Suffolk County Council

Agenda Item 7

Health Scrutiny Committee, 19 January 2017

Information Bulletin

The Information Bulletin is a document that is made available to the public with the published agenda papers. It can include update information requested by the Committee as well as information that a service considers should be made known to the Committee.

This Information Bulletin covers the following items:

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1. Frailty Update

Introduction

1.1 This item aims to provide the Committee with an overview of the innovations taking place across the system enabling integrated services between health and social care to support frail elderly individuals and their families living in Suffolk, including those at risk of falling or who have fallen in their home.

1.2 The root of this support is through the Proactive and Reactive Model, which has been built on the Health and Care Review 2014, which sets out the vision for an integrated health and care system to deliver the overarching ambitions of:

- Greater focus on prevention and self-managed care
- Locality place based provision building local resilient communities
- Coordinated holistic physical and mental health and care delivery across primary, community and acute interfaces - irrespective of age or condition.
- High cost interventions replaced with lower cost interventions: moving from a reactive care to proactive care system

1.3 The model has been developed in partnership with our local stakeholders and is seen as a system transformation to deliver integrated community services, bringing health and care services together to provide a single coordinated care response that is underpinned by prevention, self-care, early intervention, reablement and rehabilitation rather than longer term treatment and life-long service dependency.

1.4 Delivery of the model is through thirteen localities, under the banner of “Connect”, based around practice population clusters of circa 50,000.

Proactive Care

1.5 This will see health and care workers supporting work with communities to prevent and highlight areas which might cause falls, such as trip hazards in the home. Specific advice, expertise and specific specialist services will be called upon when they are needed.

Reactive care

1.6 Reactive care is a coordinated, multidisciplinary response for people. Integrated teams deliver rapid response crisis care to people whose condition has become unstable putting them at risk of an emergency admission. This is a short term urgent care intervention to stabilise the individual’s condition before transfer back to Proactive Care or self-care. This service is delivered by the Early Intervention Team (EIT) in the west and the Crisis Action Team (CAT) and Frailty Assessment Base (FAB) in the east.

Connect

1.7 Connect aims to establish a place-based ‘system of care’ in which organisations work together to improve health and care for the populations they serve. It aims to make systems simpler for patients and their carers and develop more resilient local communities through greater integration of care and a focus on improving population health and wellbeing. In west Suffolk the frailty response will be integral to Connect, with teams supporting a joined up response to support frail elderly individuals with complex health and care needs. The initiatives include:

- Implementation of My Care Wishes, which is a record of the person’s health and care management and their preferred place of care. It includes a Personalised Shared Care and Support Plan that outlines specific management of an individual should a crisis situation occur as well as supporting preferred place of care/death.
- Case management and care coordination – recognising that in all in-patient and community settings, individuals will have a point of contact, case manager or care co-ordinator. This individual will be responsible for coordinating care, keeping in touch with the patient and ensuring that the care plan is delivered and reviewed as required.
- Multi-Disciplinary Team meetings/Multi-Disciplinary Review – An interface geriatrician, an older person’s specialist, is assigned to practices within localities to provide expert clinical support and advice.

- An interface geriatrician gives focussed support as an outreach service from the acute hospital. This will take place in the form of 'local clinics' within the localities and some dedicated in-reach support to identified care homes.

1.8 Falls are an indicator of frailty and previous work to support and manage fallers is now incorporated into the frailty model.

Early Intervention Team – West Suffolk

1.9 The Early Intervention Team (EIT) provides a multi-agency response to individuals who become unwell and need to be managed safely in order to remain in their usual place of residence. The team includes Nurses, Therapists, Social Workers, Reablement Carers and Health Care Practitioners.

1.10 The principle aims of the EIT are to reduce avoidable emergency admissions into West Suffolk Hospital through the provision of an integrated and accessible community facing health, social care and voluntary sector urgent care response. In addition, EIT supports the system's response to improved coordination of care for complex frail older people through the identification of patients who repeatedly are seeking or requiring an urgent care response or assessed as vulnerable and high risk of deteriorating or requiring an emergency admission. These patients will be referred for review to a case manager or GP/Interface Geriatrician and managed as part of the frailty pathway, being provided with a personalised care and support plan (My Care Wishes folder).

1.11 EIT provides an integrated urgent reactive care response to patients in their usual place of residence preventing avoidable acute hospital admissions (nursing and care elements of the service are provided on a 24/7 basis). The team works closely with secondary responders such as the Integrated Neighbourhood Team (patients GP, Community Matron, District Nurse, Social Worker), equipment service or Specialist Nurse to support the level of response required and ensure on-going support via the frailty pathway as applicable. Patients requiring additional care support and or intensive monitoring/management are able to be stepped up to community beds or where appropriate EIT have their own Reablement Carers that are able to support patients in their own home for a limited period of time (up to 5 days). EIT will transfer over to proactive care to the Integrated Neighbourhood Team once urgent care crises is resolved for any on-going support/intervention

Crisis Action Team – Ipswich and East Suffolk

1.12 The Crisis Action Team (CAT) initially commenced as a pilot in October 2015 as a 24/7 integrated health, social and voluntary sector service with the prime aim of preventing avoidable acute hospital emergency admissions. The service is hosted by Ipswich Hospital and has a 'no wrong door' approach and endeavours to meet the needs of the person and their carers either through direct provision of care or by ensuring that their needs are met by a more appropriate service.

1.13 The team provide intensive, short term input to stabilise the crisis situation and either support the person back to their normal level of independence within a short time period or by transitioning the person onto longer term services. CAT provides short term reactive interventions in order to resolve crisis situations with a focus on returning people to independence.

1.14 The people being seen by CAT would previously have attended the Emergency Department, Emergency Assessment Units, or had an avoidable emergency admission. This would include people with sub-acute health needs or break down in carer support resulting in a risk to their safety, health and well-being. Close working relationships have been developed with primary care, the ambulance service, and the extended hours primary care hub in order to deliver clear pathways of care and maximise the number of people supported by the service.

1.15 In October 2016, CAT became CAT Plus. As well as admission avoidance, it also facilitates supported discharge from the wards at Ipswich Hospital and acts as a bridging support service. This service is aligned with the Discharge to Assess (D2A) model (currently being piloted).

Frailty Assessment Base – Ipswich and East Suffolk

1.16 The Frailty Assessment Base (FAB) initially commenced as a pilot in October 2015. FAB is a multi-disciplinary, geriatrician led, admission prevention service based within Ipswich Hospital. The service accepts referrals from GPs, community and the hospital Emergency Department with a view to supporting patients to live in their current place of residence where possible, and is accessed via the geriatrician hotline or email. FAB can provide either advice or same day assessment, but they guarantee a 48 hour response to email referrals.

1.17 The key intervention is providing rapid access to a Comprehensive Geriatric Assessment via a multi-disciplinary team. The component parts of the multi-disciplinary team are geriatrician, specialist nurse, specialist occupational therapist, specialist physiotherapist, dietitian, specialist pharmacist (as appropriate).

1.18 To empower the patients to better manage their ongoing health and reduce the risk of further emergency admissions / interventions, each patient is given a copy of a Shared Care and Support Plan upon discharge. This is also sent to the referrer and other parties involved in their care. This is intended to support people to remain stable and to reside in their normal place of residence.

1.19 Similarly to CAT Plus, FAB is also aligned with the Discharge to Assess (D2A) model (currently being piloted) which supports people to remain at home. FAB and CAT Plus will work in partnership on occasion ensuring that they tailor services to an individual's needs.

For further information please contact: Dawn Barrick, Senior Clinical Transformation Lead, Service Redesign, West Suffolk Clinical Commissioning Group and Ipswich and East Suffolk Clinical Commissioning Group; Email: dawn.barrick-cook@westsuffolkccg.nhs.uk.

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2. An update on the integration of eye services in Suffolk

Background

2.1 Over the last ten years, the Department of Health has increasingly encouraged the delivery of more routine and minor emergency eye care outside hospital in community optical practices. National guidelines for the management of

glaucoma published in 2009 by the National Institute for Health and Clinical Excellence (NICE) identified the increasing pressures on secondary eye care services. There is also evidence that, with the right safeguards, many ophthalmology services, traditionally referred to secondary care for monitoring and treatment, can now be performed safely and effectively by specialist optometrists in community settings. Around the UK, community optical practices are successfully and safely delivering local enhanced services in primary care with high levels of patient satisfaction as part of local integrated pathways linking into secondary care as appropriate

2.2 Over recent years, commissioners, hospitals and the public have worked together to improve services for those who need eye care. It has been:

- the first county to implement direct referral from optometrist to hospital
- the first area to test a single point of access referral platform on behalf of Local Optometric Committee Support Unit (LOCSU), a national body that supports Local Optical Committees (LOCs) across England, in developing local eye health services and community optometrists and opticians' work with local commissioners to make community eye services accessible for patients and cost effective for the NHS. This includes policy and direction of service development.
- New Community Glaucoma – I-Van services have been cited in the Dalton Review, NICE Quality Care Study, HSJ shortlisting and BMJ, highly commended award. .
- Consultant-led Community Clinics for Ophthalmology, commenced as a pilot starting in September 2015. This is currently being evaluated but indications show that we are reducing the need for patients to go to hospital.

2.3 By 2021 it is estimated that 24.5% of residents in Suffolk will be aged 65 and over. There are rising numbers of people being diagnosed with diabetes. Therefore, there will be an increase in those people who will require treatment for Age-related Macular Degeneration (AMD), cataracts, glaucoma and diabetes eye checks.

2.4 This means further changes need to happen to eye services.

2.5 Financial allocations have now been set for the next five years and budgets are remaining fairly static, which means there is no extra money which can be put into services without losses elsewhere. We do know that there are some further opportunities to be made in hospital follow-up services and this will be the focus for 2017/18.

Engagement

2.6 Building on the work to meet national guidelines to support rising numbers of people who have clinical problems with their eyes, the CCGs have also for the past year been seeking opinions from the Suffolk population on the existing Ophthalmology Service.

2.7 The themes from the feedback collected – through online and face to face methods – have found that most people were largely happy with the care, but had issues - predominantly in the east service - with long waiting times, cramped conditions in the clinics and parking shortages and costs.

Service Proposal

2.8 In the Autumn 2015 we informed Health Scrutiny Committee members of our proposals to redesign the eye-services as a whole. Using patient feedback, along with the NICE guidelines on eye care, a new model for delivering a truly Integrated Eye Service was submitted, with the aims of improving services in the community and in the hospital.

2.9 A multi-disciplinary clinical transformation group (CTG) developed a framework for a new service model in line with national clinical evidence. The new model of care consists of a six tiered arrangement:

1. The first tier is associated with primary prevention and self-care
2. The second tier is associated with interventions delivered by GPs, optometrists, opticians, pharmacists, school nurses and health visitors
3. The third tier is for specialist community based services delivered by ESPs and underpinned by a community consultant
4. Tier four will take all of the services that need to see an ophthalmologist but do not need the infrastructure of the hospital/eye unit
5. Tier five is the complex cases that need increased infrastructure to support their delivery.
6. Tier six remains as specialised commissioning eye care.

Update

2.10 Our original intention was to go out for procurement for a complete integrated eye services model. However due to changes in the contracting framework between Ipswich and East Suffolk Clinical Commissioning Group and Ipswich Hospital we have joined together in a contracting alliance to transform the eye services in line with our developed model for integrated care.

Next steps

2.11 The key next steps are to further the service integration and transformation to continue;

- to work with partners to move towards integration of eye services;
- to maintain current services provided by private providers to allow for safe transition of integration;
- to develop a service specification and business case to support the implementation and sustainability of the model of care;
- to develop changes in hospital base pathways and protocols to accommodate service change and delivery;
- to undertake a gap analysis on staff and equipment resource needs;
- to operationalise the integration of community and acute services in:
    - dedicated clinics set up to provide eye care services in the community and, with the Local Optical Committee, implement training and education to support wider enhanced services provided by community optometrists to identify services unable to be delivered by current providers;

- to add partner(s) via procurement to complete service delivery;
- to formalise a contractual alliance between all partners for delivery with shared values;
- to deliver all eye-care services on a programme budget approach for a longer contractual period (at least five years).

For further information please contact: Karen Dowsing, Redesign Project Manager, Planned Care, Ipswich and East Suffolk CCG, Email: Karen.dowsing@ipswichandeastsuffolkccg.nhs.uk; or Nerinda Evans Clinical Commissioning Manager Planned Care / Cancer / End of Life, Ipswich and East Suffolk CCG, Email: Nerinda.evans@ipswichandeastsuffolkccg.nhs.uk

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3. The eyes have it *(Press Release October 2016)*

3.1 An east Suffolk mobile NHS health service which provides care closer to home for elderly patients with poor vision has been awarded another prestigious accolade.

3.2 The community glaucoma I-van has won the Royal College of GPs East Anglia Faculty Clinical Quality Innovation Award 2016. This award is recognition of the how the I-van has transformed glaucoma services for elderly people in the area, reducing the need for multiple appointments and long journeys to hospital for routine reviews and check-ups.

3.3 The service is commissioned by NHS Ipswich and East Suffolk Clinical Commissioning Group (IESCCG) and delivered by eye health specialist Newmedica.

3.4 Dr John Havard, a GP in Saxmundham and a leading healthcare innovator said: “The I-van service started operating in 2013, although I first had the idea around 10 years previously. Around 4000 elderly people living with glaucoma need an annual review of their condition, yet for many of those people with poor vision it was difficult and stressful to attend hospital, sometimes needing more than one appointment.

3.5 “The I-van means they can get the care they need closer to home without the struggle or stress, being based in Ipswich and travelling to towns and villages within a 25-mile radius. This is also a great help to carers and family members who can find it difficult to take time off work to take a family member to a hospital appointment. The I-van carries all the equipment needed to review a patient’s glaucoma in one appointment lasting no more than one hour.

3.6 “The I-van has transformed glaucoma care in east Suffolk and it’s tremendously pleasing to have this acknowledgement by GPs from across East Anglia."

3.7 Nerinda Evans, associate director of redesign for IESCCG, who led the commissioning of this project said: “The I-van was one of the first services commissioned by the newly established clinical commissioning group for east Suffolk, and is a really good example of how local health services have improved over the last few years.

3.8 “Because access has been made more convenient, fewer patients are missing appointments, meaning they have the reassurance their glaucoma is stable or they can more easily access the healthcare support they need to manage their condition. This is the only community glaucoma service in the country where every patient decision made by optometrist is remotely reviewed by a consultant ophthalmologist, ensuring the very best of care.”

3.9 The success of the I-van in east Suffolk has led to the development of local eye care services by NHS West Suffolk Clinical Commissioning Group, with community glaucoma services now available across west Suffolk.

3.10 Emma Wilden, Community Glaucoma Service Manager said, “After running community services in the eastern and western areas of Suffolk for over three years from the I-van, we are absolutely delighted to have been recognised in this way. We are very pleased to show how co-operation between clinicians across the community can deliver the best care for patients.”

3.11 Dr Kate Wishart, Provost of the Royal College of General Practitioners East Anglia Faculty "We are always amazed at how general practice teams go the extra mile to provide excellent, safe, high quality care to their patients. The level of effort and ingenuity shown by all those nominated is truly impressive, and highlights how delivering great care relies on great team work - doctors, nurses, practice managers and their practice support staff.

3.12 "The I-van was the outstanding nomination in a highly competitive category, and I would like to congratulate all of those involved.”

3.13 The service has already been highly commended by the British Medical Journal Awards 2015 and recognised with a HSJ Value in Healthcare Award in 2015.

3.14 The service in the west is co-commissioned by WSCCG and West Suffolk NHS Foundation Trust.

3.15 The I-van currently visits Felixstowe, Leiston, Stowmarket, Sudbury and Bury St Edmunds.

3.16 http://www.ipswichandeastsuffolkccg.nhs.uk/Newsevents/News.aspx

For further information, please contact Isabel Cockayne, Head of Communications, West Suffolk Clinical Commissioning Group, Ipswich and East Suffolk Clinical Commissioning Group; Email: isabel.cockayne@suffolk.nhs.uk; Tel: 01473 770012

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4. Norfolk and Suffolk NHS Foundation Trust update from CQC Inspection

4.1 The Committee requested a formal update following the CQC inspection for Norfolk and Suffolk NHS Foundation Trust in July 2016.

4.2 The Trust was inspected by the CQC over a two week period in July 2016. The inspection followed an earlier inspection in 2014 which resulted in the Trust being rated as inadequate and placed in special measures.

4.3 Following the initial report, a project management team was put in place to oversee a quality improvement plan for the Trust in response to the CQC feedback. This process managed Trust-wide improvement schemes whilst improvements related to business as usual were monitored via a quality dashboard.

4.4 As required by the CQC inspection model, the Trust received support from an improvement director and a 'buddy trust' in this case, Nottinghamshire Mental Health Foundation Trust.

4.5 The table below shows the initial ratings from the CQC and the subsequent ratings achieved in 2016. The 2016 ratings include ratings achieved by the substance misuse service provided in Norfolk which was not inspected in 2014 and includes a separate inspection of the Suffolk Rehabilitation and Recovery Service which was inspected as part of the acute ward service line in 2014.

	2014	**2016**
Trust wide rating	Inadequate	Requires improvement
Safe	Inadequate	Inadequate
Effective	Requires improvement	Requires improvement
Caring	Good	Good
Responsive	Requires improvement	Requires improvement
Well led	Inadequate	Requires improvement

4.6 The Trust overall rating in 2016 is now 'requires improvement' and the Trust has been removed from special measures. An updated action plan, again based on the CQC feedback, is now in place which is reported on monthly to the Trust Board and supported by team level plans to ensure that all staff are engaged in the improvements required.

4.7 With particular regard to the safe domain, many of the issues relate to the estate and a comprehensive work plan is in place.

4.8 Staffing issues are being addressed through a number of innovative schemes as well as ensuring safe staffing numbers.

For further information please contact: Sue Barrett, Head of Governance, NSFT; Telephone: 01603 421538.

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5. Ipswich and East Suffolk CCG and West Suffolk CCG – Update on Financial Position

5.1 The Committee will remember that this year the CCGs have been working very hard to make sure they were not going to overspend the budgets during 2016/17. As reported to the Committee, this was a particularly pressing concern in July 2016 and we worked very hard to change this.

5.2 The CCGs both still face challenges - both before the end of the year, and in future years. Month 8 figures show we have a small surplus of £500,000 for Ipswich and East Suffolk CCG (overall budget £468.6m) and a deficit of £1.6m in West Suffolk CCG (overall budget £298.5m). Business rules are such that the CCGs should be producing a 1% surplus to pay back into the local NHS services during the future year.

5.3 The CCGs are focusing even harder on driving out waste and duplication in the last few months of 2016/17 as this is still a challenging situation.

5.4 Next year NHS England has indicated that our allocation will be lower than we expected. The CCGs have new contracts with our providers, which will see two year guaranteed income arrangements which is likely to support the CCGs in the medium term, but there is still much to do for the long term.

For further information, please contact Isabel Cockayne, Head of Communications, West Suffolk Clinical Commissioning Group, Ipswich and East Suffolk Clinical Commissioning Group; Email: isabel.cockayne@suffolk.nhs.uk; Tel: 01473 770012

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6. Hopton and Stanton Surgeries - Update on behalf of NHS England and West Suffolk CCG

6.1 Doctors from the Hopton and Stanton surgeries, patients and councillors from the area and representatives from NHS England and West Suffolk Clinical Commissioning Group reported to the last Health Scrutiny Committee about changes which have taken place during 2016.

6.2 Recommendations were made and this is a brief update on those actions for the practice, the CCG and NHS England.

6.3 NHS England has been invited to provide a presentation on planning and funding of infrastructure for primary care services at a future Health Scrutiny Committee meeting.

6.4 The GP pack has now been developed with local case studies, with the help of Healthwatch Suffolk and Suffolk Local Medical Committee. The draft has been shared with the chairman and vice chairman of the Health Scrutiny Committee. Healthwatch has kindly offered to design this and it will be sent out locally, then to NHS England for onward distribution in January 2017.

6.5 The engagement event reports and feedback are available on the 'News' section of the Stanton Surgery website: www.stantonsurgery.co.uk, along with the premises options appraisal report that was conducted earlier this year which demonstrates the viability of the options available.

6.6 The practice has been running a prescription delivery (and pick up point) service since 28 November. Patients are being encouraged to contact the Dispensary staff for more details if they would like to know more about the service.

6.7 A named GP partner, Dr Lucy Ross, will be attending the next Hopton Surgery Community Action Group meeting to facilitate a better working relationship. There is also a Patient Participation Group (PPG) meeting at the end of January. Details will soon be circulated to patients. The intention is that the PPG will retain its virtual entity as well as having regular face-to-face meetings for those members who wish to attend.

6.8 The partners are aware that a new-build surgery is not likely to become a reality quickly, so while funding options are explored, interim provisions will need to be made to ensure continued services in the short-mid term.

6.9 The practice will be making use of spare capacity at Stanton Community Health Centre, which is opposite Stanton Surgery, for both clinical and administrative purposes. We will be also making some internal changes to the Stanton Surgery building during January 2017. A new consulting room will be created by converting office space. This is planned to be completed by the end of January at which point the remaining services at Hopton Surgery will transfer to Stanton. The practice will circulate these details to patients and all its other stakeholders.

For further information please contact: Lois Wreathall, Head of Primary Care for West Suffolk CCG, Email: Lois.Wreathall@westsuffolkccg.nhs.uk ; Rob Freeman, Practice Manager at Hopton and Stanton surgeries or Stuart Quinton, at NHS England; Email: stuartquinton@nhs.net .

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7. Norfolk and Suffolk NHS Foundation Trust - Update on the Primary Learning Disability Liaison Nurses Evaluation

7.1 As a population, people with learning disabilities face considerable health inequalities. This information bulletin provides an update on a year long pilot project which has involved Learning Disability Nurses working alongside primary care colleagues to facilitate people with learning disabilities to access the health services they need. The information below provides details following the recent evaluation of this project.

7.2 The aim of the evaluation, undertaken by Suffolk Public Health, was to establish whether the Primary Learning Disability Liaison Nurse Service has had an impact on its stated goals including:

- improved health of service users;
- enhanced awareness, improved skills and confidence of primary care professionals;
- improved response by primary care services;
- improved patient experience;
- improved access to services.

7.3 It also aims to identify which elements of the pilot have worked well and where improvements could be made to inform future commissioning and service planning.

Background

7.4 People with learning disabilities experience significantly higher rates of mortality and morbidity, and increased levels of unmet health need in comparison to non-learning disabled peers (Suffolk County Council, 2014). Two serious case reviews for adults with learning disabilities identified issues including a lack of communication and information sharing between services, a low focus on health needs by social care providers and missed GP appointments. They recommended that the CCG commission a service to help address these issues: the new Primary Learning Disability Liaison Nurse (PLDLN) Service.

The Primary Learning Disability Liaison Nurse Service

7.5 The PLDLN Service, established in January 2016, works with service users, primary care professionals and other agencies with the overall aim of improving the health outcomes of young people and adults (aged 14 or above) with a learning disability in Suffolk.

7.6 There are four whole time equivalent PLDLNs working across the East & West localities. The posts are hosted and line managed by Suffolk Wellbeing Service (SWS), alongside the Mental Health Link Workers.

7.7 The service pilot began in January 2016, initially focussing its work with 26 GP practices. Since the interim evaluation in June it started working with another 7 practices to replace a number of practices who chose not to engage with the service.

Methods

7.8 A mixed methods approach was used, based on the Donabedian model – a conceptual model which provides a framework for assessing quality within health and social care settings. The key elements are: structure, process, outputs and outcomes and the analysis included a comparison over time and between pilot and non-pilot practices.

7.9 The main sources of data for the evaluation were SystmOne, a non-clinical 'Activity Tracker', a survey of primary care staff, case studies provided by PLDLNs and other feedback from professionals who had encountered the service.

Main Findings

7.10 Between January and November 2016, the number of patients on an LD register increased by 13% for Suffolk practices as a whole. There was a larger increase within the pilot practices compared to the non-pilot practices (15% vs 11%). The difference was statistically significant.

7.11 The proportion of patients on the LD register who had an up-to-date health check rose between January and November 2016 by 28% for Suffolk as a whole. The increase was higher amongst pilot practices (37%) than non-pilot practices (21%) and the difference was statistically significant.

7.12 The proportion of patients on the LD register in Suffolk who had an up-to-date health action plan remains low, however by the end of the evaluation period there was a statistically significant difference between pilot (19%) and non-pilot practices (7%).

7.13 The PLDLN nurses are undertaking a significant amount of activity to achieve the aims of this pilot. Three quarters of the non-clinical activity was conducted face-to-face or by telephone. Three quarters of non-clinical activity related to a physical health issues. Mental health problems were the next most common primary issue, accounting for 13% of recorded activity.

7.14 Case studies, survey feedback and other professional feedback suggests the PLDLN service is highly valued by those who have encountered it.

Conclusion

7.15 There is evidence that the PLDLN service has had an impact on its stated goals by:

- Increasing the number of patients on an LD register and the proportion of these with up-to-date health checks and health action plans.
- Improving management of long term conditions and reducing unnecessary hospital admissions.
- Increasing the knowledge and confidence of primary care staff in responding to LD patients
- Improving access to health checks, other health and social care services and wider community resources
- Promoting and facilitating more collaborative working between the patient, their families and agencies.

What are areas for improvement and development?

7.16 There are a number of possible areas for further development which include:

- Extending service provision to all GP practices to prevent inequity in this provision.
- Promoting greater engagement of GP practices and instant access to clinical record systems.
- Training and information resources for primary care staff and agreed plan of actions.
- Promote greater consistency in the use of Cardiff Annual Health Check across all practices and individual GPs.
- Health promotion campaign for young people, including availability of health check from age 14.
- Improvements to future service evaluation (e.g. service user involvement, inclusion of EMIS practices) and ensure evaluation is built in.

For further information please contact: Leigh Howlett, Director of Strategy and Resources/SIRO, Norfolk and Suffolk NHS Foundation Trust: Email: leigh.howlett@nsft.nhs.uk

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8. Essex and Suffolk Joint Health Scrutiny Committee on NHS Sustainability and Transformation Plans for Suffolk and North East Essex

8.1 Members will recall that at its meeting on 20 July 2016, the Committee received information about the requirement for health and care systems to produce Sustainability and Transformation Plans (STPs). The Committee was joined by Nick Hulme (Chief Executive, Ipswich Hospital and Colchester Hospital NHS Trusts), who had been appointed STP leader for the Suffolk and North East Essex STP Footprint, to brief the Committee on progress with the development of the STP for Suffolk and North East Essex. Members heard that Waveney was part of the STP for Norfolk and Waveney.

8.2 Members heard that there were significant challenges facing the NHS locally and nationally. The Committee was informed that these issues had led the NHS to undertake a significant redesign of services, which would be locally led and would lead to some difficult decisions being made about reconfigurations and changes in provision. At that time, an initial plan for North Essex and Suffolk had been submitted to NHS England, who had requested more detailed financial plans to be submitted to them by 16 September.

8.3 The Committee noted that the development and implementation of the STP for Suffolk and North East Essex would have implications for residents in Suffolk and Essex. The Committee agreed to ask the Chairman to approach the Chairman of Essex Health Overview and Scrutiny Committee with a view to establishing a joint committee for the purposes of reviewing the development of proposals for cross-county border health provision and to receive formal consultation on any substantial variations emerging from this work.

8.4 At its meeting on 12 October 2016, the Committee received a further update on the development of the Ipswich Hospital and Colchester Hospital partnership, which was one of the strands of work taking place under the STP. The Committee was joined for this item by Nick Hulme and Dr Shane Gordon, Director of Integration, Colchester Hospital University Foundation Trust. Members from Essex HOSC were also in attendance.

8.5 Members were informed that the partnership was in its very early stages and provided an opportunity to look at what both hospitals currently provide and to develop values and principles to underpin service redesign to create efficiencies, with patients at the heart of this work. The management boards of the two hospitals had met together for the first time to begin to discuss options. A work programme to identify and evaluate the benefits and risks had started and learning from other successful and unsuccessful partnership arrangements, both medical and non-medical, was being considered.

8.6 On 12 October, the Chairman informed members that Essex Health Scrutiny Committee had agreed to establish a joint committee with Suffolk, on a task and finish basis. The Committee agreed that the representatives from Suffolk on the joint Task and Finish Group would be the Chairman, the Vice-Chairman and one or two members of the Committee. Members were asked to send

expressions of interest in joining the Group to the Business Manager, Democratic Services.

8.7 Subsequently, Councillors Peter Coleman (Suffolk Coastal), Elizabeth Gibson-Harries (Mid Suffolk) and Dr Sian Dawson (Babergh) have agreed to serve on the joint committee as members/substitute members as necessary.

8.8 The STP for Suffolk and North East Essex was published on 17 November 2016 and further information can be found at:

http://www.westsuffolkccg.nhs.uk/health-care-working-together-differently/

8.9 Initial informal discussions are currently taking place with relevant members and officers from both authorities about how the work of the joint committee will be taken forward. It is proposed that a formal meeting of the joint committee should be arranged to take place in March 2017 and details of this will be publicised as soon as the final arrangements have been confirmed.

For further information, or to discuss the work of the joint committee, please contact: Theresa Harden, Business Manager (Democratic Services), Suffolk County Council; Email: Theresa.harden@suffolk.gov.uk ; Tel: 01473 260855.

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9. Cambridgeshire, Norfolk and Suffolk Joint Health Scrutiny Committee on Proposals for Liver Resection Services – Update on Outcomes

9.1 On 22 January 2014, the Committee received the Final Report of the Cambridgeshire, Norfolk and Suffolk Joint Health Scrutiny Committee on proposals for liver resection services.

9.2 Cambridgeshire, Norfolk and Suffolk health scrutiny committees established a joint scrutiny committee to receive and scrutinise NHS England's proposal to centralise liver resection surgery at Addenbrooke's hospital in Cambridge. Surgery had previously been provided for the population of the area at both Addenbooke's and the Norfolk and Norwich hospitals.

9.3 The scrutiny took place over two public meetings in September and November 2013. The Suffolk members on the joint committee were Councillor Tony Goldson (Chairman of the Joint Committee), Councillor Sarah Adams and Councillor Tony Simmons

9.4 The joint committee made a number of recommendations directly to the NHS England Area Team, as commissioners of the service, and other bodies. A copy of the final report, published December 2013, and recommendations made can be found here.

9.5 The joint committee and the commissioners were unable to reach full agreement on the nature of recommendations and, as a result, a local resolution meeting between the two parties took place on 2 April 2014. The report of the local resolution meeting can be found here.

9.6 The centralised service was implemented at Addenbrooke's hospital in Autumn 2015.

9.7 As part of its recommendations, the joint committee recommended to NHS England that referral and resection rates, mortality and readmission rates be audited after one year of implementation and the results reported back to the respective local authority health scrutiny arrangements.

9.8 This audit has now taken place, and the report "Metastic Liver Resection Service – Update Report December 2016" is attached as Appendix 1.

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