Great Yarmouth and Waveney Joint Health Scrutiny Committee

Date: **Wednesday, 19 January 2011**

Time: **10.30 am**

Venue: **The Jack Payne Community Room, The Cobholm and Lichfield Health and Resource Centre, Pasteur Road, Great Yarmouth, Norfolk (see location details attached to the agenda for further information)**

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 AUTHORITY	
John Bracey	Broadland District Council
Michael Carttiss (Chairman)	Norfolk County Council
Michael Chenery of Horsbrugh	Norfolk County Council
Mr P Collecott	Waveney District Council
Tony Goldson	Suffolk County Council
David Harrison	Norfolk County Council
Susan Vincent	Forest Heath District Council
Colin Walker	Suffolk Coastal District Council
Shirley Weymouth	Great Yarmouth Borough Council
Anne Whybrow	Suffolk County 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 Apologies

2 Glossary of Terms and Abbreviations (Page)

3 Minutes

To confirm the minutes of the meeting of the Great Yarmouth and Waveney Joint Health and Scrutiny Committee held on 22 October 2010. (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 Pharmaceutical Needs Assessment – Outcome of Public Consultation (Page)

Report from Francoise Price, Deputy Head of Prescribing and Medicines Management, NHS Great Yarmouth and Waveney

7 Progress in developing a GP Consortium for Great Yarmouth and Waveney

Report and presentation from Andy Evans, Chief Executive of HealthEast (Page)

8 Integrated Urgent Care Strategy (including Out of Hours GP Service) for the Great Yarmouth and Waveney Area

Report by James Elliott, Deputy Director of Commissioning and Performance, NHS Great Yarmouth and Waveney (Page)

9 Forward Work Programme

To consider and agree the forward work programme (Page)

10 Agree dates for meetings in April and July 2011

Members are asked to bring their diaries with them to the meeting

11 Information Only Items:

These items are not intended for discussion at the Committee meeting. Further information may be obtained by contacting the named officer or Committee member for each item. Alternatively, Members may wish to consider whether there are any matters arising from this information that warrant specific aspects being added to the forward work programme or future information items.

- Verbal report on meetings between commissioners and patient/carer representatives regarding proposals for ME/CFS services.
- Verbal update on engagement with stakeholders, clinicians and patients groups concerning Older People's Mental Health NHS Specialist Beds/ Dementia Strategy.
- Transfer of Community Services to a Social Enterprise - Briefing report from Peter Gosling, Project Director, NHS Great Yarmouth and Waveney attached. (Page)

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Date Agenda Published: 11 January 2011

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Item No. 2

Great Yarmouth and Waveney Joint Health Scrutiny Committee – 19.1.11

Glossary of Terms and Abbreviations

A&E	Accident and Emergency department
CRHT	Crisis Resolution and Home Treatment team
CIC	Community Interest Company
CV	Contract Variation
DH (or DoH)	Department of Health
EEAST	East of England Ambulance Service Trust
GYWCS	Great Yarmouth and Waveney Community Services
HSC	Health Scrutiny Committee
IST	Intensive Support Team
JPUH	James Paget University Hospital
KPI	Key Performance Indicator
LINk	Local Involvement Network
NHS GYW	NHS Great Yarmouth and Waveney
NQR	National Quality Requirement
OOH	Out of Hours
PCT	Primary Care Trust
PNA	Pharmaceutical Needs Assessment
SHA	Strategic Health Authority
SIH	Suffolk Integrated Health (part of the Harmoni organisation which is currently contracted to provide Out of Hours services in the Great Yarmouth and Waveney area)
SPN	Special Patient Note
TCN	Take Care Now (the provider of Out of Hours services in the NHS Great Yarmouth and Waveney area prior to 1 April 2010)

GREAT YARMOUTH AND WAVENEY JOINT HEALTH SCRUTINY COMMITTEE
MINUTES OF THE MEETING HELD ON 22 OCTOBER 2010

Present:

Michael Carttiss (Chairman)	Norfolk County Council
Michael Chenery of Horsbrugh	Norfolk County Council
David Harrison	Norfolk County Council
Susan Vincent	Forest Heath District Council
Colin Walker	Suffolk Coastal District Council
Shirley Weymouth	Great Yarmouth Borough Council

Substitute Member Present:

Peter Balcombe for John Bracey	Broadland District Council

Also Present:

Chris Humphris	Deputy Director of Commissioning and Performance, NHS Great Yarmouth and Waveney
James Elliott	Deputy Director of Commissioning and Performance, NHS Great Yarmouth and Waveney
Francoise Price	Deputy Head of Prescribing and Medicines Management, NHS Great Yarmouth and Waveney
David Sparkes	Norfolk LINk
Tony Woods	Norfolk/Suffolk LINk
Anthony Darwood	Norfolk LINk
Mickie Munio	NWMHP NHS Foundation Trust
Roy Jones	NWMHP NHS Foundation Trust
Susan Payne	Norfolk and Waveney LMC
Jennifer Beesley	Member of the Public
Keith Cogdell	Scrutiny Support Manager, Norfolk County Council
Tim Shaw	Committee Officer, Norfolk County Council

1 Apologies for Absence

Apologies for absence were received from Peter Collecott (Waveney District Council), Anne Whybrow (Suffolk County Council) and Tony Goldson (Suffolk County Council) and John Bracey (Broadland District Council).

2 Glossary of Terms and Abbreviations

The Committee noted the glossary of terms and abbreviations.

3 Minutes

The Minutes of the previous meeting held on 27 July 2010 were confirmed by the Committee and signed by the Chairman.

4 Declaration of Interest

Peter Balcombe (Broadland District Council) declared a personal interest in Item 6 (NHS Specialist Beds for Older People with Mental Health Needs) because his wife and his son both worked for the NWMHP NHS Foundation Trust.

5 Urgent Business

There were no items of urgent business.

6 NHS Specialist Beds for Older People with Mental Health Needs

The Committee received a suggested approach from Keith Cogdell, Scrutiny Support Manager, Norfolk County Council, to a report from Chris Humphris, Deputy Director of Commissioning and Performance, NHS Great Yarmouth and Waveney, concerning NHS specialist beds for older people with mental health needs.

In the course of discussion and in answer to Members' questions, the Committee noted the following:

- To relocate some of the in-patient beds for older people with mental health needs from Carlton Court, Lowestoft back to Great Yarmouth would be an inefficient use of NHS resources. The original move of assessment beds from Great Yarmouth to Carlton Court had resulted in substantial efficiency savings.

- NHS Great Yarmouth and Waveney did not have the resources to operate bed based units in both towns.

- Small NHS bed based units tended to be costly, and it was difficult to maintain quality of service.

- The Board of NHS Great Yarmouth and Waveney was of the view that it would be more useful to have a planned programme of stakeholder events about the provision of specialist beds for older people with mental health needs held throughout the Great Yarmouth and Waveney area than it would be to have a formal public consultation exercise on this matter.

- Chris Humphris said that he was in discussions with officers from Norfolk County Council about the possibility of operating a wider range of services in Great Yarmouth than was the case at present.

- Tony Woods, Norfolk/Suffolk LINk, said that service providers such as the James Paget Hospital, GPs and care home providers, needed to work together with NHS Great Yarmouth and Waveney to improve services for people with dementia and those for older people with functional mental health problems.

- In reply to questions, it was also pointed out that it was for Members of Norfolk and Suffolk LINk, rather than for Members of this Committee, to explore patients' views of the level of service provided at Carlton Court.

- During the last six months, only three patients who would have been admitted to Carlton Court, had been admitted elsewhere because of a lack of beds.

- In the NHS Great Yarmouth and Waveney area there were 12 dementia assessment beds, 12 beds for older people with mental health needs and 34 continuing care beds for people with dementia.

- One of the nurses at Carlton Court had been short-listed for the prestigious Dementia Nurse of the Year award. This was seen as an example of the high esteem in which nurses at Carlton Court were held by the nursing profession and the public. The Committee asked for their congratulations to be sent to the nurse concerned, Julie Kerton, who was not successful in obtaining the award.

The Committee agreed to nominate Susan Vincent (Forest Heath District Council) and Shirley Weymouth (Great Yarmouth Borough Council) to represent the Committee as part of the Public and Patient Engagement Programme for NHS Specialist Beds for Older People with Mental Health Needs that was due to be run by NHS Great Yarmouth and Waveney on a continual basis. It was suggested that these Members should keep the Committee informed of developments as part of the Information Bulletin.

7 Out-of-Hours GP Service for the Great Yarmouth and Waveney Area

The Committee received a suggested approach from Keith Cogdell, Scrutiny Support Manager, Norfolk County Council, to a report from James Elliott, Deputy Director of Commissioning and Performance, NHS Great Yarmouth and Waveney, concerning the out-of-hours GP service for the Great Yarmouth and Waveney area.

In the course of discussion and in answer to Members' questions, the Committee noted the following:

- The current contract with Suffolk Integrated Health (Harmoni) to provide an out-of-hours GP service had been extended to July 2011 to allow NHS Great Yarmouth and Waveney an opportunity to enhance the existing specification, including the establishment of a single point of access/call centre.

- There was no requirement for formal consultation on a change in provider because there were no changes proposed in the range of services that would be provided.

- Some Members commented that the existing OOH service suffered from a disengagement of local GPs and the subsequent loss of confidence from clinicians and the public. In reply to this point James Elliott said that approximately 70% of the GPs that provided the OOH service came from within the locality.

- James Elliott was confident that a new OOH service would be operational from July 2011.

- The Board of NHS Great Yarmouth and Waveney had approved the contract

extension with Suffolk Integrated Health in order to allow time to implement the Integrated Urgent Care Strategy and the procurement of some or all of the elements of that strategy, including a fully comprehensive and integrated OOH service.

The Committee agreed to receive a report about the Integrated Urgent Care Strategy (including comparative information about national and regional standards of out-of-hours care) at the next meeting, by which time the Board of NHS Great Yarmouth and Waveney should have considered this matter further and timescales and arrangements should have become more clear.

The Committee also noted the progress made with the contract extension with Suffolk Integrated Health, the outcome of an East of England Intensive Support Team assurance visit and the feedback from research into people's use of out-of-hours services, as set out in the report from NHS Great Yarmouth and Waveney.

8 Pharmaceutical Needs Assessment (PNA) – Public Consultation

The Committee received a suggested approach from Keith Cogdell, Scrutiny Support Manager, Norfolk County Council, to a report from Francoise Price, Deputy Head of Prescribing and Medicines Management, NHS Great Yarmouth and Waveney.

In the course of discussion and in answer to Members' questions, the Committee noted the following:

- NHS Great Yarmouth and Waveney had to publish a Pharmaceutical Needs Assessment by 1 February 2011.

- The public consultation on the Pharmaceutical Needs Assessment for the NHS Great Yarmouth and Waveney area had been extended to 26 November 2010 following DH guidance issued after the launch date.

- The PNA was due to go to the Board of NHS Great Yarmouth and Waveney for approval in January 2011 and to be published in February 2011.

- Jennifer Beesley, a member of the public, said that in some rural parts of the Great Yarmouth and Waveney area pharmacists appeared to hold insufficient quantities of certain drugs and patients in need of those drugs were either having to travel into Great Yarmouth or Lowestoft or to wait until the following day to fill a prescription. In reply, Francoise Price said that while NHS Great Yarmouth and Waveney could not discuss individual cases in public, they would be willing to take up such matters with pharmacists on production of supporting evidence from members of the public.

The Committee agreed not to make a formal response but to leave it to individual Members to respond to the consultation as members of the public, should they wish to do so. It was also agreed that the outcome of the public consultation should be reported to the January meeting of the Committee.

9 Forward Work Programme

The Forward Work Programme was agreed as follows:

19 January 2011 –	Progress in establishing a GP Consortium for Great Yarmouth and Waveney. Integrated Urgent Care Strategy (including out-of-hours GP service) for the Great Yarmouth and Waveney area. A follow up report from James Elliott, Deputy Director of Commissioning and Performance, NHS Great Yarmouth and Waveney (to include, at the request of Members, comparative information about national and regional standards of out-of-hours care). Pharmaceutical Needs Assessment – outcome of public consultation. A follow up report from Francoise Price, Deputy Head of Prescribing and Medicines Management, NHS Great Yarmouth and Waveney.
April 2011 (the date to be agreed) –	Five year strategic plan – to provide an update on achievements and difficulties over the preceding 12 months and priorities for the next 12 month. Acute hospital care – to scrutinise progress against a strategic plan to improve preventive and community support for some services to reduce the need for hospital based service provision. Information Only Item – transfer of Community Services – to provide an update on proposals to transfer Community Services to a Social Enterprise.

The meeting concluded at 12.48pm

CHAIRMAN

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Great Yarmouth and Waveney Joint Health Scrutiny Committee
19 February 2011
Item no 6.

Pharmaceutical Needs Assessment (PNA) – Outcome of Public Consultation

Introduction by the Scrutiny Support Manager

1. Background

1.1 At its last meeting, this Committee received a report from Francoise Price, Deputy Head of Prescribing and Medicines Management at NHS Great Yarmouth and Waveney, giving details of the process followed in producing the PNA, including the involvement of key partners and stakeholders as well as local people. The Committee heard that the period for public consultation would end on 26 November 2010 and that the PNA had to be published by 1 February 2011.

1.2 The Joint Committee decided not to make a formal response to the consultation but to leave it to members to respond as individuals if they so wished. However, it was requested that a report detailing the outcome of the consultation be provided for the Committee's next meeting.

1.3 Francoise Price, Deputy Head of Prescribing and Medicines Management at NHS Great Yarmouth and Waveney, and the author of the PNA document, has provided the attached report and will attend today's meeting to answer any questions or respond to any comments that Members may have.

Officer Contact:

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NHS
Great Yarmouth and Waveney

Pharmaceutical Needs Assessment (PNA) brief for Great Yarmouth and Waveney HOSC

Introduction

The Health Act 2009 contains powers within it to require primary care trusts to develop and publish PNAs by 1 February 2011. The National Health Service (Pharmaceutical Services and Local Pharmaceutical Services)(Amendment) Regulations 2010 which came into force on 24 May 2010 define pharmaceutical services and lay out the minimum content of a PNA.

A PNA is a tool used in the commissioning of pharmacy services. It reviews current provision of pharmaceutical services to the characteristics of NHS Great Yarmouth and Waveney's population and priorities for improving health and wellbeing.

Public consultation

The public consultation closed on the 26 November 2010.

Dr S Wilkinson of the University of East Anglia has produced the following documents:

- Consultation Analysis Feedback Report
  This report gathers responses to the consultation from both individual members of the public and stakeholder organisations
- PNA Consultation Compliance Report
  This report provides an independent view on how the consultation complied with the Code of Practice on Consultations published by the Cabinet Office Regulatory Impact Unit.

PNA Amendments

The draft PNA document was amended in light of feedback from the public consultation, the Local Pharmaceutical Committee and the Local Medical Committee.

The changes were agreed at the PNA Working group meeting of 7 December 2010 and approved by the PNA Project Board on the 8 December 2010. A report was submitted to NHS GYW Clinical Executive Committee on the 9 December 2010. NHS GYW Board received brief including changes to draft PNA on 22 December 2010. Françoise Price (author) responded to questions from the Board. The board members were asked to send any further comments to Françoise by the 7 January 2011.

A series of questions were raised during the public consultation, NHS GYW will respond and publish this response together with both reports by Dr Wilkinson on the NHS GYW website.

PNA Sign Off
The PNA will be submitted for sign off by NHS GYW board at the Public Board meeting on 26 January 2011 and will be published on the 1 February 2011.

Françoise Price
Deputy Head of Prescribing and Medicines Management

7th January 2010

Great Yarmouth and Waveney Joint Health Scrutiny Committee
19 January 2011
Item no 7.

Progress in developing a GP consortium for Great Yarmouth and Waveney

Suggested approach by the Scrutiny Support Manager

1. Background

At its last meeting, the Joint Committee expressed an interest in hearing about progress in setting up a GP consortium for Great Yarmouth and Waveney, in line with reforms outlined in the Health White Paper, 'Equity and excellence: Liberating the NHS.' HealthEast is a Community Interest Company that has been established to provide this consortium and its Chief Executive, Andy Evans, has agreed to attend today's meeting to provide Members with a presentation and respond to any questions or comments that Members may have. He has also provided the attached report for information in advance.

2. Suggested approach

It is suggested that members of the Joint Committee:

- Consider the information provided and raise any outstanding questions or concerns. Members may be particularly interested in hearing details of how HealthEast intends to build transparency, involvement and accountability into its arrangements.
- Decide whether they would like to receive further progress reports from HealthEast and, if so, at what intervals.

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HealthEast CIC

Background to GP Commissioning in Great Yarmouth and Waveney, January 2011

Introduction

GP commissioning was introduced as a concept in the July 2010 White Paper - *Liberating the NHS.* The white paper proposed, amongst other wider proposals, that responsibility for the commissioning of health care in England and Wales be progressively handed over to GPs working in groups known as consortia.

That responsibility would involve financial responsibility for 80–85% of the total NHS budget, with responsibility for the balance being assumed by Local authorities (Public Health/health improvement) or a new National Commissioning Board (primary care contracts, specialised commissioning).

As a result of the shift in responsibilities PCTs and SHAs would be dissolved by April 2013.

The thinking behind the proposal hinges on the fact that not only is it that clinicians are uniquely placed to be able to assess patient needs and the best way to treat them, but it is also actually clinicians who commit NHS funds, not managers, and so getting their full involvement in planning/spending decisions is vital. It builds on the fact that GPs routinely act as patients' advocates and day to day work closely with them addressing their personal issues and priorities and so really understand the practical impact of spending decisions on patients' lives.
As GP coverage is universal all spending can be tracked back to a GP practice.

GPs would not have a choice about whether they took up this opportunity because their primary contract would effectively depend on it.

In fact, the notion of delegating full responsibility for commissioning to GPs is neither new nor uniquely coalition policy. Initiatives such as GP Fund holding in the 90s and practice based commissioning very recently, are the basis of GP commissioning. The difference is the scale and speed of change at a time of great financial instability.

Enthusiasm for the white paper proposals, which will be enshrined in a Health Act in January, has been mixed because of the risks involved in such a significant change in organisation of the NHS. Enthusiasm amongst GPs in Great Yarmouth and Waveney has however been clear.

Arrangements in Great Yarmouth and Waveney

The GP practices in Great Yarmouth and Waveney (27) have been working together closely as practice based commissioners under a single management structure for some time. Originally there had been a different approach in Waveney compared to Great Yarmouth but it became clear that practices have the same approach to general practice and look after a patient base which shares many common characteristics. Indeed the Waveney and Great Yarmouth populations are very similar to each other and are different to those of the rest of Suffolk and Norfolk. Both areas have also "suffered" in financial and focus terms in the past when grouped in their much larger home counties.

GP practices have also been working very closely with NHS Great Yarmouth and Waveney over the last 18 months or so and have participated in the very significant and positive advances that the PCT have made recently. They want to protect those gains.

By comparison with practice based commissioning arrangements elsewhere in the East of England local arrangements have been recognised as being advanced for some time. As a result of this strong base, the practices unanimously agreed in August 2010 that they wished to form a single GP commissioning consortium covering the whole of Great Yarmouth and Waveney. They agreed that the previous Waveney Practice Based Commissioning company should be converted to a new Community Interest Company as the vehicle for organising GP Commissioning for the whole area – HealthEast CIC.

HealthEast CIC is a social enterprise owned by all of the practices in the area. It is a non profit making, social enterprise because the practices want to be clear for all that their reason for forming the consortium is about serving the community, not any possible opportunity to further their personal ends. Their single main purpose is to improve patient care in the most efficient way possible and protect all that has been achieved recently, for the benefit of local residents.

They believe that their unique characteristic is that they are clinically led, and that they want to work with all of the other stakeholders in the local health system to provide effective, integrated care. This cooperative approach includes wanting to work with patients, the public, local authorities and other organisations working in the field as well as the more obvious health care providers eg JPUH.

HealthEast has been recognised as a local and national leader in the development of GP commissioning and was designated a *Pathfinder* consortium in December. This confers some freedoms to innovate in the organisation of the consortium and to proceed faster than other non Pathfinder consortia.

The way forward

HealthEast are working with NHS Great Yarmouth and Waveney to accelerate to assume full responsibility for commissioning as soon as is practical. Together they are working so that HealthEast will take on all of the PCT's commissioning responsibilities, under delegated authority, from April 2011. The PCT will be dissolved at a time when HealthEast becomes the local health statutory body, probably some time between April 2012 and April 2013.

The reasons for this accelerated timetable compared to the national deadlines include a common belief that the model is the best way to arrange things and that delay will only cause inertia, loss of performance, anxiety to PCT staff and ultimately poorer patient care. At a time of financial pressure, decisive clear action is needed.

There are also risks from the new "clustering" arrangements of PCTs being introduced by June 2011 and assumption of a full role will provide a clear, unequivocal voice representing the health interests of the people of Great Yarmouth and Waveney.

HealthEast is run by a Board of Directors which includes GPs, practice managers and Lay Directors. It has a small management team but over the course of the next few months there will be transfer of some of the PCT's staff as greater responsibilities are assumed.

However, there are running cost limits for the new GP commissioning organisations and so the final team will be smaller than the current PCT although it appears responsibilities will be little changed. It is therefore vital that HealthEast works in a different, less bureaucratic way and optimises the benefits of being clinically led and working in an integrated way with other local organisations.

HealthEast looks forward to developing close working relations with
local authorities as they assume their new health responsibilities and intends to be sensitive to public/patient opinion, involving them wherever possible, in line with their social enterprise ethos.

It is however vital that at a time when Health and Well-being boards are likely to be created on a county basis, local stakeholder organisations agree how to create a strong Great Yarmouth and Waveney system to plan, organise and lead care in a way which is appropriate to local patient needs. The developing local System Leadership Board may well be this vehicle.

Andrew Evans
Chief Executive
www.healtheastcic.co.uk

Great Yarmouth and Waveney Joint Health Scrutiny Committee
19 January 2011
Item no 8.

Integrated Urgent Care Strategy (including Out of Hours GP Service) for the Great Yarmouth and Waveney Area

Suggested approach from the Scrutiny Support Manager

1. Background

1.1 The Joint Committee received update reports on Great Yarmouth and Waveney's Out of Hours (OOH) service at its meetings on 12 May and 22 October 2010. These reports highlighted a number of developments, including:

- the transfer of the contract for the Out of Hours GP service from Take Care Now (TCN) to Harmoni with effect from 1 April 2010.
- the extension of the contract period to allow for the development of a revised service specification to tender for a new out of hours provider.
- the inclusion of the Out of Hours service in a new Integrated Urgent Care Strategy, and the involvement of all Healthcare providers, social services and appropriate voluntary agencies in a new 'joined-up' service, with a single point of access.

1.2 The following key points were made in the October report:

- the extension of the contract with Harmoni until July 2011 was subject to an "enhanced" service specification which, among other improvements, included the delivery of national and regional standards and requirements.
- a 'single point of access' service would be piloted from November or December 2010 to enable patients to receive urgent advice and treatment around the clock by calling one number.
- the procurement process for a new Out of Hours service and a local call centre should be finalised by July 2011.
- the current service had been evaluated by a Strategic Health Authority Peer Support Visit on 15 September 2010 and initial feedback had been very positive. A full report would be published following the PCT's Board meeting in November.
- The PCT had recently conducted some research into why people use the Out of Hours service and one of the issues this had highlighted was the possible need to improve access to the service in Lowestoft and Gorleston.

1.3 The Joint Committee asked for the Integrated Urgent Care Strategy to be put on the agenda for its meeting in January 2011 and stipulated that the report from the PCT should include information on how the local Out of Hours service performed against national and regional standards.

2. Suggested action

2.1 It is suggested that members of the Joint Committee:

- Consider the attached report by the Deputy Director of Commissioning

and Performance, NHS Great Yarmouth and Waveney, and raise any outstanding questions or concerns.

- Clarify NHS Great Yarmouth and Waveney's intentions around consulting on its Integrated Urgent Care Strategy.
- Decide whether to add any aspect of the Integrated Urgent Care Strategy to the Joint Committee's forward work programme.

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NHS
Great Yarmouth and Waveney

Brief for Great Yarmouth and Waveney Joint Health Scrutiny Committee on The Integrated Urgent Care Strategy (including update on Out of Hours GP Service) for the Great Yarmouth and Waveney Area

Report Purpose
The purpose of this report is to:

1. provide an update on the Integrated Urgent Care Strategy and
2. feed back from the SHA Peer support visit and
3. provide an update on how the local Out of Hours service is performing against national and regional standards.

1 Update on the Integrated Urgent Care Strategy

1.2 Background

The local health care system has many of its building blocks in place to manage demand for urgent care: Minor Injury Units in Waveney, a Walk in Centre in Great Yarmouth, GPs delivering a minor injury service (recently extended to Great Yarmouth practices) and the established primary care infrastructure of GPs and pharmacists treating minor ailments and injuries, in some cases, for extended hours.

During 2010, further investment was approved for full roll out of an intensive case management service to manage patients with long term conditions at risk of emergency admissions. There are now eight community matrons in post with a further three scheduled to come on-line from February – March 2011. A new service to position a GP in Emergency Admissions and Discharge Unit (EADU) at the door of EADU in James Paget will also 'Go-Live' in January 2011. "The Acute GP Service" will be the first point of contact for clinicians referring medical patients to EADU. The service will provide advice and timely face to face assessment by local GPs that could avoid admission to hospital.

Further work to manage demand during summer 2010 included a large scale communications and media campaign to communicate alternative services outside of hospital to treat minor injuries and illnesses, and work with the local ambulance service and community and primary care providers to ensure that patients calling the ambulance service not requiring specialist A&E treatment were assessed and treated in the appropriate care setting outside of hospital. Targeted visits to local care homes with high levels of emergency admissions took place during October to offer support and advice.

A new 24/7 health helpline has also been recently launched for patients in the Great Yarmouth and Waveney area. Members of the community who have a non-urgent health problem can call the helpline 24 hours a day, seven days a week to get help, guidance and to find the best place for treatment. The helpline, which is a pilot project running until the middle of July 2011, has been set up to help advise patients and carers of the health options available.

Progress on delivery of all the unplanned workstreams is reported and discussed at the monthly Unplanned Care Clinical Programme Board and a full report of progress against plan is reported monthly to NHS GYW Board as part of the 'Portfolio Delivery and Performance Report.' The Unplanned Care Clinical Programme Board includes representation from all health and social care agencies and includes patient and public input from the Suffolk and Norfolk LINks.

A weekly operations group with key stakeholders across health and social care has also been in place since May 2010 to discuss capacity and demand and to agree joint actions on addressing key pressure points in the system.

1.3 Integrated Urgent Care Strategy

The Integrated Urgent Care Strategy was endorsed by the NHS GYW Board in September 2010 following approval by the Clinical Executive Committee and the involvement and engagement of representatives from the Unplanned Care Clinical Programme Board who contributed to its development. This board includes representation from all health and social care agencies, is clinically represented and includes patient and public input from the Suffolk and Norfolk LINks. The full strategy is attached at appendix 1 for information.

The Integrated Urgent Care Strategy Vision is to:

'Implement an integrated urgent care strategy to reduce demand for hospital based urgent care services by commissioning responsive, accessible and integrated services outside of hospital that offer choice, meet local need and are value for money.'

A specific local challenge is to achieve higher rates of completion (or closure) of cases through improved standards of call handling, advice and treatment out of hospital, and the subsequent decrease in patients needing to access the hospital Emergency Department. This should be addressed through increased provision of care in primary and community settings.

Working with partner organisations via the Unplanned Care Clinical Programme Board, including LINks, the strategy identifies the following further 'building blocks' or service developments for implementation as follows:

The first is to simplify access for patients in Great Yarmouth and Waveney through development of a single access point. The vision is that patients will be able to call one number to receive urgent care advice and treatment. The single access point will be a call centre where patients will be assessed and triaged and referred on to the most appropriate service according to clinical need.

The next is to expand and enhance services in the geographical areas which have the highest demand for assessment and treatment of minor injuries and illnesses. Analysis of activity data and patient flows has demonstrated the potential shift of up to 45% of current minor A&E activity into a care setting outside of A&E. The clusters of South Lowestoft and South Yarmouth have the highest levels of minor A&E activity.

Lowestoft is a key area of unmet local need and a local minor injury service would bring a service in line for this population with the Greyfriars Walk in Centre in Great Yarmouth which treats minor injuries and illnesses 8am to 8pm, 7 days a week.

There is an opportunity to work with the James Paget Hospital to review and re-design the front end of A&E to consider if a primary care led triage could be co-located to manage demand for minor injuries and illnesses so that the emergency team can focus their resource on those patients referred with the greatest clinical need. The cluster of South Yarmouth has the highest level of minor A&E activity.

NHS GYW also wishes to procure a provider of OOH primary care services to deliver against an enhanced specification – the current contract with the existing OOH provider expires on 15 July 2011. The aspiration is that this provider will deliver timely and quality services to local patients, develop strong clinical partnerships, build and sustain a local workforce of GPs and be a key partner in developing and expanding the new minor injury and illness services and the local call centre or single point of access. As part of the specification, the requirement will be that the OOH bases are co-located with other minor injury and illness services and for the systems and processes to be technically compliant with the call centre which will be the first contact point for patients in and out of hours for urgent care.

Finally there is also the opportunity to procure a Telehealth service to help manage the care needs of patients with high intensity needs and long term conditions in their own homes.

In summary, the following services make up the 'building blocks' of the integrated urgent care strategy:

I. OOH Primary Care – Enhanced Specification
II. Single Access Point / Local Call Centre
III. Primary care led minor injury and illness service in South Lowestoft
IV. Primary care led minor injury and illness triage and treatment service at front end of A&E
V. Telehealth

1.4 Update on implementation of the strategy building blocks above

The OOH Primary Care Enhanced Specification and Single Access Point / Local Call Centre are services out to tender and will be in place by July 2011, subject to procurement timescales.

Feasibility studies are taken place for the primary care led minor injury and illness services in South Lowestoft and at the front end of A&E. Any proposed significant service change may lead to public consultation.

The telehealth service has been put in hold. It was agreed at the September Clinical Executive Committee that the service would be reviewed in 6-9 months time in the context of the impact that other investments have made in reducing emergency admissions e.g. community matrons.

Funding identified to implement key service developments of the integrated urgent care strategy will need to be considered as part of wider NHS and East of England SHA financial context and in light of recent Clinical Executive Committee strategy investment discussions regarding any future investment priorities.

2 Summary of feedback from the SHA Peer Support Visit

On 15 September 2010 NHS Great Yarmouth and Waveney and their Out of Hours provider Harmoni, were subject to an Out of Hours peer review from the East of England team. The visit was chaired by Dr Angelo Fernandes of the Royal College of General Practitioners. Dr Fernandes is the Urgent and Emergency Care champion for the Royal College of General Practitioners, and was the expert clinician on the previous Care Quality Commission report into Take Care Now.

The visit team focused their questions around four main areas:

- Describing the care pathway system
- Clinical Governance
- Performance management
- Education and Training

The intention of the visit was also to gather examples of best practice that could be shared across all PCTs and providers.

In summary, the conclusions of the peer review team included the visiting team being very impressed with the clear strategic direction for Integrated Urgent Care in NHS Great

Yarmouth and Waveney, and the role that Out of Hours could have in this. Harmoni has responded well to the challenge of taking on the management of a service without the benefit of a procurement process, and have maintained a safe service.

Both commissioner and provider have built up a good working relationship during the interim period and have further opportunities to take forward the potential for integration. It was generally acknowledged that there is a need to balance the clear strategic vision with greater focus on the 'here and now' to ensure a safe system during further transition. The visit team commended Dr Jamie Wyllie for his leadership and the team for their effort in driving forward the Out of Hours agenda at the PCT.

2.1 Best Practice identified in the report

Describing the care pathway system

- Both the commissioner and the provider have a good understanding of the pathway. The team was particularly impressed with the commissioner's pictorial description of the pathway across the key National Quality Requirements for Out of Hours Services
- The future potential for out of hours has been articulated by the commissioner within their strategy for Integrated Urgent Care. This can be further strengthened when the out-of-hours service is formally tendered for. The strategy is being developed with input from a patient representative of LINk
- There is a stable local GP workforce
- The JPUH stroke specialist nurse is following through pathway compliance issues directly with practices based on an agreed stroke pathway for OOHs and GP practices

Clinical Governance

- There is strong clinical leadership
- The provider has the advantage of support from governance structures that span the company
- The provider has processes in place for unfilled shifts, including contingency and escalation plans
- There are prospective planning arrangements in place for peak periods which are part of the total health-care system and not just out-of-hours
- Harmoni has a clear clinical governance structure for medicines management at a company and local level

Performance Management

- The performance report has commendable depth, including unfilled shifts and palliative care
- Unannounced visits are taking place
- There are nurse-led quarterly audits
- The commissioner has systems in place for performance management, and there is a weekly discussion across partners re capacity planning

Education and Training

- There are no significant issues with recruitment of trainers
- Robust systems are in place for accrediting locums to ensure a safe service. There is risk management across the system
- As a company the provider is being innovative by exploring joint employment arrangements with general practice and with some PCTs

2.2 Development Opportunities identified in the report

Clinical Governance

- The commissioner needs to re-examine the clinical governance arrangements across the whole system, linking up in-hours and out-of-hours. In particular, there needs to be a review of whether the matrix working arrangements are safe in relation to the reporting of incidents
- Patient involvement in the Patient Safety and Quality group and the Urgent Care Programme Board needs to be looked into
- There is a need to clarify the ultimate governance responsibility within the PCT

Performance Management

- The accuracy of some data in the performance reports needs to be explored and triangulation of data strengthened
- Investigations need to be completed and signed off in a timely manner
- The matrix approach could be simplified and an overall individual lead officer in the PCT identified so that all parties are clear about accountability
- There needs to be a joint understanding of the constraints of the current IT system
- There needs to be clarification of the process for promissory notes
- The commissioner needs to walk through the medicines management pathway
- The commissioner and provider need to explore ways of recording and following through 'near misses'
- There needs to be an audit of primary prioritisation to reflect what 999 referrals represent to fully understand emergency activity as an indicator of pressure on the system and patient safety
- There is a need to formalise the agreement with regard to reporting of concerns raised for GPs who are not on the local performers list
- Plans to implement an integrated appraisal system need to be progressed
- To address NQR4, routine Clinical Audits of consultations need to be routinely reviewed and acted upon

Education and Training

- All clinical supervisors must be approved by the East of England Deanery
- The latest Deanery report needs to be shared with the commissioner
- The GP tutor arrangements need to be formalised

2.3 Notes General on the OOH service

During November Harmoni have transferred to a new IT system called Adastra which facilitates improved call handling, clinical interventions and more in depth performance reporting and management of information.

In January 2011 the OOH Service provider is to be subject to an annual clinical governance review involving Commissioners (NHS GYW and HealthEast), Local LINks and other independent panel members.

This review will include the progress made into the action plan created from the development issues identified in the peer review report, the provider's performance in relation to both the Department of Health's *National Quality Requirements for Out of Hours Services* and the relevant core standards of *Standards for Better Health.*

As a result of the Peer Review and subsequent report, an action plan has been developed and is being implemented to ensure that the issues raised are being addressed and that a constant process of review and challenge of process and monitoring is implemented.

3 Performance against national and regional standards

3.1 Performance management process

The PCT undertakes a comprehensive performance management process, involving monthly performance meetings supported by a formal performance report submitted by the OOH provider. The report indicates compliance against the 13 National Quality Standards (NQRs) which represent the Key Performance Indicators as set out in the contract.

The 13 NQRs are set out in the attached “out of hours patient journey and national quality standards”, diagram/patient pathway. This pictorial description was complimented as part of the peer review process and suggested as shared best practice.

The monthly performance meetings also focus on clinical events and untoward incidents, with clinical challenge by the PCT on learning and process development and improvement.

Of the 13 NQRs, the provider has consistently met the great majority of the requirements. Where compliance is not met, the PCT will implement remedial action. For example the provider was non compliant on 2 elements of the NQRs as identified at the November performance meeting, NQR 9c and NQR 12d. Although only marginal breaches, the provider is required to provide a weekly breach report for all underperformance to both understand causes of breach and ensure action is taken to address breaches.

A critical area identified and included within the contract extension process was the requirement to ensure 100% filling of shift occupancy. A performance measure was included in the contract with a financial penalty if the provider was not compliant.

The PCT wishes to see that as many as possible of the GP shifts are undertaken by local GPs with a good understanding of the local health system. The November performance report indicates that of the November GP shifts 67.8% of shifts were filled by local GPs with a further 20.6% by Norfolk/Suffolk GPs. The balance of shifts are filled by GPs from other PCT areas. This remains a challenging area for the provider and clearly the importance of communicating and working closely with local GPs through, for instance, the GP Commissioning consortium/HealthEast is critical.

Performance management and monitoring has been enhanced substantially over the last 18 months, and whilst there remain real challenges for the OOH provider they are continuing to meet the vast majority of the required quality standards. The PCT Board is clear that this robust performance management and monitoring should continue and that the process of transition to GP Commissioning should ensure that will happen.

James Elliot
Deputy Director of Commissioning and Performance

10th January 2011

Appendix 1

NHS Great Yarmouth and Waveney

Integrated Urgent Care Strategy

NHS Great Yarmouth and Waveney

September 2010

Executive Summary

NHS Great Yarmouth and Waveney (GYW) working with local health and care system partners is implementing an ambitious programme of work to re-design clinical pathways to improve care and reduce demand for emergency services at its local district general hospital, James Paget. This is set in the context of a local health system which is experiencing unprecedented and unsustainable levels of demand for emergency services.

The overarching aim is to implement an integrated urgent care strategy to reduce demand for hospital based urgent care services by commissioning responsive, accessible and integrated services outside of hospital that offer choice, meet local need and are value for money. Such services need to be developed around primary care clusters and natural communities.

The demand management system for integrated urgent care has many of its building blocks in place already: Minor Injury Units in Waveney, a Walk in Centre in Great Yarmouth, GPs delivering a minor injury service (recently extended to Great Yarmouth practices) and the established primary care infrastructure of GPs and Pharmacists treating minor aliments and injuries, in some cases, for extended hours.

Recently, further investment has been approved for full roll out of an intensive case management service to manage patients with long term conditions at risk of emergency admissions. Subject to funding approval, there are plans to roll out telehealth to manage long term conditions and a GP in EADU service to provide options at the door of EADU in James Paget on potential admissions and to direct patients to the most appropriate care.

There is still, however, a need to ensure that more urgent care services are accessible and available in a local community setting. A specific challenge in NHS GYW is to achieve higher rates of completion (or closure) of cases through improved standards of call handling, advice and treatment out of hospital, and a subsequent decrease in patients needing to access the hospital Emergency Department. This should be addressed through increased provision of care in primary and community settings.

In order to achieve this goal, GY&W has identified three further building blocks:

The first is to simplify access for patients in GYW through development of a single access point. The vision is that patients will be able to call one number to receive urgent care advice and treatment. The single access point will be a call centre where patients are assessed and triaged and referred on to the most appropriate service according to clinical need. The ability to link the call centre technically with health system partners will be key along with management of the local directory of services and 'live' capacity map. It is envisaged that the likely base for the call centre could be in one of the existing or new service locations where minor injury and illness services are provided and the approach could build on the already established call centres that have been developed nationally for Out of Hours care.

The next is to expand and enhance services in the geographical areas which have the highest demand for assessment and treatment of minor injuries and illnesses. Analysis of activity data and patient flows has demonstrated the potential shift of up to 45% of current minor A&E activity into a care setting outside of A&E. The clusters of South Lowestoft and South Yarmouth have the highest levels of minor A&E activity.

Lowestoft is a key area of unmet local need and a local minor injury service would bring a service in line for this population with the Greyfriars Walk in Centre in Great Yarmouth which treats minor injuries and illnesses 8-8, 7 days a week. The preferred option is the relocation, modernization and integration of primary and community (out of hospital) health services into an integrated care centre in new and accessible premises in Lowestoft. This would also link with the GP in EADU service.

NHS GY&W would also like to work with the James Paget Hospital to review and re-design the front end of A&E to consider if a primary care led triage could be co-located to manage demand for minor injuries and illnesses so that the emergency team can focus their resource on those patients referred with the greatest clinical need. The cluster of South Yarmouth has the highest level of minor A&E activity.

NHS GYW also wishes to procure a provider of OOH primary care services to deliver against an enhanced specification – the current contract with the existing OOH provider expires on 15 July 2011. The aspiration is that this provider will deliver timely and quality services to local patients, develop strong clinical partnerships, build and sustain a local workforce of GPs and be a key partner in developing and expanding the new integrated minor injury and illness services and the local call centre or single point of access. As part of the specification, the requirement will be that the OOH bases are co-located with other minor injury and illness services and for the systems and processes to be technically compliant with the call centre which will be the first contact point for patients in and out of hours for urgent care.

Finally there is also the opportunity to procure a Telehealth service as part the integrated urgent care specification**.**

Vision and Direction of Travel

The overarching aim for development of an integrated urgent care strategy is to reduce demand for hospital based urgent care services by commissioning a range of responsive, accessible and integrated services outside of hospital that offer choice, meet local need and are value for money. Such services will be developed around primary care clusters and natural communities.

Urgent Care is the range of service responses that health and social care provide to people who require or perceive the need for emergency and urgent care advice, care, support, treatment or diagnosis. People using services (patients, families and carers) 'should expect 24/7 consistent and rigorous assessment of the urgency of their care need and an appropriate and prompt response to that need'(*Direction of Travel for Urgent Care* DH 2006). Integration is where a person's care is integrated in a single process both within and across professions and organisations.

Case for Change

The paper presented to the December 2009 NHS GYW Board meeting called *'Service Models of Care: Out of Hospitals Services Delivery programmes'* sets out the intent for NHS Great Yarmouth and Waveney (GYW) to progress from promoting healthy lifestyles and effective self-management of conditions, to good identification and case management of those at greater risk of a 'crisis', and then to make sure that urgent care services work together to respond effectively, in a suitable range of locations.

An initial assessment of the key drivers for reform in NHS GYW by stakeholders suggests:

- A growing recognition that unscheduled care is not as tightly managed as elective care, even though demand is largely predictable;
- A recognition that services do not interact and integrate in as collaborative a manner as they could and as patients expect;
- A persistent, unsustainable demand for the core Accident and Emergency services despite an understanding that a high proportion of attendances are inappropriate and that alternative action and services could remedy this;
- The need to meet and sustain challenging emergency access targets;
- The impact of Quality Innovation Productivity and Prevention (QIPP) and the requirement for all NHS organisations to demonstrate effectiveness and value for money within a current national and local context of financial stability and control;
- A growing awareness that systems are available that are capable of dealing with enquires by email and text as well as by telephone.

A specific challenge in NHS GYW is to achieve higher rates of completion (or closure) of cases through improved standards of call handling, advice and treatment out of hospital, and a subsequent decrease of patients needing to access the hospital Emergency Department. This should be addressed through increased provision of care in primary and community settings.

Context

The current context is a local health system which is experiencing unprecedented levels of growth for emergency admissions and A&E attendances at the James Paget Hospital. Non-elective admissions increased by 7% for the period April 2009 to April 2010 and A&E attendances by 4.25% for the same time period. This level of demand for emergency services at the hospital is not sustainable and 'reversing this unsustainable rise in emergency admissions must be the number one priority for the NHS in England – any reform to the health service that does not tackle this will fail.' (DOH, July 2010). Furthermore, Dr Jennifer Dixon, Nuffield Trust Director recently stated that, 'Avoidable emergency admissions will continue to rise unless care is more integrated.'

The demand for urgent care is relatively predictable (as detailed in the Warwick Report, Modernisation Agency 2003) and provision therefore should be carefully planned. However, services nationally have tended to develop in an 'ad-hoc' and relatively un-co-ordinated manner. They have also been procured on an organisational and physical boundary basis as opposed to a whole system pathway that adapts to the real needs of local people. The influences of national targets and available resources have contributed to a complex system which the public do not fully understand.

In addition, improvements have been affected by the distribution of responsibility for services across many agencies such as General Practitioners (GPs), NHS Direct (NHSD), Ambulance Services, Acute Trusts, Community services, Social Services, Mental Health and Out of Hours (OOH) providers. Whilst commissioners and those 'inside' the NHS may have a grasp of all these functions, the general public do not. This results in patients taking self-selected shortcuts which tend to be limited to Ambulance and hospital-based services.

Service Model Principles and Objectives

The principles which underpin an integrated urgent care for the population of Great Yarmouth and Waveney is a service model which:

- Achieves the best outcomes for the individual and different patient groups;
- Promotes the right care in the right place and address identified peaks in demand, thus reducing inappropriate and unnecessary hospital admissions;
- Offers choice and a range of services to local people, underpinned by a simple system for accessing appropriate services e.g. single point of access;
- Simplification of the way patients and the public access unscheduled care when it is required, so that they receive consistent, high quality care and advice first time, all the time, in locations and methods most appropriate to their needs;
- Delivers quality requirements which provide consistent and rigorous assessment of urgent care need;
- Provides management and maintenance of people with Long Term Conditions, moving towards self care and discharge from services;
- Provides equitable and accessible services across Great Yarmouth and Waveney 24/7 in line with need;
- Emphasises a collaborative, integrated approach among providers through provision of seamless services with a focus on joint working and inter-agency involvement;
- Meets the key national policies, targets, guidance and good practice models; and
- Offers best value to the taxpayer.

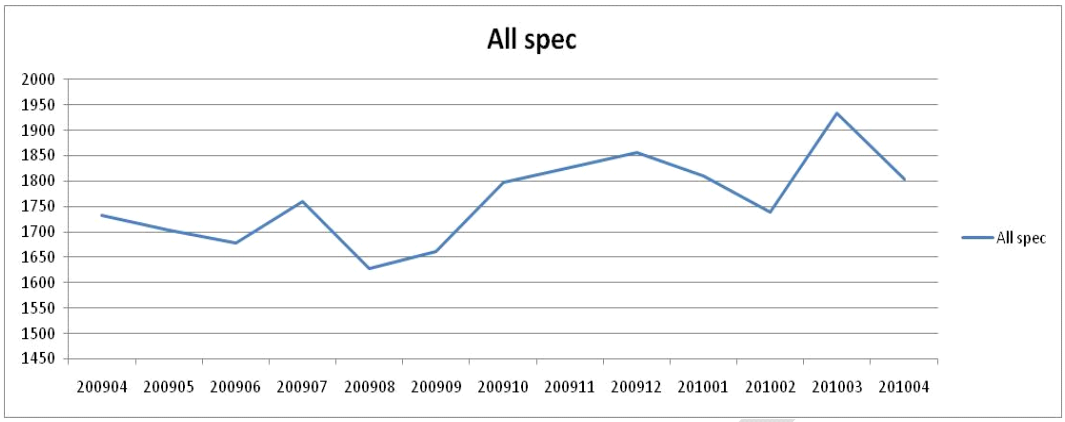
Specific objectives are:

- To effectively utilise the existing capacity of services in the community and primary care that respond to urgent care needs;
- To seek to move to equal provision of urgent care services to address identified need;
- To develop new services out of hospital for urgent care needs where there are commissioning gaps;
- To integrate urgent care services so that the care needs of patients are co-ordinated.

Analysis of patient flows and activity by cluster

Key findings from an analysis of the activity trends for emergency admissions demonstrated that for 2009/10, emergency admissions increased by 7% equating to an additional 120 emergency admissions a month. See **Fig.1**. The clusters of North Yarmouth, Central Yarmouth and South Lowestoft accounted for 79.6% of the growth with respiratory medicine and general medicine (which includes cardiac conditions and diabetes) being the largest growth areas by specialty. An analysis of inpatient non-elective admissions demonstrated that the largest growth area is admissions via A&E and the number of non-elective spells with 0 and 1 night length of stays increased by 19%.

Fig 1: Emergency admission rates 2009/10



Key actions in place to re-design clinical pathways to improve care and manage demand during 2010 are to:

- Recruit Community Matrons to manage 'at-risks' patients in North Yarmouth, Central Yarmouth and South Lowestoft, prioritising those patients with respiratory and CHD conditions.
- Implement a GP in EADU service to see, treat and discharge patients who do not need to be referred and / or managed in an acute setting (leading to reduced short stay admissions).

And early in 2011, subject to procurement timescales, to:

- Roll out Telehealth to manage respiratory and chronic heart disease patients, in line with Community Matron role, focusing on those geographical areas with the highest emergency admissions

Key findings from an analysis of the activity trends for A&E attendances demonstrated that for 2009/10 A&E attendances increased by 4.25%. For A&E attendances the analysis shows that the driver for this increase was ambulance arrivals, which have increased by 22% in April and May 2010 compared to April and May 2009. For the same periods, arrivals by all other sources decreased by 1%.

NHS GYW in partnership with EEAST and other primary and community providers have been working during June 2010 - August 2010 to re-route or divert those patients requiring minor injury assessment and treatment, (that otherwise would be transported to A&E,) to existing services in primary care and community care that are clinically skilled to manage this cohort of patients e.g. Beccles Minor Injury Unit, Greyfriars walk in centre, GP practices with a minor injury local enhanced service.

The main diagnoses for patients who arrive by ambulance and are subsequently admitted to a hospital bed in the Paget are in cardiac problems, fractures, respiratory problems, stroke, and social environment issues. The roll out of the intensive case management service and telehealth will be targeted on high intensity patients with this case mix to keep them well at home and avoid the need for emergency treatment.

Table 1 on the next page set out for 2009/10 James Paget A&E activity and cost by GP practice level. In total, for 2009/10, there were 54,331 A&E attendances at A&E. 24,372 of these attendances were coded as minors with no investigation required which is 45%. This indicates that the proportion of total attendances for minor injury and illnesses which

could potentially be treated in community or primary care setting for minor injury or illness could be as high as 45%.

The proportion of attendances requiring low cost diagnostic investigation is 14% (7,575) suggesting that diagnostics delivered in a primary or community care setting would not add substantially to the numbers of patients treated but would incur considerable costs and also have implications for the skill mix.

Cluster wise, South Yarmouth (7,134 minor A&E attendances) and South Lowestoft (5,032 minor A&E attendances) have the highest A&E attendance rates for minors. This totals 12,166 or 50% of the total number of minor A&E attendances. This analysis is set out pictorially for all clusters at **Fig.2**.

Significantly the South Yarmouth cluster is served by the James Paget Hospital which suggests that due to accessibility of the site to residents and the 4-hour wait target which leads to a timely assessment and diagnosis, many local patients are selecting this service as their local provider of choice.

Currently, there are limited service alternatives too; the nearest walk in centre, Greyfriars, is in Great Yarmouth; the closest minor injury unit is in Beccles, and until very recently, local practices have not delivered the local enhanced service for minor injury assessment and treatment (funding was approved in July and practices are being invited to sign up to this service).

For the South Lowestoft cluster, it is significant that the local area is not served by a local minor injury unit or walk in centre (the nearest is Beccles and Great Yarmouth), although all practices do deliver a local enhanced service for minor injury assessment and treatment.

If South Lowestoft and North Lowestoft clusters are considered jointly, the amount of A&E minor attendances totals 8,273 or 34%.

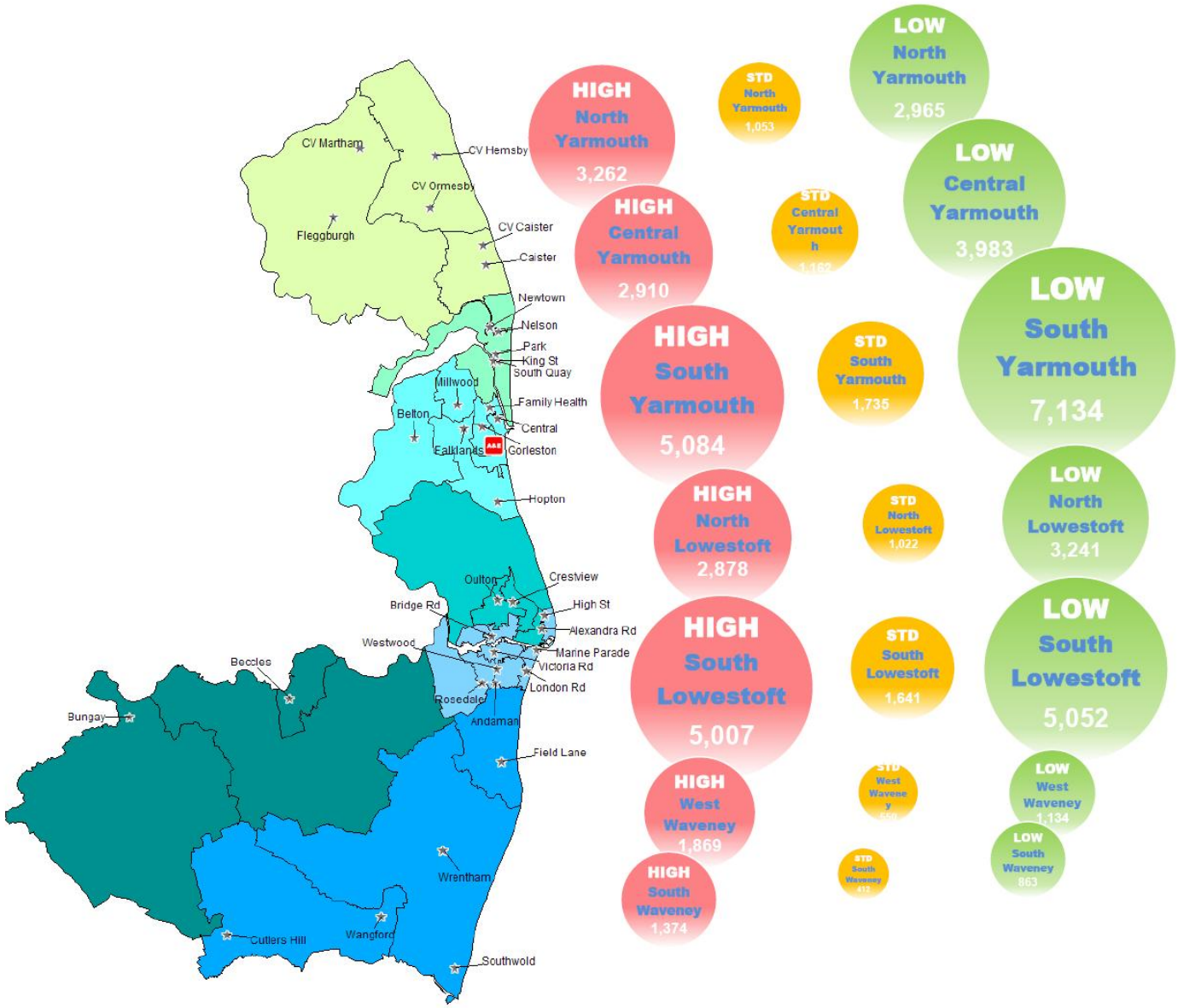
Key findings:

- The potential for shift of minor injuries and illnesses from A&E to a community setting is up to 45%
- The clusters of South Yarmouth and South Lowestoft have the highest levels of minor A&E attendances (12,166 combined) representing 50% of the total
- There is no primary care minor injury unit or walk in service situated in South Yarmouth, an area of high need
- There is no primary care minor injury unit or walk in service situated in South Lowestoft, an area of high needs
- The proportion of attendances requiring low cost diagnostic investigation is 14% (7,575) suggesting that diagnostics provided in a primary and community setting would not be cost effective.

Table 1: 2009/10 James Paget Activity and Cost by GP practice level

Activity	Tariff 10/11	North Yarmouth	Central Yarmouth	South Yarmouth	North Lowestoft	South Lowestoft	South Waveney	West Waveney	Grand Total	
High cost imaging (Died / Admitted) V01	117	72	57	93	69	114	36	41	482	
High cost imaging (Referred / Discharged) V02	117	32	54	56	35	63	22	25	287	
Other high cost investigation (Died / Admitted) V03	117	1,106	891	1,470	903	1,685	567	697	7,319	
Other high cost investigation (Referred / Discharged) V04	117	2,052	1,908	3,465	1,871	3,145	749	1,106	14,296	
Low cost investigation (Died / Admitted) V05	87	447	400	597	378	701	198	260	2,981	
Low cost investigation (Referred / Discharged) V06	87	606	762	1,138	644	940	214	290	4,594	
No investigation (Died / Admitted) V07	59	169	198	355	163	287	64	99	1,335	
No investigation (Referred / Discharged) V08	59	2,796	3,785	6,779	3,078	4,765	799	1,035	23,037	
High (V01—V04) Activity		**3,262**	**2,910**	**5,084**	**2,878**	**5,007**	**1,374**	**1,869**	**22,384**	
Standard (V05—V06) Activity		**1,053**	**1,162**	**1,735**	**1,022**	**1,641**	**412**	**550**	**7,575**	
Low (V07—V08) Activity		**2,965**	**3,983**	**7,134**	**3,241**	**5,052**	**863**	**1,134**	**24,372**	**54,331**
High (V01—V04) Cost (£)		**381,654**	**340,470**	**594,828**	**336,726**	**585,819**	**160,758**	**218,673**	**2,618,928**	**£4,715,901**
Standard (V05—V06) Cost (£)		**91,611**	**101,094**	**150,945**	**88,914**	**142,767**	**35,844**	**47,850**	**659,025**	
Low (V07—V08) Cost (£)		**174,935**	**234,997**	**420,906**	**191,219**	**298,068**	**50,917**	**66,906**	**1,437,948**	
High cost imaging (Died / Admitted) V01	117	8,424	6,669	10,881	8,073	13,338	4,212	4,797	56,394	
High cost imaging (Referred / Discharged) V02	117	3,744	6,318	6,552	4,095	7,371	2,574	2,925	33,579	
Other high cost investigation (Died / Admitted) V03	117	129,402	104,247	171,990	105,651	197,145	66,339	81,549	856,323	
Other high cost investigation (Referred / Discharged) V04	117	240,084	223,236	405,405	218,907	367,965	87,633	129,402	1,672,632	
Low cost investigation (Died / Admitted) V05	87	38,889	34,800	51,939	32,886	60,987	17,226	22,620	259,347	
Low cost investigation (Referred / Discharged) V06	87	52,722	66,294	99,006	56,028	81,780	18,618	25,230	399,678	
No investigation (Died / Admitted) V07	59	9,971	11,682	20,945	9,617	16,933	3,776	5,841	78,765	
No investigation (Referred / Discharged) V08	59	164,964	223,315	399,961	181,602	281,135	47,141	61,065	1,359,183	
Cost (£)	**Tariff 10/11**	**North Yarmouth**	**Central Yarmouth**	**South Yarmouth**	**North Lowestoft**	**South Lowestoft**	**South Waveney**	**West Waveney**	**Grand Total**	

Fig 2: Cluster wide activity rates for minor A&E attendances (2009/10)



Strategy Delivery

There are three key aspects to take into consideration when commissioning integrated urgent care pathways to redesign clinical pathways to improve care and reduce demand for hospital based services: Access, Assessment and Response. The integrated urgent care service model has been designed to take account of these three elements as follows:

Access – the means by which patients gain entry into the system for their need. How does a patient with a need for unscheduled and urgent care, access services both remotely (e.g. by telephone) or face-to-face (e.g. Emergency Department, Walk-in Centre, Minor Injury Unit) and what sort of assessment and response should they get?

Assessment – once the patient is in contact with urgent care services, how should their needs be met in the most appropriate manner?

Response – once a patient's needs have been assessed, any intervention should match the presenting need i.e. appropriate care in an appropriate location. This could be advice, diagnosis, treatment, a completed care action, or referral to either an Acute Trust or to services in Primary/Community Care.

This service model is based around five key delivery components:

Information: For many patients, an Urgent response is needed for their condition but not necessarily an Emergency one. However, the hospital four hour maximum waiting time and the availability of free care even to non-registered patients is sufficiently well-known to act as a 'magnet'. Unless patients are sure of an alternative and an appropriate course of action, this is where they are most likely to attend. This is matter of sustained branding, marketing, education and communication.

Self Care*:* This describes an approach whereby the patient manages his/her own need without seeking professional help or advice. S/he may access the local pharmacy in some instances for minor medication e.g. for sickness and diarrhoea. Again, this is primarily a matter of sustained branding, marketing, education and communication.

Access to Primary and Community care 24/7: Where self-care has failed or a diagnosis is uncertain and people require professional help in dealing with their need, delivering reliable and accessible primary and community care services 24/7 is paramount. These services need to be developed so that there is a reduced reliance on the Emergency Department and people accessing support via the telephone or in person will be signposted back to the appropriate primary/community care service.

There are opportunities to develop nurses, paramedics and other professionals to have the authority to visit and treat patients at home, to refer them to other services or to admit them to hospital. An integrated health and social care team led by Community Matrons will significantly improve the outcomes.

Telephone access (*Talk and Treat):* For life - threatening conditions – 999 and for urgent and non-urgent conditions, the introduction of a National 3 Digit number (3DN), an approach whereby a patient or carer can dial one single telephone number in order to get local information, advice, help and onward referral to the appropriate service where necessary.

See, Assess, Stream and Treat: A high percentage of the local population attend in person to receive help with their urgent care need. This includes visiting the Emergency department, Walk-in Centre, Minor Injury Unit etc. Whilst the need for longer term social marketing work regarding the influencing and management of patient self-management is planned, there is an opportunity to implement a See, Assess, Stream and Treat model wherever the patient enters the system in person.

All services could be commissioned to undertake this process when the patient presents, and to either deal with the presenting condition or signpost (stream) to the appropriate service. Performance monitoring will need to be put in place to measure appropriate responses to patient presentation.

In addition, this framework includes whole system demand management in order to reduce the numbers of patients with urgent care needs i.e. by improving primary care access, long term conditions management, individual case management and social care support. This will enable Urgent care to be seen as the 'default' and not the 'norm'. The framework also includes the expansion of innovative outreach services & assertive technology to empower patients to take control of their healthcare and pre-empt urgent care needs.

Service Model Outcomes

There are a range of positive outcomes to be delivered through delivery of this service model as follows:

- People will be encouraged to take control of their own health and will be offered a step-wise approach to seeking information and advice, long before an urgent care requirement arises;
- Services will offer equitable access and choice to every person in NHS GYW and will be available to all, regardless of gender, age, race, religion, ethnicity, sexual orientation or disability;
- The patient experience will be that all organisations providing care are working seamlessly in partnership with each other co-located as appropriate;
- Care will be provided as close as possible to where people live. This care will be supported by appropriate high quality secondary and community care services, delivered near people's homes;
- NHS GYW will ensure that people receive timely, easily understandable and accessible information on where, when and how care is provided;
- People will feel informed and able to make decisions about their care, alongside the health or social care professional;
- Alternative professionals such as pharmacists will be encouraged to act as first port of call for minor illnesses, rather than the patient having to rely on making an appointment with his/her doctor;
- Pharmacists, in partnership with GPs, will provide optimal support for people with long term conditions, including routine check-ups and monitoring;
- Where people still choose to go the Emergency Department they will be assessed on arrival by a professional who will ensure that they are directed to the service most appropriate to meet their needs;
- A journey which is smooth and seamless, where patients receive consistent assessment, advice and/or treatment and duplication is avoided;
- An integrated whole system urgent care network with clearly mapped-out care pathways and common end points;
- Improved public awareness of the range of unscheduled care services;

- Local hospital services will be able to concentrate their skills on the more serious and life threatening situations and there will be less dependence on the ambulance service and the Emergency Department;
- People's primary care needs will be addressed by their own practice or by an Urgent Care site close to home;
- Technology such as telehealth and website information will be fully utilised.

Overall, the benefits of the new system will be:

- The local population will get the right service at the right time;
- Local access will be provided wherever possible;
- There will be a reduction in waiting times for assessment and care;
- Skills will be used in the most effective way.

Historically, urgent care services have been commissioned from a variety of providers, all of whom have their own specific ways of operating. However, the proposal is to move towards a commissioning approach which has the patient at its centre so that services are contractually required to inter-link with each other and the patient receives the right care first time, every time.

A benefit of this approach is that it is building on existing building blocks and local ownership and it would deliver services from a patient pathway perspective and ensure that the patient receives the right care first time, every time.

Attached (Appendix 1) is the Demand Management System Development plan which sets out the key building blocks of the local Urgent Care System to be managed by the local Urgent Care Network. The local system is built on 5 key assumptions which have been tested in other NHS systems as sound principles on which to build a Demand Management System.

1) A complete system plan
2) Real clinical engagement
3) Good forecasting and analysis
4) Good contract management eg threshold/protocols
5) Excellent project management.

The essential building blocks which must ALL be working if the system is to be successful in Demand Management are as follows:

1) Case/Care management
2) Referral Facilitation/management
3) Contract Limit/Thresholds
4) Local Service Directory
5) Public Engagement/Guidance

In NHS GYW all 5 areas have been initiated as part of our local Urgent Care System plan and these projects plus a number of other initiatives such as GP in EADU and Admission/Discharge management are part of the overall unplanned care plan which is programme managed and monitored by the Unplanned Care Clinical Programme Board.

Commissioning intentions 2011/12

In order to deliver the integrated urgent care strategy, there are essentially two options available to NHS Great Yarmouth and Waveney:

1. Via the contracting mechanism of existing providers commissioned
2. Through open procurement of a new provider

Contracting mechanism of existing providers commissioned:

During 2010, some of the building blocks of the integrated urgent care strategy have already been commissioned through existing providers or via the health system network approach that has been established. These are as follows:

Service / Initiative	Status
Intensive case management service	This building block will be provided by NHS Great Yarmouth and Waveney Community Services and PBC
Admission and discharge project	This building block is being led by NHS Great Yarmouth and Waveney in partnership with other health partners
Local service directory	This building block is being led by NHS Great Yarmouth and Waveney in partnership with health and care partner agencies
Public awareness, public education and social marketing	This building block is being jointly led by NHS Great Yarmouth and Waveney and James Paget Hospital in partnership with other health partners. Communication and targeted marketing of services outside of hospital is key to maximize service utilization.
Provider Operations Capacity Map	This building block is being jointly led by NHS Great Yarmouth and Waveney in partnership with other health partners
Referral management - maximizing utilization of existing primary and community services for unplanned care	This building block is being led and facilitated by NHS Great Yarmouth and Waveney. It includes: • Extension of the minor injury LES to Great Yarmouth • Re-routing of ambulance journeys for patients with minor injury and illnesses to appropriate community setting e.g. minor injury unit, WIC, GPs etc • Review of referral criteria to community beds (step up and down) to maximize capacity available

Other services and initiatives to be commissioned during 2010/11:

Admission Prevention Service - NHS Great Yarmouth and Waveney is currently exploring the feasibility and affordability of extending the existing Waveney Admission Prevention Service to Great Yarmouth via the existing Community Services Provider during 2011/12.

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GP service in EADU – the building block, led by PBC is to be piloted as soon as is practical.

Workforce development / Incentive Scheme - similar to the current prescribing incentive scheme, there is an opportunity to adopt the same principles and process as a mechanism to incentivise GP to refer differently to an acute care setting for patients requiring emergency treatment. This type of scheme relies on good timely data and will also require robust targets and thresholds. This scheme would also provide an opportunity for GPs to benchmark and share best with other primary care clinicians. This requires further discussion with referral leads and GP consortia.

Open procurement of a new provider
There are some building blocks for which we do not currently have a provider and which NHS GYW plan to take out to tender during 2010/11. This includes an enhanced service specification for a new Primary Care Out of Hours provider as the existing contract will expire on 15 July 2011.

In summary, the following services could make up an integrated urgent care strategy specification for procurement:

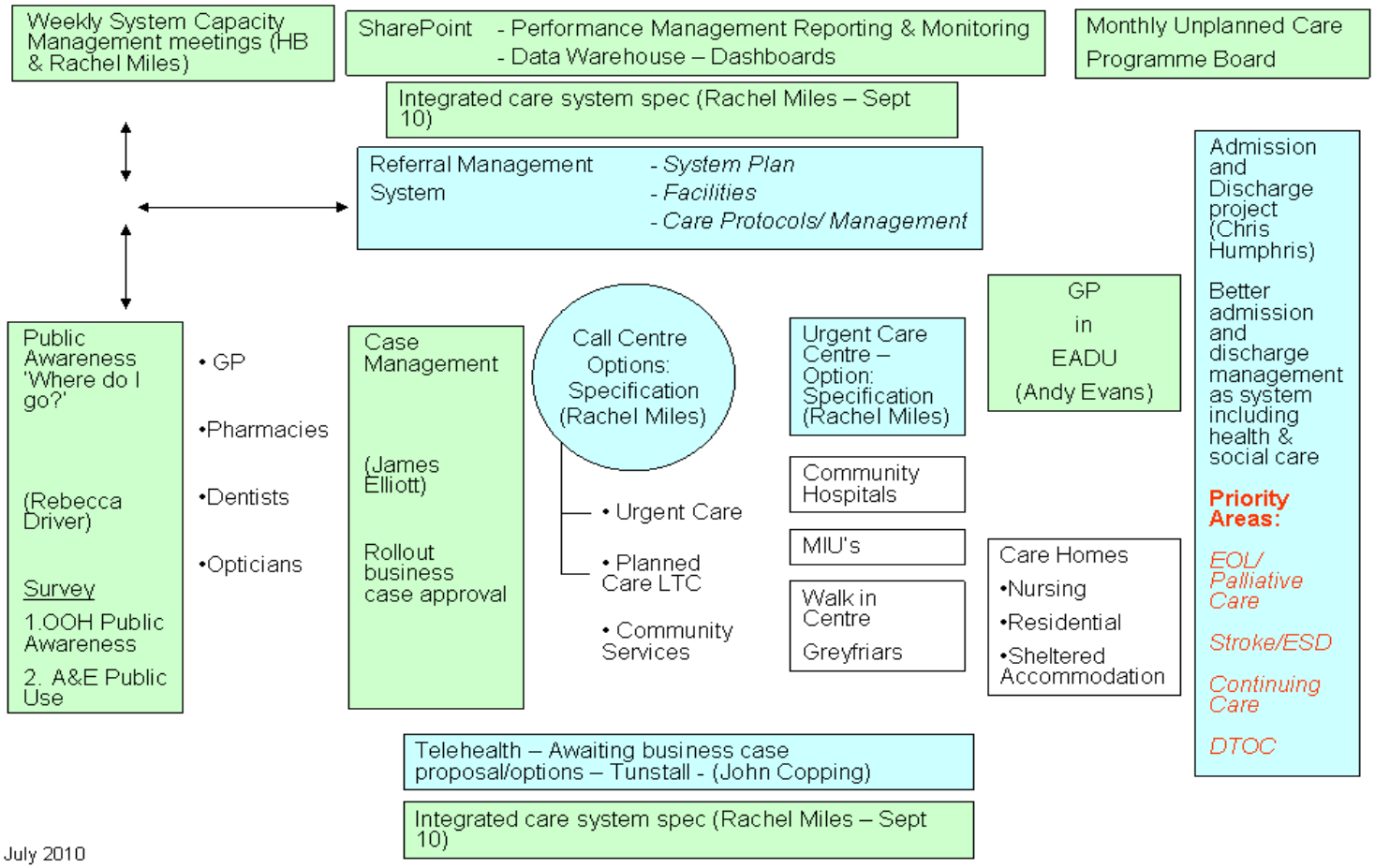
- OOH Primary Care – Enhanced Specification
- Single Access Point / Local Call Centre
- Primary care led minor injury and illness service in South Lowestoft
- Primary care led minor injury and illness triage and treatment service at front end of A&E
- Telehealth for management of COPD and diabetes

Next Steps

- Feedback on draft integrated urgent care strategy and planned service developments by Unplanned Care Programme Board and GP Consortia – August – September 2010
- NHS GYW Board feedback on draft strategy – September 2010
- Confirm 2011/12 commissioning intentions and financial feasibility / value for money – September / October 2010
- Commission building blocks which currently do not have a provider – From October 2010
- New building blocks / services in place – From 15 July 2010

Appendix 1

NHSGYW – Demand Management System – Unplanned/Urgent Care



July 2010

NHS
Great Yarmouth and Waveney

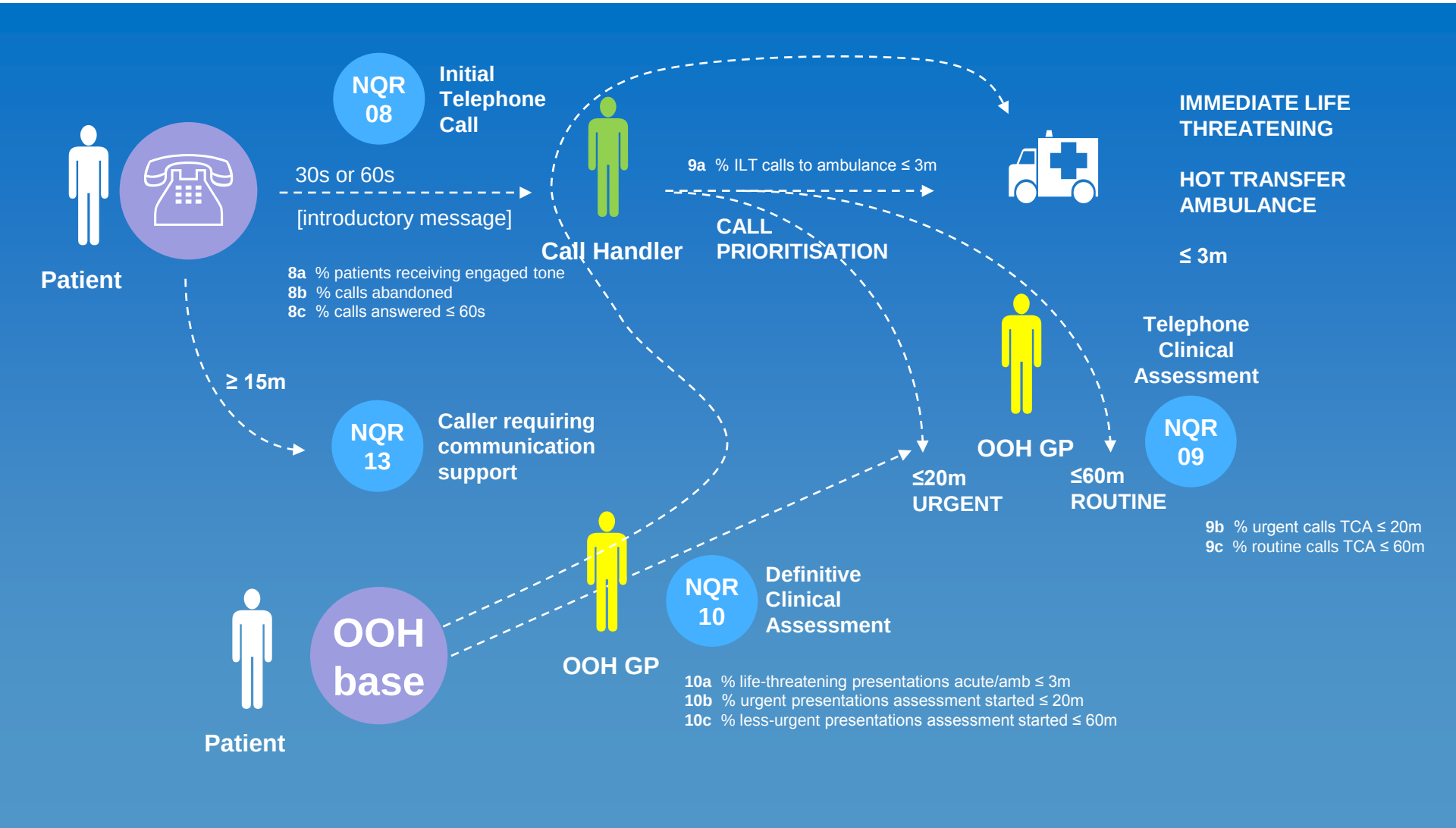
Performance Manager (Acute)

September 2010

Out-of-Hours Patient Journey and the OOH National Quality Standards

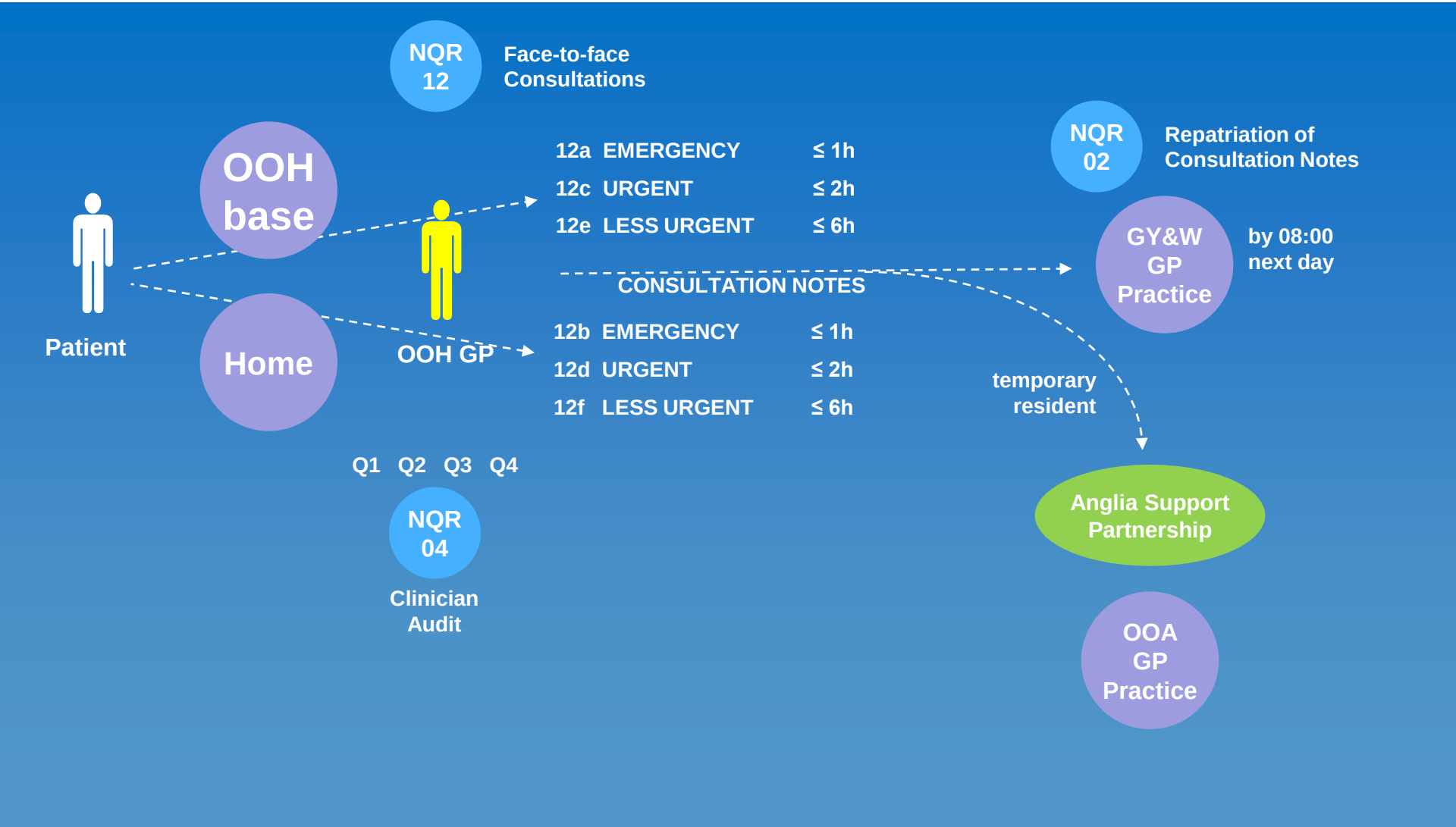
NHS
Great Yarmouth and Waveney

OOH Patient Journey – 1



Great Yarmouth and Waveney

OOH Patient Journey – 2



NHS
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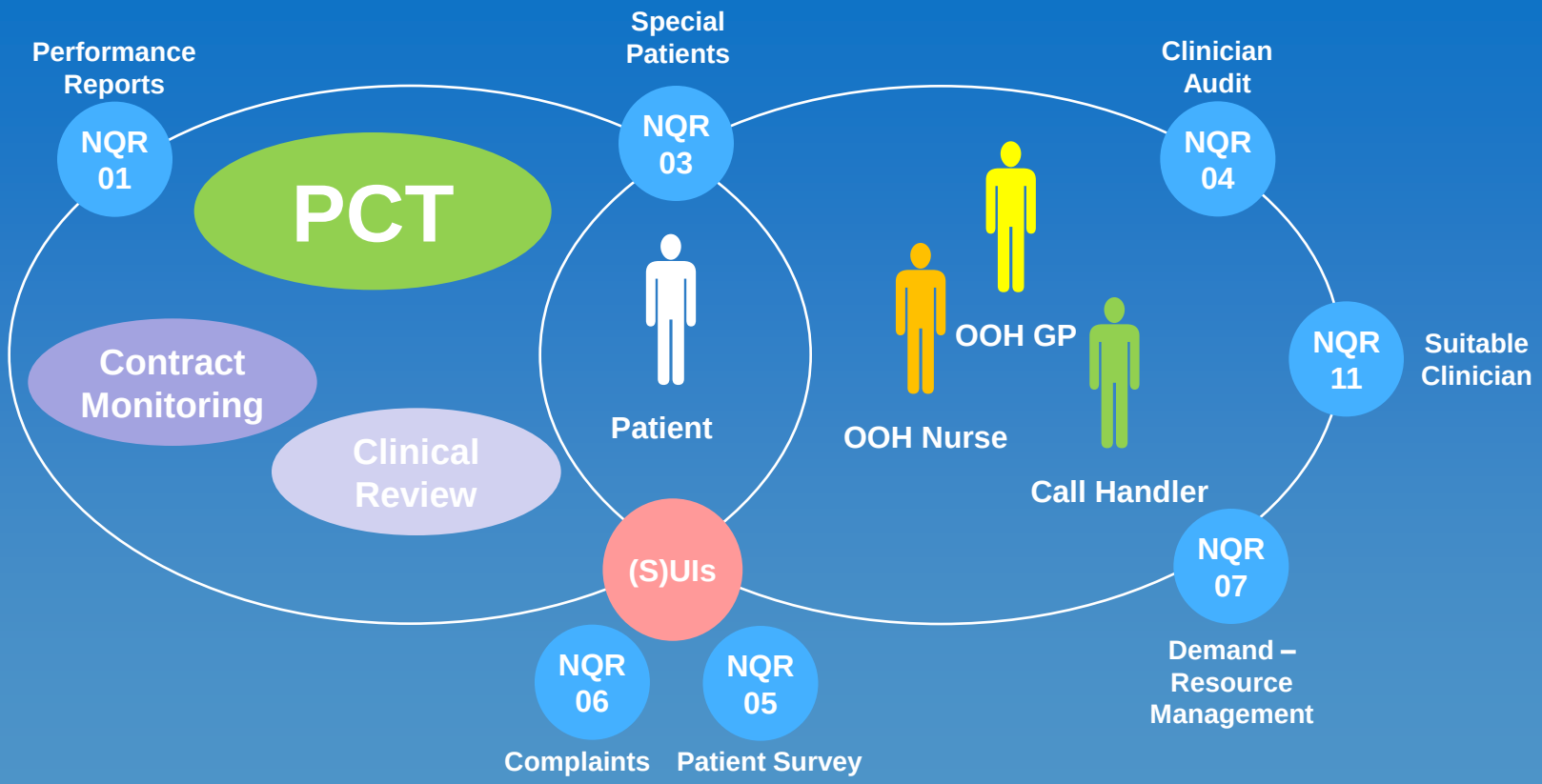
OOH Patient Journey – Whole System Assurance



19 January 2011
Item no 9.

Great Yarmouth and Waveney Joint Health Scrutiny Committee

Proposed Forward Work Programme

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 topics below
- provide clear information about why each item is on the forward work programme

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

Meeting dates	*Briefings/Main scrutiny topic/initial review of topics/follow-ups*	*Approach*
**April 2011	**5 Year Strategic Plan** – To provide an update on achievements and difficulties over the preceding 12 months and priorities for the next 12 months. **Acute Hospital Care** – to scrutinise progress against the strategic plan to improve preventative and community support for some services to reduce the need for hospital based service provision. (Committee Decision 11/3/10) **Transfer of Community Services** – to provide an update on proposals to transfer community services to a Social Enterprise.	*Scrutiny* *Scrutiny* *Information only item*
** July 2011	No items currently scheduled	

** date not yet scheduled

Provisional dates for consultations / update reports to the Joint Committee:

1. **Continuing Care Consultation** – dates of consultation not yet known. The Joint Committee has expressed a desire to consider the consultation when it is available.

NHS
Great Yarmouth and Waveney

Briefing for Great Yarmouth and Waveney Health Overview and Scrutiny Committee on NHS Great Yarmouth and Waveney Community Services: proposal to form a social enterprise - update as at 7 January 2011

As reported to the Committee last time, Great Yarmouth and Waveney Community Services (GYWCS) submitted an Expression of Interest in exploring the option of becoming a social enterprise to the NHS Great Yarmouth and Waveney (NHS GYW) Board under the Department of Health's (DH) 'Right to Request' policy. NHS GYW supported this proposal at its Board meeting on 22 September 2010. HealthEast, the new GP Commissioning Consortium for Great Yarmouth and Waveney, expressed their approval in a letter of support. The Strategic Health Authority reviewed the case and then recommended to the DH that the proposal be accepted under the 'Right to Request' scheme.

The DH announced on 16 November that GYWCS's application was one of 32 nationally that had been accepted to join the third wave of the 'Right to Request' scheme. Acceptance on the scheme offers applicants the offer of an uncontested contract for 3-5 years, the opportunity to continue to offer existing staff ongoing membership of the NHS Pension scheme after transfer and provides support for applicants in the process of becoming a social enterprise.

What is a social enterprise?
A social enterprise is a business with social aims that is set up specifically to benefit the community. It's not a charity, although it has similarities in that any surpluses are put back into the organisation for the benefit of patients and staff. It is different from a charity in that most of the funding comes from contracts or business, rather than donations. It's not part of the NHS in the sense that it will not be an NHS employer but it will provide NHS services under NHS contracts to patients who will receive those services in the same way as they do now. The ethos and values of a social enterprise are very similar to those of the NHS. It will be owned by community stakeholders and staff.

Which services are included?
It is proposed that all the services currently provided by GYWCS should transfer into the new social enterprise (if approved). These include, of course, amongst others, district nursing, health visiting, community in-patient services, physiotherapy, the Nelson Medical Centre, prison health services at HMP Blundeston, contraceptive and sexual health services, school nursing and case management. The NHS GYW Board have also agreed, following discussion with staff, that a number of health improvement services that are currently managed by the Public Health Directorate of NHS GYW should also be transferred to the new social enterprise.

What are the benefits?
It will allow the possibility of closer integration with primary care and other partners in the delivery of health and social care in Great Yarmouth and Waveney and fits with the agreed direction of travel within the local health and social care economy of developing an integrated care system.

Staff will have a much greater say in the running of the organisation and more freedom to contribute their ideas. It is proposed that there will be two staff representatives on the Board. There will be greater delegation of responsibility to service leaders and front line staff for

running services and managing resources. As an independent organisation GYWCS will have greater freedom of action and will be able to be more responsive to patients and to adapt and innovate more quickly to meet their needs. The success of the organisation will be much more in the hands of its own staff. Whilst GYWCS has continued to develop its services in recent years, the current arrangements have not enabled it to achieve the level of service transformation for the benefit of patients that we have ambitions for.

Other stakeholders representing the community will have a greater say in the way GYWCS is run and they will also be represented on the Board of the new organisation.

As a social enterprise, GYWCS will be able to undertake new contracts and seek funding from a wider range of sources for delivering health and social care and to form partnerships in new ways with other organisations to offer novel solutions for delivering care.

What are the risks?
The risks are those associated with running any business. That is why a business plan with a full market and financial analysis is being prepared, which will be thoroughly tested before approval is given for a social enterprise to be formed. The DH timescale for achieving the separation of GYWCS from NHS GYW is tight but the project is currently on track.

GYWCS does not currently have all the management capacity or the whole range of skills and expertise it will require for its future as a social enterprise. To assist with this and with developing the business plan, a new Interim Chief Operating Officer, Roger Moyse, was appointed in December and a new interim Director of Finance will be appointed shortly. NHS GYW has also been lending support to GYWCS to support the process. An advertisement for a Chair and Lay Members of Shadow Board of the social enterprise was placed in December and interviews are being held this month.

To succeed as a social enterprise staff need to support its formation. If staff were against the proposal it could not be approved. We have therefore conducted an extensive programme of communication and engagement with staff which is described below. Staff naturally have concerns but there has also been a lot of positive feedback on the proposal.

What if it is not possible to establish a social enterprise?
If at any stage if becomes clear that a viable social enterprise can not be created, the NHS GYW Board has stated that its fall back plan would be to go out to tender to find an existing provider organisation to which GYWCS could be transferred.

Where are we up to? What are the next steps?
Since the last report to the Committee, GYWCS, supported by NHS GYW has been engaged in two main areas of work: preparing and writing a business plan for the proposed social enterprise and talking to staff about what it would mean, getting their ideas and listening to their concerns.

Contact has been made with other Community Services which have become social enterprises, such as Hull and North East Essex, to learn from their experiences and to borrow material from them.

The business plan is in the process of being finalised for submission to the NHS GYW Board at its meeting on 26 January 2011.

We have conducted an extensive programme of staff engagement, which has included briefing meetings for staff, attending team meetings to explain what is happening, evening presentation involving speakers who run social enterprises elsewhere in the country, mailings of key information to staff home addresses, continuous engagement with staff and trade union representatives and weekly electronic bulletins

Providing the business plan is approved, the next stage will be for the NHS GYW to undertake a process of due diligence using external assessors to check the detail of the business plan and the soundness of the proposed governance arrangements. The Strategic Health Authority will also review the business plan and the due diligence report to ensure that the proposal is robust. If the proposal passes this test then the social enterprise will be created in shadow form for April 2011.

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7th January 2011

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