West Norfolk Clinical Commissioning Group

Stakeholder Events - July to August 2013

Summary Report
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Introduction

The West Norfolk Clinical Commissioning Group (CCG) is a ‘member organisation’ made up of healthcare professionals, including doctors and nurses from the 23 local GP practices. These practices are working together to plan and buy local healthcare and to make sure that health and care services are available for the local population when they need them.

West Norfolk CCG is committed to involving our local stakeholders in all aspects of our development and we are keen to establish and develop good working relationships and to make sure that we have good two-way communication.

These stakeholder events were organised as part of our on-going commitment to engage and inform our local partners, patients and public of some of our achievements over the past year, and the challenges we face going forward.

Format of the Events

As with the events held in 2012, our aim was ensure that as many people as possible were given the opportunity to attend the events. We therefore held three meetings at three different geographical locations across the West Norfolk area. Each event followed a similar format and was held between 10.00 am and 1.00 pm, as follows:

- **Tuesday, 30 July**  Downham Market Town Hall
- **Wednesday, 31 July**  West Norfolk Professional Development Centre, King’s Lynn
- **Friday, 9 August**  Le Strange Arms Hotel, Hunstanton

The meetings began with a series of presentations, followed by table-top discussions and ending with a question and answer panel, where attendees were invited to ask questions around the issues that were affecting them. Overall, over 80 people attended the three events.

Presentations

A full copy of the presentations for the events is available on the website.

Dr Ian Mack, Clinical Chair of the GP Governing Body opened the meetings at Downham Market and King’s Lynn. Dr Tony Burgess, Deputy-Clinical Chair of the GP Governing Body was present for the Hunstanton meeting.

The scene-setting presentation covered the following points:-

- Who are we?
- What is important to us?
- Last year you said…..and we did…..
- Our NHS – the national picture
  - national funding
  - call to action
  - local funding
The presentation then moved into the local health priorities for West Norfolk, focusing on:-

- The ageing population;
- Emergency admission data;
- Dementia, depression and learning difficulties;
- Lifestyle factors;
- Local health priorities.

At the King’s Lynn event, this information was presented by Dr Lucy McLeod, Acting Director of Public Health for Norfolk, and in Hunstanton, Sian Kendrick-Jones, Senior Public Health Officer gave the presentation.

Following on from the Public Health data, Ian Burbidge, Policy and Partnerships Manager from the Borough Council of King’s Lynn & West Norfolk highlighted the approach to integrated working which is being taken locally, focusing on:-

- A partnership strategy to improve the quality of life in West Norfolk;
- Health starts where we live, learn, work and play;
- Resources
- Integration

The next presentation introduced by Dr Sue Crossman, Chief Officer of the CCG, made the audience aware of the CCG’s priorities for Quality being at the heart of all we do, covering:-

- How do we assure the quality of our Providers;
- The West Norfolk financial challenge;
- The West Norfolk CCG budget;
- The 2013/14 financial gap;
- How we are closing that gap;
- Achievements to date;
- How do we continue to improve patient experience and efficiency.

4 The Patient Experience

At each event, we were extremely fortunate to have individual patients, or groups of patients, who were willing to share their experiences with the audience of working with the CCG or how the development of a project or service has impacted on them.

The subject areas covered were:-

- The Dementia Pathway Re-design
- The West Norfolk Community Involvement Panel
- Transforming Cancer Care in the Community
- West Norfolk Hospice at Home
At each event, round table discussions were held with groups of stakeholders to discuss:
“What else can we do to improve the integration of services?”

To introduce the topic, Dr Sue Crossman detailed the West Norfolk Integration Project, giving the aims, programme principles and an overview of how it will work. The example given to illustrate these points was of the West Norfolk Hospice at Home service.

Detailed below are the themes taken from the discussions at each event. For an unabridged version of the table-top discussions, please see Appendices 1 to 3.

“What else can we do to improve the integration of services in West Norfolk?”

**Communication:**

- One-stop shop/Single Point of Contact
- Patient/Public Welcome pack:  Health & Social Care information
- Health & Social Care Professionals Network (bi-annually?)
- Directory of Services
  - Professionals and Public:
  - who does what in each organisation – (led by CCG)
  - voluntary sector organisations – (what they offer)
- Multi-disciplinary attendance at meetings
- Language – one language all can understand
- National Best Practice Networks

**Technology:**

- ‘national integration of data system’ (use or develop!)
- Universal computer system between QEH & GP practices
- Effective use of information/information systems
- Unify GP systems

**Training/Support:**

- Residential/nursing homes
- Continuous development
- Better training in dementia for residential homes staff

**Funding:**

- Amalgamate budgets/monies from different organisations
- Small grants to local ‘groups’ to improve health
**Engagement:**
Encouraging young people to be more involved in activity
Develop volunteering
Engage with communities
Make use of PPGs
Reduce social isolation

**Integrated working:**
Talk to other bordering CCGs (i.e. Fenland, North Norfolk) – economies of scale/avoiding duplication
One stop shop/Single point of contact
Abandon organisational agendas
Simple processes/user friendly info
Shared information/sharing software
Shared accountability
Breakdown organisational barriers
“Inter-health co-ordination“ (acute and community)
Be better about valuing each other’s professionalism without being ‘precious’
Better integration between ‘physical’ and ‘mental’ health
Automatic referral of patients to services who can support – will result in closer working between statutory and voluntary sector
Continuity of clinicians
Mutual support systems

**General Practice:**
Health and Social Hub – community fed
Make more use of premises to provide wider range of information and services

**Prevention:**
Of paramount importance
Fit prevention around individual and community (bespoke services)
After the conclusion of the table top discussions, a Panel was formed by members of the CCG and our partner agencies, to answer questions from members of the audience, about the issues that are important to them.

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<td>Dr Ian Mack</td>
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<td>Dr Sue Crossman</td>
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<td>Louise Stevens</td>
<td>Dr Lucy McLeod</td>
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<td>Consultant in Public Health Medicine</td>
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<td>Quality Improvement Lead, West Norfolk CCG</td>
<td>Acting Director of in Public Health</td>
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<td>Policy &amp; Partnerships Manager, Borough Council of King’s Lynn &amp; West Norfolk</td>
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A full transcript of the question and answer session is available at Appendices 4, 5 and 6.

The themes from the table-top discussions are being fed into the prioritisation process for the CCG’s 2014/15 Commissioning Intentions and the development of an updated ‘West Quest’ – the CCG’s strategic priorities. This document will be published early in the new year.

West Norfolk Clinical Commissioning Group would like to say a big thank you to the patients and public who participated in our stakeholder events, particularly those who were willing to share their experiences with us.
West Norfolk Clinical Commissioning Group

Appendix 1

30 July 2013
Downham Market Town Hall
Table Top Discussions
What else could we do to improve the integration of services in West Norfolk?

**Personal Touch**
Feel like a **person** not a number

**Good communication – both ways**

**Integration**

A one-stop shop: A welcome pack – when moves to West Norfolk

- **Health & Social Care**
  - Package could be sent at same time
  - Sent out when registered for council tax

- Professionals meeting 6/12 to network

- Voluntary Sector – short presentations on services delivered local – contacts

**Social**

List of who does what in each organisation – need a book or internet – updated regularly.

Lead should be CCG.

Proactive – by quality improvement lead.

Computer systems – between QE and GP practices

Link further to Council

Mental Health
Abandoning organisational agendas
‘True’ partnership working
Inter-agency meetings
Action – less talk
Co-ordination role
Services mapping
User friendly info/simple processes
Single point of contact
Flexibility within contracts
Allowing for innovation
Single provider?
Patient passport, ‘travelling’ care plan
Shared info, sharing software
Shared accountability
Reducing duplication
31 July 2013
West Norfolk Professional Development Centre, King’s Lynn
Table Top Discussions
West Norfolk Clinical Commissioning Group (CCG) Stakeholder Events 2013

“Protecting the Quality of Services for the future: Come along and influence us”

Wednesday, 31 July 2013 - 10.00 am to 1.00 pm
West Norfolk Professional Development Centre, King’s Lynn
Table-Top Discussions

Table-Top Discussions

What else could we do to improve the integration of services in West Norfolk?

Communications across all sectors

‘Bable fish’ – universal language

Use of, or development of, national integration of data system.
- Stored electronically
- Access to all

Awareness of professionals and the public

Central point of information

Continuous development
- Professional log-in area
- Group log-in

- Concern around pressure on voluntary sector and reliance on volunteers
  (? Quality of volunteers)
- Get involved in volunteering out of a personal interest
- Make the most of people’s individual skills
- Communicate clearly in clear language – spell out potential benefits
- System confusing
- Support from voluntary groups can be beneficial but struggle to pass ‘NICE’ scrutiny
- Better about valuing each other’s professionalism whilst not being too precious
- GP surgeries to have the relevant literature to publicise the services available in West Norfolk
- GP surgery a hub, community fed. Services accessible GPs know what is available and can tell you how to get there
- Clarity
- How engage with community as a whole
- How individuals work together effectively
1) How much are the voluntary sector used? How can we address the issue of funding eg. If the voluntary sector is referred to, they need funds/support.

2) Personalisation is not being processed for Mental Health patients with ‘fair access to care’ assessments. The guidelines and qualifications for personal budgets are same as physical disability – to the detriment of many mental health patients. There must be backlogs elsewhere.

3) The SMI register needs to be used to promote good lifestyle and support but patients are given BP/blood tests with little or no discussion of their mental health issues.

4) Re-admission to mental health services, lots of patients falling through net and not getting back to secondary services, even when acutely symptomatic and known to services.

**Communication and ‘Bespoke’**

1) Much better information via Parish Councils - pathway and contact details and their local communications.

2) Prevention paramount
   - improving quality of life, this will help to keep people well and reduce contact with health professionals
     - social issues, housing issues (challenge is how to do it)
   - but already good examples – e.g. mental health aid, makes the case for non-health professions to delivery appropriate support.
   - Fit prevention around the individual and community (bespoke services)

   Reduce social isolation

3) Challenge of how to engage communities, when smaller than the Town Council

4) Importance of focus of bringing non health/social care into this area – challenge of encouraging and developing confidence – better training

5) Co-ordinator is a vital role, straight forward means of contact [previous work in West Norfolk Bereavement]

6) Make use of PPGs and West Norfolk Partnership
   - More promotion of the services that are already out there
   - More support for services out there
   - Integration between physical and mental health services is appalling
   - Not enough collaboration between acute wards and people with dementia
     - residential homes not qualified to help dementia patients * lack of training
   - Mechanisms in place but integration not happening – could be down to training issue? – work shadowing?
   - Levels of staffing – funding issues
   - Does improving integration begin with ‘foot soldiers’ or managers?
     - managers need to speak to staff.
   - National best practice networks
   - Personal budgets affect all of these things – can’t always afford to pay for care
   - Rather than having option to refer patients to services who can support, it should become default – automatic referral – reviewed for looking at other services who can help them which already exist (which patient/carer consent) – statutory and voluntary organisations will have to work closer together.
Feedback:

1) More promotion, support and recognition of available services
2) More training for staff – Provider organisations to ensure its up to date and relevant

IT systems need to communicate

→ more information at first point of contact e.g. GP surgeries?
Simple/adapting what is there – NCC magazine?

Lack of **continuity** with clinicians – particularly GPs

Information overload – how the right information is communicated efficiently

- (? Contact numbers?) i.e. target high risk patients.
- value of face to face information
- using all professional contacts
- all having access to same information
- continuity of what is shared
- single point of contact for information
- is there a single database of information?
  (there was a project, what happened to it?)

Health and Social hub

Mutual support system

- Quality cared for elderly
- GP practices talk to each other and greater integration
- IT systems in surgeries – how to access! (All different!)
- How to understand who does what in system following changes – from a patient’s perspective. How many groups?!
- Do we listen to patients?
- A single care plan for each patient?
- Need to get beyond ‘fine’ words to actions
- Q – what will have changed by next year’s events?
- Importance of role of GP surgery – how can we make more use of premises to provide wider range of information and services?
- Info and data/stats from across GP practices
- What are the outcomes from today – feedback/evidence of what’s happened
- More control and say by patients
Voluntary sector to be part of pathway/virtual teams

- GP is seen as first point of contact
  - can GP follow up? Keep track on what’s happening

Better communication/sharing of information

- Needs fluctuate – need to retain ‘membership’ re: access back into the system.

Publicising initiatives e.g. community involvement in CCG.

Use local media, other agencies

Timing of stakeholder events – outside the working day?
9 August 2013
Le Strange Arms Hotel, Hunstanton
Table Top Discussions
What else could we do to improve the integration of services in West Norfolk?

Residential / Nursing Homes

(Support for) (Engagement)

**Fully** joined up care plans

Effective use of information/information systems

Don’t forget the **social** aspects of healthcare e.g. cooking!

► Remove money from acute sector and transfer to community based services
► Small grants to local ‘groups’ to improve health – local authority action
► Try and encourage young people to be more involved in activity – more away idea sports
► Need to act now to get future gain. Challenge to meet current demand and also at some time **shift funding**
► All agencies put money into one pot – therefore commitment of agencies to work together
► Challenge to think differently and do things in a different way
► Use national organisations to reconfigure local services based on best practice
► Keep people out of hospital e.g. physio rather than out-patient appointment
► Cross membership on committees e.g. meetings at GP practice including district nurses, GPs, pharmacies etc – networking and knowing people to work with – voluntary, GPs, charities
► Improved communication with a wide variety of partners to inform of bids etc so voluntary sector can plan their services etc in line with bid
► E-mail/village newsletters – wide variety of means to community with communities
► What work is happening across CCGs – Fenland, North Norfolk – this may help economies of scale and avoid duplication. Liaison people while some mechanisms in place for networking
► Need to improve and further develop this
Q  Outcome measures - what is success?
Q  Budget allocation for pathways – how will this work?

Directory of Services – one stop shop.
- professionals
- public

PPIs need access to appropriate information

Resourcing pathways once identifying

Need to breakdown organisational barriers
- completing priorities – strategic and local
- goes back to national/local measurement
- has to allow for inequalities – in different areas

Autocratic/bureaucratic NHS

24/7 operation – OOH accessing pathways not there

Language
- professional language
- client languages and age language
- public take path of least resistance (999)

Diagnostic pathway good
- no help one year on
- no communication of services
- impact on family young children (autistic)
  Suicidal can’t cope with sensory overload
  CAMs only accessible via hospitalisation
- 60% autistic people unemployed

▸ about lifelong pathways
▸ about proactive services

NHS – too autocratic
Knowing who does what?

“Commissioning” needs to be ‘public-centred’ avoid duplication

Improve knowledge and understanding

Sharing

Need a long-term view

Inter-health co-ordination (Acute and Community)

“Out-of-hours” needs to be an unused phrase!

Talk to people/ secure feedback

Don’t have to understand our complexities!

One Record

Customer-focused

24/7

Single point of contact for patient

(Warwickshire)

Everyone uses SystmOne =solution

solve “Information Governance”

Duplication of services; work

nb - Young People

“We’re all patients”
Appendix 4

30 July 2013
Downham Market Town Hall
Panel Session: Questions & Answers
The Friends and Family Tests gather the views of 90,000 former patients. What are the results of the Queen Elizabeth Hospital?

Dr Sue Crossman – Chief Officer – West Norfolk CCG:

The Friends and Family Test is a survey that hospitals and Trusts use to determine whether the patients who are using their services would recommend their Trust as a place of care to their friends and family. As a CCG, we have had concerns about the administration of the test in Queen Elizabeth Hospital (QEH). They started collecting the data before it became a national requirement, but the company they had been using to administer the Test had lots of problems making the data meaningful. The scores did not reflect real patient dissatisfaction, but they had to improve their scoring mechanisms. The QEH have now changed the company they use to administer the test and since then, we have seen an increase in the scores. The score has recently increased from 44% to 66% which is more comparable with the national scores.

Was there not a nationally agreed scoring system? It makes a nonsense of it if one Trust departs from the norm.

Dr Sue Crossman – Chief Officer – West Norfolk CCG:

Yes there is. The questions are standard but originally the QEH was using a 10 point scoring system whereas other Trusts were using a 5 point scoring system. Since April, the scoring system has been standardised across the country and everyone is using the 5 point system.

Louise Stevens – Quality Improvement Lead – West Norfolk CCG:

The Test is taken monthly, so the results reflect a percentage of patients surveyed each month. But we don’t take account of this data in its own merit – we compare it with a variety of other forms of data from the Trust.

Professor Paul Jenkins – Secondary Care Doctor, Governing Body – West Norfolk CCG:

It is difficult to assess quality. The Friends and Family Test is subjective data so it is difficult to convert it into tangible figures. The data can also suffer as a result of a poor response rate. The latest results had a response rate of around 22%. People are invited to respond, but not all do – which means that as a sample, the data is flawed.

How much money is being spent on the contract to administer the Friends and Family Test?

Dr Ian Mack – Clinical Chair, Governing Body – West Norfolk CCG:

We are unable to answer that as the test is the responsibility of the QEH.
Who will be involved in the planning for integrated health and social care?

Dr Sue Crossman – Chief Officer – West Norfolk CCG:

These services are planned by a Forum made up from the Chief Executive Officers of all West Norfolk Health, Social and Voluntary Sector organisations. We are able to have open discussions about system change and the different ways that services are organised and delivered. All staff are very involved in planning and implementation and the plans filter through the organisations at all levels.

Who from Adult Care is part of that Group?

Dr Sue Crossman – Chief Officer – West Norfolk CCG:

Harold Bodmer from Adult Social Services is part of the Group as is Ray Harding from Borough Council of King’s Lynn & West Norfolk. Dr Mack referred to money going from health into social care – in West Norfolk (around £3-4 million) this will be used to support integration work and we will closely monitor how it will be planned and used.

How frequently will you come back to local community share your and our experience?

Ian Burbidge – Policy & Planning Manager, Borough Council of King’s Lynn & West Norfolk:

From the perspective of the Borough Council of King’s Lynn & West Norfolk, I’m involved in a more practical group – specifically around consultation events for older people. Our involvement with the community will be on a case by case basis as and when the opportunities arise or there is a specific need for us to engage and consult. We want to do some testing and engagement and can work with people about their experiences, specifically around what information they needed and what information they had. As we move to towards integration, we will have engagement with people at the heart of all we do.

Dr Sue Crossman – Chief Officer – West Norfolk CCG:

Regarding the Integrated Care Organisation (ICO) – these were originally formed through a Pilot across the whole of Norfolk. The ICO teams are made up of a range of community workers from health and social care, including physiotherapists, occupational therapists, social workers, etc, working around GP practices. The teams meet together and talk about their caseloads, sharing information so everyone is co-ordinating the care of those patients, and therefore helping to avoid admissions into the Acute Hospital. Here in West Norfolk, we are extending the pilot. In terms of the financial challenge we face, the system as it is currently configured is not sustainable. We have to make sure that the organisations we use to provide care are delivering the right care. The West Norfolk Executive Forum is the group leading the redesign of services to ensure that the future of services in West Norfolk is protected.
Stop A&E being overloaded via better out of hours support for dementia and mental health support.

Professor Paul Jenkins – Secondary Care Doctor – Governing Body:

In my view, there are three things that need to be addressed to improve A&E:

• Demands on the ‘front door’ of hospitals have changed hugely over recent times and it is a state of constant change. Older patients were infrequently seen at the front door of the hospital and patients used to attend hospital for clinical conditions. Nowadays with people living longer, multiple conditions appear and patients have more social needs and the design of A&E services hasn’t changed to keep up with demand.

• In the past, congestion at the front door has been solved by new initiatives, ways of doing things, more staff, but the biggest problem is the inability to move patients through hospital. To sort out issues regarding overloading A&E, there needs to be a whole system approach and improved flow/patient discharge.

• Personnel – there are a lot of initiatives in place for emergency services and in my view, too much attention has been paid to bricks and mortar in the past and there has not been enough recognition of the fact that units only work because of the personnel that support them. There have been many problems faced with training, the demands of modern technology and more and more specialism training. Added to this, the generalist approach to patient care is proving quite difficult. If we really want to make a difference, the patient needs to see the ‘decision maker’ at a very early stage.

I was a clinical academic working for many years in Australia and have often been asked which is better – the Australian system or the NHS. My answer to that is that the NHS is better without any question.

Aren’t there questions about lumping dementia care with Mental Health?

Dr Ian Mack – Clinical Chair, Governing Body – West Norfolk CCG:

It is absolutely true that mental health isn’t the solution for all dementia care. We recognise that there is a whole host of other services that need to be in place to provide the majority of support for patients with dementia. The services provided by the Norfolk & Suffolk Foundation Trust are just the tip of the iceberg and represent a small proportion of the overall care that a number of dementia patients require, so we greatly value the input of all other services providing dementia care. Part of the dementia pathway work that we are currently undertaking is to map the other services that are available.

What controls will be in place to check the care of vulnerable people in their own homes?

Dr Sue Crossman – Chief Officer – West Norfolk CCG:

We can reassure you that there is a lot of work happening around safeguarding – it is a hugely important area. There are already a number of multi-disciplinary teams working across boundaries where staff are able to raise concerns about individuals or organisations where safeguarding issues have been highlighted. This is already well established and works in an integrated way. The concerns are flagged quickly and action plans put in place to deal with the issues.
Does the Out of Hours GP service put pressure on A&E?

In short no. In fact the Out of Hours GP Service has the opposite effect on A&E, relieving pressure when patients inappropriately / unnecessarily attend A&E when they should have attended their own GP practice in hours or the Out Of Hours GP service after 6.30 pm or at weekends and bank holidays. The only time the Out of Hours GP service may place pressure on A&E is when the out of hours clinical team are on a home visits. However with a GP, Emergency Care Practitioner and/or Nurse Practitioner on site this should rarely happen.

The Out of Hours service should be local and under the control of the CCG

When the current Out of Hours/111 contract was awarded, it was for a 3 year term and at the present time, 18 months of the term remains. Until this contract period has ended, it is not possible to renegotiate the Out of Hours/111 service to a local level. Once the negotiations for a new contract begin, the CCG will have the opportunity to feed into the service specification review and procurement process.

Doctors should revert to providing cover at weekends.

When the national General Medical Services contract was offered to GPs in 2004 by the then Government, GPs were offered an opt-out clause for the provision of out of hours cover. They opted to decline with the continuation of 24 hours a day, 7 days a week cover. Since 2004 GPs pay an annual amount for this opt out clause, with this funding going to support the existing Out of Hours/111 contract.

Replace the 111 Service with service from GP Surgery?

The Out of Hours and 111 services are combined within the one contract. The current Out of Hours/111 contract was awarded for a 3 year term and has another 18 months to run. The 111 service succeeds NHS Direct and is a national service that is delivered at a regional level.

What extra resources are GPs given to service/operate CCGs? Is it true that most of the admin support necessary to complete the (delayed) April 2013 contract with the QEH was actually provided by the QEH?

Clinical Commissioning Groups (CCGs) were established under the Health and Social Care Act 2012. In implementing the Act, a maximum cost envelope of £25 per head of population is available nationally to all CCGs for management and support functions. For West Norfolk CCG this equates to £4.08 million (less than 2% of total CCG expenditure), which covers four main areas:

- The cost of the Governing Body (including GP members, who are paid in general to do 1 day per week for the CCG)
- CCG employed staff and infrastructure (e.g. office space)
- Support services provided by Anglia Commissioning Support Unit (CSU)
Clinical engagement (i.e. paying for additional ad-hoc GP time to support the CCG’s commissioning activities. This enables the relevant practice to provide back-fill for the GP’s time so that the core primary care commitment is not compromised).

In relation to the negotiation of the QEH contract for 2013/14, the majority of the administrative support necessary to complete the contract was provided by Anglia CSU (for instance the task of actually completing the lengthy contract documentation). However, all parties involved in the discussions provided a high level of input as necessary, from administrative staff, experienced NHS managers, and clinicians (whose focus was on the quality requirements within the contract).

For clarification, Anglia CSU is the NHS organisation that provides us with commissioning and contracting transactional support, such as processing information and producing contractual documentation.

**Q**

What expertise do GPs have to do this job? Do they buy it in? Who from? How much does it cost?

**A**

The role of GPs is set out within the Health and Social Care Act, which was extensively debated in Parliament before becoming law. This requires all GP practices to be members of a CCG and to be held accountable for the delivery of the statutory responsibilities set out within the Act, and with particular reference to the listed general duties of Clinical Commissioning Groups within the Act.

1. Duty to promote NHS Constitution;
2. Duty as to exercise its functions effectively, efficiently and economically;
3. Duty as to improvement in quality of services;
4. Duty to support NHS England in securing continuous improvement in quality of Primary Medical Services;
5. Duty to reduce inequality;
6. Duty to improve involvement of each patient;
7. Duty as to patient choice;
8. Duty to obtain appropriate advice, particularly for prevention, diagnosis or treatment of illness and protection or improvement of public health;
9. Duty to promote innovation;
10. Duty in respect of research;
11. Duty as to promoting education and training;
12. Duty as to promoting integration.

GPs fulfilling the role of Chair or Chief Office were required to successfully complete a rigorous competency assessment prior to being appointed. Those in more part time roles, including Governing Body membership are provided with professional development training to fulfil the role.

GPs on the CCG work closely with other clinical and managerial colleagues with a range of relevant training and experience to perform these duties. There is therefore constant clinical input to planning and decision-making within the organisation.

Externally, there are regular meetings between GPs on the Governing Body and the Medical Directors and Clinical Directors of the Queen Elizabeth Hospital to discuss clinical issues and collective approaches to improvement. There are regular quality review meetings between all the NHS Providers in West Norfolk and teams from the CCGs which involve GP clinical leads meeting with senior clinicians within the Trusts. Our GP lead on innovation has worked closely with senior clinicians at the QEH to support bids for new IT for the hospital and the West Norfolk health community.

Continued over page...
In terms of the 2013 contract for the Queen Elizabeth Hospital, the Quality Schedule was discussed in detail between CCG Governing Body GPs and senior clinicians at the Hospital. Any costs for clinical or management support are within the cost envelope detailed previously and provided by substantive NHS managers or interim managers under the same terms and conditions that were in use by the PCTs previously.

**Q** CCGs in England have begun implementing new restrictions on referrals to secondary care as they strive to manage their resources amid increasing financial restraints. Some CCGs have tightened thresholds for access to low priority surgery such as hernia and joint problems, while others have introduced new systems to restrict the flow of patients sent to hospital.

**A** West Norfolk CCG has inherited from NHS Norfolk policies relating to procedures of low clinical efficacy from existing evidence bases and works with other Norfolk CCGs to use ‘prior approval’ processes and panels for Individual Funding Requests (IFR) in cases of exceptionality. There have been no changes introduced to the existing thresholds but the policies are reviewed on a rolling basis by public health consultants. Any review of the evidence base and subsequently of the policies is subject to a Governing Body debate in public.

**Q** This year the CCG is spending less on buying operating resources than was allocated last year to the QEH. Is this rationing patients’ access to hospital for non-urgent operations at a time of growing non-static or lessening demand? Press reports recently about 11% of CCGs already rationing access to hospital.

**A** The 2013/14 contract between the CCG and the QEH is based on the same level of activity as was provided by the Trust in 2012/13. The price paid for this activity is slightly lower than it was in 2012/13 due to the impact of nationally determined price changes for acute care, which expect acute hospitals to deliver efficiency savings year on year (i.e. to deliver the same amount of work at a lower cost). The CCG has therefore not reduced the volume of work that it is seeking to commission from the QEH. Equally it has not increased the volume of non-urgent work commissioned, as the QEH was performing well last year in terms of meeting waiting times for planned surgery, and there was no evidence of increased demand for 2013/14. Furthermore, the CCG is closely monitoring waiting times for planned surgery in 2013/14 and is requiring the QEH to increase activity in certain specialties where work is currently being delivered below the planned levels.

**Q** The CCG is responsible for buying operating time from the QEH – where do they get the expertise?

**A** The CCG does not buy operating time from the QEH as such, but rather buys hospital “spells”, which often include an operation. Increasingly data is available on outcomes and complications from surgical procedures and is published by NHS England, and is available to the CCG. This is reviewed by experienced GPs and nurses via the CCG’s Clinical Quality and Patient Safety Committee. The CCG also works closely with public health to look at health outcomes data. The new inspection teams announced by the Medical Director of NHS England, Sir Bruce Keogh, will also be inspecting operation data and capacity as part of their review processes and this data will be available to the CCG and the public.
When the QEH was built in the 1980s it was estimated to have a 30 year life span and capacity for A&E was designed for a maximum through-flow of 17,000. It is now seeing 70,000 – what is the CCG doing about this?

The QEH building was a ‘Best Buy’ design and several other hospitals in the region have maintained and developed the same design to be fit for purpose today. Each hospital has a capital investment programme with a scheme of work to maintain the fabric of the premises. Where additional capacity or new design is proposed, the trust would develop a business case to put to NHS England.

Issues around Urgent Care are the subject of close working between the CCG and all NHS Providers in West Norfolk. An Urgent Care Board has been established where senior clinicians and managers work together to improve all aspects of urgent care, including Accident & Emergency (A&E). Last year, attendances at QEH were around 55,000 and this has remained ‘flat’ this year to date.

Recently a bid was made jointly by West Norfolk CCG and the Queen Elizabeth Hospital for additional monies to improve Urgent Care over this winter. This bid was successful and £3.9 million was awarded. A proportion of this will be used to improve facilities and staffing in A&E. Further work between the CCG and Queen Elizabeth Hospital will focus on longer-term plans for urgent and emergency care facilities.

However, it should be noted that the CCG’s role is to commission the right level of care for its population in the right places to the right level of quality. It is up to NHS Trusts and Foundation Trusts (such as the QEH) to provide the physical infrastructure to deliver the commissioned services.

How can we improve response rates for Occupational Therapy and Speech Therapy?

It has proved extremely challenging for providers to recruit Occupational Therapists and Speech Therapists in the West Norfolk locality. The CCG is working with providers to assist with the recruitment process and through the service specification and contract negotiation process, continues to insist on improved response and waiting times for both services.

Which private providers has the CCG got contracts with? Will patients still have the choice as to who their provider is?

The CCG has a number of private provider contracts ranging from BMI and Spire to physiotherapy in the community. One of the main objects when using private providers is for the CCG to ensure that the patient remains at the centre of the decision making process and that patient choice is maintained.

Why not use the voluntary organisations more - for more ‘hands-on’

The CCG actively encourages all providers to engage with and involve voluntary organisations and volunteers in the provision of services in the community. The CCG wholly approves the use of voluntary organisations in the provision of local community services.
Regarding the Pioneer Programme Principles – how will the CCG check this is happening and how frequently will you hold local meetings?

The drive towards care being better co-ordinated around the individual will underpin all the work of the CCG and will be a feature in all public meetings.

If Adult Services are cutting staff, how will they be able to ‘share’ in the joint work with health?

The cut in funding for adult social care services will present a challenge. However, it will also serve to emphasise the importance of better integrated working in order to mitigate any possible impact of these cuts on people receiving services. In this respect, Adult Social Care is more, not less, committed to joint working.

How will you increase the proportion of healthcare provided in the community rather than in hospitals?

We know that a proportion of patients who currently attend Accident & Emergency – some of whom are admitted – could be treated equally as well in the community and we plan to increase the availability of community treatment options to help facilitate this. We are already engaging with our community and primary healthcare providers to increase the range of treatments that can safely be delivered in the community. This work also involves making sure that even where a stay in hospital is necessary, the patient is discharged as early as possible to be cared for back in their own home/community.
West Norfolk Clinical Commissioning Group

Appendix 5

31 July 2013
West Norfolk Professional Development Centre, King’s Lynn
Panel Session: Questions & Answers
What is meant by quality?

Louise Stevens – Quality Improvement Lead – West Norfolk CCG:

We summarise quality as the patient's experience of a service, clinical effectiveness and patient safety – so a whole range of things which are measured in lots of different ways all the time. We are constantly looking at the data that is available to us – nationally (for example the Mid-Staffs (Francis) Report) – and question whether any of the elements of the report apply to us. We reflect on the findings and the Queen Elizabeth Hospital does the same. We look at the data from local reports and the reports and data from each of the trusts we commission services from. We don’t take on any of the data at face value – we investigate further, get more information and drill down. The information we gather includes patient surveys and the results of the Friends and Family Test, as well as incident reports and serious events. We aim to understand the strengths and weaknesses of all organisations and work with them to make improvements, including producing Action Plans if needed. Quality is a lot of things – and is on-going all the time. All organisations can improve.

Q

i) What does the CCG spend on commissioning the voluntary sector in West Norfolk?

ii) Who negotiates the contracts with Providers and what qualifications are required?

Dr Sue Crossman – Chief Officer – West Norfolk CCG:

i) The current spend on voluntary sector contracts is £700,000. This is being reviewed and Roger Hadingham, our Head of Integrated Commissioning is leading on the review of the contracts.

ii) There is a team of people who negotiate the contracts both for the commissioners and the providers. Both commissioners and providers are involved in the discussions about what our commissioning intentions are for a large part of the year and these are then developed into robust contracts. This team includes experts in the gathering of information – for example a Business Intelligence and Data Analyst, financial experts and senior directors in each organisation. Quality Leads are also essential in the contract negotiation phase. A range of qualifications will be required for each functional role and we have a very collaborative approach to the negotiation process.
**Q** How much does this team cost? It sounds expensive.

**A** Dr Sue Crossman – Chief Officer – West Norfolk CCG:
These posts are essential posts and are part of the CCG staff. They are required for managing the contracting elements throughout the year. Each organisation will be able to breakdown the costs individually. As a CCG we are working with a small team and our running costs are transparent. The staffing figures go to public Governing body for discussion and are open to scrutiny. The staffing costs for the NHS have been reduced by 50% over the recent period.

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**Q** What incentives are there for small business to enable a growing economy?

**A** Dr Lucy McLeod – Acting Director of Public Health – Norfolk County Council:
At the moment, Public Health is offering support to small and medium businesses to improve the health of their workforce. National statistics indicate that male routine and manual workers (i.e. shift workers, self-employed) tend to die earlier than the average — so Public Health are trying to get workplace health support into businesses – which will have both a business and economic benefit. This will also help to reduce gaps in inequality. There is also an on-going debate about how people can be supported to stay in work if they are or have been unwell — using the ‘fit note’ system rather than the traditional ‘sick-note’ system. This is seen by examples of chronically long-term incapacity benefit claimants who have left work for one reason but because they have been out of work for so long and are struggling to get back into work, they begin to claim for benefits on mental health grounds.

**A** Ian Burbidge – Policy & Planning Manager - Borough Council of King’s Lynn & West Norfolk:
The Borough Council’s “Do Something Different Programme“ helps to address issues around employee health and wellbeing and is available for organisations to buy into. The Borough Council also has information available on its website which details a plethora of support organisations which are available to help. The Borough Council’s Economic Development team lead on this. Information can be found on the Borough Council’s website at [www.west-norfolk.gov.uk](http://www.west-norfolk.gov.uk).

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**Q**

i) Regarding Mental Health – 24/7 crisis support – What is provided now and how do people know who to contact in a crisis – not 999?

ii) What is being done to address Wellbeing service?

**A** Dr Mark Funnell – Governing Body GP – West Norfolk CCG:

i) There is a Crisis Team Helpline which is provided by Mental Health services. All GPs should have a note of it and the Hospital should also know. This is now a 24 hour service.

ii) The waiting times for the Wellbeing service are long. The Wellbeing Service is a primary care mental health service — your GP will refer you into the service if you need that initial level of input. It offers interventions such as Cognitive Behavioural Therapy (CBT) etc and depression is the most common condition for which patients are referred. The Governing Body answers to all GPs in the West Norfolk area and the feedback from our GPs is that there are very long waits for the service. Patients who require the ‘basic level’ interventions (i.e. individual/group therapy) are generally seen within 6-8 weeks of the initial contact. Patients requiring the higher level of input seem to wait the longest time. This issue has been raised at the Quality Meetings held with Mental Health Team and although the issue has yet to be sorted, it is very high on the CCG’s agenda.
With regard to referrals that are made to the Access and Assessment Team (AAT) - I have huge concerns about the readmission of patients into the mental health services. I feel they are falling between the gaps.

Dr Mark Funnell – Governing Body GP – West Norfolk CCG:

Patients presenting with the most serious illnesses are seen by the AAT. GP referrals generally go to the Wellbeing Service. Patients are encouraged to self-refer – and information about how to do that is available on the www.readytochange.org.uk website.

You’ve mentioned self-referral – it has been said that when people self-refer, they are often the most ill people of all. If people don’t have access to the internet and they want to self-refer, how do they do it? I have heard of patients who were given the 0345 number and were then directed to the A&E or to dial 999 – and that has an impact on hospitals and the misuse of A&E which must be a worry?

Dr Mark Funnell – Governing Body GP – West Norfolk CCG:

As a GP, I hand out leaflets – which lists the options for post, telephone or online self-referral routes. The most seriously ill would be contacting the emergency assessment team, which would involve social workers. GPs are happy to refer patients, but we also encourage them to self-refer if they want to.

Dr Ian Mack – Clinical Chair, Governing Body – West Norfolk CCG:

Issues around the Norfolk & Suffolk Foundation Trust (NSFT) are also on the CCG’s Risk Registers which are discussed at the Governing Body meetings. This ensures that we are constantly given assurances about the processes.

How many people self-refer?

Dr Ian Mack – Clinical Chair, Governing Body – West Norfolk CCG:

We have told the NSFT that we need more meaningful data from them regarding referrals. Self-referral is often the best thing for patients, but it doesn’t work for everyone. The Governing body looks at the data and considers this along with the anecdotal evidence from people who have experience of the service.

There are very significant issues with the Crisis Service. Not everyone who answers the phone will be fully trained. People with severe mental health issues will get worse and there is currently a period of consultation with the community teams which will mean there will be fewer staff.

Dr Mark Funnell – Governing Body GP – West Norfolk CCG:

As GPs we are concerned about the mental health services locally and we are not prepared to let things go. The process has just begun.
Data is available regarding the counselling element of the wellbeing service and recovery rates. The West has the highest performing organisation in the county. People with long-term mental health problems tend to die 20 years earlier than the average and they tend to have a number of issues making them the most vulnerable patients who are the most expensive to treat.

Louise Stevens – Quality Improvement Lead - West Norfolk CCG:
From a quality perspective, we are trying to put in robust systems to capture patient feedback. The Quality Incident Reporting (QIR) forms give GPs the opportunity to feedback to the CCG what isn’t working so we can measure the trends and this gives us the evidence to back up courses of action.

I sit on the Clinical Quality Review Meeting (CQRM) and I do recognise that improvements are being made.

We need to assess people who are not engaged with health services.

What responsibility does the CCG have for identifying infrastructure provisions and requirements, in particular the core strategy for housing?

Ian Burbidge – Policy & Planning Manager, Borough Council of King’s Lynn & West Norfolk:
The Local Development Framework is a suite of documents setting out development in the Borough. Partnership networks look at the implications for a wider delivery of services. There is an initial meeting for this in August. We need to be building communities, not just houses and we need to ensure that take account of all the infrastructure that is required, including housing, housing with care, health, etc.

There has been no mention of Healthwatch. How do we intend to work with Healthwatch now that it seems to be functioning?

Dr Sue Crossman – Chief Officer – West Norfolk CCG:
There has been a bit of a hiatus in the transition between LINk and Healthwatch. We will be working with them to ensure that the engagement we have together is meaningful and not tokenistic representation. We are talking to them about the best way to achieve this meaningful engagement. Currently the Healthwatch structure has five leads which have specialist areas giving them county-wide responsibility. Healthwatch has a seat on the Norfolk Health & Wellbeing Board which is a vital role because it gives them the opportunity to scrutinise and challenge the action taken by the health organisations, but it is important that they remain detached from the CCG.

Can we stop using the word ‘elderly’ – it is always pejorative and never positive. Please use ‘Older People’.

The important of prevention – osteoporosis awareness and the falls programme. How much notice is taken of this?

Dr Mark Funnell – Governing Body GP – West Norfolk CCG:
Falls and osteoporosis have been an issue in West Norfolk for long time and it remains an ongoing priority for us. The Falls Service started in West Norfolk and it was then ‘generalised’ to become a central Norfolk service. About 18 months ago we commissioned a mobile DEXA scanner which is very well received by patients. It is supported by a specialist nurse and and visits three locations across West Norfolk - Docking, Swaffham and St James Clinic, King’s Lynn.
What is being done to ensure there is support for people with dementia in the locality, such as ‘day’ support as there is very little or none at present?

Dr Ian Mack – Clinical Chair, Governing Body – West Norfolk CCG:
We had a dementia conference in April, from which two work streams were developed to look at specific issues around support for carers and support for healthcare professionals and which have been advising on the best ratio of community care/the voluntary sector. The discussions from the work streams are being pulled together into an action plan which will be discussed at a follow-up dementia workshop on 17 September 2013 with a view to modifying the pathway from next April.

The following questions have been answered since the event:

Less admissions to acute care = better community care in mental health?

NSFT have put more resources into the Crisis Resolution and Home Treatment Team which ought to assist with less admissions to acute care. When developing new services and reviewing current services, WNCCG will always consider the most appropriate place for care to be delivered and endeavour to reduce unnecessary and inappropriate admissions to acute care.

There needs to be greater integration between physical and mental health services – there is a lack of holistic care.

WNCCG is supportive of integration of services in order to provide holistic care and will encourage such an approach in its planning for all services.

How do you see the CCG engaging with the Recovery Colleges set to commence in September within the NSFT?

WNCCG has a MH Conference planned for 2nd April 2014 and the key note speaker is Lynn Skipper from NSFT who is leading on and responsible for the dissemination of information relating to the Recovery Colleges. WNCCG consider the recovery colleges to be an important aspect of Mental Health services.
Appendix 6

9 August 2013
Le Strange Arms Hotel
Hunstanton
Panel Session:
Questions & Answers
How do we communicate with the CCG?

Dr Sue Crossman – Chief Officer - West Norfolk CCG:

There are a number of ways people can communicate with the CCG. These Stakeholder Events are held around the patch annually, our governing body meetings are held in public, we have a contact email address (contact.wnccg@nhs.net), through the ‘Contact Us’ pages on the website (www.westnorfolkccg.nhs.uk). Through your GP – issues raised at your GP practice are fed back through the Council of Members. Through the Patient Participation Groups at your local surgeries. We have events and meetings for specific pathways and services which will be advertised on our website and in the local press. We have recently set-up a Community Involvement Panel and there is a complaints process.

People wonder who they can direct a query to at the CCG?

Dr Sue Crossman – Chief Officer - West Norfolk CCG:

The messages in our ‘contact’ email address are read daily and any queries are forwarded on to the most appropriate person for action. If people want to write to a named individual, I would be the best person, as Chief Officer of the CCG.

How do you expect surgeries to integrate with Patient Groups?

Dr Tony Burgess – Deputy Clinical Chair, Governing Body – West Norfolk CCG:

GPs are all members of the CCG. We have regular meetings with representatives of the practices to discuss issues and have conversations about performance and quality etc. The arrangements for Patient Participation Groups (PPGs) are encouraged by contractual arrangements but how they work is left largely to the way practices want them to be. Initially PPGs were very much about fundraising etc, but now they are far more challenging. As GPs get more used to having the patients’ voice, they will get more used to listening and responding to them. There are a number of practices which haven’t had PPGs for long and for them, it is a bit of a journey.

In West Norfolk there is also a Patient Partnership where representatives from the PPGs meet together and discuss common issues and support each other in developing.
What process with the CCG use to ensure new (LDF) residential plans are capable of supporting the health needs of the community?

Ian Burbidge - Policy & Planning Manager, Borough Council of King’s Lynn & West Norfolk:

The Local Development Framework (LDF) has recently gone out to consultation, with consultation events taking place in various towns and villages (details on the council website). The consultation event in Hunstanton is taking place on 12 August in the Town Hall. At this meeting, the wider effect on services will also be discussed. This process also includes a presentation to a strategic group of senior public sector leaders – asking the question how can population growth be better planned for and what this would mean for the local communities.

Do you have any figures to show that more people are dying at home as a result of the Hospice at Home service? How is success measured and what is the success?

Dr Sue Crossman – Chief Officer - West Norfolk CCG:

This was one of our priorities this year and one of our Integrated Commissioning Managers is overseeing the project and collecting the available data so we can review the service regularly. Patients are generally stating a preference to die at home. We will have comparative date later this year.

What process with the CCG use to ensure new (LDF) residential plans are capable of supporting the health needs of the community?

Ian Burbidge - Policy & Planning Manager, Borough Council of King’s Lynn & West Norfolk:

Re: The Directory – how are you collating information and from where to ensure it is up to date? How will you promote it and how will you monitor its success?

Ian Burbidge - Policy & Planning Manager, Borough Council of King’s Lynn & West Norfolk:

We have employed a project officer to pull the information together and they will be working closely with the Council’s call centre staff. All the information will be put into a database and the Project Officer will then engage with a whole range of people to ensure the database is accurate. Keeping the information up to date will be tricky but having a dedicated project officer will help. The new directory will be fully marketed and promoted when it’s ready to go live – along with the relevant phone numbers etc. Monitoring the success of the directory is a good question – providing and tracking the information will help us to see what needs are out there and what the gaps in services are, and whether the services are being used.
In an integrated service, how is budgeted allocation managed?

Dr Sue Crossman – Chief Officer, West Norfolk CCG:
Part of the work of the West Norfolk Executive Forum is to develop an alliance for West Norfolk. We will be looking at how individual organisations almost ‘suspend’ their organisational identity and accept that they are part of an alliance that has its own identity. Elements of each organisation’s budgets will be pooled, giving the alliance a budget with which to work. Governance arrangements for the sharing of funds are in place which each organisation has signed up to. This is an ambitious approach, but something we are pushing for. The success of integration depends partly on the recognition of a collective identity.

High levels of smoking/alcohol consumption/obesity are key factors that highlight poverty and deprivation. What considerations are the CCG giving to wider partnership working to address these issues? The CCG can’t do it alone!

Dr Sue Crossman – Chief Officer - West Norfolk CCG:
We have some really good local groups working already. The Public Health forum meets regularly to talk about demographic change and health needs and looks at prevention programmes, CAIs, smoking cessation, etc and a key part of the approach is to involve partner agencies to make the services as effective as possible. The Borough Council and County Council have strong connections with prevention programmes, including ‘Prevention First’.

Sian Kendrick-Jones – Senior Public Health Officer, Norfolk County Council:
West Norfolk CCG is very forward thinking and works closely with public health to look at prevention.

Has the CCG written a plan of where it would like to be in 2020?

Dr Sue Crossman – Chief Officer - West Norfolk CCG:
We have a three year plan, but we are currently working with the West Norfolk Alliance on a very ambitious piece of work to consider what the future looks like. We have to ensure that the local health system is sustainable in the context of the current financial climate, and the difficulties we are facing. Our plan for 2020 is working on a vision together about what West Norfolk services should look like in order to be sustainable. We will need to look at some difficult areas regarding organisations to deliver care and what they look like. By 2020 we aim to have a more sustainable system and processes in place which will make it easier for staff to deliver care without the complications of working across organisations.

2020 is too far away. We need to talk about something radically different in the next two years. To make services viable, we need to do it very much more quickly than 2020.

Dr Sue Crossman – Chief Officer - West Norfolk CCG:
We are already involved in a very time-limited piece of work which will result in us starting to do things differently by the next contracting round, and then to build on that each year. Each organisation is looking at an internal inspection, sharing information and working together to keep things improving.
What is being done to increase support and services for carers so they have the confidence and emotional and physical resilience to continue caring for people with long-term conditions at home for longer? (Tony Burgess said the CCG wants people with long-term conditions to be able to remain at home for longer, but what about the people who will look after them?) NB – Carers here is family carers and also staff in residential care homes.

Dr Tony Burgess – Deputy Clinical Chair, Governing Body – West Norfolk CCG:

If patients end up in hospital, the carers’ experience is usually worse. Carers haven’t been recognised nearly enough. In the last 10 years, recognition of carers has increased and the support has become better. GPs have a better understanding of who the carers are and their needs. Using the community nursing teams and community matrons etc helps to identify the needs of carers and as a result, we are much better at supporting carers than we once were. The same true of social care colleagues. There are also specific organisations to help support carers e.g. Crossroads and West Norfolk Carers. Members of these teams come into GP surgeries to help improve the support for carers.

Dr Pallavi Devulapalli – Governing Body GP – West Norfolk CCG:

There is still work to be done. Carers are not always aware of what support is out there for them and they save the NHS and Social Services an enormous amount of money.

How does the CCG commission services without it becoming ‘patchy’ using the Any Qualified Provider (AQP) model?

Dr Tony Burgess – Deputy Clinical Chair, Governing Body – West Norfolk CCG:

We went outside the traditional commissioning routes when we commissioned the DEXA scanning service in 2011 and described the services we expected to have between providers.

What is the CCG doing to join up planning and services with other CCGs?

Dr Sue Crossman – Chief Officer - West Norfolk CCG:

We work together with the other CCGs in Norfolk as part of a collaborative commissioning group. There are benefits of working together and sharing resources where it makes sense to do so – an example being the Safeguarding Team – and we co-commission services for the community, such as Mental Health services from the Norfolk & Suffolk Foundation Trust. The Chairs and Chief Officers of each CCG meet monthly and the Chief Officers meet together on a fortnightly basis.

There is a gap in service for children with autism (high functioning). What is going to be done about this?

Dr Sue Crossman – Chief Officer - West Norfolk CCG:

This has come to my attention very recently as a particular problem. We have had some letters recently from individuals highlighting some of the issues. I am the Chair of the Norfolk-wide Children and Maternity Services Commissioning Board, so that puts me in a good position to start the debate across the county. The information we’ve been given has highlighted big gaps for children and adults with autism having access to the services they need. This is not just a West Norfolk problem, but Norfolk-wide. This has now been raised at the Board and a talk and finish group has been put in place to look at the specific problems, including the long waiting times and a series of very complicated gateways to access the services. There is a lot of work to be done, but it is now underway.
How will the CCG prevent smaller services that provide services locally becoming unviable if commissioning is undertaken by picking aspects of care and not whole services, leading to local services being provided in more central units – i.e. Norwich?

Dr Sue Crossman – Chief Officer - West Norfolk CCG:

We have demonstrated already that we value every organisation so small charitable organisations have a very valuable role. It is clear to see that they may become vulnerable, so we need to look at the services as a whole, which means asking ourselves why we would be commissioning similar services in three different organisations. If we have duplication, we don’t have a comprehensive overview of what's in the package or recognise where the gaps are. We should be looking at what services we need to provide and who would be the best at providing which element. It’s not about stripping out services, but about being clear about what is required so we can ensure that services are provided in the right place and in the appropriate way.

What is success and how can you measure it?

Professor Paul Jenkins – Secondary Care Doctor, Governing Body – West Norfolk CCG:

There are a number of factors which need to be taken into account, including mortality, effectiveness, quality and morbidity. Success is not killing people, not doing them harm, and dealing with them in an appropriately kind, timely and affective way.

In terms of measuring success – you would think it would be easy to measure against mortality, but that has problems. If you measure against gold standards, there are a number of related factors to take into account, for example, how privileged the community is, the demography, ethnicity, average age. All of these factors create a hospital’s standardised mortality rate. If the Queen Elizabeth Hospital was compared with a similar hospital in terms of size, demography and social standing, you would have a more appropriate measurement benchmark. Effectiveness can be measured by the speed with which patients are moved through the hospital, though the four-hour target tells you nothing about quality.

Louise Stevens – Quality Improvement Lead - West Norfolk CCG:

From the point of view of the Quality Team, we are constantly pulling information from a variety of services. We have to be clear about the data sources and the quality of that data, so we use different measuring tools, like the Quality Incident Reporting forms and patient experience surveys, to pick up trends. We also use the learning from national projects and reports. Although the issues may not be specific to us, we can still learn from them.

The following questions have been answered since the event:

How do you feel about consortium-led commissioning for Ambulance Services?

The CCG does not object to a consortium approach for Ambulance Services once the needs and requirements of the West Norfolk population are met in a timely and clinically safe manner. The CCG meets with the Consortium Lead and the Ambulance service on a regular basis to discuss performance and improvement plans.
You have included the fact that volunteering is lower in West Norfolk than elsewhere. What can we do collectively to increase volunteer participation? Do you know why volunteering is less here than other areas?

There are a number of factors in West Norfolk which contribute to lower volunteering rates, including the geography and rurality of the area and poor transport. It is felt that West Norfolk does have a wealth of informal volunteers and the development of a more comprehensive system for volunteering would be of help.

Is the CCG investigating the benefits of volunteers within health care and the social return on investment?

The CCG proactively encourages all providers to look to and seek out volunteers to support them, where appropriate, in the provision of services. The QEH, Ambulance Service, local Charities, etc. actively use volunteers to assist in the delivery of services.
Appendix 7

List of Attendees
The following list shows the organisations represented at the stakeholder events:

- Representative – Age Concern
- Branch Manager – Alzheimer’s Society, King’s Lynn
- Dementia Advisor – Alzheimer’s Society, King’s Lynn
- Borough Councillor – Borough Council of King’s Lynn & West Norfolk
- Planning Policy Officer – Borough Council of King’s Lynn & West Norfolk
- Chair - Breckland Older People’s Forum
- General Manager – East Anglian Ambulance Services NHS Trust
- Paramedic – East Anglian Ambulance Services NHS Trust
- Representative – First Focus Fakenham
- Representative – First Focus Fakenham
- Representative - Flagship Housing
- Representative – Homestart King’s Lynn & West Norfolk
- Patient/Carer
- Patient/Carer
- Patient/Carer
- Patient/Carer
- Patient/Carer
- Patient/Carer
- Patient/Carer
- Patient/Carer
- Patient/Carer
- Patient/Carer
- Patient Participations Group Representative – Campingland Surgery, Swaffham
- Patient Participation Group Representative – Gayton Road Health Centre
- Patient Participation Group Representative – Gayton Road Health Centre
- Patient Participation Group Representative – Gayton Road Health Centre
- Patient Participation Group Representative – Gayton Road Health Centre/Healthwatch
- Patient Participation Group Representative – Great Massingham & Docking Surgeries
- Patient Participation Group Representative – Heacham Group Practice
- Patient Participation Group Representative – St James Medical Practice/QEH Governor
- Patient Participation Group Representative – The Hollies, Downham Market
- Representative – Labour Party
- Locality Manager - Norfolk Community Health & Care
- Assistant Director, West Locality - Norfolk Community Health & Care
- Chief Executive - Norfolk Community Health & Care
- Community Nurse - Norfolk Community Health & Care
- Diabetes Educator/Practitioner Service Lead - Norfolk Community Health & Care
- Smokefree Norfolk - Norfolk Community Health & Care
- Social Worker – Norfolk County Council – QEH based
- Social Worker – Norfolk County Council – QEH based
Representative - Norfolk Health Overview & Scrutiny Committee
Representative - Norfolk Health Overview & Scrutiny Committee
Representative - Norfolk Healthwatch
Chief Executive – Norfolk Hospice Tapping House
Representative - Norfolk Social Services
Representative – One to One Project
Audiology Services Manager – Queen Elizabeth Hospital NHS Foundation Trust
Chief Executive – Queen Elizabeth Hospital NHS Foundation Trust
Clinical Director & Consultant Anaesthetist – Queen Elizabeth Hospital NHS Foundation Trust
Director of Strategy & Transformation – Queen Elizabeth Hospital NHS Foundation Trust
Dietetics Practitioner – Queen Elizabeth Hospital NHS Foundation Trust
Governor – Queen Elizabeth Hospital NHS Foundation Trust
Governor – Queen Elizabeth Hospital NHS Foundation Trust
Representative – Queen Elizabeth Hospital NHS Foundation Trust
Representative – Queen Elizabeth Hospital NHS Foundation Trust
Representative – Queen Elizabeth Hospital NHS Foundation Trust
Representative – Queen Elizabeth Hospital NHS Foundation Trust
Medical Director – Queen Elizabeth Hospital NHS Foundation Trust
Patient & Public Involvement Lead – Queen Elizabeth Hospital NHS Foundation Trust
Representative – Spice Innovations
Patient/Representative - University of the 3rd Age
Patient/Representative - University of the 3rd Age
Chief Executive – Wells Community Hospital
Executive Manager – West Norfolk Carers
Representative – West Norfolk Carers
Representative – West Norfolk Carers/West Norfolk Community Involvement Panel
Representative – West Norfolk Community Involvement Panel
Chair – West Norfolk Mental Health Service Users Forum/ Community Involvement Panel
Chief Executive – West Norfolk MIND
Representative – West Norfolk National Autistic Society
Chair - West Norfolk Older People's Forum
Representative - West Norfolk Older People's Forum
Representative – West Norfolk Community Transport
Representative – West Norfolk Disability Information Service
Chair – West Norfolk Patient Partnership
Representative - West Norfolk Voluntary Community Action
Representative - West Norfolk Voluntary Community Action
Representative - West Norfolk Voluntary Community Action

If you want to speak to someone or request this document in another format, please call Caroline Howarth on: 01553 666913 or email: caroline.howarth@nhs.net