Health & Wellbeing Board

Date: **Wednesday 24 April 2019**
Time: **11:00 am**
Venue: **Edwards room, County Hall**

Representing	Membership	Substitute
Adult Social Care Committee, Norfolk County Council (NCC)	Cllr Bill Borrett	Cllr Shelagh Gurney
Adult Social Services, NCC	James Bullion	Debbie Bartlett
Borough Council of King's Lynn & West Norfolk	Cllr Elizabeth Nockolds	Cllr Sam Sandell
Breckland District Council	Cllr Paul Claussen	Cllr Lynda Turner
Broadland District Council	Cllr Shaun Vincent	Cllr Roger Foulger
Children's Services Committee, NCC	Cllr Stuart Dark	Cllr Judy Oliver
Children's Services, Norfolk County Council	Sara Tough	Sarah Jones
Director of Public Health, NCC	Dr Louise Smith	
East Suffolk Council	Cllr Mary Rudd	Cllr Alison Cackett
Great Yarmouth Borough Council	Cllr Cara Walker	Cllr David Drewitt
Healthwatch Norfolk	David Edwards	Alex Stewart
NHS England, East Sub Region Team	Simon Evans-Evans	
NHS Great Yarmouth & Waveney CCG	Dr Liam Stevens	
NHS Great Yarmouth & Waveney CCG	Melanie Craig	
NHS Norwich CCG	Tracy Williams	
NHS Norwich CCG	Jo Smithson	
NHS North Norfolk CCG	Dr Anoop Dhesi	
NHS North and South Norfolk CCG	Frank Sims	
NHS South Norfolk CCG	Dr Hilary Byrne	
NHS West Norfolk CCG	Dr Paul Williams	
NHS West Norfolk CCG	John Webster	
Norfolk Constabulary	ACC Nick Davison	Supt Chris Balmer
Norfolk County Council	Cllr David Bills	
North Norfolk District Council	Cllr Angie Fitch-Tillett	Cllr Becky Palmer
Norwich City Council	Cllr Matthew Packer	Adam Clark
Police and Crime Commissioner	Lorne Green	Dr Gavin Thompson
South Norfolk District Council	Cllr Yvonne Bendle	Cllr Florence Ellis
Sustainability & Transformation Partnership (Chair)	Rt Hon Patricia Hewitt	
Sustainability & Transformation Partnership (Executive Lead)	Melanie Craig	
Voluntary Sector Representative	Vacancy	Jonathan Clemo
Voluntary Sector Representative	Dan Mobbs	Laura Bloomfield
Voluntary Sector Representative	Elly Wilson Wickenden	Alan Hopley

Standing invitation to attend Board meetings:

East Coast Community Healthcare CIC	Jonathan Williams	Tony Osmanski
James Paget University Hospital NHS Trust	Anna Hills	Anna Davidson
Norfolk Community Health & Care NHS Trust	Josie Spencer	Geraldine Broderick
Norfolk Independent Care	Dr Sanjay Kaushal	
Norfolk & Norwich University Hospital NHS Trust	Mark Davies	John Fry
Norfolk & Suffolk NHS Foundation Trust	Prof Jonathan Warren	Marie Gabriel
Queen Elizabeth Hospital NHS Trust	Caroline Shaw	Prof Steve Barnett

Persons attending the meeting are requested to turn off mobile phones.
For further details and general enquiries about this Agenda please contact the Committee Administrator:
Hollie Adams on 01603 223 029 or email: committees@norfolk.gov.uk

Health & Wellbeing Board
Agenda
Time: 11:00 am to 1pm

1	Apologies	Clerk	
2	Chairman's opening remarks	Chair	
3	Minutes	Chair	(Page 3)
4	Actions arising	Chair	
5	Declarations of interests	Chair	
6	Public Questions (How to submit a question)	Chair	
7	Joint Strategic Needs Assessment (JSNA) – informing and supporting our system	Suzanne Meredith	(Page 12)
8	Norfolk & Waveney Sustainability and Transformation Partnership (STP):		
	• Update, including integrating heath and care services	Patricia Hewitt/ Melanie Craig	(Page 17)
9	Better Care Fund and integration plan – end of year 2017/19	James Bullion/ CCGs x 5	(Page 21)
10	Homes and Health - system progress at mid-year	Adam Clark	(Page 32)
11	Health & Wellbeing Board governance update	Louise Smith/ Linda Bainton	(Page 39)

Information updates

- **Public Health Transformation Six Years On: Partnership and Prevention** – this recent LGA publication includes a Norfolk Case Study
- **NHS Long Term Plan** – further information about a series of events and online survey being organised by Healthwatch Norfolk can be found here: www.healthwatchnorfolk.co.uk/news/what-would-make-the-nhs-work-better-for-you
- **Further information about the Health and Wellbeing Board** – can be found on our website at: About the Health and Wellbeing Board

Health and Wellbeing Board
Minutes of the meeting held on 13 February 2019 at 09:15am
in the Edwards Room, County Hall.

Present:	**Representing:**
Cllr Bill Borrett	Adult Social Care Committee, Norfolk County Council (NCC)
James Bullion	Adult Social Services, NCC
Cllr Elizabeth Nockolds	Borough Council of King's Lynn & West Norfolk
Cllr Lynda Turner	Breckland District Council
Sara Tough	Children's Services, Norfolk County Council
Dr Louise Smith	Director of Public Health, NCC
David Trevanion	Healthwatch Norfolk, (Vice-Chair)
Dr Liam Stevens	NHS Great Yarmouth & Waveney CCG
Tracy Williams	NHS Norwich CCG
Frank Sims	NHS North and South Norfolk CCG
Dr Paul Williams	NHS West Norfolk CCG
Adam Clark	Norwich City Council
Dr Gavin Thompson	Police and Crime Commissioner
Cllr Yvonne Bendle	South Norfolk District Council
Rt Hon Patricia Hewitt	Sustainability & Transformation Partnership (Chair)
Karen Barker	ICS Development Director (substitute for STP Executive Lead)
Jonathan Clemo	Voluntary Sector Representative
Dan Mobbs	Voluntary Sector Representative
Alan Hopley	Voluntary Sector Representative
Cllr Mary Rudd	Waveney District Council

Providers Present:	
Jonathan Williams	East Coast Community Healthcare CIC
Geraldine Broderick	Norfolk Community Health & Care NHS Trust
Dr Sanjay Kaushal	Norfolk Independent Care
Patrick Johnson	Queen Elizabeth Hospital NHS Trust

Officers Present:	
Stephanie Tuvey	Project Manager, HealthWatch Norfolk
Sally Hughes	Public Health Commissioning Manager
Linda Bainton	Senior Planning & Partnerships Officer, Public Health, NCC
Chris Butwright	Head of Performance and Delivery, Public Health, NCC
Hollie Adams	Clerk

1. Apologies

1.1 Apologies were received from Dr Hilary Byrne, Cllr Paul Claussen (Cllr Lynda Turner substituting), Melanie Craig (Karen Barker substituting), Cllr S Dark, Mark Davies, ACC Davison, David Edwards (David Trevanion substituting), Cllr Angie Fitch-Tillett, Cllr Roger Foulger, Lorne Green (Dr Gavin Thompson substituting), Antek Lejk, Paul Martin (Jon Clemo substituting), Cllr Matthew Packer (Adam Clark substituting), Cllr Frank Sims (Clive Rennie substituting), Jo Smithson, John Webster, and Elly Wilson-Wickenden (Alan Hopley substituting).

1.2 Also absent were Christine Allen, Cllr David Bills, Dr Anoop Dhesi, Simon Evans-Evans and Cllr Cara Walker.

2. Chairman's Opening Remarks

2.1 The Chairman

- Welcomed David Trevanion, Patrick Johnson and Karen Barker to the meeting

- Reported that the Chair and Vice Chairs Group had endorsed the Better Care Fund Quarter 3 monitoring report for submission to NHS England on behalf of the Board. An End of Year report on the funding would be brought to the next meeting in April 2019

3. Minutes

3.1 The minutes of the meeting held on the 31 October 2018 were agreed as an accurate record and signed by the Chairman

4. Actions arising from minutes

4.1 Page 5, Paragraph 7.2, 3rd bullet; Joint Health and Wellbeing Strategy 2018-22: since the Health and Wellbeing Board meeting on 31 October 2018, it had been confirmed that the Norfolk & Norwich University Hospital NHS Hospital Trust and Queen Elizabeth Hospital NHS Trust had formally signed up to the Health and Wellbeing Board Strategy

4.2 Page 8, paragraph 9.3; Health and Wellbeing Board District Councils' Sub Committee: The Sub Committee was due to meet to progress their work prioritising homes and health in March 2019

5. Declarations of Interests

5.1 There were no declarations of interest.

6. Public Questions

6.1 No public questions were received

7. Our Joint Health and Wellbeing Strategy 2018-22 – implementation planning

7.1.1 The Health and Wellbeing Board (HWB) received the paper providing a draft high-level Implementation Framework based on the agreed Strategic Framework and outlining next steps for the Strategy

7.1.2 The Head of Performance and Delivery, Public Health (PH), introduced the report

- moving forward, it was important to consider how HWB meetings could reflect partners' ongoing work and plans and how organisations would come together to deliver on key strategies
- the key actions on page 41 of the report included developing a partnership approach for children and young people and a focus on workplace health, including the wider workplace
- There were plans to launch a HWB Chairman's award to recognise transformation work in Norfolk; an approach for putting forward nominations was being developed

7.2.1 During discussion the following points were noted:

- The Chairman commented that the Strategy was fundamental to how partner organisations work together as a system, with HWB partners working alongside and feed into organisational strategies
- Dr Paul Williams considered that the Strategy fitted well with population health work being carried out at a local level in the West and invited PH to be involved in this work. Dr Louise Smith **agreed** to discuss what PH could offer to this work outside of the meeting
- Adam Clark spoke about the Healthy Norwich Programme (HNP) with its focus on how collectively we can do more as a system. He commented that it fitted well with the Strategy and that a recent HNP workshop had drawn on the message from the key note speaker at the 2018 HWB Conference – "Think like a system, act like an Entrepreneur". Mr Clark

offered to share information about how the programme was working.

- The importance of monitoring and evaluating progress was discussed and Vice-Chair Cllr Bendle reported that a new way of evaluating prevention work was being developed in South Norfolk and was currently being evaluated by the District Council's Network; Cllr Bendle **agreed** to send this to Dr Louise Smith. Dr Smith was mindful that our monitoring and evaluation should not be driven by a dashboard of quantitative data – we will also need to rely on more qualitative information, for example, asking ourselves questions such as: Are we moving in the right strategic direction in relation to our Integrated Care System? Or are we strong on our strategic approach to children and young people's mental health?

7.3 The Health and Wellbeing Board

1. **AGREED** the draft high-level Implementation Framework
2. **AGREED** to develop an Implementation Action & Delivery Plan
3. **COMMITED** to action to take this work forward

8. NHS 10 Year Plan - Briefing

8.1.1 The HWB considered the report outlining key messages from the NHS Long Term Plan (LTP) published in January 2019, setting out a strategy for the health service for the next ten years and providing a framework for local systems to develop plans

8.1.2 The Director of Public Health, Dr Louise Smith introduced the report:

- Dr Smith thanked Norwich Clinical Commissioning Group (CCG) for sharing their paper which had helped inform the report
- Welcomed the LTP chapters on prevention and on workforce, together with the acknowledgement of digital innovation as important for the development of a modern health and social care system
- Confirmed that the implications of the LTP for the system would be discussed in the HWB development session outside of the main HWB meeting on 24 April 2019

8.2 During discussion the following points were noted:

- Rt Hon Patricia Hewitt welcomed the LTP's 5-year planning horizon for funding and the clear statement about the integration of health and care systems
- The arrival of the LTP had been followed by the announcement new GP contract
- James Bullion welcomed the LTP but commented that there was a lost opportunity, with the social care green paper still awaited. Norfolk & Waveney was reasonably well advanced on its 'journey' and well placed to respond to the initiatives set out in the LTP, which would build on work already underway across the system. He **suggested** it would be helpful for the HWB to see the developing plans for the N&W 5-year plan and to 'hold to account', in a dual way with the ICS process.
- It was recognised that the workforce was key. Alan Hopley commented that we would need to consider the wider workforce including, volunteers working in the NHS, voluntary sector paid staff, and private sector care provision.
- Vice-Chair Cllr Bendle championed the benefits of partnership working across social prescribing, face-to-face work with connectors and early help to give effective support.
- Sara Tough welcomed the focus around children and young people, particularly children and young people's mental health. It was noted that a further workstream in the STP had just been introduced with a focus on children and young people and work was underway to develop an integrated children's system.
- HealthWatch Norfolk welcomed the messages laid out in the plan, particularly around partnership working and integrated working, and commented on the importance of informing and consulting the public.
- Dr Sanjay Kaushal commented on the setting up of the Residential Care and Care Home Steering Group and the recognition of the importance of the role of the private care sector

in planning

- Dr Louise Smith welcomed the focus on prevention. Dr Smith reminded Board members of the decline in investment in prevention over the past 5 years and drew attention to the Smoking Strategy and the need for us as a system to tackle smoking in the community, particularly smoking in pregnancy.

8.3 The Health and Wellbeing Board

1. **DISCUSSED** the implications of the NHS Long Term Plan for our local health and wellbeing system and **NOTED** that there would be further discussion in the HWB development session outside of the main HWB meeting on 24 April 2019.

9. Norfolk & Waveney Sustainability and Transformation Partnership (STP) – Update, including integrating health and care services

9.1.1 The HWB discussed the report providing an update on the Norfolk and Waveney Sustainability and Transformation Partnership (STP), with a focus on progress on key pieces of work since the last report in October 2018.

9.1.2 The STP Chair, Rt Hon Patricia Hewitt, introduced the report:

- A single, accountable officer would be appointed for the 5 Clinical Commissioning Groups (CCGs), and would become the Executive Lead for the STP
- A Norfolk and Waveney plan in response to the long-term plan would need to be in place by September 2019
- There would be full engagement with service users, carers and agency and voluntary sector partners
- A workshop with the HWB would be extremely helpful to discuss ideas and the process to be followed, and to start to develop the Norfolk and Waveney 5 - year plan
- Due to a change in NHS England processes, all areas across the country would be 'shadow' ICSs (Integrated Care Systems) from April 2020, unless they had gone on to become an ICS; Norfolk and Waveney (N&W) STP aimed to become an ICS from April 2020
- Strong foundations were in place which we would build on; there was, for example, closer working between the 3 acute hospitals. The biggest challenge was the financial situation, with Norfolk and Waveney NHS heading towards a deficit of nearly £100m in 2019-20. A medium term financial recovery plan had been put in place to address this but it was a big challenge and reinforces the need for everybody working more closely together to address things at the earliest stage.
- The "Aspirant ICS programme" had been helpful in progress towards an ICS and our developing ICS would be based on three levels as outlined in the report: 20 neighbourhoods, focussed around GP practices and based on delivery; place level which was based around CCG cluster boundaries and would involve District Council input; and Norfolk and Waveney level.

9.2 The following points were discussed and noted

- There was a discussion about boundaries and the complexity of the health and wellbeing landscape in which we are operating; effective partnership working, with the appropriate representation at neighbourhood and place level would be essential.
- A whole system understanding of demand and capacity would be needed; demand and capacity work to date had focussed on the known deficit area, which at that time was the NHS
- Karen Barker, agreed to produce a timeline of key dates leading up to submission of the Norfolk and Waveney plan in September 2019, to be provided at the HWB development session on 24 April 2019.
- The draft Adult Mental Health Strategy would be sent to the Joint Strategic Commissioning

Committee the following week; Dr Smith asked Vice-Chair Tracey Williams to send this to HWB Members for comments

- NHS resource was invested in the voluntary sector and it was important that they were included in discussions
- The Chairman was hopeful about development towards a common delivery pattern across the county and towards a common offer where all people in Norfolk could expect the same high levels of support

9.3 The Health and Wellbeing Board:

1. **AGREED** to assist with building awareness of the three levels our Integrated Care System will have within their organisations, in order to build a consistent and shared understanding of how the system will work together to improve health and care
2. **CONSIDERED** the role that partners could play, both collectively and individually, in the development and implementation of our 20 Primary Care Networks across Norfolk and Waveney
3. **SUPPORTED** the continued involvement of service-users, carers, staff and other stakeholders in the implementation of our mental health strategy.
4. **COMMITED** to supporting the development of the Norfolk and Waveney five-year plan.

10. Clinical Commissioning Group (CCG) Annual Reports

10.1 The HWB considered the draft narratives submitted by each Clinical Commissioning Group (CCG) in Norfolk and Waveney for their Annual Reports 2018-19, focussing on how they had supported and contributed to the delivery of Health and Wellbeing Board priorities.

10.2 Vice-Chair Tracey Williams reported that CCGs were due to be submitted to NHS England in mid-April 2019

10.3 The Health and Wellbeing Board:

- **AGREED** the narratives
- **ENDORSED** the move to a single management team in 2019

11a. Access to health and social care services for Norfolk Families with Autism

11a.1 The HWB received a presentation (see Appendix 1) by Stephanie Tuvey, Healthwatch Norfolk, on the key findings of a recent HealthWatch Norfolk report;

- Families raised a lack of understanding of autism from professionals which limited the ability of families and children with autism to access services
- Barriers to accessing support were raised by families, some of which was caused by attitudes from professionals
- Families felt services for Autism Spectrum Disorder (ASD) in Norfolk needed to change; waiting times were often long and many rated services as poor
- The findings emphasised the need to listen and engage more with families and service users using the service.
- Families discussed a lack of support post diagnosis

11a.2 The Health and Wellbeing Board **NOTED** the presentation, which provided context for the discussion of the next item.

11b. All Age Autism strategy update

11b.1 The HWB received the report providing an update on the development of the All-Age Autism Partnership Board and the workstreams in place to support development of a local All-Age

Autism Strategy

11b.2 The Executive Director of Adult Social Services, James Bullion, introduced the report:

- Welcomed the HWN presentation of the key findings; we know that we need to engage, and we are engaging
- The All-Age Autism Partnership board had been developed over a year by engaging with partners. As Co-Chair of the Partnership board, the Executive Director, played tribute to those with learning disabilities who are participating the Partnership board and urged them to continue to participate.
- The Partnership board had looked at the Autism diagnostic pathway and their findings validated the findings of HealthWatch Norfolk, as outlined in the presentation at 11a
- There was a need for a culture change in Norfolk around the services and support for families and children with Autism and Asperger's
- The HWB requested to be kept up to date with progress on this work

11b.3 The Health and Wellbeing Board:

a) **ACKNOWLEDGED** the work undertaken in the continued development of Norfolk All-Age Autism Partnership Board, Norfolk All-Age Autism Group and the working groups in place to undertake priority work identified

b) **AGREED** to champion active engagement from services across Norfolk County Council (the Council) to the strategy

c) **AGREED** to receive the local all-age autism strategy that will be informed by the completion of the National Autism Self-Assessment (completed 14 December 2018) with a co-produced all age strategy available March 2018

12. Prevention Concordat for better Mental Health

12.1 The HWB considered the report showing the context and principles set out in the Prevention Concordat for Better Mental Health and asking partners to sign up to a cross sector approach

12.2 Sally Hughes, Public Health Commissioning Manager (Vulnerable People), introduced the report commenting that it was a good fit with the HWB's strategic aspirations around prevention.

12.3 During discussion the following points were noted

- The Concordat was welcomed as the right approach but it should work with the overall aims of our system focus on mental health
- It was suggested that the focus should be on mental wellbeing, as well as mental health

12.4 The Health and Wellbeing Board

1. **REVIEWED**, **AGREED** and **SIGNED-UP** to the set of statements, listed below.
2. **AGREED** to work together to develop a shared system action plan for better mental health

The Meeting Closed at 11.01

Bill Borrett, Chairman,
Health and Wellbeing Board

healthwatch Norfolk

Access to health and social care services for families with autism

October 2018, Steph Tuvey (Project Manager)

Background on Norfolk services supporting children with ASD

- **ASD diagnostic services**
- **NCHC: Neurodevelopmental service (NDS)** *[Covers the rest of Norfolk but not Great Yarmouth & Waveney or Thetford]*
- **JPUH: Joint Pathway Child, family and young people Mental Health services & Community paediatrics for diagnosis and ongoing support for CYP with neurodisabilities** *[solely for Great Yarmouth and Waveney]*
- **General Health & Social care services**
- **Voluntary sector organisations**

Our approach…

As a result of being told that local services for children with ASD were unsatisfactory, a priority project was launched.

We wanted to understand families experiences of:
1) Health & social care services
2) ASD diagnostic services
3) Trying to access ASD support

Mixed methods approach


Parent Questionnaires


Parent support groups


Local Public ASD events

Respondants…

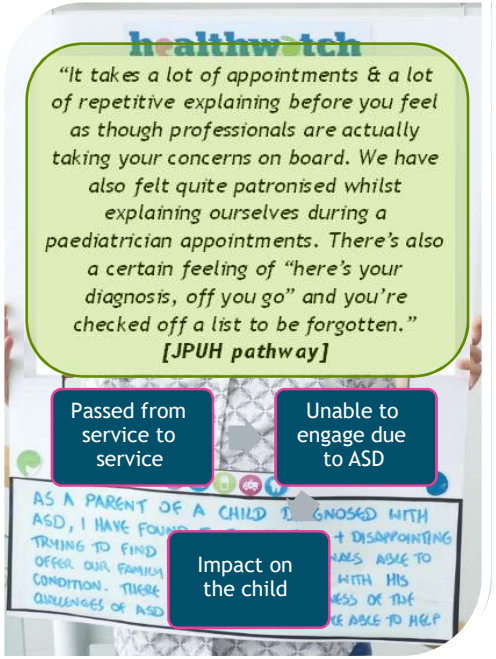
112 families completed questionnaires representing **133 children** (aged between 1 – 18 years

Health and social care…a lack of understanding

- Families felt professionals did not understand the reality of what it was like to live with ASD and how it affects individuals everyday lives.

"People to have the patience to understand that with autism you are going to get behaviours. It's going to take people who have autism a lot longer to be looked at. They don't always understand what's going on. Things they hear see [and] smell are going to upset or make them curious and may need time to touch, smell possibly lick etc for them to process their surroundings. And people's attitude towards autism need to change. They may feel like they are having a bad time treating someone with autism but that's nothing compared to the child with autism is actually going through. They are acting this way because they don't understand, don't feel safe or it's out of their daily routine. So please be patient with them."

- There was a lack of understanding across all health and social care services.
- Attending appointments could be challenging and the importance of understanding ASD and the individual child was vital.



Difficulty getting help at the right time

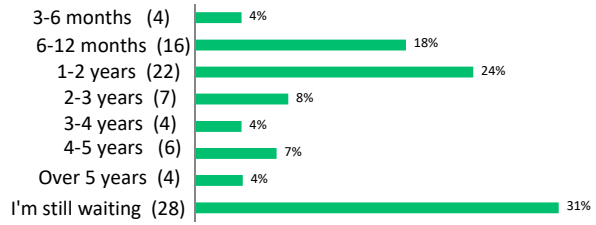
- Families commonly expressed how there were always barriers to accessing help.

"There now seems to be so many barriers/hurdles put in place that you have to 'jump' before you can access the services that you need/your child is entitled to. If you are not a determined parent it is too easy to fall by the wayside."

- Some parents felt that attitudes needed to change and parents needed to be listened to.

Frustration over long waiting times, services need to change

- 91 out of 96 families, identified they were accessing NHS services for a diagnosis and reported waiting **between 3-6 months to over 5 years,** this demonstrated clear differences in waiting time for all families in Norfolk.

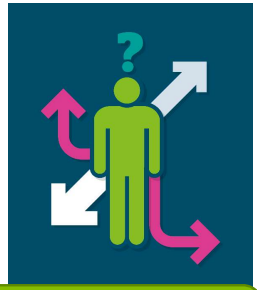


How families rated the diagnostic services:

- 50% (42 families) of families rated ASD diagnostic services in Norfolk as 'very poor or poor'.
- 27% (22) rated them as 'neither good nor bad' (based on 83 families of the 112 who chose to rate their experiences).
- 22% (19) felt the services were 'very good or good'.

Families unaware of the diagnostic process: Parents call for clearer information and advice

- Parents felt there was a lack of communication from ASD diagnostic services.
- The pathway process for a diagnosis was not explained to parents.
- Parents often recalled the feeling of being forgotten as they did not know where they were in the process.



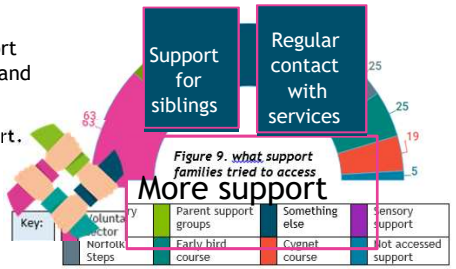
"You're on a pathway but no one tells you what direction, where you are going!"

"Having more support/communication during the assessment period. No one explained or gave us information on the process/timescales/what needed to be carried out."

*I feel very pleased that my boys (twins) were diagnosed before they started school. The only thing I would improve is by having a plan/chart available to show the diagnosis process and the various steps along the way...as I was always wondering what the 'next stage' in the process would be." **[NCHC pathway]***

Lack of support for families

- Most commonly parents accessed support through voluntary sector organisations and parent support groups - no judgement.
- Continuous fight for services and support.
- A lack of support available post diagnosis, resulted in parents describing the feeling of being 'dropped in the ocean' and left to survive on their own.



"…this is a lifelong condition but once you have a diagnosis you are discharged from health and social care and expected to cope with a child whose needs are changing as they grow up. Voluntary support services are all that is available."

come across challenging behaviour you're not sure how to deal

"No support for parents who are waiting for a diagnosis. When we finally after 4 years received the diagnosis of ASD we we're briefly told about it and given several leaflets and sent home to sort it out for yourselves. It's really stressful having a child with special needs so to be finally diagnosed and given leaflets and shown the door is so overwhelming." **[NCHC pathway]**

Recommendations

1. Leadership is required to coordinate more awareness of ASD diagnostic services, their process and procedures involved and openly share with families when accessing the service.
2. As opportunities arise, involve parents in the redesign of services, buildings and waiting areas used for autistic patients.
3. Leadership is required to provide training across all universal health and social care services.
4. The AAPB to monitor and ensure that parents are involved in a review of current parent support programmes to ensure they are accessible for all. E.g. considering digital platforms.
5. The AAPB have responsibility to ensure recommendations are achieved in the development of the strategy for Norfolk and ensure that all service contracts are regularly monitored.

Thank you for your time

- The detailed report, summary and easy read document can be found on our website: www.Healthwatchnorfolk.co.uk

Report title:	**New Joint Strategic Needs Assessment (JSNA) website, JSNA governance and process**
Date of meeting:	**24 April 2019**
Sponsor (H&WB member):	**Dr Louise Smith, Director of Public Health**

Reason for the Report

The Joint Strategic Needs Assessment (JSNA) is a statutory requirement as part of the Health and Social Care Act 2012. It provides data and analyses on the health status and trends needed to inform the development and implementation of the Joint Health and Wellbeing Strategy (JHWBS). Norfolk County Council (NCC) and the Clinical Commissioning Groups (CCGs) in Norfolk have equal and joint duties to prepare the JSNA and the JHWBS, through the Health and Wellbeing Board (HWB).

Report summary

This report outlines a new governance structure and process for managing the JSNA to ensure that the information is up-to-date, relevant to the current public health and HWB priorities, accessible and easy to use for a wide range of audiences. It describes the process of managing and quality assurance of new documents and presents the recent upgrade of the JSNA website to a modern, more functional and flexible software (Instant Atlas Online). A JSNA working group has been set up to manage content planning, production, quality assurance, sign-off and dissemination of the JSNA products.

Recommendations

The HWB is asked to:

1. Endorse the proposed JSNA Governance and Process.
2. Identify members of the HWB from each partner organisation (NCC Adult Social Care, Children's Services, each CCG, each DC, Public Health) to act as a Liaison Group between the HWB and the JSNA Working Group.
3. Support the use of the JSNA products in the commissioning plans of its member organisations.

1. Background

1.1 **Norfolk Insight** is a locality-focused information system, providing data and analysis across Norfolk and Waveney. A new collection of tools and data are available to empower you with up-to-date knowledge of local communities, providing an evidence-base to inform and explore.

1.2 **Joint Strategic Needs Assessment** (JSNA), hosted on Norfolk Insight, informs on the health and wellbeing of Norfolk and Waveney and is used to support the Health and Wellbeing Board Strategy.

2. The JSNA Website, Governance and Process

The new JSNA Website

2.1 Norfolk Insight and the JSNA have been upgraded. The upgraded website and software allow for:

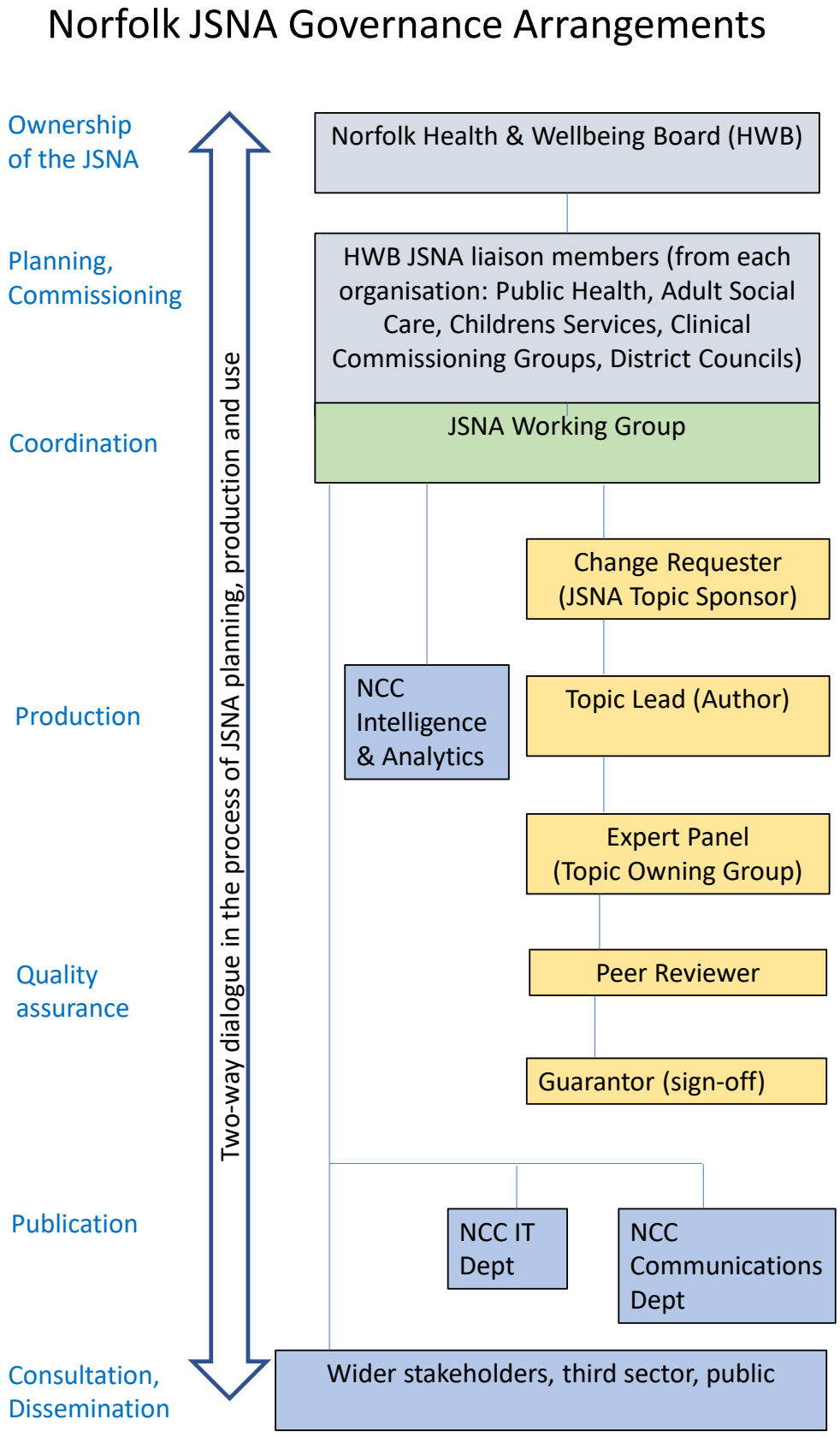
- **Better reporting and profiling**: multi-theme overview reports for Wards and individual themed reports across all geographies for eight themes: population, children and young people, health and social care, housing, crime and community safety, deprivation, economy and employment, and environment

- **New Map Explorer**: you can produce a wide range of thematic maps with our interactive map explorer, using different classifications and colour schemes, show animated time-series, view ranked data tables and download or export data.

- **New Data Explorer**: the dedicated data explorer allows you to search more than 5,000 indicators in our data catalogue and download them in a specified format.

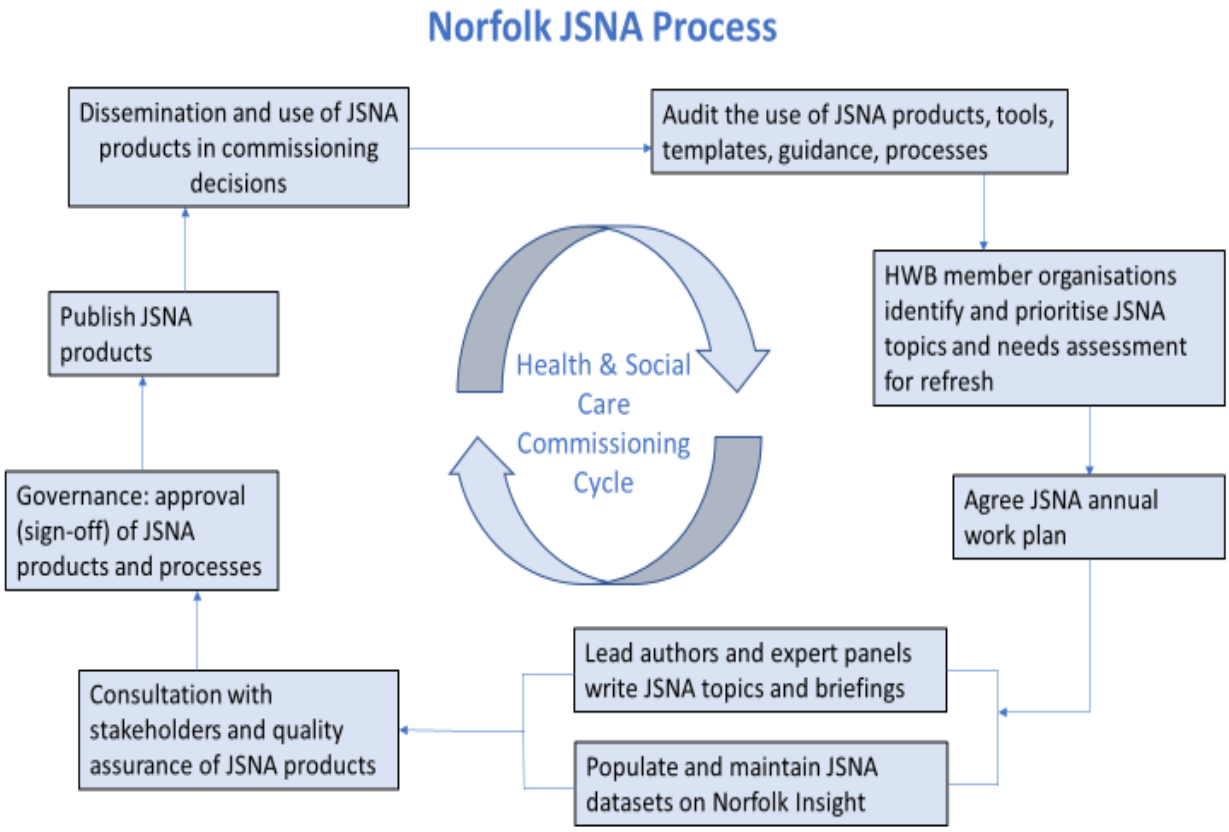
- **New content structure for the JSNA**: the way information is accessed has been improved, enabling a simplified menu structure.

2.2 JSNA Governance



The Process of the JSNA in Norfolk

2.3 A flowchart showing the process of Norfolk JSNA is provided below. Each step in the process is described in the following paragraphs.



2.4 **Prioritise JSNA topics for production or refresh**: Individuals, HWB members and external organisations can propose new topics, changes to the existing JSNA products or archiving of a document. The HWB Liaison Group can propose topics to be included in the JSNA Working Group annual workplan, following from the HWB's Strategy. The main products of the JSNA will be concise briefing papers. Commissioning decisions can be made based on a number of relevant JSNA briefing papers and underlying data on Norfolk Insight. This approach ensures a more dynamic content of the JSNA which can be updated more regularly and can cover more relevant topics.

2.5 **Agree JSNA annual workplan**: An annual workplan for the JSNA is submitted by the JSNA Working Group to the HWB Chair each year. This may include new JSNA topics, topic updates or further analyses on existing topics. The annual workplan is relevant to the priorities of the member organisations of the HWB and aims to inform their commissioning decisions. The HWB approves the annual workplan.

2.6 **Write JSNA briefings and reports**: Once a change request has been approved by the JSNA Working Group, the JSNA Programme Officer will liaise with the requester to identify a Lead Author and an Expert Panel from the relevant NCC

Department or other HWB member organisation, who will write the topic commentary/briefing. They will work closely with the NCC Intelligence & Analytics team and other stakeholders to include relevant data sources and to perform data analysis.

2.7 **Peer review and quality assurance of JSNA products***:* The Expert Panel will identify a peer reviewer for the new topic. The Lead Author integrates any changes requested by the peer reviewer. The Expert Panel identifies a guarantor (a senior officer from the relevant NCC Department or HWB member organisation), who approves and signs off the final product.

2.8 **Publish JSNA products: JSNA written reports**, such as briefings or topic refreshers can be published on the JSNA website after they have been quality assured through a peer review process and signed off by a senior officer.

2.9 **Populate and maintain the local information system (Norfolk Insight):** The local information system Norfolk Insight is populated and maintained by the NCC IMT (Information Management Technology) team.

2.10 **Dissemination of JSNA products:** The JSNA Working Group takes an active approach to disseminating the JSNA products and will ensure that the JSNA is actively promoted amongst all partner organisations, and members of the general public. Specific products will be further disseminated and promoted directly amongst those organisations and users who would benefit from the information.

2.11 **Annual review of the JSNA**: The JSNA topic areas will be reviewed on an annual basis. The JSNA Programme Officer maintains a database of all documents and resources published on the JSNA website with a rolling programme of review and update when new data is released. The JSNA Working Group will submit an annual report to Norfolk HWB with key indicators demonstrating progress towards the implementation of the Joint Health & Wellbeing Strategy.

Officer Contact

If you have any questions about matters contained in this paper please get in touch with:

Name	**Tel**	**Email**
Suzanne Meredith, Deputy Director of Public Health	01603 638456	suzanne.meredith@norfolk.gov.uk

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Item 8

Report title:	**Norfolk and Waveney Sustainability and Transformation Partnership (STP) update**
Date of meeting:	**24 April 2019**
Sponsor (H&WB member):	**Patricia Hewitt, STP Independent Chair / Melanie Craig, STP Interim Executive Lead**

Reason for the report

The purpose of this paper is to update members of the Health and Wellbeing Board (HWB) on the Norfolk and Waveney Sustainability and Transformation Partnership (STP), with a focus on progress made with key pieces of work since the last report in February 2019.

Recommendations:

Members of the Health and Wellbeing Board are asked to:

1. Agree to be fully involved in the development of the Norfolk and Waveney five year plan
2. Assist with building awareness of the NHS Long Term Plan and encourage their patients, service users, carers and staff to get involved in the development of the Norfolk and Waveney five year plan.
3. Note that the final Norfolk and Waveney Adult Mental Health Strategy will be brought to the HWB

in good health
The Norfolk and Waveney Health and Care Partnership

1. System financial position

1.1 NHS organisations in Norfolk and Waveney are currently managing three key financial challenges: 1) delivering the 2018/19 financial plan, 2) developing realistic organisational plans for 2019/20, and 3) negotiating new contracts. Balancing these important tasks and at the same time developing Norfolk and Waveney wide efficiency strategies is therefore challenging.

1.2 Our NHS organisations are currently projecting making £103.8m of efficiency savings by the end of the financial year. Despite this, they are projecting a combined deficit of £95.8m for 2018/19. The projected deficit is £32.4m higher than the £63.4m deficit that was planned for at the start of the financial year. Our aim is to half the deficit in 2019/20.

1.3 Further information about the 'system' financial position can be found in the new STP system finance report being discussed in public at CCG governing body and provider board meetings.

2. Performance of our health and care system

2.1 We are developing a performance framework for the STP in order to enable us to address our performance issues together, supportively and effectively. As a partnership we will focus on a small number of significant indicators, including referral to treatment waiting times, cancer, emergency care and out of area placements.

2.2 Our approach will be proactive, supportive and collaborative, with appropriate challenge from peers. We will develop timely reporting to enable discussion, challenge and delivery. The STP is expecting to produce new performance reports from April onwards, which like the finance report will be discussed in public at CCG governing body and provider board meetings.

3. Our five year plan for health and care services

3.1 A priority for our partnership over the next few months is to develop our five year plan, which will set-out how we are going to improve care and realise the ambitions in the NHS Long Term Plan. In addition to drawing on what people have told us in engagement work carried out recently, for example through the engagement we did around the reviews of adult mental health services and Child and Adolescent Mental Health Services (CAMHS), the STP is working with Healthwatch to provide a range of opportunities for people to reflect on the NHS Long Term Plan and how it should be delivered in Norfolk and Waveney.

3.2 Healthwatch is organising a series of events and running online surveys to enable people to give their views. Further information about both can be found here: www.healthwatchnorfolk.co.uk/news/what-would-make-the-nhs-work-better-for-you

4. Developing our Primary Care Networks

4.1 The NHS Long Term Plan sets out a new service model for primary and community health and care services based on Primary Care Networks (PCNs), which must be in place throughout England and operating from July 2019. This is reinforced by funding to develop PCNs and the new five-year GP contract.

4.2 Development of 20 proposed PCNs is already underway in Norfolk and Waveney. It is intended they will form the fundamental building blocks of our Integrated Care System and be where we position integrated primary/community teams:

- Each PCN will have a new role of clinical director.
- Our mental health strategy commits to the co-location of services with PCNs.
- Adult social care are committed to reconfiguring services to integrate with our PCNs.
- We are exploring the fit between children's services and our PCNs.
- There is clear national guidance for community provider organisations to reconfigure services around PCNs, and we are developing plans for what this will look like locally.
- Clinical Commissioning Groups (CCGs) are providing financial support and support in kind to develop our PCNs, and we are looking to develop a consistent offer across our CCGs.

4.3 In terms of next steps, by 15 May each PCN must have applied to register itself with the full agreement of constituent practices and have an identified lead clinical director. Each PCN must have a plan in place for how they will work by the end of June.

5. Our Mental Health Strategy

5.1 The Norfolk and Waveney Adult Mental Health Strategy is still in the process of being finalised. A final draft was presented to the STP Mental Health Forum in March, and will be agreed by the STP Executive and Joint Strategic Commissioning Committee (JSCC) in April.

5.2 We've received a lot feedback from people that use mental health services locally, carers and stakeholder on the draft released in December 2018. There is strong agreement that the six commitments that form the basis of the strategy are effective and realistic. Many have asked for more detail on how each commitment will be delivered, and the process has begun to develop project plans against each of the workstreams which will implement our six commitments.

5.3 The updated draft of the strategy published in December has responded to the request to include more information on the finance and resource currently available across the mental health system, the training and workforce development needed to deliver the six commitments going forward, the role of unpaid carers and families in supporting people with mental health needs, and the links the strategy must make with the wider health and care system, particularly crisis provision.

6. Digital

6.1 The STP has developed a draft digital strategy, which outlines the ambition of the health and care system to deliver care in new and innovative ways for our patients and citizens by harnessing digital solutions. The draft will be presented to the STP Executive after further engagement by the digital workstream leads.

6.2 The STP digital workstream has delivered a Strategic Outline Case for our three acute hospital trusts to consider a single Electronic Patient Record system in line with our draft digital strategy.

6.3 There are areas of cutting edge innovation in the STP; we have commenced projects to use Artificial Intelligence for Radiology Clinical Decision Support and Cancer Pathway Management.

6.4 Our immediate focus is also on using some of our external funding (in excess of £7m over three years) to put in place a larger team of staff who will drive forward our objectives. These include:

- Developing and integrating clinical software/applications
- Rolling out new methods of patient consultation; we shall shortly be in a position to appoint a provider for online consultations following a competitive tender process
- Replacing the N3 network in the longer term by the new Health and Social Care Network which will enable integration and also online consultations (due to expanded bandwidth)
- Developing or promoting new assistive technologies such as remote patient monitoring

- Developing population health analytics that will greatly assist population health management
- Creating a Norfolk Care Innovation Hub.

6.5 The NHS App will 'go live' in Norfolk and Waveney during April. This will enable patients to interact with surgeries via the App. At the moment the App is 'live' for download but is restricted to 'symptom checking' via NHS111 online. Once their practice is connected, patients will be able to:

- Book and manage appointments at their GP practice
- Order their repeat prescriptions
- Securely view their GP medical record
- Register as an organ donor
- Choose whether the NHS uses their data for research and planning

7. Funding

7.1 The STP has recently been awarded the following funding from NHS England:

- £100,000 to develop a new role of General Practice Assistant, a business support function in practices.

- £485,000 of recurrent funding to expand Individual Placement and Support services which assist people with severe mental health conditions to find gainful employment.

- £1,048,000 awarded in total to various providers on a match funded basis to be used for upgrading buildings to save money (for example changing old lighting to LED).

Officer Contact

If you have any questions about matters contained in this paper please get in touch with:

Officer Name:	**Tel No:**	**Email address**:
Chris Williams	01502 719500	chris.williams20@nhs.net

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Health and Wellbeing Board

Item 9

Report title:	**Better Care Fund and Integration Plan**
Date of meeting:	**24 April 2019**
Sponsor (H&WB member):	**James Bullion**

Reason for the Report

The Health and Wellbeing Board (HWB) oversees the Better Care Fund programme and Norfolk's Better Care Fund (BCF) and Integration Plan for 2017-19, established according to national guidelines in 2017. This report explains progress for the second (and final) year of the plan, including information on how the Improved Better Care Fund (iBCF), Disabled Facilities Grants (DFGs) and the High Impact Change Model (HICM) have been applied to help meet our strategic objectives. A further one-year plan is in preparation and this report makes recommendations for the key components which the HWB will be required to support.

Report summary

Norfolk has made good progress with its BCF and Integration Plan and the initiatives funded through BCF have made an important contribution to STP (Sustainability and Transformation Plan) priorities.

The complexity of the health and social care system in Norfolk means there is further work to do in order to achieve the priorities identified for system-wide change, which will be the ongoing focus of the BCF and Integration Plan.

Generally, Norfolk has been successful in achieving the objectives stated in its BCF and Integration Plan. Where it has been least successful has been in reducing a relatively high level of Delayed Transfers of Care (DToCs) to the NHSE (NHS England) target for the county. A significant volume of system-wide work has taken place to understand and rectify the position, with more planned.

In particular, a significant amount of iBCF funding has been invested into initiatives that contribute to addressing performance on DToC across the system. The iBCF funding has been focused on areas in the recently developed High Impact Change Model (HICM) that social care can influence effectively, such as Trusted Assessors, Enhanced Home Support Services and Accommodation Based Reablement.

Social prescribing is an example of how we've used iBCF to pursue wider STP and BCF objectives. (See **Appendix 3**)

Recommendations:

The HWB is asked to:

- Review progress that has been made on Norfolk's 2017-2019 Better Care Fund and Integration Plan and DToC challenges.
- Review and comment on the proposals for developing a revised Better Care and Integration Plan for the transitional year 2019-20
- Delegate decision-making on the final version of the revised Better Care and Integration Plan 2019-20 to the HWB Chair and Vice-Chair's Group for submission nationally.

1. Background

1.1 The HWB is responsible for developing and implementing the strategic plan for the Norfolk Better Care Fund. A progress update for the first year was provided to the HWB on 2 May 2018. We are now at the end of the initial two-year planning phase.

1.2 In accordance with government guidance a further one-year interim plan is being developed for 19-20, based on the existing plan. During the year the government will undertake work on a more fundamental reshaping of the Better Care Fund, in part related to the planned national Comprehensive Spending review. Consequently, this report also contains proposals for the content of an interim plan for Norfolk.

2. Progress report on Norfolk's Better Care Fund (BCF) and Integration Plan 2017-19

2.1 Norfolk's Better Care Fund and Integration Plan 2017-19 is published on the HWB pages of the website.

Governance and Funding

2.2 The HWB oversees Norfolk's BCF programme, in line with its system-wide strategic oversight role and accountability for achieving an integrated, sustainable health and wellbeing system. Adult Social Care and CCG Chief Officers are responsible for ensuring the plan is delivered and reported appropriately to NHS England on a quarterly basis. They receive regular progress reports and review quarterly reports.

2.3 Funding for the plan is via a section 75 agreement and has totalled almost £70m for each of 2017-18 and 2018-19. This includes Disabled Faculties Grant capital funding of nearly £7m. An additional £20m IBCF (Improved Better Care Fund) for Norfolk was granted in the 2017 spring budget for 2017-18 and this rises to £34m for 2019-20, though this is non-recurring funding.

Progress against the five priorities

2.4 Norfolk's Better Care Fund and Integration Plan provides a delivery framework for five priority areas as follows:

Priority 1: Locality Integrated Care Programme Infrastructure
Priority 2: Care Homes
Priority 3: The Home Environment
Priority 4: Out of Hospital schemes
Priority 5: Crisis Response

2.5 Good progress has been made against all priorities, with milestones being met or updated to take account of new initiatives, including those funded by iBCF, or the impact of a new strategic decision on a previously planned activity.

2.6 A review of progress for 2018-19 against the plans for the five priority areas is provided in **Appendix 1**. Each quarterly return this year has required a narrative on a 'success' story. Those chosen for Norfolk have been: The Norwich Emergency Avoidance Team (NEAT), housing related supported based in the acutes and accommodation based reablement. A synopsis of these 'success' stories is contained in **Appendix 2** with Social Prescribing included as **Appendix 3** and Enhanced health in care homes in **Appendices 1 and 4.**

High Impact Change Model (HICM)

2.7 Implementation of the HICM was introduced as a mandatory national condition for the BCF during 2017. This comprises tried and tested ways to improve DToC. Each area is required to gauge progress quarterly against eight identified system changes:

1. Early discharge planning
2. Systems to monitor patient flow
3. Multi-disciplinary/multi-agency discharge teams, including the voluntary and community sectors
4. Home first/discharge to assess
5. Seven-day services
6. Trusted assessors
7. Focus on choice
8. Enhancing health in care homes.

2.8 The HICM supports system-wide integrated working and in Norfolk the use of iBCF funding has helped to accelerate progress on three of the eight changes. There is further work to be undertaken to progress work on the model across the Norfolk health and social care system, particularly to ensure that the eight changes link in an integrated way. This is being led by the STP Urgent and Emergency Care Board Transformation Programme.

2.9 There is a requirement that all areas must reach a (self-assessed) 'maturity' by April 2019, though it has been announced that this requirement is to be relaxed and shifted to April 2020. An outline of progress for Norfolk is contained in **Appendix 4.**

BCF Metrics

2.10 The four key metrics against which Better Care Fund performance is judged, show that targets for new admissions to care homes and non-emergency hospital admission (NEA) avoidance to hospital are on track, despite monthly variation against historical performance. The percentage of avoidable admissions for the Norfolk and Norwich University Hospitals NHS Trust, the county's largest hospital, is the lowest in the region.

2.11 Changes to local recording and reporting have impacted on the historically high rate of success in reablement. Furthermore, the reablement offer has been extended to more people, some of whom are less likely to benefit from the service and these reasons together account for Norfolk's performance dipping recently below target level. However, the percentage remains high when compared to other areas

2.12 Despite the considerable investment through iBCF and other health and social care funding, the target for DToC will not be met. Over the course of the year under review, a number of improvements and investments targeting support for helping people home and preventing admission have been put in place – including additional investment in reablement, strengthened liaison with care providers, clearer processes for identifying care home vacancies, and earlier multi-disciplinary discussions on wards. Concerns about the reliability of data recording have resulted in detailed joint working to understand discrepancies and put in place mechanisms to ensure sign-off by both health and social care before national submission.

2.13 Critical to a step-change in improvement will be a whole-system commitment to a 'home first' ethos, and commitment to follow the revised NHS guidance (issued in November

2018) which ensures consistent ways of working between health and social care, and clarity about recording and attributing delays.

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3. BCF Plan 2019-20

3.1 It is clear that the Government wants to continue with the BCF, at least for the foreseeable future. The NHS 10 Year Plan calls for an enhanced focus on integration across health and social care with stronger links to housing and an expected stronger co-ordination with the work of Sustainability & Transformation Partnerships (STP) and successor Integrated Care Systems. It is expected that this will be replicated in BCF Guidance. However, it needs to be recognised that, for Norfolk, the geographic footprints and governance differ from those for the STP.

3.2 A new BCF and Integration Plan offers a useful opportunity to take forward new policy initiatives and to embed learning from the past two years. This includes:

- Publication of the NHS 10 Year Plan by NHSE e.g. the promotion of Integrated Care Systems and Primary Care Networks
- Implementation of key messages from the central Norfolk Multi-Agency Discharge Event (MADE) and Local Government Association (LGA) Peer Review
- Achieving 'maturity' of HICM elements and better co-ordination between them
- Mainstreaming successful pilots at pace and scale plus improved shared learning across localities
- Embedding the 'Living Well' approach to social care
- Dovetailing Plan with CCG Operational Plan intentions
- Greater emphasis on understanding person-centred experiences of the interface of health and social care services, in particular the importance of 'seamless' services and appropriate handovers
- Social care budget challenges and the impact of ending non-recurrent iBCF funding
- Use of transitional year to ensure less focus on specifics of BCF funding and more on integrated services systemwide
- Vision on what national 'full integration by 2020' means for Norfolk and Waveney testing against the Social Care Institute of Excellence (SCIE) Model
- Melding local integrated delivery with system-wide planning

3.3 Depending on the degree of change expected by national guidance, a new plan structure with four priorities is proposed as follows:

1. Prevention and Early Intervention (NEA, reablement and dementia metrics)
2. Integrated Community Care (care homes metric)
3. Admission Avoidance and Safe and Timely Discharges (NEA, DToC and reablement metrics and to HICM)
4. Improving the Home Environment (NEA and DToC metrics)

Officer Contact

If you have any questions about matters contained in this paper please get in touch with:

Name	Tel	Email
Toni Jeary	01603 223062	Toni.jeary@norfolk.gov.uk
Mick Sanders	01603 222279	Mick.sanders@norfolk.gov.uk

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BCF Narrative Summary – progress against plans

1. Good progress has been made across all five priority areas

Priority 1: Locality Integrated Care Programme Infrastructure

2. As the Primary and Community Care workstream of the Norfolk and Waveney STP progresses, five Local Delivery Boards (LDGs) have been established to enable further integration between primary, community, social care, the voluntary sector and district councils.

3. **Local Delivery Groups** The *YourNorwich* LDG is focussed on developing an integrated model of care for Norwich wrapped around GP practices/Primary Care Networks (PCNs). Plans are in place to establish Clinical Directors of the PCNs in Norwich and a review of One Norwich governance is underway to ensure that PCNs are fundamental to the transformation of primary care in Norwich.

4. North and South Norfolk Clinical Commissioning Groups (CCGs) are working to introduce the GEMIMA Risk Stratification Tool in all GP practices as part of the LDG focus. Identifying patients most at risk of hospital admission within 6 and 12 months, the tool allows specific searches to target patients for further intervention.

5. In South Norfolk, attendance at LDG meetings is now established and a workshop was held between the CCG and District Council to look at future collaboration which can be taken forwards through LDG. Discussion is ongoing between system partners in relation to the formation of PCNs

6. Great Yarmouth and Waveney are sending local system leaders to the 'Transformational Change through System Leadership' course, delivered through NHS Improvement. Priority areas of frailty and deprivation, and discussions around establishing measurable outcomes for these, remains a focus at LDG meetings.

7. West Norfolk LDG have now established key representatives required from Health & Social Care. Work around the use of population health data and how this can inform the future direction of development is currently underway. LDG workshops have taken place to feed into this agenda and discussions in relation to the formation of PCNs are in progress.

Priority 2: Care Homes

8. A draft STP Enhanced Health in Care Homes (EHCH) plan for 2019-20 has been submitted to NHS England. Following extensive engagement and feedback, a final version will be published during April 2019.

9. Work is ongoing around the data, but comparing the first 6 months of 2018/19 with the same period in 2017/18, there was an overall reduction of 23% in admissions from hospital to care homes. In the last year there was also an improvement in the number of homes in Norfolk and Waveney rated good or outstanding following CQC inspection.

10. From March 2018 to March 2019, the proportion of nursing and residential homes rated good/outstanding following Care Quality Commission (CQC) inspection increased by 4.6% to 78.4%. While this remains lower than the average for East of England (83.6%) and England (81.4%), the performance gap is decreasing.

Priority 3: The Home Environment

11. **Disabled Facility Grants** NCC is paying district councils the full MHCLG designated DFG funding for the current year. Work on the impact and outcomes of DFGs is reviewed at quarterly countywide meetings, with progress on DFG and related initiatives contained in Locality Plans monitored every six months. It has been agreed that district councils will top-slice some of their 19/20 DFG allocation to support people with dementia to live at home independently.

12. **District Direct** – See Appendix 2 Integration Examples
13. **Integrated Community Equipment Service (ICES**) Commissioned by NCC for NCC and the five Norfolk CCGs, this service provides a link between health and social care, providing equipment to help people stay safe, either in their own home or in a care home setting, keeping people out of hospital wherever possible. The partnership remains successful and contract performance is good.

14. The service was extended in October 2018 to include Waveney health and social care (with Suffolk County Council joining the delivery model). This means that the whole of the Great Yarmouth and Waveney CCG area is now covered by a single equipment service and a consistent and more efficient service is provided.

15. ICES Equipment Review and Recalls Project is making significant savings through collecting equipment from Care Homes which is no longer being used. Success of the project in Norwich has led to expansion into South and North Norfolk.

Priority 4: Out of Hospital Schemes

16. **Reablement -** see Appendix 2 Integration Examples
17. **Social Prescribing** – Appendix 3

Priority 5: Crisis Response

18. **Single Point of Access** – see Appendix 2 Integration Examples
19. **Flexible dementia provision & EHSS (iBCF)** A systemwide review of dementia provision and pathways, coordinated by South Norfolk CCG, is continuing. Review work around community support and engagement, to feed into this STP review, is also underway.

20. **Enhanced Home Support Service (EHSS)**. Launched in February 2018, a Year 1 review highlighted the increased number of hours provided and number of people supported. This reflects both the increasing familiarity with the service by practitioners and the longer timescales for which people can be supported. The average number of days of EHSS support over the first 5 months was 14 days, over the year this increased to 26 days. As the length of time people can be supported increased, this impacted on flow through the service, highlighting increased demand. Additional winter monies are being used to increase capacity of the service. Improved utilisation of the service has resulted in better value for money.

21. **Services to Carers** - The Carers charter was successfully launched in December 2018. Development of a new Carers Strategy is underway. Phase 1 from January to June 2019 is focusing on engagement with carers about what they would want in the strategy.

22. Following the review and remodelling of short breaks for carers contract, plans are being developed to invest in increased respite options for carers. Meanwhile, Carers Matters Norfolk provide a good quality service, with work ongoing to ensure that target numbers of carers are being reached.

Integration Success Stories

NEAT (Norwich Escalation Avoidance Team)

1. Norwich NEAT continues to operate on a seven-day basis, providing support for both admission avoidance and hospital discharge. Norwich NEAT recently presented at a Regional Admission Avoidance best practice workshop. Impact was demonstrated by highlighting that 82% of admission avoidance cases were still at home 7 days after referral to NEAT.
2. NEAT also supports Discharge to Assess pathways 1 and 2 from the NNUH, supporting people to be discharged to reablement provision, or home with additional temporary support. 90% of these supported discharge cases had not been re-admitted to hospital.
3. Norwich NEAT was shortlisted in the Health Service Journal Awards category for "Improved Partnerships Between Health and Local Government". Its success is also evidenced by the roll-out of similar models in the four other CCG areas in Norfolk and Waveney.
4. In South and North Norfolk, NEATs (Norfolk Escalation Avoidance Teams) were launched in Autumn 2018. North NEAT received 191 referrals in the first 12 week. South NEAT had received 94 referrals up to 8th February.
5. The Single Escalation Avoidance Team (SEAT) went live in the Great Yarmouth & Waveney locality early 2019. This service is being monitored through in partnership with the CCGs to ensure robust understanding of the impact across health and social care.

6. The West NEAT is continuing to develop in line with learning from the Norwich model.

Housing related support

7. Progress continues to be made on providing housing related support for people leaving acute care to assist in enhancing appropriate and timely discharge, with schemes covering the whole of Norfolk.

8. In the Great Yarmouth area two schemes operate. **Healthy Homes Assistance** which enables vulnerable people referred into the scheme, to have safety improvements made to their homes. The aim is to lower the risk of falls and other accidents at home, reducing avoidable hospital admissions/re-admissions. **I'm Going Home** is a short-term solution to enable hospital patients to be discharged as soon as they are medically fit, to recover fully at home. Families can be nervous about their vulnerable relative going home alone. I'm Going Home provides reassurance for families by loaning, for up to six weeks, a special pack including a 24/7 monitored community alarm and front door key safe. The projects were funded mostly by Great Yarmouth Borough Council, with additional funding secured through a partnership with Great Yarmouth and Waveney CCG and NCC. Capital works are funded by the Disabled Facilities Grant through the BCF. In 2018 the schemes were submitted for an HSJ award.

9. **District Direct**, focuses on the Norfolk and Norwich University Hospital (NNUH) catchment area, building on the pilot from the five central districts councils. Over 400 people have benefitted from the service and funding has been provided until July 2019. Work in underway to evidence the systemwide impact of District Direct to cover readmission rates, wellbeing, impact on excess bed days, DToCs and the impact of adaptations on the ability of someone to live independently, regional funding has been granted to support this work.

10. Similarly, **Home First** is a one-year pilot funded by Kings Lynn and West Norfolk Borough Council, supporting flow from the acute setting. Going forward, there are plans to regularise these services (including names), so that there becomes a common offer across Norfolk.

Accommodation Based Reablement (ABR)

11. ABR is an iBCF funded scheme, supporting discharge from hospital. This is a new initiative to Norfolk, the aim is to maximise independence and reduce the number of people going into residential care. ABR works with people to ensure they regain their independence in a safe

environment, usually after an illness or injury. People return to their usual place of residence or an appropriate placement to meet their needs, having completed a reablement programme. The service is also offered to people who are at risk of going into hospital or long term residential care, have the potential to be reabled and would benefit from ABR.

12. There are various ABR schemes operating across the county. By the end of December 2018, 40 ABR beds were operational across seven locations in Norfolk. To the end of December, ABR has been used by 269 people, of which 247 were discharged and 22 remained within the service. An evaluation indicates that 74 % of people were re-abled to return home. (45% returned home with home based reablement, 18% needed no further service, 4% entered housing with care and 6% returned home with home care). Of the 26% of people who were not re-abled, 18% returned to hospital, 5% entered permanent residential care, 1% died and 1% entered short-term residential care.

13. An evaluation of the outcomes of ABR has been undertaken, looking at the outcomes and value for money of the different models in place across different schemes. A further review will be completed later in 2019 to inform decisions about the future of ABR schemes.

Enhanced Health in Care Homes

14. This is requirement of the High Impact Change Model which has achieved ‘Mature’ status. For further details please see Appendix 1 – Q4 BCF Narrative Summary (Priority 2: Care Homes) and Appendix 4 High Impact Change Model – HIC8.

Social Prescribing

15. For details on this integration success story, please see Appendix 3 – Social Prescribing.

Social Prescribing

1. In Norfolk, Social Prescribing services have been set up as a two-year pilot, beginning in July 2018, and funded by Adult Social Services iBCF monies and Public Health.

2. The vision for Social Prescribing in Norfolk is as a means of enabling GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services to help them meet their needs. Social prescribing schemes 'connect' people with other organisations or activities that can help them to reduce or resolve their problems. It is also intended that Social Prescribing services will reduce avoidable demand on Social Care provision.

How does Social Prescribing work in Norfolk?

3. Thorough effective partnership working and a positive approach to integration Social Prescribing is now available across the whole of the county with referral pathways from GP Practices, from Norfolk County Council and in some areas, via Early Help Hubs. There are five locality models: North Norfolk; Great Yarmouth; Norwich & Broadland; West and Breckland; and South.

4. 'Connectors' are recruited and based within District Councils and Voluntary Sector Partners (this varies by locality) and receive referrals from the above routes. People referred are then triaged and the Connector will work with them to identify what type of support or advice they need. There is a focus on encouraging people to self-manage where possible and consider more creative solutions to their arising issues and take charge of their next steps.

5. The service is time limited and is focused on connecting people with other organisations and activities, rather than working with them for long periods of time. There is a recognition that sometimes people's needs may be too complex and additional support will be needed – in these cases Social Prescribing will not be suitable.

What's next for Social Prescribing?

6. The Social Prescribing models in Norfolk will be evaluated centrally and will have a Health and Social Care focus. Full evaluation will be completed following the pilot while an initial six-month evaluation is due to report shortly. So far Social Prescribing has received 2,175 referrals and some localities have exceeded the early indicators around demand for the service. Norfolk County Council have also been working with the Life Chances Fund to plan for social prescribing services beyond the pilot period using a Social Impact Bond.

7. The NHS Long-Term Plan (January 2019) committed to make personalised care, including Social Prescribing, business as usual across the health and care system. NHS England recommend that 'Social prescribing connector schemes are commissioned collaboratively, with primary care networks, local authorities, CCGs, other local agencies, the voluntary and community sector and people with lived experience all working together.' Norfolk's Social Prescribing offer places us in a strong position and it will be important to consider locally how best to integrate the new resources within the existing models of Social Prescribing avoiding the risk of a fragmented system.

8. There are initial discussions across the CCG's to advise further on the existing model and options for development in collaboration. In addition, Social Prescribing services will sit within the context of the wider review and recommissioning of Information, Advocacy and Guidance services which has been reported on in previous quarters.

High Impact Change Model

1. The High Impact Change Model (HICM) is a mandatory national condition in the Better Care Fund, delivering the requirements of the HICM requires co-operation and engagement across the health and social care system. The model identifies eight system changes which will have the greatest impact on reducing delayed discharge.

2. There had been a national requirement for all 8 elements to be at a 'mature' level by March 2019, but it's now accepted that this will not be achieved everywhere. The expected level of maturity has been revised to March 2020.There are five levels of status reporting.
    1. Not yet established
    2. Plans in place
    3. Established
    4. Mature
    5. Exemplary

3. Following Q3 reporting, progress on the HICM was discussed at the A & E Delivery Board, where there was agreement of the Urgent and Emergency Care (UEC) Transformation Programme priorities and governance, and the impact this should have on system wide delivery of the HICM. As part of UEC Transformation Delivery Plan, 3 HICs have been identified as key areas of prioritisation to support implementation of the whole model across the system.
    - **HIC 1 – Early Discharge Planning** Current status **Plans in Place**
    - **HIC 2 – Systems to monitor patient flow** Current status **Established**
    - **HIC 4 – Discharge to Assess/ Homefirst** Current status **Established**

4. A review of Discharge to Assess has already been completed, reviews of the other two will be undertaken as a matter of urgency.

HIC 3 – Multi-disciplinary Discharge Teams (MDT): Current status **Established**. At James Paget University Hospital (JPUH), the Integrated Discharge Hub (Team) are now co-located with social care staff, housing officer and British Red Cross. Norfolk and Norwich University Hospital (NNUH) MDT practice includes social workers attending daily board rounds so they can be involved earlier in discharge decisions. At Queen Elizabeth Hospital (QEH), informed by the NHS Emergency Care Intensive Support Team intervention, board rounds practice is continuing to be developed alongside the reintroduction of Red2Green.

HIC 5 – 7-day service: Current status **Established**. QEH continue to use UEC Transformation winter monies to fund staff at weekends to ensure that discharges and the discharge planning function is maintained 7 days a week. At JPUH social workers in the acute hospital project are on rotas for 7-day coverage. The NNUH Integrated Discharge Team has a 7-day service.

HIC 6 – Trusted Assessor: Current status **Established**. The Trusted Assessment Facilitators project is moving to Phase 2 which will focus on the development of the Trusted Assessment form to take forward Phase 1 work. Workshops will be held in April/May with care home providers to co-produce a generic provider assessment form.

HIC 7 – Focus on Choice: Current status **Established**. System-wide, the Direction of Choice policy is currently being reviewed to ensure it aligns to national guidance. It is intended that the procedures across the different NHS Trusts will be combined into one document, which will then be agreed by the STP.

HIC 8 – Enhanced Healthcare in Care Homes (EHCH): Current status **Mature**. A draft STP EHCH plan for 2019-20 has submitted to NHS England. Following extensive engagement and feedback, a final version will be published during April 2019. (Please see Appendix 1).

Health and Wellbeing Board

Item 10

Report title:	**Homes and Health**
Date of meeting:	**24th April 2019**
Sponsor (H&WB member):	**Louise Smith (Director of Public Health) on behalf of the Health and Wellbeing Board District Councils' Sub Committee**

Reason for the Report

This report updates the Board on actions of the District Councils' Sub Committee agreed at the HWB meeting of 31st October 2018. It seeks HWB agreement to the proposals made at the Sub Committee meeting on 11 March 2019.

Report summary

In October 2018, Homes and Health was agreed as a priority for the new District Councils' Sub Committee, to include three key areas of activity:

1. Warm and healthy homes
2. Piloting joint working to build housing interventions into multi-disciplinary teams (MDTs), and
3. Improving discharge from hospital.

The Norfolk Warm Homes Fund programme has been established and has committed £217,000 worth of expenditure toward the installation of first time central heating. District staff have attended some flu clinics to provide advice to those attending. Residents have been supported to find cheaper fuel prices.

Housing input to MDTs has begun in the three pilot districts and training initiatives started. A learning event to reach a larger audience is being planned for autumn 2019.

A business case for a hospital discharge service covering acute, community and mental health hospitals is being developed to take to the Joint Strategic Commissioning Committee (JSCC).

Recommendations

The HWB is asked to endorse the following further steps in the Homes and Health programme proposed by the Sub Committee:

1. To develop a communications campaign on the Warm Homes Fund to secure engagement and referrals from partner staff going into residents' homes
2. To hold a county-wide learning event to increase knowledge of potential housing solutions to health and care needs
3. To support taking the discharge from hospital service business case to JSCC.

1. Background

1.1 In October 2018, Homes and Health was agreed as a priority for the new District Councils' Sub Committee, with three key areas of activity:

- **Warm and healthy homes** - To promote how to stay well in winter, provide energy and money saving advice and install central heating systems to fuel poor households
- **Workforce joint working** - Pilot location of housing staff within MDTs to identify needs in homes and increase knowledge of housing solutions to support health and care needs based on joint learning
- **Discharge from hospital** – work together to establish a single and sustainable model and to extend the district offer to include discharge from mental health and community hospitals.

1.2 The original paper can be found here: Homes and Health report 31 October 2018.

2. Homes and Health

2.1 The Homes and Health approach supports all three of the Joint Health and Wellbeing Strategy goals of prevention, tackling inequalities and integration. The approach also formed part of the programme to tackle winter pressures led by the STP Prevention Board. It recognises that the homes in which people live are key factors in mental and physical health and wellbeing.

2.2 Since October, the three Homes and Health workstreams have been overseen by the District Councils' Sub Committee and its Officer Action Group. Progress to date is described below and in the updated action plan in **Appendix 1**.

Warm and Healthy Homes

2.3 **Norfolk Warm Homes Fund**: this two year programme, with funding of £3.1m, covers the installation of first time central heating systems to fuel-poor households as well as support on energy efficiency and finance. The programme is now in place and has so far received 325 referrals with 145 requests for assistance on heating and has committed £367,000 in expenditure. Promotion of the programme to residents and agencies has been undertaken to help to identify fuel-poor clients. Further work is being done to see what information can be provided to simplify referral routes and assessment criteria to a range of non-housing frontline staff. At the Sub Committee meeting on 11 March 2019, it was proposed to run an information campaign to raise awareness amongst those going into homes of those the programme seeks to reach. The programme is also seeking to increase the number of local contractors involved to meet demand and build skills.

2.4 **Switch and save campaigns**: regular offers are run to support residents to find cheaper fuel prices in order to keep homes adequately heated. The latest campaigns were in November 2018 and February 2019. For example, in the two most recent processes within Broadland, Norwich and South Norfolk, nearly 2,900 residents switched, with an annual average saving of about £120 (estimated £350,000 total annual savings).

2.5 **Flu clinics**: this workstream involved district council staff attending flu clinics (aligned to the 2018 flu jab campaign) in order to provide access to non-health advice and services for those at risk over winter. For example, Broadland identified

three surgeries where data suggested an intervention would target residents with worse health or other outcomes. Surgeries were approached and a range of 'whole council' staff made available with a simple leaflet to explain what the council could offer. An estimated minimum of 2,500 residents were seen of whom 1,500 were thought to be from within the Broadland area. Surgery feedback has been positive.

2.6 Some districts reported difficulty getting staff into surgeries to offer face to face assistance. Good advance planning is needed to facilitate attendance and to enable busy surgeries to make adequate provision in terms of space and time. Other options may need to be explored, for example working through social prescribers.

Integrated working with multi-disciplinary teams

2.7 This workstream aims to build housing interventions into MDT activities and to improve awareness of potential housing solutions to health and care needs. A grant of £36,000 was received through Health Education England to pilot improving the knowledge and access that MDT professionals have to services from district councils and to better spot signs which may require a housing solution.

2.8 The pilot involves three district councils. Broadland is targeting a number of surgeries where previous activity had already been started. King's Lynn is expanding the work done with discharge from Queen Elizabeth Hospital and South Norfolk is working with one large practice with known health and other outcome inequalities.

2.9 Staff have begun attending the agreed locations. King's Lynn are reporting better referral routes into home adaptations work and linking into, for example, dementia care services. Broadland have attended or booked half a dozen sessions at surgeries and have plans to agree details at a range of others. South Norfolk are focussing on complex patients to reduce GP appointments.

2.10 Early signs suggest an increase in referrals into district services from surgeries involved. Training and information events have started to roll out across the three districts, and a variety of tools to share across health and social care partners to expand learning are being considered (for example an online video).

2.11 The pilot scheme will be reviewed and lessons learned will be shared at a cross-county learning event being planned for the autumn, which the District Councils' Sub Committee endorsed. The event will also include a training element to reach greater numbers of health and care frontline workers.

Discharge from hospital

2.12 This workstream aims to establish a sustainable model to support discharge from hospital and to extend the district offer to include mental health and community hospitals. There is currently provision in all three acute hospitals. The work with the mental health trust has taken more time to get started, but a District Direct officer is now working one morning per week at Hellesdon Hospital. The work involves fewer but more complex patients. Future work with community hospitals would work with those in rehabilitation.

2.13 Metrics and cost criteria have been agreed across the acute hospitals, CCGs and districts, and a business case is being prepared to take to the Joint Strategic Commissioning Committee (JSCC) – this will cover acute, community and mental

health hospitals. The HWB District Councils' Sub Committee endorsed this endeavour.

Officer Contact

If you have any questions about matters contained in this paper please get in touch with:

Name	Tel	Email
Diane Steiner	01603 638417	diane.steiner@norfolk.gov.uk

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Appendix1 - Action Plan 31st October 2018 – progress at 19th March 2019

Theme – warm and healthy homes – Lead: Broadland DC			
What	**Why**	**Who**	**When**
WHF[1] – install 500+ new C/H systems where none exist, offer advice and assistance and support warm homes improvements	Improve warmth and health in line with funding criteria	Led by Broadland but promoted and supported across all councils and partners	First referrals already taken – final completion May 2020
This is a two year programme but the team is up and running and has so far received 145 requests and committed £367,000 expenditure. Further work is being undertaken to see what information can be provided to simplify referral routes and assessment criteria to a range of non-housing front line staff.			
Continue to run "Switch and Save" campaigns	Support residents to find cheaper fuel prices and be able to keep homes adequately heated	All district councils	Most recent programme ran to Feb 19
Regular offers are run, with the most recent closing in November 2018 and February 2019. Longer term not all districts may remain signed up, opting instead to deliver a different offer. For example, in the two most recent processes within Broadland, Norwich and South Norfolk nearly 2,900 residents switched, with an annual average saving of about £120 (estimated £350,000 total annual savings).			
District council staff to attend flu clinics this winter	Provide access to non-health advice and services for those at risk over winter	All districts based upon agreement of appropriate interventions and clinics with CCG colleagues	Aligned to the 2018 flu jab campaign
Broadland took a proactive approach to identify three surgeries where data suggested an intervention would target residents with worse health or other outcomes. Surgeries were approached and a range of "whole council" staff made available and a simple leaflet to explain what the council could offer. An estimated minimum of 2,500 residents were seen of whom 1,500 were thought to be from within the Broadland area. Surgery feedback has been positive. Within the Broadland area North Norfolk CCG co-ordinated organisations' attendance, which may not have aligned to a targeted allocation of resource. Norwich City Council report that they have difficulty getting staff into surgeries to offer face to face assistance. There may be a case for a system or STP wide in principle support for an approach, built upon demonstrable successes where districts have been able to attend. Plans do need to be early to facilitate both attendance and to enable surgeries to make adequate provision in terms of space and time at what are busy periods			

[1] Warm Homes Fund – this programme has started and is recruiting staff and beginning to take referrals but is a two year programme

Theme – integrated working with MDTs – lead officers from Broadland, King's Lynn & South Norfolk			
What	**Why**	**Who**	**When**
Identify MDTs within the three pilot areas in which to trial working with housing-related staff	To ensure areas chosen to reflect both need, opportunities for success and learning across different MDT models	Three trial area councils in discussion with appropriate CCGs	November 2018
Plans agreed to work within specific MDTs / surgeries / hubs in each of the three pilot districts – Broadland targeted a number of surgeries where previous activity had been started, King's Lynn looking to expand the work done with discharge from the acute and South Norfolk working with one large practice with known health and other outcome inequalities			
Pilot co-location and working within MDTs of housing staff within three district council areas	To ensure continuation of existing district services whilst support more intense work within MDTs	Home improvement-related staff in Broadland, King's Lynn and South Norfolk councils	December 2018
Staff have started attending agreed locations although it is too soon to fully understand impacts and reach. King's Lynn are reporting better referral routes into home adaptations work and linking into, for example, dementia work. Broadland have already made or booked half a dozen sessions at surgeries and have plans to agree details at a range of others. Early signs suggest an increase in referrals into district services from surgeries they have attended.			
Pilot training offers to health and social care staff	Transfer knowledge, manage a housing related case load, explore future opportunities and success criteria	Three trial area councils in discussion with appropriate CCGs with support from Public Health and data analysis	January 2019
Training and information events have started to roll out across the three districts and in one case an online video is being commissioned to share across health and social care partners to expand learning			
Evaluate pilot scheme and present business case for continuation subject to success and costings	If proven to work then roll out a model across Norfolk	District, health and social care partners	Complete by March 2019
It is unlikely that activity will be sufficiently progressed and enough numbers seen to evaluate within this timescale. However there will be opportunities to spread learning and reflect on learning at the future cross county event.			

Theme – discharge from hospital – Lead: South Norfolk DC			
What	**Why**	**Who**	**When**
Develop action plan to support a discharge process from mental health and community hospitals	To deliver the same opportunities across the whole range of hospital settings	Led by South Norfolk with support from other districts and health and care colleagues	Started – review progress in 6 months
A District Direct resource from NNUH now working one morning at Hellesdon Hospital.			
Agree a single model based on joint learning and shared improvements across all three acute hospitals	Consistency of support countywide and improved outcomes for patients	Led by South Norfolk with support from other districts and health and care colleagues	Work started – initial shared learning report Dec 2018
Metrics and evaluation and cost criteria agreed across the acute, CCG and district areas.			
Prepare costed option with expected benefits for continuation of service after the end of current funding	Subject to successful evaluation establish as business as usual to improve discharge and prevent readmissions	Led by South Norfolk with support from other districts and health and care and public health colleagues	April 2019
A business case will be prepared based upon agreed evaluation criteria above.			

Report title:	**Health and Wellbeing Board – Governance update**
Date of meeting:	**24 April 2019**
Sponsor:	**Dr Louise Smith, Director of Public Health**

Reason for the Report

The Health and Wellbeing Board (HWB) is operating in a rapidly changing landscape. It is appropriate for the Board to consider its governance on a regular basis to ensure that it continues to work efficiently and effectively and is well placed to pursue its strategic priorities.

Report summary

This report highlights some key areas of the HWB's governance arrangements in terms of membership and invites members to endorse proposals for change.

Recommendations:

The HWB is asked to:

1 Endorse the proposal by the HWB Chair and Vice Chairs that the Chief Executives and Chairs of the key providers become full members of the HWB

2 Endorse the proposal by the HWB Chair and Vice Chairs that the list of key providers is extended to Cambridgeshire Community Services NHS Trust

3 Note the changes to HWB membership which are a consequence of the County Council's decision to change to a Cabinet system of governance (**Appendix A**)

4 Note that Norfolk County Council will be asked to consider amending its constitution to enable the changes above at its Annual General meeting in May 2019

5 Note the HWB attendance record (Appendix B)

1. Background

1.1 The Health and Wellbeing Board (HWB) operates as system leader providing oversight and strategic leadership of the wider health, care and wellbeing system. The system is complex, involving many organisations and systems, and commissioning across the NHS, social care, public health and wider services.

1.2 The HWB works in a rapidly changing landscape and reviews its governance regularly to ensure it continues to be effective and the Board is well placed to pursue its strategic priorities. The HWB last reviewed its governance in May 2018 and introduced changes to bring the arrangements up to date and strengthen the HWB's governance in the light of working practice. The report is available at this link: HWB Governance and system leadership approach

2. Membership

2.1 Since 2016, the Chief Executive or Chair of the key providers have had a standing invitation from the Chairman to join each HWB meeting to enable full-rounded discussions as wider health and care system leaders. This has worked well, enabling meaningful engagement, improving shared understanding and enriching discussion and debate.

2.2 Each of our key providers have formally signed up to the HWB's Joint Health and Wellbeing Strategy and demonstrated their commitment to the HWB's vision of a single sustainable system, prioritising prevention, tackling inequalities and integrated ways of working.

2.3 The key providers are not, however, listed in the County Council's Constitution as this has been an informal arrangement. The HWB Chair and Vice Chairs have discussed this and agree that we should strengthen the arrangement by formalising it in the Council's Constitution. In addition, the Chair and Vice Chairs propose that the list of key providers should extend to Cambridgeshire Community Services NHS Trust, who deliver the integrated 0-19 Healthy Child Programme for Norfolk.

2.4 Therefore, **it is proposed that:**

- The Chief Executive or Chair of the key providers become full members of the HWB
- The list of providers on the HWB is extended to include Cambridgeshire Community Services NHS Trust

2.5 The proposed HWB membership is outlined in **Appendix A.**

3 Annual attendance update

3.1 The annual record of attendance at formal HWB meetings is at **Appendix B.**

4 Next steps

4.1 Norfolk County Council will be considering amendments to its constitution as it moves to a Cabinet system of governance at its Annual General meeting in May 2019, when the Council will be asked to consider amending the Constitution in the light of the proposed changes above.

Officer Contact

If you have any questions about matters contained in this paper, please get in touch with:

Name	**Tel**	**Email**
Linda Bainton	01603 223 024	linda.bainton@norfolk.gov.uk

Appendix A

HWB Membership – proposed

Representing	Membership	Substitute
Leader, or their nominee, NCC	To be confirmed	
Relevant Cabinet member for Adults, NCC	To be confirmed	
Relevant Cabinet member for Children's Services, NCC	To be confirmed	
Borough Council of King's Lynn & West Norfolk	Cllr Elizabeth Nockolds	Cllr Sam Sandell
Breckland District Council	Cllr Paul Claussen	Cllr Lynda Turner
Broadland District Council	Cllr Shaun Vincent	Cllr Roger Foulger
Director of Public Health, NCC	Dr Louise Smith	
Director Adult Social Services, NCC	James Bullion	Debbie Bartlett
Director of Children's Services, NCC	Sara Tough	Sarah Jones
East Suffolk Council	Cllr Mary Rudd	Cllr Alison Cackett
Great Yarmouth Borough Council	Cllr Cara Walker	Cllr David Drewitt
Head of Paid Service, or their nominee, NCC	To be confirmed	
Healthwatch Norfolk	David Edwards	Alex Stewart
NHS England, East Sub Region Team	Simon Evans-Evans	
NHS Great Yarmouth & Waveney CCG	Dr Liam Stevens	
NHS Great Yarmouth & Waveney CCG	Melanie Craig	
NHS Norwich CCG	Tracy Williams	
NHS Norwich CCG	Jo Smithson	
NHS North Norfolk CCG	Dr Anoop Dhesi	
NHS North and South Norfolk CCG	Frank Sims	
NHS South Norfolk CCG	Dr Hilary Byrne	
NHS West Norfolk CCG	Dr Paul Williams	
NHS West Norfolk CCG	John Webster	
Norfolk Constabulary	ACC Nick Davison	Supt Chris Balmer
North Norfolk District Council	Cllr Angie Fitch-Tillett	Cllr Becky Palmer
Norwich City Council	Cllr Matthew Packer	Adam Clark
Police and Crime Commissioner	Lorne Green	Dr Gavin Thompson
South Norfolk District Council	Cllr Yvonne Bendle	Cllr Florence Ellis
Sustainability & Transformation Partnership (Chair)	Rt Hon Patricia Hewitt	
Sustainability & Transformation Partnership (Exec Lead)	Melanie Craig	
Voluntary Sector Representative	Vacancy	Jonathan Clemo
Voluntary Sector Representative	Dan Mobbs	Laura Bloomfield
Voluntary Sector Representative	Elly Wilson Wickenden	Alan Hopley
Providers:		
Cambridgeshire Community Services NHS Trust	[To be confirmed]	[To be confirmed]
East Coast Community Healthcare CIC	Jonathan Williams	Tony Osmanski
James Paget University Hospital NHS Trust	Anna Hills	Anna Davidson
Norfolk Community Health & Care NHS Trust	Josie Spencer	Geraldine Broderick
Norfolk Independent Care	Dr Sanjay Kaushal	
Norfolk & Norwich University Hospital NHS Trust	Mark Davies	John Fry
Norfolk & Suffolk NHS Foundation Trust	Antek Lejk	Marie Gabriel
Queen Elizabeth Hospital NHS Trust	Caroline Shaw	Prof Steve Barnett

Appendix B

HWB Public meetings attendance record

Organisation/Representing	Name/sub	2 May 2018	17 July 2018	31 Oct 2018	13 Feb 2019
Chair, Adult Social Care Committee	Cllr Bill Borrett	Present	Present	Present	Present
Chair, Children's Services Committee	Cllrs Penny Carpenter/Stuart Dark	Present	Present	Absent	Apols
Director Public Health, NCC	Dr Louise Smith	Present	Present	Present	Present
Director, Adult Social Services, NCC	James Bullion	Present	Apols	Present	Present
Director, Childrens Services, NCC	Sara Tough	Present	Apols	Present	Present
Borough Council of Kings Lynn & West Norfolk	Mrs Elizabeth Nockolds	Present	Present	Present	Present
Breckland District Council	Cllrs Paul Claussen/Lynda Turner	Present	Present	Present	Present
Broadland District Council	Cllrs Andrew Proctor/Roger Foulger	Present	Present	Present	Apols
Gt Yarmouth Borough Council	Cllrs Andy Grant/Cara Walker	Absent	Apols	Apols	Absent
Healthwatch Norfolk	William Armstrong/ David Edwards/ Alex Stewart	Present	Present	Present	Present
Managing Director, NCC	Wendy Thomson	Present	Apols	Present	N/A
NHS England, East Sub Region Team	Simon Evans-Evans	Absent	Absent	Absent	Absent
NHS Great Yarmouth &Waveney CCG	Melanie Craig, Chief Officer	Present	Present	Present	Apols
NHS Gt Yarmouth & Waveney CCG	Dr Liam Stevens, Chair	Absent	Present	Present	Present
NHS Norwich CCG	Tracy Williams, Chair	Present	Present	Present	Present
NHS Norwich CCG	Jo Smithson, Chief Officer	Apols	Present	Apols	Apols
NHS North Norfolk CCG	Dr Anoop Dhesi, Chair	Absent	Absent	Present	Absent
NHS North and South Norfolk CCG	Antek Lejk/ Frank Sims, Chief Officer	Apols	N/A	Absent	Apols
NHS South Norfolk CCG	Dr Hilary Byrne, Chair	Apols	Absent	Present	Apols
NHS West Norfolk CCG	Dr Paul Williams, Chair	Present	Apols	Present	Present
NHS West Norfolk CCG	John Webster, Chief Officer	Apols	Apols	Apols	Apols
Norfolk Constabulary	ACC Paul Sanford/Nick Davison	Present	Apols	Present	Apols
Norfolk County Council	Cllr David Bills	Present	Present	Present	Absent
North Norfolk District Council	Cllr Maggie Prior/Angie Fitch-Tillett	Present	Present	Present	Apols
Norwich City Council	Cllr Kevin Maguire/Matthew Packer/Adam Clark	Present	Present	Present	Present
Police and Crime Commissioner	Mr Lorne Green/Dr Gavin Thompson	Apols	Present	Apols	Present

Organisation/Representing	Name/sub	2 May 2018	17 July 2018	31 Oct 2018	13 Feb 2019
STP Chair	Patricia Hewitt	Present	Present	Present	Present
STP Executive Lead	Melanie Craig/Karen Barker	Present	Present	Present	Present
Voluntary Sector	Dan Mobbs/Laura Bloomfield	Present	Present	Present	Present
Voluntary Sector	Joyce Hopwood/ Elly Wilson-Wickenden/ Alan Hopley	Present	Present	Present	Present
Voluntary Sector	Janka Rodziewicz/Paul Martin/Jon Clemo	Present	N/A	Apols	Present
Waveney District Council	Cllr Mary Rudd/Cllr Alison Cackett	Present	Apols	Present	Present
East Coast Community Healthcare	Jonathan Williams/Tony Osmanski	Present	Present	Present	Present
James Paget University Hospital NHS Trust	Christine Allen/Anna Davidson	Present	Apols	Apols	Absent
Norfolk Community Health & Care NHS Trust	Roisin Fallon-Williams/Josie Spencer/ Geraldine Broderick	Absent	Present	Absent	Present
Norfolk Independent Care	Sanjay Kaushal	Present	Apols	Present	Present
Norfolk & Norwich Hospital University NHS Trust	Mark Davies/sub/John Fry	Absent	Apols	Present	Apols
Norfolk and Suffolk NHS Foundation Trust	Julie Cave/Antek Lejk/Gary Page/Marie Gabriel	Absent	Apols	Present	Apols
Queen Elizabeth Hospital NHS Trust	Jon Green/ Caroline Shaw/Patrick Johnson/Professor Steve Barnett	Absent	Absent	Apols	Present