Norfolk County Council

Norfolk Health Overview and Scrutiny Committee

Date: **Thursday, 11 January 2018**

Time: **10:00**

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

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

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

Membership

Main Member	Substitute Member	Representing
Mrs J Brociek-Coulton	Ms L Grahame	Norwich City Council
Michael Chenery of Horsbrugh	Mr S Eyre	Norfolk County Council
Ms E Corlett	Miss K Clipsham/Mr M Smith-Clare	Norfolk County Council
Mr F Eagle	Mr S Eyre	Norfolk County Council
Mrs M Fairhead	Vacancy	Great Yarmouth Borough Council
Mrs S Fraser	Mr T Smith	King's Lynn and West Norfolk Borough Council
Mr A Grant	Mr S Eyre	Norfolk County Council
Mr D Harrison	Mr T Adams	Norfolk County Council
Mrs L Hempsall	Mr J Emsell	Broadland District Council
Mrs B Jones	Miss K Clipsham/Mr M Smith-Clare	Norfolk County Council
Dr N Legg	Mr C Foulger	South Norfolk District Council
Mr R Price	Mr S Eyre	Norfolk County Council
Mr P Wilkinson	Mr R Richmond	Breckland District Council
Mr G Williams	Vacancy	North Norfolk District Council
Mrs S Young	Mr S Eyre	Norfolk County Council

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

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A g e n d a

1		**To receive apologies and details of any substitute members attending**	
2		**NHOSC minutes of 7 December 2017**	**Page 5**
3		**Declarations of Interest** If you have a **Disclosable Pecuniary Interest** in a matter to be considered at the meeting and that interest is on your Register of Interests you must not speak or vote on the matter. If you have a **Disclosable Pecuniary Interest** in a matter to be considered at the meeting and that interest is not on your Register of Interests you must declare that interest at the meeting and not speak or vote on the matter In either case you may remain in the room where the meeting is taking place. If you consider that it would be inappropriate in the circumstances to remain in the room, you may leave the room while the matter is dealt with. If you do not have a Disclosable Pecuniary Interest you may nevertheless have an **Other Interest** in a matter to be discussed if it affects - 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		**Any items of business the Chairman decides should be considered as a matter of urgency**	
5		**Chairman's Announcements**	
6	**10:10 - 11.00**	**Delayed discharges / transfers of care - the District Direct pilot** **Appendix A** (Page 21) - District Direct pilot report	**Page 15**

	11:00 - 11:10	**Break at the Chairman's Discretion**	**Page**
7	**11:10 - 12:00**	**Children's autism services (central and west Norfolk) - assessment and diagnosis** **Appendix A** (Page 31) - Clinical Commissioning Groups' report	**Page 27**
8	**12:00 - 12:10**	**Forward work programme**	**Page 35**
		Glossary of terms and abbreviations	**Page 37**

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Date Agenda Published: 02 January 2018

Norfolk County Council

NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE
MINUTES OF THE MEETING HELD AT COUNTY HALL, NORWICH
on 7 December 2017

Present:

Michael Chenery of Horsbrugh (Chairman)	Norfolk County Council
Mrs J Brociek-Coulton	Norwich City Council
Ms E Corlett	Norfolk County Council
Mr F Eagle	Norfolk County Council
Mrs S Fraser	King's Lynn and West Norfolk Borough Council
Mr D Harrison	Norfolk County Council
Mrs L Hempsall	Broadland District Council
Dr N Legg	South Norfolk District Council
Mr R Price	Norfolk County Council
Mrs S Young	Norfolk County Council

Also Present:

Julie Cave	Interim Chief Executive, Norfolk and Suffolk NHS Foundation Trust
Bohdan Solomka	Medical Director, Norfolk and Suffolk NHS Foundation Trust
Debbie White	Director of Operations, Norfolk and Suffolk NHS Foundation Trust
Jocelyn Pike	Chief Operating Officer, South Norfolk CCG (representing all the CCGs in Norfolk)
Dr Tony Palframan	South Norfolk Clinical Commissioning Group and Chair of Norfolk and Waveney Mental Health Network
Terry O'Shea	Campaign to Save Mental Health Services in Norfolk and Suffolk
Peter Oates	Communications Officer, Unison
Maureen Orr	Democratic Support and Scrutiny Team Manager
Chris Walton	Head of Democratic Services
Tim Shaw	Committee Officer

1. Apologies for Absence

Apologies for absence were received from Mr A Grant (Norfolk County Council), Mrs B Jones (Norfolk County Council), Mrs M Fairhead (Great Yarmouth Borough Council), Mr P Wilkinson (Breckland District Council) and Mr G Williams (North Norfolk District Council).

2. Minutes

The minutes of the previous meeting held on 26 October 2017 were confirmed by the Committee and signed by the Chairman.

3. Declarations of Interest

Mrs J Brociek-Coulton declared a personal interest as a member of UNISON and a member of the Labour Party which was affiliated to the Campaign to Save Mental Health Services in Norfolk and Suffolk.

Ms E Corlett declared a personal interest as a member of UNISON and a member of the Labour Party which was affiliated to the Campaign to Save Mental Health Services in Norfolk and Suffolk.

4. Urgent Business

There were no items of urgent business.

5. Chairman's Announcements

5.1 There were no Chairman's announcements.

6 Norfolk and Suffolk NHS Foundation Trust-mental health services in Norfolk

6.1 The Committee received a suggested approach by Maureen Orr, Democratic Support and Scrutiny Team Manager, to the latest Care Quality Commission inspection of Norfolk and Suffolk NHS Foundation Trust (NSFT) on the provision of mental health services in Norfolk. The Committee also received (with a supplementary agenda) a letter from UNISON that contained additional information on the issue from the union perspective.

6.2 The Committee received evidence from Julie Cave, Interim Chief Executive, Norfolk and Suffolk NHS Foundation Trust, Bohdan Solomka, Medical Director, Norfolk and Suffolk NHS Foundation Trust, Debbie White, Director of Operations, Norfolk and Suffolk NHS Foundation Trust, Jocelyn Pike, Chief Operating Officer, South Norfolk CCG (representing all the CCGs in Norfolk) and Dr Tony Palframan, South Norfolk Clinical Commissioning Group and Chair of Norfolk and Waveney Mental Health Network. The Committee also heard from Terry O'Shea, Campaign to Save Mental Health Services in Norfolk and Suffolk and Peter Oates, Communications Officer, Unison.

6.3 In introducing and welcoming the speakers the Chairman said that the Norfolk and Suffolk NHS Foundation Trust and South Norfolk CCG (the lead commissioners for mental health services in Norfolk) were invited to today's meeting to discuss the response to the latest inspection of the Norfolk and Suffolk NHS Foundation Trust by the Care Quality Commission (CQC) and to consider how the mental health services moved on from here. He said that Members might wish to refer to NSFT's past actions in the course of seeking assurances about the Trust's current direction but with the Interim Chief Executive in attendance the main focus should be on the current service and improvements for the future.

6.4 In their introductory remarks the speakers made the following key points:

- The NSFT had been assigned an Improvement Director.

- The East London NHS Foundation Trust (ELFT) (rated 'outstanding' by the CQC) was the "buddy" Trust to the NSFT.
- While the NSFT itself was rated 'inadequate', the 'caring' by staff was rated as 'good'.
- The Interim Chief Executive drew a distinction between the action to deal with "systemic challenges" and the action to deal with the 'must dos' and 'should dos' contained within the CQC report.
- The ELFT provided support and advice with regards to the "systemic challenges" which were described as the long-term issues such as leadership, staff engagement, clinical engagement and the culture within the NSFT.
- The NSFT had already completed approximately a third of the 25 'must dos' and 'should dos' and expected work on the remainder to be completed by the end of March 2018. A re-inspection of the 'must do's' and 'should do's' would occur before July 2018 and a full inspection was expected within 12 months of the NSFT having entered 'special measures'. This was likely to be in the autumn of 2018.
- The CQC and NHS Improvement (NHS I) were monitoring the NSFT's progress.
- The speakers confirmed that the reporting mechanisms within the NSFT for delivering on the action plan were in place at Quality Programme Board and at Trust Board level.

6.5 Terry O'Shea of the Campaign to Save Mental Health Services in Norfolk and Suffolk, spoke to a paper that the Campaign had submitted to the Committee and which could be found at Appendix D to the report**.** Terry O'Shea questioned the accuracy of the picture that could be drawn from data provided by the NSFT and the lead commissioners. He explained data provided by the Campaign which he said was more representative of the current overall picture and of the challenges faced by the NSFT.

6.6 The Committee also heard from Peter Oates, Communications Officer, Unison, who spoke to a paper which they had submitted. This paper had been circulated to Members with a supplementary agenda.

6.7 Maureen Orr, Democratic Support and Scrutiny Team Manager, said that one of the Campaign's questions was addressed to the Committee. Namely, "had the Committee been too wary of using its powers of referral to the Secretary of State?" In reply, Maureen Orr, Democratic Support and Scrutiny Team Manager, said that a health scrutiny committee could make referrals to the Secretary of State in two circumstances:-

1. When it had been consulted about a proposed substantial change to local health services and considered that the proposed change was not in the interests of the local health service.
2. When it had not been consulted about a substantial change and thought it should have been.

Maureen Orr, Democratic Support and Scrutiny Team Manager, said that referral was intended as a health scrutiny committee's power of last resort and it was right to be cautious about using it. Any referral must include evidence of the steps that health scrutiny had taken to try to reach agreement with the NHS body and evidence that the sustainability, or otherwise, of the local health service in the area had been taken into account. It would not be appropriate for the Committee to try to re-assess judgements made by NHOSC or any of the joint committees on which its members

had served in the past. Their decisions were based on the information available to them at the time.

6.8 The Chairman then asked that Members question the NHS and CCG speakers within the following subject headings by allowing the whole Committee to ask questions relevant to each heading before moving on to the next heading.

- NSFT's overall approach to improvement
- Availability of beds and out of trust / out of area placements
- Staffing
- IT system
- Future commissioning strategy and funding

6.9 NSFT's overall approach to improvement

The following key points were noted:

- The Chairman asked the speakers if they considered the NSFT to be too large an organisation. In reply, the speakers acknowledged that because the NSFT covered a large geographical area it was difficult to get messages out to all service users and all staff at the same time.
- The speakers said that the NSFT's service requirements were addressed through the Norfolk and Waveney STP and the Suffolk and North East Essex STP. If there were differences in mental health work-streams then this would have implications for the NSFT.
- The speakers explained the governance arrangements (set out in the report) that had been put in place to track and deliver progress against the action plan. In reply to questions, the speakers said that no further changes in personnel were proposed at Board level, however, the Board would be able to call on additional project management support if needed.
- The speakers said that in the past the NSFT was managed mainly from the centre. In the future the NSFT would drive forward improvements in service standards through a more decentralised area based management approach that involved placing more decision making powers with individual service leads.
- Members then questioned whether the actions the NSFT should take to get out of special measures were achievable within the current level of funding from the CCGs. (Note: See minutes 6.13 and 6.14 for more detailed comments on this matter).
- In reply, the speakers acknowledged that the NSFT required additional funding to cope with the rising demand for mental health services and to provide greater public access to mental health services.
- The NSFT was seeking additional investment to meet the demand for crisis and urgent care. This was one of the subjects of discussion that the NSFT was having with South Norfolk CCG ((the lead commissioners for mental health services in Norfolk) about mental health service funding for the financial year 2018/19.
- The speakers said that plans had been made for a crisis hub (and a small number of additional step down beds) to be set up and running in a city centre location by the end of October 2018. It was also planned to have a similar arrangement in place in the west and in the east of the county (with public transport made available to the hubs) at some future date.
- The introduction of crisis hubs would help reduce hospital admissions and alleviate the pressure on mental health beds.

- The speakers said that pressures on mental health beds could be reduced by the taking of measures to reduce transfers of care and the provision of more care in the community. The NSFT was currently dealing with an average of between eight and eleven health related delayed transfers of care a day.
- The NSFT recognised that it had to engage with the wider community; particularly those who were currently excluded from accessing NSFT services and those who were on the waiting list. With this in mind, the NSFT planned to undertake a service user and carer review of how the trust-wide set of standards for crisis, home treatment and in patient services would function in the future. The public consultation exercise would be with the broadest possible range of service users and members of the public, including recently discharged patients.
- Members were of the opinion that service users should be able to participate in the public consultation exercise at a time and place of their choosing.
- Members said that the NSFT should collect and keep data to show service user participation was representative of the service user population as a whole, in terms of age, gender, ethnicity and geographic locality.
- The speakers confirmed NSFT data collection included discharged patients and that discharged patients were monitored for a year after discharge.
- Members spoke about the need for more public information on the type of help that was available to members of the public and about where those with suicide tendencies could go to find help in the community in the quickest possible time.

6.10 Availability of beds and out of trust / out of area placements

The following key points were noted:

- Members said that the NSFT should acknowledge that there was not enough beds for working age adults and adults in later life, as identified by the CQC inspection and mentioned in the evidence provided to the Committee by Unison. The NSFT should look again at reopening redundant beds otherwise the Trust would continue to struggle.
- Members said that they expected the NSFT not to place patients in out of trust / out of area placements that were rated by the CQC as inadequate overall or inadequate for reasons of patient safety. They asked to be reassured that the NSFT planned to provide itself with a more robust and regular oversight of out of trust / out of area placements so that safeguarding, quality services and safety of care were fully monitored. In the event that an out of trust/out of area bed provider went into special measures it should be expected that the placement of NHS patients would cease with existing in-patients moved elsewhere as soon as it was clinically safe to do so.
- In reply, the speakers said that the NSFT had reviewed its procedures so to ensure senior management received a more regular oversight of trust / out of area placements. Senior clinicians now attended senior management meetings on a weekly basis to discuss the availability of beds and out of trust / out of area placements and to examine safety of care and quality of care issues.
- It was pointed out that NHS Improvement had added out-of-area placements to its single oversight framework as part of the national drive to eliminate out of area placements by 2020-21.
- By July 2018 the NSFT hoped to have an additional 15 beds opened at Yare Ward at Hellesdon Hospital. To achieve this aim, the NSFT had to negotiate funding from the CCGs for the extra beds and for the increased demands that this would place on staffing levels.

6.11 Staffing

The following key points were noted:

- The speakers said that across the whole NHS system there were fundamental workforce challenges. Norfolk remained a difficult area in which to recruit and retain clinical staff and there were overall shortages of qualified staff with specialist skills. The challenges were all the more difficult to meet in the field of mental health where they were linked with having to deal with issues such as suicide risk, homelessness and the need for specialist social care support in the home environment. The NSFT intended to review its policies on suicide and dual diagnosis deaths in accordance with the policy published by the Department of Health in autumn 2017.
- The speakers said that the support and engagement of staff and stakeholders was fundamental to the success of the NSFT. They said that steps were being taken to bring mandatory training up to acceptable levels and to take staff training out to the localities.
- The speakers said that the NSFT was looking to find new ways to keep and develop existing staff and to put in place local incentives to attract staff to areas and services with the most vacancies.
- NSFT was liaising with NHS Improvement on the kinds of staff improvement issues that an external company could be asked to examine from January 2018.
- Members suggested that the NSFT and the CCGs should liaise with the Local Housing Authorities in Norfolk to identify housing opportunities available for incoming staff.
- The speakers pointed out that seven out of the nine locum doctors that were available in west Norfolk had recently taken on substantive positions with the NSFT.
- It was noted that the NSFT planned to introduce regular staff workshops and to encourage staff participation in monthly skype broadcasts by senior management.
- Going forward, finding new ways to empower frontline staff and encourage staff to share their experiences was seen as essential in setting the right culture of the organisation. It was recognised that the cultural issues would also have to be addressed by making recruitment and retention of existing staff an organisational priority.

6.12 IT system

The following key points were noted:

- It was acknowledged by the speakers that the poor performance of the single electronic records system had a negative impact on staff morale and patient care.
- It was pointed out that because the agreement for the introduction of the electronic records system was between NHS Digital and the system suppliers, the NSFT was unfamiliar with some of the details contained in the contract. NSFT was working with NHS Digital and the system supplier to set a date by which improvements would be made.

- The existing contract was due to come up for renewal in the next 3 years at which time changes could be expected to be made to meet the particular requirements of mental health trusts such as the NSFT.

6.13 Future commissioning strategy and funding

The following key points were noted:

- It was pointed out that there were 15 beds at the Fermoy Unit (and 1 escalation bed) and no plans to close the Fermoy Unit before relocation to Chatham House was completed in 2018.
- It was also pointed out that after Mundesley Hospital had closed in October 2107, NHS beds were commissioned at Priory Group's Ellingham Hospital in Attleborough (rated by the CQC as good overall). The Priory Group was reported to be looking at whether it would be possible to increase the small number of adult mental health beds that they had available.
- The overall cost to the NSFT of out-of-Trust placements had not increased as a result of patients transferring out of Mundesley Hospital.
- Members said that funding for mental health services should reflect "parity of esteem" with physical health services.
- It was noted that the funding issues had for the most part been considered by the Committee as part of the discussion of the other subject headings.
- Members said that the level of funding that the NSFT received from the commissioners had fallen in real terms in recent years. While in cash terms investment in the NSFT had risen, the percentage share of CCG budgets provided to the NSFT had fallen between 2013/14 and 2016/17. For 2017/18 the percentage share had continued.to fall. As discussed earlier in the meeting, this came at a time when demand for NSFT services continued to rise.
- It was suggested that the CCGs should develop a formula for funding that took into account increases in referrals to secondary mental health care and demographic variation.

6.14 The Committee made the following comments and recommendations to the Commissioners and NSFT based on the information received during the meeting:

- **NSFT and South Norfolk CCG (lead commissioners for mental health) should update the Committee on 5 April 2018 about progress with the action plan to address the Care Quality Commission (CQC) requirements.**
- **The Committee should be kept informed about NSFT's progress in advance of the 5th April 2018 meeting via the NHOSC Briefing.**
- **NHOSC Members were invited to visit the mental health services to learn more about progress.**
- **A detailed point made during the meeting by Cllr Corlett regarding the reduction of NSFT's share of CCG budgets since 2013/14 and the rise in demand for NSFT's services in the corresponding period should be put**

in writing. A written response should be provided by South Norfolk CCG and shared with NHOSC Members via the NHOSC Briefing.

6.15 The Committee then went on to make the following more detailed comments and recommendations:

With regard to the NSFT overall approach to improvement

Comments:-

- **NHOSC welcomed NSFT's approach to encouraging feedback from frontline staff.**

Recommendations:-

1. **NSFT should ensure that service user participation in NSFT's improvement was genuine co-production, with the broadest range of service users possible and should monitor whether the service user participation was representative of the service user population as a whole.**

2. **NSFT should give clear, easy to understand feedback to all service users about what service changes or developments had taken place as a result of their feedback, along with information on how to escalate concerns if the feedback was not acted on without reasonable explanation.**

With regard to the availability of beds and out of trust / out of area placements

3. **NSFT should give NHOSC a more detailed account to provide assurance of its oversight of the service received by patients in out-sourced beds.**

4. **The CCGs should provide funding to enable NSFT to open 15 adult acute beds at Yare Ward, Hellesdon Hospital.**

With regard to staffing

5. **NSFT should consider use of retention bonuses rewarding length of service and special responsibility payments for hard to recruit areas.**

6. **NSFT should consider the business case for 'return to practice' incentives for:-**

    i) **Those who were out of service that still had valid professional registration**
    ii) **Those whose professional registration had lapsed**

7. **NSFT and the CCGs should liaise with all the Local Housing Authorities in Norfolk to identify housing opportunities available for incoming staff.**

With regard to future commissioning strategy and funding

8. **The CCGs should develop a formula for funding that took into account increases in referrals to secondary mental health care and demographic variation.**

7 Forward work programme

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

7.2 The forward work programme was agreed as set out in the agenda papers with the addition of the following item for the 5 April 2018 meeting:-

- **Norfolk and Suffolk NHS Foundation Trust – mental health services in Norfolk – an update on progress since 7 December 2017**

7.3 The Committee asked for information on the following items to be included in the January NHOSC Briefing to enable Members to decide whether or not they should be included on a future agenda:-

- **Maternity services – information on the rates of Caesarean sections at the N&N, JPUH and QEH; rates of spending on services (including health visiting); comparisons of neonatal health.**

- **New A&E provision for the elderly at the N&N - an update on the initiative and on the effect it was having on the rest of the A&E service.**

- **Pharmacy – information on the local impact of a dispute between the Department of Health and medicine suppliers over agreed costs of drugs.**

7.4 Cllr Brociek-Coulton agreed to provide Maureen Orr, Democratic Support and Scrutiny Team Manager, with information about current issues with the Speech and Language service so that these could be raised with the commissioners / provider in advance of their attendance at NHOSC on 5 April 2018.

7.5 The Committee was reminded that a Joint Norfolk and Waveney Health Scrutiny Committee would need to be established as and when the STP partners made specific proposals for substantial changes across the Norfolk and Waveney footprint. This would meet on the same day as NHOSC and might mean that subjects on the NHOSC forward work programme had to be rearranged for later dates.

Chairman

The meeting concluded at 13.00 pm

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Delayed discharges / transfers of care – the District Direct pilot

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

A report on District Direct, which is being piloted by local district councils and the Norfolk and Norwich Hospital to support patient discharge, and its effect on delayed discharges / transfers of care.

1. Background

1.1 On 26 October 2017 Norfolk Health Overview and Scrutiny Committee (NHOSC) added the subject of delayed transfers of care to its forward work programme. The committee agreed to focus on 'District Direct', which is a pilot between local district councils and the Norfolk and Norwich (N&N) hospital to address delays due to needs for housing adaptations and other measures to support patients' return to their own homes. The pilot will run until April 2018.

1.2 Previous scrutiny of delayed discharges

1.2.1 NHOSC last looked at the wider subject of delayed discharges from hospital in Norfolk in 2014 when Members of NHOSC and Community Services Overview and Scrutiny Panel formed a joint scrutiny task and finish group to examine the situation. The task & finish group reported to NHOSC on 17 July 2014. Its report is available on the County Council website:-
NHOSC 17 July 2014 , agenda item 8.

The report noted the situation regarding delayed transfers of care (for any reason) at the N&N across the 6 months from August 2013 to January 2014. It ranged from about 65 people on the worst days to about 21 on the best days. On average there were always between 30 and 40 people delayed at the N&N during that period.

1.2.2 The 2014 task & finish group concentrated on the NHS and social care responsibilities in relation to transfers of care from acute, community and mental health hospitals and made 8 recommendations to the acute hospitals, the NHS community providers, Norfolk County Council Adult Social Care and Public Health and the CCGs.

The report did not make recommendations in respect of housing, or touch on the role of district councils, but it did mention the importance of people receiving healthcare at home and that more accommodation suitable for people with mental health needs was required. During the scrutiny the group also looked at the re-ablement services provided by health and social care, including provision of equipment to enable people to manage in their own homes.

1.2.3 NHOSC revisited the subject on 16 October 2017 when it appeared that all its recommendations had been accepted and were in the process of being implemented by health and social care.

1.3 Delayed transfers of care – the current situation at the N&N

1.3.1 The national NHS Monthly Situation Report collects data on the total delayed days during the month for all patients delayed throughout the month and the data is available back to August 2010. Data is shown at NHS provider organisation level and also at Local Authority (i.e. County or Unitary) level. The data is split by the agency responsible for the delay, the type of care that the patient receives (acute or non-acute) and the reason for delay.

All the data is published on the NHS England website https://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/delayed-transfers-of-care-data-2017-18/

Table 1 overleaf shows the number of delayed days at the N&N from November 2016 to October 2017 and the reason for delays.

1.3.2 One of the categories for recording the reason for delay on the Monthly Situation Report (Sitrep) is '(I) Housing – patients not covered by the NHS and Community Care Act'. The guidance for the Sitrep refers to the Care Act, which places a duty on local authorities to assess and meet the eligible care and support needs of all adults who are ordinarily resident in a local area (which means their established home is there).

Where a patient is covered by the Care Act the guidance makes it clear that remaining in hospital while long term housing adaptations are made is not an option and that social care is responsible for making appropriate interim arrangements for the patient to move out of the medical environment.

Any delay in providing interim care has to be recorded under an appropriate alternative category, e.g. (D) Awaiting residential home / nursing home placement. Only patients who are not covered by the Care Act, e.g. asylum seekers or single homeless men, and who are delayed by a housing need, are recorded in category (I).

Delay category (F) 'Delays due to awaiting community equipment and adaptations' refers to equipment and adaptations that are specifically the responsibility of the NHS or the social care authority.

The national collection of delayed transfers of care data was designed to support financial transactions between the NHS and social care. It is not informative about the extent to which patients may be delayed from returning to their own homes due to waiting for the Local Authority housing services or housing providers to make adaptations.

Table 1 – Norfolk and Norwich University Hospitals NHS Foundation Trust – Number of delayed days, Nov 2016 – Oct 2017*

Month (Nov 2016 - Oct 2017)	(A)Awaiting completion of assessment	(B)Awaiting public funding	(C)Awaiting further non-acute NHS care	(Di)Awaiting residential home placement or availability	(Dii)Awaiting nursing home placement or availability	(E)Awaiting care package in own home	(F)Awaiting community equipment and adaptations	(G)Patient or family choice	(H)Disputes	(I)Housing – patients not covered by NHS and Community Care Act	(O) Other	Total
Nov	123	55	202	21	180	64	7	153	0	0	-	805
Dec	245	37	158	21	139	53	19	117	0	0	-	789
Jan	197	95	405	41	98	62	28	126	46	0	-	1,098
Feb	125	44	260	17	158	61	25	61	13	2	-	766
Mar	124	25	489	67	217	71	31	108	0	0	-	1,132
Apr	333	42	239	92	181	127	26	112	0	9	0	1,161
May	228	19	319	115	142	133	2	27	0	0	0	985
Jun	145	11	345	46	144	142	0	44	0	0	0	877
Jul	100	28	471	56	102	138	0	3	0	0	0	898
Aug	104	19	442	61	103	131	0	0	0	0	0	860
Sep	145	28	454	167	127	96	7	3	0	0	0	1,027
Oct	317	43	678	204	201	235	4	14	0	0	0	1,696

A. Awaiting completion of assessment – i.e. an assessment of future care needs and an identification of an appropriate care setting. This can include an assessment by health and / or social care professionals of a patient's future care needs.
B. Awaiting public funding – awaiting Local Authority funding (e.g. for residential or home care), or NHS funding (e.g. for NHS-funded Nursing Care or NHS Continuing Healthcare). Includes cases where the LA and NHS have failed to agree funding for a joint package or an individual is disputing a decision of fully funded NHS Continuing Healthcare in the independent sector. Does not include delays due to arranging other NHS services (residential or community) – see below.
C. Awaiting further non-acute NHS care (including community and mental health; including intermediate care, rehabilitation services etc.) – assessment complete but transfer delayed due to awaiting further NHS, non-acute care. Includes patients where a decision has been made to defer a decision on NHS Continuing Healthcare eligibility, and to provide NHS-funded care (in a care home, the patient's own home or other settings) until an eligibility decision is made but the transfer into this care is delayed.
D. Awaiting residential home placement or availability – because of lack of a suitable nursing / residential home placement to meet assessed needs. Does not include patients where LA funding has been agreed but they are exercising their right to choose a home (these are in G).
E. Awaiting care package in own home – this may be the responsibility of the NHS (Continuing Healthcare) or LA social care, or both.
F. Awaiting community equipment and adaptations – this may be the responsibility of the NHS, the LA or both.
G. Patient or family choice – where patients have received a reasonable offer of service from health, social care or both but have refused it
H. Disputes – disputes between statutory agencies about responsibility for a patient's care.
I. Housing – patients not covered by NHS and Community Care Act – delayed for housing reasons that are not covered by the Care Act's emphasis on LAs and housing providers working together to meet people's needs for care & support. Examples could be asylum seekers or single homeless people.
J. Other

Table 2 below shows the N&N DTOC data split by responsible organisation (health or social care)

Table 2 - Norfolk and Norwich University Hospitals NHS Foundation Trust – Delayed Transfers of Care, November 2016 – October 2017*[1]

Month (Nov 2016 –Oct 2017)	Delayed days				DTOC Beds			
	NHS	Social Care	Both	Total	NHS	Social Care	Both	Total
November	666	139	0	805	22	4	0	26
December	656	125	8	789	21	4	0	25
January	921	172	5	1,098	30	5	0	35
February	534	232	0	766	19	8	0	27
March	841	291	0	1,132	27	9	0	36
April	539	590	32	1,161	18	20	1	39
May	462	514	9	985	15	17	0	32
June	562	301	14	877	19	10	0	29
July	655	209	34	898	21	7	1	29
August	614	236	10	860	20	8	0	28
September	669	351	7	1,027	22	12	0	34
October	1,004	688	4	1,696	32	22	0	55

1.4 **National expectations and local action around delayed transfers of care**

1.4.1 On 27 September 2017 Norfolk Health and Wellbeing Board received a report about hospital discharge in Norfolk. The report is available on the County Council website via the following link:- Health and Wellbeing Board 27 Sept 2017 (agenda item 8).

The report noted the importance of reducing delayed transfers of care for the benefit of patients. It also made clear that the nationally proposed targets for reducing DTOCs are challenging and that failure to meet them could mean a reduction in the additional funding available to social care in 2018-19 via the Better Care Fund.

1.4.2 The report to the Health and Wellbeing Board, and an earlier report to Adult Social Care Committee on 4 September 2017, set out the local action underway to reduce DTOCs. District Direct is one such initiative, but there are others across Norfolk to enable people to return to or stay in their own homes. Examples include Home First crisis homecare, Healthy Homes Project and Hospital Care at Home.

1.4.3 It is County Council policy to get people directly back to their own homes wherever possible rather than going to residential care as a stepping-stone after leaving hospital.

[1] * Table 1 & 2 data source - NHS England https://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/delayed-transfers-of-care-data-2017-18/

2. Purpose of today's meeting

2.1 NHOSC agreed to focus on the 'District Direct' pilot which aims to support patients being discharged from the N&N hospital, prevent unnecessary hospital stays and re-admissions in future. It was initially resourced by five Districts (South Norfolk, North Norfolk, Breckland, Broadland and Norwich) and involves working with the N&N Hospital Discharge Team to identify where services can support patients to return home.

Members of the committee were concerned it was taking some time to establish the pilot and that cases where housing related issues are a barrier to discharge have not been dealt with quickly enough in the past.

2.2 The Healthy Living Manager, South Norfolk Council, has provided a report about the pilot District Direct service (attached at **Appendix A**) and will attend the meeting to answer Members' questions. Representatives from the Norfolk and Norwich University Hospital NHS Foundation Trust will also attend to answer questions on the N&N's role in the pilot.

3. Suggested approach

3.1 After the Health Living Manager and N&N representatives have presented the report, Members may wish to discuss the following areas with them:-

3.2

a) Paragraph 3.0 of the District Direct report (Appendix A) mentions that updated data on patients seen between 11 September and 9 November 2017 will be shared with NHOSC today. What are the figures?

b) It appears that where a patient is delayed due to a housing need it is the responsibility of social care to find an interim solution to enable their discharge from hospital while the housing issue is resolved. These cases are not identifiable in the national Sitreps Delayed Transfers of Care (DTOC) figures, but will fall under the delays attributed to social care in Table 2 above. Do the N&N or District Council representatives know the current numbers of such cases?

c) Are there other patients delayed at the N&N for reasons connected to housing who do not appear in the reported DTOC figures?

d) What are the connections between the District Direct pilot and other services / initiatives operated by health and social care to facilitate patients' return to their own homes.

e) It is understood that similar initiatives are underway around the Queen Elizabeth and James Paget Hospitals. Will the learning be shared across the county?

f) There are many factors affecting discharge from hospital and numerous authorities and agencies involved. What are the N&N and District Direct's views about how co-ordination of the process could be improved.

g) What assessment / action takes place when a homeless person is admitted to hospital to prepare for their discharge?

4. Action

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

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

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

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District Direct Pilot (Evaluation 11th September – 15th December)

1.0 Background

In May 2017 the District Councils agreed to work directly with the integrated hospital discharge hub to investigate reducing delayed transfer of care. An initial meeting was arranged between all Districts and the Norfolk & Norwich University Hospitals (NNUH) staff, this usefully clarified a few misconceptions between the two organisations, for example, Districts preference for referral at point of admission rather than once the patient is deemed medically fit for discharge and statutory and non-statutory services delivered by District Councils that can support patient discharge. The meeting also highlighted significant inconsistencies in adherence to the hospital discharge policy.

We identified and actioned the following; -

- Reviewed the current hospital discharge policy
- Identified and implemented a set of initial triage questions that could help identify potential DTOC/bed blocking patients where Districts could intervene at point of admission
- Reviewed hospital discharge data to identify pinch points
- Established a referral pathway to Districts from the East of England Ambulance Trust for patients who are not transported to NNUH but at risk of admission
- Collectively resourced a district officer presence within the integrated hospital discharge hub for 12 weeks as a pilot

2.0 Pilot delivery

District Direct was initially resourced by five Districts (South Norfolk, North Norfolk, Breckland, Broadland and Norwich) for the duration of a 12-week pilot. This was via 5 officers being seconded one day per week to be located within the NNUH integrated discharge team.

Officers came from a range of backgrounds including those who were experienced in dealing with homelessness, housing adaptations and benefits. It was a conscious decision that the District Direct team would be resourced from different teams to enable us to assess the range of skills required. The analysis identifies the skills required going forward as well as a good knowledge base of District services.

All officers are collocated within the integrated hospital hub and have access to hospital systems.

The hospital discharge coordinators identify patients at point of admission who would have the potential to become a DTOC or bed block via a set of triage questions;

a) Where do you live when you're not in hospital?
b) Do you own your home, or who do you pay your rent to?

c) Do you find it difficult getting into and around your home, in/out of the bath, or up and down the stairs?
d) Do you find it hard to carry out small repairs and odd jobs around the home and garden?
e) Do you have contact with one or more people on a frequent basis?

If the Discharge Coordinators identify an issue, with the permission of the patient, they are then referred to the District Direct officer. DD Officers will visit the patient on the ward, provide assessments, liaise with the patient's home district and put an action plan in place with the patient and the patient's family to support the patient to return home to live independently.

Being co-located within the integrated discharge hub and DD officers attending frequent discharge meetings has meant that the DISCOs and wider discharge team have support at hand to deal with non-medical issues preventing patients from returning home. The officers involved in the project report that the type of referrals coming through have been diverse and have produced a positive outcome for residents, reflected in the performance data.

As well as dealing with specific cases the officers have reported that both within the integrated discharge hub and on the wards across the hospital they have provided general help and advice with cases on an ad hoc basis. This has moved the medical staff to consider the patient's wider needs particularly around housing.

The success of the pilot was very quickly recognised and after sharing initial findings at the NNUH A&E Delivery Board it was agreed that NNUH would fund the extension of the pilot until March 2018 to maintain momentum of the service until more sustainable funding could be secured. Savings from the pilot are shared between the NNUH, Adult Social Care and the CCG.

3.0 Pilot outcomes

Bed days*****

Saved 203 bed days over 11 weeks (5-day week) pilot leading to a saving of £40,600

Over the course of a year (7-day week) this could lead to a saving of £262,800

Length of Stay (LoS)*****

Halved average LoS in Geriatric medicine beds

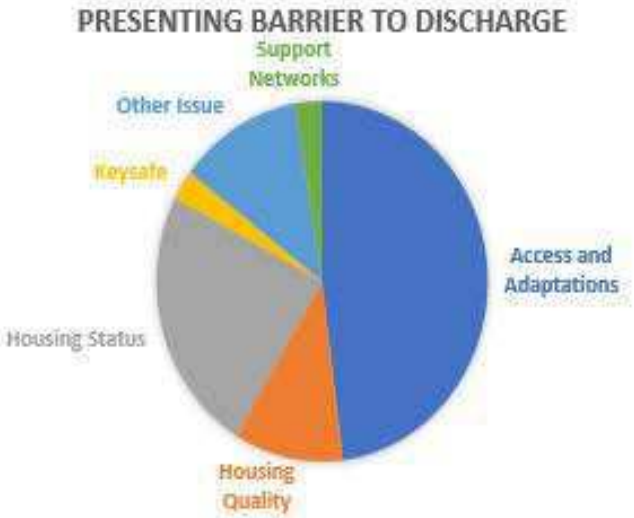
Overall reduced length of stay by 36%

On patients seen between 11th September – 9th November, updated data to be shared at Health Overview & Scrutiny Committee

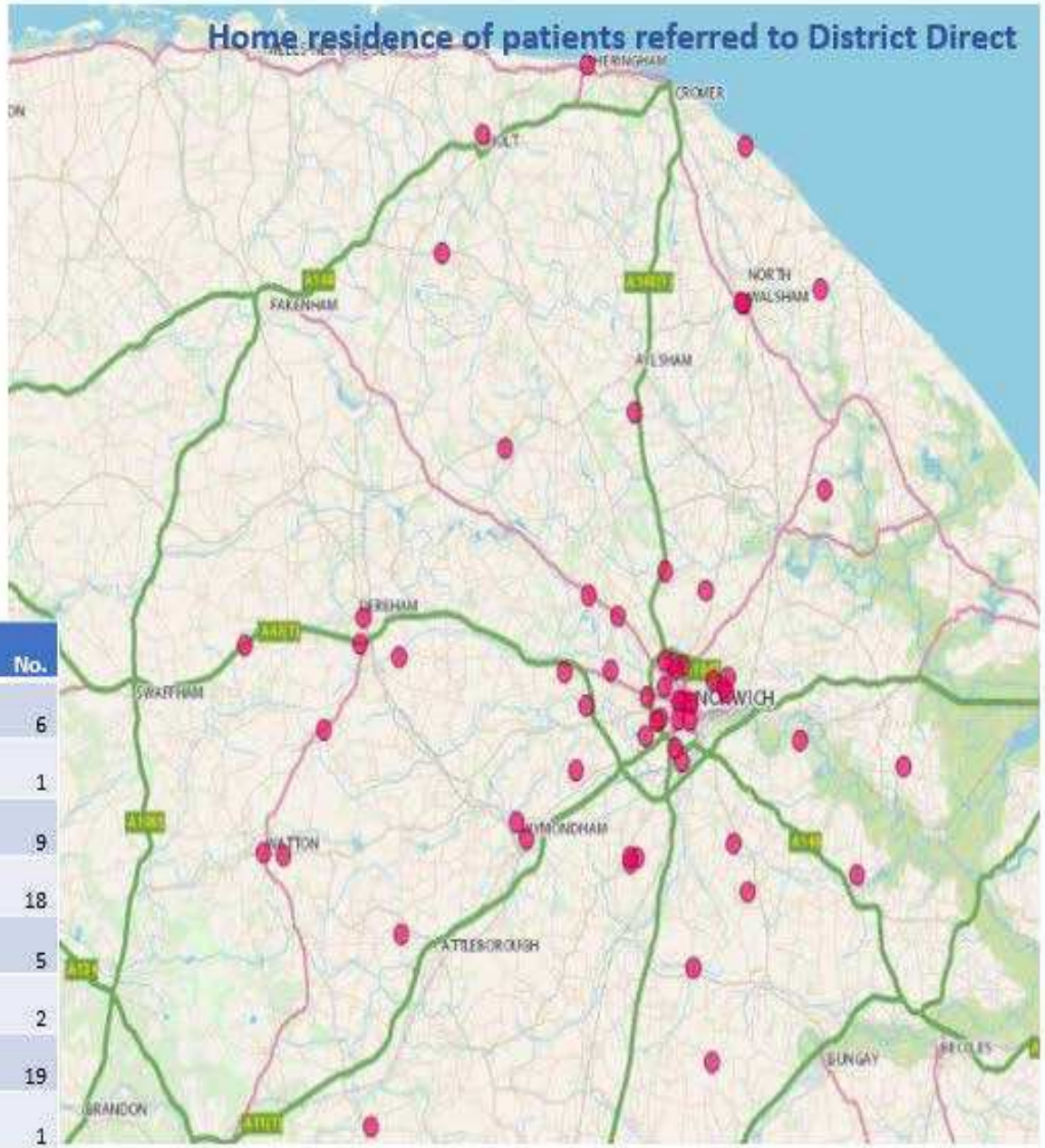
Pilot review

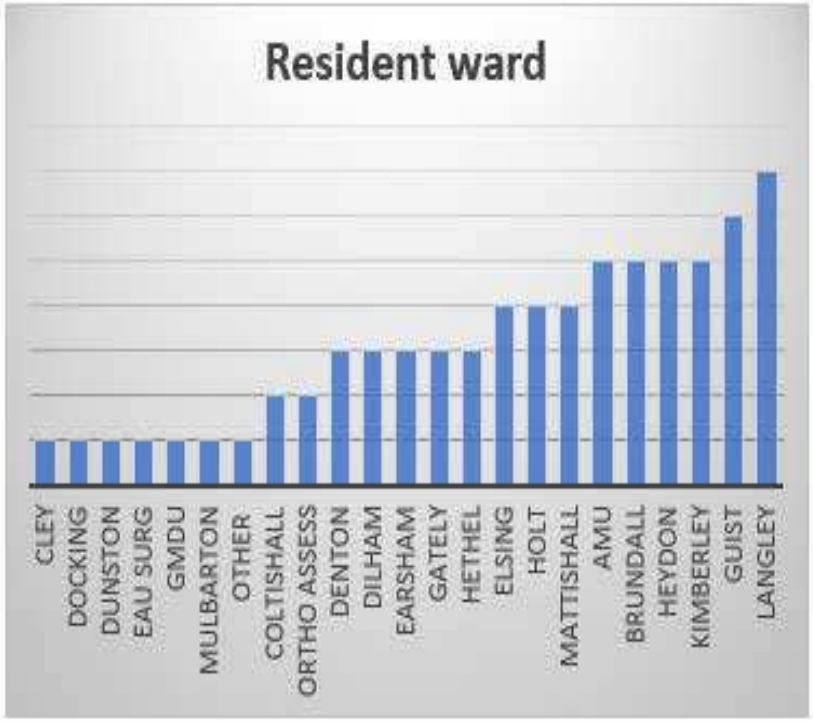
To date the pilot has supported 80 patients, undertaken 132 interventions and provided wider information and advice. Patients have ranged from 31 to 96, with an average age of 71 years.

All but 1 of the patients were emergency admissions.

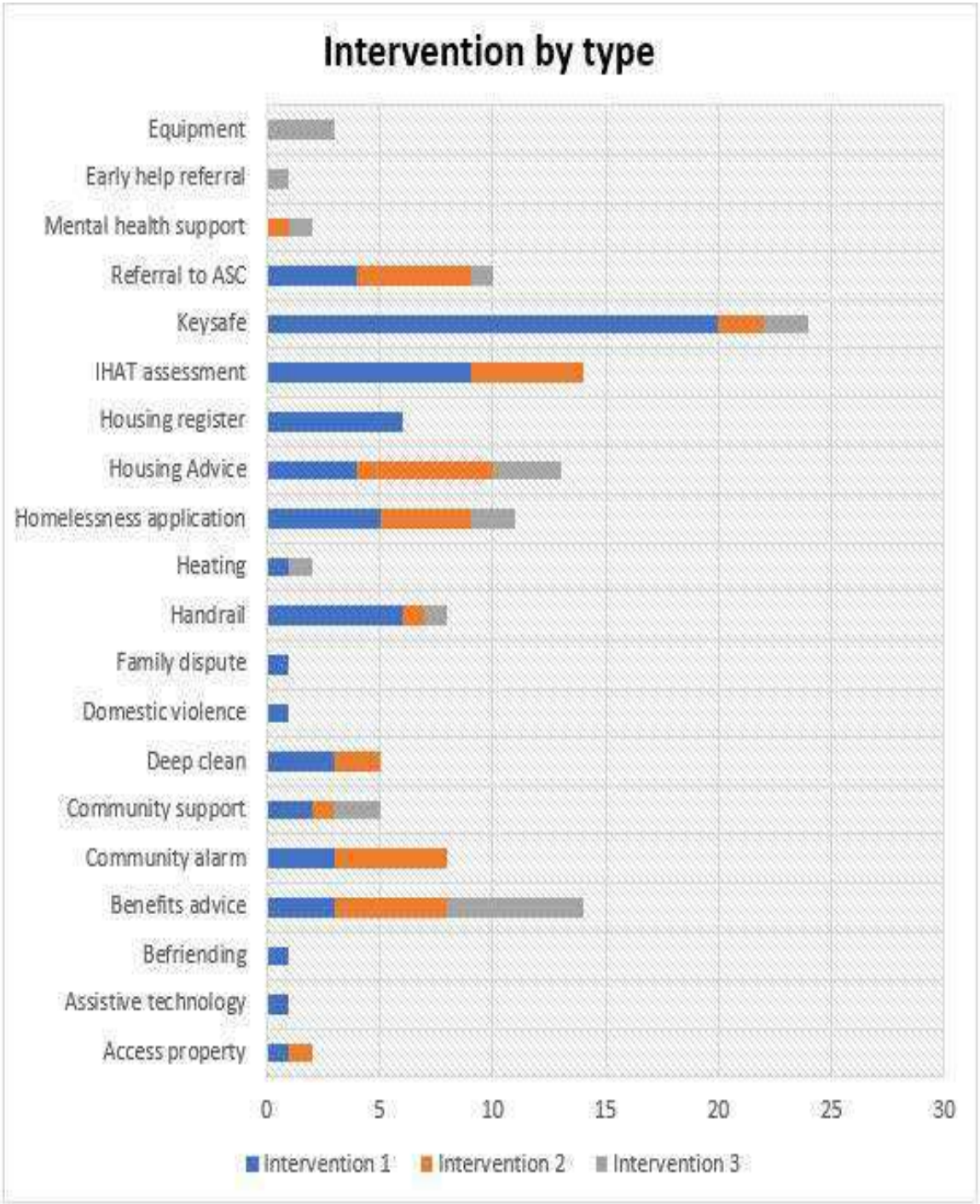


District	No.
Broadland	6
West Norfolk	1
North Norfolk	9
Norwich	18
Norwich City	5
Out of Area	2
South Norfolk	19
Unknown	1




Resident ward
CLEY
DOCKING
DUNSTON
EAU SURG
GMDU
MULBARTON
OTHER
COLTISHALL
ORTHO ASSESS
DENTON
DILHAM
EARSHAM
GATELY
HETHEL
ELSING
HOLT
MATTISHALL
AMU
BRUNDALL
HEYDON
KIMBERLEY
GUIST
LANGLEY


Resident Tenure
NFA
Other
Owner Occupier
Private Rented
Social Housing
Temporary
Unknown


Intervention by type
Equipment
Early help referral
Mental health support
Referral to ASC
Keysafe
IHAT assessment
Housing register
Housing Advice
Homelessness application
Heating
Handrail
Family dispute
Domestic violence
Deep clean
Community support
Community alarm
Benefits advice
Befriending
Assistive technology
Access property
0
5
10
15
20
25
30
Intervention 1
Intervention 2
Intervention 3

4.0 Case Studies

Case Study 1

Referral received for a very vulnerable man with some MH issues. He was admitted to hospital following a very dangerous self-harming incident. He reported to staff that he has been staying in a tent. The patient was referred to District Direct, further investigations identified he had his own home (NCC tenant) but was worried about going back there because he thought he was going to be evicted. He was under-occupying his home, accruing rent arrears and had just lost his job. The District Direct Officer was able to notify the right people (housing officer) and reassure him that going back to his home, not his tent, was the best thing for him and that he wasn't being evicted. He was linked with specialist support services to deal with benefit claims, budgeting and moving to smaller more affordable home, and a home visit was arranged the day after he was discharged.

Case Study 2

Appeared no issues to prevent patient from returning home from hospital, however was flagged to District Direct as her Son was struggling to pay bills and maintain the house during her inpatient stay. The DD officer contacted the son, arranged for the district welfare rights and debt adviser and other support services to visit, contacted the energy companies to prevent services being cut off and made sure all benefits were in order. The DD Officer worked with the Integrated Care Coordinators who had concerns around the living arrangements and made sure an appropriate care package was in place for the patient's return home.

Case study 3

A patient required assistive technology and a key safe in order to have a safe discharge. The DD Officer contacted the relevant company to install an alarm and identified funding that would reduce the cost for the patient. The District where the patient lived did not have a handyperson service so the DD officer arranged for another District to provide this service and recharge.

5.0 Future for the pilot

To date the pilot is resourced by officers from each district through existing resource, a more efficient and sustainable option would be to recruit 2 District Direct officers to cover the role on behalf of the districts covering 7 days at a cost of £71,194 per annum. This role would sit with the districts and be governed by the IHAT Strategic Board.

Focus on the pilot to date has been targeting wards, it is felt the number of homelessness cases are fairly represented, which is more likely in A&E (and not being admitted). We will look to target A&E also which should pick up considerably more referrals from this target group.

Keen to roll out the pilot to other acute trusts, community hospitals, mental health inpatients and prison release.

NHS England have chosen to use the District Direct pilot as a case study of best practice and will be sharing details of the pilot nationally.

For more information please contact Sam Cayford, Healthy Living Manager, South Norfolk Council scayford@s-norfolk.gov.uk 01508 533694

Children's autism services (central & west Norfolk) – assessment and diagnosis

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

An update from NHS commissioners and providers on action to reduce waiting times.

1. Introduction

1.1 On 7 September 2017 Norfolk Health Overview and Scrutiny Committee (NHOSC) received a report on 'Children's autism and sensory processing assessment / sensory integration therapy' in central and west Norfolk and met with representatives from the provider, Norfolk Community Health and Care NHS Trust, and the Clinical Commissioning Groups.

1.2 The local NHS is responsible for the assessment and diagnosis of autistic spectrum disorders (ASDs) and local authorities are the lead agencies for the provision of any support that comes after diagnosis.

1.3 One of NHOSC's main concerns was that waiting times for assessment and diagnosis of children's ASD's was too long. The commissioners acknowledged that there had been a significant increase in demand in the last five years and that not enough service capacity had been commissioned to keep up with demand. NHOSC was assured that there would be significant additional investment to address this situation. The details were still under discussion between the commissioners and the provider at the time of 7th September meeting. Potential for adding expertise for specialist sensory assessments to the assessment team was part of the discussion.

1.4 NHOSC asked the commissioners and provider attend a future meeting to report on progress with the commissioning of additional capacity and the situation in terms of reducing waiting times for assessment and diagnosis of children's ASD in central and west Norfolk.

1.5 The Great Yarmouth area was not included in the original report to NHOSC because the Great Yarmouth and Waveney Joint Health Scrutiny Committee (GY&W JHSC) was already looking at children's ASD in its area. This continues to be the case, with the GY&W JHSC expecting its next update on 2 February 2018.

1.6 Other on-going, wider work around children's autism includes:-

Healthwatch Norfolk – Autism is one of Healthwatch Norfolk's three key priorities this year which has led to a defined focus upon families and their access to services. Healthwatch Norfolk are looking to understand more about families experiences of health and social care services supporting their child's/children's needs. Healthwatch Norfolk are gathering experiences from parents/carers of children/young people (18 and under) with ASD (or possible ASD) when trying to access help and support from health and social care services. This also includes the diagnostic services and post diagnostic support across the county. Healthwatch Norfolk are enabling feedback from parents and carers in a variety of methods; by working in partnership with local organisations supporting families with children with ASD, attending parent support groups and information sessions, listening to parents stories on a 1 to 1 basis and using a survey to gather parents views anonymously across Norfolk.

Norfolk Health and Wellbeing Board – is due to receive a report on the All Age Autism Strategy for Norfolk at its meeting in July 2018.

Children's Services Improvement Board – received an update on work to address delays in ASD assessment & diagnosis on 18 December 2012. The Board asked for assurance that Looked After Children are being prioritised and that providers are tracking and reporting on the data.

2. Purpose of today's meeting

2.1 Great Yarmouth and Waveney CCG is the lead commissioner of Child Health and Maternity across the whole of the Norfolk and Waveney area and has been asked to report back to NHOSC with:-

- the CCGs' progress in understanding the proportion of funding from each commissioner for children's autism services within the block contract with Norfolk Community Health and Care NHS Trust (NCH&C)
- progress on commissioning additional capacity for assessment & diagnosis, and the amount of additional funding, if possible.
- details of what the additional funding is being used for
- has it been possible to add more sensory expertise to the assessment team?
- any improvements yet on waiting times / the pathway to diagnosis as a result of the extra investments
- has there been success in shortening the Paediatrician pathway (i.e. with skilled triage to identify children, particularly over 5s, to refer on more quickly for ASD assessment) and standardising the info in the Paediatrician pathway so that it is more meaningful for those working in the ASD pathway?
- how the oversight & monitoring of waiting times / the pathway has increased to manage the waiting list
- has consideration been given to equality of access to assessment / diagnosis for children and young people without strong advocates?
- the numbers of children currently on the waiting list for assessment / diagnosis and current waiting times

- the numbers of children currently waiting to see a Paediatrician (the 18 week referral pathway) and the current waiting times
- an update on current staffing and numbers and types of vacancies.

The CCG's report is attached at **Appendix A** and representatives will be in attendance to answer Members' questions.

2.2 Representatives of the NHS provider of services for children with autism in central and west Norfolk, Norfolk Community Health and Care NHS Trust (NCH&C), have also been invited to attend to answer questions which may arise about current delivery of the commissioned services.

3. Suggested approach

3.1 After the CCG representatives have presented their reports Members may wish to discuss the following areas:-

(a) Are the CCG representatives satisfied that all 5 CCGs in Norfolk are now commissioning children's autism assessment and diagnosis services to an appropriate level?

(b) The trajectory for improving waiting times for ASD assessment predicts that by 1 May 2018 no child will be waiting more than 52 weeks for assessment to start, assuming the predicted staffing is available. Is this an interim waiting time target? What is the ultimate target for waiting times for the ASD assessment service?

(c) The additional post of 0.6 whole time equivalent (WTE) Nurse Specialist to provide Autism Diagnostic Observation Schedule (ADOS) assessments was readvertised due to a lack of applicants from the original advertisement. Have there been sufficient applicants this time?

(d) What is included in the Positive Behaviour Support Programme places offered to families whose child is waiting for an ASD assessment?

4. Action

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

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

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

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Great Yarmouth and Waveney
North Norfolk, South Norfolk
Norwich, West Norfolk
Clinical Commissioning Groups

Briefing for Norfolk Health Overview and Scrutiny Committee

Children's Autism and Sensory Processing Assessment / Therapy

1. Introduction

1.1 Norfolk Health Overview and Scrutiny Committee (NHOSC) have requested an update from Central and West Norfolk health commissioners and providers with respect to Children's Autism Spectrum Disorder (ASD) services – assessment and diagnosis.
This report seeks to address the specific queries raised by NHOSC.

2. The Clinical Commissioning Groups' (CCGs) progress in understanding the proportion of funding from each commissioner within the block contract.

2.1 Whilst it is not possible to disaggregate the funding for each CCG for ASD assessment and diagnosis services for children and young people, it is possible to identify funding for children's services as a whole within the Norfolk Community Health and Care (NCHC) block contract. With new arrangements in place for Great Yarmouth and Waveney to act as the lead organisation for commissioning services for children and young people on behalf of partner organisations, funding arrangements will be revised to reflect this.

3. Progress on commissioning additional capacity for assessment and diagnosis (and the amount of additional funding, if possible). Details of what the additional funding is being used for.

3.1 In September 2017 the Norfolk CCGs agreed additional investment for the diagnostic service to enable the provider to increase staffing capacity in order to address increased demand and unacceptably long waiting times for assessment for ASD.

3.2 Norfolk Community Health and Care (NCHC) received approval to commence recruitment to additional substantive posts. Posts were advertised and interviews for the following posts took place in October, November & December 2017.

- One WTE (whole time equivalent) Occupational Therapist (OT) post for specialist sensory assessments.

- 0.6 WTE ASD Nurse Specialist to provide Autism Diagnostic Observation Schedule (ADOS) assessments
- One WTE Speech and Language Therapist (SaLT) to provide specialist assessment of communication skills in high functioning children.
- 0.2 WTE nurse band six to provide the continuation of positive behaviour workshops for parents/carers in partnership with Family Action Swaffham.

3.3 From these interviews one WTE OT and one WTE SaLT were appointed and start in post in January 2018. Due to a lack of applications for the specialist nurse post this was re-advertised with interviews planned for January 2018. In the interim NCHC have been able to assign a SaLT from another pathway to temporarily fill this gap, with effect from 19th February 2018 this individual will complete ADOS assessments until the nurse has been recruited and is in post.

3.4 In addition funding has been agreed to appoint a further one WTE band six nurse/SaLT for a fixed term period of 18 months to support backlog reduction of children and young people waiting for assessments. Interviews took place on the 7th December 2017. A candidate was appointed, and will start on 2nd January 2018.

3.5 In order to add further capacity an interim 0.6 WTE SaLT was appointed on 25th September 2017 and is undertaking specialist Autism Diagnostic Observation Schedule (ADOS) assessments. This therapist has now been appointed to the fixed term contract, (para 3.4.). NCHC anticipates this resource will be able to deliver five assessments per week.

3.6 The agreed investment is expected to deliver by 1st April 2019:
- 150 OT specialist sensory assessments delivered yearly with follow up for 100 cases.
- An offer of Positive Behaviour Workshops to all eligible families across Norfolk.
- Waiting times for first appointment to be within 18 weeks

4 Has it been possible to add more sensory expertise to the assessment team?

4.1 Additional sensory expertise has been added through the appointment of one WTE OT post for specialist sensory assessments. This appointment will ensure that the ASD assessment and diagnostic service is fully NICE compliant from February 2018.

5 Any improvements yet on waiting times / the pathway to diagnosis as a result of the extra investments.

5.1 During October 2107 the records of all 323 children on the waiting list for an ASD assessment have been clinically reviewed by either a SaLT, Clinical Psychologist, or Paediatrician.

5.2 167 of these children had an assessment started by 6th November 2017.

5.3 With regard to the remaining 156, all the families have been offered a place on a Positive Behaviour Support Programme (PBSP) to provide a level of support whilst awaiting assessment. Twelve PBSPs have been arranged to take place between December 2017 and November 2018 (one each month) and will be co-delivered with Family Action. On acceptance of referral for assessment, all families are made aware of this course and invited to enrol. Although not all families take up this offer feedback from families of young children has been positive, and many have valued the sharing of knowledge and tips within the groups.

5.4. Children & young people who had been waiting 52 weeks or more have been prioritised for assessment. At the end of November 2017 all families who were still waiting more than 52 weeks for their assessment to commence were contacted to reassure them that new CCG investment has been made available and that appointments for their child would be made as soon as possible.

The table below demonstrates a reduction in numbers of children waiting over 52 weeks.

	8/8/17	**5/12/17**
Over 52 week waiters	164	125
Over 52 week waiters with NO appointment booked for assessment to commence	Not available, as not reportable at that time	78
Over 52 week waiters with appointment booked	Not available, as not reportable at that time	47
Assessments in progress	148	284 (figure reduces when diagnoses are fed back to families)

NCHC's trajectory predicts that, by 1st May 2018, no child will be waiting more than 52 weeks for assessment to commence; this assumes that the predicted staffing is available.

6 Has there been success in shortening the paediatrician pathway (i.e. with skilled triage to identify children, particularly over fives, to refer on more quickly for ASD assessment) and standardising the information in the paediatrician pathway so that it is more meaningful for those working in the ASD pathway?

6.1 It has been possible to shorten wait times on the paediatric pathway. Waiting times to see a community paediatrician are now within the 18 week target. All GP requests for an assessment for ASD are triaged by both a paediatrician and a clinical psychologist. Community paediatricians' developmental assessments contribute towards the ASD assessment process, and thus help shorten the overall assessment period. This enables decisions on an ASD diagnosis to be made sooner.

6.2 For school age children (over six years) an assessment by a paediatrician will not always be necessary, but may be requested by the ASD pathway team.

7 How the oversight & monitoring of waiting times / the pathway has increased to manage the waiting list.

7.1There is now a single waiting list and patients will be seen sequentially.

7.2 NCHC have developed 2 trajectories showing:

- Commencement of assessment against 18 weeks target
- Commencement of assessment against 52 week target.

The trajectory is monitored at contract meetings by the lead commissioner and by Great Yarmouth and Waveney CCG as health commissioning leads for CYP.

8 Has consideration been given to equality of access to assessment and diagnosis for children and young people without a strong advocate?

8.1 The requirement for supplementary information to be available from an educational psychologist to support referrals has been extended to include Special Educational Need Coordinators (SENCOs) and other professionals. This reduces delays in the referral and improves access for individuals where there is limited access to a psychologist. NCHC has outlined in its referral criteria the level of detail and quality required in the supporting information.

8.2 All referrals are triaged on the basis of clinical need, with priority given to Looked After Children, (LAC) are subject to a Child Protection Plan (CPP) or who have experienced school exclusions.

8.3 Once accepted onto the pathway children are assessed in chronological order, subject to the priorities of LAC, CPP and exclusions.

8.4 Appointment times are agreed with families before confirmation, in order to minimise the likelihood of did not attend / was not brought.

Tracy McLean: Head of Children Young People and Maternity Norfolk and Waveney
Alan Hunter: Head of Service (Children) Norfolk Community Health and Care Trust (NCH&C)

Norfolk Health Overview and Scrutiny Committee

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

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

Proposed Forward Work Programme 2018

Meeting dates	*Briefings/Main scrutiny topic/initial review of topics/follow-ups*	*Administrative business*
22 Feb 2018	Continuing healthcare – an update on progress since Feb 2017. Physical health checks for adults with learning disabilities	
5 April 2018	Children's speech and language services – progress update since 7 September 2017 Norfolk and Suffolk NHS Foundation Trust – mental health services in Norfolk – an update on progress since 7 December 2017	
24 May 2018	Access to NHS dentistry in West Norfolk (including for service personnel's families at RAF Marham)	
12 July 2018		

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

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

To be scheduled –Implementation of the Suicide Prevention Action Plan 2016-21 (relating to the county-wide Suicide Prevention Strategy) - progress by service providers

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

Clinical Commissioning Groups

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

NHS Provider Trusts

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

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Norfolk Health Overview and Scrutiny Committee 11 January 2018

Glossary of Terms and Abbreviations

ADOS	Autism Diagnostic Observation Schedule
A&E	Accident and emergency department
ASC	Adult Social Care
ASD	Autistic Spectrum Disorders
CCG	Clinical Commissioning Group
CPP	Child Protection Plan
CYP	Children and young people
DD	District Direct – a 2017-18 district council pilot to support patients to return to their own homes when medically fit for discharge from the Norfolk and Norwich hospital
DISCO	Discharge Co-ordinator
DTOC	Delayed transfer of care
Family Action	A national charity providing practical, emotional and financial support to those experiencing poverty, disadvantage or social isolation
GY&W JHSC	Great Yarmouth and Waveney Joint health Scrutiny Committee (which includes Members from Norfolk and Suffolk Health overview and Scrutiny Committees)
IHAT	Integrated Housing Adaptations Team
LA	Local Authority
LAC	Looked After Child
LoS	Length of stay
MH	Mental health
NCC tenant	Norwich City Council tenant
NCH&C (NCHC)	Norfolk Community Health and Care NHS Trust
NHOSC	Norfolk Health Overview and Scrutiny Committee
NICE	National Institute for Health and Care Excellence
NNUH (N&N, NNUHFT)	Norfolk and Norwich University Hospitals NHS Foundation Trust
OT	Occupational Therapist
PBSP	Positive Behaviour Support Programme
SaLT	Speech and language therapy
SENCO	Special Educational Need Co-ordinator
WTE	Whole time equivalent