Norfolk County Council

Norfolk Health Overview and Scrutiny Committee

Date: **Thursday 3 September 2015**

Time: **10.00am**

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

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

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

Membership

MAIN MEMBER	SUBSTITUTE MEMBER	REPRESENTING
Mr C Aldred	Mr P Gilmour	Norfolk County Council
Mr R Bearman	Mr A Dearnley	Norfolk County Council
Mr B Bremner	Mrs M Wilkinson	Norfolk County Council
Ms S Bogelein	Ms L Grahame	Norwich City Council
Mr M Carttiss	Mr N Dixon / Mrs S Gurney/ Mrs A Thomas/ Miss J Virgo	Norfolk County Council
Mrs J Chamberlin	Mr N Dixon / Mrs S Gurney/ Mrs A Thomas/ Miss J Virgo	Norfolk County Council
Michael Chenery of Horsbrugh	Mr N Dixon / Mrs S Gurney/ Mrs A Thomas/ Miss J Virgo	Norfolk County Council
Mrs A Claussen-Reynolds	Mr N Smith	North Norfolk District Council
Mr D Harrison	Mr B Hannah	Norfolk County Council
Mrs L Hempsall	Mr J Emsell	Broadland District Council
Dr N Legg	Mr C Foulger	South Norfolk District Council
Mrs S Matthews	Mr R Richmond	Breckland District Council
Mrs M Somerville	Mr N Dixon / Mrs S Gurney/ Mrs A Thomas/ Miss J Virgo	Norfolk County Council
Mrs S Weymouth	Mrs M Fairhead	Great Yarmouth Borough Council
Mrs S Young	Vacancy	King's Lynn and West Norfolk Borough Council

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

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

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

2. Minutes

To confirm the minutes of the meeting of the Norfolk Health Overview and Scrutiny Committee held on 16 July 2015. (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 – 11.10**	**Diabetes Care within Primary Care Services in Norfolk** Reports on the services delivered in primary care from • NHS England Midland and East (East) • West Norfolk Clinical Commissioning Group Presentation from central Norfolk Integrated Diabetes Management Group	(Page 11) (Page 15) (Page 20)
	11.10 – 11.20	**Break at the Chairman's discretion**	
7.	**11.20 – 11.40**	**Forward work programme**	(Page 33)
Glossary of Terms and Abbreviations			(Page 40)

Chris Walton
Head of Democratic Services

County Hall
Martineau Lane
Norwich
NR1 2DH

Date Agenda Published: 25 August 2015

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Norfolk County Council

NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE
MINUTES OF THE MEETING HELD AT COUNTY HALL, NORWICH
On 16 July 2015

Present:

Mr C Aldred	Norfolk County Council
Mr R Bearman	Norfolk County Council
Ms S Bogelein	Norwich City Council
Mr M Carttiss (Chairman)	Norfolk County Council
Mrs J Chamberlin	Norfolk County Council
Mrs A Claussen-Reynolds	North Norfolk District Council
Mr D Harrison	Norfolk County Council
Dr N Legg	South Norfolk District Council
Mrs S Matthews	Breckland District Council
Mrs S Weymouth	Great Yarmouth Borough Council
Mrs S Young	Borough Council of King's Lynn and West Norfolk

Substitute Member Present:
Mrs J Virgo Norfolk County Council

Also Present:

Dr Sue Crossman	Chief Officer, West Norfolk Clinical Commissioning Group
Michael Scott	Chief Executive, Norfolk and Suffolk NHS Foundation Trust
Marcus Hayward	West Locality Manager, Norfolk and Suffolk NHS Foundation Trust
Andrea Patman	Head of Commissioning, NHS England Midlands and East (East)
Fiona Theadom	Contract Manager, NHS England Midlands and East (East)
Robert Kybird	Vice Chairman of the NHS Workforce Planning in Norfolk Task and Finish Group.
Chris Walton	Head of Democratic Services
Maureen Orr	Democratic Support and Scrutiny Team Manager
Anne Pickering	Committee Officer

1. Apologies for Absence

Apologies received from Mr B Bremner, Mrs M Wilkinson, Mrs L Hempsall, and Mrs M Somerville.

2. Minutes

The minutes of the previous meeting held on 28 May 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 The Chairman made no announcements.

6. Development of dementia services in West Norfolk

6.1 The Committee received a suggested approach from the Democratic Support and Scrutiny Team Manager to a report from the NHS West Norfolk Clinical Commissioning Group which presented its engagement plans regarding permanent changes to dementia services following the end of a two year trial period.

6.2 The Committee received evidence from Dr Sue Crossman, Chief Officer, West Norfolk Clinical Commissioning Group and Marcus Hayward, West Locality Manager, Norfolk and Suffolk NHS Foundation Trust.

6.3 In the course of further discussion the following key points were made:-

- Following the establishment of the pilot scheme DIST, (Dementia Intensive Support Team) two work streams were identified. Firstly to focus on communicating with service users and families and secondly to work with professionals.

- At the start of the scheme the diagnosis rate for dementia in West Norfolk was 34% which was very low in comparison to the rest of the country. After 1 year, the diagnosis rate had increased to 55%. The rise in the number of diagnoses had meant there was an increase in the need for support which was putting further pressure on services.
  It was important to note that despite the increase in diagnosis the number of admissions for dementia had fallen and it was felt this was due to the multi-disciplinary agency approach with organisations working together which was providing service users with greater options.

- In response to a question raised by the Committee, it was explained that there was a protocol in place for carers to claim for travel costs, which could be received in cash or via bank transfer.
  Care Co-ordinators were required to inform the carer at first admission about the protocol and then one week later ward staff were required to check that the carer was aware of the protocol and provide necessary forms.

- More robust data collection and transparency was needed within the system to ensure that the claims made specifically by carers could be identified separately to other claims.

- Support for carers was essential; information needed to be provided to the families and carers to make them aware of what support is available in the community. Support also needed to be provided to the voluntary sector organisations that gave a lot of this support.

- Dementia friendly towns in the West of Norfolk were Swaffham and soon to be Downham Market.

- Young people needed to be educated around the issues surrounding dementia, to make them aware and help with understanding. Opportunities should be looked into for the Trust to go into schools to provide this information.

- When there was a delay in finding beds for people, they would be put into a holding situation which would involve the individual being returned to their home with a professional to monitor and keep them safe until a bed could be found.

- The DIST service was available 7 days a week and included the use of non-medical prescribers; it was recognised that this role was highly necessary while GPs were not available, especially at weekends.

- Younger people with dementia were a challenging group to help as most were of working age and often even younger carers were involved and most of the issues were concerning social aspects rather than medical.

- The beds at the Julian Hospital were for specialised care of complex cases that required high level expertise, which could not be provided in all areas. The admission of a patient with dementia was a last resort as it was deemed better for them to remain in their own homes but have the option of beds when required. Homes such as the Paddocks provided community support and offered respite for carers.

6.4 NHOSC **agreed** the following comments:-

- Norfolk and Suffolk NHS Foundation Trust (NSFT) should ensure transparent accounting to allow the payment of west Norfolk carers' claims for travelling expenses to the Julian Hospital to be identified.
- NSFT should engage with schools to ensure that children are informed and educated around the issues surrounding dementia.

NHOSC **agreed** that in relation to changes in dementia services in west Norfolk:-

- Consultation with the committee has been adequate
- The changes to the dementia services in west Norfolk are in the interest of the local health service.

7. Access to Primary Care Services in Norwich

7.1 The Committee received a suggested approach from the Democratic Support and Scrutiny Team Manager to a report from NHS England Midlands & East (East) regarding plans to maintain and improve access to primary care services in Norwich and surrounding areas.

7.2 The Committee received evidence from Andrea Patman, Head of Commissioning, NHS England Midlands and East (East) and from Fiona Theadom, Contract Manager, NHS England Midlands and East (East).

7.3 The commissioners from NHS England Midlands & East (East) had been looking at Norwich Practices Ltd's GP registered list service and the Norwich walk-in service.

The commissioning responsibility for maternity and phlebotomy services, was to be passed to the CCG after the end of the current contract in 2016. The GP registered list service and the walk-in service was to be re-procured by NHS England Midlands and East (East) after an engagement process with patients, the public and key stakeholders.

7.4 The Chairman invited Mr S Bloomfield Norwich Practices Ltd's business manager to join the speakers at the table.

In the course of further discussion the following key points were made:-

- It was claimed that the Norwich Walk-In Centre offered a lower cost option than the GP out of hour's service; the Committee asked that Mr S Bloomfield would provide any evidence that may be available to support this.

- In response to a question regarding the use of the walk in centre by out of area patients the Committee were informed that a large number were holiday makers especially during the summer months.

- GP recruitment to the Walk-In Centre was an issue, however they had seen an increase in applications since the recent advertisement.

- Members suggested that the title of the forthcoming patient survey in relation to a new contract for services at Norwich Practice's Health Centre should explicitly refer to the 'walk-in centre' as this was the name most people would recognise.

- Parking bays outside the front of the Walk-In Centre had been allocated as Blue Badge spaces and it was felt that this provision was sufficient. In addition there was ongoing discussion with the Castle Mall over the possibility of allowing 1 hour free parking at the Castle Mall carpark for those visiting the walk in centre.

- The rationale behind the Walk-In Centre was the need for improved access to primary care which was multifaceted.
  Some people used the Accident and Emergency department at the Norfolk and Norwich University Hospital as their first primary care point, especially at weekends.
  It was important for patients to be provided with the correct guidance and information to allow them to access the most appropriate service.

7.5 The Committee agreed to endorse the approach that NHS England Midlands & East (East) was taking in regards to the walk-in centre and Norwich Practices Ltd's GP registered list service in Norwich.

8. NHS workforce planning in Norfolk

8.1 The Committee received the report from the scrutiny task & finish group on NHS Workforce Planning in Norfolk for approval and endorsement of the recommendations.

8.2 The Committee gave thanks to the Vice-Chairman, Robert Kybird and the rest of the working group for their hard work and to Maureen Orr for support given in producing the report.

8.3 The Committee commented on the recruitment of GP's; it was noted that the University of East Anglia medical school had a higher percentage of GP trainees than the national average.

8.4 The Chairman invited Cllr A Kemp and Mr A Stewart to join the speakers at the table.

- Cllr Kemp gave an update to the third recommendation in the report regarding making arrangements for UEA nursing students to be offered placements in West Norfolk; a meeting had been organised to facilitate this.
- Mr A Stewart gave an update on the number of GP students enrolled to start at UEA in Sept, currently there were 300.

8.5 The Committee discussed the need for planning authorities and NHS organisations to liaise more effectively to ensure that the building of additional homes and care homes could be supported by the current GP surgery in the area. It was discussed that 1 GP was meant to cater for 1800 people, however if a care home was in the area, the residents could occupy 1 GP's entire caseload.
The Committee **agreed** that as part of the first recommendation that a planning protocol be added to ensure that the LPAs consult effectively with the NHS.

8.6 The Committee **RESOLVED** to approve the task and finish group's report and endorse the recommendations with the following amendment:-

Recommendation 1
That Public Health, Norfolk County Council, takes the lead to co-ordinate liaison between local planning authorities (LPAs) and the local NHS to

i) create a county wide protocol to ensure that the LPAs consult effectively with the NHS
ii) ensure that the NHS has the necessary information to be able to respond, based on evidence of growing needs modelled on the LPA geographic area

8.7 The Committee **Agreed** to direct the recommendations to the appropriate organisations /individuals outlined in the report with the addition of:-

- Send the report to the District Planning Authorities for comment.
- Send to Lord Prior, Parliamentary Under Secretary of State, Department of Health in the first instance with an additional letter from the Chairman congratulating him on his appointment
- That the Norfolk MPs are contacted once feedback had been received at the October Norfolk Health and Overview Scrutiny Committee meeting.

9. Norfolk Health Overview and Scrutiny Committee appointments

9.1 The Committee received the report from Democratic Support and Scrutiny Team Manager which asked the Committee to appoint members to act as link members with local NHS provider trusts and Clinical Commissioning Groups.

9.2 The following appointments were made:-
Link member appointments:

Mrs J Chamberlin	Norfolk Community Health and Care NHS Trust
Mr M Chenery of Horsbrugh	Queen Elizabeth Hospital NHS Foundation Trust

Mrs M Somerville	NHS Great Yarmouth and Waveney CCG

Substitute link member appointments:

Mr D Harrison	NHS North Norfolk CCG
Vacancy	NHS South Norfolk CCG
Vacancy	NHS Great Yarmouth and Waveney CCG
Mrs S Young	NHS West Norfolk CCG
Mrs S Bogelein	Norfolk and Suffolk NHS Foundation Trust
Mrs S Young	Queen Elizabeth Hospital NHS Foundation Trust

10. Forward work programme

10.1 The proposed forward work programme was agreed subject to additional topics suggested by Committee members.

1) Locum/agency doctors – vetting process.
2) Provision of mental health services for children.

Chairman

The meeting concluded at

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Diabetes Care within Primary Care Services in Norfolk

Suggested approach from Maureen Orr, Scrutiny Support Manager

NHS England Midlands and East (East), West Norfolk Clinical Commissioning Group and central Norfolk Integrated Diabetes Management Group report about the services delivered in primary care.

1. Background

1.1 Norfolk Health Overview and Scrutiny Committee (NHOSC) looked at the subject of diabetes care within primary care services in Norfolk on 26 February 2015 and discussed the issues with representatives from Diabetes UK and Norfolk County Council Public Health. NHS England, who are the responsible commissioners for primary care in Norfolk, submitted a report to the committee but were unfortunately unable to send a representative on the day of the meeting. A representative from Norfolk County Council Public Health attended and answered members' questions on NHS Health Checks and prevention of diabetes.

1.2 The committee received results from the National Diabetes Audit 2012-13 which showed variations in primary care across different CCG areas for the delivery of eight care processes and six treatment targets for diabetes. The overall rankings of 19 CCG areas in the east of England placed the Norfolk CCG areas as follows:-

1st North Norfolk
2nd South Norfolk
7th West Norfolk
11th Norwich
19th Great Yarmouth and Waveney

1.3 The care processes and treatment targets taken into account in the audit were:-

Eight care processes	Six treatment targets
HbA1c (blood glucose level measurement)	HbA1c<48mmol/mol
Blood pressure measurement	HbA1c<58mmol/mol
Cholesterol level measurement	HbA1c<86mmol/mol
Serum creatinine testing	Blood pressure<=140/80
Urine albumin testing	Cholesterol<4mmol/L
Foot surveillance	Cholesterol<5mmol/L
BMI monitoring	
Smoking status check	

1.4 At the request of Great Yarmouth and Waveney Joint Health Scrutiny Committee, the Director of Clinical Transformation, NHS Great Yarmouth and Waveney CCG provided information on 22 July 2015 about plans to improve service for people with diabetes in the area by commissioning an integrated model of care. This will include specialist foot clinics, integrated working with pharmacists in the community and recruitment from the voluntary sector to take pressure off primary care and to support patient self-management.

2. Purpose of today's meeting

2.1 As requested by NHOSC on 26 February 2015, NHS England Midland and East (East) (NHS E M&E(E)) has been invited to attend today's meeting as the responsible commissioner for primary care across Norfolk. NHS E M&E(E) has been asked to address the following areas relating to provision of diabetes services in primary care:-

- The financial incentives for GPs to provide diabetes care
- Other ways the commissioners can encourage / support good practice
- Ways of encouraging general practice to participate in the National Diabetes Audit
- Ways of encouraging general practice to share learning / good practice
- The possibility of deep dive audits in areas where evidence points towards potentially poor practice
- Commissioner engagement with patients to make sure that services meet requirements
- Liaison with commissioners of NHS community care to commission joined up services for diabetes.

The report originally submitted to NHOSC by NHS England (East Anglia Area Team) in February 2015 is attached at Appendix A for reference. NHS E M&E(E) has provided the supplementary report at Appendix B, which focuses on the contractual arrangements with GPs which cover all of their services, including those provided for people with diabetes.

2.2 At the meeting on 26 February 2015 NHOSC heard about some particular strengths in the west Norfolk area:-

- There was a high level of diagnosis of people with diabetes (Diabetes UK estimated there were 10,723 people diagnosed and just 617 people undiagnosed with diabetes in west Norfolk, which was a better rate than most of Norfolk).
- education was offered to a higher percentage of people with diabetes than the national average and a much higher percentage than any other area in Norfolk (21.1% are offered education in west Norfolk; the national average is 19.1%)
- west Norfolk was the best ranking area in Norfolk for recording serum creatinine measurement in patients.

NHOSC agreed to invite a representative from west Norfolk to discuss how GPs in the area achieve such a high level of diagnosis and to discuss a number of the care processes and treatment targets where west Norfolk did not show so well in the Diabetes UK audit. These areas included recording foot surveillance, where primary care in west Norfolk was ranked 11 out of 19 CCG areas and recording body mass index (BMI), which was ranked 17 out of 19 CCG areas.

West Norfolk Clinical Commissioning Group (CCG) has submitted the report at Appendix C.

2.3 'Best practice commissioning diabetes services – An integrated care framework' produced by the NHS and multiple partners in March 2013 points out that people with diabetes benefit from a well-integrated health care system and coordination of services around the patient.

Professor Mike Sampson, Joint Chairman of the Central Norfolk Integrated Diabetes Management (NIDM) Group and Consultant Diabetologist at the Norfolk and Norwich Hospital and Dr Nigel Thomson, Joint Chairman of the Central Norfolk Integrated Diabetes Management (NIDM) Group, Chairman of the Diabetes Facilitator Management Board and a GP, have been invited to today's meeting to inform the committee about integrated work to support care of people with diabetes in primary care.

Professor Sampson will present to the committee on:-

- The Norfolk Diabetes Prevention Study
- Norfolk Diabetes Facilitator programme
- Retinal screening programme in Norfolk

2.4 A summary of the results of the National Diabetes Audit 2012-13, which was presented to the committee in February 2015, is attached at Appendix D for ease of reference.

3. Suggested approach

3.1 After the representatives from NHS England (East), West Norfolk CCG and the Central Norfolk Integrated Diabetes Management Group have presented their reports the committee may wish to discuss the following areas:-

(a) In February 2015 Diabetes UK informed the committee that the participation rate of GP practices in the National Diabetes Audit 2012-13 across England was lower than in previous years. GPs refusing to opt in, CCGs not having support locally to help practices extract the necessary data and IT system problems were cited as possible reasons why participation had reduced.

Are there steps that NHS England Midlands and East (East) and Diabetes Networks can take to make it easier for primary care to participate in diabetes audits and research?

(b) When is the new national system linking diabetic eye screening programmes with GP systems (GP2DRS) expected to be fully operational?

(c) The Norfolk Diabetes Prevention Study depends on participation by local primary care providers. Given the current pressures on primary care, has the study been able to proceed as planned?

(d) The Diabetes UK 2012-13 audit shows that west Norfolk has achieved a better rates of diabetes diagnosis and made more offers of education to people with diabetes than other Norfolk localities. How has this been achieved?

(e) The Norfolk Diabetes Prevention Study is researching how exercise, diet, information and motivation can reduce the risk of developing type 2 diabetes. Are there any early indications of new methods that may be successful?

(f) How does the Norfolk Diabetes Prevention Study fit with the National NHS Diabetes Prevention Programme that was launched in March 2015.

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NORFOLK HEALTH OVERVIEW & SCRUTINY COMMITTEE

FOR INFORMATION

1 Introduction

1.1 This report is to provide Norfolk Health Overview and Scrutiny Committee with an overview of diabetes care in primary care.

2 Background

2.1 NHS England commissions primary medical services using a variety of contracts: General Medical Services (GMS), Personal Medical Services and Alternate Primary Medical Services contracts. The GMS contract was introduced in 2003 and covers three main areas:

- the global sum – covering the costs of running a general practice, including some essential GP services. This ensures that practices provide services required for the management of registered patients who are ill with conditions from which recovery is generally expected, terminally ill or, suffering from chronic disease; and all appropriate ongoing treatment and care including the referral of patients for other services;
- the Quality and Outcomes Framework (QOF) – covering the two areas of clinical and public health. Practices can choose to provide these services; and
- Enhanced services (ES) – covering additional services that practices can choose to provide. ES can be commissioned nationally by NHS England or locally by the Clinical Commissioning Groups to meet the populations healthcare needs.

3 Diabetes care in Primary Care

3.1 Effective control and monitoring of diabetes mellitus can reduce mortality and morbidity. Much of the management and monitoring of diabetic patients, particularly those with Type 2, is undertaken by the GP and members of the primary care team.

Quality Outcomes Framework

3.2 The indicators are based on widely recognised approaches to the care of diabetes. Detailed guidelines for health professionals are published by NICE and SIGN.

3.3 There are a number of indicators within QOF which are generally those expected to be done or checked in an annual review. There is no requirement for the contractor to carry out all the items (e.g. retinal screening) however it is the contractor's responsibility to ensure they have been done. (Attached is an extract from QOF relating to the diabetes indicators for information)

3.4 In brief, the indicators are:

- Contractor establishes and maintains a register of all patients aged 17 or over with diabetes mellitus which specifies the type of diabetes where a diagnosis is confirmed;
- Maintain records of percentages of patients with diabetes, on the register:

- in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less;
- in whom the last blood pressure reading (measured in preceding 12 months) is 140/80 mmHg or less
- whose last measured cholesterol is 5 mmol/l or less
- with a diagnosis of nephropathy (clinical proteinuria) or micro-albuminiuria who are currently treated with an ACE-! (or ARBs)
- in whom the last IFCC HbA1c is 59 mmol/l or less in preceding 12 months
- in whom the last IFCC HbA1c is 64 mmol/l or less in preceding 12 months
- in whom the last IFCC HbA1c is 75 mmol/l or less in preceding 12 months
- with a record of foot examination and risk classification: low risk, increased risk, high risk or ulcerated foot, within preceding 12 months
- percentage of newly diagnosed patients in the preceding year who have a record of being referred to a structured education programme within 9 months after entry onto the register; and
- who have had an influenza immunisation in preceding August – March.

3.5 QOF data is extracted from practices systems on an annual basis and may be used by other organisations to measure standards of care and prevalence. It should be noted that in 2013/14, NHS England East Anglia Area Team made a local offer to practices regarding payment of QOF and therefore data extracted for that financial year may not be reliable.

3.6 The CCGs are responsible for commissioning support services such as podiatory and diabetic nurse clinics.

Diabetic eye screening commissioning and delivery across Norfolk

3.7 NHS England with the expertise of Public Health England (PHE) commission the annual diabetic eye screening programme (DESP). The aim of the programme is to identify changes at the back of the eye (Retinopathy) from Diabetes, which is a leading cause of blindness in the adult population.

3.8 People above the age of 12 years with Diabetes will be invited for an annual eye screen to check for Retinopathy. If any changes are identified they are referred either into Surveillance clinics for more frequent monitoring or hospital eye services for early treatment.

3.9 The programme is delivered by two providers:-

- Norfolk and Norwich DESP which is provided by the Norfolk and Norwich University Hospital Trust (NNUHT) ophthalmology team. This is a stable service which has been delivering screening since the inception of the screening programme in 2005. It serves the population of north and south Norfolk and Norwich, a total of around 500,000 population.

- The East Anglia DESP is provided by Health Intelligence Ltd, a provider of 4 years' experience, which after procurement, took on the staff from the Suffolk PCT community provider which previously delivered the programme. It serves the population of West Norfolk, Great Yarmouth and Waveney, Cambridgeshire fenlands, Suffolk, Mid and North Essex.

<u>Identifying the eligible population</u>

3.10 NNUHT rely on the GP practices referring people into the screening service. There are national standards for referral timescales – people must be screened within 3 months of diagnosis of diabetes. The programme monitors these referrals and advises the PHE team if there appears to have been a delayed referral. The PHE team will then investigate this directly with the GP practice to assure all parties that the referral pathway is robust. The team deliver to a number of community and GP practice sites within an on-going rota every year. Prior to the expected date of screening, the team send notice of those people within their register and ask each practice to review and inform them of any changes. (This is a similar approach undertaken by the cervical cancer screening programme). At least once a year, the practices are asked to carry out a QOF report which identifies all patients with diabetes aged 17 years and over. The numbers and names are then cross matched with the screening register. The programme screens those aged 12 years and above and as such the diabetes register should always be larger than the QOF report.

3.11 Nationally a system linking screening programmes with GP systems called GP2DRS is in the throes of being rolled out. This link will automatically identify all people with a diabetes code, enabling a more efficient and accurate identification process to ensure no person is missed. There continue to be some hold-ups nationally and so in the meantime, the usual method is employed.

3.12 EADESP IT service links to all GP practices and some acute trusts to the screening programme. The GP practice retains overall control of the data sharing with the full bespoke service allowing all people with a diabetes READ code, conditions associated with diabetes and medications used in the control of diabetes to be identified. This system is run on a monthly basis and ensures that the practice staff review the data and include or remove all relevant people. The efficiency of this service has found several patients with diabetes who were unknown to the screening programme. Commissioners therefore can be assured that the likelihood of any eligible person being missed from the screening register is remote. To satisfy a number of practices which had data sharing concerns, a lesser data sharing agreement was developed identifying people with a diabetes code but no other associated code. Although not as thorough as the full agreement, it nonetheless ensures that once the practice have diagnosed the person and coded them correctly they will be identified and offering a screen within weeks.

Table below shows the uptake of screening within the two DES programmes covering Norfolk for 2013/14

DES1-uptake	2012-13	2013-14	2013-14	2013-14	2013-14
	Q4 12/13	Q1 13/14	Q2 13/14	Q3 13/14	Q4 13/14
EADESP	87.40%	88.90%	89.26%	89.1%	88.91%
Norfolk and Norwich	93.30%	90.20%	87.50%	88.55%	89.10%

3.13 The performance and quality of programmes are monitored by NHS England Public Health and in addition there is a Quality assurance visit to the programmes every 3 years undertaken by the PHE screening QA service.

NHS Health Checks

3.14 Cardio vascular disease (CVD) is the biggest cause of preventable deaths and health inequalities in the UK. The NHS Health Check is a national risk assessment and prevention programme that identifies people at risk of developing heart disease, stroke, diabetes,

kidney disease and vascular dementia and helps them take action to avoid, reduce or manage their risk of developing these health problems. The health check is for people aged 40 – 74 without existing CVD, takes 20 – 30 minutes and people are assessed every five years.

3.15 Since April 2013 Norfolk County Council was mandated to provide the NHS Health Check programme for its residents. It is commissioned by Public Health and forms part of a wider strategy to reduce premature mortality and improve the health of the adult population.

3.16 In order to provide accessibility and patient choice in a large rural county, the service is delivered by a range of providers. Currently 95 GP's and 55 Pharmacies provide the service. Almost 80% of NHS Health Checks are delivered in GP practice and 20% delivered in the community by Pharmacy (both "on site" and "off site" at community events and in workplaces). The service is also delivered by the occupational health services of two large employers and in three Norfolk prisons.

Performance

3.17 In 2013 – 2014 a total of 24,625 people in Norfolk had an NHS Health Check, see table 1 (this is 65% of delivery target). There were 49,860 eligible people who were offered an NHS Health Check (this is 85% of the offer target).

Table 1: Location and Number of NHS Health Checks delivered across Norfolk 2013 - 2014

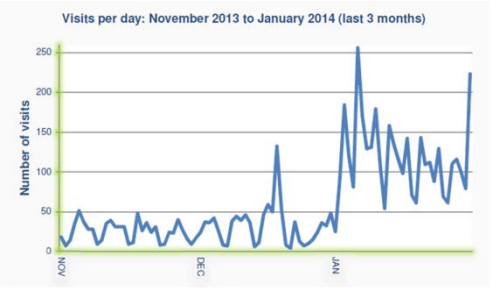
Location	Number	%
GP's	19,658	80%
Pharmacy	3,919	16%
Workplace & prison	1048	4%
Total	24,625	100%

In Norfolk since 2009 a total 114,540 people have had an NHS Health Check.

Precious Moments campaign

3.18 In order to increase uptake of NHS Health Checks and raise awareness in the community, the Precious moments" campaign was launched in January 2014. The key message was to look after your health, by having an NHS Health Check so you 'Don't miss out on life's precious moments', such as: a new baby, graduation, wedding, hobbies or holiday of a lifetime.

3.19 The campaign involved press, radio and promotional print material in health and community settings such as GP's pharmacy, libraries, petrol stations and on buses in rural and urban areas. The campaign saw a rise in enquires to the customer service centre and traffic to the Health Check page on the Norfolk's Living Well website. This translated to an increase in uptake of NHS Health Checks on the previous quarter.



Peaks and troughs reflect midweek (high) and weekend (lower) visitor numbers.

Plans for 2015 - 2016

3.20 In 2015 – 2016 the programme will:

- extend pharmacy provision to the Great Yarmouth area
- pilot an Outreach Service for people least likely to access mainstream services such as gypsies and travellers, homeless people and BME groups.
- establish an effective call / recall facility
- audit the service
- achieve 70% of delivery target (40,656) and deliver a total of 28,459 NHS Health Checks in Norfolk.

For more information about NHS Health Checks
visit: www.norfolkslivingwell.org.uk/nhshealthchecks

13 February 2015

Authors:

Sarah Mossop, Screening and Immunisation Manager. NHS England
Dr Shylaja Thomas, Screening and Immunisation Lead, NHS England
Fiona Theadom, Contract Manager, NHS England
Lucy Macleod, Interim Director of Public Health, Norfolk County Council

NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE

TITLE OF PAPER: Primary Care Commissioning – Diabetes

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1 PURPOSE

1.1. To inform the Norfolk Health Overview & Scrutiny Committee about how Primary Care services are commissioned by NHS England and to set out details relating specifically to contracted activity relating to Diabetes.

2 BACKGROUND

2.1. NHS England (Midlands & East – East) receives an annual financial allocation to enable the commissioning of Primary Care services for its geographic population (Essex, Norfolk, Suffolk, Great Yarmouth & Waveney, Cambridgeshire and Peterborough).

2.2. NHS England (Midlands & East – East) has responsibility for commissioning General Medical Services, Dental Services (including secondary care and community dental services), Pharmaceutical Services and Optometry Services.

2.3 The range of activity associated with the above responsibilities can be categorised in the following ways:

- **Planning**
  The optimum services to meet national standards and local ambitions, including estates and premises developments

- **Securing services**
  Through the contracting route which delivers the best quality and outcomes for patients, including procurements for Alternative Provider Medical Services, General Dental Services, Personal Dental Service

- **Monitoring**
  Management and monitoring of all medical (+ QOF/Enhanced Services) dental, pharmaceutical and optometry contracts and associated assurance and quality processes including sanction and breach notices where appropriate

- **Performance Management**
  Led by the Medical Directorate, the management of individual performer issues, validation and appraisals.

- **Transactional**
  Contractual and direct payment management, issuing of contract notices and variations, list closures, practice mergers, regulatory processes eg.market entry pharmacy.

3. CONTEXT

3.1. General Practitioners are Independent Contractors who hold one of the following contract types with NHS England:

- **General Medical Services (GMS),** contract which is a nationally negotiated contract.

- **Personal Medical Services Contract (PMS)** contract which is based on a national framework and regulations and allows local flexibilities.

  Both PMS and GMS contracts are considered to be "life time" contracts as they do not generally contain an end date. It should be noted that these types of contracts can be terminated by either party.

- In 2009, a new type of contract was introduced called **Alternative Provider Medical Services (APMS**) contract which are time limited generally for a period of 5 years.

In the event of contract termination by either party, NHS England is responsible for determining whether the practice list should be dispersed, i.e patients registered with another practice, or subject to procurement.

Where practices choose to merge contracts, they would need to seek agreement with NHS England to enable a change in the contractual arrangements.

3.2 GMS and PMS contract terms are reviewed on an annual basis to reflect national or local negotiated contract changes, with NHS England issuing contract variation notices to GP contractors to reflect the agreed changes.

NHS England is undertaking a national process to review all PMS contracts to ensure that any additional resources associated with these contracts has demonstrable additional services and benefits to the patients served by this contract.
Midlands & East are close to concluding these reviews with the number of PMS contractors retaining some or all of the additional resource is small. Any freed up resource will be allocated to the relevant CCG who are required to invest this resource into Primary Care on an equitable basis. Many PMS contractors have decided to revert to a GMS contract as part of the review process.

3.3 The main terms of the above contracts are:

Essential Services

The contractor must provide-
Services to patients who are, or believe themselves to be:

- Ill with conditions from which recovery is generally expected
- Terminally ill or,
- Suffering from chronic disease

and delivered in a manner determined by the practice in discussion with the patient.

Additional Services

- Cervical screening services
- Contraceptive services
- Vaccinations and immunisations
- Childhood vaccinations and immunisations
- Child health surveillance services

3.4 The number of GP contracts in Norfolk and Great Yarmouth and Waveney are as follows:

- Great Yarmouth & Waveney = 26
- North Norfolk = 19
- Norwich = 24
- South Norfolk = 26
- West Norfolk = 21

Total = 116

4 FINANCE

4.1 GP contractors are paid for the delivery of their contract in a number of ways. An annual global sum is paid to the contractor for their registered list which is adjusted depending on the increase or decrease in the numbers of patients registered with the practice. The funding is based on a weighted capitation formula which is known as Carr- Hill. This formula takes into account the additional workload associated with certain demographic groups which has the effect of an increased funding allocation where, for example, the practice has a higher than average number of older patients or patients residing in areas of deprivation.
GP contractors can also receive payments for participating in the annual Quality Outcome Framework (QOF) which is voluntary. GP contractors are also invited on an annual basis to participate in a range of Directed Enhanced Services (DES).
The Clinical Commissioning Groups are also able to commission services from Primary Care contractors via Local Enhanced Services, the range of which varies from area to area. Local Authorities also commission Local Enhanced Services from GP contractors which include smoking cessation and Sexual Health Services.
GP contractors do not receive any other specific payments from NHS England relating to Diabetes services but are able to participate in the Annual Quality Outcomes Framework process where payments are made on achievement on a wide range of indicators including Diabetes.

4.2 Quality Outcomes Framework (QOF)

The Quality and Outcomes Framework (QOF) rewards contractors for the provision of quality care and helps to standardise improvements in the delivery of primary medical services. It should be noted that Contractor participation in QOF is voluntary but in general, all practices participate in the QOF process.
Changes to QOF are agreed as part of wider changes to the General Medical Services (GMS) contract. Changes to the GMS contract are negotiated annually by NHS Employers (on behalf of NHS England) and the British Medical Association (BMA) General Practitioners Committee (GPC). These changes would be mirrored in PMS contracts.

The following principles have been agreed by the negotiating parties:

- Indicators should, where possible, be based on the best available evidence.
- The number of indicators in each clinical condition should be kept to the minimum number compatible with an accurate assessment of patient care.
- Data should never be created purely for audit purposes.
- Only data which is useful in patient care should be collected. The basis of the consultation should not be distorted by an over emphasis on data collection.
- An appropriate balance has to be struck between excess data collection and inadequate sampling.
- Data should never be collected twice e.g. data required for audit purposes should be data routinely collected for patient care and obtained from existing practice clinical systems.

The QOF indicators relating to Diabetes are attached for information at Appendix 1.

This table sets out the specific requirements for Diabetes within QOF and also the number of points associated with these indicators. It is not possible to set out the financial value of the points as the calculation is based on a wide range of factors at a practice level.

The indicators for diabetes are generally those which would be expected to be done, or checked, in an annual review. There is no requirement for the contractor to carry out all of these items (e.g. retinal screening) but it is the contractor's responsibility to ensure that they have been done.

The achievements against the 14/15 QOF indicators are not yet published but will be available publicly from **September 2015** on the HSCIC website.

4.3 Directed Enhanced Services (DES)

Enhanced Services are used to fund specific pieces of work in addition to the GMS/PMS contractual obligations. These areas of work can also be to evaluate the effect of a specific intervention by General Practice. These services are usually commissioned for a period of one or two years. After an evaluation of a service, it may be incorporated into the GMS/PMS contract in future years subject to negotiation.

There are a range of Enhanced services used to support the Public Health Immunisation Programme which are activity based services.

The list of national Directed Enhanced Services in place for 14/15 are as follows:

Enhanced Services
Avoiding unplanned admissions
Facilitating timely diagnosis and support for people with dementia
Learning Disabilities Health Check Scheme
Minor Surgery
Extended Hours
Public Health Vaccination Programmes

Meningococcal Freshers Vaccination Programme
Childhood Immunisations
Routine Shingles
Pertussis (pregnant women)
Seasonal and Childhood Flu
Pneumococcal
Shingles catch-up
Rotavirus
MMR (aged >16
Hep B babies
Meningitis C booster
HVP Booster

5 Conclusion

5.1 Members of the Norfolk Health Overview and Scrutiny Committee are asked to note the contents of the briefing note.

Andrea Patman – Head of Commissioning, NHS England Midlands & East (East) – Cambridgeshire and Norfolk Locality

2nd September 2015

Diabetes mellitus (DM) Indicator

Indicator	Points	Achievement threshold
Records		
DM017: The contractor establishes and maintains a register of all patients aged 17 or over with diabetes mellitus, which specifies the type of diabetes where a diagnosis has been confirmed NICE 2011 menu ID: NM41	6	
Ongoing Management		
DM002: The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less *NICE 2010 menu ID: NM01*	8	53-93%
DM003. The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less *NICE 2010 menu ID: NM02*	10	38-78%
DM004. The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less	6	40–75%
DM006. The percentage of patients with diabetes, on the register, with a diagnosis of nephropathy (clinical proteinuria) or micro-albuminuria who are currently treated with an ACE-I (or ARBs)	3	57-97%
DM007. The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 12 months *NICE 2010 menu ID: NM14*	17	35–75%
DM008. The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months	8	43–83%
DM009. The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months	10	52-92
DM012. The percentage of patients with diabetes, on the register, with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer) or 4) ulcerated foot within the preceding 12 months *NICE 2010 menu ID: NM13*	4	50-90%
DM014. The percentage of patients newly diagnosed with diabetes, on the register, in the	11	40-90%

preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register NICE 2011 menu ID: NM27		
DM018. The percentage of patients with diabetes, on the register, who have had influenza immunisation in the preceding 1 August to 31 March	3	55-95%

Norfolk Diabetes QOF 2013-14

CCG Name	Prevalence 2012-13 Prevalence (per cent)	Prevalence 2013-14 Prevalence (per cent)	Prevalence Year on Year Change (per cent)	Achievement 2012-13 Achievement (per cent)	Achievement 2013-14 Achievement (Points available increased from 88 to 107) (per cent)	Achievement Year on Year Change (per cent)	Exceptions 2012-13 Overall Exception Rate (per cent)	Exceptions 2013-14 Overall Exception Rate (per cent)	Exceptions Year on Year Change (per cent)
NHS GREAT YARMOUTH AND WAVENEY CCG	6.97	7.36	5.65	98.07	88.60	-9.65	8.00	9.46	18.26
NHS NORTH NORFOLK CCG	6.37	6.66	4.56	98.59	90.01	-8.70	6.53	9.41	43.99
NHS NORWICH CCG	4.73	4.82	1.78	97.42	85.99	-11.73	7.49	8.67	15.74
NHS SOUTH NORFOLK CCG	5.81	6.00	3.41	98.78	86.48	-12.45	6.27	8.09	29.02
NHS WEST NORFOLK CCG	7.59	7.75	2.05	96.90	87.15	-10.06	7.53	9.33	23.95
ENGLAND	6.01	6.21	3.24	96.10	90.08	-6.26	7.12	8.88	24.74

Grey shaded columns were "Retired" in 2014 15

CCG Name	DM002 BP<150/90 Percent achievement	DM003 BP < 140/80 Percent achievement	DM004 Cholesterol <5 Percent achievement	DM005 (Urine test) Percent achievement	DM006 ACE inhib if proteinuria /or microalbuminuria Percent achievement	DM007 HbA1c <59 Percent achievement	DM008 HbA1c < 64 Percent achievement	DM009 HbA1c <75 Percent achievement	DM010 (Flu) Percent achievement	DM011 (retinal screen) Percent achievement	DM012 Foot exam Percent achievement	DM013 (Dietary review) Percent achievement	DM014 Education referral Percent achievement	DM015 (ED record) Percent achievement	DM016 (ED advice etc) Percent achievement
NHS GREAT YARMOUTH AND WAVENEY CCG	86.41	71.33	68.57	77.71	81.46	59.01	68.02	79.20	77.50	84.36	80.45	79.41	84.15	79.82	85.90
NHS NORTH NORFOLK CCG	86.99	71.11	70.46	81.44	77.65	61.18	71.44	83.99	77.54	85.66	81.37	67.30	87.09	68.61	75.91
NHS NORWICH CCG	86.50	66.53	70.83	81.54	77.80	58.70	67.51	79.92	79.34	84.64	83.66	78.39	86.91	68.12	72.06
NHS SOUTH NORFOLK CCG	87.68	70.17	70.96	81.65	78.52	59.66	69.62	82.65	78.59	85.14	84.26	76.46	82.08	71.97	70.50
NHS WEST NORFOLK CCG	87.48	71.36	74.75	80.31	80.50	58.06	67.43	80.08	76.58	79.92	81.09	78.43	90.72	77.52	87.69
ENGLAND	87.31	71.93	72.26	80.63	81.36	61.46	69.56	80.19	78.37	82.64	82.11	82.20	84.41	81.63	87.93

Diabetes Care within Primary Care Services in West Norfolk

Much of the management and monitoring of diabetic patients, particularly those with Type 2, is undertaken by the GP and members of the primary care team; West Norfolk has a comprehensive, integrated multi-discipline Diabetes service that supports the diagnosis and on-going care for patients with diabetes and also provides education and support to both patients and service providers.

We commission a Diabetes service from our community provider, Norfolk Community Health & Care (NCHC) which includes a Diabetes Educator/Practitioner, Service Lead. Over the last year, the service has received 3,000 contacts from GPs.

Education sessions are conducted, supported by industry, when new products are launched. These sessions are led by the Diabetes Community Team to ensure a non-biased view is delivered, with information detailing how new medications fit into the current pathway.

Following the launch of all new diabetic medicines the Diabetes Community Team collect audit data to illustrate benefits and fit within the current pathway. This work is undertaken and achieved through close working with the West Norfolk CCG Medicines Management Team.

Primary Care
The service supports and educates primary care practitioners in the management of patients with diabetes, facilitating standardised care for all West Norfolk patients; examples of which are:

- Quarterly education sessions for practice nurses, community nurses and matrons, link nurses from both community and hospital, and interested GPs
- Workshops on diet and blood glucose meter training for practice nurses. This is carried out on a 2 yearly cycle to maintain competency
- Regular mandatory training on foot care for all staff that are caring for patients with diabetes, including HCA's
- Implementation of national guidance such a NICE.
- Specialist clinics within practices
- All practices are offered a half day clinic on a monthly basis, giving an opportunity to work with practice nurses and trainee GPs. This provides shadowing opportunities to increase awareness of the diabetes pathway.

Other Agencies
The service also supports other agencies such as Nursing and Care Homes, providing an essential link to potentially high risk patients. As well as specific training programs on insulin use, the service will provide general ad hoc training on request.

The service works with voluntary agencies such as Diabetes UK and British Red Cross to raise public awareness of diabetes. Through events held by these voluntary agencies, stands are made available where diabetes testing can be offered to identify people with diabetes.

In addition, the service in-reaches to the Diabetes Team at The Queen Elizabeth Hospital, working closely with Consultants, in-patients, and follow up out patient referrals from hospital and GP practices

Patients and Carers
The service delivers structured patient education sessions for newly diagnosed Type 2.

The Type 2 Diabetes Education Programme is for people newly diagnosed with Type 2 Diabetes. It is a group session, delivered by Healthcare professionals held over 4 hours. Patients are referred onto the programme at diagnosis by their GP or Practice Nurse and covers:

- Diet
- Foot care
- Medicines Management
- Explanation of diabetes
- Annual review/self-management

The Programme has received very positive patient feedback, some of which can be seen below:

> "Opportunity to ask questions and hearing other people describe their diabetes issues"
> "Presenters very approachable and good clear information"
> "A well presented session – first class instructions and able to ask questions as the session moved on"
> "Easy to understand"

In addition to service provision, an annual symposium, with National Speakers is arranged by the Service Lead. This has been held each year for the last 16 years, attracting between 120 -150 attendees each year.

Due to the high prevalence of 65+ population and house-bound patients within West Norfolk, the measurement and recording of Body Mass Index (BMI) can be particularly challenging. Whilst weight is relatively easily recorded within this patient cohort, the recording of patient height required for the BMI calculations, can be difficult, particularly with those patients who are non-weight bearing. SystmOne, which is the most commonly used clinical system in primary care across West Norfolk, will not record or re-calculate BMI when a weight is entered, unless the height is also re-entered.

Going Forward
As demonstrated, there are an ongoing number of initiatives to ensure the continued improvement in quality of service to patients. In addition to the education programme offered by the Service Lead of NCHC we are in the process of developing a competency framework for Practice Nurses in West Norfolk, with the intention to establish a comprehensive education and development plan in 2015/16. Further to the additional information gained from the Health Education England (HEE) GP Workforce summit meetings, a competency framework survey has been

developed in order to undertake a detailed analysis of Practice Nurse Competencies. This survey will enable the CCG to identify:

- Qualifications and professional development,
- Quality Improvement – clinical supervision, health & safety, clinical audit,
- Assessment and Triage,
- Clinical Skills-treatment room, health screening and health promotion, immunisations and travel health,
- Management of long term conditions including Diabetes.

This programme will enable us to focus on any additional training that may be required particularly around recording of treatment targets such as foot surveillance and body mass index as highlighted by the Diabetes UK's Eastern National Diabetes Audit 2012-2013. There is however, also a pressure on existing resources when we are effectively detecting more undiagnosed cases of diabetes. We will endeavor to align our resources in order to meet the increased activity.

Eastern National Diabetes Audit 2012-13 Data Summary

Percentage of all patients in Eastern area receiving the care processes and treatment targets broken down by Clinical Commissioning Group area

CCG description	Registrations*	Eight care processes	Eight care processes Rank	Meet all six treatment targets	Meet all six treatment targets Rank
Basildon and Brentwood CCG	11,977	51.8%	15	41.9%	1
Bedfordshire CCG	17,368	45.9%	17	30.8%	17
Cambridgeshire and Peterborough CCG	28,696	54.9%	11	30.2%	18
Castle Point and Rochford CCG	9,369	59.7%	8	40.5%	2
East and North Hertfordshire CCG	12,201	42.4%	18	36.8%	6
Great Yarmouth and Waveney CCG	2,441	51.9%	14	33.8%	13
Herts Valleys CCG	10,496	63.2%	5	35.8%	9
Ipswich and East Suffolk CCG	15,110	47.3%	16	39.6%	4
Luton CCG	11,070	60.4%	7	33.4%	15
Mid Essex CCG	16,956	N/A	N/A	34.8%	10
North East Essex CCG	8,205	67.2%	1	34.1%	12
North Norfolk CCG	7,114	63.9%	4	35.9%	7
Norwich CCG	5,920	65.5%	2	31.6%	16

Eight care processes

HbA1c

Blood pressure

Cholesterol

Serum creatinine

Urine albumin

Foot surveillance

BMI

Smoking

Six treatment targets

HbA1C<48mmol/mol

HbA1C<58mmol/mol

HbA1C<86mmol/mol

Blood pressure<=140/80

Cholesterol<4mmol/L

Cholesterol<5mmol/L

* Registrations – figures may not include all registered patients in the CCG area if not all GP practices took part in the audit

CCG description	Registrations	Eight care processes	Eight care processes Rank	Meet all treatment targets	Meet all treatment targets Rank
South Norfolk CCG	7,924	64.6%	3	34.1%	11
Southend CCG	5,736	53.4%	13	39.7%	3
Thurrock CCG	5,976	55.2%	10	38.7%	5
West Essex CCG	10,006	54.0%	12	35.8%	8
West Norfolk CCG	5,942	55.6%	9	33.5%	14
West Suffolk CCG	7,013	60.7%	6	28.5%	19
England	**1,858,974**	**59.5%**		**36.0%**	

Overall ranking	CCG	Sum of each ranking (8 care processes & 6 treatment targets)	**Overall ranking**	CCG	Sum of each ranking (8 care processes & 6 treatment targets)
1	North Norfolk CCG	77	**11**	Norwich CCG	165
2	South Norfolk CCG	95	**12**	Thurrock CCG	169
3	Castle Point and Rochford CCG	105	**13**	Southend CCG	179
4	Ipswich and East Suffolk CCG	113	**14**	East and North Hertfordshire CCG	183
5	North East Essex CCG	113	**15**	Herts Valleys CCG	184
6	Basildon and Brentwood CCG	143	**16**	Cambridgeshire and Peterborough CCG	200
7	West Norfolk CCG	144	**17**	Bedfordshire CCG	201
8	Mid Essex CCG*	150	**18**	West Essex CCG	216
9	Luton CCG	157	**19**	Great Yarmouth and Waveney CCG	226
10	West Suffolk CCG	163			

Forward work programme and appointment of substitute link members with Clinical Commissioning Groups

Report by Maureen Orr, Democratic Support and Scrutiny Team Manager

The Committee is asked to:-

(a) Consider 'Children's mental health services in Norfolk' as a topic for inclusion in the forward work programme
(b) Consider the current forward work programme and suggest issues for future scrutiny.
(c) Appoint substitute link members with South Norfolk and Great Yarmouth and Waveney Clinical Commissioning Groups.

1. Children's mental health services in Norfolk

1.1 On 16 July 2015 Cllr Sandra Bogelein suggested 'Children's mental health services in Norfolk' as a topic for future consideration by Norfolk Health Overview and Scrutiny Committee (NHOSC) and agreed to supply additional information about the concerns that prompted the suggestion.

1.2 A draft terms of reference for scrutiny of 'Children's mental health services in Norfolk' (Appendix A) has been compiled based on the information Cllr Bogelein supplied.

2. Forward work programme

2.1 The current forward work programme is attached at Appendix B.

3. Substitute link members with South Norfolk and Great Yarmouth and Waveney Clinical Commissioning Groups (CCGs)

3.1 Norfolk Health Overview and Scrutiny Committee appoints link members to attend local CCG Governing Body meetings. The nominated member or a nominated substitute member may attend in the capacity of NHOSC link member.

3.2 The role of the link member, or nominated substitute, is to attend the NHS body's meetings in public to observe and keep abreast of developments in the Trust or CCG's area and alert NHOSC to any issues that may require the committee's attention.

3.3 The link member holds no formal position with the NHS body whose meetings they attend but is present at the formal request of NHOSC. Any other member of NHOSC may attend NHS meetings in public in a personal capacity if they wish.

3.4 Nominated NHOSC formal link members are listed on the Forward Work Programme paper presented at each meeting (Appendix C). NHOSC appointed members to most of the link and substitute link roles on 28 May 2015 and 16 July 2015 but two vacancies remain; substitute link members with South Norfolk CCG and Great Yarmouth and Waveney CCG.

3.5 Cllr Marlene Fairhead, substitute member of NHOSC for Great Yarmouth Borough Council, is willing to serve as substitute link with Great Yarmouth and Waveney CCG. Cllr Margaret Somerville is willing to serve as substitute link member with South Norfolk CCG.

4. Action

4.1 NHOSC is asked to consider the following:-

4.1.1 Children's mental health services in Norfolk

(a) Does the committee wish to scrutinise this subject at a future meeting?
(b) If so, the committee is asked to approve or amend the draft terms of reference at Appendix A.

4.1.2 Forward work programme

Members are asked to consider the current forward work programme (Appendix B):-

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

4.1.3 Substitute link members

The committee is asked to make the following appointments, or to suggest alternatives:-

- Great Yarmouth and Waveney CCG substitute link member – Mrs Marlene Fairhead

- South Norfolk CCG substitute link member – Mrs Margaret Somerville

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Terms of Reference

Norfolk County Council

Norfolk Health Overview and Scrutiny Committee (NHOSC)

Terms of reference for scrutiny of

Children's mental health services in Norfolk

Scrutiny by

Full committee

Reasons for scrutiny

Concerns because of perceptions that:-

1. It is difficult to get an appointment for assessment of children with emotional, behavioural and mental health issues.
2. Following assessment, children with a level of need may not get the appropriate level of intervention.
3. Mild to moderate cases only receive 6 appointments for treatment.
4. There is insufficient joining up between mental health services and other specialist services for children, such as the autism service, for considering co-diagnosis or for other services to receive advice from mental health professionals about specific cases.
5. There is insufficient support for children who have attended A&E following attempted suicide.
6. A more systemic and family based approach is needed when working with children with mental health issues.
7. There has been a decrease in proactive support especially during the school holidays.
8. Reductions in third sector organisations' funding means that they are unable to bridge the gaps in NHS services.

Purpose and objectives of scrutiny

1. To receive information about the level of mental health service provided to children in Norfolk.
2. To ascertain how services have changed in recent years.
3. To comment on Norfolk's Local Transformation Plan for children and young people's mental health.

Areas to be addressed

1. The protocol and follow-up treatment of children after a suicide attempt.
2. The link between mental health services and other specialist services for children.
3. Waiting list for children's mental health provisions.
4. General mental health provision for children (which programs are available, how many appointments are available) and treatment outcomes, as well as re-referrals.
5. Complaints about the provision of children mental health services.
6. Capacity to deliver a more systemic and family based approach to children's mental health services.
7. Future plans for meeting increased need for children mental health services.
8. The changes to services planned in the Local Transformation Plan for children and young people's mental health services.

People to speak to

- The commissioners – Child and Adolescent Mental Health Services (CAMHS) in Norfolk are commissioned by a Joint Commissioning Group made up of partners from health (Clinical Commissioning Groups) and Norfolk County Council Children's Services. Tier 4 in-patient services for complex cases are commissioned by NHS England Specialised Commissioning.
- The key providers:-
  - Point 1
  - Norfolk and Suffolk NHS Foundation Trust (NSFT)
  - Norfolk Community Health and Care NHS Foundation Trust
- Referrers of children to mental health services.

Style and approach

Full NHOSC meeting with witnesses.
The subject may be dealt with in one or two meetings.

Planned outcomes

An information report to Norfolk Health Overview and Scrutiny Committee and comments by the committee about the Local Transformation Plan for children and young people's mental health, as appropriate.

Terms of reference agreed by	**Date**
Norfolk Health Overview and Scrutiny Committee	3 September 2015

Appendix B

Proposed Forward Work Programme 2015-16

Meeting dates	*Briefings/Main scrutiny topic/initial review of topics/follow-ups*	*Administrative business*
15 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). NHS Workforce Planning in Norfolk – responses to NHOSC's recommendations agreed on 16 July 2015.	*The UEA evaluation of the Norfolk pilot will be available in Nov 2015. Move to a later meeting?*
3 Dec 2015	Stroke Services in Norfolk - update (12 months after the responses to stroke recommendations, presented to NHOSC 27 November 2014) Continuing Heath Care – consultation by the Norfolk CCGs' (excluding Great Yarmouth and Waveney CCG) on proposals for policy changes.	*Depending on progress by the CCGs / CSU*
14 Jan 2016		
25 Feb 2016	Continuing Health Care – final consideration of the CCGs' proposed policy changes Ambulance response times and turnaround times n Norfolk – an update to the East of England Ambulance Service NHS Trust, Norfolk and Norwich University Hospitals NHS Foundation Trust and Clinical Commissioning Group report presented in February 2015	*Depending on progress by the CCGs / CSU*

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 2016

14 Apr 2016 – Service in A&E following attempted suicide or self-harm episodes (an update to the report presented in April 2015 by Norfolk and Suffolk NHS Foundation Trust and the three acute hospitals)

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

Clinical Commissioning Groups

North Norfolk	-	M Chenery of Horsbrugh (substitute Mr David Harrison)
South Norfolk	-	Dr N Legg (substitute *Vacancy*)
Gt Yarmouth and Waveney	-	Mrs M Somerville (substitute *Vacancy*)
West Norfolk	-	M Chenery of Horsbrugh (substitute Mrs S Young)
Norwich	-	Mr Bert Bremner (substitute Mrs M Somerville)

NHS Provider Trusts

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

Norfolk Health Overview and Scrutiny Committee 3 September 2015

Glossary of Terms and Abbreviations

ACE	ACE inhibitors can lower the amount of protein being lost in the urine
A&E	Accident And Emergency
APMS	Alternative Provider Medical Services
ARB	Angiotensin receptor blocker
BMA	British Medical Association
BME	Black minority ethnic
BMI	Body Mass Index
CCG	Clinical commissioning group
Cholesterol	A fatty substance known as a lipid, vital for the normal functioning of the body. It is mainly made by the liver but can also be found in some foods. Having and excessively high level of lipids in the blood can have an effect on health. High cholesterol itself does not cause any symptoms but it increases the risk of serious health conditions such as heart attack and stroke.
CSU	Commissioning Support Unit
CVD	Cardio vascular disease
DES	Directed Enhanced Services
DESP	Diabetic eye screening programme
DIST	Dementia Intensive Support Team
DM	Diabetes mellitus
EADESP	East Anglia Diabetic Eye Screening Programme
ES	Enhanced Services
GMS	General Medical Services
GP	General Practitioner
GPC	General Practitioners Committee
GP2DRS	A system linking health screening programmes with GP computer systems
HbA1c	Glycated haemoglobin Glycated haemoglobin develops when haemoglobin, a protein within red blood cells that carries oxygen throughout the body, joins with glucose in the blood, becoming ‘glycated’. By measuring glycated haemoglobin clinicians are able to get an overall picture of what average blood sugar levels have been over a period of weeks/months. For people with diabetes this is important as the higher the HbA1c, the greater the risk of developing diabetes-related complications.

	Targets for HbA1c are as follows:- • For people without diabetes the range is 20-41 mmol/mol (4% - 5.9%) • For people with diabetes an HbA1c level of 48 mmol/mol (6.5%) is considered good control • For people at greater risk of hypoglycaemia (lower than normal blood sugar) a target of HbA1c of 59 mmol/mol (7.5%) to reduce the risk of hypos.
HCA	Health Care Assistant
HEE	Health Education England
Hep B	Hepatitis B – an infectious disease caused by the hepatitis B virus which affects the liver. It can cause both acute and chronic infections.
HSCIC	Health and Social Care Information Centre
HPV	Human papilloma virus
IFCC	International Federation of Clinical Chemistry and Laboratory Medicine
IT	Information Technology
LPA	Local Planning Authority
MMR	Measles, mumps, rubella
NCH&C	Norfolk Community Health and Care NHS Trust
NHOSC (OSC)	Norfolk Health Overview and Scrutiny Committee
NHS E M&E(E)	NHS England Midlands & East (East)
NICE	National Institute for Health and Care Excellence
NIDM	Norfolk Integrated Diabetes Management
NNUHT	Norfolk and Norwich University Hospitals NHS Foundation Trust
NSFT	Norfolk and Suffolk NHS Foundation Trust (the mental health trust)
PCT	Primary Care Trust
PHE	Public Health England
PMS	Personal Medical Services
QOF	Quality Outcomes Framework
SIGN	Scottish Intercollegiate Guidelines Network
UEA	University of East Anglia