Health & Wellbeing Board – Norfolk and Waveney

Date: **Wednesday 31 October 2018**
Time: **11:00 am – Please note later start time**
Venue: **Council Chamber, 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	
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	
Norfolk County Council	Cllr David Bills	
Norfolk County Council	Dr Wendy Thomson	
North Norfolk District Council	Cllr Maggie Prior	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	Paul Martin	Alan Hopley
Voluntary Sector Representative	Dan Mobbs	Laura Bloomfield
Voluntary Sector Representative	Elly Wilson Wickenden	Jonathan Clemo
Waveney District Council	Cllr Mary Rudd	Cllr Alison Cackett
Standing invitation to attend Board meetings:		
East Coast Community Healthcare CIC	Jonathan Williams	Tony Osmanski
James Paget University Hospital NHS Trust	Christine Allen	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	Gary Page
Queen Elizabeth Hospital NHS Trust	Jon Green	Edward Libbey

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 – Norfolk and Waveney
Agenda

Time: 11:00am

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	Our Joint Health and Wellbeing Strategy 2018 -22	Louise Smith/ Chris Butwright	(Page 19)
8	Norfolk & Waveney Sustainability and Transformation Partnership (STP):		
	a) Update	Patricia Hewitt/ Melanie Craig	(Page 24)
	b) Winter planning – Urgent & Emergency Care	Nikki Cocks/ Mark Burgis	(Page 29)
	c) Prevention Winter plan	Louise Smith	(Page 36)
	d) Adult Social Care Winter Plan	James Bullion	(Page 45)
9	Homes and Health	HWB District Council Group	(Page 66)

Information updates

- **Carers' Charter –** please follow the link for information about the development of a Carers' Charter
- **Further information about the Health and Wellbeing Board** – can be found on our website at: About the Health and Wellbeing Board
- **Norfolk Health Overview & Scrutiny Committee (NHOSC)** agenda papers relating to items on the HWB agenda include:
  - Consultation from Norwich CCG on vision for its new model of care delivered by integrated community primary care teams – 6 September 2018
  - Physical health checks for adults with learning disabilities – 6 September 2018

Health and Wellbeing Board – Norfolk and Waveney
Minutes of the meeting held on Tuesday 17 July 2018 at 11am
in the Edwards Room, County Hall

Present:

Cllr Yvonne Bendle	South Norfolk District Council
Cllr David Bills	Norfolk County Council
Cllr Bill Borrett	Norfolk County Council
Cllr Penny Carpenter	Norfolk County Council
Adam Clark	Norwich City Council
Jon Clemo	Voluntary Sector Representative
Melanie Craig	NHS Great Yarmouth and Waveney CCG
Cllr Roger Foulger	Broadland District Council
Rt Hon Patricia Hewitt	Sustainability & Transformation Partnership (Chair)
Dr Joyce Hopwood	Voluntary Sector Representative
Cllr Elizabeth Nockolds	Borough Council of King's Lynn & West Norfolk
Cllr Maggie Prior	North Norfolk District Council
Dr Louise Smith	Director of Public Health, NCC
Jo Smithson	NHS Norwich CCG
Dr Liam Stevens	NHS Great Yarmouth and Waveney CCG
Alex Stewart	Healthwatch Norfolk
Dr Gavin Thompson	Office of Police & Crime Commissioner
Cllr Lynda Turner	Breckland District Council
Tracy Williams	NHS Norwich CCG
Elly Wilson	Voluntary Sector Representative

Invitees present:

Josie Spencer	Norfolk Community Health & Care NHS Trust
Jonathan Williams	East Coast Community Healthcare CIC

1. Apologies

1.1 Apologies were received from Cllr Paul Claussen (Breckland District Council – Cllr Lynda Turner substituting); Dr Paul Williams (NHS West Norfolk CCG); Dr Sanjay Kaushal (Norfolk Independent Care); Gary Page (Norfolk & Suffolk NHS Foundation Trust); Cllr Matthew Packer (Norwich City Council – Adam Clark substituting); Cllr Cara Walker (Great Yarmouth Borough Council); Christine Allen and Anna Davidson (James Paget University Hospital; ACC Paul Sanford (Norfolk Constabulary); James Bullion (Adult Social Services, Norfolk County Council); Dr Wendy Thomson, (Norfolk County Council); Mr W Armstrong (Healthwatch Norfolk – Alex Stewart substituting); Sara Tough (Norfolk County Council); Dan Mobbs (Voluntary Sector – Elly Wilson substituting); Mark Davies (Norfolk & Norwich University Hospital); John Webster (West Norfolk CCG) and Cllr Mary Rudd (Waveney District Council).

2. Election of Chair

2.1 Mrs Y Bendle proposed, seconded by Mr R Foulger, that Mr B Borrett be elected Chair of the Health and Wellbeing Board for the ensuing year. There being no other nominations, the Board **agreed** that Mr B Borrett be elected Chair of the Board.

Mr B Borrett, Chair in the Chair.

3. Election of Vice-Chairs

Mrs E Nockolds proposed, seconded by Mr R Foulger, that Mrs Y Bendle be elected Vice-Chair of the Board. There being no other nominations, the Board agreed to appoint Mrs Yvonne Bendle as Vice-Chair of the Board for the ensuing year.

Dr L Stevens proposed, seconded by Dr L Smith, that Ms T Williams be elected Vice-Chair of the Board. There being no other nominations, the Board agreed to appoint Ms T Williams as Vice-Chair of the Board for the ensuing year.

4. Chairman's Opening Remarks

4.1 The Chair paid tribute to Joyce Hopwood who was retiring in September 2018 and would be standing down as Voluntary Sector representative on the Health & Wellbeing Board. Lady Hopwood had been a member of the Board since 2012, working on the development of the Shadow Board, and then when the Board became fully operational in April 2013. The Board, thanked Joyce for her work and wished her a well-earned retirement.

4.2 The Chair also thanked William Armstrong who was standing down as Chair of Healthwatch Norfolk and therefore as a member of the Health and Wellbeing Board (HWB). William could not be present at the meeting, but the Board passed on their thanks to him for the contribution he had made to Norfolk and wished him a well-earned retirement.

4.3 The Chair drew the Board's attention to the following action which had been undertaken since the last meeting:

1. Better Care Fund (BCF) Quarterly Monitoring - The Chair and Vice Chairs Group had signed off, on behalf of the HWB, the BCF Qtr 1 monitoring report for submission to NHSE by the deadline

4.4 The Chair also drew the Board's attention to changes in the NHS England requirements for the Annual Refresh of Local Transformation Plans (LTP) – in that they no longer required full HWB approval. In light of this change, it was proposed that the LTP Annual Refresh for 2018-19 should be delegated to the Chair and Vice Chairs Group to consider in October before submission to NHSE by the deadline of 31 October 2018. A Draft Resolution to this effect had been circulated to the HWB with the agenda papers and is attached at Appendix A to these minutes.

4.5 **The Board** resolved **to:**

- Agree that the HWB Chair and Vice Chairs Group consider the annual refresh of the LTP in advance of its submission to NHSE.

5. Minutes

5.1 The minutes of the Health and Wellbeing Board (HWB) held on 2 May 2018 were agreed as a correct record and signed by the Chairman, subject to the inclusion of Mr W Armstrong in the list of apologies.

6. Matters Arising

6.1 The Chairman updated the Board as follows:-

6.2 Page 4, Para 2.5 District Councils work on the wider determinants of health

The HWB District Council members, together with their senior lead officers, had taken part in a workshop earlier that morning and the theme for discussion had been housing and homes and the impact on health and wellbeing. The Group had agreed on some areas of focus and recommendations, which would be brought to the HWB at its next meeting.

7. Declaration of Interests

7.1 There were no interests declared.

8. Public Question

8.1 The public question from Elizabeth Pyne and the response can be found at Appendix B to these minutes. Ms Pyne asked the following supplementary question:

"People with Autistic Spectrum Disorder can be more sensitive to medication. The European Medicines Agency recently held a public hearing into fluoroquinolones due to thousands of reports of persistent, possibly permanent, multi-systemic adverse reactions. These very strong drugs are still being used for non-serious infections and causing damage. What mechanisms exist in the CCGs to influence prescribing practice?"

The Chairman thanked Ms Pyne for her supplementary question and agreed that a written response would be forwarded as soon as possible and attached to the minutes.

The Board agreed to consider agenda items 9a and 9b together.

9a. Norfolk & Waveney Sustainability and Transformation Partnership (STP) – Update including the integration of health and care services.

9a The Board received the report updating it on the integration of health and care services in Norfolk and Waveney and about significant developments with STP projects.

9b. Norfolk & Waveney Sustainability and Transformation Partnership (STP) – Update on Governance.

9b The Board received the report updating it on the current governance arrangements.

9.2 In introducing the two reports, the Rt Hon Patricia Hewitt, STP Chair, provided some background information. The following points were noted:

In terms of the national context:

- The details of the recent new NHS funding settlement were awaited - the commitment was for the next 5 years (ie a longer funding period).

- The Rt Hon Matt Hancock, MP for West Suffolk, had recently been appointed Health Secretary and it was hoped the focus of bringing health and social care partners together would continue.

In relation to Norfolk and Waveney:

- Norfolk & Waveney STP continued to be well regarded by NHS England (NHSE), particularly the good working relationship between the NHS, NCC and District Councils. NHS England had commended the work carried out on various work streams as well as the collaboration between organisations.

- The financial position remained a considerable challenge. Approximately £1.6bn per annum was spent on services, with an approximate overspend of £60m per annum which amounted to approximately 4%.

- It was important to focus on areas where better quality of care could be delivered and supported, and where money could be saved. Despite all the work being done on this in the NHS, some areas of inefficiency and waste remained, such as medicines being issued inappropriately.

- As part of the move to becoming an integrated care system, a shadow Integrated Care Systems (ICS) Board would be established in 2019. This would involve an intensive period work over the next 10 months and detailed proposals would be brought back to the Health and Wellbeing Board.

- It is the STP's intention that it would hold some of its meetings in public and publish minutes of those meetings if it becomes an ICS. In the meantime, the STP has started publishing a report after each meeting of the STP Chairs Oversight Group on the Healthwatch Norfolk website.

9.3 Melanie Craig, STP Executive Lead, presented both STP reports (9a and 9b), outlining the work which had taken place. The following points were noted:

- Ms Craig remained Chief Officer of Norfolk & Waveney STP and had taken on additional responsibilities as Interim Executive Lead for the STP.

- The intention of the Partnership was to improve outcomes for Norfolk and Waveney and reducing variation was a key challenge.

- The STP had been offered funding from NHSE for external support for some organisational development work, building on the very positive relationships.

- Norfolk and Waveney were one of 10 areas across the country piloting new ways of providing maternity services.

- In relation to governance, the Partnership had made changes to simplify the system to deliver transparency, pace and rigour.

- As part of these governance changes, the Prevention workstream had been more integrated into the Primary and Community Care workstream. It was considered important that the Prevention workstream had a strong focus and position as it was integral to each of the other workstreams. There was no change to the workstream itself or its leadership.

9.4 In response to questions from the Board about both reports, the following points were noted:

9.4.1 The Board was pleased external funding had been obtained for suicide prevention.

9.4.2 Some Members expressed disappointment that there was no mention in the report of the work carried out with District Councils as most of them had a number of preventative workstreams in place. The STP Executive Lead agreed that this was an omission and she would ensure the critical role of District Councils was recognised in future reports. Ms Craig outlined how the 8 District Councils across Norfolk and Waveney were working with the STP and offered an open invitation to District Councils to attend their Local Delivery Group meetings, which were the local mechanisms for implementing the work of the Primary and Community Care workstream.

9.4.3 The Director of Public Health referred to the HWB District Council members' workshop earlier that morning which had focussed on their role and contribution to prevention. Dr Smith reported that District Council colleagues were doing an enormous amount to contribute, however, the system continues to face a financial sustainability challenge. The DCs Group had agreed that although there were a number of areas that needed attention, there was a need to prioritise. As a first step the focus would be on housing and homes, and some specific projects had been identified.

9.4.4 Ms T Williams referred to the "Healthy Norwich" partnership programme which had a focus on prevention and was an excellent example of working good practice which could be shared with others.

9.4.5 In reply to a query it was confirmed that the alignment of CCGs financial planning was still being considered by the CCGs in terms of what could be done better together, while maintaining focus.

9.4.6 Norfolk & Waveney STP had just submitted its bid to the Capital Funding bid programme. The Norfolk & Waveney bid represented considerable work by a range of partners and focussed on the need to be able to make use of void space and on how land could be sold to generate resources.

9.5 Norfolk & Waveney Sustainability and Transformation Partnership (STP) – Update including the integration of health and care services.

9.5.1 The Board **resolved** to:

1. Support the continued development of our integrated care system.
2. Endorse conducting a strategic review of mental health services and the development of a long-term mental health strategy for Norfolk and Waveney.
3. Agree to align the work programmes of the STP and the Health and Wellbeing Board.
4. Agree to receive two reports from the STP at future meetings; a paper providing an overview of progress and a detailed report into one of the strategic workstreams.

9.6 Norfolk & Waveney Sustainability and Transformation Partnership (STP) – Update on Governance.

9.6.1 The Board **resolved** to:

1. Note the current governance arrangements and consider the implications for the wider health and wellbeing system.

10. Our Joint Health and Wellbeing Strategy 2018-22

10.1 The Board received the report from the Director of Public Health, Norfolk County Council, which outlined the Board's development of its draft Joint Health and Wellbeing Strategy over past months. The report included the key points from the HWB workshop on 2 May, which focused on the outstanding issues following consultation with all HWB Partners and how they might be addressed.

10.2 The Board received a tabled copy of the final draft Strategy.

10.3 The Board received a presentation from Chris Butwright, Head of Public Health Performance & Delivery, a copy of which is attached at Appendix C.

10.4 The Board welcomed the final Strategy and suggested that links from other partners' strategies could be included in the document.

10.5 In relation to the case study on Dementia, Joyce Hopwood advised that Professor M Hornberger, Professor of Medicine at the UEA, had been appointed as Chair of the Dementia Partnership Norfolk & Waveney when she retired.

10.6 Following a question about the population increase in people aged 16-64, the Director of Public Health reported that looking forward 20 years, the expected increase in population was likely to be approximately 100k, with a number of those

being aged 65 and over. This meant the challenge faced was not only age-related but also the growth in the non-working population as by 2037, one in three of the population was not expected to be economically active.

10.7 The Chairman confirmed that this Strategy pulled together the threads of partners existing Strategies and asked all Board Members, with regard to recommendation 2, to confirm whether or not their organisation agreed the strategy.

10.8 Board members **resolved** to:

1. Confirm that they were happy with the content and agree the HWB's Joint Health and Wellbeing Strategy 2018-22.
2. Agree to taking the finalised Strategy to HWB partners' organisations/bodies boards for formal sign off prior to 31 October 2018 and report back to the Board. .
3. Commit to taking an active role in the implementation of the Strategy, as outlined at paragraph 3.2 of the report.

11. Autism Strategic Update

11.1 The Board received the report by the Executive Director Adult Social Services, Norfolk County Council, updating the Board on progress to support the implementation of the Autism Act (2009), National Autism Statutory Guidance (2016) and Strategy 'Think Autism' over the past six months.

11.2 The report provided Members of the Board with information on work activity underway to support the statutory bodies responsibilities in undertaking its duties under the Autism Act 2009, Statutory Guidance 'Think Autism' 2014, Care Act 2014 and the Equality Act 2010, including the development of an All Age Autism Partnership Board and the wider engagement of people with autism to inform the development of a local partnership All Age Autism Strategy.

11.3 During the presentation of the report the Board noted that the report was an update on the work in progress and was to raise awareness; the aim was to bring an All Age Autism Strategy to a future meeting of the HWB.

11.4 The Board noted that the All Age Autism Partnership Board had been formed and had sat for the first time at the end of April 2018. Work was underway through the development of four co-production working groups and the Board was asked to support the working groups in the following areas:

1. Interagency Workforce and Training Plan

2. Engagement

3. Diagnostic pathways

4. Data Collection – which would feed into the national autism self-assessment. The survey commenced in July and would be completed by the end of November, covering both Adult and Children with autism.

10.5 Mr A Stewart, Chief Executive Healthwatch Norfolk, raised some concerns about the engagement process, particularly around holding meetings at inappropriate times and at inappropriate venues and sought assurance that these issues would be addressed. In response, the Board was reassured that this was being addressed and that there was a commitment to listening to expert's advice and taking appropriate action– for example, holding meetings at different times of day in order to try to meet individual needs, providing a quiet room for individuals who felt uncomfortable in large groups.

10.6 Dr L Smith, Director of Public Health, thanked Mr Stewart for the helpful feedback which would be passed on to the organisers.

10.7 Members welcomed the update report and suggested that consideration be given to training and awareness programmes being rolled out to wider workforce such as NHS staff and police.

10.8 The Board **resolved** to:

1. Acknowledge the development of The Norfolk All Age Autism Partnership Board.
2. Acknowledge and support the development of the working groups in the undertaking of priority work.
3. Agree to receive the Norfolk All Age Autism Strategy that will be informed by the completion of the National Autism Self-Assessment (2018).
4. Support the undertaking of a community engagement exercise that will seek to obtain the life experiences of people with autism and their families living in Norfolk further inform the priorities of a local autism strategy.

11. Information and Support for unpaid carers in Norfolk (Healthwatch Norfolk presentation).

11.1 The Board received a presentation from Ed Fraser, Healthwatch Norfolk, and Sharon Brooks, Chief Executive of Carers Council for Norfolk, a copy of which is attached at appendix D.

11.2 A next step, and one of the recommendations from the Carers Charter Network (CCN), was trying to find ways to ascertain how those young carers, who were not known carers, could be reached. Members discussed possible ways of capturing this information, including working with education colleagues and exploring involving GP practices more proactively.

11.3 Social isolation was seen as a key issue faced by carers and the Carers Council for Norfolk confirmed that there was evidence to support this.

11.4 The Board **noted** the presentation and its links to the next item on the agenda.

12. Norfolk and Waveney Strategy for Carers

12.1 The Board received a report by the Executive Director Adult Social Services, Norfolk County Council providing Members with information about unpaid carers' in

Norfolk and Waveney and asking the Board to support the development of a Norfolk and Waveney Carers Strategy.

12.2 In Introducing the report, the Head of Integrated Commissioning said she was delighted with the level of interest and engagement. A strategy was needed in order to strengthen the approach for carers in Norfolk and Waveney and what could be done to support them. It was estimated there were more than 106,000 carers in Norfolk and developing a set of principles on how to support carers would help them provide better care and also keep them safe and well.

12.3 The Department of Health and Social Care had recently published an Action Plan for carers, looking at 5 broad areas, including helping young people with education and supporting older carers with their working commitments.

12.4 The following points were noted in response to questions:

12.4.1 The work is intended to be system-wide and it was important that District Councils were involved.

12.4.2 To ensure that all key stakeholders were given as much opportunity as possible to engage in the process, it was suggested that the timing of the phase of engagement with key stakeholders should be moved back by one month, as the level of engagement was unlikely to be high between July and September due to the summer holiday period. This suggestion would be considered.

12.4.3 The Chairman praised the work so far and recommended it to the Board for endorsement.

12.5 Board members **resolved** to:

1. Agree to the development of a Norfolk and Waveney Carers Strategy, which is overseen and monitored by the Health and Wellbeing Board.
2. Agree to receive a report in October 2018 with a more detailed plan for developing the strategy in a way which puts the voice of carers at the centre, and through good collaboration ensures the commitment of key health and social care stakeholders.
3. HWB Members, including District Councils and VCSE representatives, are asked to engage their own organisations in discussions about the issues set out in the report in readiness for a fuller report in October 2018.

The meeting concluded at 1.02 pm

Chairman

Appendix A

Health and Wellbeing Board meeting
17 July 2018

Draft Resolution

Annual Refresh of the Local Transformation Plan for Norfolk & Waveney (Children and Young People's Mental Health)

1. Each autumn, in accordance with the NHS England (NHSE) Local Transformation Plan (LTP) planning requirements, the HWB is asked to consider and approve the annual refresh of the Norfolk and Waveney LTP in advance of its submission to NHSE.

2. NHSE have recently confirmed that there is no longer the requirement for HWB's to sign off the annual refresh – the requirement is for the Chair of the HWB and their nominated lead members to have been consulted about the proposed key priorities of the refreshed Plan.

3. The annual refreshed LTP for 2018/19 is under development, building on earlier iterations and influenced by ongoing consultation with children, young people and stakeholders. The deadline for submission of the refreshed LTP to NHSE is in October 2018.

4. In the light of the change of requirements, agreement is sought from the Board that the HWB Chair and Vice Chairs Group considers the annual refresh of the LTP in advance of its submission to NHSE in October.

The HWB resolves to:

- Agree that the HWB Chair and Vice Chairs Group consider the annual refresh of the LTP in advance of its submission to NHSE.

Appendix B

Health and Wellbeing Board
17 July 2018

8. Public Questions.

Question from Ms E Pyne:

What training is envisaged for GPs and hospital staff relating to dealing with patients on the autistic spectrum? There is a great deal of ignorance amongst medical professionals in both the mental health service and physical health services. Patients may need extra time and a written record of a consultation to avoid misunderstandings. They often find hospital settings overwhelming. Patients with Asperger's syndrome do not have learning difficulties and must not be treated as such. Comments please. In my experience much time and money will be wasted if a new strategy is not put in place, indeed harm may result.

Answer:

The Norfolk All-Age Autism Partnership boards role is to deliver a Norfolk All-Age Autism Strategy that will inform the vision and priorities to enable people with autism to live rewarding and fulfilling lives. The Engagement workstream is developing a questionnaire that will provide insight into the lives of the Norfolk autism community including parents carers. The tool developed with experts by experience asks particular questions regarding people with autism's experience of GPs, hospital staff, health and mental health workers amongst other things. In addition the Interagency Workforce and Training Plan workstream is also looking to put in place a workforce development plan. This plan, for example, will include face to face autism training for social care staff meeting our statutory duty but also an e-learning programme for interagency workers and hopefully wider depending on the training need. Once the level of training need is understood from the engagement tool, the Norfolk All-Age Autism Partnership Board we will be in a good position to understand the training needs, to ensure the training it fit for purpose and be in a position to share this information with our wider partners.

Supplementary question from Mrs E Pyne:

People with Autistic Spectrum Disorder can be more sensitive to medication. The European Medicines Agency recently held a public hearing into flouroquinolones due to thousands of reports of persistent, possibly permanent, multi-systemic adverse reactions. These very strong drugs are still being used for non-serious infections and causing damage. What mechanisms exist in the CCGs to influence prescribing practice?

The committee can watch the hearing on the EMA website. There you can see testimonies of a number of people whose lives have been decimated by these drugs. This is potentially as big as the problem with Valporate, mesh and thalidomide.
The CCGs should know about this as money is being spent on drugs causing harm. The EMA is looking at revising prescribing guidelines, possibly saying that Flouroquinolones should only be used in very serious, life-threatening situations.

Answer:

Norfolk is adopting the National approach, applying the principles of stopping the over medication STOMP of all vulnerable groups, including Autism with or without a learning disability.

Locally South Norfolk Clinical Commissioning Group is coordinating the STOMP agenda, Sue Graham is the Quality Manager involved in ensuring alignment to the national programme.

Also, as part of the autism work undertaken in Norfolk, we will work with GP (and others) to raise the awareness of autism.

Appendix C

Joint Health and Wellbeing Strategy 2018 - 22

Chris Butwright
Head of Performance and Delivery
Public Health, Norfolk County Council

Our Strategy

- Where have we got to?
- Purpose – going forward
- How it works?
- What now?
- Towards implementation

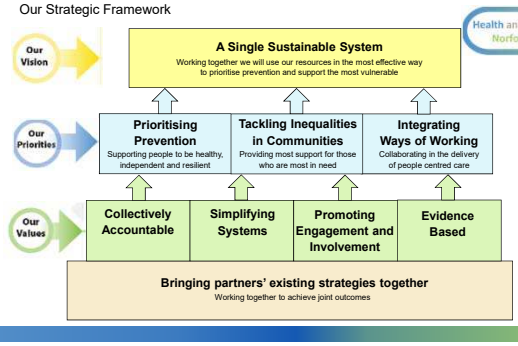
Our Strategy: where have we got to?

- System Leadership – being able to demonstrate and measure - based around our priorities
- Effectiveness of cross organisational working
- Ensuring we are accountable and transparent

Joint Health and Wellbeing Strategy 2018 – 2022

"A single sustainable health & wellbeing system"

Our Strategic Framework



Our Priorities

Our vision of a single sustainable system requires us to work together, implementing what the evidence is telling us about health and wellbeing in Norfolk and Waveney, on these key priorities:

Priorities	By this we mean
1. A single sustainable system	Health and Wellbeing Board partners taking joint strategic oversight of the health, wellbeing and care system - leading the change and creating the conditions for integration and a single sustainable system.
2. Prioritising Prevention	A shared commitment to supporting people to be healthy, independent and resilient throughout life. Offering our help early to prevent and reduce demand for specialist services.
3. Tackling Inequalities in Communities	Providing support for those who are most vulnerable in localities using resources and assets in localities to address wider factors that impact on health and wellbeing.
4. Integrated ways of working	Collaborating in the delivery of people centred care to make sure services are joined up, consistent and makes sense to those who use them.

Our Values

Our values describe our shared commitment to working together to make improvements and address the challenges:

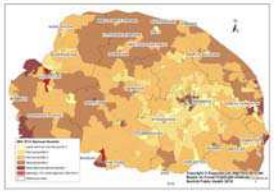
Values	By this we mean:
Collectively Accountable	As system leaders, taking collective responsibility for the whole system rather than as individual organisations.
Simpler system	Reducing duplication and inefficiency, with fewer organisations - a commitment to joint commissioning and simpler contracting and payment mechanisms.
Engagement	Listening to the public and being transparent about our strategies across all organisations.
Based on evidence of needs	Using data, including the Joint Strategic Needs Assessment (JSNA), to target our work where it can make the most difference - making evidence-based decisions to improve health and wellbeing outcomes.
Bringing partners' existing strategies together	Under the umbrella of the Health and Wellbeing Board for Norfolk and Waveney - identifying the added value that collaboration brings and working together to achieve joint outcomes.

Our Strategy: Purpose – going forward

- Main purpose is outlined in the joint message from the Health and Wellbeing Board's Chairman and Chief Officer – Bill and Louise
- Acknowledges the context we are all working in
- Steers how we all work together as system leaders to drive forward transformation and improvement
- Emphasises the connection to the Norfolk and Waveney Sustainability & Transformation Partnership
- Brings partners' existing plans and strategies together

Our Strategy: How it works…

- Evidence of need and key statistics
- What's important strategically?
- Key Challenges
- Priority **Actions**
- Key **Measures**
- Case Studies to illustrate



Our Strategy: What now?

- Agree our Joint Health and Wellbeing Strategy 2018-22 today
- Agree to take it to our organisations' committees/ boards/ governing bodies for formal sign off (prior to 31 October 2018)
- Commit to take an active part in the implementation of our Strategy

Our Strategy: Towards implementation

This means we are going to:

- Identify the actions that we will each take
- Develop an implementation plan
- Develop an outcomes framework
- Bring reports regularly to our HWB meetings
- Carry out in-depth reviews
- Hold ourselves to account
- Keep our Strategy active

Finally…

- Opportunity today to consider our Strategy together
- Thank you

Appendix D

healthwatch Norfolk

Information and support for unpaid carers in Norfolk (January 2018)

A Healthwatch Norfolk and Carer's Council for Norfolk survey

Introduction

Background
- Previous HWN survey with CCN in 2016
- Living Longer, Living Well 2016-18

Aims
1. Experiences of Carers Assessments (last 12 months)
2. Experiences accessing information and support

Methods
- Survey (30qs) co-designed with input from local carers
- Social media; established networks; posted to CCN members

Respondents
- 255 carers completed the survey
- Diverse characteristics but not representative (older)
- Insufficient numbers for cohort analysis
- But a good deal of detailed qualitative feedback

Findings: Carers Assessments

Summary
- 73 respondents received CA within last 12 months
- Generally positive experiences (56% rated 4-5*)

Positives (4-5*)
- Staff particularly praised (57%)

Negatives (1-3*)
- Lack of outcome frustrating for many (48%)
- Sometimes the process felt impersonal (29%)

Findings: Info & Support

Information
- Most respondents felt able to access info/advice
- 16% said they did not know where to look
- 18% used friends/family or their own research

Support
- 37% felt able to maintain health/wellbeing
- 68% felt confident to continue caring

What would help?

Respite support (both planned and short-term)
- Knowing that someone could step in and support my husband at short notice if I needed a break away.

Reassurance and future planning
- Knowing that my child will be cared for in adulthood.

Access to flexible, reliable and consistent home care
- Carers coming in at weekends, I have asked twice and they have not had the staff to provide any carers at present.

Support to manage health and wellbeing
- A carers health check at the GP surgery. Carers tend to neglect their own health…

Moving away from…

"I don't want to be trapped in this caring role."

"I feel like I'm doing this all alone."

Towards…

"My son requires a high level of care. I feel we have been supported and respite has been put in place."

"The assessor was caring and listened to my needs rather than my husband's. For the first time for a long while I felt someone cared for me."

Next steps

Five recommendations (CCN):

1. The importance of respite in supporting carers to manage their health/wellbeing needs to be better recognised
2. All carers are supported to have plans for the future and emergencies
3. Working with home care providers to improve outcomes for unpaid carers
4. Supporting carers to manage their health and wellbeing
5. Monitoring and evaluation of outcomes

Report title:	**Our Joint Health and Wellbeing Strategy 2018-22 - Implementation**
Date of meeting:	**31 October 2018**
Sponsor (H&WB member):	**Dr Louise Smith, Director of Public Health, Norfolk County Council**

Reason for the Report

In July 2018 the Health and Wellbeing Board (HWB) agreed its Joint Health & Wellbeing Strategy 2018-2022. HWB partners agreed to take the Strategy their organisations' boards/bodies for formal sign up and to take an active role in its implementation. This report provides an update on progress

Report summary

This paper outlines how HWB partners are committed to action through formal sign up to the Strategy. It outlines actions and next steps as we move into implementation phase and it provides the published Joint Health and Wellbeing Strategy 2018-22.

Recommendations:

Members of the HWB are asked to:

1. **Note the outcome of partner organisations' sign up to the Strategy**

2. **Agree the next steps with implementation and commit to action to take this forward**
   - **Developing and agreeing our high-level implementation plan** - which will inform our action and prioritisation and enable us to focus on the added value that collaboration through the HWB brings
   - **Developing and agreeing an outcomes framework** - so we can monitor our progress towards achieving our priorities

1. Background

1.1 At its meeting in July the HWB agreed its Joint Health & Wellbeing Strategy for 2018-22, with HWB partners:

- Agreeing a vision - **A single sustainable health and wellbeing system**
- Agreeing our strategic priorities - **Prioritising prevention**, **Tackling inequalities in communities** and **Integrating ways of working**
- Confirming our values – **Collective accountability**, **Simplification of systems**, **promoting engagement and involvement**, **based on evidence of needs**.

- Bringing together **existing strategies** and agreeing to work together to achieve joint outcomes

1.2 The Strategy has been published and is available at the following link: Joint Health and Wellbeing Strategy 2018-22.

2. Sign up to the HWB Strategy

2.1 At the July meeting, HWB partners agreed to take the Strategy back to their organisations' governing bodies/boards to ensure governance arrangements were fully in place in preparation for implementation.

2.2 Good progress is being made with formal sign up, which at the time of writing is as follows:

- Seven (out of nine) **local councils** have formally signed up (Broadland District Council's Cabinet due to consider on 23 October and North Norfolk District Council due to consider on 29 October)
- Norfolk and Waveney **Sustainability and Transformation Partnership** (STP) is formally signed up
- **Clinical Commissioning Groups** (CCGs) – All five CCGs have formally signed up
- **Healthwatch Norfolk** has formally signed up
- **Voluntary & community sector** partners – have formally signed up
- The **Police** have signed up and the **Police & Crime Commissioner** - due to be considered 23 Oct
- One (out of three) **acute Hospital Trusts** have formally signed up – confirmation is awaited from the Norfolk & Norwich Hospital NHS Trust and Queen Elizabeth Hospital NHS Trust
- The two **community health and care providers** have formally signed up
- **Norfolk & Suffolk NHS Foundation Trust** has formally signed up
- **Norfolk Independent Care** – confirmation is on track for 31 October

2.4 As HWB partners work to complete this stage of formal sign up to the Strategy we are able to demonstrate the shared commitment being made to collective and collaborative action.

3. Implementing our Strategy – early action

3.1 An implementation plan is under development which will inform our action and prioritisation. In the meantime, early action is outlined below.

A single sustainable health, wellbeing and care system

3.2 Working together as system leaders, we are launching our Joint Health and Wellbeing

Strategy 2018-22 at our Annual Health and Wellbeing Board Conference on 5 December 2018.

3.3 The event will be an opportunity for us to launch our Strategy to a wider audience - sharing our vision and our ambitions, building relationships, leading the change, creating the conditions for an integrated sustainable system, and engaging wider stakeholders in how we will need to work together creatively to deliver our priorities.

.

Strategic Priority - Prioritising prevention

3.4 Through the Strategy, HWB partners have committed to working towards supporting people to be healthy, independent and resilient throughout life as well as offering help early to prevent and reduce demand for specialist services.

3.5 This strategic priority has direct links to the work partners are doing through the Sustainability & Transformation Partnership (STP) Prevention workstream. Partners involved in the STP Prevention Workstream are bringing a paper to the HWB (see item 10c on this agenda) which provides us with an opportunity of challenging ourselves on areas where improvements are needed and supporting action needed to deliver improvement and bring about change. Given the stage we are in the year, the report to the HWB has a focus on planning for winter.

3.6 It directly supports delivery of our Joint Health and Wellbeing Strategy in relation to this strategic priority and is contributing towards a number of **Priority Actions** including:

- Providing joint accountability so that as a system we are preventing, reducing and delaying needs and associated costs
- Promoting and support healthy lifestyles with our residents, service users and staff

Strategic Priority - Tackling inequalities in communities

3.7 Through the Strategy, HWB partners have committed to providing support for those who are most vulnerable in localities using resources and assets to address wider factors that impact on health and wellbeing.

3.8 Work is well underway in this area with the HWB District Council's Group having carried out an in-depth review of initiatives and good practice at a local level and agreeing a focus on homes and health to deliver improvements in health and wellbeing through interventions in the home.

3.9 The Group has identified three specific workstreams and is bringing a paper to the HWB for action (see item 11 on this agenda). The Group's report to the HWB directly supports delivery of our Joint Health and Wellbeing Strategy in relation to this strategic priority and is contributing towards a number of **Priority Actions** including:

- Improving locality working and sharing best practice (all)
- Providing and using the evidence to address needs and inequalities

Strategic Priority - Integrating ways of working

3.10 Through the Strategy, HWB partners have committed to integrating ways of working in the delivery of people centred care.

3.11 This strategic priority has direct links to the work partners are doing through the STP and several workstreams are directly contributing to this, not least with the planning towards developing an integrated health and care system (ICS).

3.12 A current focus for our health and care system is on winter planning, with our ageing population combined with increasing numbers of people with a long term health condition meaning that demand for both health and social care is increasing. This is particularly across the urgent care system and partners are working together to ensure plans are in place to manage and support this. (See item 10b: STP Urgent and Emergency Care update on this agenda).

3.13 Another key area for the system is a major work to transform local mental health (MH) services. In the light of the national Five Year Forward View for MH, and locally emerging models of care, a systematic review of the quality, sustainability and affordability of current MH commissioning and provision is being undertaken in order to meet the needs of the Norfolk and Waveney population over the next 10 years.

3.14 This STP workstream aims to ensure the accessibility of sustainable services in the future to support the prevention of poor mental health, support people who live with mental health issues, reduce the incidence of mental health crisis, self-harm and suicide; and provide access to mental health support and care as close to home as is safe to do so through a variety of methods and services.

3.15 The above work is directly supporting delivery of our Joint Health and Wellbeing Strategy in relation to this strategic priority and is contributing towards a number of **Priority Actions** including:

- Collaborating in the delivery of people centred care to make sure services are joined up, consistent and makes sense to those who use them.

3.16 Given the considerable work already underway, a key stage in the implementation planning of our Strategy will be for us to focus on the actions that we, as a HWB, can and will do that will bring added value.

4. Summary and next steps

4.1 In line with our Strategy, HWB partners are already sharing thinking and planning - looking to understand the challenges faced by each part of the system and to identify the opportunities for new ways of working and transformation.

4.2 Partners are also carrying out in-depth reviews and bringing reports to our HWB meetings, so we can challenge ourselves on areas where improvements are needed and support action to bring about change.

4.3 Next steps include:

- **Developing and agreeing our high-level implementation plan** - which will inform our action and prioritisation and enable us to focus on the added value that collaboration through the HWB brings

- **Developing and agreeing an outcomes framework** - so we can monitor our progress towards achieving our priorities

Officer Contact

If you have any questions please get in touch with:

Name	Tel	Email
Chris Butwright	01603 638339	Christopher.butwright@norfolk.gov.uk

If you need this Report in large print, audio, Braille, alternative format or in a different language please contact 0344 800 8020 or 0344 800 8011 (textphone) and we will do our best to help.

Item 8a)

Report title:	**Norfolk and Waveney Sustainability and Transformation Partnership (STP) update**
Date of meeting:	**31 October 2018**
Sponsor (H&WB member):	**Patricia Hewitt, STP 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 July 2018.

Recommendations:

Members of the Health and Wellbeing Board are asked to:

1. **Consider and comment on the report**
2. **Identify actions that the HWB/member organisations could take to accelerate progress on delivering the changes necessary to deliver sustainable services**
3. **Support the engagement around the mental health review**

in good health

1. Integrating health and care services in Norfolk and Waveney

1.1 Our partnership has been selected as one of six sustainability and transformation partnerships (STP) nationally to participate in the Aspirant Integrated Care System (ICS) Development Programme. The programme is aimed at helping health and social care leaders develop the skills they need to make accelerated progress this year and give their partnership the best chance of meeting the ICS Programme entry criteria for 2019/20.

1.2 The purpose of the programme is to provide space for reflection, sharing of learning, and continuing professional development for system leaders in five core areas, related to the core ICS baseline capabilities:

- Effective leadership and relationships, capacity & capability
- Coherent and defined population
- Track record of delivery
- Strong financial management
- Focus on care redesign

1.3 It is a structured programme of support being delivered over 11 weeks from September to December 2018 by Optum Health Solutions (UK) and PwC, and funded by the NHS

nationally. The programme is being tailored to the needs of our health and social care system.

1.4 Our system was identified by regional and national NHS England and NHS Improvement colleagues as making good progress. Their support is a positive endorsement of our progress to date. Over the autumn and winter we will continue to engage the public, staff, the voluntary and community sector and other stakeholders in the development of our integrated care system.

2. System financial recovery plan

2.1 A priority for our STP is to create a strong financial plan to address our significant variance to our control totals and to enable the system to return to financial health. We have had detailed discussions with NHS England about the actions we are taking to address this and what more we need to do. There is a clear expectation from NHS England that we work together, are bolder and act quickly, otherwise our financial position will overshadow the good progress we are making in other areas.

2.2 Our System Financial Recovery Group, made-up of finance directors from all the organisations involved in our partnership, has now developed a much more detailed picture of our collective financial position than we've had previously.

2.3 An important first step we are taking is to move to block contracts between the clinical commissioning groups and the three hospitals. These will guarantee a regular fixed payment for patients treated. The value of the contract is independent of the number of patients treated. Block contracts work well because they are a timely, predictable and a relatively flexible payment arrangement. They mean providers of services like hospitals can predict in advance what they will be paid, and CCGs know in advance how much they will spend. There are also low transaction costs associated with block contracts.

2.4 A block contract has been agreed between the James Paget University Hospitals NHS Foundation Trust and NHS Great Yarmouth and Waveney CCG. The CCG and the trust have also agreed to set-up a joint Transformation Programme Board to oversee delivery of joint cost reduction and activity management programmes. Further work needs to be done to agree block contracts with the Norfolk and Norwich University Hospitals NHS Foundation Trust and the Queen Elizabeth Hospital King's Lynn NHS Foundation Trust.

2.5 Looking towards the next financial year, we are exploring putting in place Minimum Income Guarantee Contracts for 2019/20 with all three acute hospital trusts. These are a more sophisticated contracting arrangement, which help clinical commissioning groups and hospitals to understand their financial position and make plans for delivering services, whilst reducing the risk of spending more money than we have.

2.6 Our clinical commissioning groups and the providers of health services have shared more information with each other about their savings and efficiency programmes that they are currently working on. By the end of September we will have reviewed all of these to see if there are opportunities to learn from each other or identify ways of expanding savings programmes so that they save more money.

2.7 Cost Improvement Programmes (CIPs) are the savings and efficiency programmes run by hospitals and other NHS trusts. These are not currently jointly monitored or managed by the different healthcare providers in Norfolk and Waveney. Instead, each provider trust has their own internal process. We are going to create a Joint Provider CIP Board to align opportunities and increase the pace and rigour of cost savings and the standardisation of CIP reporting.

Demand and capacity review

2.8 Boston Consulting Group (BCG) has formally been awarded the contract to conduct our demand and capacity review. The purpose of the review is to analyse and model in more detail:

- the collective finances of all the organisations involved in our STP
- demand for health and care services in Norfolk and Waveney
- our resources and capacity to meet the demand for health and care services.

2.9 This review is building on all of the work we have done to date and will provide us with a more detailed picture of the impact of the changes we are making and provide a modelling structure for the future. It will enable us to use our collective capacity better, help us to meet the standards expected of us and ultimately improve the care we provide.

2.10 BCG are already conducting our mental health review. They will be able to make sure that these two significant pieces of work are joined-up, and provide us with a strong evidence base and detailed plans as we move towards becoming an integrated care system.

3. Developing a long-term strategy for mental health

3.1 Work has started on our strategic review of mental health services and the development of our ten year mental health strategy for Norfolk and Waveney. Engagement with service users and carers, as well as professionals from primary care, secondary care and mental health services, is vital to the review. A full programme of engagement has been developed, including attendance at existing local forums, public meetings and opportunities for people to take part online. Full details can be found here: https://www.healthwatchnorfolk.co.uk/ingoodhealth/stp-mental-health/.

3.2 BCG are mapping the provision of services across the region and using data analysis to assess how well they are performing against the needs of the population. They are also reviewing international best practice models for mental health provision and assessing what could work in Norfolk and Waveney.

3.3 The review will be completed by the end of 2018 and the strategy finalised by next spring. We are working very closely with colleagues in Suffolk who are conducting a very similar piece of work.

4. Cancer care in Norfolk and Waveney rated as good and outstanding

4.1 All of the CCGs in the Norfolk and Waveney have recently been rated as good or outstanding for cancer services by NHS England. In particular one year survival rates have shown a significant improvement across all five CCGs. Our patient experience scores continue to be rated as ‘good’ across the STP, this reflects well on the care provided across both primary and secondary care.

4.2 We’re continuing to look for ways to improve cancer care though. Work is underway to review the pathways for lung and prostate cancer at each of the acute hospitals with a view to aligning these (whilst allowing for local variation to reflect the staffing and equipment available at each hospital). Initial changes to pathways will be made by the end of 2018 and implementation will be complete by April 2019.

4.3 A priority for the workstream is to implement the new Faecal Immunochemical Testing (FIT) for bowel cancer. It is a relatively simple testing process which should speed-up ruling out a cancer diagnosis. It should lead to earlier detection of polyps and improved prevention of colorectal cancer, as well as result in a reduction in invasive hospital procedures and unnecessary travel to hospital for patients. We are going to pilot FIT in primary care as a diagnostic support tool. We want to assess the potential for the use of FIT as a risk stratification/triage tool in secondary care.

5. Developing our workforce: launch of the nursing associate training programme in Norfolk and Waveney

5.1 We have started training our first 70 nursing associates in Norfolk and Waveney. Once qualified, our new nursing associates will be an important part of the workforce in future by providing hands-on care to patients and people receiving health and social care across Norfolk and Waveney. They will join our existing healthcare support workers, nurses, care home staff and others in providing excellent care for local people.

5.2 The role will help to increase clinical competence and capability of the workforce, as well as allow for innovative approaches to workforce modelling and the use of skill mix within settings. The involvement of social care sets us apart from other areas of the country which have taken part in the first two waves of the trainee nursing associate programme.

6. Funding to modernise the NHS and our digital technology

6.1 NHS England has announced £412.5 million of funding which will be invested in the digitisation of hospital, ambulance, community and mental health providers over the next three years.

6.2 Our partnership will receive almost £7.5 million over the next three years:

	2018/19	2019/20	2020/21	Total
Revenue			£3.9m	£7.455m
Capital	£1.88m	£1.67m		

6.3 We have submitted initial proposals for how we will use the 2018/19 funding and we are now developing detailed business cases for each of these. Our proposals include:

- Electronic observations
- Outline business case for electronic patient record system
- E-roster development
- Norfolk and Waveney integrated digital care record
- SystmOne inpatient bed module for NCH&C
- Clinical decision support tool for better radiology requesting across the STP
- Business intelligence development
- Transfers of care improvements

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

If you need this report in large print, audio, Braille, alternative format or in a different language please contact 0344 800 8020 or 0344 800 8011 (textphone) and we will do our best to help.

Health and Wellbeing Board – Norfolk and Waveney

Item 8b)

Report title:	**Winter planning - STP Urgent and Emergency Care**
Date of meeting:	**31 October 2018**
Sponsor (H&WB member):	**Jo Smithson, NHS Norwich CCG Chief Officer and STP UEC Senior Responsible Officer**

Reason for the Report

To provide the Board with an update summary on the focus and work of the STP Urgent and Emergency (UEC) workstream, particularly in terms of winter planning and resilience.

Report summary

The STP UEC Workstream has been established as one of the five STP workstreams. Its focus is:

- To ensure that system resilience is robust and that surge and escalation plans are agreed at a local level that will deliver safe and timely urgent and emergency patient care.
- To agree the Urgent and Emergency Care Strategy and detailed Urgent and Emergency Care Delivery Plan which includes key priorities, milestones and outcomes.

Winter Planning is the key priority to ensure plans are in place to manage the surges in demand and acuity and schemes are implemented to support this. The plans are STP-wide and one particular area of focus for the winter schemes is to reduce long hospital stays.

The Transformation Plans aim to deliver system stability on an ongoing basis and are split between four main areas: Integrated Urgent Care, Ambulances, Hospital and Hospital to Home.

The whole system recognises that working collaboratively to deliver the care required is the most effective and efficient way to deliver that. The challenge is always to maintain that focus and hold fast to plans in light of increasing operational pressures.

Recommendation

The HWB is asked to:

- **Note and comment on the operational and transformation work that is underway to manage the STP-wide operational plans, to provide system coordination and improved grip.**

1. Background

1.1 The STP UEC Workstream is one of five STP workstreams that has been established with all provider chief executives, CCG accountable officers and county councils, and Healthwatch represented. The A&E Delivery Board meets monthly and its priority is to ensure that there is robust governance in place to ensure, and provide assurance to the STP Executive that, there are adequate systems and process in place to support delivery of all unplanned care across the system.

2. Detailed Report

2.1 With regard to urgent and emergency care there are two areas of focus of the Board and the governance has been established accordingly. The focus is

- To ensure that system resilience is robust and that surge and escalation plans are agreed at a local level that will deliver safe and timely urgent and emergency patient care.
- To agree the Urgent and Emergency Care Strategy and detailed Urgent and Emergency Care Delivery Plan which includes key priorities, milestones and outcomes.

2.2 See Appendix A for the Governance Chart for the workstream.

Winter 2018/19 – strategic and operational grip

Overview

2.3 Demand for urgent and emergency care continues to grow. It is an aim of our STP to manage this demand by helping and empowering people to manage their conditions better, find health and care solutions within the community wherever possible, and use best clinical practice and joint working by our provider trusts to ensure that when patients do need to go to hospital they are treated in good time.

2.4 Daily activity data from the ambulance service demonstrates that our area is subject to particularly heavy demand compared to other areas. For example, on many days the Norfolk and Norwich University Hospital receives more ambulance arrivals than any other hospital in the East of England. It can receive more arrivals than the QEHKL and JPUH combined.

2.5 Our NHS 111 service has experienced an 11% increase in demand in 2018 on 2017. 30% of its activity is between December and February. IC24 is predicting an increase of nearly 9,000 calls in December 2018 over the previous year, totalling 50,000 in the month.

2.6 The East of England Ambulance Service has seen the average number of calls increase from 3,000 a day to 3,300 a day over three years.

2.7 This demonstrates both the daily pressure that our services face and the challenges faced by our staff. We acknowledge the incredible efforts of staff and management to cope with this demand.

Planning

2.8 Our system-wide focus is very much on Winter Planning across the Norfolk & Waveney STP. It requires aligning the key priorities of each of the three acute systems to ensure that challenges are identified, quantified and mitigated as far as possible.

2.9 In order to do this the A&E Delivery Board has progressed with the following:

- A new STP-wide Winter Room structure is being set-up:
    - A Norfolk and Waveney Winter Room Director, Mark Burgis, is now in post
    - Winter Rooms in West, Central and East areas in preparation
- Key Prevention Priorities have been agreed
    - Infection Prevention and Control
    - Respiratory Conditions
    - Cardiovascular Conditions
    - Housing
    - Social Prescribing

Winter 2017/18

2.10 The pressures on our system last winter are widely acknowledged. We experienced a severe cold snap that made many roads impassable for all citizens, including our own workforce. Despite that, many people made Herculean efforts to remain in work or get to work by walking, using 4x4s and even farm vehicles. We also experienced a flu outbreak that was much more serious than in previous years.

2.11 This should be placed in context, in that significant pressures occur every winter throughout the UK and Norfolk and Waveney is no exception.

2.12 Actions taken in response to winter 2017/18:

2.13 Reviews of Norfolk and Waveney performance took place soon after the winter period. Learnings included:

- Identifying key drivers in demand (these included more admissions due to respiratory conditions and falls)
- Good system collaboration in development of plans and operations
- Funding for additional capacity had not been confirmed until December 2017, which did not help with planning and implementation of resilience schemes
- Ambulance / acute admissions capacity was significantly challenged leading to sporadic delays in conveyance/handover
- On occasions pressure on acutes was an ‘Admission’ more than ‘Discharge’ driven issue (central Norfolk)
- First signs of pressure in the system emerged in late October / November but were exacerbated over the Christmas break
- Young-elderly (71-80yrs) saw the greatest increase in admissions (24% vs 10-14% in older & younger adults) (central Norfolk)

Winter preparations for 2018/19 based on above learnings

Planning

2.14 Co-ordinated planning has been undertaken in three local systems and also across Norfolk and Waveney as a whole. As described above this was based on learning from previous years and is intended to make our services for patients and residents more resilient this coming winter.

2.15 Earlier identification of additional funding to enable partners to plan increases in capacity more effectively. Funded schemes were agreed over the summer.

Financial

2.16 We are seeing additional investment on top of existing NHS resources of more than £3 million to add capacity and introduce new services. The Board will also be aware that in a recent letter from the Health and Social Care Secretary, Norfolk County Council has been allotted an extra £4.1 million and Suffolk County Council has been allotted £3.2 million for social care, to speed discharge from hospitals.

2.17 The Secretary of State has written to us: “This additional funding is intended to enable further reductions in the number of patients that are medically ready to leave hospital but are delayed because they are waiting for adult social care services.”

Workforce

2.18 Workforce remains a key risk. All providers continue to recruit to vacancies although it is acknowledged nationally that the UK requires more clinical and care staff in particular skill sets. GP recruitment and nursing/medical staffing in our Trusts is a priority.

System leadership

2.19 At times of significant pressures, Trusts and partners respond to the NHS OPEL (Operational Pressures Escalation Levels) framework of escalation. This triggers different levels of response from an operational and leadership perspective.

2.20 As described above, this year each hospital will have a dedicated winter room, with staff drawn from many agencies such as mental health, community and social care. They will respond to daily pressures, working as one integrated team, liaising with colleagues across Norfolk and Waveney. Each winter room will work in co-ordination with the Norfolk and Waveney Winter Room Director.

2.21 Every day we hold ‘system-wide’ teleconferences, in which health and care leaders discuss the day’s particular challenges and how we can tackle them.

2.22 Whenever major pressures build in hospitals or on other services, senior leaders will hold teleconferences, in which partners support each other and co-ordinate our response.

Our approach to winter resilience

2.23 Our approach is to continue delivering appropriate health and social care at a time of considerable pressures and reducing pressure on urgent and emergency services:

- Self-care and self-management - encouraging and empowering patients to keep themselves as well as possible, and use services such as pharmacies and walk-in / urgent treatment centres
- Expanding hospital capacity to help ambulances handover patients to the

hospitals and get back on the road
- Getting the flow through hospitals right
- Discharging patients who are fit to return home earlier, to free up beds
- Helping people to remain at home safely and independent - where they want to be.

What is going to be different this year?

2.24 As follows:

- A major drive to encourage eligible people to have the flu jab and major campaigns among health and care staff, including unpaid carers and care homes.

- The NNUH '8-point plan' which includes:

  - A new discharge suite to improve the patient's experience on leaving hospital and improve patient flow through the hospital
  - 8 more rapid assessment spaces for the Emergency Department to assist with ambulance handover and early patient assessment
  - Older People's Emergency Department opening hours to be extended
  - NNUH at Home - a pilot project that aims to provide care at home for patients who are medically well enough to leave hospital but still require care under the supervision of the hospital.

- Enhanced ambulatory care unit at JPUH

- Greater use of day surgery at QEHKL

- Hospital Ambulance Liaison Officers to improve handovers at hospitals

- Specialist ambulance paramedics and rapid response vehicles to help more patients at home rather than conveying to hospital

- Falls vehicles staffed by ambulance and community nurses and therapists

- More GP appointments at evenings and weekends

- More clinical cover in the 111 service to help callers resolve their problems without recourse to the urgent and emergency care system

- Provision to manage outbreaks of flu in care homes

- A night time mental health crisis hub spanning weekends in Norwich

- Additional mental health provision in in-patient settings

Transformation

2.25 Supporting system resilience work is the transformation work. This is focussed on both national must dos and local priorities. It is organised around 4 areas;

- **Integrated Urgent Care**
  - Linking with Admission Avoidance Schemes

- Implementation of the revised national specification
- Robust Triage of demand: 'Consult and Complete'
- Coordinated Urgent Care Provision e.g. Urgent Treatment Centres

- **Ambulances**
  - Improved alignment with NHS 111
  - Alternatives to conveyance

- **Hospital**
  - Managing flow through from ED to discharge
  - Alternative and more appropriate pathways for e.g. Frail Elderly

- **Hospital to Home**
  - Based on the 8 High Impact Change Model
  - Early Discharge Planning
  - Home first model

3 Key Risks

3.1 In light of all the planning and work being undertaken it must be recognised that the key Health and Social care partners are managing critical risks to delivery. In particular,

- Workforce
- Operational Pressures
- Financial Pressures
- Engagement of all partners
- Achieving a reduced Length of Hospital Stay (national focus).

4. Conclusion

4.1 The whole system recognises that working collaboratively to provide services is the most effective and efficient way to deliver the patient care required. The challenge is always to maintain that focus and hold fast to plans in light of increasing operational pressures.

Officer Contact

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

Name	Tel	Email
Nikki Cocks	01603 613325	Nicola.cocks@nhs.net
Mark Burgis	01603 613325	Mark.Burgis@nhs.net

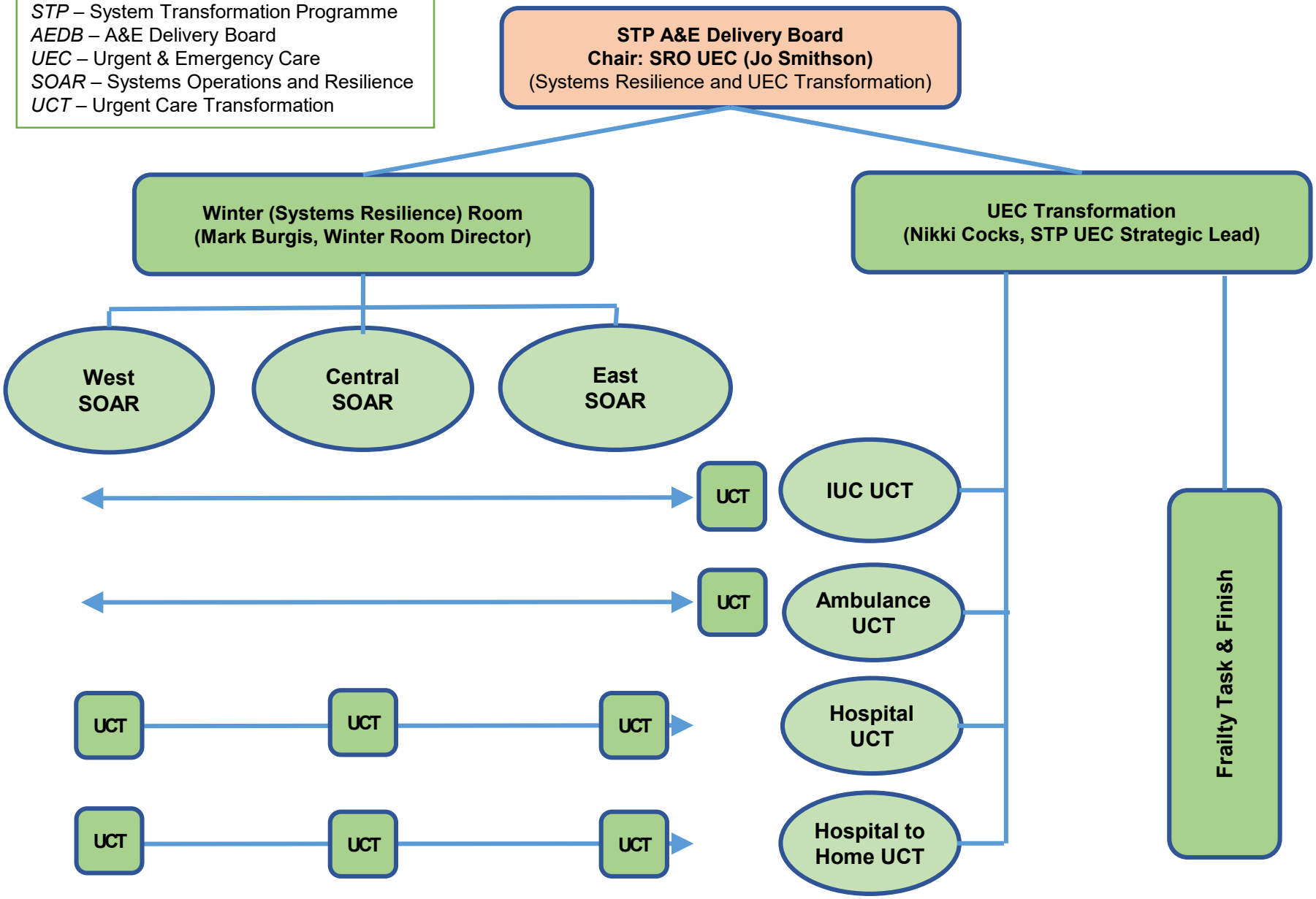
IN TRAN communication for all

If you need this Report in large print, audio, Braille, alternative format or in a different language please contact 0344 800 8020 or 0344 800 8011 (textphone) and we will do our best to help.

in good health

Norfolk & Waveney STP UEC Governance: August 2018

STP – System Transformation Programme
AEDB – A&E Delivery Board
UEC – Urgent & Emergency Care
SOAR – Systems Operations and Resilience
UCT – Urgent Care Transformation



Health and Wellbeing Board

Item 8c)

Report title:	**Winter in Norfolk and Waveney- The Top 5 for Prevention: an update from the Prevention workstream of Norfolk and Waveney STP**
Date of meeting:	**31st October 2018**
Sponsor (H&WB member):	**Dr SJ Louise Smith, Director of Public Health, STP Prevention Workstream Senior Responsible Officer**

Reason for the Report

This report sets out the top 5 priorities of the Sustainability & Transformation Partnership (STP) Prevention workstream which are focussing on system delivery outcomes to help the system be sustainable this winter. It seeks commitment from HWB members to support and contribute to these priorities.

Report summary

Analysis of the STP Prevention workstream work programme suggested that there would be more benefit to having fewer, more specific priorities that were more closely linked to system delivery outcomes that will help the system be sustainable. This led to the development of the 'Top 5 Prevention priorities', a plan with achievable actions addressing areas which could make the biggest difference across the system this winter.

The approach has been to work with local leads of existing groups to agree a small number of high impact but achievable actions to be delivered within a short timescale.

The top 5 prevention priorities include a focus on infection control (flu and norovirus) and prevention work around respiratory and cardiovascular conditions, which are the highest preventable causes for admissions during the winter. There are also specific priorities for working with District Councils and voluntary, community and social enterprise (VCSE) organisations around Homes and Health and Social Prescribing.

Work continues with partners to develop project plans for each of the priorities and impact will be monitored via a data dashboard.

This work fits with the strategic priorities of the Joint Health and Wellbeing Strategy: Prioritising prevention, Tackling Inequalities in Communities and Integrated Ways of working.

Recommendation

The HWB is asked to:

- **Support the 'Top 5 for prevention' priorities developed by the STP Prevention workstream**

1. Background

1.1 The STP Prevention workstream was established in early 2018 and originally covered thirteen different projects areas. Analysis suggested that there would be more benefit to having fewer, more specific priorities that were more closely linked to system delivery outcomes that will help the system be sustainable. This led to the development of the 'Top 5 Prevention priorities' which have been discussed and refined through consultation with stakeholders.

1.2 The Senior Responsible Officer (SRO) for the Prevention workstream is the Director of Public Health. Following the recent STP governance changes the Prevention workstream now reports to the Primary and Community Care Programme Board. Diabetes and Cancer prevention workstreams now also report to their own separate groups.

2. Winter in Norfolk and Waveney: The Top 5 for prevention

2.1 The top 5 prevention priorities include a focus on infection control (flu and norovirus) and prevention work around respiratory and cardiovascular conditions, which are the highest preventable causes for admissions during the winter. There are also specific priorities for working with District Councils and VCSE organisations around Homes and Health and Social Prescribing.

2.2 The approach has been to work with local leads of existing groups to agree a small number of high impact but achievable actions to be delivered within a short timescale. A summary of the agreed actions is detailed below. Further detail, the rationale and the potential impact are included in **Appendix A**.

- **1. Infection Prevention and Control** – A STP wide infection control winter resilience group is overseeing a co-ordinated approach to influenza planning and infection control. This work includes:
    - Establishing care home influenza outbreak response teams across all CCGs
    - An influenza vaccination campaign for 'at risk' groups and supporting areas with low uptake
    - Ensuring NHS Trusts and Care organisations meet staff vaccination targets
    - Communication campaigns to prevent the spread of gastrointestinal and flu-like illness

- **2. Respiratory conditions** – This builds on the work being led by the STP wide Right Care Respiratory group and Public Health campaigns. The actions include:
    - Promoting Stop Smoking through local Stoptober campaigns and promoting e-cigarettes as a safer alternative to smoking tobacco.
    - Promoting SOS packs for COPD patients – (packs containing emergency medication) as part of medication reviews and empowering patients to use them
    - Introducing easier access to Stop Smoking specialist advice for clinics in Acute Hospitals (including opt-out rather than opt-in referrals in Respiratory clinics)

- **3. Cardiovascular conditions** – This builds on the work being led by the STP Right Care Cardiovascular Disease prevention group. The actions include:
    - Improving the diagnosis and treatment of Atrial Fibrillation in flu clinics to reduce the risk of stroke (which increases in the cold weather).

- Re-running the successful “Get Checked” campaign to help identify and treat people living with undiagnosed high blood pressure (and subsequently reduce their risk of heart attacks and strokes).
- Support people with Heart Failure – including looking at the possibility of SOS packs for Heart Failure (as already established for COPD), and implementing a workforce development project to improve tissue viability in people living with heart failure.

- **4. Homes and Health** – builds on the work being led by the District Council’s Group (a separate paper on this topic with more detail is included on the agenda today) and Adult Social care. The actions include:
  - Warm and Healthy Homes – promoting winter wellness, installing Central heating systems and offering energy and money saving advice
  - Integration with MDTs – district council officers attending MDT meetings in GP practices so that housing and home safety support are an integral part of supporting people with frailty.
  - Supporting discharge from hospital – supporting people being discharged from hospital to return home or access suitable accommodation prior to discharge and reduce readmissions – by maximising the learning from existing projects and pilots and expanding to other settings such as mental health and community hospitals.

- **5. Social Prescribing** – working with District Councils and VCSE organisations to drive forward the implementation of the five social prescribing schemes that are now established across Norfolk (and seek assurance on progress on neighbouring Suffolk County Council scheme in Waveney). The actions include:
  - A communications strategy to ensure all stakeholders are aware of social prescribing and how to refer into the schemes
  - Create links with Social Prescribing and the Social Isolation/loneliness delivery in each locality
  - Evaluate the impact using common evaluation framework

3.0 Next steps

3.1 Work continues with partners to develop a more detailed project plan for each of the priorities and impact will be monitored via a data dashboard.

Officer Contact

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

Name	Tel	Email
Suzanne Meredith	01603 638456	suzanne.meredith@norfolk.gov.uk

in good health

FOR DISCUSSION

V3.9

Winter in Norfolk and Waveney:

The Top 5 for Prevention

1. Infection Prevention and Control

AIM: To reduce staff sickness absence, increase bed capacity and improve care home availability.

Respiratory and gastrointestinal viruses put additional pressure on NHS services over the winter. These illnesses impact on bed capacity by increasing demand at the same time as leading to ward and care home closures. They also contribute to increased staff sickness.

In Norfolk there were 33 respiratory outbreaks in care homes between September 2017 and April 2018. This compares to only 12 in the same period the previous year. The number of gastrointestinal outbreaks was less variable: 68 in 2016/17 compared to 72 in 2017/18. Norfolk reported 13% of all respiratory outbreaks in the East of England between September 2017 and April 2018, and 23% of all gastrointestinal outbreaks.

Staff uptake of influenza immunisation in 2017/18 met the national target of 70% across 5 out of 7 trusts in Norfolk and Waveney. The target for the next influenza season has increased to 75%, which means 3 trusts need to increase uptake next year.

Influenza vaccination uptake meets national targets in school-aged children, but not in the over-65s, under-65s at risk, pregnant women or preschool children. Uptake needs to be increased by 7 percentage points to meet the target for under-65s at risk and pregnant women.

ACTIONS

- Ensure a coordinated approach to influenza planning is in place.
- Establish care home influenza outbreak response teams across all CCGs.
- Run an influenza vaccination campaign aimed at the general population and targeted at general practices with low uptake.
- Ensure NHS trusts and care organisations meet staff influenza vaccination targets.
- Run communications campaigns aimed at the general public, care homes and schools to prevent spread of gastrointestinal and flu-like illness.

AMBITIONS:

- Meet national targets for influenza vaccination coverage.
- Meet 75% target for the vaccination of health care staff in all NHS trusts.
- Prevent and control outbreaks of flu-like illness and gastroenteritis in care homes, schools and hospitals.

IMPACT:

- Vaccine coverage of 48% in full-time care home staff can prevent 5 deaths, 2 hospital admissions, 7 GP consultations and 9 cases of flu-like illness per 100 residents during periods of moderate flu activity.
- Vaccination of 75% of the risk population could avert 9402 cases of flu in Norfolk. This could mean 148 fewer deaths and save £707,427 in healthcare costs.

Lead: Anna Morgan, STP Lead Nurse, Director of Nursing and Quality, NCHC

2. Respiratory conditions

AIM: To reduce ambulance calls, A&E attendances and emergency admissions due to respiratory conditions.

The incidence of respiratory illness increases as the outdoor temperature drops, leading to a high impact on health and care services in the winter. In 2014/15, pneumonia was the leading cause of emergency admissions to hospital. Smokers are more likely than non-smokers to develop respiratory conditions. They are also more likely to becomes seriously unwell and require hospital admission.

ACTIONS

- Promote e-cigarettes as a safer alternative to smoking tobacco, through a Stoptober publicity campaign supported by all STP organisations.
- Promote SOS packs for COPD patients.
- Introduce specialist stop smoking provision into respiratory clinics in all acute trusts.

AMBITIONS:

- No smoking on the premises of any STP organisation.
- Nicotine replacement products made available on NHS sites.
- NHS organisations recognise e-cigarettes as being safer than smoking tobacco.
- Opt out referral system to stop smoking services in place in respiratory and antenatal clinics.
- COPD care pathway in place.

IMPACT:

- For every 100 hospital inpatients offered smoking cessation advice and pharmacotherapy, 6 would avoid readmission at 30 days compared to those receiving only written advice. 12 would avoid readmission over a year. 5 people would avoid an emergency department attendance at 30 days and 6 deaths would be avoided over a year.

LEAD: Rosa Juarez, Lead for Right Care Respiratory, Head of Planning, Norwich CCG

3. Cardiovascular conditions

AIM: Improve early detection and treatment of hypertension, atrial fibrillation and heart failure, to prevent stroke, exacerbations of heart failure, myocardial infarction and death.

The incidence of stroke and myocardial infarction increases when the outdoor temperature drops below 8 degrees Celsius, leading to an increased impact of these conditions on services in the winter. Cold weather also leads to an increase in admissions to hospital for congestive heart failure.

Hypertension is one of the biggest risk factors for premature death and disability in England. For every 10mmHG increase in blood pressure, an individual has a 33% increased risk of stroke. The risk of suffering a stroke is increased by nearly 500% for patients with atrial fibrillation (AF). Identifying those at risk and intervening is one of the most effective ways GPs can reduce the widening gaps in life expectancy and health outcomes.

Myocardial infarctions and strokes can be prevented by identifying and treating people with undiagnosed hypertension and AF. Nearly a third of the Norfolk adult population has hypertension, with nearly half of them being undiagnosed. Exacerbations of heart failure can also be prevented by aggressive management of risk factors.

ACTIONS

- Diagnose atrial fibrillation at flu clinics using AF monitors.
- Re-run a local "Get Checked" campaign to detect hypertension.
- Complete a mapping exercise for heart failure services.
- Review the evidence for heart failure SOS packs.
- Implement a workforce development project to improve tissue viability and heart failure management skills.

AMBITIONS:

- Diagnose and treat hypertension, atrial fibrillation and heart failure early.

IMPACT:

- In Norfolk and Waveney undiagnosed AF is estimated at 10,600 people. Treating an extra 2,300 AF patients could prevent 390 strokes and 185 deaths over 5 years.
- Treating an additional 24,321 people with undiagnosed hypertension could prevent 195 deaths, 363 strokes and 243 heart attacks over 5 years.
- Controlling hypertension in an additional 3,543 patients who are already diagnosed could prevent 28 deaths, 53 strokes and 35 heart attacks over 5 years.

LEAD: Mark Lim, Lead for Right Care CVD, Programme Director – Clinical Commissioning, Great Yarmouth and Waveney CCG

4. Homes and health

AIM: Increase bed capacity, through timely discharge and prevention of emergency admissions caused by housing problems.

In 2013, 21% of houses in England did not meet the standards recommended for decent housing. There is a contrast between owner-occupied and rented accommodation, with private rented accommodation being less likely to meet standards than owner-occupied and housing association houses. Housing is a key determinant of good health and in total, inadequate housing costs the NHS £1.4 billion per year. Houses that are cold, damp or hazardous increase the risk of respiratory disease, cardiovascular disease and falls. This means people in inadequate housing are more likely to become unwell and to use healthcare services. In addition, problems with housing are a key reason for delayed discharge from hospital.

In Norfolk, 11% of households live in fuel poverty. This means that due to low income, high fuel costs and poor insulation, they cannot afford to heat their houses adequately. The proportion of households in fuel poverty is higher in Norfolk than the East of England and England averages. 9000 houses in Norfolk do not have any central heating, with Great Yarmouth having a particularly high proportion of houses without central heating. It is estimated that 10% of excess winter deaths are attributable to fuel poverty.

ACTIONS

- Develop multi-disciplinary teams (MDTs) involving district council housing officers and other community organisations to prevent hospital admissions.
- Implement the 'district direct' and other related schemes in all trusts, including mental health, community and acute trusts: district council housing officers working in hospital MDTs to facilitate discharge from hospital.
- Use the Warm Homes Fund to install central heating systems and offer benefits and advice for those in fuel poverty across all districts.
- The 'Warm and Well' campaign, delivered by Community Action Norfolk. Proactive energy switching campaigns.

AMBITIONS:

- Reduce delayed transfer of care.
- Prevent emergency admissions to hospital.
- Prevent the acute events that lead to crisis admissions.
- Reduce excess winter deaths.

IMPACT:

- Implementing the 'district direct' scheme for a full year could save 1653 bed days and £330,690.
- Residents aged over 60 who receive housing improvements could see a 39% reduction in emergency admissions for cardiorespiratory conditions and injuries compared to those receiving no improvements.

LEAD: Matthew Cross, Deputy Chief Executive, Broadland District Council

5. Social prescribing

AIM: Reduce demand for primary care; prevent unnecessary hospital admissions and A&E attendances.

Social prescribing is listed as one of the ten high impact actions in the General Practice Forward View. A considerable amount of primary care time is spent on the consequences of social problems or medical problems exacerbated by social problems. An estimated 20% of GP appointments are not related to any clinical condition.

Social prescribing involves linking people with social, emotional or practical needs to a range of non-clinical services to improve their health and wellbeing and to reduce avoidable appointments.

ACTIONS

- Implement social prescribing in each locality to meet the needs of the community.
- Evaluate the impact of social prescribing using an agreed framework.
- Develop a communications strategy to ensure primary care staff are aware of social prescribing and how to refer patients to it.
- Create and develop links between Social Prescribing and Social Isolation and loneliness delivery in each locality.

AMBITIONS:

- Ensure all general practices, libraries and adult social care have access to social prescribing.
- Achieve approximately 5000 social prescribing referrals per year across Norfolk and Waveney.

IMPACT:

- Modelling suggests that among patients referred to social prescribing we could achieve:
  - A 13% reduction in the average number of GP appointments.
  - A 20% decrease in the number of hospital admissions 12 months following referral.
  - A 20% reduction in accident and emergency attendances.
  - A 20% reduction in the number of outpatient appointments.
  - A reduction in prescribing of antidepressants.

LEAD: Rob Cooper, Head of Integrated Commissioning, Norfolk County Council / South Norfolk CCG

Norfolk Health and Wellbeing Board

Item No 8d)

Report title:	**Winter Resilience Planning**
Date of meeting:	**8 October 2018**
Responsible Sponsor	**James Bullion, Executive Director Adult Social Care**

Strategic impact

There are extreme pressures on health and social care during the winter months – and increasingly at other times in the year. Joint planning across the health and social care system has improved significantly, and the contribution that Adult Social Services makes towards supporting a stable system over winter is fully recognised.

Summary

Norfolk Adult Social Services plays a critical role in ensuring the health and social care system runs as effectively as possible during winter and other periods of intense pressure. Whilst much of the focus is naturally on the NHS, the contribution made by adult social services and the wider voluntary and community sector is significant.

This report asks Board members to agree the Norfolk Adult Social Services winter plan which sets out, in a single view, the department's arrangements for the winter period. The Plan prepares the organisation to maintain Adult Social Care services during winter whilst at the same time, supporting system partners in maintaining good patient flow and safety. Alongside the plan, there is a series of improvement activities, which are summarised in this report.

In October 2018, the Government announced additional one-off funding for Adult Social Services nationally to support winter pressures. For Norfolk, the allocation is £4.179m. This paper sets out the principles for allocating that additional funding to protect, sustain and improve health and social care. These will be considered by Adult Social Services Committee at its meeting on 5 November 2018.

Recommendations:

The HWB is asked:

- **To agree the Adult Social Services Winter Plan – attached at Appendix A**

1. Background

1.1 An ageing population combined with increasing numbers of people with a long term health conditions means that demand for both health and social care is increasing, and we know that these pressures increase during winter months, particularly across the urgent care system. As we head into winter with an already pressured position across the Norfolk wide system, this winter will prove challenging for all stakeholders.

1.2 Adult Social Services is committed to playing its full role in supporting the health and social care system, and will be contributing to system-wide resilience plans co-ordinated by the NHS Urgent and Emergency Care board.

1.3 However, in addition, there is a need to have a single view of how the department will marshal its resources and prioritise interventions in line with a 'home first' culture and in line with our strategy Promoting Independence.

2. Review of Winter 2017/18

2.1 Winter 2017/18 saw a long period of intense activity for the health and social care system. Winter, in effect, lasted until April, with a late surge of activity as a result of the Beast from the East. The prolonged summer heat also continued to see high levels of demand for hospital and community services.

2.2 As previously reported, the health and social care system struggled to meet challenging delayed discharges of care targets, despite greater investment in prevention and reablement, admission avoidance schemes, and stronger liaison with care homes.

2.3 In July, Adult Social Services organised a two-day system-wide event to look at what more could be done by health and social care to ensure people ready to leave hospital could do so without unnecessary delay. Over 80 representatives from the Norfolk and Waveney system were joined by experts from the Local Government Association (LGA) in partnership with the Better Care Support Team, National Health Service England (NHSE) and National Health Service Improvement (NHSI). Key findings from the event were:

a) A need to break away from 'linear' ways of working which are driven by processes and not people
b) A need to work at all levels with a culture of 'home first' so that all professionals involved are working towards getting people home
c) Better communications at all levels – between different professionals, with care providers and particularly residential and nursing homes, and with individuals and families

2.4 The findings were reflected in the initial feedback from the Local Government Association Peer Review, commissioned by Adult Social Services, which found there was not a shared single understanding of recording of delayed discharges of care, nor of the practice to reduce and challenge current ways of working. The team's view was that there was an over prescription of care packages, particularly at the point of discharge, without timely review so the opportunities for rehabilitation and were sometimes lost.

3. Winter Planning and improvement for 2018/19

3.1 The main objectives of our winter planning are to:

- Assure the continuity and successful response of adult social care and health services during periods of high demand and enable effective contingencies to be implemented in a planned and managed basis
- Provide solutions that are not based on placements
- Provide a strategic approach to demand & capacity management within the organisation by implementing new initiatives in time to deliver additional capacity to support the delivery of services to meet high levels of demand.
- Ensure that social care and health teams have sufficient staff and access to care capacity and that commissioned providers, specifically home support services, have their own capacity management plans in place.
- Undertake capacity planning across all hospital, community care and social care teams to ensure staff across Norfolk can be used flexibly to support elements of the system depending upon priorities

- Ensure effective communication with staff including those of external providers where there are forecasts of increased demand or potential adverse weather events affecting service delivery to support service planning and caseload management.
- Maintain effective flows and pathways of care to ensure that people receive care in the most appropriate setting and in a timely manner
- Engage key staff to embed proactive winter planning across all services including non statutory services
- Work collaboratively with other partners to ensure the winter plan meshes with other key providers including external providers to provide a coordinated and well managed response to winter pressures

3.2 To strengthen Adult Social Services the following improvement themes are being implemented:

- **Operational leadership** – a senior post with accountability for adult social services hospital discharges across the Norfolk system has been assigned. As well as the remit to make changes in ways of working within the hospital discharge teams, the Assistant Director will have an influential voice on A&E Delivery Boards covering the county, and work closely with the health and social care Winter Director – a new appointment for the NHS this year.

- **Brokering and arranging care** – whilst the vast majority of people go home from hospital, we know that delays happened because of the difficulty of finding a place in a care home for people who need it. Good quality, reliable information about vacancies is critical, and this year we have invested in an improved 'Bed Tracker' – an online system where care homes can record vacancies. Bed tracker is the first point of call for adult social services in looking for vacancies, so there is an obvious incentive for homes to use that site. Analysis over the summer of ways of working have cut out duplication, and ensured that valuable social worker time is not taken up with ringing around homes for vacancies – a practice which and become too frequent.

- **Communication and liaison with care homes and providers** – trusted assessors began their roles last winter, and have developed trusted arrangements which avoid the need for care homes to carry out their own assessments before they accept patients. A joint health and social care group is working specifically on a set of actions to improve working with care homes; this will address the importance of GP alignment to care homes, medicines management for people returning to their care homes, and contractual arrangements to ensure people's places are still there for them to return to after a stay in hospital.

- **Reablement** – the expansion of reablement both home based and in special accommodation makes a significant impact on people's independence. As well as more capacity, we will be ensuring front-line social work staff are considering reablement as the default option for most people. In addition, we will be looking at how other short-term beds are used. Our research has showed that beds we commission in care homes for a short-term stay, invariably turn into a permanent admission. On occasions, this may be appropriate, but we believe with more reablement and therapy input, more people could return to their home.

- **Prevention and early intervention** – investments made last year in social prescribing, reducing social isolation, will be fully felt this winter. There is now a network of community connectors across the county, working in alignment with our own Integrated Care Co-ordinators alongside primary care. Each CCG area has in place a dedicated service designed to avoid admission to hospital and

address crisis. Norfolk's Enhanced Home Support Service helps individuals to regain their independence, confidence and resilience following a crisis.

- **Data, recording and intelligence** – our discharge teams in hospitals were last winter required to produce many returns and requests for data. This was sometimes as many as 30 different reports in a single week. Despite this level of activity, the intelligence has remained weak. Adults will be seeking to influence NHS colleagues to consolidate reporting and to have a common, consistent set of metrics collected and reported across all hospitals.

- **Communications** – the MADE event in July urgent the Norfolk system to address the need for good communications. This was within and between different professionals in hospital setting, between primary care and hospitals, and between social work teams and others in the system. There is also a need to ensure that conversations with families are handled effectively, and that people receive consistent messages about maximising independence from different professionals within the system.

Additional one-off monies for Adult Social Services from the Department of Health and Social Care

3.3 In a pre-budget announcement in October, the Secretary of State for Health and Social Care announced additional one-off funding for social care for winter. For Norfolk, this translates into £4.179m. Whilst specific funding conditions are awaited, we know the funding will need to be used to support winter resilience, specifically activities which reduce and delay the need for formal care and support the safe discharge of people from hospital.

3.4 We anticipate the funding will build upon the key areas identified in 2017 to protect, sustain and improve social care. Key priorities for the system are:

a) Supporting financial pressures within ASC

Ensuring that the budget is managed sustainably and ensuring that expertise and capacity is available in the event of market/provider failure

b) Supporting capacity to manage winter pressures including embedding D2A

Embedding a culture of 'home first' and ensuring that services to support that are in place and effective

c) Bolstering short term capacity in the care market - homecare and care home markets to ensure sustainable care provision and managing potential market failures. Investment in the market to increase capacity and recruitment

Early proposals are:

Invest and improve

- Measures to avoid unnecessary delays in hospitals for people with mental health difficulties, for people with dementia and for people who are at the end of their life and want to die at home
- Additional intensive help for people in their own homes for the first critical period when they are discharged from hospital

Sustain

- Additional locally targeted recruitment campaign for the independent care sector to maximise the impact of the national campaign due to be launched shortly
- Better system-wide real time information, particularly for home care to speed up discharge and sustain efficient use of capacity
- Additional reablement – expanding accommodation based reablement and reaching in to short-term housing with care beds to build confidence and skills to help people home
- Additional swifts to take on more preventative work – in addition to their highly valued reactive service which saves the NHS money through avoiding admissions
- Change management to embed the 'home first' culture identified as critical by the MADE event for the system as a whole

Protect

- Additional protection for Adult Social Services budget in the face of sustained pressures, ensuring sufficient packages of care to meet anticipated increased demand
- Bolstering short term capacity in the care market - homecare and care home markets to ensure sustainable care provision and managing potential market failures.

3.5 Whilst the additional grant has been made to local authorities, there is an expectation that proposals for how it is best used will be shared with health partners, and the Executive Director of Adult Social Care will ensure this takes place.

3.6 The Adult Social Care Committee will be asked to agree the principles underpinning the use of the additional grant at its meeting on 5 November 2018. The additional monies complement the existing Better Care Fund and Improved Better Care Fund.

3.7 The Better Care Fund was set up by the Department for Health and Social Care in 2013 to further accelerate the join up health and care services so that people can manage their own health and wellbeing and live independently in their communities for as long as possible. Whilst there was no new money from the Government for the fund, both CCGs and local authorities were asked to pool some of their existing funds and agree a single spending plan for the pooled fund.

3.8 The improved Better Care fund was a feature of the 2017 budget and was an allocation over three years to local authorities. In Spring 2017 a further one-off grant element of the improved Better Care Fund was announced, covering the three years 2017-2020 with an expectation that it would be used along similar lines to the core better care fund to protect, sustain and enhance the social care and health system.

3.9 Taken together, these funds target a range of system improvements across these themes:

- Strengthened community based services which help people stay at home and avoid the need for a hospital admission
- Strengthened working with care homes to support the overall sustainability of independent care homes and to use their expertise to help their residents avoid the need for hospital admission and return back to their home after an episode of acute care
- A system-wide culture of 'home first' which improves joint working between different professions in and out of hospitals.

3.10 Taken together the Better Care Fund and the iBCF will see £57m in 2018/19 aligned towards these joint health and social care objectives.

Risks

3.11 The key risks the County Council's Adult Social Services department is managing this winter are:

- **Recruitment, retention and wellbeing** – sustaining staffing levels over winter in the whole care sector is vital, together with staff wellbeing which minimise short-term sickness absence. Arrangements are in place for all Norfolk county Council front-line social care staff to have a free flu jab. Nationally, there is provision for all care home staff and home care staff to access the flu jab.

- **Market capacity** – the majority of delays attributed to Adult Social Services has been people waiting for a support package. Homecare continues to be difficult to access in some parts of Norfolk.

- **Holding lists** – the department has made good strides in reducing the holding list over the last year; however, urgent demand from acute hospitals to support people back home can increase workloads for community teams, and allow less urgent requests to build up.

- **Maintaining our strategy** - at peak periods, the very high numbers of people seeking urgent medical care puts strain on the capacity we have to prevent and reduce the need for formal care. We know from previous years that increased numbers of people are admitted to residential and nursing care during winter months, and whilst for many this will be the right outcome, there could be those for whom alternatives might have been possible.

- **Financial** – at times of pressure, there is a risk that a 'safety first' culture leads to more intensive packages of support for people. If these are not reviewed there is a risk that we build in greater dependency for longer which in turn is more costly to the department.

- **Reputation** – as a system Norfolk did not perform well last winter against key measures from the Department of Health and Social Care. It is important for the confidence of people who use our services, that the contribution of Adult Social Care is not overlooked.

Officer Contact

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

Name	Tel	Email
Debbie Bartlett	223034	debbie.bartlett@norfolk.gov.uk

If you need this Report in large print, audio, Braille, alternative format or in a different language please contact 0344 800 8020 or 0344 800 8011 (textphone) and we will do our best to help.

Norfolk County Council

Norfolk County Council

Winter Plan

Introduction

Winter creates an annual challenge for the local health and social care systems by placing additional pressure on services. Therefore, it is essential for organisations within the health and social care systems to create and share their plans to address and mitigate these pressures in order to maintain the safety of the local population.

The winter period is between 1 October and 31 May. While winter will have ended as a season, the system remains in an escalated state until the end of May due to the two May Bank Holidays and the added pressure experienced at these times.

This Adult Social Services Department (ASSD) wide winter plan sets out the organisation's arrangements for the winter period. Winter is not an emergency or considered an unusual event but recognised as a period of increased pressure due to demand both in the complexity of people's needs and the capacity demands on resources within the Trust and the local health and social care system.

In addition, the winter period often brings with it untoward events such as widespread infectious diseases including Norovirus and there is the risk of the onset of the unusual such as pandemic flu which can affect patients and staff alike.

The Winter Plan prepares the organisation to maintain its service during winter and support system partners in maintaining good patient flow and safety.

- Focus on prevention
- Create the capacity to meet increased demand
- Link the Winter Plan to the West and Central System Resilience Plan
- Robustly performance manage the system to maintain quality, activity, safety and experience

Norfolk County Council (NCC) ASSD provides an assessment and care arranging facility and contracts care from the region's care market. It also provides a number of in-house services such as Norfolk First Support (NFS) which aid the system to operate as smoothly as possible and minimise cost. The top four interventions within this report are:

- Reduction of social care attributed DTOC (Delayed Transfer of Care) in acute and community hospitals
- The reduction and avoidance of admissions through greater co-operation between NCH&C (Norfolk Community Health & Care NHS Trust) and services within the community, CAS (Care Arranging Service) and other ambulatory pathways within primary & community care
- Building the resilience of teams to meet demand
- Developing operational infrastructure

This document should be read in conjunction with the NCC Adverse Weather Policy, Major Incident and Business Continuity Plan, Emergency Preparedness Resilience & Response (EPRR) Policy and Service Business Continuity Plans.

Key Lessons Learned from winter 2017/18

Links with the care market

The Trusted Assessors and incentive schemes were deployed during winter 2017/18. While incentives were welcomed, their efficacy is yet to be proven. However, working with the market has identified issues which need addressing to improve access to care, especially at weekends. Homes and care providers express a lack of confidence in the quality of discharge which is heightened at weekends when accessing support from health services is perceived to be challenging.

Resilience and Escalation Plans

Norfolk County Council ASSD did not report OPEL (Operational Pressures Escalation Level) status throughout the previous winter therefore, there was no standard means of measuring operational pressures within the department from which to base decisions to take escalation actions. A learning event conducted in spring, identified the importance of conducting a regular systematic review of operational pressures linked to an escalation framework to ensure consistent responses to escalation which is communicable to other system partners.

Approach to Operations Management for Winter 2018/19

Operations Centre

Norfolk County Council, in partnership with NCH&C, will establish an Integrated Winter Operations Centre in order to create a common operational picture, monitor performance and activity, coordinate and manage escalation, and act as liaison with other system providers regarding system performance.

During winter 2018/19, the operations centre will be operational five days a week between 09.00 and 17.00 and existing on-call management will be available between 17:00 and 09:00 each day and 24 hrs a day at weekends and Bank Holidays. A request for winter funding has been made to extend the Winter Operations Room to seven days a week. The outcome of the request is unknown at the time of writing this plan.

The Operations Centre will be responsible for collating information and sharing operationally relevant information with system partners on the daily silver calls and will manage any response to service escalation. In the event of a Significant Incident or Major Incident, the Operations Centre will work alongside the incident control room.

The STP (Sustainability and Transformation Plan) will deploy a winter operations room to oversee service delivery and resilience across the region. The integrated NCC and NCH&C operations room will report into the STP operations room.

Capacity Planning and Operational Control

Operational and commissioning teams will remain accountable for the development and delivery of their capacity plans, set during annual planning, and ensure their operating models and processes are in line with the local system they are supporting. These capacity plans may be represented as rosters and will remain responsible for the coordination of the daily work activity to deliver services. The Operations Centre will monitor these capacity plans and escalate issues, such as roster gaps or gaps in market provision, to relevant senior managers for resolution. In addition, the Operations Centre will monitor the daily work activity to ensure it meets required productivity requirements and escalate any issues, such as an increase in DTOC, to relevant senior operations and commissioning managers for resolution.

OPEL

For winter 2018/19 NCC will provide the system with a daily OPEL report which will be coordinated through the Winter Operations Centre.

All operational teams within ASSD will be required to create a daily OPEL report and submit this to the Operations Centre by 09.30. The service will be expected to take action in-line with their local escalation plans and for SITREPs (Daily Situation Reports) to be provided to the Operations Centre by 15.00 if the service has escalated to OPEL 4.

Services

Contact Service Centre (CSC) and Social Care Centre of Expertise (SCCE)

The CSC, which is also home to SCCE, provides a vital access point for those who need social services support. The department receives approximately 350,000 contacts per year via telephone, email, web and, increasingly, social media channels. Around 90% of these are managed and dealt with in the department, without the need to involve other teams.

The Social Care Centre of Expertise is managed by qualified social care staff which enables social care assessment and reviews to be conducted by phone. In addition, SCCE provides a weekend and Bank Holiday Emergency Duty Team.

The role of CSC and SCCE means it is an essential part of the service offer as well as an integral part of Adult Social Services resilience. The CSC and SCCE will monitor staffing regularly to ensure adequate staffing is available to maintain service outcomes.

ASSD support to Acute Services

Norfolk County Council provides three acute social work teams to facilitate a person's timely discharge back to their normal place of residence or the least restrictive, least costly option for long term care as well as supporting safeguarding investigations.

In-line with NCC Promoting Independence plans, the responsibility for supporting discharges from the James Paget Hospital Foundation Trust, and the staff supporting this process, will transfer to the locality team in the East and Suffolk. This change will take place on 1 November , prior to winter pressures starting. The change in the East of Norfolk will be reviewed prior to changes to other teams.

The team based at the NNUHFT (Norfolk & Norwich University Hospital Foundation Trust) will work collaboratively with the acute Trust to improve current multi-disciplinary working within the Discharge Hub, particularly in respect to patients who do not clearly fit existing discharge pathways. In addition, the team will work directly with wards known to be high referrers, to introduce the 3 Conversations approach in order to reduce the number of assessment and discharge notices being issued and rejected.

To support and maintain flow through the acute hospitals during winter 2018/19 additional assessment capacity will be required. The services will aim to maintain 80% of their establishment to be at work to ensure the service is resilient.

A standard definition for DTOC will be in place across all NHS Trusts and a DTOC validation process will be fully embedded before the start of winter.

Trusted Assessors, part of the Promoting Independence and iBCF (Improved Better Care Fund) plans, were introduced during 2017/18 and continue to develop relationships with the care market to reduce DTOC. Learning from the pilot will be used to develop new action plans and business cases for the winter of 2018/19.

The Enhanced Home Support Service (EHSS) and Short Term Beds have been seen as a positive addition to the system by the acute based social work team. This will continue throughout 2018/19 to contribute to a reduction in DTOC. The capacity of these discharge options will be reviewed prior to winter.

Community Social Care Teams

The community Social Care Teams (East, North, Norwich, South and West) provide assessments for older people, people with physical disabilities and working age adults.

In-line with the Care Act and the NCC Promoting Independence strategy, the community social work teams focus on people's strengths and look for community based opportunities to support individuals and carers to maximise their wellbeing. The teams are currently trialling the Living Well: 3 Conversations approach, which is a strengths focused and preventative model supporting people to maximise their independence. These teams provide in-reach to community wards to support discharge.

The teams work closely, in an integrated way, with primary care and community health services. The teams include Integrated Care Coordinators, Assistant Practitioners, Social Workers, Practice Consultants and Social Workers. Social work is a key component of developments within community and primary care.

Priorities

For winter 2018/19 the Community Social Care Teams are focusing on prevention. This includes maximising work already underway:

- 3 Conversations (Promoting Independence)
- Reducing holding lists (Promoting Independence)
- Reducing reviews list (Promoting Independence)
- Engaging with local development groups and GP practices

There will be a specific focus on the following to help reduce pressure on acute Trusts during winter:

- Falls
- Dementia
- Social Isolation

Teams will plan to be at or above 75% of their establishment at all times to ensure they have sufficient capacity to respond to community based needs. Additional capacity in Social Work and Occupational Therapy is being recruited in order to increase responsiveness of the teams and further improve outcomes.

The Community Social Work Team supports community hospitals to safely discharge patients. In early 2018/19 the model of support was changed, and each ward has now been assigned a social worker. The ward attached social worker works as part of the Ward MDT (Multi-disciplinary Team) and is part of the daily Red to Green meetings which enables good communication and ensures long term needs are identified early in line with the HICM (High Impact Change Model).

LD and Mental Health

Learning Disabilities (LD)

The Integrated LD team works to improve the quality of life for people with learning disabilities, in their homes and communities. During winter, people supported by this team will need ongoing support from a resilient service. Like many community based services, the LD team will be affected by weather and service users will be taken ill and access acute care. The Acute Support Team (AST), which also offers support out of hours, is particularly at risk due to adverse weather and learning from winter 2017/18 could benefit from closer working with other out of hours services. A comprehensive resilience plan will be in place before winter 2018/19.

There will be times when people supported by the service will be admitted to acute care. The three acute Trusts in Norfolk are supported by a liaison nurse and acute pathways are in place to provide support and facilitate discharge back home. The pathway will be checked to ensure all parties are fully aware of how to access it prior to winter 2018/19.

Adult Mental Health

Supporting people with their mental health to remain well throughout winter is challenging. Avoiding crisis and supporting people when they are in crisis is essential for their wellbeing, as well as avoiding placing pressure on other services which, in many cases, are not always set up to meet their specific needs.

For winter 2018/19 requests for winter funding have been made and approved to support people to avoid crisis and, if they do escalate, for alternatives to the emergency department to be available.

These requests are:

- Increase day centre-based step-down capacity in Norwich to support mental health discharges for working age adults by providing a safe space for patients who need more intensive support than can be provided in their own home. This aims to enable earlier discharge and prevent unnecessary admissions
- Additional dedicated AMHP (Approved Mental Health Professional) cover to meet expected increase in demand over winter in order to improve response to requests for MHAs (Mental Health Assessments)

Older People's Mental Health

Norfolk has a rapidly aging population and is experiencing a growth in age related mental health needs. Older people's mental health is supported by the community care social work teams who work closely with Norfolk and Suffolk NHS Foundation Trust (NSFT). The social work team provides essential support to maintain flow through NSFT beds and work to avoid DTOC.

Named social workers are linked to NSFT older person wards and attend regular discharge meetings. Many cases are complex and require significant effort to identify suitable long term care. Many patients present with both physical and mental health needs and identifying discharge opportunities is challenging.

Winter funding has been requested and approved to procure additional short term beds to specifically provide step down and admission avoidance for older people with both physical and mental health needs.

Commissioning and Care Market

The care market for both home care and residential care is a dynamic environment. The NCC Market Development Team and commissioners work closely with a wide range of private providers to enable access to high quality long term care.

To enable a response to meet the highly variable demand upon the market a number of initiatives have been put in place.

- **Commissioning Manager; Transfer of Care** – this post works closely with social workers to address issues affecting discharges and causing DTOC
- **Enhanced Home Support Service** – provides flexible and enabling support for up to seven days to help support the individual at home following discharge or to prevent admission
- **Short Term Beds** – provide bed based short term placements to enable Care Act assessments to take place outside of a hospital
- **Norfolk First Support** – increases the capacity for home based re-enablement
- **Accommodation Based Reablement Units** – provide short term bed based reablement to facilitate hospital discharge and prevent avoidable admissions
- **Enhanced Health in Care Homes** – a support to providers to understand how and when to seek health intervention and training to enable providers to safely meet needs within care home settings
- **Social Prescribing Project** – provides additional community connector roles aligned to GP practices enabling GP access to VCSE (Voluntary, Community and Social Enterprise) services in the community
- **ICES – Integrated Community Equipment Service** – access to equipment for both health and social care staff will be made more responsive over the winter period

A bed tracker is available to capture available residential and nursing home capacity. This relies on homes providing their bed availability. Approximately 60% of the market is currently actively inputting their available capacity. This information is used by the Care Arranging Team to quickly locate potential placements. A new version is due before winter 2018/19 which will enable a greater range of information to be captured and enable a more efficient brokerage process. A longer term plan is in place to move to an eBrokerage system which will be developed following winter 2018/19.

The Trusted Assessors and the Commissioning Manager for Transfer of Care are working with providers to increase their confidence and address concerns. They are working with acute services with the aim of reducing the need for homes to conduct assessments and ensure appropriate health services are available and accessible in the community when required.

Service Brokerage is undergoing a review as part of the Promoting Independence Programme. The output of the review was not available at the time of writing this plan. This plan will be updated once the review is completed and published.

Norfolk County Council ASSD provides in house services under the brand of Norfolk First Response (NFR). These include:

- Norfolk First Support (NFS) – home based reablement service

- Swift Response – 24-hour unplanned needs service
- Benjamin Court – accommodation based reablement

These services aim to support people to return to independence and reduce the need for long term care.

During 2018/19 NFS received additional funding to increase their capacity by 15%. Recruitment is underway and aims to be complete by winter 2018/19. Ensuring NFS is responsive and resilient is a key action for this coming winter and work to enable rapid step down to long term care providers is underway. The additional capacity includes salaried relief staff to provide an additional level of service resilience.

Norfolk First Support is introducing an electronic capacity monitoring system which will improve efficient use of capacity. The system is expected to be in place prior to winter.

Benjamin Court will continue to provide bed based re-enablement throughout winter 2018/19; recent recruitment has enabled all 18 reablement beds to be available.

The NFS service recognises how important the relationship is between their service and the acute Trusts. A team of hospital liaison practitioners provide a critical link with all three acute Trusts in Norfolk.

Norfolk County Council ASSD requires service providers to operationally provide to the full terms of their contractual agreement. This includes having the level of staff required to deliver the service fully and safely, having a plan in place for the event of significant service impact including staff illness and inclement weather, and ensuring service users are not impacted by a reduction in regular service provision. All service providers are required to have business contingency/continuity plans in place. In the event of serious impact on service delivery, providers are required to inform the Council of the situation as soon as practical to do so.

Providers will be informed and reminded of key periods of pressure (for example, Bank Holidays) and updated on how they can help and what support is available to them.

Historically, NCC has supported local care providers to remain resilient through offering advice and support online. This information will be reviewed prior to winter and updated as part of the Winter Communication Plan.

Advice is available for vulnerable people and those looking after them (https://www.norfolk.gov.uk/what-we-do-and-how-we-work/campaigns/stay-well-this-winter). This advice includes:

- Tips for staying well this winter
- How to make homes energy efficient and safe
- How to claim financial help
- What to do if you are worried about a friend or relative

Social isolation is a significant issue throughout the year; however, winter can bring additional challenges. Norfolk County Council is working with local businesses to help combat social isolation through the "In Good Company" campaign (https://www.norfolk.gov.uk/what-we-do-and-how-we-work/campaigns/in-good-company).

District Councils offer a number of local initiatives, such as slipper swaps, access to handyperson services, benefit checks and electric blanket checks. These initiatives vary across district councils and more information will be made available as information is released.

Factors Affecting Service Delivery during Winter

Change Programme

There are no significant change projects planned that will impact on operational capacity during winter 2018/19. Programme leads have been requested to inform the Assistant Director of Operations and Patient Flow of any projects which will have an impact on operational capacity.

Infections

Infections, such as flu and Norovirus, can affect staff and access to care homes. If teams contract illnesses, then assessment capacity is adversely affected. Norfolk County Council provides Public Health services for Norfolk and ensures information regarding predicted risks and outbreaks are shared across the health and social care system.

Flu Plan

Acute based teams aim to ensure all staff are immunised against flu in-line with advice from Public Health. Care and nursing homes are encouraged to protect their staff and are provided with advice on how to access free flu vaccinations for paid carers. Clinical Commissioning Groups (CCGs) and local primary care providers are required to ensure their "at risk" populations have access to vaccinations which include those living in nursing and care homes.

Winter Plan Action Log

NOTE – actions under review by the Assistant Director Hospital Systems and monitored through the Winter Resilience Group

Ref	Issue	Required Outcome	Action Needed	By When?	Progress (18/10/18)
OPS A1	Operational reporting is not currently standardised across operational teams.	For operational reporting to be standardised and automated where possible.	Review of current operational reporting practice. Standard reporting framework established.	September 2018 October 2018	Information from all localities and acute teams has now been received. Review of reporting requirements underway. To progress once above is completed.
OPS A2	NCC does not report OPEL states.	For NCC to report daily OPEL states in line with system partners.	Development of OPEL reporting framework. Deploy framework.	September 2018 October 2018	Triggers and action cards being reviewed by Central, West and East. Changes to be made and agreed W/C 29 October. Progress on daily monitoring/reporting delayed due to OPS A1.
Acute A1	Additional assessment capacity will be required to meet demand.	Increase of assessment capacity for winter 2018/19.	Recruitment of additional social workers or agency social workers.	1 Oct 2018	Funding request has been made to use pay budget underspend or one-off funding routes. Awaiting response.
Acute A2	The NNUHFT discharge hub has not fully integrated.	For the NNUHFT discharge hub to be effective and reduce DTOC.	Form an Integrated Discharge Hub leadership group with rotating chairperson to lead discharge hub and provide cohesive leadership for teams operating in the hub. Set up senior MDT to take place x three per week to agree group plans on discharging highly complex cases with clear escalation routes if consensus cannot be achieved. Work with high referring ward to deploy 3 Conversations and	August 2018 August 2018 August 2018	In place – further work needed to improve how the collaborative team works together. In place. Delayed due to operational pressure on the NNUHFT social work team.

			collaborative working (avoidance of transactional management of discharge).		
LD A1	AST is a small team which works independently of other out of hours services which means it may struggle to meet service user needs during adverse weather.	For the AST to be resilient out of hours.	To link AST to other out of hours services such as Night Owls and NCHC OOH Nursing Service for support and resilience.	October 2018	In place – AST linked to NCHC out of hours team who will provide a "buddy" system for the AST team.
LD A2	LD discharge pathway not fully established in NNUHFT.	For LD pathway to be fully established in NNUHFT.	LD team to ensure NNUHFT Discharge Hub are aware of LD pathway and it is fully established.	October 2018	Pathway written and agreed within LD team. To engage with NNUHFT team.
MH A1	There are an insufficient number of short term beds for older people with mental and physical health needs.	Three additional beds for 22 weeks	Submit winter funding request. Commission beds.	July 2018 October 2018	Bid submitted but not approved by AEDB.
MH A2	There is insufficient capacity within day services to meet the winter need.	Additional AMHP capacity.	Submit winter funding requests. Source additional AMHP.	July 2018 Oct 2018	Bid submitted by not approved by AEDB.
Com A1	There is a delay in the discharge of nursing and residential care home residents from hospital as care home managers are not able to do assessments before agreed discharge dates.	Patients from and going to nursing and care homes are actively managed with TAFs (Trusted Assessment Facilitators) and discharge co-ordinators working closely with Nursing and Care home managers who have confidence in assessments completed by TAFs to facilitate speedy discharges.	TAFs will have visited the top 50 LGA funded and high-risk care homes across Norfolk and Waveney and be competent to complete assessments on their behalf so that DTOC are minimised.	1 October 2018	TAFs have visited and are competent to assess on over 60 care homes across Norfolk and Waveney. They are now promoting the use of the bed tracker with the care homes who have the most LGA funded beds so that we know where bed vacancies are.
COM A2	Availability of providers who will accept EMI patients (Elderly Mentally ill) particularly OoHs and over the weekend.	Increase number of EMI beds available in each locality with the expectation that they can accept referrals and trusted assessments seven days a week, and referrals up until 20:00 for returning residents.	To undertake a procurement exercise to test and put in place arrangements in each locality for EMI beds over the winter period.	Mid November 2018	Procurement exercise complete; currently work with Procurement to explore options for competitive process and putting in place block contracts.
COM A3	Supporting effective system working and business continuity through periods of system pressure and severe weather.	Ensure social care providers are kept informed of operational, commissioning and quality issues/opportunities/resources through the winter.	Produce a communications calendar for winter that will deliver key messages on actions (held by social care) in the Winter Plan with a clear.	1 October 2018	Winter communications underway, focusing in October on the flu vaccine, Bed Tracker and TAFs, communication plan is almost complete, and will be shared with Corporate Comms Team and STP.

			communication lead for operational teams		
COM A4	There are many care providers in the region and greater intelligence on their services will enable timely action to take place.	For NCC to have detailed intelligence in place for each provider to support efficient sourcing of care and prompt hospital discharges. To include: • Availability of beds and prices (if not accepting NCC rates) • Mobile contact details for current assessor • Availability for accepting discharges	Update bed tracker to include this information requirement; Trusted assessors to help compile local intelligence.	October 2018	Bed Tracker due to be launched 30 October for care and nursing homes across Norfolk and Waveney; all required outcomes achieved; vacancy report to be shared with brokerage teams in CCGs; engagement planned throughout Winter to secure providers use the tool.
COM A5	Lack of availability of equipment is causing delays in discharge from acute hospitals.	Access to equipment will be facilitated so that delays waiting for equipment are minimised.	Same day deliveries made to acute hospitals over the Christmas period. Prescribers able to prescribe equipment for people going into care homes. NFS able to access peripheral stores and collect equipment from care homes.	December 2018	Setting up process for same day delivery around seasonal Bank Holidays; new 'Equipment in Care Homes' process in development; working with Peripheral Stores and Providers to improve resilience and communications.
COM A6	EHSS is benefiting the system, further work is required to ensure up-take of current capacity and strong links to admission avoidance teams.	For EHSS to support admission avoidance work and ensure that the service capacity is utilised to support step down referrals.	Continue to promote the EHSS Service and ensure that the service is used to its full capacity. Continue to simplify and streamline EHSS systems including the referral process.	November 2018	Engagement work with acute social work teams, Brokerage Service and other operational teams underway and ongoing; planning underway to simplify EHSS community and referral process.
COM A7	NFS are holding packages of care. This is using capacity which could be used to avoid admissions, avoid DTOC and reduce amount of long term care being commissioned.	For commissioners to review unmet needs list and find solutions to areas of unmet need working in tandem with NFS.	To reduce holding list so that unmet needs are resolved within seven days per locality	November 2018	Unmet needs list has validated so now have clarity on where 'real' unmet needs are.
COM A8	NFS is not fully established.	For NFS to be fully established, including the additional 15% and BCU staffing.	Recruit to establishment.	October 2018	Northern and Southern SCS teams brought into NFS team to meet immediate demand; recruitment campaign underway to meet future demand; currently working on establishing a career pathway and introducing an apprenticeship framework.

Appendix 1 – Domiciliary, Residential and Nursing Capacity across Norfolk

Provider Type	Number of Providers Across the County	Number of Hours/Beds	Notes
Domiciliary Care		Approx. 63,000 hours per week across the county	
Residential/Nursing Care	**Norfolk:** 362 Homes 299 Residential 63 Nursing **East:** 47 Homes 38 Residential 9 Nursing **Central (North/Norwich/South)** 258 Homes 212 Residential 46 Nursing **West** 57 Homes 49 Residential 8 Nursing	**Norfolk:** 9,655 Beds 6,911 Residential 2,744 Nursing **East:** 1,014 Beds 767 Residential 247 Nursing **Central (North/Norwich/South)** 6,855 Beds 4,812 Residential 2,043 Nursing **West** 1,786 Beds 1,332 Residential 454 Nursing	Nursing = home is registered for nursing, estimate is that c.50-60% of beds only are "nursing" beds in these homes Geographic area = CCG derived, Norfolk only

Report title:	**Homes and Health**
Date of meeting:	**31st October 2018**
Sponsor:	**Louise Smith (Director of Public Health) on behalf of the Health and Wellbeing Board District Councils' Group**

Reason for the Report

This report confirms the creation of the District Councils' Sub Committee of the Board. It also confirms that its priority in the first year will be homes and health.

Report summary

The homes in which people live are key factors in health and wellbeing. This can include the physical impact in terms of warmth, damp, hazards etc. and wider impacts affected by security of tenure, affordability, space etc.

There have been two meetings of the sub committee of all seven district councils alongside Public Health, Integrated Commissioning and the Chair of the Health and Wellbeing Board. Homes and Health is an agreed priority with three key areas of activity:

1. Warm and healthy homes
2. Building housing interventions into multi-disciplinary teams (MDTs), and
3. Improved discharge from hospital

These areas of work fit with all three priorities of the new Joint Health and Wellbeing Strategy (JHWBS): prevention, reducing inequalities and increasing integration. They also fit the priorities of the STP Prevention workstream.

This builds upon existing work and cross-partner opportunities to overcome barriers to better working. There would be further reports back to Board on delivery of an agreed action plan. This report asks partners to commit to these priority areas.

Recommendations

The Board is asked to agree:

1. This Group is **formally established as the District Council's Sub Committee** of the Health and Wellbeing Board, with a view to meeting at least twice a year
2. That this Sub Committee **prioritises homes and health for 2019** and reviews the position at the end of the first year, ahead of planning for winter 2019
3. To focus on **three priority areas** and support cross partner working on:
   - **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. Background

1.1 This approach supports the Joint Health and Wellbeing Strategy agreed in July 2018 and aligns itself to tackling winter pressures via the STP Prevention work programme. It also builds on the work with district councils outlined in a HWB report in February 2017 highlighting the opportunities to maximise their preventative role and impact of their work within localities.

1.2 It also supports the Norfolk and Waveney STP whose governance was also reviewed and established five key workstreams including “Primary and community care” (which includes prevention) and “Acute transformation”

2. Joint Health and Wellbeing Strategy

2.1 The Joint Health and Wellbeing Strategy 2018-2022 was agreed at the last meeting and sets out the Health and Wellbeing Board’s vision of a single sustainable health, wellbeing and care system, with partners working together and using resources in the most effective way to prioritise prevention and support the most vulnerable.

2.2 The Strategy prioritises:

1. Prevention
2. Tackling Inequalities in Communities, and
3. Integrating Ways of Working

2.3 This work contributes toward all priority areas

3. Why homes and health?

3.1 The homes in which people live are key factors in health and wellbeing. This can have both physical health and broader well being impacts related to physical conditions in the home as well as security of tenure, affordability, space etc.

3.2 There are general challenges to meet the need for new and affordable housing. The vast majority of residents however will continue to live in homes which are already built. Consequently, activity to support better use of and improvements to current homes will have a positive effect on people’s health and well being

3.3 We know that in Norfolk for example:

- Around one in five homes were built before 1919
- Located primarily within the private rented and owner-occupied sector there are an estimated 60,000 “Category 1” hazards in people’s homes which represent direct risk to health and wellbeing. It is likely to cost an estimated £25M to correct these but could deliver savings across health and social care systems (see JSNA briefing)
- Fuel poverty is affected by property design, incomes and energy prices and can therefore occur across a range of tenure types and locations. Excess Winter Deaths are of particular concern in parts of the county and cold-related health risks affect already vulnerable groups and will result in demand for primary and secondary health services

4. Proposal

4.1 As outlined above recent discussions within this Group agreed Homes and Health as the priority for the current year. Particular focus will be upon:

1. Warm and healthy homes (led by Broadland DC)
2. Building housing interventions into multi-disciplinary teams (MDTs) (led by Adult Social Services), and
3. Improved discharge from hospital (led by South Norfolk DC)

1. Warm and Healthy Homes

4.2 *Promote existing initiatives such as messages to stay well in winter, providing energy and money saving advice and installing central heating systems to fuel poor households.*

Actions

- Housing and associated staff from district councils to attend flu clinics in 2018, provide information, signpost and facilitate referrals to District Council and other services across sectors
- Promote messages to reduce hospital admissions and tackle excess winter deaths
- Provide advice and first time central heating systems to help reduce bills, improve comfort and improve health outcomes for some of the most severe levels of fuel poverty in Norfolk supported by the investment of £3.1 from the Warm Homes Fund. Including:
    - Installation of 250 Oil/LPF boilers by February 2020
    - Installation of 150 Gas boilers by February 2020
    - Installation of 118 Air Source Heat Pumps by February 2020
- Continue to deliver welfare rights and debt advice services to those struggling to afford to pay their heating, lighting and other energy costs
- Provide a range of energy switch and save-style initiatives to enable residents to find cheaper energy suppliers. The current programme runs between October and November 2018

Outcomes

- Lower bills - supporting households to keep warm for less by moving away from expensive forms of heating
- Increased comfort and health – to provide fuel poor households with affordable central heating systems installed for the first time and consequent reduction in the need for health and social care interventions
- Reduced demand – fewer residents requiring primary or acute support arising from cold-affected health conditions.

Timeline

Short term ongoing targeted advice to vulnerable households and work with existing flu clinics. Delivery against the Warm and Healthy Homes rolling programme of activities over a two year period through to the winter of 2020/21.

Governance

A working group led by Broadland District Council has already been established to deliver the objectives of the Warm Homes Fund. This will report on progress to the District Directors' Group. It was agreed that there would be a review by the group in April 2019 to prompt and progress partnership engagement.

Risks

These include:

- Lack of or poor engagement by some partners
- The need to secure further efficiencies to the public sector
- Lack of opportunity to lever in future funding and build on the achievements made.

2. Integration with MDTs

4.3 *Build housing interventions into with Multi-Disciplinary Team activities and improve awareness of potential housing solutions to health and care needs*

Actions

4.4 Using £36,000 secured through Health Education England (HEE) a pilot using home improvement officers will offer housing and home safety support to MDT meetings across three district council areas. This will improve the knowledge and access that MDT professionals have of services from district councils and enable them to better spot signs which may require a housing solution.

- Overlaying data from public health, district councils and social care to target MDTs in three district areas (Kings Lynn, Broadland and South Norfolk) that indicate higher than expected levels of need
- Offer district council training session to identified MDTs and develop a countywide training opportunity where funds and resource allows
- Subject to resource co-locate home improvement officers within these MDTs to take on a caseload.

Outcomes

- District Council services integrated into health and social care winter delivery plans
- Shift from crisis support towards earlier identification of people with housing needs and earlier access to DFGs
- Better understanding of gaps in services and future role districts could play in supporting people in their own homes
- Reduction in emergency hospital admissions

Timeline

Key milestones include by November 2018:

- Identification of potential GP practices and MDTs based upon need and likely impact
- Locate staff within MDTs

By March 2019:

- Roll out training aligned to HEE funding
- Develop a business case for ongoing integration subject to evaluation

Governance

4.5 All three pilot district council areas to report into District Directors' group as well as the Norfolk and Waveney Healthy Ageing Steering Group

which will be responsible for the development of the frailty training package

Risks

- Co-ordinating and not replicating other projects already working in this area.
- Managing expectation that this is not to work with people with severe conditions
- Effective targeting of resources

3. Discharge from hospital

4.6 *Establish a sustainable model and to extend the district offer to include discharge from mental health and community hospitals*

Actions

4.7 Review current activity across the three acute trusts with an aspiration to have a single model and seek common interventions across all the hospitals:

- Working in partnership with Norfolk & Norwich University Hospital to update the processes for hospital discharge to ensure residents can return home or access suitable alternative accommodation prior to discharge from hospital
- Kings Lynn & West Norfolk Borough Council are funding a 12-month pilot at the Queen Elizabeth Hospital Trust using the District Direct model as a proof of concept.
- Healthy Homes Assistance which undertakes works to a patient's property to facilitate safe hospital discharge or to prevent admission to the James Paget hospital.
- Explore how discharge from mental health and community hospitals can be improved by understanding the barriers and resource requirements to support a reduction in out of area placements.
- Collate data and evaluate results from pilots for stakeholders to consider options for future sustainability.

Outcomes

- Reduction in delayed discharge
- Fewer re-admissions
- Delayed need for residential care or moves to care homes

Timeline

Activity	Dates
Initial NNUH pilot	September 2017 – March 2018
NNUH project funded	August 2018 – August 2019
Queen Elizabeth Hospital	August 2018 – August 2019

Governance

4.8 Governance of the hospital discharge projects to be embedded within the Integrated Housing Adaptations Strategic Board.

Risks

- Identifying future sustainable funding
- Seeking agreement on the measures that demonstrate successful interventions

Lack of suitable supported accommodation

Action Plan

4.9 A high level action plan has been drafted (see **Appendix 1**). This will be developed in greater detail under the leadership of the District Directors' Group.

Officer Contact

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

Diane Steiner 01603 638417 Diane.steiner@norfolk.gov.uk

IN TRAN communication for all

If you need this Report in large print, audio, Braille, alternative format or in a different language please contact 0344 800 8020 or 0344 800 8011 (textphone) and we will do our best to help.

Appendix 1 – Action Plan 31st October 2018

Theme – warm and healthy homes – Matthew Cross, 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
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	Current programme runs to Nov 18
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
Theme – integrated working with MDTs – lead officer TBC			
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
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
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
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

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

Theme – discharge from hospital – Jamie Sutterby, 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
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
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