Norfolk County Council
at your service

Health and Wellbeing Board
Minutes of the meeting held on Wednesday 10 July 2013
at 10am in the Anna Sewell Room, County Hall Annexe

Present:

Cllr Yvonne Bendle	South Norfolk Council
Harold Bodmer	Director Community Services
Dr Jon Bryson	South Norfolk Clinical Commissioning Group
Dr Anoop Dhesi	North Norfolk Clinical Commissioning Group
Tracy Dowling	Director of Operations & Delivery, NHS England, East Anglia Team
Richard Draper	Voluntary Sector Representative
Cllr Angie Fitch-Tillet	North Norfolk District Council
Kate Gill	Great Yarmouth & Waveney Clinical Commissioning Group
Joyce Hopwood	Voluntary Sector Representative
Cllr Penny Linden	Great Yarmouth Borough Council
Dr Ian Mack	West Norfolk Clinical Commissioning Group
Lucy Macleod	Interim Director of Public Health
Jenny McKibben	Deputy Police and Crime Commissioner
Dan Mobbs	Voluntary Sector Representative
Dr Chris Price	Norwich Clinical Commissioning Group
Cllr Andrew Proctor	Broadland District Council
Cllr Dan Roper	Cabinet Member for Public Protection, Norfolk County Council
CS Jo Shiner	Norfolk Constabulary
Alex Stewart	Chief Executive, Healthwatch Norfolk

Others present:
Debbie Bartlett, Head of Planning, Performance and Partnerships, NCC

1 Election of Chairman

Cllr Dan Roper, Norfolk County Council was elected Chair of the Health and Wellbeing Board.

Cllr Dan Roper, Norfolk County Council in the Chair.

The Chairman welcomed everyone to the Health and Wellbeing Board meeting and round the table introductions were made.

2 Apologies

Apologies were received from Cllr Brenda Arthur, Norwich City Council; Stephen Bett, Norfolk Police & Crime Commissioner (Jenny McKibben substituted); Lisa Christensen, Norfolk County Council; Pip Coker, Voluntary Sector (Dan Mobbs substituted); T/ACC Nick Dean, Norfolk Constabulary (Chief Superintendent Jo Shiner substituted); Andy Evans, Great Yarmouth & Waveney CCG (Kate Gill substituted); Anne Gibson, Norfolk County Council; Cllr James Joyce, Norfolk County Council; Cllr William Nunn, Breckland District Council; Elizabeth Nockolds, KLWN BC; Cllr and Cllr Sue Whitaker, Norfolk County Council.

3 Minutes of the Health and Wellbeing Board meeting held on 17 April 2013.

The minutes of the Health and Wellbeing Board (H&WB) meeting held on 17 April 2013

were agreed as a correct record and signed by the Chairman, subject to the following amendment to paragraph 12.2 to replace the words “a reablement service” to read “the reablement service”.

The Director of Community Services, Norfolk County Council informed the Board that the proposal for spend of the funding transfer from NHS England to the County Council was nearing completion and once the document had been finalised it would be forwarded to NHS England and the CCGs for final comments before publication.

4 Declarations of Interest

There were no declarations of interest.

5 To receive any items of business which the chairman decides should be considered as a matter of urgency.

There were no items of urgent business.

6 Director of Public Health – Annual Report

6.1 The Board received a presentation (copy attached at Appendix A) by the Interim Director of Public Health (DPH) during which the following key points were highlighted:

- The forecast population increase from approximately 990,000 in 2012 to approximately 1,100,000 in 2022 was predominantly made up from older people rather than an increase in birth rates, with people tending to live longer.
- Further work would be needed to ascertain the reasons for the widening gap between the best off and worst off male population figures in South Norfolk; this figure was increasing in South Norfolk whilst figures were decreasing in the other local authority areas in Norfolk.
- The impact of an aging population would provide huge challenges which would need to be considered in relation to all forms of care, including palliative care and end of life.
- The impacts of deprivation and inequality would need to be considered in relation to future service challenges and not solely in relation to individual behaviours.
- Finding breakpoints in the cycle of deprivation would be key.
- This is, or will be, a community wide problem and requires solutions to be developed and co-ordinated across communities.

6.2 The following points were noted during the general discussion:

- The DPH emphasised that the issues raised in her Report suggested that this was about systems change, rather than making small or incremental changes, to address for example, the attainment in the most deprived areas versus birth-rate.
- A clearer understanding was needed of need in rural areas– ie understanding individual need, not just the totality.
- A discussion took place about the benefits of using a social marketing approach to capture and identify the most deprived people across Norfolk. It was felt this kind of approach could help provide the flexibility needed and enable us to target people, rather than areas.

- The DPH's annual report would be finalised and published on-line on the JSNA, with a web-link to the report circulated to the Board.

6.3 The Board agreed that the DPH Annual Report helped set the context for its work going forward and that the key messages would form part of the evidence base for the development of the Joint Health and Wellbeing Strategy.

7 Welfare Reform – understanding and mitigating the impacts in Norfolk on health and wellbeing.

7.1 The Board received a report setting out the key findings from a workshop held on 13th June 2013, which brought together voluntary and statutory agencies to look at the potential impact of welfare reforms. The purpose of the workshop was to share concerns and consider mutual and effective responses, especially in identifying the needs of those most at risk. Shared concerns and common themes were fed back to the Health and Wellbeing Board and the report suggested some possible courses of action.

7.2 In presenting the report, Dan Mobbs confirmed that the workshop had identified that the welfare reform in Norfolk was causing greater inequality because it was disproportionately cutting income from the poorest households and that an integrated approach was needed, with the Health & Wellbeing Board taking a strategic leadership role.

7.3 The following points were noted during the ensuing discussion:

- There was some discussion about inequality and poverty, and where the focus should lie and it was noted that the workshop had concluded from the evidence that inequality was the biggest determinant of health and wellbeing problems.

- There were clear links with the earlier discussion under item 6 about 'targeting people rather, than targeting areas' and that the people who were most affected by this would be the same as those the Board would be concerned about in relation to other health and wellbeing issues, such as obesity.

- It was noted that Norfolk County Council's Community Services Overview and Scrutiny Panel were looking at fuel poverty and its impact on the health and wellbeing of the population of Norfolk, both in rural and urban areas, and the outcome of this might usefully feed into this.

- Board members expressed their concerns about the impact on inequality in Norfolk, as outlined in the report. A possible way of tackling some of these problems might be to set up Healthy Towns and Health Community schemes in areas of deprivation.

- A practical and pragmatic approach would be needed and the Board focus on what it could influence in terms of inequality, for example, in relation to housing, employment, education including early years, access to care and advice, etc.

- It was recognised that this was something where the wider partners had a role to play and considered useful for the impact to be collectively monitored. The DPH confirmed that, if the Board could agree collectively what was useful to measure, and where that data was, then she would take this forward as there were

appropriate skills and sufficient resources from within the public health team to drive such a monitoring group.

7.4 The Board considered the report of the workshop and agreed:

- To undertake a piece of work on sharing the information that enables individual partners to better target their communities, not geographies.
- To think about the evidence of what works
- That rather than taking this forward as a separate workstream, the key issues should feed into the development of the Board's Joint Health and Wellbeing Strategy 2014-17.

8 A Review of Norfolk Joint Strategic Needs Assessment – outline approach.

8.1 The Board received the annexed report (8) by the Interim Director of Public Health (DPH), proposing improvements both to ensure that the Joint Strategic Needs Assessment (JSNA) can support the development of the 2014/17 Health and Wellbeing Strategy, and longer term development proposals for the Board to consider.

8.2 In presenting the report the DPH referred to one of the development proposals in the report for immediate action which was to 'bring the JSNA to life by having a programme of regular briefings on topics of interest drawing information from partners and the JSNA'.

The DPH asked Board members to let her know their suggestions for topics for JSNA briefing sessions by emailing her at the following address: lucy.macleod@norfolk.gov.uk

8.3 The following points were noted during the discussion:

- In response to a question about integrated data sharing the DPH agreed to look at other areas and to locate a template document which might be populated with the relevant information and linked into the JSNA.

- The DPH also asked all Board members to help define the data-sharing by thinking about what they wanted to know - what data they wanted - from the other Board members around the table and to let her know by email to the following address: lucy.macleod@norfolk.gov.uk.

- There was some discussion about the need for information in the JSNA to be at the lowest level of geography and to be 'live' over a period of time so that it could be used to evaluate progress, for example, to better understand why some people access services and other don't. The DPH confirmed that work was being undertaken with the CCGs to understand the health needs of the population and identify any correlation between those needs and the people who were accessing the services.

- The DPH referred again to the benefits of using a social marketing approach to identify those people who needed services and target those most affected wherever they are. It was noted that there would be a resource implication to this and the DPH suggested that the Board could look to utilise the County Council's resources in terms of community engagement skills and techniques. Dan Mobbs, voluntary sector representative, confirmed that the voluntary sector was well placed to help with such work.

8.4 The Board agreed:

- To note the findings of the JSNA Review.
- To approve the production of an annual JSNA report to assist in monitoring needs and to support future planning with the first report to be published in September to support the development of the 2014/17 Health and Wellbeing. In future years, the report would be published in March/April.
- The rest of the proposals for development, as outlined in the report.
- The creation of a JSNA Officer Working Group to oversee the developments, agree the prioritisation of the JSNA work plan going forward and to deliver the agreed actions.

9 Norfolk Joint Health and Wellbeing Strategy 2014-17 – outline approach.

9.1 The Board received the annexed report (9) by the Head of Planning, Performance and Partnerships and the Interim Director of Public Health, NCC. The report consolidated the work that had been done to date on the development of a three-year Health and Wellbeing Strategy which added value to the work on health and wellbeing already taking place in Norfolk.

9.2 In presenting the report, the Head of Planning, Performance and Partnerships (PPP) confirmed that, whilst there were a number of areas that the Board could potentially look to improve, there had been a strong message from the workshop that the Board needed to focus its efforts through its strategy on a small number of priorities where it could make a difference. It had been suggested that three priorities were an optimum number and that these might usefully be of three different types to both reflect the Board's core purpose and increase engagement of people from different organisations and with different perspectives.

9.3 The Head of PPP drew the outlined the two options (A or B) contained in the report and asked the Board for their views on how to progress.

9.4 The following points were noted during the discussion:

- Driving integration was strongly threaded through both the options as outlined in the report and this was considered a key area for the Board.

- Option A would enable the Board to target key population groups and take an holistic approach through which it could drive forward integration. This option would also enable the Board to focus on the necessary culture change that will be required.

- Option B would enable the Board to adopt three overarching goals for the 14-17 period and a set of priorities and deliverables towards meeting them. It would facilitate all partners working together for the benefit of Norfolk's diverse populations and would enable the Board to focus on working differently.

- It was also noted that all partners had their own set of priorities they were currently working on and the Board's job, regardless of whether we choose option A or B, should be to challenge each other and ask, for example, how they were working to

address integration.

- It was important for the Board to deliver results and any goals set would need to be effective and measurable. The Board should also look to learn from work undertaken in other areas.

- In many respects, options A and B represented two different ways of looking at the same thing, perhaps just a difference of approach.

9.4 The Board voted on whether to proceed with Option A or Option B. With 4 votes for Option A and 11 votes for Option B, the Board agreed to use Option B as the basis for the development of the strategy.

The Head of PPP would take this option forward for discussion and development at the workshop to be held on 19 August 2013, the details of which had already been circulated.

9.5 Any nominations for members to be appointed to the sub-group of the Board to progress the development of the JHWS to be forwarded to the Head of Planning, Performance and Partnerships by the end of July 2013. Please send nominations to **Debbie.bartlett@norfolk.gov.uk**

9.6 The Board agreed:

- To support the principles and content outlined that would underpin the development of the JHWS 2014/17.
- To use Option B as the basis for the development of the strategy.
- The steps identified and the key milestones were reasonable.
- To keep up the momentum of work outside of formal Board meetings, through the establishment of a sub-group of the Board to progress the development of the JHWS.
- That they were committed to early engagement with service users, providers and commissioners on how to tackle the strategy's priorities.

10 Integration of health and social care service in Norfolk: an update.

10.1 The Board received the annexed report (10) by the Director of Community Services which set out the approaches to integration which are being taken in Norfolk and provided an update on activity towards integration in Norfolk. The report also outlined the recent launch of the national Integration Pioneer Programme, where invitations were sought from local areas to spearhead implementing models of integration. Three bids had been prepared in Norfolk and the Health and Wellbeing Board were asked to support and endorse them.

10.2 In introducing the report the Director of Community Services said that this was about whole system change – which had resonated throughout the discussion so far at this Board meeting. It was about working very differently, with very different models, and it was broader than health and social care – housing, public health, education, the third sector, etc were all key partners.

10.3 The Director of Community Services confirmed that the work included in the three Integration pioneer bids was already underway but that those bids would not, in

themselves, change the way services were delivered – this would require a change in the culture. Additionally, some work was also underway with social workers and other key workers to try to establish a different way of providing health and social care services. This was being resourced by some monies from the Kings' Fund.

10.4 The following points were noted during the discussion:

- The 3 x Integration Pioneer bids were formally endorsed by the Board.

- The Director of Community Services stated that it would be helpful to set some challenges – to think about what the Board wanted to see by way of progress in a year's time.

- There followed some discussion about the potential for pooled budgets and both our preparedness for doing this in Norfolk and the capacity needed in the system to support it. It was agreed that partners should continue to build on the work underway in progressing integration and prepare for the longer term - so that Norfolk was well placed and ready to make the best use of pooled budgets when the time was right.

- There was some discussion about the pivotal role of housing in this and the strong view that it needed to be a part of the work at the outset.

- It was noted that the Board had just agreed that Integration would be an overarching goal in the Joint Health & Wellbeing Strategy and that even if the Integration Pioneer Bids were not successful the work contained within them would continue and the Board – or a Task & Finish Group could provide the strategic support needed for it. The Board needed, collectively, to look at the issues.

- It was suggested that Integration be included as a standard item on future agendas so that the Board could monitor its progress.

- It was agreed that the Director of Community Services would set up a Task and Finish Group and report back to the next Board meeting in October. The following Board members were appointed to the Task & Finish Group to progress integration in service provision:
    - Angie Fitch-Tillett, North Norfolk District Council
    - Kate Gill, Great Yarmouth & Waveney CCG
    - Joyce Hopwood, Voluntary sector
    - Lucy MacLeod, Interim Director for Public Health
    - Alex Stewart, Healthwatch Norfolk

10.5 The Board:

- Noted the progress and proposed approaches to integration in Norfolk.
- Confirmed its support for the three Norfolk bids to the Integration Pioneer programme from:
    - West Norfolk
    - North Norfolk
    - Great Yarmouth and Waveney
- Agreed to set up a task and finish group, to articulate 3-5 practical deliverables

needed to progress integration in service provision and seek Norfolk-wide commitment to put each of them in place within a defined time period.

11 Accountability framework – outline of performance and quality measures.

11.1 The Board received a report (11) by the Head of Planning, Performance and Partnership, NCC, outlining the thinking on possible means for the performance monitoring of the work of the Health and Wellbeing Board over the next three years. The Board was asked to review and comment on the content of the report specifically to adopt a performance monitoring framework that was light-touch and able to provide a good understanding of how the Board was functioning, what impact it was having on the health and wellbeing of the people of Norfolk, what progress it was making with the implementation of a JHWS 2014/17 and a sense of emergent issues around the safety of services commissioned and provided in the health and social care system.

11.2 The Board agreed:

- To receive an annual appraisal process of how the Board worked using a series of structured questions, similar to those in the LGA tool.
- To monitor either one, or a set of, global indicator(s) of the health and wellbeing of the people of Norfolk.
- To a light touch way of reporting on progress against the strategy priorities for 13/14 and 14/17, using qualitative and quantitative data.
- To a regular slot on the agenda of the Board to enable key issues from the Quality Surveillance Networks to be shared.

12 In-year monitoring of Health and Wellbeing priorities.

12.1 The Board received a report (12) by Norfolk's Clinical Commissioning Groups and the Head of Planning, Performance and Partnerships, NCC, outlining the submissions from each of the CCGs' annual 'Plan on a Page', their three local priorities identified for the purpose of the national 'Quality Premium' and their Prospectuses for residents and patients.

12.2 Dr Anoop Dhesi, Chairman, North Norfolk CCG presented their report and outlined the priorities. It was noted that since it had been established North Norfolk Clinical Commissioning Group had built up an excellent working relationship with North Norfolk District Council. A North Norfolk and Rural Broadland Strategic Partnership Board had been set up and had met on five occasions and that Board had set out their key objectives and good developmental and learning outcomes were being achieved.

12.3 Kate Gill, Director of Operations, Great Yarmouth and Waveney CCG presented their annual plan, and outlined their local health priorities, the details of which were included in the report.

12.4 Dr Jon Bryson, Chairman, South Norfolk CCG, presented the plan for South Norfolk CCG. The plan included working with the local government to tackle their priorities which included alcohol abuse, smoking cessation and an obesity strategy, and an integrated approach and how this could be achieved.

12.5 Dr Chris Price, Chairman, Norwich CCG, presented their plan, outlining the three local priorities they had chosen as a result of feedback from patients, GP practices and the

voluntary sector. Work had already commenced on the gathering of patient views on the services they received, which it was hoped would give an indication of where problems may occur in the future.

12.6 Dr Ian Mack, Chairman, West Norfolk CCG presented their plan and outlined the priorities, the detail of which could be found in the report.

12.7 During the general discussion, the following points were noted:

- CCGs were required to produce an annual plan and that, in future, the plans would need to be approved by the Health and Wellbeing Board before they were formally adopted. It was noted that this had been reflected in the Boards' forward work programme.

- It had been very useful to see the range of work being done by the different CCGs in the region.

12.8 The Board **noted** the report, the annual plans, local priorities and the prospectus from each of the CCG's and agreed that consideration of future prospectuses would need to be completed earlier in the year and would be added to the forward work programme.

13 Services for Adults with a Learning Disability: Outcomes of the Winterbourne View Enquiry.

13.1 The Board received a report (13) by the Director of Community Services, Norfolk County Council, updating members on the progress that has been made in delivering on the actions that related specifically to Norfolk from the Winterbourne View Enquiry Report into abuse in a private sector assessment and treatment facility for adults with a learning disability.

13.2 The Director of Community Services confirmed that Children's Services Department would be included within the multi-agency steering group.

13.3 The Board **agreed** the need:

- For a Norfolk wide consistent approach to the operation and development of the Joint Plan
- To establish a multi-agency steering group with direct accountability to the Board

The multi-agency group would include representatives from Mental Health & Learning Difficulty Commissioning Board, Children's Services and the Social Care sector. The multi-agency steering group would bring their Terms of Reference to the next meeting of the Board for approval.

14 Healthwatch Norfolk

14.1 In commenting on the minutes, Alex Stewart, Chief Executive, Healthwatch Norfolk (HWN), announced that William Armstrong, the retiring coroner for Norfolk, had now been appointed Chair of the HWN Board. The H&WB received and noted the Healthwatch minutes of the meetings held on 5 March 2013.

15 NHS England

15.1 The Board received a verbal update from Tracy Dowling, Director of Operations and Delivery, NHS England East Anglia Team, including feedback from the Local Quality Surveillance Group (QSG). The following points were noted:

- The first round of quarterly checkpoint meetings with the CCGs were taking place, although the frameworks were still being developed. The interim framework was being used to carry out the checks until the frameworks had been finalised.

- The draft CCG emergency plans for care had just been received. These plans would be used to identify what could be done differently for Accident and Emergency Departments and emergency care to eliminate the long waiting times that had been experienced in the past.

- The local Quality Surveillance Group (QSG) had met on 9 July 2013 and Tracy Dowling provided the following brief feedback:

    - The rates of C.difficile infections had been discussed and it had been recognised that good work was being done to address the root causes. The next meeting of the QSG would focus on C.difficile infections and the further feedback would be provided at the next meeting of the Board.

    - The full report from a recent Care Quality Commission (CQC) visit to the Queen Elizabeth Hospital at King's Lynn was being drafted. One of the key issues was how long patients had been required to wait in the Accident and Emergency Department and how this issue could be addressed in future.

    - In the light of the major changes taking place with the Norfolk and Suffolk NHS Foundation Trust's (Mental Health) plans for radical pathway redesign the QSG was keeping a watching brief on waiting times for appointments.

The Chairman thanked the Director of Operations and Delivery, NHS England East Anglia Team, for the report.

16 Norfolk Health Overview and Scrutiny Committee

16.1 The Board received and noted the minutes from the Norfolk Health Overview and Scrutiny Committee meeting held on 11 April 2013.

17 Pharmaceutical Needs Assessment – Interim Report

17.1 The Board received and noted the annexed report (17) by the Interim Director of Public Health, summarising the position on Norfolk's current Pharmaceutical Needs Assessment (PNA) and outlining the timetable and process for preparing the Norfolk PNA 2015.

18 Election of Vice-Chairs

Dr Ian Mack, West Norfolk CCG and Cllr Yvonne Bendle, South Norfolk District Council accepted nominations to be Vice-Chairs of the Board and were duly appointed.

The next meeting would take place on **Wednesday 23 October 2013** at 10am in **the Green Room, Norfolk Archive Centre,** County Hall site, Norwich.

The meeting closed at 12.40pm

Chairman

Norfolk County Council

Appendix A

Report of the Director of Public Health for Norfolk and Waveney 2012-13

Lucy Macleod, Interim Director of Public Health

Norfolk County Council

A Word on Jargon…..

- MSOA – Medium Super Output Area
- Quintile – 20%, one fifth of the population
- IMD – Index of Multiple Deprivation

…..and time delays….

Norfolk County Council

Population Headlines for Norfolk and Waveney

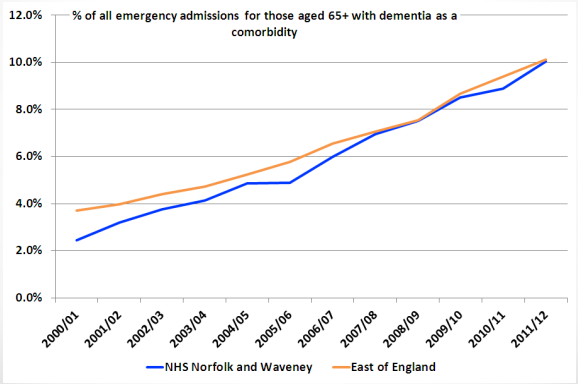
- a greater proportion of older people than elsewhere in England
- a smaller proportion of working age people between 25 and 39
- a smaller proportion of children under 15
- Registered population is forecast to increase from about 990,000 in 2012 to about 1,100,000 in 2022

Norfolk County Council

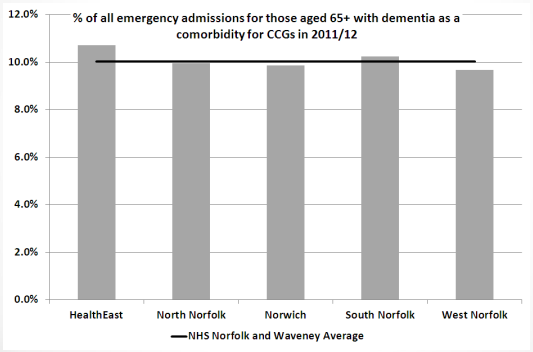
Implications for services

- The old and the very young increase the demand on health and social care services.
- Lower proportion of working age people - there may be fewer people to provide services for the aging population.
- Higher proportion of older people means more people are likely to have long term conditions and chronic diseases
- Over the next ten years the number with dementia is forecast to increase by about 5,000.
- About 10% of hospital admissions for the over 65s have a comorbidity of dementia.
- This is increasing and appears to be consistent across the CCGs in NHS Norfolk and Waveney. In line with the East of England at about 10% of admissions.

Trend in Dementia as Co-morbidity in Emergency Admissions



At CCG Level



Norfolk County Council

Life Expectancy Headlines

Male:

•Great Yarmouth and Norwich lower than the national average. All other districts significantly better than the national average.

•Ranges from 71.3 years for an area in Great Yarmouth to 83.7 years for part of North Norfolk.

•The gap in years of life expectancy between the best-off and worst-off is highest in Great Yarmouth.

•In most local authorities the gap between the best off and the worst off is decreasing. However, the gap in South Norfolk appears to be increasing.

Norfolk County Council

Life Expectancy Headlines

Female:

•For Norfolk overall is significantly higher than the England average.

•Female life expectancy in Great Yarmouth is significantly lower than the national average.

•All other districts significantly better than the national average.

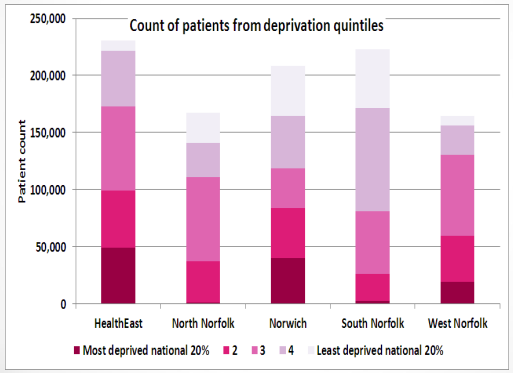
•Ranges from 77.5 years for an area of Great Yarmouth to 90.4 years for an area of North Norfolk.

•The gap between the best-off and worst-off is highest in Waveney.

•In most District Council areas the gap between the best off and the worst off is remaining the same or decreasing.

Norfolk County Council

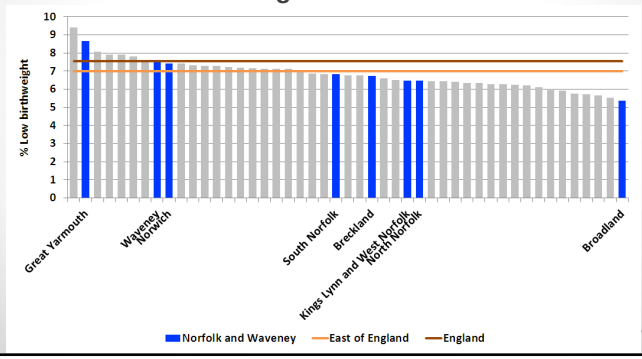
Deprivation



Norfolk County Council

Implications for Individuals and Services

Children: Low Birth Weight

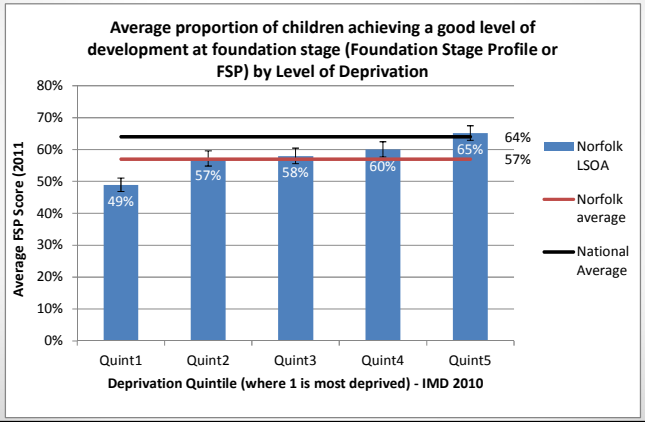


Norfolk County Council

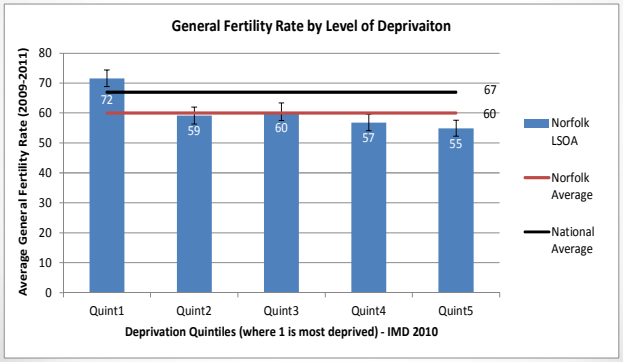
- The proportion of children in poverty is significantly higher than the national average for the districts of Norwich and Great Yarmouth.
- Great Yarmouth has the highest inequality in child poverty across Norfolk and Waveney and contains area with the highest proportion of child poverty (49%) and the area with the lowest proportion of children in poverty (6.5%).
- The districts with the lowest proportion of children in poverty are Broadland and South Norfolk.

Norfolk County Council

Deprivation and Attainment



Norfolk County Council



Norfolk County Council

Working Age Adults – Early Death (Male)

Male all cause mortality under 75 2008-10	Local Number	Local Value	Eng Avg	Local Worst	Norfolk and Waveney Range	Local Best
Breckland	656	266.0	345.5	378.3		182.8
Broadland	605	256.4	345.5	392.9		151.5
Great Yarmouth	659	378.4	345.5	693.3		204.2
King's Lynn and West Norfolk	861	315.0	345.5	606.4		209.8
North Norfolk	628	290.0	345.5	375.0		168.7
Norwich	728	416.7	345.5	695.4		223.6
South Norfolk	599	264.0	345.5	393.0		225.0
Waveney	700	320.5	345.5	589.3		179.7
Norfolk	4,736	306.0	345.5	695.4		151.5

Directly age-standardised mortality rate due to all causes, including mortality at all ages registered in the respective calendar years. Standardised using the European Standard Population. Source: ERPHO

Better than England average
Not significantly different from England average
Worse than England average

England average
Worst
Best
local authority range

Norfolk County Council

Working Age Adults – Early Death (Female)

Female all cause mortality under 75 2008-10	Local Number	Local Value	Eng Avg	Local Worst	Norfolk and Waveney range	Local Best
Breckland	490	192.5	219.5	310.2		107.5
Broadland	427	173.5	219.5	234.1		128.5
Great Yarmouth	460	245.1	219.5	428.1		144.1
King's Lynn and West Norfolk	563	196.2	219.5	352.7		97.8
North Norfolk	381	164.4	219.5	220.7		100.1
Norwich	418	231.2	219.5	345.4		149.8
South Norfolk	443	194.0	219.5	248.9		142.5
Waveney	460	197.6	219.5	301.9		131.8
Norfolk	3,182	196.1	219.5	428.1		97.8

Better than England average
Not significantly different from England average
Worse than England average

to all causes, including mortality
ndard Population. Source: ERPHO

England average
Worst
Best
local authority range

e calendar

Incapacity Benefit and Mental Ill Health

Incapacity Benefit / Severe Disablement Allowance with a diagnosis of mental health May 2011 per 1000	Local Number	Local Value	Eng Avg	Local Worst	Norfolk and Waveney Range	Local Best
Breckland	1,335	17.9	21.7	29.3		9.1
Broadland	1,175	16.6	21.7	23.1		12.7
Great Yarmouth	1,695	30.2	21.7	70.1		10.9
King's Lynn and West Norfolk	1,865	23.6	21.7	50.0		8.3
North Norfolk	1,230	23.4	21.7	49.4		13.9
Norwich	3,060	30.9	21.7	69.6		8.2
South Norfolk	1,125	16.3	21.7	25.7		7.2
Waveney	1,435	22.0	21.7	55.9		7.6
Norfolk	11,485	22.9	21.7	70.1		7.2

Better than England average
Not significantly different from England average
Worse than England average

England average
Worst
Best
local authority range

Claimant count (rounded to the nearest 5) for IB/SDA with a diagnosis of mental health, crude rate per 1000 resident working age population. Working age is defined as females aged 16 to 59 and males aged 16 to 64. Source: Department of Work and Pensions

Norfolk County Council

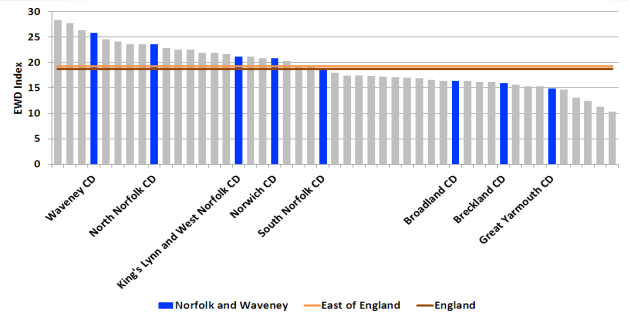
Other Measures

- About 11% of the Norfolk population are in the most deprived group in England
- Over a quarter of households in North Norfolk are estimated to be fuel poor.
- Fuel poverty ranges from over 40% of households for an MSOA in West Norfolk to about 10% for an area in Broadland.
- Long term unemployment for Norfolk as a whole is lower than the England average, however in Great Yarmouth and Norwich Districts it is higher.
- Between MSOAs the long term unemployment rate ranges from 1 per 1000 to 35 per 1000.

Norfolk County Council

Deprivation and Older People

- Excess Winter Deaths



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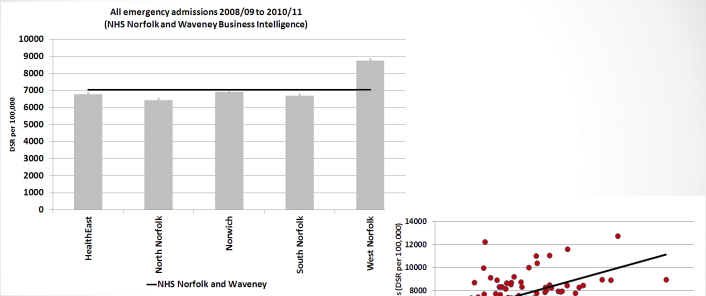
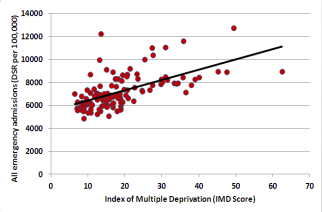
- Emergency Admissions and Deprivation





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Lifestyles and Behaviours

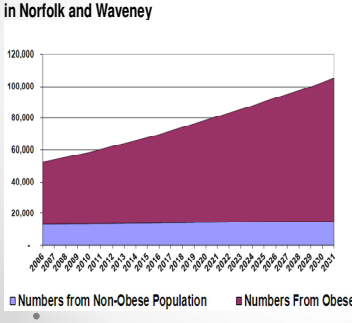
In 90% of cases the risk of a first heart attack is related to nine potentially modifiable risk factors;

- Smoking/tobacco use
- Poor diet
- High blood cholesterol
- High blood pressure
- Insufficient physical activity
- Overweight/obesity
- Diabetes
- Psychosocial stress – linked to ability to influence the potentially stressful environments in which people live
- Excess alcohol consumption

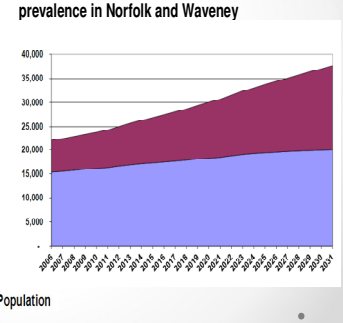
Obesity

Over the next 25 years if trends continue it is estimated that there will be an additional, 50,000 diabetics and an additional 9,000 strokes due to obesity.

Estimated impact of rising obesity on Diabetes prevalence in Norfolk and Waveney



Estimated impact of rising obesity on Stroke prevalence in Norfolk and Waveney



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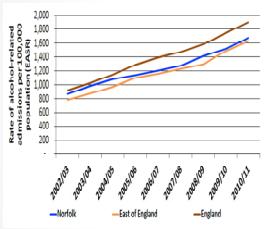
Smoking

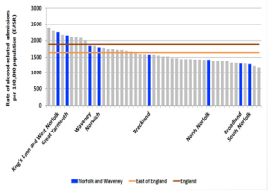
- Inequality in male death rates attributable to smoking is largest in NHS Great Yarmouth and Waveney.
- Great Yarmouth and Norwich have death rates higher than the national average
- Range in male death rates attributable to smoking from 115 for a MSOA in South Norfolk to 529 for a MSOA in Norwich.
- Range in female death rates attributable to smoking from 55 for a MSOA in South Norfolk to 243 for a MSOA in Great Yarmouth.

Alcohol Related Admissions

Trend in alcohol related admissions (NI39)



Alcohol related admissions (NI39) across the East of England 2010/2011



Health Protection

- **MMR immunisation** under 24 months is increasing across Norfolk and Waveney. However there is still considerable variation between practices.
- **Cervical screening** uptake has been declining slightly over the last few years though it is above the national average.
- The districts with the lowest uptake are King's Lynn and West Norfolk and Norwich.
- The range in practice uptake is from about 55% to 93%.
- **Flu immunisation** uptake for those aged 65 and over has been decreasing and is below the 75% target. At a local authority level only South Norfolk and Waveney are close to or better than the target.

Norfolk County Council

Infection Prevention and Control

- In 2012/13 there were no cases of MRSA arising the Norfolk hospitals
- C. difficile infections were within the ceiling set by the Department of Health in both community and hospital settings as was MRSA.
- Norovirus levels were low compared with national rates which increased by approximately 80% on the previous year.
- Notifiable diseases – whooping cough reports in 2012 were considerably increased compared to previous years. Food poisoning notifications are rising year on year. Acute Infectious Hepatitis also appears to be increasing.

Norfolk County Council

Key Messages

- The impact of an aging population will provide huge challenges which need to be considered in relation to all forms of care including palliative care and end of life.
- The impacts of deprivation and inequality must be considered in relation to future service challenges and not solely in relation to individual behaviours.
- Finding breakpoints in the cycle of deprivation is key
- This is, or will be, a community wide problem and requires solutions to be developed and co-ordinated across communities.