



Great Yarmouth and Waveney Joint Health Scrutiny Committee

Date: **Thursday 30 July 2009**
 Time: **10.30am**
 Venue: **The OrbisEnergy Centre, Wilde Street, Lowestoft**

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

Members of the public or interested parties who have indicated before the meeting that they wish to speak will, at the discretion of the Chairman, be given five minutes at the microphone. Others may ask to speak and this again is at the discretion of the Chairman.

Membership –

MEMBER

Mr M Carttiss
 vacancy
 Mr P Collecott
 vacancy
 Mr D Harrison
 Mrs J Midwood
 Mrs S Vincent
 Mr D Yorke Edwards
 vacancy
 Mrs S Weymouth

AUTHORITY

Norfolk County Council
 Suffolk County Council
 Waveney District Council
 Norfolk County Council
 Norfolk County Council
 Suffolk County Council
 Forest Heath District Council
 Suffolk County Council
 Norfolk County Council
 Great Yarmouth Borough Council

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

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

- 1 **Election of Chairman and Vice-Chairman**
- 2 **To receive apologies and details of any Substitute Members attending**
- 3 **Glossary of Terms and Abbreviations** (Page)
- 4 **Minutes**
To confirm the minutes of the meeting of the Great Yarmouth and Waveney Joint Health and Scrutiny Committee held on 12 May 2009. (Page)
- 4 **Members to Declare any Interests**

Please indicate whether the interest is a personal one only or one which is prejudicial. A declaration of a personal interest should indicate the nature of the interest and the agenda item to which it relates. In the case of a personal interest, the member may speak and vote on the matter. Please note that if you are exempt from declaring a personal interest because it arises solely from your position on a body to which you were nominated by the County Council or a body exercising functions of a public nature (e.g. another local authority), you need only declare your interest if and when you intend to speak on a matter.

If a prejudicial interest is declared, the member should withdraw from the room whilst the matter is discussed unless members of the public are allowed to make representations, give evidence or answer questions about the matter, in which case you may attend the meeting for that purpose. You must immediately leave the room when you have finished or the meeting decides you have finished, if earlier. **These declarations apply to all those members present, whether the member is part of the meeting, attending to speak as a local member on an item or simply observing the meeting from the public seating area.**
- 5 **To receive any items of business which the Chairman decides should be considered as a matter of urgency**
- 6 **Norfolk and Suffolk ME/CFE Services**
An update on pre-consultation discussions by NHS Great Yarmouth and Waveney and NHS Norfolk. Note: Appendix B is not yet available. (Page)

- 7** **Changes to Older People’s Mental Health Services in the NHS Great Yarmouth and Waveney Area** (Page)
An update report by Chris Humphris, Interim Head of Joint Commissioning, NHS Great Yarmouth and Waveney
- 8** **NHS Great Yarmouth and Waveney’s Five Year Strategic Plan**
Presentation of the first year operating plan and an overview of progress to date
- 9** **Agree Dates for Further Meetings in 2009/2010**
Members are asked to bring their diaries with them to the meeting
- 10** **Forward Work Programme** (Page)
To consider and agree the forward work programme

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Date Agenda Published: 22 July 2009



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Great Yarmouth and Waveney Joint Health Scrutiny Committee – 30.7.09**Glossary of Terms and Abbreviations**

CBT	Cognitive Behavioural Therapy
CFS	Chronic Fatigue Syndrome
EAME	East Anglia ME Patient Partnership
EoE	East of England
GET	Graded Exercise Therapy
GP	General Practitioner
HOSC	Health Overview and Scrutiny Committee
LINK	Local Involvement Network
ME	Myalgic Encephomyelitis
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NWMHFT	Norfolk and Waveney Mental Health Foundation Trust
PBC	Practice Based Commissioning
PCT	Primary Care Trust
PCQ	Pre Clinic Questionnaire
PPI	Patient and Public Involvement
SDPG	Service Design Project Group
SHA	Strategic Health Authority
UK	United Kingdom
WHO	World Health Organisation

**GREAT YARMOUTH AND WAVENEY JOINT HEALTH SCRUTINY COMMITTEE
MINUTES OF THE MEETING HELD ON 12 MAY 2009**

Present:

Mrs J Eells	Norfolk County Council (Chairman)
Mr P Collecott	Waveney District Council
Mr D Lockwood	Suffolk County Council
Mrs S Vincent	Forest Heath District Council
Mr D Yorke Edwards	Suffolk County Council
Mr B R Walker	Norfolk County Council
Mrs S Weymouth	Great Yarmouth Borough Council

Also Present:

Patrick Thompson	Norfolk LINK
Elaine Bond	NHS Great Yarmouth and Waveney
Catherine Phillips	Norfolk LINK
Tina Walton	Norfolk LINK
Barbara Robinson	Carer/Suffolk Family with two ME Patients
Keith Cogdell	Scrutiny Support Manager, Norfolk County Council
Tim Shaw	Democratic Services, Norfolk County Council
Shirley Peters	Norfolk LINK
James Elliott	Director of Commissioning, NHS Great Yarmouth and Waveney
Keith Barton	NHS Great Yarmouth and Waveney
Stephanie Groom	Commissioning Manager, NHS Great Yarmouth and Waveney
Chris Humphris	Interim Head of Joint Commissioning, NHS Great Yarmouth and Waveney

1 Apologies

Apologies for absence were received from Mr M Cherry and Mrs J A Howe.

2 Glossary of Terms and Abbreviations

The Joint Committee noted the glossary of terms and abbreviations used in the agenda papers.

3 Minutes

The Minutes of the previous meeting held on 16 January 2009 were confirmed by the Joint Committee and signed by the Chairman.

4 Declarations of Interest

There were no declarations of interest.

5 Urgent Business

There were no items of urgent business.

6 Norfolk and Suffolk CFS/ME Services

The Joint Committee received a suggested approach by Keith Cogdell, Scrutiny Support Manager, Norfolk County Council; an update report on a re-design of CFS/ME Services by Stephanie Groom, Commissioning Manager, NHS Great Yarmouth and Waveney, and a report in response from Catherine Phillips, Facilitator for Norfolk LINK. The response by Norfolk LINK was introduced by Tina Walton.

During the course of discussion, the following key points were noted:

- Members expressed disappointment at the fact that little progress had been made since the last meeting of the Committee in January 2009.
- NHS Great Yarmouth and Waveney was still working with others on the service model for CFS/ME and how this fitted with the guidelines issued by the National Institute for Health and Clinical Excellence (NICE).
- A draft CFS/ME service model had been shared with all the relevant parties in April 2009, but more work was needed before this could be finalised.
- Norfolk LINK had taken the lead in pulling together a Consultation Reference Group of all the relevant parties to progress the matter. This had met on one occasion and more meetings were needed.
- It was confirmed that the proposed service model would include children and young people's services and services for the severely affected.
- When the service re-design work had been completed, the proposed service model would be put before the Trust's Board, and the Joint Committee given an opportunity to discuss the issues before the service model was put out to public consultation.
- It was hoped to have the proposed service model agreed by the Trust's Board by the end of June 2009.

Resolved –

That the Joint Committee consider the matter further as soon as possible after a decision has been made by the Trust's Board, expected by the end of June 2009.

7 Changes to Older People's Mental Health Services in the NHS Great Yarmouth and Waveney Area

The Joint Committee received a suggested approach from Keith Cogdell, Scrutiny Support Manager, Norfolk County Council, and a report from Chris Humphris, Interim Head of Joint Commissioning, NHS Great Yarmouth and Waveney, concerning Older People's Mental Health Services in the NHS Great Yarmouth

and Waveney area.

During the course of discussion, the following key points were noted:

- Assistance with transport was available for family and friends going to Carlton Court, Lowestoft, from Great Yarmouth, but there had been little take up. This assistance had been extensively advertised and the PCT had received no complaints about it.
- A minibus had been laid on for use by staff and this was well used. This had helped NHS Great Yarmouth and Waveney to retain skilled staff.
- Since the start of the year, use of the Julian Hospital in Norwich by NHS Great Yarmouth and Waveney had reduced significantly. The need to use beds at the Julian Hospital had mainly been caused by refurbishment work at Carlton Court.
- The publication of the National Dementia Strategy had been delayed until February 2009. This was a five year vision for the transformation of dementia services.
- NHS Great Yarmouth and Waveney was working with Norfolk and Suffolk County Councils as well as colleagues in NHS Norfolk and NHS Suffolk to develop a county-wide Dementia Strategy.
- Members spoke about the need for future bed provision in Great Yarmouth as part of the wider pattern of services for people with mental health problems and said that NHS Great Yarmouth and Waveney had previously given a number of commitments on this matter.
- NHS Great Yarmouth and Waveney was carefully examining the commitments that they had given.
- A small multi-agency group with representatives of interested bodies had been set up to examine the issues. It was suggested that it would be helpful for Norfolk LINK to be part of this process.
- It was pointed out that the intention was to have both a Dementia Strategy Action Plan for Great Yarmouth and Waveney and the specific proposals for future Older People's Mental Health Services completed by the end of October 2009.

Resolved –

That a progress report on Older People's Mental Health Services be brought to the next meeting of the Joint Committee.

8 Additional NHS Dental Services

The Joint Committee received a suggested approach from Keith Cogdell, Scrutiny Support Manager, Norfolk County Council, and a report from Elaine Bond, Head of Contracts (Primary Care Independent Contracting) at NHS Great Yarmouth

and Waveney, about additional NHS dental services in the area.

During discussion, the following key points were noted:

- NHS Great Yarmouth and Waveney was looking to open a new NHS dental practice in Southwold and increase dental capacity in Lowestoft and Great Yarmouth.
- The Southwold practice was expected to cater for around 4,500 patients each year, while existing dental services in Lowestoft and Great Yarmouth were expected to show an annual increase of around 4,000 and 3,000 respectively.
- The new dental facilities were due to be launched in July 2009.
- NHS Great Yarmouth and Waveney already had one of the best records in the country for the number of patients able to access an NHS dentist and they were keen to make even more improvements.
- It was pointed out that NHS Great Yarmouth and Waveney was preparing detailed plans for improved dental services for those living in nursing and residential homes. A needs assessment would be completed by the end of October at the latest, after which there would be a period of consultation on a new service. The PCT would also be consulting on a new sedation service.
- NHS Great Yarmouth and Waveney was looking at options for the future delivery of dental services in the Martham area.
- A needs assessment for those requiring NHS dental services in the Halesworth and Bungay areas was due to be completed by the end of October 2009.
- The appointment of a new orthodontic specialist dentist would help to reduce waiting times and increase access to this service. From April 2010, patients would be able to access the service within 15 weeks of making an appointment.
- NHS Great Yarmouth and Waveney was congratulated on their commitment to NHS dentistry.

Resolved –

That the report be noted and an update report be brought to the Committee in 12 months' time.

9 NHS Great Yarmouth and Waveney's Five Year Strategic Plan

The Joint Committee received a presentation from James Elliott, Director of Commissioning, NHS Great Yarmouth and Waveney, on the latest developments and the PCT's plans to address the issues raised by the World Class Commissioning Panel report.

The Joint Committee received on the table a copy of the World Class

Commissioning Panel report concerning NHS Great Yarmouth and Waveney.

During discussion, the following key points were noted:

- The PCT had scored “red” for strategy, finance and Board in the Governance Assessment of the Panel report.
- A number of significant improvements were being planned, and efforts were being made to ensure that the rate of improvement within the PCT was faster than elsewhere in England.
- The PCT was no longer “red” for finance and was looking to make significant improvements during the summer.
- Significant progress had already been made in improving corporate governance.
- The PCT had submitted its development plan to the SHA.
- It was reported that Mr David Edwards had recently been appointed as Chairman of the Trust, which since his appointment had been re-focused at Board level.
- The PCT was looking to significantly improve access to services by:
 - Reducing waiting times for 90% of referrals for treatment for acute or community services to a maximum of 16 weeks at local providers with further year on year reductions;
 - Extending the 12 hours a day opening of primary care services to progressive percentages of the population over the five year period;
 - Commissioning more services provided closer to where people live.
- Next year’s World Class Commissioning assessment would be a crucial milestone in judging where the PCT was heading in the long term.

Resolved –

That the Joint Committee be kept informed of developments at future meetings.

10 Divestment of NHS Great Yarmouth and Waveney Community Services

The Joint Committee received a presentation by Keith Barton, Project Lead for Community Services, NHS Great Yarmouth and Waveney, about divestment of NHS Great Yarmouth and Waveney Community Services. He explained the programme to separate the management of community services from the PCT and find a suitable provider for these services.

During discussion, the following key points were noted:

- Detailed contractual terms would be drawn up for the provision of services.

- The procurement process was due to start in mid-June 2009 and would take three to six months before services were transferred.
- Procurement experts would be taken on to help in the process.
- No formal consultation was required with the staff.
- The changes were part of an on-going process and the PCT was mid-way through the project.

Resolved –

That the Joint Committee receive a further report at their next meeting, should there be anything new to report.

11 Future Meetings

It was agreed that the next meeting of the Joint Committee should be held in July 2009, following the County Council elections in June and that Members should be consulted as to a date. It was also noted that the following meeting would be held in October 2009.

12 Forward Work Programme

The Joint Committee discussed the draft forward work programme set out in a report by Keith Cogdell, Scrutiny Support Manager, Norfolk County Council. The Joint Committee amended its forward work programme so that reports would be expected for the next meeting about Norfolk and Suffolk CFS/ME Services, and progress with changes to Older People's Mental Health Services in the NHS Great Yarmouth and Waveney area, and (if there was anything new to report) on divestment of NHS Great Yarmouth and Waveney Community Services, and the Five Year Strategic Plan. It was also agreed to add into the forward work programme that a report would be brought back to the Joint Committee about additional NHS dental services in 12 months' time.

The meeting concluded at 13.15 pm

CHAIRMAN

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Norfolk and Suffolk ME/CFS Services

Suggested approach from Maureen Orr, Scrutiny Support Manager

An update on ME/CFS pre consultation work, explaining the reasons for a delay in starting the formal consultation. The Joint Committee is asked to consider how it will handle the formal consultation, which is expected to begin in September 2009.

1. Background

- 1.1 Suffolk Health Scrutiny Committee referred the issue of services for people with ME/CFS to the Joint Committee in March 2008. Reports to the Joint Committee on 12 August 2008 highlighted past and current concerns of patient and carer groups about the level and nature of service provision, and clarified the arrangements for service commissioning and delivery.
- 1.2 The Joint Committee decided to focus its attention on work being undertaken by NHS Great Yarmouth and Waveney to revise the service specification, and how this fitted with the guidelines issued by the National Institute for Health and Clinical Excellence (NICE). A report to the Committee on 22 October 2008 from the Chief Executive of NHS Great Yarmouth and Waveney described the approach being taken by the PCT in reviewing the service specification and linking this work to the NICE guidelines. The report also highlighted a delay in completing this work in respect of a key element of the NICE guidelines on 'Treatment and Management', and how this would be managed in respect of meeting deadlines for tendering for the services by April 2009. The Chief Executive made a commitment that there would be no change to current services until the revised service specification and the tendering process with the new provider are completed.
- 1.3 It was pointed out by representatives of user groups that the NICE guidelines were at this time the subject of a judicial review in the High Court initiated by two people with ME who claimed that NICE had made "irrational and perverse" restrictions on the treatments available for ME sufferers, and that there needed to be alternative treatments available to cognitive behaviour therapy and graded exercise therapy. However, it was announced on 14 March that this challenge had been unsuccessful, although the ME Association promised to "continue to ask NICE to review the contents of what we maintain is a seriously flawed and unhelpful guideline."

2. The consultation

- 2.1 On 12 May 2009 the Joint Committee heard that NHS Great Yarmouth and Waveney was working with a pre-consultation reference group including

Norfolk LINK, service users and carer representatives and that a proposed service model would be ready for formal consultation by the end of June 2009.

- 2.2 NHS Norfolk is now leading the development of the ME/CFS consultation document on behalf of the three PCTs and at the time of writing is still in the process of drafting it with input from service users and carers. The consultation timescales are currently:-

Draft consultation document for PCTs' sign off – August 2009

12 week consultation period begins – September 2009

Independent analysis of response and report produced – Dec 2009 – Jan 2010

PCT Boards for ratification – February 2010

- 2.3 NHS Great Yarmouth and Waveney has been asked to brief the Joint Committee on the work with the pre consultation reference group and the reasons for the delay in the consultation. Its report is attached at Appendix A. Representatives of both NHS Great Yarmouth and Waveney and NHS Norfolk will be present to answer Members questions.
- 2.4 Norfolk LINK has been asked to give its perspective on the pre-consultation process on behalf of the service users and carers. Its report is attached at Appendix B.

3. Suggested approach

- 3.1. Members may wish to question the representatives from the PCTs and Norfolk LINK to establish whether service user and carers' views are being properly considered during the pre consultation process.
- 3.2 In September 2009 the PCTs will be consulting the Joint Committee about the proposed ME/CFS service model along with other stakeholders and the public. Members may wish to consider how the Joint Committee will deal with the consultation. The options are:-

(a) Not to respond to the consultation.

(b) To respond to the consultation, in which case the Committee may wish to:-

1. Consider the consultation at its meeting in October 2009 by hearing the views of service users and carers, exploring any issues with the PCTs and formulating its response during the meeting.

OR

2. Nominate five Members to a Task and Finish Group to scrutinise the consultation, hear the views of service users and carers, explore any issues with the PCTs and formulate a suggested response for consideration by the Joint Committee at its meeting in October 2009.

3.3 The final stage of the Joint Committee's consideration of the proposed ME/CFS service model should take place after the PCTs have analysed the results of the consultation and their Boards have decided on what action to take (in February 2010). At the final stage the Joint Committee can consider:-

(a) Was the consultation with the Joint Committee adequate?

(b) Is the new ME/CFS service model in the interests of the local health service?

In considering (b) the Joint Committee can take into account whether the PCTs have responded adequately to legitimate concerns raised by service users and carers or other stakeholders during the consultation process.

The Joint Committee will be due to meet in January 2010 but may wish to delay its meeting until near the end of February 2010 so that it can complete final consideration of the ME/CFS proposed service model shortly after the three PCT Boards have made their decisions.



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Great Yarmouth and Waveney

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE MEETING 30TH JULY 2009

REPORT OF: Stephanie Groom, Commissioning Manager, NHS Great Yarmouth and Waveney.

SUBJECT: ME/CFS Service Redesign

FOR: Information

1.	<p>SUMMARY</p> <p>A revised service model for patients with ME/CFS is being developed by Commissioners at NHS Great Yarmouth and Waveney, NHS Norfolk and NHS Suffolk following an extensive re-design project which included the involvement of patient and carer representatives.</p> <p>The proposed service model will be subject to a full 3-month public consultation, the outcome of which will influence the 2010/11 Commissioning Intentions of the PCT.</p>
2.	<p>INTRODUCTION</p> <p>Myalgic Encephalomyelitis / Chronic Fatigue Syndrome (ME/CFS) is a relatively common illness which can cause profound, prolonged illness and disability, and involves a complex range of symptoms.</p> <p>NHS Great Yarmouth and Waveney has commissioned Great Yarmouth and Waveney Community Services (the PCT's arms-length provider organisation) to provide a specialist outpatient service for patients with ME/CFS. The ME/CFS Service provided by Great Yarmouth and Waveney Community Services is also commissioned by NHS Norfolk and NHS Suffolk for their respective patient populations under separate contractual arrangements.</p> <p>Following correspondence and representations from the East Anglian ME Patient Partnership (EAME) regarding the ME/CFS Service, the service model for patients with ME/CFS has been reviewed jointly by the 3 commissioning PCTs through a service design project group (SDPG) and a revised service model for public consultation is being developed. The existing service continues to be provided to patients in the interim.</p>
3.	<p>SERVICE RE-DESIGN PROCESS</p> <p>The SDPG was established in summer 2007 and membership included commissioning representatives from NHS Norfolk, NHS Suffolk, and NHS Great Yarmouth and Waveney, together with 5 patient/carers representatives and a public health researcher from NHS Great Yarmouth and Waveney.</p> <p>The patient/carers representatives of the SDPG were nominated by EAME, and they drafted many elements of the first draft of the service model. As the PCTs would</p>

	<p>expect the proposed ME/CFS Service to be evidence-based and reflect NICE guidance, a small sub-group of the SDPG was established to compare proposals from patient representatives with the NICE guidance, and to ensure that they understood the rationale for any proposed variances in order that a proposed service model could be developed by NHS Great Yarmouth and Waveney on behalf of the 3 PCTs, and in agreement with the SDPG.</p> <p>A draft service model for the proposed ME/CFS Service was considered by the SDPG at its meeting in January 2009 and it was agreed that this model, with possible future amendments, would be subject to a full public consultation.</p>
<p>4.</p>	<p>CONSULTATION REFERENCE GROUP</p> <p>The consultation will be carried out jointly by NHS Norfolk, NHS Suffolk and NHS Great Yarmouth and Waveney, with NHS Norfolk taking the lead.</p> <p>A pre-consultation document (Appendix 1) was prepared by NHS Great Yarmouth and Waveney to support the pre-consultation process and to clarify the proposed service model. It collates the information contained within the draft service model and supporting paper (“General Principles of Care”) presented to the SDPG in January.</p> <p>The purpose of the pre-consultation document was to form the basis of the consultation document, and a Consultation Reference Group has been formed to agree and take forward the consultation process and draft the consultation document. Membership of the Consultation Reference Group includes Patient and Public Involvement (PPI) leads for NHS Norfolk, NHS Suffolk and NHS Great Yarmouth and Waveney, Norfolk and Suffolk LINKs and patient representatives.</p>
<p>5.</p>	<p>CONSULTATION PROCESS AND TIMESCALES</p> <p>Public consultation will take place on an agreed service model over a period of 3 months and the draft Patient and Public Involvement Plan for the joint consultation is attached as Appendix 2.</p> <p>The Consultation Reference Group will submit a draft Consultation Document to NHS Great Yarmouth and Waveney, NHS Norfolk and NHS Suffolk for approval. Subject to approval from each PCT, it is expected that a formal consultation will then take place over a period of 12 weeks. The timetable is therefore dependent on the Consultation Reference Group being able to agree a draft Consultation Document for approval in August. Any delay in this will inevitably cause a delay in the overall timetable.</p> <p>The results of the consultation will be independently analysed and a report submitted to Commissioners. The report will be used by Commissioners to prepare the final service specification to be ratified by the PCT Boards, and will subsequently influence the PCTs 2010/11 Commissioning Intentions.</p>
<p>6.</p>	<p>CONCLUSION</p> <p>Members are asked to note the contents of this paper.</p>



Great Yarmouth and Waveney

PRE-CONSULTATION PREPARATORY DOCUMENT

PROPOSED SERVICE MODEL FOR A
SPECIALIST ME/CFS SERVICE

MAY 2009

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PART ONE: BACKGROUND AND PURPOSE

1. BACKGROUND TO ME/CFS

Myalgic Encephalomyelitis (or Encephalopathy) / Chronic Fatigue Syndrome (ME/CFS) is a relatively common illness with physical symptoms as disabling as Multiple Sclerosis, Systematic Lupus, Erythematosus, Rheumatoid Arthritis and other chronic conditions. Overall, evidence suggests a population prevalence of at least 0.2 – 0.4%, which means that a general practice with a population of 10,000 patients is likely to have up to 40 patients with ME/CFS, half of whom will need input from a specialist ME/CFS service. However, there is a lack of epidemiological data in the UK, and therefore population estimates are based on extrapolations from other countries. The aetiology of ME/CFS is currently unknown.

ME/CFS can cause profound, prolonged illness and disability, and involves a complex range of symptoms that include fatigue, malaise, headaches, sleep disturbance, difficulties in concentration and muscle pain. The pattern and intensity of symptoms may vary between people and the course of their illness, and people often have symptoms for a number of years prior to the diagnosis of ME/CFS.

2. THE SERVICE REDESIGN PROCESS

The Norfolk and Suffolk ME/CFS Service is provided by Great Yarmouth and Waveney Community Services, the Arms-Length Provider Arm of NHS Great Yarmouth and Waveney. The Norfolk and Suffolk ME/CFS Service is commissioned by NHS Great Yarmouth and Waveney, NHS Norfolk and NHS Suffolk for their respective patient populations.

Following correspondence and representations from the East Anglian ME Patient Partnership (EAME), regarding the Norfolk and Suffolk ME/CFS Service, the service model for patients with ME/CFS has been reviewed and NHS Great Yarmouth and Waveney established and co-ordinated a Service Design Project Group (SDPG) for this purpose. Membership of the SDPG includes commissioning representatives from NHS Norfolk, NHS Suffolk, and NHS Great Yarmouth and Waveney, and 5 nominated patient/carer representatives. The paper/carer representatives were made up as follows:

- 1 x Representing NHS Great Yarmouth and Waveney patient and carers;
- 1 x Representing NHS Norfolk patient and carers;
- 1 x Representing NHS Suffolk patient and carers;
- 1 x Representing Severely Affected patient and carers; and
- 1 x Representing Children and Young People and carers.

The patient/carer representative members of the SDPG were self-nominated by EAME, and drafted many elements of the service model. As the PCTs would expect the proposed Specialist ME/CFS Service to be evidence-based and reflect NICE guidance, a small sub-group of the SDPG was established to compare proposals from patient representatives with NICE guidance, and understand the rationale for any proposed variances in order that a proposed service model could be developed by the PCT (NHS Great Yarmouth and Waveney) for agreement with the wider SDPG. A draft service model for the proposed Specialist ME/CFS Service was consequently agreed in principle by the SDPG at its meeting on 9th January 2009, subject to minor amendments, and it was agreed that this amended service model would be subject to a full public consultation.

3. PURPOSE OF THE PRE-CONSULTATION PREPARATORY DOCUMENT

This pre-consultation preparatory document collates the information contained within the draft service model and supporting paper (“General Principles of Care”) presented to the SDPG on 9th January. The document has been prepared in response to comments received from patient representatives and LINks in order to clarify the proposed Service Model upon which public consultation will be undertaken and to support the pre-consultation process. Such a document was not been prepared previously in order to avoid any suggestion of “*fait accompli*” and is intended to form the basis of the consultation document to be prepared by the Consultation Group.

The proposed Service Model for public consultation is set out within Part Two of this document. It incorporates those changes agreed by the SDPG and documented within the minutes of the SDPG meeting held on 9th January 2009. For ease of reference, the amendments are set out and cross-referenced below:

Ref.	Change agreed at SDPG meeting held 9 th January 2009	Reference within the Proposed Service Model
1	<u>Agenda Item 04.09 “Service Model – Interactive Discussion”</u> . Para 6, pg 2. Advice to GPs and healthcare professionals – agreed that agencies should also receive updates.	<u>“4.3 Advice to GPs and other Healthcare Professionals”</u> . Para 2. Text reads: “...the proposed Specialist ME/CFS Service will also provide updates to other agencies (e.g. education) as required”.
2	<u>Agenda Item 04.09 “Service Model – Interactive Discussion”</u> . Para 8, pg 3. Patient representatives requested that the title of the model be referred to as ME/CFS (not CFS/ME) – agreed.	Title of Service Model referred to as “Specialist ME/CFS Service” – consistent terminology used throughout.
3	<u>Agenda Item 04.09 “Service Model – Interactive Discussion”</u> . Para 10, pg 3. Suggested that a telephone helpline / advice line be available within the Service Model – agreed.	<u>“4.2.4 Support and Follow-up”</u> . Para 1. Text reads: “...and the service will offer a telephone advice line / helpline...”
4	<u>Agenda Item 04.09 “Service Model – Interactive Discussion”</u> . Para 13, pg 3. It is the patient’s right to refuse to treatment not ability – agreed.	Already incorporated in the service model and referred to thought the document <i>including</i> <u>“3.2 Shared Decision Making”</u> Para 2 where text reads: “All patients will have the right to refuse or withdraw from any component of their care without this affecting other aspects of their care, or their future choices about care”.
5	<u>Agenda Item 04.09 “Service Model – Interactive Discussion”</u> . Para 14, pg 3. Perception that treatment options are listed in order of priority which is not the case – agreed to clarify.	<u>“4.2.3 Treatment/Intervention”</u> . Para 2. Text inserted to read: “...not listed in any order of priority”.
6	<u>Agenda Item 04.09 “Service Model – Interactive Discussion”</u> . Para 24, pg 4. Requested that once patient pathways are developed that the general process should be set out diagrammatically within the	Pathways attached to proposed Service Model. Not presented at SDPG meeting on 9 th January, but based on pathways set out within NICE guidance.

service model – agreed.	
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A number of additional comments were received from patient representatives at the SDPG meeting of 9th January 2009. These comments are not incorporated within the proposed service model, but will be included/reflected within the service specification (or other documentation) and are therefore documented here for reference:

Ref.	Additional Comments/requirements received from Patient/Carer representatives	Action Required
1	Include detail of staffing requirements.	Service Model refers to staff having the “appropriate skills and expertise in the condition”. Staffing details (skills and competencies) will be more appropriately included in the Service Specification, but will not specify exactly who should provide the service.
2	WHO code to be used when talking about ME/CFS.	To be included within the detail of the Service Specification.
3	Patient evidence to be included.	Level of detail to be included in the Service Specification.
4	2-tier menu of treatment/interventions	Not agreed – no action required. Informed consent and individualised approach to delivery of treatment / interventions explicit within Service Model
5	Locations of providing services	Anticipated that potential providers will have innovative solutions to ensure access to the service.
6	Include definition of what is meant by GET/CBT	To be included within the consultation document.
7	Service Model to be posted on patient representative’s website for comment during consultation.	To form part of the consultation/communications plan.

For the avoidance of doubt, the purpose of the **Service Model** is to set out the service to be provided. It will form a significant element of the **Service Specification** which will depict a detailed description of the Commissioner’s requirements for the purposes of tendering the agreed **Service Model**. The Service Specification will therefore be informed by the results of the public consultation and will be prepared by commissioners in line with the legal requirements of the procurement process.

4. CONSULTATION PROCESS

NHS Great Yarmouth and Waveney has agreed to work with NHS Norfolk and NHS Suffolk to undertake a joint public consultation on the proposed service model. Public consultation will ensure that consultation is open, inclusive and comprehensive, and will ensure that all stakeholders are able to respond.

Prior to the consultation, a pre-consultation exercise will take place, which will include producing a draft consultation engagement plan which patient representatives will be consulted on and help to develop. A consultation group will be established to develop a final engagement plan

and the draft consultation document. It is anticipated that the consultation group will consist of stakeholders and patient representatives including:

- NHS Commissioning Bodies
- NHS Patient and Public Involvement Representatives
- Norfolk and Suffolk LINKs Representatives
- Practice Based Commissioners
- Independent analyst(s); and
- Other patient representatives

The East of England Strategic Health Authority (EOE SHA) and the Joint Health Overview and Scrutiny Committee (Joint HOSC) will need to approve consultation processes and documents before the final consultation document can be printed, and it is anticipated that a briefing will be provided to the PCT Board in June 2009, with the consultation document being submitted to the Joint HOSC in July 2009.

Consultation will take place over a minimum 90 day period. All feedback will be analysed and a final report provided, and final recommendations/feedback will be submitted to Board of each PCT (NHS Great Yarmouth and Waveney, NHS Norfolk and NHS Suffolk) for approval prior to commencement of the tendering process.

A further SDPG meeting will be co-ordinated by NHS Great Yarmouth and Waveney following completion of the consultation process in order to feedback the outcomes.

PART TWO: PROPOSED SERVICE MODEL

1. INTRODUCTION AND OVERVIEW TO THE PROPOSED SPECIALIST ME/CFS SERVICE

The proposed Specialist ME/CFS Service will provide expertise in assessing, diagnosing and advising on the clinical management of patients with Myalgic Encephalomyelitis (or Encephalopathy) and Chronic Fatigue Syndrome (ME/CFS) and will provide a range of specific interventions. The proposed Specialist ME/CFS Service will aim to improve awareness, diagnosis, treatment and care of patients with ME/CFS and improve the quality of life of patients and their carers.

The proposed Specialist ME/CFS Service will work within agreed pathways for the management of ME/CFS, and will provide an evidence-based diagnostic and rehabilitative outpatient service for patients with ME/CFS. The proposed Specialist ME/CFS Service will offer a range of interventions for adults and children/young people who are mildly, moderately and severely affected with ME/CFS, and will also provide specialist advice, support and education to GPs and other healthcare professionals.

2. AIMS AND OBJECTIVES OF THE PROPOSED SPECIALIST ME/CFS SERVICE

The proposed Specialist ME/CFS Service will:

- Provide access to specialist assessment, diagnosis and advice on the clinical management (including symptom management) of ME/CFS to patients (and carers, as appropriate) and to other healthcare professionals;
- Support GP Practices and other healthcare professionals to manage patients with ME/CFS, by providing them with recommendations and advice on treatment, rehabilitation and support;

- Undertake comprehensive assessments, and provide a multidisciplinary care package for each patients, to include carer and family support;
- Deliver a range of specific evidence-based interventions/rehabilitative treatment packages, and use care pathways, protocols and other decision-support tools to optimise care;
- Facilitate the continuity of care of patients with ME/CFS following their discharge from the ME/CFS service through referral to, and liaison with, other support agencies; and
- Provide education and training to GPs and other healthcare professionals in the recognition and management of ME/CFS.

3. PRINCIPLES OF CARE

The proposed Specialist ME/CFS Service will be based upon the following principles of care:

3.1. Approach

The proposed Specialist ME/CFS Service will adopt a biomedical, evidence-based approach to patient care, and will work within agreed pathways for the management of ME/CFS. The proposed Specialist ME/CFS Service will follow best practice, including as described within the National Service Framework for Long-Term (Neurological) Conditions.

3.2. Shared Decision Making

The proposed Specialist ME/CFS Service will ensure that shared decision-making between the patient with ME/CFS and healthcare professionals take place during diagnosis and all phases of care. In particular, staff within the proposed Specialist ME/CFS Service will:

- 3.2.1. Acknowledge the reality and the impact of ME/CFS and the symptoms;
- 3.2.2. Provide information about the range of interventions and management strategies (including the benefits, risks and likely side-effects) to enable patients to make informed decisions about their care;
- 3.2.3. Provide information on the possible causes, nature and course of ME/CFS;
- 3.2.4. Provide information on returning to work or education, and with the patient's consent, liaise with employers, education providers and support services;
- 3.2.5. Take into account the patient's age (particularly for children younger than 12 years), the severity of their ME/CFS, their preferences and experiences, and the outcome of previous treatments; and
- 3.2.6. Offer information about local and national self-help groups and support groups for patients with ME/CFS and their carers.

The proposed ME/CFS Service will ensure that all patients will have the right to refuse or withdraw from any component of their care without this affecting other aspects of their care, or their future choices about care.

Patients will be in charge of the aims and goals of the overall management plan, and the pace of progression throughout the course of any intervention will be mutually agreed.

The proposed Specialist ME/CFS Service will provide diagnostic and therapeutic options to patients with ME/CFS in ways which are suitable for individual patients. This will include providing domiciliary services (including specialist assessment), and using alternative

methods such as the telephone, email or text-messages, whilst adhering to the principles of data protection and information security.

3.3. Support and Information

The proposed Specialist ME/CFS Service will establish a supportive and collaborative relationship with the patient and their carers, and will recognise that engagement with the family and carers is particularly important for children and young people, and for people with severe ME/CFS.

Patients referred to the proposed Specialist ME/CFS Service will be allocated a named healthcare professional within the ME/CFS team who will be responsible for co-ordinating their ME/CFS care, and patients will be provided with accurate information at all stages. The information will be tailored to their circumstances, including the stage and duration of their ME/CFS, the symptoms experienced and relevant personal and social factors.

The proposed Specialist ME/CFS Service will ensure that information to be given to individuals will be regularly updated, and include review and input from patient groups. Information will be available in a variety of formats, which patients with ME/CFS (and their carers) can refer to at home, and in the clinical setting. Additionally, following each patient consultation/appointment, the proposed Specialist ME/CFS Service will send a report to the patient's referrer, which will include details of the consultation and advice on future management. A copy of the report will be sent to the patient.

3.4. Provision of Care

Staff providing care to patients within the proposed Specialist ME/CFS service will have the appropriate skills and expertise in the condition.

All patients will be assessed and commence treatment within 13 weeks of referral to the proposed Specialist ME/CFS Service, and priority will be given to children and young people, and to those patients who are severely affected.

All patients will be offered:

- Information about the ME/CFS;
- Acceptance and understanding;
- Assistance negotiating the healthcare, benefits and social care systems (as appropriate); and
- Assistance with occupational activities, including work and education (as appropriate)

The proposed Specialist ME/CFS Service will recognise that symptoms of ME/CFS are often highly individualistic, and will agree individualised care plans with each patient (and their carers, if appropriate). Care plans will be reviewed and updated with each contact the patient has with the proposed Specialist ME/CFS Service.

The proposed Specialist ME/CFS Service will also acknowledge the impact a chronic and long-term illness has on family dynamics and carers, and will provide support and sign-posting to families and carers as appropriate.

3.5. Additional Principles of Care for Patients who are Severely Affected with ME/CFS

The proposed ME/CFS Service will recognise that the management of severe ME/CFS is difficult, and that specialist expertise is needed when planning and providing care for patients with severe ME/CFS:

- 3.5.1. Care will be developed and implemented carefully to lessen the risk of exacerbation or setback/relapse;
- 3.5.2. The proposed Specialist ME/CFS Service will liaise with a range of other healthcare professionals in order to provide specialist input concerning the patient's ME/CFS; and
- 3.5.3. Patients who are severely affected by ME/CFS will, in line with all patients, have the right to withdraw or refuse any part of their care plan.

The proposed Specialist ME/CFS Service will ensure that the diagnosis, investigation, management and follow-up care of patients Severe ME/CFS will be supervised or supported by a specialist in ME/CFS. These patients will therefore remain on the active caseload of the proposed Specialist ME/CFS Service, and be reviewed (by the proposed Specialist ME/CFS Service) regularly. The proposed Specialist ME/CFS Service will ensure that home visits will be available for severely affected patients who are housebound, or would otherwise be unable to access the proposed Specialist ME/CFS Service

Most patients with ME/CFS do not need hospital admission. However, Patients with severe ME/CFS may need to use other community services at times. These services may include nursing, occupational therapy, dietetics, respite care, psychology and physiotherapy. The proposed Specialist ME/CFS Service will ensure that processes are established to ensure that they are made aware of such referrals (where they are not initiated by the ME/CFS Service) so that they can be co-ordinated/overseen/monitored by the patient's named healthcare professional within the ME/CFS Service.

People with severe ME/CFS will be offered a summary record of every consultation.

Adults who have severe ME/CFS will be unable to access conventional further/higher education and therefore individualised learning plans need to be developed. The proposed Specialist ME/CFS Service will therefore liaise closely with those providers delivering education to patients at home, and will ensure that these cognitive activities are included within the care plan agreed with patients. The proposed Specialist ME/CFS Service will recognise that it may be necessary for the service to provide some training to the teachers/tutors concerned regarding ME/CFS.

3.6. Additional Principles of Care for Children and Young People affected with ME/CFS

Children and Young People (including the severely affected) with ME/CFS are subject to the same principles and assumptions as Adults and have the same right to withdraw or refuse any part of their care plan. Additionally:

- When providing care for children and young people, the proposed ME/CFS Specialist Service will follow best practice as described in the National Service Framework for Children; and
- The proposed Specialist ME/CFS Service will consider the need to repeat investigations if there is no improvement after 1 year.

The proposed Specialist ME/CFS Service will work closely with social care and education services to ensure a common understanding of the goals of the patient:

- The use of a flexible approach to education will be discussed, including home tuition and the use of equipment that allows a gradual reintroduction into education as appropriate;
- The service will ensure that Care Plans and Activity Management ensure a balance between times spent attending school or college and doing homework, and time spent on home and social activities; and
- The Service will recognise that Education should not be the only activity a child or young person with ME/CFS undertakes.

Children and young people who have Severe ME/CFS will be unable to access conventional education and therefore individualised learning plans need to be developed:

- The Service will liaise closely with those providing education at home;
- The Service will ensure that these cognitive activities are included within the care plan; and
- The Service will recognise that it may be necessary to provide some training to the teachers/tutors concerned regarding ME/CFS.

The proposed ME/CFS Service will follow Guidance from the Department for Children, Schools and Families on education for children and young people with medical needs, or equivalent statutory guidance, and will ensure the smooth transition of children and young people from paediatric to adult services. At all times, the proposed Specialist ME/CFS Service will take care to acknowledge the patient's age, and the problems and sensitivities associated.

4. SCOPE

The proposed Specialist ME/CFS Service can be summarised as follows:

- Pre-assessment Screening and Triage;
- Specialist Outpatient Service;
 - Diagnosis;
 - Assessment;
 - Treatment/Intervention; and
 - Support & Follow-up
- Advice to GPs and other Healthcare Professionals;
- Training and Education; and
- Provision of Information.

4.1. Pre-Assessment Screening and Triage

All patients will be sent a pre-clinic questionnaire (PCQ) and information pack upon receipt of their referral.

The PCQ will be returned to the proposed Specialist ME/CFS Service by patients, and referrals will be triaged by a senior member of the specialist ME/CFS team using the information contained within the PCQ and the referral letter. This will be undertaken in order to identify the urgency of the referral, and ensure the patients are offered an appointment with the most appropriate member of the specialist ME/CFS team for assessment and treatment.

4.2. Specialist Outpatient Service

4.2.1. Diagnosis

Patients referred to the proposed Specialist ME/CFS Service will usually have a provisional, or confirmed, diagnosis of ME/CFS, and the Canadian criteria may be used as an aid to diagnosis. However, the proposed Specialist ME/CFS Service will also accept referrals for patients where no diagnosis has been made, but where ME/CFS is suspected and alternative diagnoses have been excluded.

Basic investigations, as recommended by NICE, will be undertaken prior to referral to the service. The proposed Specialist ME/CFS service will undertake any further investigations required, as appropriate for individual patients.

4.2.2. Assessment

The proposed Specialist ME/CFS Service will undertake an initial biomedical assessment of all patients referred to the service in order to confirm diagnosis and severity. All patients will be assessed by an appropriate senior member of the Specialist ME/CFS Team.

A combination of GP referral information, PCQ and clinical evaluation will be utilised to assess the severity of each patient with ME/CFS. A standardised tool suitable for such purposes (e.g. Karnofsky Scale) will be used. The assessing practitioner will confirm diagnosis, discuss/agree options for treatment/intervention with the patient (and carers, as appropriate), ensuring that appropriate consent is received for all intervention to be provided.

4.2.3. Treatment/Intervention

An individual, person-centred programme will be offered to all patients with ME/CFS who are referred to the proposed service.

The Service will provide a range of evidence-based interventions and management options as appropriate to, and agreed with, individual patients (and carers) which will include the following (not listed in any order of priority):

- General Management Strategies including:
 - Symptom Management, including nutritional advice;
 - Sleep Management Advice, including advice on rest periods etc; and
 - Teaching of relaxation techniques;
- Provision of equipment to maintain independence;
- Cognitive-Behavioural Therapy
- Graded Exercise Therapy (GET)
- Activity Management Programmes
- Pacing; and
- Pharmacological Interventions / Prescribing

The proposed Specialist ME/CFS Service will ensure that treatment/intervention will be provided in ways suitable for individual patients (e.g. through domiciliary visits) and will also offer onward referral to other services/agencies as appropriate to the patients individual needs.

The rationale and content of the different programmes, including their potential benefits and risks will be fully explained to the patient to enable them to make informed consent.

This will include advising patients that no single strategy/intervention is successful for all patients, or during all stages of the condition. The service will respect the right of patients to refuse, or withdraw from, any treatment or intervention.

4.2.4. Support and follow-up

The proposed ME/CFS Service will recognise that ME/CFS is a long term condition and that after diagnosis and agreement of a care plan, patients with ME/CFS will require on-going monitoring and review, together with on-going information and support. Telephone advice, reassurance and on-going support will be provided to patients (and their carers) as appropriate and the service will offer a telephone advice line/helpline. Patients will also be seen at home, or in the clinic as appropriate.

The proposed Specialist ME/CFS Service will undertake regular, structured review and follow-up of all patients on its caseload. These will include (if appropriate):

- Assessing improvement or deterioration in symptoms (including any new symptoms);
- Reviewing the care plan and agreeing any adjustments required;
- Assessing any adverse or unwanted effects of therapy;
- Ongoing investigations;
- Considering the need to repeat investigations & undertaking such investigations;
- Reviewing the diagnosis, specifically if signs and symptoms change;
- Reviewing equipment needs; and
- Assessing any additional support needs.

The timing of reviews and follow-up will depend on the severity and complexity of the patient's symptoms, the effectiveness of any interventions, and the patient's individual needs. All patients on the caseload will be reviewed at least annually, and more often if clinically appropriate.

The Service will encourage patients to contact them should they experience an increase in symptoms that lasts for longer than a few days after starting the care plan/a new intervention, or if symptoms are severe or distressing.

When a patient has been discharged from the service, on-going review and follow-up will be undertaken by the patient's own General Practitioner, who will be able to refer the patient back to the proposed Specialist ME/CFS Service if additional specialist support is required.

4.3. Advice to GPs and other Healthcare Professionals

The proposed Specialist ME/CFS Service will assist and support GPs, and other Healthcare Professionals, providing services to patients with ME/CFS. This will include advising Healthcare Professionals of adverse reactions and intolerance that patients with ME/CFS may experience to forms of therapy, medication and medical procedures.

Telephone advice, reassurance and support will be made available by the proposed Specialist ME/CFS Service to GPs and other Healthcare Professionals as appropriate, and the proposed Specialist ME/CFS Service will also provide updates to other agencies (e.g. education) as required.

4.4. Training and Education

The proposed ME/CFS Service will provide education and support for GPs and other Healthcare Professionals in treating patients with this condition, and will offer training and

education in the recognition, diagnosis and management of ME/CFS in line with evidence-based practice.

4.5. Provision of Information

The proposed Specialist ME/CFS Service will make information available in a variety of formats as appropriate (e.g. printed copy, electronic and audio) which patients with ME/CFS (and Carers) will be able to refer to at home, and in the clinical setting.

The proposed ME/CFS Service will ensure that information to be given to individuals will be regularly updated, and will include review and input from patient groups.

5. DISCHARGE

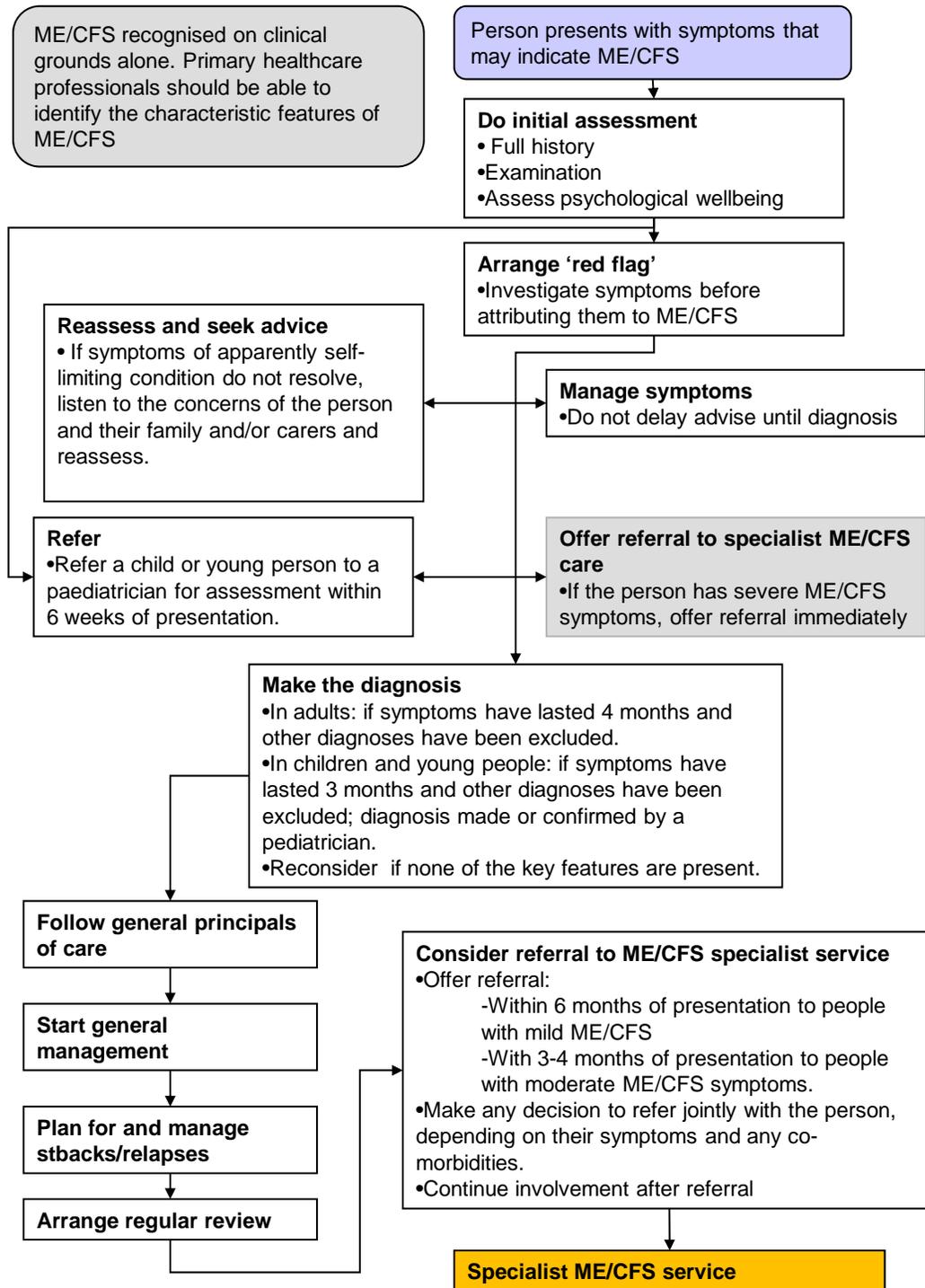
ME/CFS is a long-term condition, and patients with ME/CFS may need care and support over a long period of time.

Patients will be discharged into the care of their own GP once the agreed treatment and rehabilitative goals/objectives have been achieved to the optimal outcome, the patient is able to self-manage, and no further intervention is required by the Specialist Service.

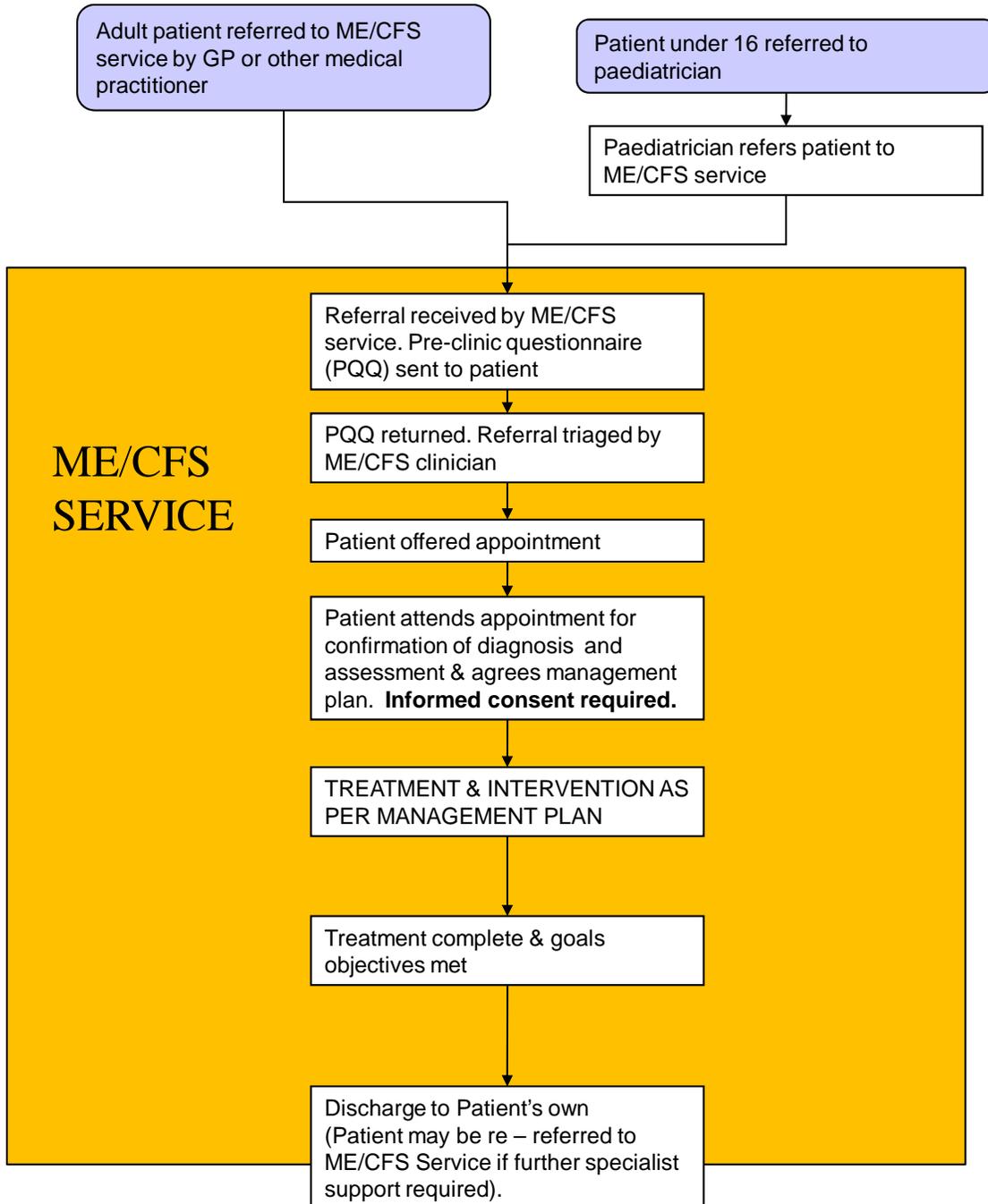
Once discharged from the service, patients will contact their own GP if they require additional specialist support or advice, and may be re-referred to the service at any time.

APPENDICES

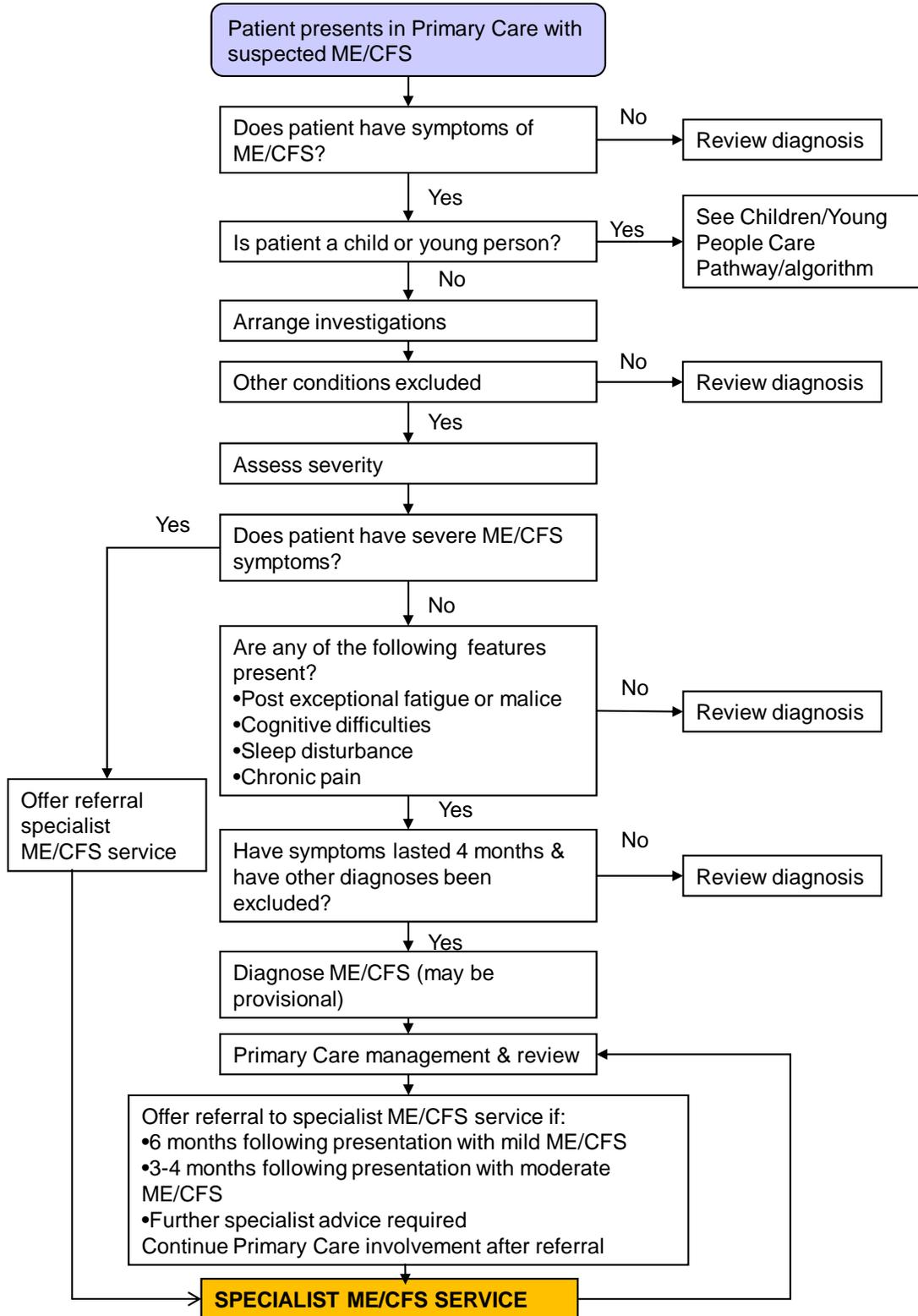
Appendix 1 – Overarching ME/CFS Care Pathway



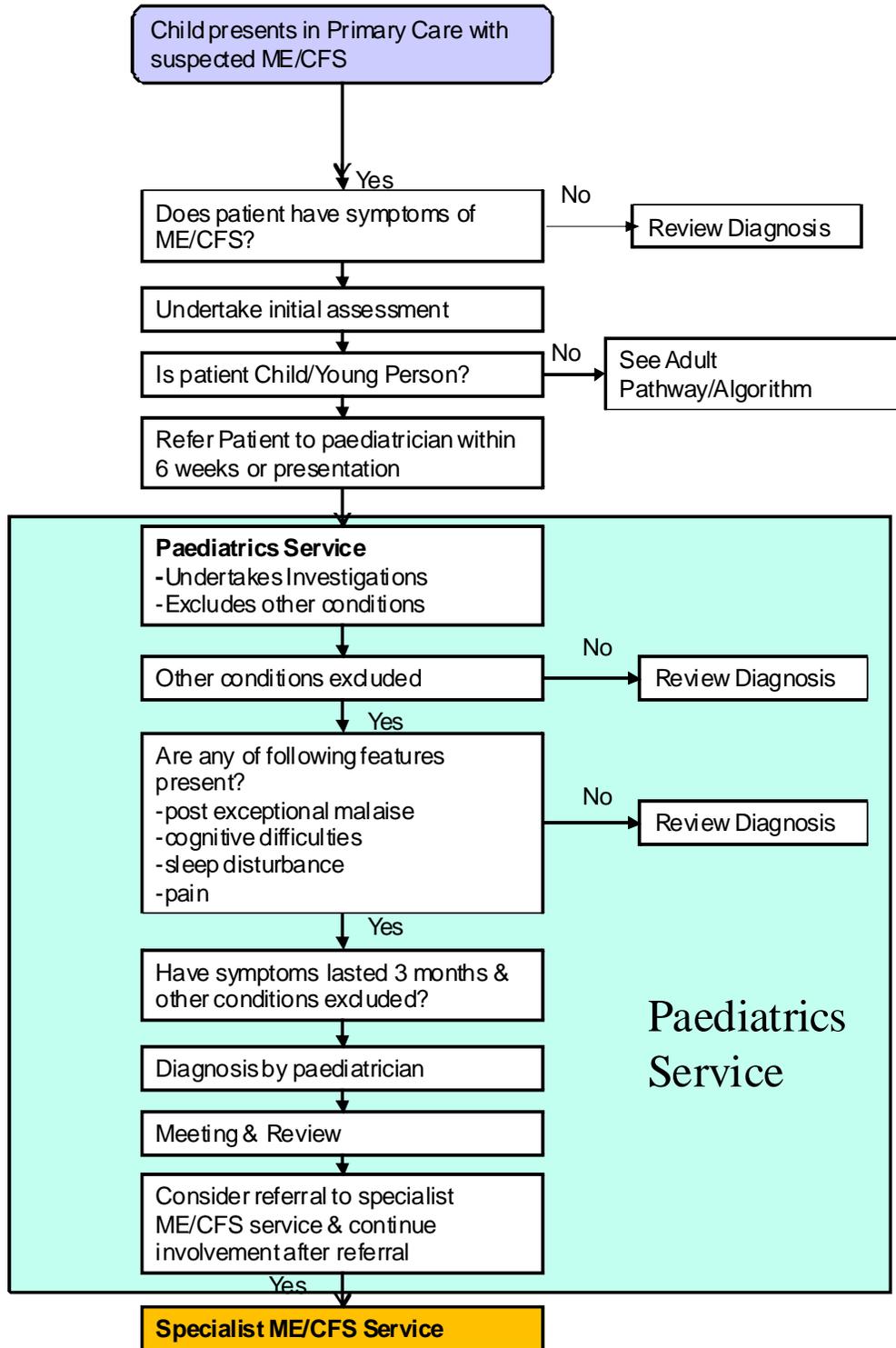
Appendix 2 – ME/CFS Referral Pathway



Appendix 3 – Adult ME/CFS Care Pathway/Algorithm



Appendix 4 – Children/Young People ME/CFS Care Pathway/Algorithm



Appendix 2

Draft Patient and Public Involvement Plan

DRAFT Patient and Public Involvement (PPI) plan for Myalgic Encephalomyelitis / Chronic Fatigue Syndrome (ME/CFS)

Joint Consultation between NHS Norfolk, NHS Suffolk, and NHS Great Yarmouth and Waveney.

1. Rationale for Patient and Public Involvement

A draft service model has been developed by the Commissioning Leads for NHS Norfolk, NHS Suffolk and NHS Great Yarmouth and Waveney, in discussion with patient groups.

It has been agreed by NHS Norfolk, NHS Great Yarmouth and Waveney and NHS Suffolk that the service specification requires further involvement with service users, carers and clinicians from the areas.

2. Background

The draft service model was presented to the CFS/ME Service Design Project Group on 9 January 2009. The group was chaired by NHS Great Yarmouth and Waveney and was made up of commissioners and people who use services and their carers.

3. How NHS Norfolk, NHS Suffolk and NHS Great Yarmouth and Waveney will involve the local population and stakeholders

The draft plan for patient and public involvement is:

- Produce a consultation document (written via a reference group including lead commissioners, patient representatives, Social Services, HOSC and LINKs) based on the draft service model, distributed to targeted service users/groups/clinicians;
- Independent development of questionnaire and analysis of responses.

4. Reporting and Timing

It is important that the consultation process is as thorough and inclusive as possible. To ensure that the process is undertaken in this way, it is proposed that the timetable be as follows:-

Draft Consultation Document for PCT sign-off	August 2009
12 week consultation period begins	September 2009
Independent analysis of response and report produced	December - January 2009
PCT Boards for ratification	February 2010

A document will then be produced to outline what has been agreed as a result of the feedback from participants. This will be sent to all participants in the consultation. Participants will also be given the opportunity to feedback on how well the consultation has been carried out.

**Great Yarmouth and Waveney Joint Health Overview and scrutiny
committee meeting 30th July 2009**

**Norfolk LINK report on ME/CFS services in response to NHS Great
Yarmouth and Waveney Report**

Norfolk LINK has been working closely with Patient representatives, Carers and Members to improve services for ME/CFS since the summer of 2008. In NHS GT Yarmouth and Waveney's report to the Joint committee 30th July 09, there is no mention of current service provision. It is vital that this issue is addressed in conjunction with the development of future services.

History

ME/CFS Patient Representatives have been expressing concern to Gt Yarmouth & Waveney NHS regarding ME/CFS Services since 2005. In June 2007 following the East Anglian ME Patient Partnership letter of concern to previous Chief Executive Mike Stonard and Chair Bernard Williamson in March 2007, patient representatives met the PCT, a new ME/CFS Service Design Project Group (SDPG) was set up in August 2007. The SDPG includes commissioners from NHS Gt Yarmouth & Waveney, NHS Norfolk and NHS Suffolk along with 5 patient and carer representatives. At each meeting of the SDPG patient representatives raised concerns regarding the current level of service provision. This is now known as **Interim Service Provision**. This issue was first taken to Suffolk Health Overview and Scrutiny committee (HOSC) in March 2007 who in turn decided to refer this to the Great Yarmouth and Waveney Joint HOSC. This issue was first brought to the Joint HOSC for there forward work plan in 2007.

At the Joint HOSC in October 2008 the Scrutiny committee stated that they wanted to see a ME/CFS Service specification by December 2008.

Patient Representatives provided information to NHS Gt Yarmouth & Waveney within agreed timescales, but no service specification has yet been delivered by NHS Gt Yarmouth & Waveney. A SDPG meeting was held on 9th January 2009 to discuss a proposed service model. Some progress was made, but there was no agreement made to this proposed service model on the 9th January as stated in Great Yarmouth and Waveney's HOSC report.

Patient Representatives have carried out a survey of people in Norfolk and Suffolk between January and March 2009 to find out what patients think of the current service and how it can be improved. Please see (Appendix 1). NHS Gt Yarmouth and Waveney were invited to participate, but declined. Of 179 respondents 77% rated the provision of a **Biomedical Consultant lead** as very important, and 15% as important.

Current Service Provision

Current Service Provision now recognised as **Interim Service Provision** has consistently been at the forefront of **all** discussions with NHS GT Yarmouth and Waveney, NHS Norfolk and NHS Suffolk. Norfolk LINK has evidence that shows NHS GT Yarmouth and Waveney as providers of this service to NHS GT Yarmouth and Waveney, NHS Norfolk and NHS Suffolk has breached its duty of care and is not / has not been providing adequate Service Provision for ME/CFS service users. This is having a detrimental effect on those who are severely affected, including Children and Young People. The joint HOSC need to be aware that ME/CFS can be life threatening and there have been deaths nationally due to a failure of duty of care by health providers. Please see Appendix 1 Statements from Service Users regarding current service.

It is 2 years since the SDPG was set up, and 16 months since this issue was first taken to HOSC. NHS GT Yarmouth and Waveney have not yet addressed this serious issue. Instead the Trust is choosing to wait for the outcome of the Public Consultation which has not commenced yet. When it does it will run for 3 months, and then there is a tender process to go through.

Norfolk LINK question

- Why has the Interim Service Provision not been addressed as a matter of urgency?
- How can current service users be expected to wait until April 2010 before they receive adequate care?

The constant delay in improving the interim service is not acceptable. Since 2007 there has been no care for the severely affected, acute/emergency patients, and no overall clinical oversight.

NHS Gt Yarmouth & Waveney have maintained that the ME/CFS Service does not merit a consultant led service on the following grounds

1. There is no 'speciality' of ME/CFS
2. Other ME/CFS Services do not provide a consultant

These arguments simply do not hold water:

- Other ME/CFS Services provide consultant neurologists, immunologists, endocrinologists etc who have a specialist knowledge of ME/CFS
- The Action for ME website has a database of ME/CFS Service provision¹ throughout the country. The most commonly provided healthcare professional is a consultant

http://www.afme.org.uk/me_cfsDirectoryServices.asp

3. The SHA Long Term Conditions Programme Board expects that there will be consultant level provision for people with ME/CFS in Norfolk and Suffolk

Patient Representatives are also seeking clarity regarding the following:

- Where the service is currently placed within the clinical management structure of GT Yarmouth & Waveney PCT and a commitment for the future model.
- Is ME/CFS to be managed by NHS GT Yarmouth & Waveney under the National Service Framework for Long Term Conditions, as is the case in NHS Norfolk? Is it to be formally placed under the LTC Programme Board work stream, in accordance with Strategic Health Authority recommendation and their 10 year vision: "Towards the best, together - A clinical Vision for the next decade."

This also reflects the recommendations contained within the East of England Joint HOSC Report July 2008 and requirements for World Class Commissioning.

In addition:

1. ME/CFS has been classified by the Department of Health as a long term neurological condition. Neurology departments at hospitals across Norfolk and Suffolk provide one and often more consultants.

A key target in Gt Yarmouth & Waveney NHS 5 Year Plan is to reduce health inequalities

2. Patient survey for Norfolk and Suffolk clearly demonstrates that any patient group including people with ME/CFS given the choice between a service led by a consultant who has specialist knowledge of and an understanding of the pathology of ME/CFS and that led by an OT (as now) they would choose the consultant.
4. There is a precedent for the provision of a consultant for ME/CFS Services in Norfolk and Suffolk. The bid made to the CFS/ME Investment Steering Group for ring fenced funding in 2004, to which GT Yarmouth & Waveney signed up clearly states:

1.3 Job Title – Clinical Lead – CFS/ME Service for Norfolk and Suffolk
Consultant Haematologist /Specialist in Chronic Fatigue Syndrome/ME

In 2005 GT Yarmouth and Waveney changed the service to 'therapy led'. Despite repeated requests to NHS GT Yarmouth & Waveney have **failed to provide any evidence** that patients were involved in the decision making process for this significant variation in service provision.

Any interim service should provide a consultant as there was no discussion with patients when a consultant was removed from the service.

5. Commissioners for NHS Norfolk, NHS Suffolk, and NHS GT Yarmouth & Waveney have accepted that the current service is inadequate and have agreed to referrals out of area through 'special and exceptional circumstances'. Patients and Carers say the current service is inadequate because there is no consultant. Providing a consultant and keeping patients in county would be more cost effective, plus long distance journeys could have an adverse effect on patients therefore excluding the patient from taking up the option.

Consultation Group

In April 2009 at a meeting proposed by Norfolk LINK, NHS GT Yarmouth and Waveney, NHS Norfolk and NHS Suffolk agreed to carry out a Public Consultation on ME/CFS Services. In May 2009 a Consultation Reference Group was formed. This reference group consists of PPI leads from the three Trusts, Norfolk LINK, Suffolk LINK, Carers and Patient Representatives (PR) from the three Trust areas. The PR also provides representation for those moderate/severely effected service users, children and young people. To date 3 meetings have been held and a great deal of progress has been made in writing the Consultation Document. PR and Norfolk LINK would like to take this opportunity to thank NHS Norfolk for taking the lead in co-ordinating this work.

Timescales

At the Joint HOSC on 12 May 2009 it was agreed that:

When the services re-design work had been completed, the proposed service model would be put before the Trust's Board, and the Joint Committee given an opportunity to discuss the issues before the service model was put out to public consultation. It was hoped to have the proposed service model agreed by the Trust's Board by the end of June 2009.

Resolved-

That the Joint Committee consider the matter further as soon as possible after a decision has been made by the Trust's Board, expected by the end of June 2009.

The Joint Committee amended its forward work programme so that reports would be expected for the next meeting about Norfolk and Suffolk CFS/ME Services²

NHS Norfolk has addressed timescales in their report (appendix 2) GT Yarmouth and Waveney HOSC document. Norfolk LINK agrees that these timescales need to be met. No member of the consultation reference group wishes to delay the implementation of this much needed improved service.

However PR have insisted that any Service Specification developed as a result of this consultation process must provide a **Biomedical Consultant Lead**. This is the only way acute and severe needs can be met and providers of this service can gain the expertise they need for delivery (Appendix 1).

Requests

- Norfolk LINK asks NHS GT Yarmouth and Waveney the Service provider to address without any further delay the serious issues surrounding interim service provision for ME/CFS.
- If NHS GT Yarmouth and Waveney as the provider arm for this service do not address this issue Norfolk LINK will ask NHS Norfolk and NHS Suffolk and NHS GT Yarmouth and Waveney to formally address these issues as commissioners.
- Norfolk LINK request that the Joint HOSC ask NHS GT Yarmouth and Waveney to come back to the next HOSC meeting and show that they have addressed these serious issues alongside the Consultation Document.

Appendix 1

2009 Patient Survey

Comments made by people with ME/CFS about the level of service provision in Norfolk and Suffolk

1. They [service staff] need more support and funding to provide an adequate service to those of us that so desperately need it. I have not smoked my way to this illness; I have not overeaten my way to this illness. I have done nothing to make myself ill. The government and NHS should be ashamed of themselves for not providing adequate care!!
2. I'm so glad that someone is finally doing something about the awful ME services in Norfolk. All a ME sufferer wants is ongoing care and support for which can be a horrible frightening debilitating illness. It can truly rob you of your life as I know. It's about time ME was given the care medical backup and support it deserves.
3. The services in East Anglia - Norfolk and Suffolk especially are very, very poor. I am lucky to have such a good GP but it is very frustrating, after 8 years that there is even less help and support available than when I was first diagnosed, and even then it was very poor
4. I believe my condition would improve with a proper structured programme of help in place. At the moment I feel like a prisoner in my own body, left to rot by the NHS.
5. How can one have such a debilitating condition that totally rules life and yet have no help or treatment to improve it?
6. OT's are clearly working at the limits, or outside, of their knowledge base, and are unable to provide a complete service on their own. There is far too much of the "I'll phone a friend" feel to the service. Without a consultant, the friend isn't there
7. I've had much more help with the treatment of my anxiety and depression which has been a secondary symptom of CFS. I feel I have just been left to get on with it.
8. ME in our area is treated like it doesn't exist.
9. As far as we are concerned there is no service currently
10. My condition is severe but I haven't seen a ME consultant for 2 years. I have other friends who are in a similar position. We desperately need a clinical lead. There are hundreds of people who are severely ill but essentially invisible.

11. Due to the fact there is no ME consultant I have not had a

review of my medication for about 4 years. My GP refuses to alter this without advice from a consultant so I'm left in limbo. I have very unsatisfactory letters from Mr xxxx & the [GY&W] PCT - it was a real fiasco with absolutely no satisfactory or indeed no answers. I'm convinced they know we are too ill to fight anymore for appropriate medical help.

12. A question: What other life changing and potentially chronic medical condition receives so little funding and support from the NHS? What I've written is in no way meant as a criticism of the people involved in the existing service - but the lack of direction and ongoing treatment and support there appears to be can leave pwme feeling abandoned.
13. I got myself better because you certainly didn't bother. I am better but not by the service you offer. Get rid of it and start again. At least pick up the phone & make sure they are ok.
14. I think your service is disgusting & I would be embarrassed if I was a member of staff there. You constantly fail your patients & everyone I know who has had this awful illness is so disappointed in your service. I was in bed unable to lift a muscle & for all you know I'm still there. You haven't even bothered to so much as lift up telephone.
15. I would very much like a hospital appointment to the ME Clinic for help advice and support. I think it is very unfair I have been ignored I have only been once and have had no follow up appointment. I think it is disgraced the way I have been treated.
16. If you are a long-time ME/CFS patient they (the authorities) just do not want to know. When you have tried all they have given you they do not seem to have any answers & just forget about you
17. Where is any follow up? Even people who are only mildly affected could really, really do with some support - PLEASE do not give up on us!
18. I have been referred to the clinic many times over the years but each time they cannot offer the help that I need or the appointments cannot be followed up. My condition is slowly getting worse, which puts a strain on my whole family.
19. I do not feel they have the knowledge to deal with the severely affected sufferer. They did not take on board anything I told them. After my visit they just sent a list of things to do and then increase them. No follow up visit or enquiry was made. That took 3 months to come and no further contact has been made in over a year. Home visits should be made regularly,
20. I have not been able to get any specialist ME/CFS help and support because of being too ill to get to the clinic for an initial assessment.
21. My GP is very supportive but needs specialist advice from a

biomedical consultant. Also a neurologist who understands ME is neurological and willing to travel

22. Know how awful I feel daily - and I'm able to get out of bed I would hate to think of the suffering of those confined to bed. I think that the postcard lottery of services with in the NHS needs to focus more on the needs of patients and not balancing the books.
23. If a more supportive and available service was accessible to more people in all walks of life sufferers would not feel so isolated.
24. 100% patients should be able to refer themselves because those with a none understanding GP becomes neglected and completely forgotten about and end up becoming completely disillusioned with the NHS
25. People are desperate for help and support from professionals who really know what ME is and are not under the illusion that it is psychological
26. I applied for help through Age Concern and was awarded attendance allowance - not for ME but because I have arthritis!
27. I had to change GPs twice to get someone to acknowledge I was ill. Following this I was housebound. I was at this stage referred to xxxx (consultant) (still without diagnosis or acknowledgement my illness was "real"). I had to wait 6 months for a one off appointment. I had to travel from Ipswich and was extremely unwell for weeks following the journey. I was given a diagnosis of ME/CFS with no medical testing. Just a consultation appointment. No treatment plan was offered. The only useful thing was the literature they gave me, as it helped to explain my condition to work and family. I am now well enough to work, however this has no been due to ANY intervention or care offered by the NHS.



Taking a Step Back to Visualise the Problem- check list ;tick box style; to decide remit, Service Specification & Core Service

Start Here:

Step 1. Identify the Problem¹

Step 2. Accept the Problem

Step 3. Quantify the Problem-How?+££?

Use information from Workforce Development day.

use appropriate tools

"Quality Outcomes"
existing service

Measure; assess; respond
Evaluate -££?

DATA;

££?

Epidemiology; local; national

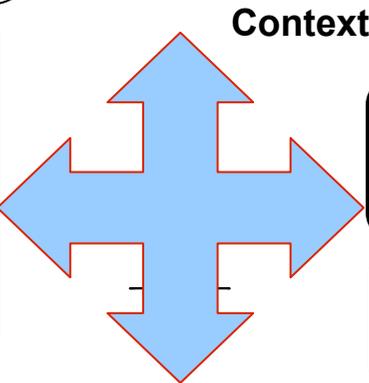
Survey; questionnaires

Sickness Impact profiles

Quality of Life Assessments

Service audit satisfaction survey

Decide REMIT of regional/ local service
According to the already endorsed
Canadian DIAGNOSTIC Criteria
For
ME/CFS



CONTEXT; SHA/PCT 10 year & 5 year plans

Health Inequality issue

Long Term Conditions programming Board ££?

Liaise with Clinical Network Coordinating Centre

HUB-CNCC Peterborough PCT

Long Term Neurological Conditions £ per patient

SPOKE-NHS Norfolk

Long Term Conditions- Neurology

Remit; Clinical lead biomedical service

Adult

Children

Young people

Severely Affected

+ Special and Exceptional

Choose and Book Special And Exceptional ?

"Other" Provider

SPOKE-NHS Suffolk

Planned Care

Adults

Children

Young People

Severely Affected

+ Special and Exceptional

SUB HUB-NHS GT. Yarmouth & Waveney

Current and new service model proposal

Community Therapy service

Out of step with

DoH; SHA; CNCC and Norfolk & patient survey data and patient requests ?

Adults

Children

YP

Severely Affected

+Special and Exceptional

Provisional Draft Service "Wish List"; check list- mark up for discussion

Patient/carer; Pre Assessment/Triage/Referral, Assessment Diagnosis, Information, Feedback, Monitoring & Oversight," (ESPECIALLY COMORBIDITY) Liaison"/ Support for -Primary Care- GPs, education/training ,social care, employers, benefits agencies, ongoing care, prescribing rights, treatment guidance, recommendation for further expert advice, referral to other tertiary services, via advice to GP (eg mental health and well being) IF requested by patient/carers. Other Agencies and professionals-expert support, education and training (CPD accredited)

Quality Outcome Measures;

Eg, permanency prognosis QuoL outcomes

1 11/06/09 /home/barb/Suffolk_Youth_and_Parent_Suppor_2005t/final+powerpoint_SHA2009_version.odp

2 http://www.norfolk.gov.uk/consumption/idcplg?ldcService=SS_GET_PAGE&ssDocName=NCC060196&ssSourceNodell=&ssTargetNodell=3507

Changes to Older People's Mental Health Services in the NHS Great Yarmouth and Waveney area

Suggested approach from Maureen Orr, Scrutiny Support Manager

This report updates Members on progress towards a Dementia Strategy Action Plan for the Great Yarmouth and Waveney Area and consequent proposals for the future of Older People's Mental Health services in the area.

1. Background

- 1.1 The Joint Committee received a formal consultation from NHS Great Yarmouth and Waveney in September 2007 about the removal of Older People's Mental Health in-patient services from Northgate Hospital in Great Yarmouth to Carlton Court in Lowestoft. The Joint Committee raised no objection to the PCTs proposals but asked to be updated on the issue of transport assistance for patients' families and friends and for staff.
- 1.2 The Joint Committee received updates from the PCT on 22 October 2008 and 12 May 2009. There has been very limited uptake of assistance with transport arrangements by relatives or friends of patients at Carlton Court but the minibus laid on for use by staff has been well used.
- 1.3 NHS Great Yarmouth and Waveney's report in May 2009 also informed the Joint Committee that the PCT intended to have a Dementia Strategic Action Plan and specific proposals for future Older People's Mental Health Services ready for consultation by the end of October 2009. A small multi-agency group was to be formed to work on the Plan, including Norfolk Local Involvement Network (LINK).
- 1.4 Norfolk LINK raised an issue with the Joint Committee on 12 May 2009 concerning placement of patients at the Julian Hospital, Norwich, due to insufficient beds at Carlton Court. The PCT said that this was mainly due to refurbishment work at Carlton Court and the numbers had reduced since establishment of a Crisis Resolution and Home Treatment Service.

2. Purpose of today's meeting

- 2.1 The Joint Committee asked NHS Great Yarmouth and Waveney to bring a progress report on Older People's Mental Health Services to today's meeting. The PCT's report is attached at Appendix A and a representative is present to answer the Committee's questions.
- 2.2 At the meeting on 12 May 2009, the PCT informed the Joint Committee that it

would be organising a small multi-agency group, including Norfolk LINK, to examine issues involved in the future provision of Older People's Mental Health services. The first meeting of that group will take place on 29 July, one day before this meeting.

Norfolk LINK has been asked to comment on the PCT's progress with the Dementia Strategy Action Plan and any other issues arising on Older People's Mental Health in the area but its report, at Appendix B, had to be written before the multi-agency group meeting on 29 July 2009. A representative from Norfolk LINK will therefore be present to give a verbal update to the Committee from the service user perspective.

3. Suggested approach

3.1 After presentation of the reports by NHS Great Yarmouth and Waveney and Norfolk LINK, Members may wish to seek further clarification on issues raised in the reports, and in particular:

- When does the PCT expect to start formal consultation with the Joint Committee on specific proposals for future services?



If you need this document in large print, audio, Braille, alternative format or in a different language please contact the Scrutiny Support Team on Tel 0344 800 8020 or Textphone 0344 800 8011 and we will do our best to help.

Older People's Mental Health Services in the NHS Great Yarmouth and Waveney area

Progress report by Chris Humphris, Deputy Director of Commissioning, NHS Great Yarmouth and Waveney

1. Introduction

- 1.1 The Committee received a report at the last meeting on this subject. It was agreed that a progress report be brought back to this meeting.

2. Dementia Strategies for Norfolk and Suffolk

- 2.1 NHS Great Yarmouth and Waveney are contributing fully to work in both counties.
- 2.2 In Suffolk a draft Dementia Strategy has been prepared. This has been cited as an "exemplar" by the Strategic Health Authority. Whilst this Strategy has not yet been formally ratified by the various agencies that contributed to it a Joint Dementia Board has been formed to ensure that work on implementing the key elements in the Strategy is progressed rapidly.
- 2.3 In Norfolk progress on a Dementia Strategy has been slower. However the County recently refreshed its Older People's Strategy "Living Longer, Living Well" and this has a key chapter on Dementia services within it. It is intended to produce a Dementia Strategy later this year.

3. Successful bids for Dementia Adviser pilots

- 3.1 I am delighted to report that NHS Great Yarmouth was part of successful bids for piloting "Dementia Advisors" in both Norfolk and Suffolk. As these were two of only three bids in the East of England that were supported we were really pleased to be part of both of them.
- 3.2 Dementia Advisors are recommended within the national dementia Strategy. These are individuals who will provide support and advice to individuals and their family carers from the point of diagnosis onwards. They will help signpost people onto the array of services that are potentially available to them and provide that single point of contact. They will be employed by voluntary agencies (Alzheimers Society and Age Concern).
- 3.3 In Norfolk the intention is to have one adviser for each District Council area and so we will have one in Great Yarmouth. They will probably be part timers (eg: half a person per area)

In Suffolk there will be the equivalent of two full-time advisers. One of these is for the Waveney area, probably based at Carlton Court. We have therefore secured 50% of the pilot funding available to Suffolk.

4. Planning future services

- 4.1 A stakeholder event is being held on the 29th July. A report back on this event will be available at the Scrutiny Committee meeting in the form of a presentation. This event will be discussing the wider vision that we wish to have of Dementia services for Great Yarmouth and Waveney. Within this context we will also be discussing what are the potential options for in-patient beds for the area. We are committed to bringing forward a formal consultation

document containing options for this future bed provision to serve the Great Yarmouth and Waveney area.

5. Learning from others

- 5.1** We know that we can learn from other countries in developing our vision of what we wish Dementia services in Great Yarmouth and Waveney to look like in the future. Some colleagues recently visited Sweden and we wish to show a brief DVD to members of what services in this country look like. We hope that, like those who have visited Sweden, you will find it inspirational.

**Great Yarmouth and Waveney Joint Health Overview and
Scrutiny Committee 30th July 2009
Norfolk LINK report on Older People's Mental Health Services
in the NHS Great Yarmouth and Waveney area**

History

In 2007 Older People's Mental Health in – patient service provision was removed from Northgate Hospital to Carlton Court in Lowestoft. This was never meant to be a permanent solution but an interim provision for a period of three years. We are about to enter the third year and no future vision for the provision of services has been established as yet. Great Yarmouth and Waveney PCT must now make a decision on the Services they will put in place for older people in the Great Yarmouth and Waveney area. Norfolk LINK would like to draw the committee's attention to the fact that this service must include provision for both **Functional** and **Organic** Mental Health Service Users and their cares. It has been reported to Norfolk LINK that there are huge pressures throughout the Mental Health service for functional beds in both Norfolk and Suffolk. This issue needs to be addressed.

Norfolk LINK Commentary

At the last Joint Health and Overview and Scrutiny meeting in May the committee tasked NHS Great Yarmouth and Waveney to bring back a progress report on Older People's Mental Health Services to this meeting. Norfolk LINK would have liked the opportunity to give constructive comment on this report but due to NHS Great Yarmouth and Waveney's **delay** in organising the Stakeholder event (which only took place on the 29th July one day before this meeting) Norfolk LINK find themselves unable to do so in this written report.

However Norfolk LINK requests the opportunity to verbally address this committee today to give comment.

Suggested Way Forward

NHS Great Yarmouth and Waveney have made a greater effort to involve Norfolk LINK and we would like to acknowledge this.

We have been invited to be stakeholders in their dementia workshop and communications have improved. Norfolk LINK looks forward to a continued productive working relationship with NHS Great Yarmouth and Waveney.

PUBLIC BOARD MEETING 22nd July 2009

REPORT OF: John Turner Interim Director of Performance

SUBJECT: Performance report

FOR: Information

1. SUMMARY

Following approval by the board in March 2009 and subsequent approval by the Strategic Health Authority, officers of NHS Great Yarmouth and Waveney have been working to implement the actions agreed within the Annual Operating Plan for 2009/2010. This report provides board with an update on the progress of implementation of the plan in the current financial year.

Updates set out within the document reflect progress to the 15th July 2009. At this point in the financial year it is clear that a minimal number of key deliverables will be completed within each project area and therefore a majority of progress will be reported in the yellow and amber groupings within the reporting process.

This report sets out progress in the year to date for the Care Quality Commission Key Performance Indicators for 2009/2010 together with indicators that the PCT will monitor in addition to these.

Data until the end of June 2009 is presented where available from national reporting systems.

2. KEY MESSAGES

Operating Plan

The overall Operating plan summary is set out the table below:

Operating Plan at a glance progress summary - July 2009

Heading	Responsible Director	Actions 2009/2010				Total
		Achieved	On plan	Off plan recovery expected	Area of concern	
1. Patient Experience and Clinical Safety	Director of Nursing	2	11			13
2. Primary and Community Care	Director of Commissioning		4	4		8
3. Long Term Conditions	Director of Commissioning	1	5	4		10
4. Mental Health	Director of Commissioning		3	1		4
5. Unplanned Care	Director of Commissioning			2		2
6. Staying Healthy	Director of Public Health	1	12	5		18
7. Planned Care	Director of Commissioning	1	10	2		13
8. Children and Young People	Director of Commissioning		6			6
9. Maternity	Director of Commissioning		2	2		4
10. End of Life	Director of Nursing		3			3
11. Cancer	Director of Nursing		8	1		9
12. Dementia	Director of Commissioning		2			2
13. Learning Difficulties	Director of Commissioning	1	3	2		6
14. Miscellaneous	Director of Commissioning		2			2
Total		6	71	23	0	100

The key issues arising from the above analysis show that progress for each objective has maintained at a level to that reported last month. Further detail is set out in appendix 1

Two clusters of activity are highlighted for further reporting due to their amber status:

- Primary and community care – specifically work to implement a new PMS contract for General Practice. The key risk identified is the need to resource a team to negotiate and implement the contract. Work is on going through the Commissioning directorate to identify the resource needed. This project is still planned to deliver in year.
- Unplanned care – Two streams of work have been identified in the operating plan designed to deliver an improved winter and capacity plan. The key risk is the need to identify the capacity needed to deliver the work. This is being progressed by the Commissioning Directorate.

Since the last board meeting work has commenced to link the PCT investment plan to the operating plan objective areas. Stage one of this is complete in linking specific sums to the plan. Stage 2 will be complete for the September Board report which will set out progress in spending in each of the planned areas. This approach will support the work of the Finance team in ensuring a link between the investments in the 5 year strategy

and the operational plan.

Key Performance Indicators

Progress for each of the 3 areas of monitoring is set out in appendices 2, 3 and 4 to this document. Detailed discussion of these indicators takes place at the monthly Performance subcommittee of the Board at which non executive Directors are present.

There are no additional risks to report to Board this month. Action plans are now in place to improve performance in Smoking Cessation, Chlamydia screening and Choose and Book. This together with a programme of work to improve further the Diabetic Retinopathy Screening service will secure improved performance across a range of indicators.

3. CONCLUSION

The Board is asked to note the contents of this report

Appendix 2 - Existing Commitments 2009/2010

Meeting Existing Commitments KPIs 2009/2010

PI CODE	VITAL SIGN REF	KEY TARGETS	UNIT	TARGET	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MARCH	Year to Date	2008/09 Outturn	Forecast Traffic Light	NOTES
EC01		Access to a GUM % of first attendances at GUM service offered an appt within 48 hours	%	100	100	100	available c. 20/7										100	100		
EC02		Ambulance Response Times Cat A 8m Category A calls meeting 8 minute target (regional)	%	75.00	79.98	77.96	75.98										77.82	74.49		The PCT performance is the Ambulance trust performance at East of England level. This applies to all PCT's in NHS East of England
EC03		Ambulance Response Times CAT A 19m Category A calls meeting 19 minute target (regional)	%	95.00	95.72	96.78	96.63										96.94	95.96		
EC04		Ambulance Response Times Cat B 19m Category B calls meeting 19 minute target (regional)	%	95.00	95.72	94.63	94.31										94.84	93.64		
EC05		Commissioning Crisis Resolution/Home Treatment Services No. of home treatment episodes by CR teams	#				available late July													
EC06		Commissioning Early Intervention in Psychosis Services No. of people with newly diagnosed cases of first episode psychosis receiving early intervention	#				available late July													
EC07.1		Data Quality on Ethnic Group - Finished Consultant Episodes	%	90																
EC07.2		Data Quality on Ethnic Group - Mental Health Minimum Dataset	%	99																
EC08		Delayed transfers of care - No. of patients occupying a hospital bed with delayed discharge	#				available late July													
EC09		Diabetes retinopathy screening - No. of people with diabetes offered screening	#	100%			available late July													
EC10		Inpatients waiting longer than 26 week standard	breach	zero	0	0	available c.25/7										0	0		
EC11		Outpatients waiting longer than 13 week standard	breach	zero	1	1	available c.25/7										2	0		May: outpatient waiting 17+ weeks
EC12		Revascularisation Patients waiting longer than 13 weeks	breach	zero	0	0	available c.25/7										0	2		
EC13		Thrombolysis % patients ≤ 60 minute call to needle time	%	100			available c.25/7													
EC14		A&E 4h Wait % of patients seen within 4 hours	%	98.00	98.24	98.72	98.69										98.55	98.25		

KEY
 = No data expected

Appendix 3 - National Priorities 2009/2010

Meeting National Priorities KPIs 2009/2010

PI CODE	VITAL SIGN REF	KEY TARGETS	UNIT	TARGET	APR	MAY	JUNE	Year to Date	2008/09 Outturn	Forecast	Responsible Director	NOTES
NP01	VSA04_A	18 weeks referral to treatment (admitted patients)	%	90.00	91.20	91.70	available c.18/7	N/a	90.76 Mar 09			
	VSA04_B	18 weeks referral to treatment (non-admitted patients)	%	95.00	96.61	97.06	available c.18/7	N/a	97.44 Mar 09			
NP02	VSA06_06	Access to a GP % of patients able to be offered a routine appointment within two working days	%	90.00								
NP03	VSB18_01	Access to NHS Dentistry - 24 month access (since March 2006)	%	↑ in access since Mar 06			available c. 21/07					
		Access to NHS Dentistry - 24 month access (since last quarter)	%	↑ in access since prev. qtr			available c. 21/07					
		% Projected UDA vs Contracted	%	96.00			available c. 21/07					
		Dental patient satisfaction survey - treatment		indicator being developed			available c. 21/07					
		Dental patient satisfaction survey - accessibility		indicator being developed			available c. 21/07					
		Dental PCT Estimate Gross Over/under spend	%	+ve			available c. 21/07					
		Dental PCT Estimate Net Over/under spend	%	+ve			available c. 21/07					
NP04		All Cancers: 31 days standard % treated ≤ 31 days from decision to treat to first treatment	% (breach)	DH to publish standards by end of July	97.9 (2)	98.9 (1)	available c. 25/7	98.4 (3)				Estimated unadjusted performance under the new monitoring system (effective 1 January 2009) = 98.00%
NP05		All Cancers: 62 days standard % treated ≤ 62 days from urgent GP referral to first treatment	% (breach)	DH to publish standards by end of July	83.3 (6)	97.4 (1)	available c. 25/7	90.35 (7)				Estimated unadjusted performance under the new monitoring system (effective 1 January 2009) = 86.00%
NP06		All Cancers: 2 weeks standard % seen ≤ 2 weeks from urgent GP referral to first appointment	% (breach)	DH to publish standards by end of July	94.9 (18)	97.3 (8)	available c. 25/7	96.1 (26)				Estimated unadjusted performance under the new monitoring system (effective 1 January 2009) = 93.00%
NP07	VSB01	All Age All Cause Mortality	rate	females: 470/100,000 males: 645/100,000								
VSB09	VSB09	Childhood Obesity Rate	rate	Reception Yr: 10.29%								
NP09	VSB09	Childhood Obesity Rate	rate	Yr 6: 18.86%								
NP10	VSB13_03	Chlamydia Screening % population aged 15-24 accepting a test/screen for chlamydia	#	6,324	278	214	available mid July					
NP11	VSB12	CAMHS Commissioning a comprehensive child and adolescent mental health service (score 1-4 to 4 questions)	score	3-3-4-3			3-3-4-3					
NP12		Experience of Patients	score	target to be determined following 08/09 data ratification								
NP13	VSB05	Four Week Smoking Quitters	#	1,562	138	available mid July	available mid August					
NP14	VSA03	Incidence of <i>Clostridium difficile</i>	#	102	10	8	available c.20/7	18	109			
NP15	VSB17	NHS Staff Satisfaction	%	74								
NP17	VSB11	Prevalance of Breastfeeding 6-8 weeks	%	87.7% Coverage 38.6% Prevalance			available c. 14/07					

Appendix 3 - National Priorities 2009/2010

Meeting National Priorities KPIs 2009/2010

PI CODE	VITAL SIGN REF	KEY TARGETS	UNIT	TARGET	APR	MAY	JUNE	Year to Date	2008/09 Outturn	Forecast	Responsible Director	NOTES
NP18	VSB10	Immunisations Coverage	%	As below								
	VSB10_03	Children - Aged 1 - Diphtheria, Tetanus, Polio, Pertussis, Haemophilus Influenzae type b (Hib) / (DTaP/IPV/Hib)		95%								
	VSB10_08	Children - Aged 2 - Pneumococcal infection (PCV Booster)		95%								
	VSB10_09	Children - Aged 2 - Haemophilus influenza type b and Meningitis C (Hib/MenC booster)		95%								
	VSB10_10	Children - Aged 2 - Measles, mumps & rubella (MMR)		89%								
	VSB10_14	Children - Aged 5 - Diphtheria, Tetanus, Polio, Pertussis (DTaP/IPV)		90%								
	VSB10_15	Children - Aged 5 - Measles, Mumps & Rubella (MMR)		85%								
	VSB10_18	Females - Aged 12-13 - 3 doses of HPV		90%								
NP19	VSB03_01	Under 75 years Cancer Mortality Rate	rate	91 per 100,000								
NP20	VSB02_01	Under 75 years CVD Mortality Rate	rate	62 per 100,000								
	VSA14_03	Stroke Care Proportion of people who spend at least 90% of their time on a stroke unit	%	70.00 by year end				available c. 14/07				
NP21	VSA14_06	Stroke Care Proportion of people who have a Transient Ischaemic Attack (TIA) who are scanned and treated < 24 hours	%	55.00				available c. 14/07				
NP23	VSB08_03	Teenage Conception Rate	rate	33.85/1000 females aged 15-17								
NP24	VSB06_03	12 Week Midwifery Target	%	88.00				available c. 14/07				

Appendix 4 - Additional Continuing Priorities 2009/2010

Additional Continuing Priorities 2009/2010

PI CODE	VITAL SIGN REF	KEY TARGETS	UNIT	TARGET	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	Year to Date	2008-2009 Performance	Forecast Traffic Light	NOTES
		Access to GUM % of first attendances at GUM service seen within 48 hours	%	95.00	95.41	98.15	available c.20/7										96.78	94.74	Yellow	
		Ambulance Response Times Cat A 8m Category A calls meeting 8 minute target (PCT)	%	75.00	84.85	82.33	83.36										83.41	80.60	Yellow	
		Ambulance Response Times CAT A 19m Category A calls meeting 19 minute target (PCT)	%	95.00	96.62	98.26	97.46										97.56	97.05	Yellow	
		Ambulance Response Times Cat B 19m Category B calls meeting 19 minute target (PCT)	%	95.00	96.07	96.91	96.81										96.56	95.75	Yellow	
		MRSA	#	10	2	0	available c.20/7										2	10	Yellow	
		Proportion of patients using choose and book	%	70.00	60.76	67.33	58.48										N/a	63.00 March 09	Red	

OBJECTIVE	RAG Status	Current progress
1. Patient Experience and Clinical Safety - Pam Fenner		
Patient Experience Board Established and delivering patient experience agenda	Green	First meeting of Patient Experience Board held on 25/6/09: ToR and workplan agreed; to be monitored through PS&CG; Board presentation in July
Monitoring Pis - CQUIN / Dr Foster / tracker	Yellow	Patient tracker projects being progressed at JPUH and Community Services: reporting through Patient Experience Board and PS&CQ
Implement proposals for roll out of national guidelines re CQUIN, Quality Accounts etc developed	Yellow	Content of CQUIN is agreed and metrics; financial distribution being confirmed by contracting process
Production of a patient prospectus	Yellow	Production planned for end of August
Mixed sex accommodation and sanitary facilities eradicated	Yellow	JPUH action plan on DSSA received 30/6/09; PCT action plan submitted to SHA and published on PCT website on 30/6/09/ To be monitored through CQ Review meetings; presentation to Board in July
Maintain target levels of MRSA / Cdiff	Yellow	Monitoring is ongoing
Monitor MRSA screening levels of elective patients	Yellow	Monitoring is ongoing
Implement screening of non-elective patients	Yellow	In place from 15/6/09
VTE screening being implemented	Yellow	VTE audit to be completed at end of quarter 1; awaiting report
Monitor action to address JPH HSMR above 100	Yellow	
Detailed Dr Foster analysis undertaken	Green	HSMR has fallen (latest figure is 93.5): detailed work is
Action plan to improve data recording	Yellow	continuing to try and understand reasons for change in
Action plan for reducing HSMR in 3 highest areas	Yellow	HSMR

2. Primary and Community Care - James Elliott		
Develop new PMS contractual framework OUTCOME: Contract framework developed ready for release to individual Practices.		2007/08 Practice payment data validation complete. Body contract with Bevan Brittan Solicitors. Internal PCT discussions as to content of Development Framework have taken place. PCT Project Group being established. Information management, development of balanced scorecard and financial profiling capacity not in place yet. PCT negotiating position and team not yet confirmed
Negotiate framework with GP practices OUTCOME: Framework documentation agreed through discussions with LMC and implemented.		LMC/GP Practice Advisory Group currently being established through discussions with the LMC. PCT negotiating position not yet confirmed, PCT project team identified. Capacity for individual contract negotiation also requires urgent consideration.
Evaluate impact of Great Yarmouth's Equitable Access Centre and review options OUTCOME: Evaluation of new Yarmouth Equitable Access Centre with in 2009/10 Financial Year and options paper presented to Executive Team		Full service commenced 11th May 09. Regular meetings established with Practice.
Extend primary medical care service capacity in Lowestoft. OUTCOME: Improved Access in place to primary medical care in the Lowestoft area.		Draft criteria for the development of primary care premises re Estates Strategy have been developed for discussion with PBC and LMC
Commission and procure new dental practice in Southwold / Reydon area OUTCOME: Patients able to access new NHS dental facility in the Southwold / Reydon area.		New NHS dental contract awarded. Service commencement end July 09
Commission dental services for Martham / Halesworth / Bungay OUTCOME: New NHS dental services available for Martham, Halesworth and Bungay patients		Market tested through unsuccessful full procurement process. Reviewing options re service development with existing providers.
Evaluate CSIP / virtual ward concept OUTCOME: A comprehensive understanding of the impact of current initiatives and agreement on the next steps		No change
Transfer of Community services and staff to a new provider		SHA content with approach and progress to date. They have asked for some supplementary information. Report coming to 22 July Board.

3. Long term Conditions - James Elliott		
Long term conditions website online and roll out of 20 LTC personal health plans		No change
Personal Health Plans are offered to 10,000 diabetes patients and 1000 Heart failure patients		No change
DESMOND / DAFNE schemes on target		No change
Redesigning of COPD, Parkinsons disease and Ischaemic heart disease 'whole system' pathways		No change
Extend generic expert patient programmes (EPP and other types of programme)		No change
Navigator / support roles integrated into Practices for PHP		No change
Pilot personal health budgets		No change
EPP awareness training for staff across 15-20 practices		No change
Agree and measure new set of PIS from SHA (need to clarify current position) - include in revised specifications		No change
PHPs to be issued for all LTC conditions during 2010/11		No change

4. Mental Health - James Elliott		
Procure and monitor IAPT programme		Pilot project continues to run well. Interim evaluation report is complete. Finalising documentation necessary for issuing of ITT.
OUTCOME: Full IAPT service procured and in place (Nov 2009)		
Review and redesign primary care and community mental health pathways incorporating IAPT		On track. Further discussion required with key partners to drive this forward.
OUTCOMES: Pathways reviewed and redesigned (Nov 2009)		
Above work incorporated into commissioning intentions (Dec 2009)		
Ensure that all Mental Health services meet the new 18 week maximum waiting time target		Awaiting findings of baseline analysis, which will be available later in July..
OUTCOME: Robust plans and contractual arrangements in place to meet target by April 2011 (Mar 2010)		
Review and redesign Eating Disorder service across the whole PCT area		Baseline analysis of current demand on services being carried out. Scoping of current service provision taking place. Visit and review of inpatient bed commissioned by NWMHFT at All Hallows taking place on August 5th 2009 by EoESCG and PCT.
OUTCOME: Review completed and results incorporated into future commissioning intentions (Dec 2009)		

5. Unplanned Care - James Elliott		
Review unplanned care pathway including OOHs, UCCs and flexible use of resources across social / community / acute care		Workshop held to scope this work. A draft PID and project plan is now being drawn up to tackle the current pressures in the system and to address these as part of our "winter plan". This plan will require senior leadership support across the system and specific project management, both of which are being sought.
OUTCOME: A better balanced system that avoids excessive pressures at the JPH and reduces delayed discharges		
Development of Winter Plan		See above in relation to pathway and capacity planning. Workshop to establish process for developing the Winter Plan.
OUTCOME: Winter Plan developed (Nov 2009)		

6. Staying Healthy - Alistair Lipp		
Review and update sexual health strategy OUTCOME: Sexual Healthy strategy and Commissioning intentions document produced (DEC 2009)		Service mapping completed. Work on needs assessment in hand. "Visioning" day being planned for September.
Increase uptake of Chlamydia screening OUTCOME: Chlamydia screening target of 25% achieved for 2009/10 (MAR 2010)		Current performance below target for first two months. Action plan prepared with specific actions to achieve target by end of year.
Conduct Older people & Substance misuse needs assessment (in conjunction with Norfolk) OUTCOME: Needs assessment completed and fed into future commissioning intentions (MAR 2010)		Completed.
Evaluate package of interventions targeting problematic alcohol use		Plans for place of safety pilots are on track. Delay on acute setting pilot as Business Case not yet approved. Evaluation planned for January.
OUTCOMES: Pilots of place of safety bus carried out in Lowestoft and Yarmouth, evaluated, and recommendations made for the future. (Mar 2010) Pilot commenced at JPH and interim evaluation produced (MAR 2010)		
Deliver brief intervention training for primary care practitioners including harm minimisation and reducing risk		Training in place.
OUTCOME: Number of people receiving training in year. Training evaluated as high quality.		
Review the needs of the Prolific & Other Priority Offender Scheme in both Norfolk & Suffolk OUTCOME: Gap analysis completed and recommendations made for the future (MAR 2010)		Questionnaire to be completed and sent out shortly via Great Yarmouth and Waveney PPO schemes
Health at Work programme targeting 10 businesses to provide tailored healthier lifestyle packages		No change
Roll-out of CVD risk Assessments for people aged between 40-74 highest risk categories		No change
Social Marketing strategy completed		Awaiting implementation of Comms and Engagement strategy. Asst Dir Comms has been appointed. Start date Sept 14th.
Examine social marketing commissioning opportunities		Awaiting implementation of Comms and Engagement strategy. Asst Dir Comms has been appointed. Start date Sept 14th.
Health trainers service providing targeted support in our 20% most deprived		No change
Increase contestability of smoking cessation providers		No change
Monitor Smoking quitters targets		No change
Commission an obesity needs assessment and develop a commissioning strategy		Service spec written for needs assessment. went out for competitive quotes Contract not awarded. Work will be done in house by PH information team 01.09.09 Commissioning strategy will be work undertaken once needs assessment completed.
Monitor progress of Mini MEND & HENRY pilots		HENRY 18 month pilot running in Waveney – One Trainer completed national HENRY training based in the PCT. Delivered core HENRY training 2 day training to 45 health and early years' practitioners very good evaluation another 15 practitioners booked for August 09.2 parent programmes delivered. Mini MEND recruitment difficult Jan – May 2009 5 programmes delivered to 45 children and families across the patch. local intelligence indicates that this would not be the programme of choice. UEA evaluation in progress.
Monitor progress of MEND		Family recruitment difficult although feedback from NCMP was encouraging Publicity ++planned over Summer holidays for September delivery
Monitor range of breastfeeding initiatives		Designated Breast Feeding Team in place, 4 baby café running across the patch a further 2 work in progress Commissioned UNICEF training and train the trainer X2 Social marketing research project completed, looking at the increasing rates in our 4 most deprived wards Pilot 24 hour support phone line in progress
Joint programme with LSPs on improving built/natural environment & support active transport		No change

7. Planned Care - James Elliott		
Evaluation of pilot initiatives on shifting care setting OUTCOME: Clear assessment on the success of pilots agreed in 2008/09 and outcome measures for those approved in 2009/10 resulting in recommendations re permanency and expansion		Internal work to draw together and confirm all pilots started
Develop proposals to shift care from a secondary care to primary care OUTCOME: Specific proposals are set out for implementation from 2010/11 and acute hospital contract amended accordingly		Initial internal discussions re the opportunities presented in Neil Wilson and Associates report have taken place. Andy Evans is drafting a PID for this project.
Complete Pharmaceutical Needs Assessment OUTCOME: PNA Available on PCT Web site		Webstar Health engaged to produce interim PNA for publication on PCT Website. Pharmacy information
Commission orthodontic additional capacity to reduce backlog OUTCOME: Orthodontic backlog reduced to meet Pledge 2 18 weeks target.		Previous orthodontic waiting list initiative extended for 09/10 financial year to clear backlog of assessments by Dec 09
Measure new clinical, quality of life/experience outcomes		No change
Monitor Contract to ensure Consultant lead services with JPH reduce to 16 weeks RTT		No change
Monitor Contract Community Services achieve a maximum of 18 week waits		No change
Monitor Orthodontic services delivering maximum 18 week wait target		No change
Data and information being collected and informing PCT on mental health waits		NWMHFT currently collecting information in Quarter 1 to inform work on achieving 18 week target in 2010/11.
Data and information being collected and informing PCT on community service waits		No change
Pulmonary rehabilitation achieving uptake of 0.23% pop		Contract agreed JPH but delay to start-up to 1 July 09
Cardiac Rehab achieving NICE target		Phase 4 ready to be commissioned summer 09
Ensure provision of 24/7 service for stroke thrombolysis		Thrombolysis service available Monday - Friday at James Paget. Confirmation of timetable for delivering 24/7 to be advised at next Contract & Performance Review Group (15 July)

8. Children and Young People - James Elliott		
Implement the Child Health Strategy. Improve range of preventative and expand health promotion in different settings.		Assessing health visitor and school nursing capacity to deliver on targets.
Prepare Commissioning intentions that align with Norfolk and Suffolk plans		Aligned with Norfolk plans but not yet in Suffolk.
OUTCOME: Both Children's Trusts to approve our Commissioning intentions (Sep 2009)		
Support the schools targeted mental health programme		Primary health care worker lead appointed. Renewed contract schedules.
OUTCOME: TAMS rolled out across Great Yarmouth and Waveney (Sep 2010)		
Comply with the CAMH national proxy targets		On target to comply with 4 09/10 "proxy" targets.
OUTCOME: Achieve all 4 targets (May 2010)		
Embed joint commissioning arrangements for Aiming High programme and provide innovative choice for respite and short break provision		Service provisions are planned. Norfolk and Suffolk have commissioning arrangements in place.
OUTCOME: 17 children with complex health needs provided with respite support (Mar 2010)		
Implement the You're Welcome Programme		Young people's interview training planned for September.
OUTCOME: The views of children and young people are taken into account in planning and delivering services.		

9. Maternity - James Elliott		
Plans developed for co-located midwife led unit OUTCOME: Midwife led unit in place and running (June 2010)		Physical area identified at JPH. Detailed planning being carried out by working group. Not yet received detailed implementation plan. Plan requested from JPH.
1 to 1 midwifery care in place for all women OUTCOME: JPH delivering 1 to 1 midwifery care for all women during established labour (Jan 2010)		Business Case has been produced and is being considered by the PCT.
Audit uptake of direct access to midwives and choice of antenatal care OUTCOME: Women provided with direct access to midwives and choice of antenatal care		A survey is being conducted. Results available by end of September. Routine auditing will then follow.
Plans in place to work with those identified as being in most need OUTCOME: Plan approved for supporting those identified as being in most need (Jan 2010)		Midwife for vulnerable women approved. Postnatal options available. Work with teenage mothers service planning underway.

10. End of Life - Pam Fenner		
Complete needs assessment and gap analysis of end of life services		Delayed until September
Develop delivery arrangements and new service model for commissioning		Phase 1 report delayed; revised timescale is September
All providers using agreed tools for advance care planning in last year of life		Work ongoing: GSF is picked up as part of QOF

11.Cancer - Pam Fenner		
Negotiate with provider roll out of breast screening age extension		Bids submitted for national funding
Full implementation of IOG for Upper GI, Head and Neck, Urology and Gynaecological Cancers		no change
Full implementation of IOG for skin cancers		no change
Full implementation of IOG for Pancreatic Cancers		no change
Full implementation of IOG for Children & YP, Brain and CNS, and Sarcoma		no change
Ensure working towards achieving cancer waits		no change
Monitor age extension targets for breast cancer screening		bids submitted for national funding
Monitor age extension targets for bowel cancer screening		no change
Examine potential spare capacity with local providers of radiotherapy to relieve capacity in s/t		Work continues

12. Dementia - James Elliott		
Produce a Dementia Strategy for Great Yarmouth and Waveney incorporating the Norfolk and Suffolk strategies OUTCOME: Local Dementia Strategy and commissioning intentions produced incorporating Norfolk and Suffolk Strategies (Mar 2010)		Dementia Strategy continues to be developed in Norfolk (Suffolk Strategy complete). Successful bids for the pilot projects for dementia advisors have been confirmed in both Norfolk and Suffolk (1 wte in Waveney & 0.5 wte in Gt Yarmouth)
Produce a plan for the future provision of older people's mental health NHS funded beds OUTCOMES: Proposals for beds fully consulted upon (Jan 2010) Commissioning intentions produced (Mar 2010)		Preconsultation exercise arranged for 29th July 2009 including all relevant stakeholders.

13. Learning Difficulties - James Elliott		
1 - Finalise development of PCT vision for Learning Disability Services. OUTCOME - Strategy and action plan approved by PCT Board and endorsed by Commissioning partners (Sep 2009)		Development of strategy and action plan continues in liaison with the work that is happening in Norfolk & Suffolk
2 – Deliver 2009/10 actions in action plan OUTCOME - Self-Assessment RAG scores improved (Mar 2010)		Work to produce detailed plans for delivery continue as does the liaison with the work which is happening in Norfolk & Suffolk.
3 – Agree formal Joint Commissioning arrangements for Norfolk and Suffolk OUTCOME - Section 75's arrangements signed off (May 2009)		Complete.
4 – Transfer of 'Social Care' Resources to local authorities agreed for 2010/11 OUTCOME - Resources identified and formal transfer agreed (Mar 2010)		Further return sent to the Dept of Health on 26th June 2009.
5 – All people with learning disabilities who have been living in NHS Campus Provision will be living in their own homes. OUTCOME - All individuals re-settled into appropriate accommodation (Mar 2010)		Confirmation of Stage 3 Capital Bid received. Whole amount of £2,490,000 awarded for the remainder of reprovision across Suffolk. Current detailed timetable and plan being reviewed in light of news on capital funding.
6 – Improve Access to Primary Care OUTCOMES - At least 20 out of 26 GP Practices signed up to the DES (Dec 2009) Plan in place to achieve Health Action Plans for all adults with a learning difficulty who want one by Mar 2011 (Sep 2009) 50 % of ALD offered a Health Action Plan (Mar 2010)		18 out of 26 GP surgeries have signed up to the LD DES. Draft business case for Health Care Facilitator has been completed. The ability to drive forward the primary care agenda for people will be dependant on this post being agreed.

14. Miscellaneous - James Elliott		
Carers support workers in place and working across NHS / LA and 3rd Sector		Stroke carers service agreed from Sept/Oct 09. Generic support worker pilot GY.
Ensure and monitor recommendations from prison health needs assessment are completed		Plan to be drawn up to achieve all the recommendations. This will be monitored through the Prison Partnership Board.

Great Yarmouth and Waveney Joint Health Scrutiny Committee

ACTION REQUIRED

Members are asked to:

- suggest issues for the forward work programme that they would like to bring to the committee's attention
- consider whether there are topics to be added
- consider and agree the scrutiny topic below

Please consider issues of priority, practicality and potential outcomes you wish to achieve before adding to the work programme.

Proposed Forward Work Programme

<i>Meeting dates</i>	<i>Briefings/Main scrutiny topic/initial review of topics/follow-ups</i>	<i>Administrative business</i>
October 2009	<ul style="list-style-type: none"> • Divestment of NHS Great Yarmouth and Waveney Community Services - Update by Peter Gosling, Project Lead, on presentation given at meeting on 12 May 2009. • NHS Great Yarmouth and Waveney's Five Year Strategic Plan – Update on any developments, including progress in delivering the World Class Commissioning Development Plan submitted by the PCT to the Strategic Health Authority. • Norfolk and Suffolk ME/CFS Services – Response to consultation. 	
January 2010 <i>(Delay until Feb 2010??)</i>	<ul style="list-style-type: none"> • ME/CFS proposed service model – Final consideration of the consultation process and the PCTs' decisions. 	<i>Delay meeting to Feb2010 (depending on when PCTs ratify ME/CFS proposals)</i>
April 2010	<ul style="list-style-type: none"> • NHS Dental Services – Update on report presented to the joint committee on 12 May 2009. 	<i>Originally programmed for May 2010</i>

Provisional dates for consultations / update reports to the Committee

?? after October 2009 – consultation on changes to Older People's Mental Health Services, arising from the Dementia Strategy Action Plan.