Norfolk County Council

NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE
MINUTES OF THE MEETING HELD AT COUNTY HALL, NORWICH
on 6 December 2018

Present:

Michael Chenery of Horsbrugh (Chairman)	Norfolk County Council
Ms E Corlett	Norfolk County Council
Mr F Eagle	Norfolk County Council
Mr M Fulton-McAlister (substitute for Mr D Fullman)	Norwich City Council
Mrs S Fraser	Borough Council of King's Lynn and West Norfolk
Mr D Harrison	Norfolk County Council
Dr N Legg	South Norfolk District Council
Mrs B Jones	Norfolk County Council
Mr G Middleton	Norfolk County Council
Mr R Price	Norfolk County Council
Mrs S Young	Norfolk County Council

Also Present:

Dawn Newman	Head of Quality in Care, Great Yarmouth and Waveney CCG
Jill Shattock	Director of Integrated Continuing Care, Norfolk Continuing Care Partnership, Norwich CCG
Rachael Peacock	Head of Adult Continuing Care, Norfolk Continuing Care Partnership, Norwich CCG
Jo Smithson	Chief Officer, Norwich CCG
Jeanette Patterson	Continuing Healthcare Lead, Norfolk County Council
Rebecca Hulme	Chief Nurse, Great Yarmouth and Waveney CCG
Sam Revill	Business Development Manager, Healthwatch Norfolk
Caroline Fairless-Price	Member of the public (& a CHC service user)
Dr Chris Price	Member of the public and carer
Dr Sue Vaughan	Member of the public
Sarah Taylor	Nurse at the NNUH
Mark Davies	Chief Executive, Norfolk and Norwich University Hospitals NHS Foundation Trust
Professor Nancy Fontaine	Chief Nurse, Norfolk and Norwich University Hospitals NHS Foundation Trust
Richard Parker	Chief Operating Officer, Norfolk and Norwich University Hospitals NHS Foundation Trust
Melanie Craig	Interim Executive Lead for the STP & Chief Officer Great Yarmouth & Waveney CCG
Frank Sims	Chief Officer, North Norfolk CCG (lead commissioners for the N&N)
Maureen Orr	Democratic Support and Scrutiny Team Manager
Chris Walton	Head of Democratic Services
Tim Shaw	Committee Officer

1 Apologies for Absence

1.1 Apologies for absence were received from Mrs A Claussen-Reynolds, Ms E Flaxman-Taylor, Mr D Fullman, Mr F O'Neill and Mr P Wilkinson.

2. Minutes

2.1 The minutes of the previous meeting held on 18 October 2018 were confirmed by the Committee and signed by the Chairman.

3. Declarations of Interest

3.1 There were no declarations of interest.

4. Urgent Business

4.1 There were no items of urgent business.

5. Chairman's Announcements

5.1 There were no Chairman's announcements.

6 Continuing Healthcare

6.1 The Committee received a suggested approach by Maureen Orr, Democratic Support and Scrutiny Team Manager, to a report on the management of NHS continuing healthcare by Norfolk Continuing Care Partnership (NCCP) for the four Clinical Commissioning Groups (CCGs) in central and west Norfolk and by Great Yarmouth and Waveney CCG for its area.

6.2 The Committee received evidence from Jill Shattock, Director of Integrated Continuing Care, Norfolk Continuing Care Partnership, Norwich CCG, Rachael Peacock, Head of Adult Continuing Care, Norfolk Continuing Care Partnership, Norwich CCG, Jo Smithson, Chief Officer, Norwich CCG, Jeanette Patterson, Continuing Healthcare Lead, Norfolk County Council, Rebecca Hulme, Chief Nurse, Great Yarmouth and Waveney CCG and Dawn Newman, Head of Quality in Care, Great Yarmouth and Waveney CCG.

6.3 The Committee also heard from Sam Revill, Business Development Manager, Healthwatch Norfolk, and Dr Chris Price, a carer for (and speaking on behalf of) Caroline Fairless-Price, a member of the public and a CHC service user.

6.4 Sam Revill, Business Development Manager, Healthwatch Norfolk, explained how Healthwatch Norfolk had worked with the NCCP since Spring 2018 on the need for timely provision of information and better communication with both patients and carers in the central and west Norfolk area about NHS continuing healthcare issues (CHC). Sam Revill said Healthwatch wanted to see what was described as a 'communications boost' to raise awareness and understanding about CHC amongst the general public. Healthwatch Norfolk had held four workshops with the NCCP and voluntary organisations on this subject. The workshops had come up with recommendations for improving family and patient carer leaflets, for correspondence with family members and next of kin, and for how the public could raise complaints.

One of the key messages from the workshops was that the NHS Continuing Healthcare process had to be communicated clearly and in writing to the individual or their representative, as soon as was reasonably practicable. For those approaching the end of their lives, it was vital that they received appropriate information about their condition and care and for this to be communicated with honesty and sensitivity by professionals who had the expertise to do so.

6.5 Dr Chris Price, speaking on behalf of Caroline Fairless-Price, a member of the public and CHC service user, said that there was a serious problem with staffing levels in care and support and this was getting worse. Wherever the care came from and however it was paid for, the same problem existed: there were not enough carers specifically trained in the care that CHC service users needed and reliably available at the time when that care was needed. People and organisations were taking carers from one another to fill gaps and this was not a solution. Developing a safety net for CHC clients had to be about looking further than the odd occasion when care failed. It had to be about the lack of carers to set up reliable care packages.

6.6 During discussion the following key points were made:

- The four CCGs that made up the Norfolk Continuing Care Partnership (NCCP) had not made any changes to the National Framework for NHS Continuing Healthcare because this was set at the national level and not within the power of local CCGs to change.
- The speakers said that for the foreseeable future integration would continue to be a key theme for both health and social care services.
- The NCCP was moving towards the position on continuing healthcare taken by Great Yarmouth and Waveney CCG.
- The speakers said that for historical reasons a lot of different models for the delivery of continuing healthcare were used in Norfolk that did not provide for equitable treatment throughout all the CCG areas.
- One of the reasons why Great Yarmouth and Waveney CCG had historically developed a different model of care was because they had to work with both Norfolk County Council and Suffolk County Council.
- Each patient at the James Paget Hospital was allocated a named CHC Practitioner. The CHC Practitioner worked with the patient and their representatives throughout the patient's stay, and in so doing provided for continuity and personalisation of care and support throughout the assessment process.
- Members stressed the importance of a consistent decision-making approach for all parties and providers of CHC. They said that the difficulty of individuals experiencing a multiplicity of care workers needed resolving to ensure continuity for the patient and flexibility for service provision.
- The speakers said that the assessment teams made sure that the patient played a full role in the assessment and decision-making process and that the patient knew what to expect and where to get information and advice. This was usually done by the patient asking for a friend or relative to help them explain their views.
- The speakers said that patients could be referred to the advocacy services provided by Beacon, a charitable organisation and an independent NHS continuing healthcare adviser that also provided the CCGs with training, advice and advocacy services.
- The speakers from the Norfolk Continuing Care Partnership (NCCP) and Great Yarmouth and Waveney CCG were asked to provide the take up figures on how many people under assessment for CHC took up advocacy services to help them get through the process.

- The speakers said that the STP System Resilience Group had an overview role when it came to workforce winter planning. They and other planning groups within the NHS recognised that a coordinated approach to staff training, based on minimum standards of quality assured training, was required for everyone involved in the CHC assessment process. In reply to questions, the speakers from the CCGs said that in addition to supporting staff in meeting their training needs they recognised the importance of providing a wide range of staff incentives to raise productivity.
- Members drew attention to the additional NHS and social care funding for 2018-19 to fund winter pressures and support winter resilience, specifically for those activities which reduced the need for people to receive formal social care and support and provided for their safe discharge from hospital. It was pointed out that when this matter was considered at Adult Social Care Committee some concern was expressed that some of this funding might have to be used to bolster short term capacity in the homecare and care home markets and to manage potential market failures, such as that which had occurred with Allied Healthcare.
- The speakers said that the quality standards within service contracts helped to ensure that the CCGs were able to hold providers to account for the quality of continuing health care that they provided.
- The speakers explained how the CCGs had developed local protocols between themselves, other NHS bodies, Norfolk County Council and other relevant partners that set out each organisation's role and how responsibilities were to be exercised in relation to hospital discharge thereby improving contingency planning in the event of service failure.
- Steps were being taken to ensure that the services that providers of NHS Continuing Healthcare were expected to supply was clearly set out in the service specification or contract between provider and CCG.
- It was pointed out that where the patient had a rapidly deteriorating condition and was entering a terminal phase, then the Fast Track Tool could be used.
- The intention of the Fast Track Pathway was that it should identify individuals who needed to access NHS Continuing Healthcare quickly with minimum delay.
- The CCGs accepted all Fast Track referrals that had gone through the correct referral process.
- The significantly lower number of CHC Fast Track referrals in West Norfolk was due to the existence of other commissioned End of Life services which could be accessed without the need for completion of a Fast Track referral.
- The Norfolk Hospice (Tapping House) provided specialist palliative care to people with life shortening illnesses and as such had the effect of reducing the referral rate for continuing health care assessments in West Norfolk.
- It was pointed out that in West Norfolk, approximately 75% of Fast Track referrals came from the QEH, 10% from community hospitals and 15% from the NNUH and other acute hospitals and other sources.
- The detailed breakdown of the number of patients in receipt of CHC and the regional variations in the numbers of patients assessed as eligible for NHS CHC could be found in the report.

6.7 The Committee **noted** that rates of referrals for fast track CHC were lower than the English average in both the Great Yarmouth and Waveney Clinical Commissioning Group area and across the Norfolk Continuing Care Partnership area, and that Great Yarmouth and Waveney CCG intended to provide staff training in the James Paget Hospital on when it was appropriate to make a fast track referral.

6.8 The Committee **recommended**:

- That Norfolk Continuing Care Partnership should consider providing staff training at the Norfolk and Norwich and Queen Elizabeth hospitals on when it was appropriate to refer patients for fast track CHC assessment.

The Committee **agreed**:

- Norfolk Continuing Care Partnership (NCCP) and Great Yarmouth and Waveney CCG should provide the figures on how many people under assessment for CHC took up advocacy to help them with the process.
- Great Yarmouth and Waveney CCG and NCCP should provide a progress update for the NHOSC Briefing including a response to the committee's recommendation and evidence of the trends in referrals and assessment of eligibility for CHC and explanation of those trends (see Forward Work Programme below)
- In noting the effect of a shortage of healthcare workers for CHC patients, and the workforce shortages elsewhere in the local NHS, the Committee agreed to ask the Norfolk & Waveney Sustainability Transformation Partnership (STP) Workforce workstream Lead to report on what was being done to address the shortfalls (see Forward Work Programme below).
- An update on the information provided in the National Audit Office's 'The CHC process' diagram to be provided, if available (the diagram, on p.15 in the agenda papers, was based on 2015-16 data).

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

7.1 The Committee received a suggested approach by Maureen Orr, Democratic Support and Scrutiny Team Manager, to a report from the Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH) about the NNUH response to the report of the Care Quality Commission's (CQC) inspection between 10 October 2017 and 28 March 2018, published on 19 June 2018.

7.2 The Committee received evidence from Mark Davies, Chief Executive, Norfolk and Norwich University Hospitals NHS Foundation Trust, Professor Nancy Fontaine, Chief Nurse, Norfolk and Norwich University Hospitals NHS Foundation Trust, Richard Parker, Chief Operating Officer, Norfolk and Norwich University Hospitals NHS Foundation Trust, Melanie Craig, Interim Executive Lead for the STP & Chief Officer Great Yarmouth & Waveney CCG and Frank Sims, Chief Officer, North Norfolk CCG (lead commissioners for the N&N).

7.3 The Committee also received a PowerPoint presentation from the speakers (which can be found at page 77 of the agenda) and heard from Sarah Taylor who had started on a Return to Nursing practice course at the beginning of September 2018.

7.4 Sarah Taylor said that she had previously been a nurse for 22 years and had worked at NNUH in Cardiology, as a Resuscitation Officer, as part of the site operations team and in main theatre recovery. She said that although the NNUH was far busier than when she had last worked at the hospital11 years ago, she was impressed to see the staff provided excellent, compassionate and clinically skilful care every day and that patient satisfaction was high.

7.5 During discussion the following key points were made:

- The speakers said that the NNUH had taken immediate enforcement action in relation to the most significant concerns raised in the Care Quality Commission's (CQC) inspection report.
- There had previously been recognisable divisions within the NNUH executive team and the team had not functioned as effectively and cohesively as they should. Steps had been taken to address these managerial concerns and for the hospital to have a more "clinically led" management structure.
- Since the publication of the CQC report, the NNUH had done a lot more to listen to staff concerns, to encourage staff feedback and to put in place improved mechanisms for staff to report issues to management. Monthly staff get togethers were regularly attended by 200 or more staff and the Chief Executive took a "hands on approach" and regularly attended these meetings.
- A "buddy trust" for the NNUH was expected to be appointed by NHS Improvement shortly.
- The NNUH aimed to be out of special measures by mid-2019 and to be rated as outstanding in the next five years.
- The NNUH had reviewed the forms that were used for the collection of patient data to ensure they were fully compliant with national guidance and met the requirements of NNUH policy. The NNUH had also taken steps to collect more of its key performance data in an electronic form.
- The speakers said that to meet the pressures on the NNUH, hospital services were being delivered in new ways.
- The pressures that the hospital faced included:
    - The capacity constraints of the NNUH building.
    - Finding new ways of working with NHS organisations that were outside of the NNUH's direct control (such as with the Ambulance Service).
    - Devising new methods for incentivising staff which at the same time helped improve hospital productivity.
    - Dealing with a significant increase in the number of patients aged 70-79 years old.
    - Dealing with an ongoing NNUH 8% budget deficit.
- It was pointed out that all NHS organisations were expected to return to a balanced budget position in the next two to three years.
- The NNUH was making representations to Government for help in meeting the hospital's £20m a year in PFI commitments which were for the next 20 years.
- The NNUH had commissioned a virtual ward with a third-party care provider, Homelink Healthcare, who would use their own staff for this purpose.
- In reply to questions from the Chairman, the speakers said that the NNUH had agreed to help the QEH in any way they could to provide hospital services for patients who were waiting to undergo surgery for cancer.
- It was pointed out that some 430 consultants worked at the NNUH and of these some 70 also worked at the QEH.

7.6 The Committee **agreed** that information on the allocation of additional Winter funding (2018-19) for Norfolk and Waveney should be circulated to Members.

7.7 The Committee **noted** the N&N's good progress towards completing the 'must do' and 'should do' actions in the CQC's report and that the CQC was expected to return to the hospital in the new year.

7.8 The Committee **agreed** to await the CQC's follow-up report before deciding if they wished to return to this issue.

8 Forward Work Programme

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

8.2 The Committee **agreed** the forward work programme with the following additions:

11 April 2019 –*Local action to address health and care workforce shortfalls* – a short report by Norfolk & Waveney (STP) Workforce workstream lead.

May 2019 – *Access to palliative and end of life care* – follow-up from the meeting on 18 October 2018

8.3 The Committee **agreed** to add to the NHOSC Briefing (information briefings to enable Members to consider whether to add items to a future agenda):

- Continuing healthcare – response to the committee's recommendation (see item 6 above) and evidence of the trends in referrals and assessment of eligibility for CHC and explanation of those trends.
- Community eating disorder service – capacity, quality and consistency
- Physical health checks for adults with a severe mental illness – process for identifying patients for the register and the numbers of health checks delivered
- GP core services – description of what should be provided under the standard General Medical Services contract

8.4 The Committee **proposed** that a NHOSC Member should be included on the Member Group that had been set up by the Policy and Resources Committee on 29 October 2018 to examine palliative and end of life care. It was **noted** that the Member Group was expected to start its deliberations when NHOSC completed its scrutiny of 'Access to palliative and end of life care' (scheduled for May 2019).

Chairman

The meeting concluded at 1.10 pm