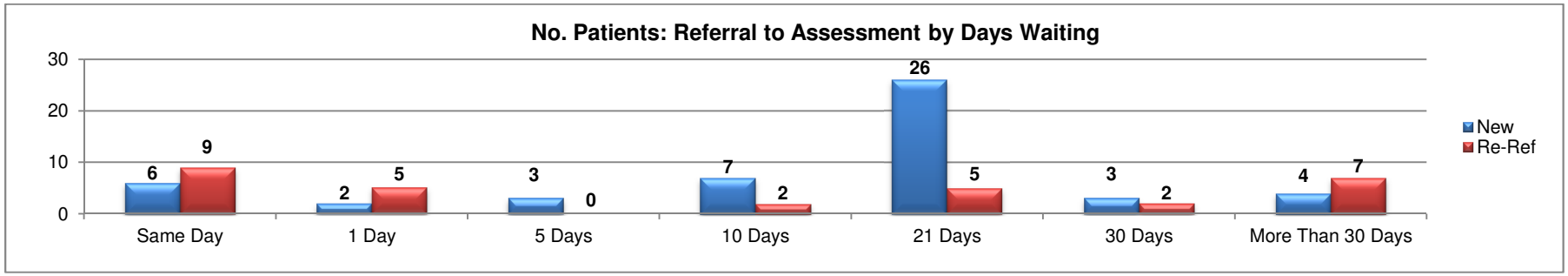

Total Contacts
150
100
50
0
95
82
49
102
115
113
140
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15

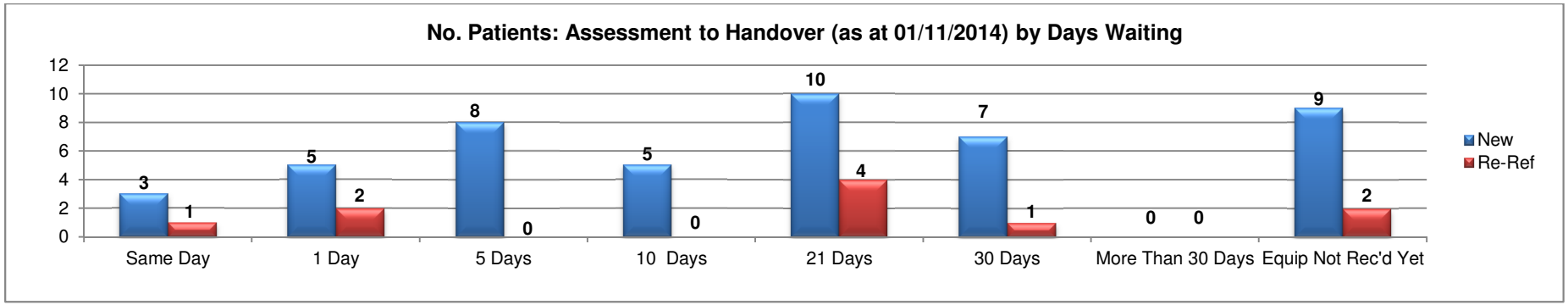

Total No. of Active Patients
2440
2420
2400
2380
2360
2340
2320
2354
2379
2377
2372
2380
2392
2416
Apr
May
Jun
Jul
Aug
Sept
Oct
Nov
Dec
Jan
Feb
Mar

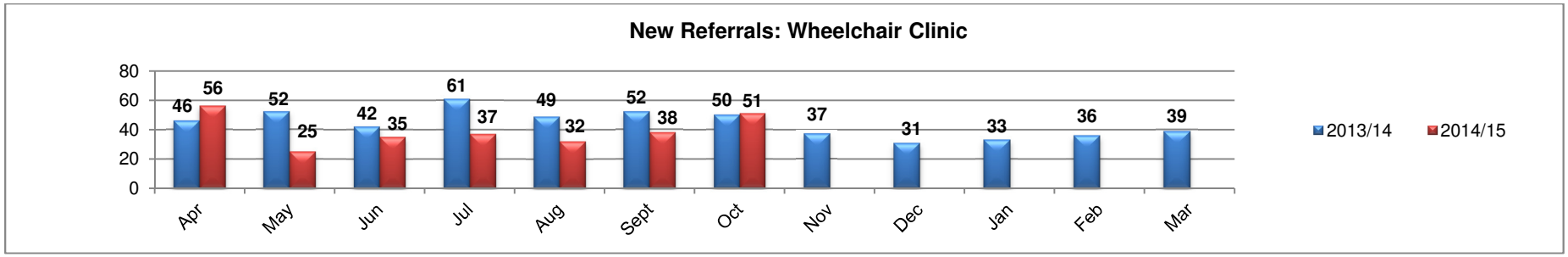

18 Wks: No. of Patients Waiting (Referral to Handover)
160
140
120
100
80
60
40
20
0
75
87
107
137
119
117
120
Apr
May
Jun
Jul
Aug
Sept
Oct
Nov
Dec
Jan
Feb
Mar

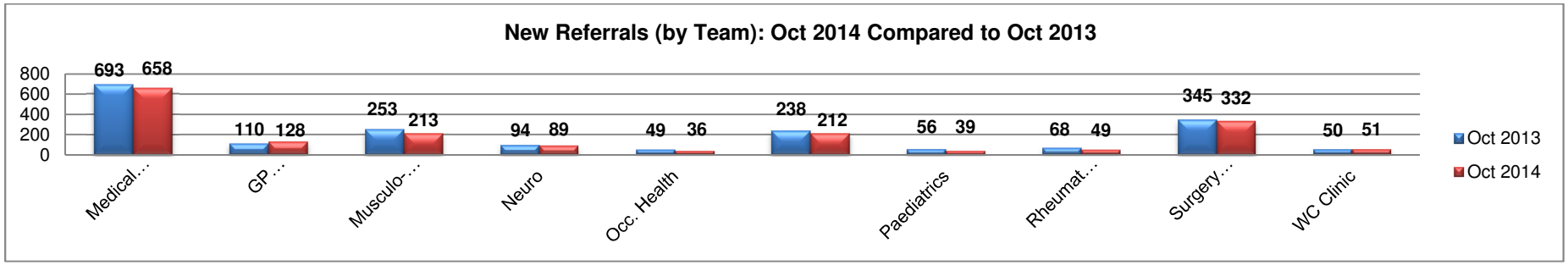

Total No. of Referrals
60
50
40
30
20
10
0
56
28
25
38
35
30
42
50
32
42
38
31
51
30
Apr
May
Jun
Jul
Aug
Sept
Oct
Nov
Dec
Jan
Feb
Mar
GP Referrals
Self Referrals


Total Contacts (by Staff) - October 2014
100
80
60
40
20
0
80
60
Steve Sheldrake
Mick Bovington


No. Patients: Referral to Assessment by Days Waiting
30
20
10
0
6
9
2
5
3
0
7
2
26
5
3
2
4
7
Same Day
1 Day
5 Days
10 Days
21 Days
30 Days
More Than 30 Days
New
Re-Ref


No. Patients: Assessment to Handover (as at 01/11/2014) by Days Waiting
12
10
8
6
4
2
0
3
1
5
2
8
0
5
0
10
4
7
1
0
0
9
2
Same Day
1 Day
5 Days
10 Days
21 Days
30 Days
More Than 30 Days
Equip Not Rec'd Yet
New
Re-Ref


New Referrals: Wheelchair Clinic
80
60
40
20
0
46 56
52 25
42 35
61 37
49 32
52 38
50 51
37
31
33
36
39
Apr
May
Jun
Jul
Aug
Sept
Oct
Nov
Dec
Jan
Feb
Mar
2013/14
2014/15


New Referrals (by Team): Oct 2014 Compared to Oct 2013
800
600
400
200
0
693 658
110 128
253 213
94 89
49 36
238 212
56 39
68 49
345 332
50 51
Medical…
GP …
Musculo-…
Neuro
Occ. Health
Paediatrics
Rheumat…
Surgery…
WC Clinic
Oct 2013
Oct 2014

NHS East Anglia Area Team update to Norfolk HOSC (27th November 2014)

Specialised wheelchair services in Norfolk

Q1 = 220 referrals
Q1 = 590 appointments
Q1 = 94% of patients seen within 5 weeks
No patients waited more than 12 weeks for first appointment following referral

Following the most recent (Q2) contract monitoring meeting with the trust on 28th October 2014 the trust reported

Q2 = twice as many patients required and initial assessment compared to Q1. Whilst the percentage of patients seen within 5 weeks fell marginally to 92% this is due to the large increase in the total number of patients seen. The large increase was due in part to temporary change in working practice to reduce a backlog waiting list, as well as the service now being at full staff complement.

DNA rates remain unchanged at 2.5%, compared to Q1.

Norfolk CC HOSC Wheelchair Services review – Family Voice update on Children's Wheelchair Services, November 2014

Consultation

Parents of children and young people using wheelchair services in Norfolk (from Queen Elizabeth Hospital (QEH) NHS Trust, Kings Lynn, and Wheelchair Assessment Centre (WAC) NCH&C), were consulted for this update. There were 9 new responses since our last update in April 2014.

Background

Family Voice Norfolk was founded in 2006 and is a collective of parent carers covering more than 450 families across Norfolk including the Yarmouth and Waveney PCT area. The Parent Carer Forum is the strategic voice working in partnership with NCC, CCGs, Health Trusts including NCH&C, and Healthwatch. It is funded through a direct DfE grant and by Norfolk County Council.

The purpose of this consultation was to gather qualitative data, via telephone interviews with members, by listening to families' responses to the questions below.

Key messages

As we have presented previously, families wish to:

- be informed;
- have choice;
- be involved;
- receive a consistent service.

These issues are still live. At the time of the last meeting we had already been contacted by NHS Anglia (NEL CCG) CSU and this had continued, but following the last meeting FV was promised participation by NCH&C Trust, and QEH. The involvement has been patchy, however:

- we have been to two meetings with WAC and provided a list of potential user group members (carers or young people) although there has been no direct involvement of families to date as they have found forming a user group difficult and there have been communication difficulties;
- we have been involved with NEL CCG CSU, helping to construct their tender for wheelchair services and arranging for them to talk to wheelchair users at a Norwich special school;
- we have attended Healthwatch meetings to help them formulate their Children's Strategy and will attend their Steering group;
- we have had no contact from other commissioning groups or CCGs.

Parental responses

From our small sample, overall the feeling is that the services have improved. Parents were asked the following question:

"Do you feel that the wheelchair service has changed over the last three years? Has it got worse or better or has there been no change for you and your child?"

As an addendum they were also asked whether they had received a questionnaire or been asked by wheelchair services (WS) for feedback.

Parent A. Overall it's improved, slightly better in referrals from physio, more involved than OT in getting chairs. Service runs better and runs much quicker now that physios are involved. The service is much improved. Physios try and attend appointments with families, which really helps. It's always a friendly service. Bowthorpe Norwich staff are always friendly and helpful.
[Never been asked for feedback.]

Parent B. I do think it's got better, no problems lately. After putting in a complaint it's been a lot better. We have been assigned a named person, but other parents I speak to don't have this and I think they should as it's a really good way of doing this.
[Filled in feedback form.]

Parent C. Can't comment about how it was three years ago as relatively new to the service, but wasn't happy with first contacts. We got a buggy that was fine, but they couldn't provide us with a manual wheelchair that was suitable for postural support, nor could they support an electric wheelchair, with correct postural support, so didn't have chair. So we fundraised and got the chair we needed. The whole experience for us was quite frustrating, it wasn't an easy experience and obstacles are put in the way all the time. I feel that it is all down to money; it was a fight to get a voucher and had to add to it, had to get a second opinion to get a voucher. [Member was very upset at this point.] Workers at the WS need empathy. Original person at WS didn't even have children. How could she know about children? The chair he has now, which we fundraised for, will last for another 5 years and we don't think we will go back to WS to get help. Might ask for voucher, but it was such a struggle. In the end we got what we wanted but really had to fight for it. We really don't feel that when we wrote a letter of complaint it helped as the manager rang up to say how dare you complain about us! Accessories for wheelchairs are so expensive parents have to fund regardless of where funding for wheelchair comes from , you wouldn't want them if you didn't need them.
[Don't think they want my feedback.]

Parent D. I do think it has got better, probably due to Family Voice feedback. They have been given a kick up the backside because they know people are asking questions. They are more on the ball.
[Never been asked for feedback.]

Parent E. Don't have a lot to do with them now, but I wasn't happy in the first place so had to buy my child a chair. He has a rod in his back, so the OT in Norwich referred us to Kings Lynn WS. All they gave us was a wheelchair with a reclining back- but it wasn't suitable. Consultation fine, equipment reasonable, not at all fulfilling requirements.. It was a cheap option, definitely due to money. I feel over the last three years the service is probably the same. They have always provided inadequate wheelchairs not fit for my child's needs; it's a reasonable wheelchair but not fit for my child's needs. He needed support, which is what he was referred for in the first place.
[Not had feedback form or questionnaires.]

Parent F. I think the service has improved. I haven't had much contact with them for a couple of years as The East Coast Truckers funded a new chair for my child. But recently OT has made a referral to WS, I had to cancel appointment and got another one a week or so later. We now have a man called M. who deals with my child, who is very sensitive to my child's needs. My child has a startle reflex and he was seen by a lady who used a tape measure that made my child upset with the clicking noise, a horrible experience she refused to see us in the end, but M. is very good with him.
[No feedback or questionnaires from WS.]

Parent G. Has not been asked for any feedback from WS, but hasn't had dealings with them for 18 months. From personal experience it hasn't changed at all. BUT was speaking to a Mum last week also with a complex health needs child and it seems you now do get more than in days gone by. WS give a thorough assessment and then a voucher is given for £3000.
[No feedback or questionnaires.]

Parent H. As far as member could remember she had not been asked for feedback from WS But felt the service has got better. When I asked why do you think that, she replied that they found a chair that they (WS) paid for, so she didn't have to find the money or fundraise £3000.
[Can't recall if asked for feedback.]

Parent I. WS did seem to put off seeing my child. I wanted an assessment, but they wouldn't see her in person. When I finally got an appointment, they said she needed a chair two sizes bigger. Is that due to money? Overall the service is good, but it doesn't seem any different over last 3 years. However I did ring for an assessment and have got an appointment in the post for not too long away. I am happy with that.
[Can't recall if asked for feedback.]

Norfolk Health Overview and Scrutiny Committee

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

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

Proposed Forward Work Programme 2015

Meeting dates	*Briefings/Main scrutiny topic/initial review of topics/follow-ups*	*Administrative business*
15 Jan 2015	Integration of health and social care services, central and west Norfolk – a progress report from the CCGs and social care. *Ambulance response times and turnaround times at hospitals in Norfolk – a progress report from the East of England Ambulance Service NHS Trust*	*Subject to NHOSC agreement on 27/11/14*
26 Feb 2015	*Diabetes – provision of services within primary care*	*Subject to NHOSC agreement on 27/11/14*
16 Apr 2015		
28 May 2015	Changes to services arising from system wide review in West Norfolk –consultation with the committee. Changes to mental health services in west Norfolk – consultation with the committee regarding permanent changes following the trail period ending in March 2015.	

Committee members requested information on the following items (to be included in the NHOSC Briefing:-

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

Provisional dates for reports to the Committee / items in the Briefing 2015

Oct 2015:-

- Policing and Mental Health Services - an update from the Police & Crime Commissioner for Norfolk, Norfolk and Suffolk NHS Foundation Trust and Norfolk Constabulary (further to the presentation given to NHOSC in October 2014).

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

Clinical Commissioning Groups

North Norfolk	-	Mr J Bracey
South Norfolk	-	Dr N Legg (substitute Mr R Kybird)
Gt Yarmouth and Waveney	-	Mrs S Weymouth
West Norfolk	-	M Chenery of Horsbrugh
Norwich	-	Mr J Bracey

NHS Provider Trusts

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

Norfolk Health Overview and Scrutiny Committee 27 November 2014

Glossary of Terms and Abbreviations

AF	Atrial fibrillation
ARCP	Annual Review of Competency Progression
CCG	Clinical Commissioning Group
CCT	Certificate of Completion of Training
CEO	Chief Executive Officer
CHC	Continuing health care
CNSRG	Central Norfolk System Resilience Group
COO	Chief Operating Officer
COWA	College of West Anglia
CPD	Continuing professional development
CQC	Care Quality Commission
CQUINs	Commissioning for Quality and Innovation
CSU	Commissioning support unit
DATIX	Leading supplier of patient safety incidents healthcare software
DfE	Department for Education
Dr Foster	An organisation that collects and publishes healthcare data. Dr Forster Intelligence is a joint venture with the Department of Health
DSA	Double staffed ambulance
DST	Decision support tool (for continuing health care)
EAAT	East Anglia Area Team
ECCH	East Coast Community Healthcare
EEAST	East of England Ambulance Service NHS Trust
EoE	East of England
ESD	Early supported discharge
FEI	Further education institution
FV	Family Voice
GP	General practitioner
GPC	General Practitioners Committee
GY&WCCG	Great Yarmouth and Waveney Clinical Commissioning Group
HEE	Health Education England
HEEE	Health Education East of England
HEI	Higher education institution
HOSC	Health Overview and Scrutiny Committee
IAPT	Improving Access to Psychological Therapies
JPUH & JPH	James Paget University Hospital
LETB	Local Education and Training Board
LMC	Local Medical Committee
MP	Member of Parliament

NEL	Non elective activity
NCH&C (NCHC)	Norfolk Community Health and Care NHS Trust
NHOSC	Norfolk Health Overview and Scrutiny Committee
NHS	National Health Service
NHS E	NHS England
NICE	National Institute for Health and Care Excellence
NNCCG	North Norfolk Clinical Commissioning Group
NNUH (N&N, NNUHFT)	Norfolk and Norwich University Hospitals NHS Foundation Trust
NSWP	Norfolk and Suffolk Workforce Partnership
NWLMC	Norfolk and Waveney Local Medical Team
ONS	Office of National Statistics
ORH	Organising / optimising resources for health
OSC	Overview and Scrutiny Committee
OT	Occupational Therapist
PCT	Primary Care Trust
PFD	Personal fair and diverse
PFI	Private Finance Initiative
PMO	Programme Management Office
PMS	Personal Medical Services
QEH	Queen Elizabeth Hospital, King's Lynn
QOF	Quality outcomes framework
RCA	Root cause analysis
RRV	Rapid response vehicle
SNCCG	South Norfolk Clinical Commissioning Group
SRG	System Resilience Group
UEA	University of East Anglia
VTS	Vocational Training Scheme
WAC	Wheelchair assessment centre
WNCCG	West Norfolk Clinical Commissioning Group
WS	Wheelchair service