# Health & Wellbeing Board

Date: **Wednesday 13 February 2019**
Time: **9:15 am**
Venue: **Edwards room, County Hall**

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

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

# Health & Wellbeing Board
# Agenda

## Time: 9:15am to 10:45am

| | | | |
|---|---|---|---|
| 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)<br>Deadline for questions: **9am, Monday 11 February 2019** | Chair | |
| 7 | Our Joint Health and Wellbeing Strategy – implementation planning | Chris Butwright | (Page 39) |
| 8 | NHS 10 Year Plan - Briefing | Louise Smith / Linda Bainton | (Page 43) |
| 9 | Norfolk & Waveney Sustainability and Transformation Partnership (STP) - Update, including integrating heath and care services | Patricia Hewitt/ Melanie Craig | (Page 53) |
| 10 | CCGs Annual Reports 2018/19 – Draft extracts relating to the Joint Health & Wellbeing Strategy | Tracy Williams | (Page 59) |
| 11 | Autism:<br>a) Access to health and social care services for Norfolk Families with Autism (**presentation only**) | David Trevanion/ Stephanie Tuvey | |
| | b) All Age Autism Strategy – update | James Bullion/ Tracey Walton | ***To Follow*** |
| 12 | Prevention Concordat for better Mental Health | Louise Smith/ Sally Hughes | (Page 73) |

**Information updates**

- **Further information about the Health and Wellbeing Board** – can be found on our website at: About the Health and Wellbeing Board
- **Healthwatch Norfolk** – the report on 'Access to health and social care services for Norfolk Families with Autism- at this link: HWN Project Report 2018
- **Norfolk Health Overview & Scrutiny Committee (NHOSC):** Agenda papers relating to items on the HWB agenda include: Children's autism services (central & west Norfolk) – assessment and diagnosis (Jan 2018, Item 7)

**Health and Wellbeing Board**
**Minutes of the meeting held on 31 October 2018 at 11am**
**in the Council Chamber, County Hall.**

| **Present:** | **Representing:** |
|---|---|
| Cllr Bill Borrett (Chairman) | Adult Social Care Committee, Norfolk County Council |
| James Bullion | Adult Social Services, Norfolk County Council |
| Cllr Elizabeth Nockolds | Borough Council of King's Lynn & West Norfolk |
| Cllr Paul Claussen | Breckland District Council |
| Cllr Roger Foulger | Broadland District Council |
| Sara Tough | Children's Services, Norfolk County Council |
| Dr Louise Smith | Director of Public Health, Norfolk County Council |
| David Edwards | Healthwatch Norfolk |
| Dr Liam Stevens | NHS Great Yarmouth & Waveney Clinical Commissioning Group (CCG) |
| Melanie Craig | NHS Great Yarmouth & Waveney CCG *and* Sustainability & Transformation Partnership (Executive Lead) |
| Tracy Williams (CCG Vice-Chair) | NHS Norwich CCG |
| Dr Anoop Dhesi | NHS North Norfolk CCG |
| Dr Hilary Byrne | NHS South Norfolk CCG |
| Dr Paul Williams | NHS West Norfolk CCG |
| Supt Chris Balmer | Norfolk Constabulary |
| Cllr David Bills | Norfolk County Council |
| Dr Wendy Thomson | Norfolk County Council |
| Cllr Maggie Prior | North Norfolk District Council |
| Cllr Matthew Packer | Norwich City Council |
| Cllr Yvonne Bendle (District Council Vice-Chair) | South Norfolk District Council |
| Rt Hon Patricia Hewitt | Sustainability & Transformation Partnership (Chair) |
| Dan Mobbs | Voluntary Sector Representative |
| Alan Hopley | Voluntary Sector Representative |
| Cllr Alison Cackett | Waveney District Council |

| **Invitees Present:** | **Representing:** |
|---|---|
| Jonathan Williams | East Coast Community Healthcare CIC (Community Interest Company) |
| Dr Sanjay Kaushal | Norfolk Independent Care |
| Gary Page | Norfolk & Suffolk NHS Foundation Trust |
| Cursty Pepper | Norfolk & Norwich University Hospital NHS Trust |

| **Officers Present:** | |
|---|---|
| Hollie Adams | Clerk |
| Linda Bainton | Senior Planning & Partnerships Officer, Public Health, Norfolk County Council |
| Mark Burgis | Winter Room Director, NHS |
| Chris Butwright | Head of Performance & Delivery, Public Health |
| Suzanne Meredith | Deputy Director of Public Health (Healthcare Services) |
| Jamie Sutterby | Director of Communities & Wellbeing, South Norfolk Council |

## 1. Apologies

1.1 Apologies were received from Christine Allen, Mark Davies (Cursty Pepper substituting), ACC Nick Davison (Supt Chris Balmer substituting), Jon Green, Lorne Green, Antek Lejk (Gary Page substituting), Paul Martin, Cllr Mary Rudd (Cllr Alison Cackett substituting), Jo Smithson, Elly Wilson Wickenden (Alan Hopley substituting), Cllr C Walker and John Webster.

1.2 Also absent were: Cllr S Dark, Simon Evans-Evans and Frank Sims.

## 2. Chairman's Opening Remarks

2.1 The Chairman welcomed new members Stuart Dark, David Edwards, Frank Sims, Cllr Alison Cackett, new voluntary and community sector representatives Paul Martin and Elly Wilson Wickenden, and Alan Hopley who was present substituting for Elly Wilson Wickenden.

2.2 The Chairman updated the Board on

- Changes to the County Council's Constitution considered by the Constitution Advisory Group in September and agreed by Full Council on 15 October 2018 to include a Waveney District Council representative (and substitute) and the Sustainability and Transformation Partnership Chair and Executive Lead as full Members of the Health and Wellbeing Board
- The Better Care Fund Quarter 2 submission which had been signed off by the Chair and Vice Chairs Group on behalf of the Board and submitted to NHS England
- The Annual Refresh 2018-19 of the Local Transformation Plan for Norfolk & Waveney (Children and Young People's Mental Health) which had been delegated to the Chair and Vice Chairs Group to consider before the 31 October 2018 deadline. In future, the CCGs' Joint Strategic Commissioning Committee would approve this before being brought to the Chair and Vice Chairs Group for sign off
- The Carers' Charter had been presented to Full Council in October 2018 and adopted with cross party support

## 3. Minutes

3.1 The minutes of the meeting held on the 17 July 2018 were agreed as an accurate record and signed by the Chairman.

## 4. Actions arising from minutes

4.1 The Chairman updated Members on matters discussed in the minutes of the 17 July 2018:

- Page 5, Paragraph 6.2: District Council Board Members and lead officers had worked on the impact of housing and homes on health and wellbeing, reported at item 9
- Page 8, Paragraph 9.4.6: The outcome of the Norfolk & Waveney Sustainability and Transformation Plan (STP) Capital Funding Bid Programme was expected in November
- Page 9, paragraph 10.8: Partners had taken the agreed Strategy to their organisations for formal sign up as shown in the report at item 7 of the agenda
- Page 9, paragraph 11.3: The All Age Autism Strategy was in development and would be brought to the Health and Wellbeing Board meeting on the 13 February 2019
- Page 11, paragraph 12.5: A Carers Strategy was being developed and would be brought to the Health and Wellbeing Board on 13 February 2019

## 5. Declarations of Interests

5.1 There were no declarations of interest.

## 6. Public Questions

6.1 One question and supplementary question were received and the answers circulated; see **appendix A.**

6.2 Questions received after the deadline for the meeting of the 17 July 2018 were responded

to outside of the forum of the meeting.

## 7. Our Joint Health and Wellbeing Strategy 2018-22

7.1 The Board received the report outlining the commitment by Health and Wellbeing Board (HWB) partners through formal sign-up to the Strategy, and next steps for implementation. Copies of the Joint Health and Wellbeing Strategy were circulated; see **appendix B.**

7.2 During discussion the following points were noted:

- David Edwards reported that the Healthwatch Norfolk Board agreed with the Strategy but felt more detail was needed on implementation. An implementation plan would be developed with partners and brought to a future Health and Wellbeing Board meeting. It was also noted that the Strategy was about bringing the system together, with organisations' existing strategies or plans.
- The next Health and Wellbeing Board workshop, due to be held on the 5 December 2018, would be the Annual Conference at which the Strategy would be launched to wider stakeholders; all HWB partners were asked to publicise the HWB Conference to their partner organisations
- The Chairman praised the high level of sign up to the Strategy as a success for the Health and Wellbeing Board, noting that the Norfolk & Norwich University Hospital and Queen Elizabeth Hospital were yet to sign up

7.3 The Health and Wellbeing Board:

1. **NOTED** the outcome of partner organisations' sign up to the Strategy
2. **AGREED** the next steps with implementation & **COMMITTED** 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 Health and Wellbeing Board brings
   - **Developing and agreeing an outcomes framework** - so we can monitor our progress towards achieving our priorities

## 8a. Norfolk & Waveney Sustainability and Transformation Partnership (STP): a) Update

8a.1.1 The Board discussed the report with an update on the Norfolk and Waveney Sustainability and Transformation Partnership (STP), focussing on progress of key pieces of work since the last report in July 2018.

8a.1.2 Rt Hon Patricia Hewitt, STP Chair, introduced the report, highlighting that:

- In moving towards becoming an Integrated Care System (ICS) it was important to engage with a wider range of stakeholders, so work was being done to engage with the public via social media platforms and this would involve members of the public, patients and service users through focus groups and other means
- There were two immediate priorities identified which were:
  - to improve winter performance through the system working better together; and
  - to build a medium term financial plan, looking across the whole system and considering any staff and patient time wasted due to fragmentation.

8a.2 Melanie Craig, STP Executive Lead, highlighted the engagement around the Mental Health Review and confirmed that events were being held for the public and patients to enable people to make their views known. The events would be held on the 7, 14 and 19 November 2018 and the STP executive Lead asked for details of these events to be publicised widely. [The news release with details of the events was sent to HWB partners immediately following the meeting].

During discussion the following points were noted:

- The good and outstanding ratings for cancer care across Norfolk and Waveney were highlighted
- Board members welcomed the system wide approach to the work underway, both in terms of commissioning for the future and, for example, in looking at workforce in the round. The importance of harnessing the work of the voluntary sector in mental health and other areas was discussed and it was noted that the mental health review was co-led by representatives of the two voluntary sector infrastructure groups.
- District Councils highlighted some of the work they were doing, for example winter homes projects which help mitigate against winter conditions and work on adaptations of care and reablement, and asked that District Councils are involved in future system-wide discussions

8a.3 The Health and Wellbeing Board

1. **CONSIDERED** and **COMMENTED** on the report
2. Agreed to **IDENTIFY** actions that the Health & Wellbeing Board/member organisations could take to speed up progress on delivering the changes necessary to deliver sustainable services
3. **SUPPORTED** the engagement around the mental health review

**8b. Norfolk & Waveney Sustainability and Transformation Partnership (STP): b) Winter Planning; Urgent & Emergency Care**

8b.1.1 The Board considered the report containing an update on the focus and work of the STP Urgent and Emergency (UEC) workstream focussed on winter planning and resilience.

8b.1.2 Copies of the draft Winter Resilience booklet were circulated; see **appendix C.** Mark Burgis, Winter Room Director, introduced the report:

- Winter preparation was being planned by looking at how the service could be set up to manage pressures
- £3m funding received from the NHS had been invested in areas which had been weaker in previous years and where a difference could be made
- Available workforce could be an issue in some areas; it was important to keep staff safe and well over winter
- Effective communication on how the service would be made more resilient over winter was key, as a “help us to help you keep well” approach was being taken with the public

8b.2 During discussion the following points were noted:

- It was suggested that the booklet should contain information on the relevant work of the District Councils and links to related websites. Mark Burgis **agreed** to take this suggestion on board
- Due to the distance from and availability of minor injuries units in some areas it was suggested it would be helpful for information to be advertised over social media; Mark Burgis **agreed** to take this suggestion away to consider as part of the social media strategy work
- Whilst the approach to winter planning was a positive step forward, it was important to bear in mind that services were under pressure all year round
- Members were assured that evaluation would be a key part of the winter plan for 2018-19
- Mark Burgis **agreed** to discuss engagement with the wider voluntary sector with the HWB VCSE representatives outside of the meeting.
- The Director of Public Health, Norfolk County Council, reported that an unexplained national spike in deaths was seen in 2015-16 and that it was thought these were linked

to cold snaps, triggering strokes and heart attacks, and to circulating flu. Excess winter deaths was something that the system could decide to measure itself by.

8b.3 The Health and Wellbeing Board **NOTED** and **COMMENTED** on the operational and transformation work that was underway to manage the STP-wide operational plans, to provide system coordination and improved grip.

**8c. Norfolk and Waveney Sustainability and Transformation Partnership: c) Prevention Winter Plan**

8c.1 The Board considered the report setting out the top 5 priorities of the Sustainability & Transformation Partnership (STP) Prevention workstream focussing on system delivery outcomes for winter system sustainability and seeking commitment from the Health and Wellbeing Board to support and contribute to them.

8c.2 During discussion the following points were noted:

- The Chairman felt the report was very focussed, showing key areas for action
- In relation to the priorities around housing & homes and social prescribing, it would be helpful to use the learning from this winter to identify investment priorities for 2019-20
- The Board noted that embedding next steps in locality areas would be most effective if more GPs could be involved in the prevention workstream
- Facebook was discussed as a good forum for advertising prevention strategies and helping people to understand them; work was planned with community pharmacies to take this forward also
- It was also noted that there had been a successful Twitter flu jab campaign run in West Norfolk West Norfolk CCG.

8c.3 The Health and Wellbeing Board **SUPPORTED** the 'Top 5 for prevention' priorities developed by the STP Prevention workstream

**8d. Norfolk & Waveney Sustainability and Transformation Partnership (STP): d) Adult Social Care Winter Plan**

8d.1.1 The Committee received the report detailing the Norfolk Adult Social Services winter plan which set out the department's arrangements for the winter period 2018-19.

8d.1.2 The Executive Director of Adult Social Care, introduced the report highlighting that:

- In the October 2018 budget announcement, the £4.1m government fund for 2018-19 had been confirmed to continue for a further year
- A senior manager had been appointed across our system who will work with the Winter Room Director
- A bed tracker was in place covering Norfolk and Waveney
- By joining with the voluntary sector, the level of staff vacancies across the service could be minimised; with extension of the fund, this work could be continued for a further year

8d.2 During discussion the following points were noted:

- The huge efforts of our staff in winter and the need to celebrate this more
- Voluntary Sector representatives were keen to see a greater emphasis on poverty in the winter plan and discussed concern about the impact of universal credit
- The Chairman took on board comments about sustaining winter planning through the summer and **agreed** to discuss the voluntary sector concerns outside of the meeting

8d.3 The Health and Wellbeing Board **AGREED** the Adult Social Services Winter Plan

## 9. Homes and Health

9.1.1 The Board considered the report confirming the creation of the District Councils' Sub Committee of the Board and its priority in the first year, homes and health.

9.1.2 Vice-Chair Cllr Bendle introduced the report and work done in districts to support people during the winter; Jamie Sutterby, Director of Communities and Wellbeing, South Norfolk Council gave a presentation to the board; see **appendix D.**

9.2 During discussion the following points were noted:

- District Council representatives welcomed the opportunity to formalise the work they were doing around this as well as the opportunities to help improve their services
- The issue of homelessness and the impact this workstream could have on it
- The importance of having both short term and long-term priorities
- The Chairman commented on the significant role the District Councils played in the health, care and wellbeing system and was keen for the work of this sub-committee to continue.

9.3 The Health and Wellbeing Board **AGREED**

1. That this Group was **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 Multi-Disciplinary Teams 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 & sustainable model and to extend the district offer to include discharge from mental health and community hospitals

## 10. Any Other Business

10.1 The Health and Wellbeing Board Annual Conference was due to be held on the 5 December at the Kings Centre in Norwich; Professor Sir Nicholas Black would be giving the key note speech on this new era for health and care systems - focusing on relationships and releasing creativity.

10.2 The next Health & Wellbeing Board meeting and how systems worked across health and social care was arranged for Wednesday 13 February 2019.

The Meeting Closed at 12.17

**Bill Borrett, Chairman,**
**Health and Wellbeing Board**

# 5. PUBLIC QUESTIONS TO HEALTH AND WELLBEING BOARD: WEDNESDAY 31 OCTOBER 2018

## 5.1 Question from Mrs S Vaughan

The consultation that closed on 26th October about the proposed ICP contract says that “An Integated Care Provider will not be right for every area”, page 16, easy read version. Assuming that this is accurate, what features of Norfolk and Waveney footprint make NHSE think we will be suitable and what factors would make an ICP the wrong way to go?

### Response from Chairman of Health and Wellbeing Board

NHS England have said they don’t think that Integrated Care Provider (ICP) contracts will be right for every area. They explain that they’ve created the ICP contract in response to “the demand in some areas for a single contract through which general practice, wider NHS and in some cases, some local authority services can be commissioned from a ‘lead’ provider organisation, responsible for delivering integration of services”. ICPs are not a new type of legal entity, but rather provider organisations which have been awarded ICP contracts.

It will be up to us, as a partnership of local health and care organisations, to assess whether this is a contract which we might want to use in Norfolk and Waveney. We will be able to decide this once NHS England has published the final version of the contract, taking into account all the feedback it received during the consultation.

At the moment the Norfolk and Waveney Sustainability and Transformation Partnership (STP) is working towards becoming an Integrated Care System (ICS), because we believe that this will accelerate the improvement in our health and care system. Becoming an ICS would mean formalising how we work together and building on what we are already doing, but it does not require us to commission using an ICP contract.

### Supplementary question from Mrs S Vaughan

Item 5 of the Update on the Norfolk and Waveney Sustainability and Transformation Partnership (October2016) also refers to "engagement with the public, staff, voluntary and community sector and other stakeholders in the development of our integrated care system". How is this being done?

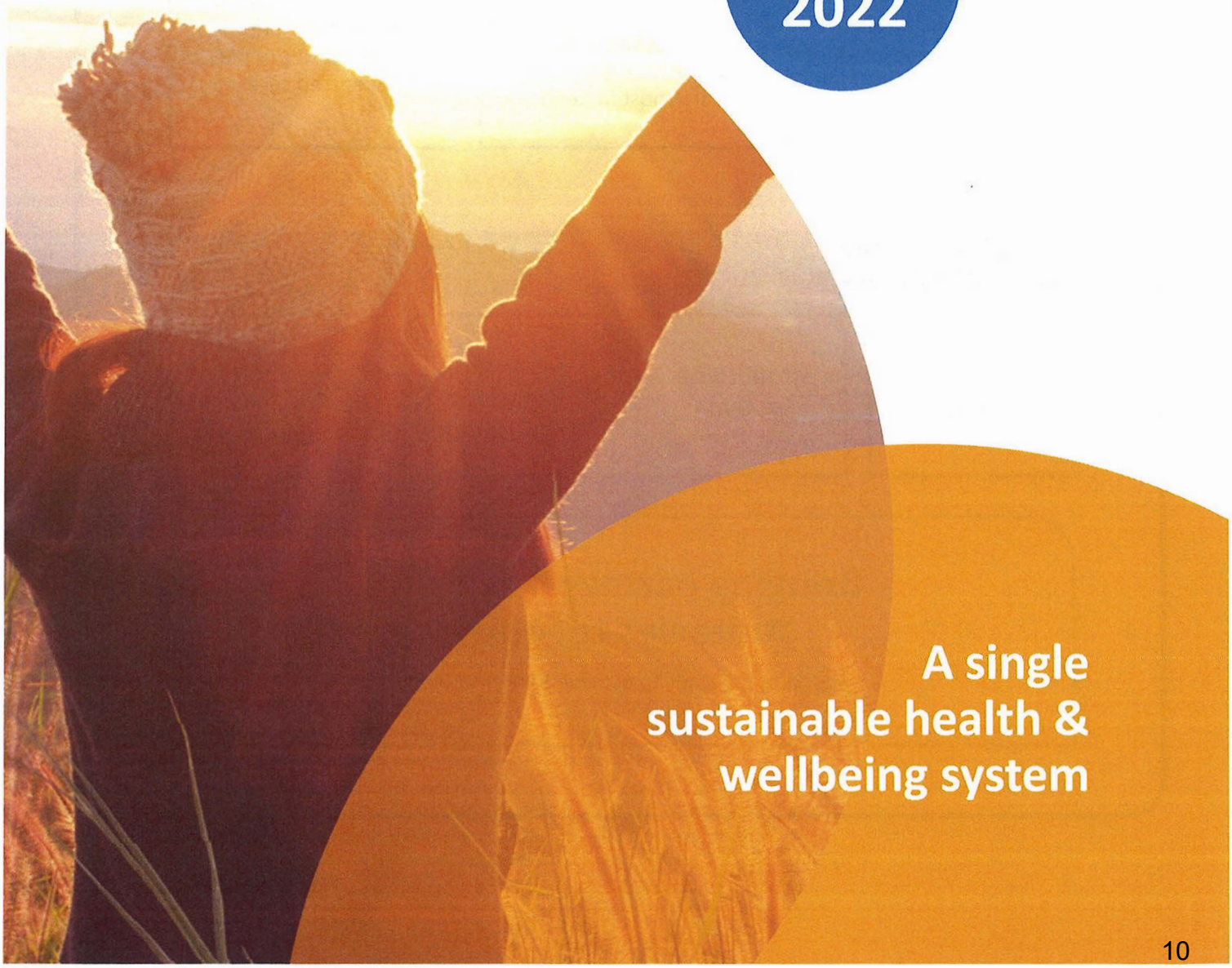
### Response from Chairman of Health and Wellbeing Board

We are organising a programme of engagement for the autumn and winter to develop our integrated care system. This started off with an event in mid-October for non-executive directors of provider boards, lay members and GP leads from CCG governing bodies and councillors. We’re now having discussions with CCG governing bodies, provider boards, the Norfolk Health and Wellbeing Board and the Sector Leadership Group for the voluntary, community and social enterprise sector (VCSE). The purpose of our engagement is to make sure we have a shared understanding of what an integrated care system is, and is not, and to talk about what becoming an ICS could mean for Norfolk and Waveney. We are continuing to develop our engagement plans, which will include further VCSE and stakeholder events, attending existing forums of local groups and opportunities for the public to have their say too, details of which will be publicised shortly.

Health and Wellbeing Board
Norfolk & Waveney

# Joint Health & Wellbeing Strategy

2018 – 2022



# Our Strategic Framework

Health and Wellbeing Board
Norfolk & Waveney

## Our Vision

### A Single Sustainable System

Working together we will use our resources in the most effective way to prioritise prevention and support to the most vulnerable

## Our Priorities

**Prioritising Prevention**
Supporting people to be healthy, independent and resilient

**Tackling Inequalities in Communities**
Providing most support for those who are most in need

**Integrating Ways of Working**
Collaborating in the delivery of people centred care

## Our Values

- Collectively Accountable
- Simplifying Systems
- Promoting Engagement & Involvement
- Based on Evidence of Needs

### Bringing partners' existing strategies together

Working together to achieve joint outcomes

# Welcome

We are delighted to introduce our **Joint Health and Wellbeing Strategy 2018-22: A single sustainable health and social care system** for the people and communities in Norfolk and Waveney.

This Strategy is **different** - it's about **how we all work together** as system leaders to drive forward improvement in the health and wellbeing of people and communities, given the unprecedented challenges facing our health, care and wellbeing system.

Health and care services across the country are under **considerable financial strain** - and Norfolk and Waveney is no exception. There is a significantly large total annual budget for health and social care services in Norfolk and Waveney, but with growing demand our budget spend continues to increase leading to over-spend which needs to be addressed.

At the same time, our **population continues to grow**, and the pattern of family life has changed. **People are living longer** and have access to many more medical specialists than in the past. **Families are under increasing pressure**, and society's concern for children's and adults' safety has placed additional responsibilities for ensuring their protection.

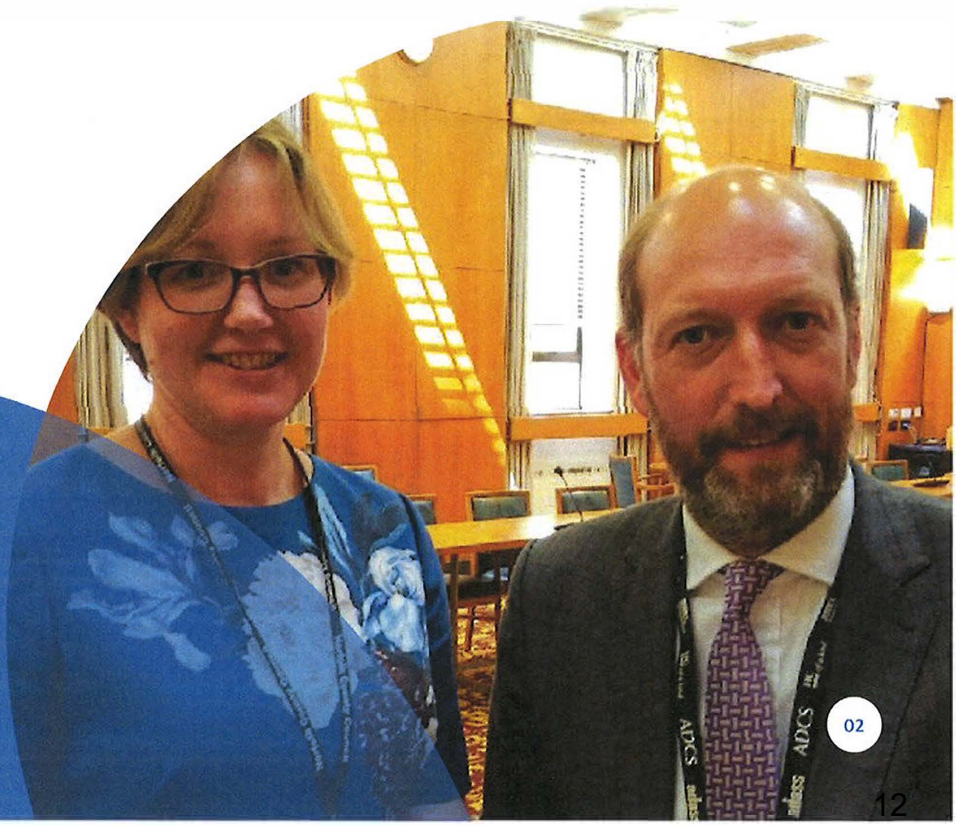
The health and social care system is working together under the **Norfolk and Waveney Sustainability & Transformation Partnership** and underpins support for the move towards an **integrated care system** from the Health & Wellbeing Board for Norfolk and Waveney.

This Strategy builds on that **collaborative mandate - our top priority is a sustainable system** and we are evolving our longer-term priorities from our previous Joint Health & Wellbeing Strategy to help us face the challenges of the future. **Prevention and early intervention is critical** to the long term sustainability of our health and wellbeing system. Stopping ill health and care needs happening in the first place and targeting high risk groups, as well as preventing things from getting worse through systematic planning and proactive management. Through our Strategy, we are focusing the whole system on **prioritising prevention, tackling health inequalities in our communities and integrating our ways of working** in delivering people centred care.

**Dr Louise Smith**
Director of Public Health

**Cllr Bill Borrett**
Chairman of the Health and Wellbeing Board

**Through our Strategy, we are making a difference – creating a single sustainable health and wellbeing system for Norfolk and Waveney.**



# 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. |
| Simplifying Systems | Reducing duplication and inefficiency with fewer organisations - a commitment to joint commissioning and simpler contracting and payment mechanisms. |
| Promoting Engagement and Involvement | 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 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 to address wider factors that impact on health and wellbeing. |
| 4 Integrating 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. |

# 1 A Single Sustainable System

**Working together we will use our resources in the most effective way to prioritise prevention and support to the most vulnerable.**

## Our Population

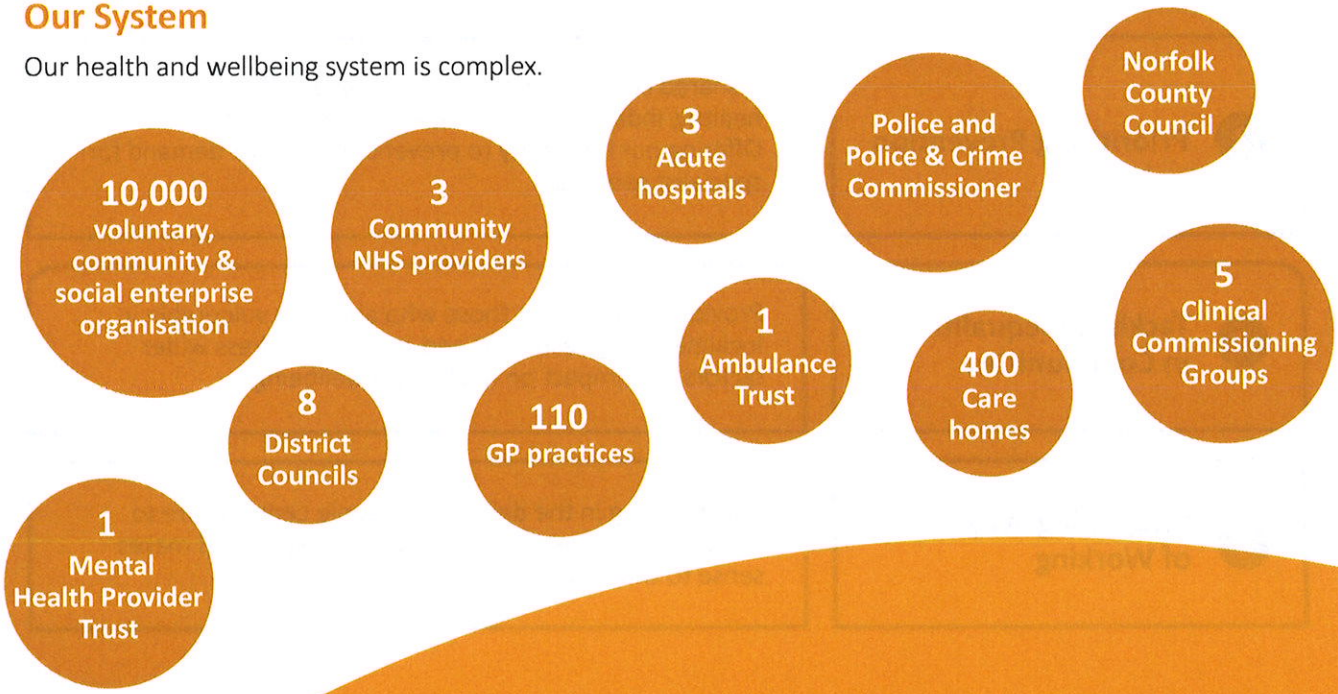
Norfolk and Waveney's population of 1.01 million is forecast to increase by over 10% by 2037, about 120,000 people.

The main population growth will be people aged 65+ years. Life expectancy is 80 years for men and 84 years for women.

Currently 90% of retirement age people are economically inactive. By 2037 this is forecast to be 1 in 3 of the population.

## Our System

Our health and wellbeing system is complex.




## Future Activity

**Planning future services is challenging with increasing demand and needs alongside reducing or level budgets.**

**What has happened between 2011 and 2016**

Median age for emergency admissions has increased from 62 to 64

- Births from 10,600 to 10,200 per year
- 20% A&E attendances from about 204,000 to 245,000
- A&E ambulance arrival from 63,000 to 82,000
- 12% Emergency admissions from 90,000 to 101,000
- 12% Average ordinary admission from about 34,800 to 30,500
- 26% Day case admissions from 125,400 to 158,600
- 10% 10,300 to 11,400 in 2016

**What is likely to happen between 2016 and 2022**

- Births remained about the same 10,200 per year
- 27% A&E attendances from about 245,000 to 313,000
- 28% A&E ambulance arrival from 82,000 to 105,000
- 24% Emergency admissions from 101,000 to 125,000
- 15% Average ordinary admission from about 30,500 to 26,000
- 41% Day case admissions from 158,600 to 224,100
- Deaths will remain about the same 11,500 per year

# 1 A Single Sustainable System - Actions

## What's important strategically?

Norfolk and Waveney has an annual budget in excess of £1.5bn for health and social care services. However as a system we are seeing increasing demand resulting in budget pressures.

Needs are becoming increasingly complex and so our service improvements must be more co-ordinated and effective for the service user and their carer.

Services are improved where there is a coordinated, effective and seamless response.

### Key Challenges

- Addressing needs with all partners managing on reducing or level budgets.
- Working as a single system in the delivery of people centred care, across a complex organisational and service delivery landscape.
- Driving the cultural change necessary to deliver a single sustainable health and wellbeing system.

### Key Measures

**Each HWB organisation can clearly report to the HWB how they are:**

1. Contributing to financial sustainability and an integrated system.
2. Reviewing the impact of strategy and outcomes.
3. Using the evidence intelligently – including evidence from service users- in our discussions and our planning.
4. Working in partnership with others to support delivery of partners' transformation plans.

## Priority actions

**We will work together to lead change for an integrated financially sustainable system by:**

- Sharing our thinking, planning, opportunities and challenges – informing new ways of working and transformation.
- Engage with and listen to service users, residents and communities to inform our understanding and planning.
- Undertake needs assessments, including the JSNA, to help us keep our Strategy on track and understand its impact.
- Use partners' existing plans- building on the priorities partners are already working hard to address, identifying the added value that collaboration through the HWB's Strategy can bring.
- Develop mechanisms such as risk stratification tools and the sharing of information to target care where it is needed most.

# 1 A Single Sustainable System - Case Study

## Healthwatch Norfolk (HWN)

The development of the Pharmaceutical Needs Assessment (PNA) is a good illustration of collaborative working in Norfolk.

The Health and Wellbeing Board is responsible for publishing and updating the PNA which sets out the current pharmaceutical services available in Norfolk, identifies any gaps in services, and makes recommendations on future development.

Healthwatch Norfolk (HWN) were selected to coordinate and produce the PNA through a steering group of partners. A HWN survey to support the assessment resulted in over 2700 responses.

**Alex Stewart, Chief Executive of Healthwatch Norfolk, said:**

**"This has been the liveliest and most interactive Needs Assessment that HWN have been involved in to date and we have had pleasure in helping to ensure that the voice of the public and patients are represented in this process. A feeling of trust and sound working relationships built over time between several group members has enhanced the sense of achievement. Other additional benefits to this collaborative partnership approach has brought a cultural sensitivity to the PNA. Recommendations around translation services in pharmacies have identified possible cost savings with avoidance of potential adverse events."**

# 2 Prioritising Prevention

**Supporting people to be healthy, independent and resilient.**

## Children & Young People

About 283,300 under 25 year olds live in Norfolk and Waveney- this number is forecast to rise slightly.

The health and wellbeing of children is consistent with the England average, as are recorded levels of child development.

1 in 4 children are overweight by age 4 – 5.

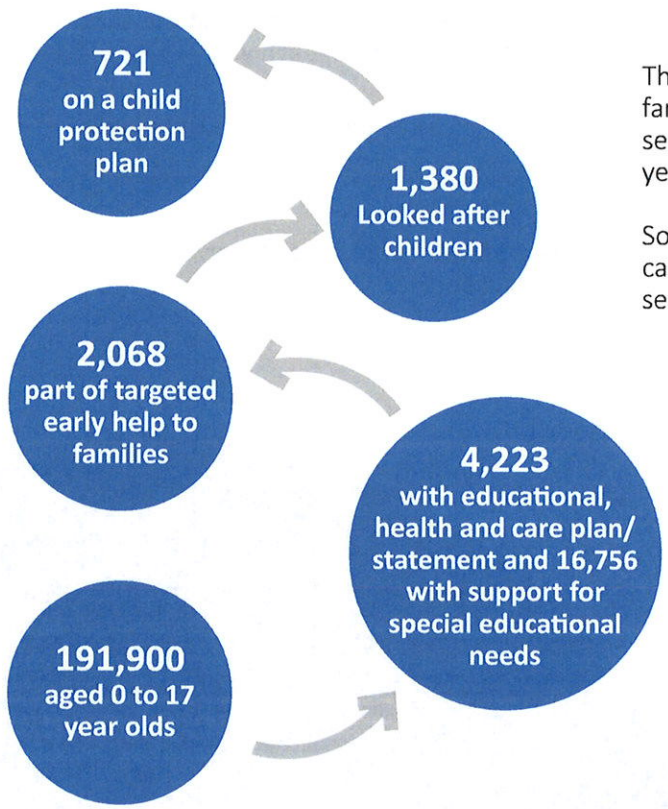
There are fewer teenage pregnancies but we remain above the England average in Great Yarmouth and Norwich.

1 in 7 women are smokers at the time of having a baby.

Levels of anxiety in young people are rising as are hospital admissions for self-harm.

1 in 7 children live in relative poverty.

| 2015 | | Change | 2025 |
|---|---|---|---|
| 54,200 | 0-4 | ↑ 1% | 54,700 |
| 74,400 | 5-11 | ↑ 6% | 78,700 |
| 73,400 | 12-18 | ↑ 12% | 82,500 |
| 81,300 | 19-25 | ↓ 10% | 73,500 |




The vast majority of children and families are supported by universal services such as health visiting, early years provision, schools and colleges.

Some children access additional social care and educational support and services based on their needs.

# 2 Prioritising Prevention

**Unhealthy lifestyles impact on our health outcomes and need for health services.**


## Healthy lifestyles and health services

### We are seeing demands on our hospital based services with:

- 10,900 smoking attributable hospital admissions in 2016/17.
- 8,911 hospital admissions where obesity was the main or secondary diagnosis.
- 6,020 hospital admissions for alcohol related conditions.
- 3,852 emergency hospital admissions due to falls in people aged 65 and over.

## Inequalities in healthy lifestyles

### If the most deprived areas had the same rates as other areas then each year we would see:

- 400 more children at a healthy weight.
- 1,000 fewer emergency admissions for older people.
- 60 fewer deaths due to preventable causes.

# 2 Prioritising Prevention - Actions

## What's important strategically?

There is strong evidence that interventions focussed on prevention are both effective and more affordable than just focussing on providing reactive emergency treatment and care. To build a financially sustainable system means we must promote healthy living, seek to minimise the impact of illness through early intervention, and support recovery, enablement and independence.

**Priority areas for prevention are:**

- Creating healthy environments for children and young people to thrive in resilient, safe families.
- Delivering appropriate early help services before crises occur.
- Helping people to look after themselves and make healthier lifestyle changes.

### Key Challenges

- Identifying and protecting investment in prevention within budgets.
- Identifying needs early and providing early access to support.
- Embedding prevention across all of our strategies and policies.
- Raising awareness of the impact of lifestyle on health, for example with diabetes.

### Key Measures

**Each HWB organisation can clearly report to the HWB how they are:**

1. Implementing an integrated strategy and a single system approach for children and young people where need is understood and priority actions shared.
2. Prioritising prevention both at a policy level and in decision-making.
3. Promoting the health and wellbeing of their workforce.

### Priority actions

**We will work together to lead change for an integrated financially sustainable system by:**

- Developing, in partnership, a systematic approach for children and young people's support and provision.
- Embedding prevention across all organisational strategies and policies.
- Providing joint accountability so that as a system we are preventing, reducing and delaying needs and associated costs.
- Promoting and supporting healthy lifestyles with our residents, service users and staff.

# 2 Prioritising Prevention - Case Study

## Early Help and Family Focus

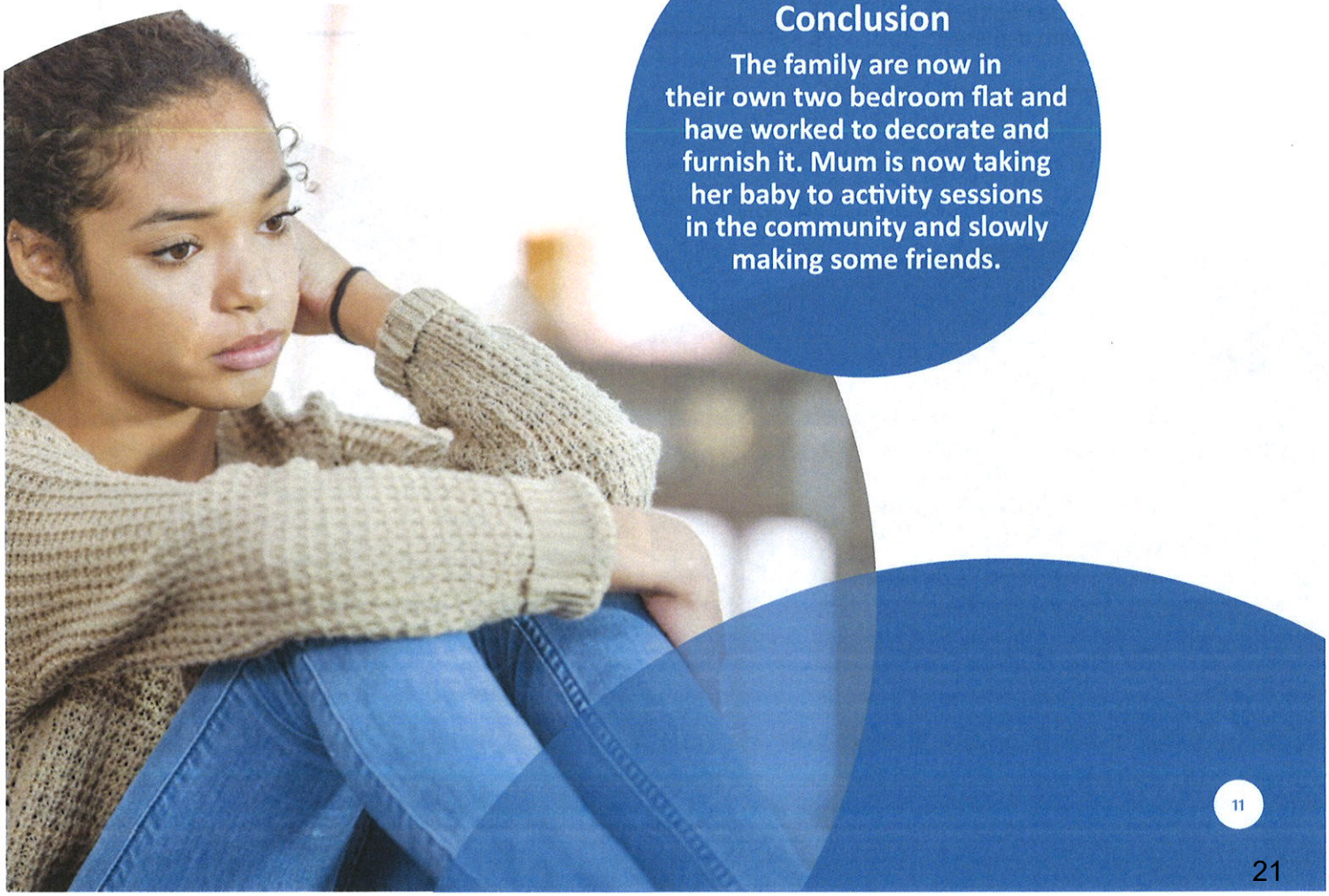
Early Help and Family Focus Broadland received a request for support for a young couple who had just had a baby and were homeless with no extended family support. The early help practitioner arranged a joint visit with the health visitor and talked with them about their worries and what was working well for them. (This is the Signs of Safety approach). The 'team around' the family then worked with the young parents to produce a plan which resulted in the following support:

## Who did what

The young parents met with the debt advisor from Broadland District Council who helped them understand how to plan a budget and manage their finances. A benefits advisor made sure they were claiming the correct benefits.

The Early Help practitioner supported the young parents to talk with each other and to understand both their own and each other's emotions - encouraging them to argue less.

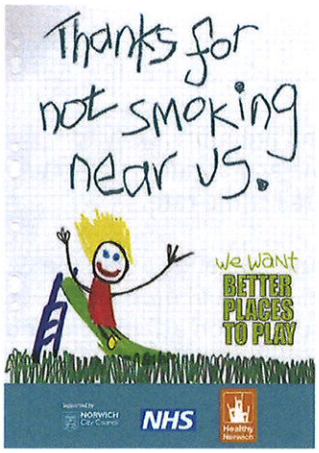
The Early Help practitioner worked with the health visitor to explain to the young parents how babies develop and what they need at the different stages of development.



**Conclusion**

**The family are now in their own two bedroom flat and have worked to decorate and furnish it. Mum is now taking her baby to activity sessions in the community and slowly making some friends.**

# 2 Prioritising Prevention - Case Study




## A Smoke Free Norfolk

**Healthy Norwich** is an example of an approach to improving health and wellbeing in the greater Norwich area by working together to make a healthier community.

**Smoke Free Park** signage has been placed in play areas to ask adults not to smoke nearby. This voluntary code will directly **help prevent children and young people taking up smoking** and potentially help smokers to **seek support to quit**.

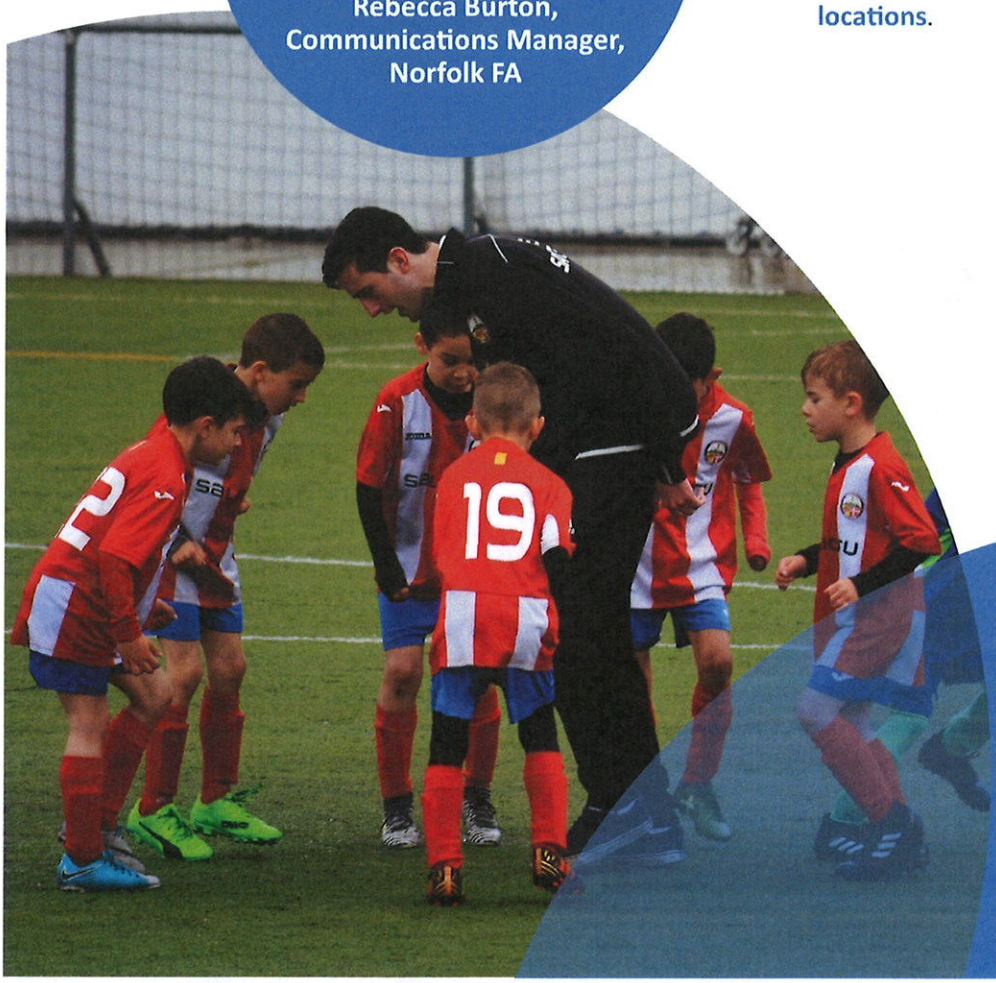
Smoke-free sport, including **#Smokefree Sidelines**, is backed by Norfolk Football Association (FA) where local youth football clubs are championing the message that smoking has no place in youth sport.

**"#Smokefreesidelines uses non-judgemental messaging and will encourage people to think twice before exposing young people to smoking. This will make the idea of smoking less normalised."**

**Rebecca Burton, Communications Manager, Norfolk FA**

As well as discouraging smoking, **Smoke Free Sport** brings about additional benefits including:

- **Protecting the environment** and saving money by reducing tobacco-related litter.
- Offering further protection from the **harmful effects of second-hand smoke**.
- Providing the opportunity for public acceptance of voluntary **smoke-free locations**.



# 3 Tackling Inequalities in Communities

**Providing most support for those who are most in need.**

## Deprivation

Norfolk has average levels of deprivation but an estimated 68,700 people live in the most deprived areas of England.

Norfolk and Waveney has a diverse population and deprivation can be experienced in both urban and rural settings.

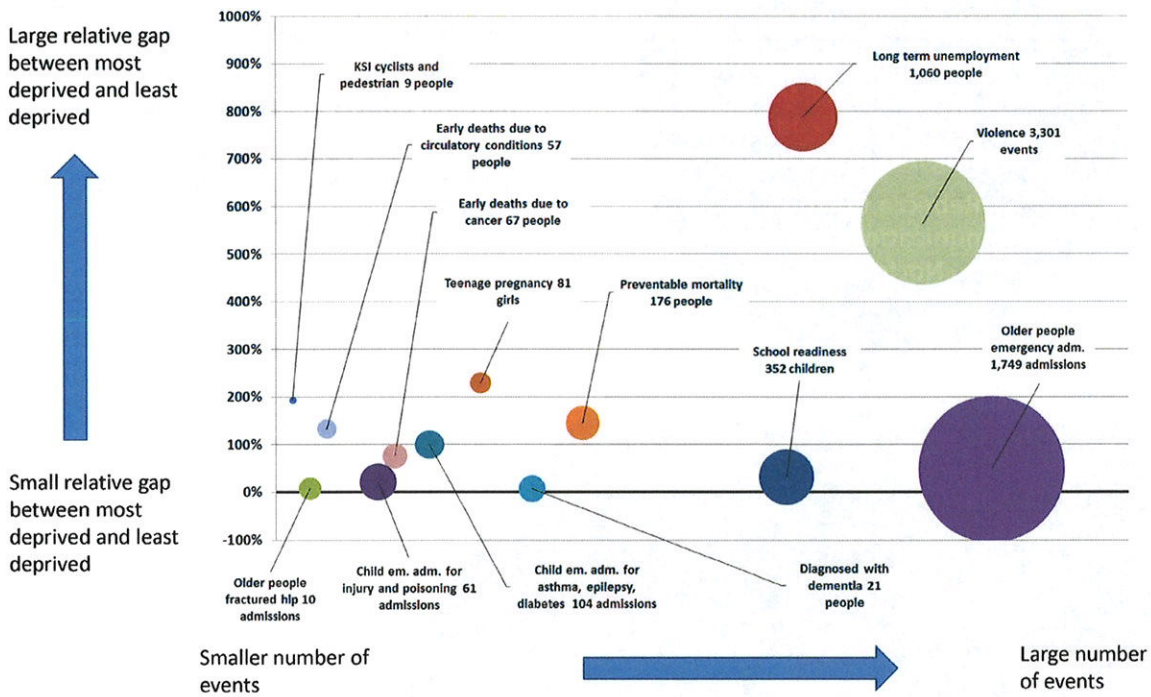
People living in deprivation are more likely to experience violence, crime and accidents despite Norfolk having a low overall crime rate.

Four districts in Norfolk and Waveney are in the lowest quintile in England for social mobility - driven by lower levels of education attainment and skill level.

## Inequalities and life expectancy

The difference in life expectancy gap between those living in the most deprived and the least deprived areas is about 7 years for men and 4.5 years for women.

People living in our 20% most deprived areas are more likely to smoke, have an unhealthy diet and be less active.




Preventable illness, violence, drug overdose, suicide and accidents outcomes do correlate with deprivation. For example, if the most deprived experienced the same rates as the least deprived there will be 3,301 fewer violent events per year.

# 3 Tackling Inequalities in Communities - Actions

## What's important strategically?

Those living in our most deprived communities experience more difficulties and poorer health outcomes. We recognise that together, we need to deliver effective interventions, to break the cycle, mobilise communities and ensure the most vulnerable children and adults are protected.

To be effective in delivering good population outcomes we need to most help those in most need and intervene by working together at county, local and community levels to tackle issues reflecting whole system priorities as well as specific concerns at the right scale.

Reducing inequalities in health and wellbeing will involve addressing wider issues that affect health, including housing, employment and crime, with community based approaches driven by councils, the voluntary sector, police, public sector employers and businesses.

### Key Challenges

- Identifying and ensuring access to services for those most vulnerable.
- Promoting healthy relationships in families and communities.
- Helping people out of poverty, particularly hidden rural poverty.

### Key Measures

**Each HWB organisation can clearly report to the HWB how they are:**

1. Promoting alignment and consistency in local delivery partnerships to plan for, and with, their local community.
2. Reducing the impact of crime, injuries and accidents in our most deprived areas.
3. Using source data available (including from the JSNA) to inform strategic plans.

### Priority actions

**We will commit to working together to build on the strengths in local communities, rural and urban, by:**

- Improving locality working and sharing best practice.
- Providing and using the evidence to address needs and inequalities.
- Addressing the impact of crime, violence and injuries.
- Joining up development planning by working with those with planning responsibilities.

# 3 Tackling Inequalities in Communities - Case Study

## Great Yarmouth - Neighbourhoods that work

Neighbourhoods that Work (NTW) is a partnership initiative led by Great Yarmouth Borough Council together with seven partner organisations. NTW aims to connect local communities to the benefits of economic growth by:

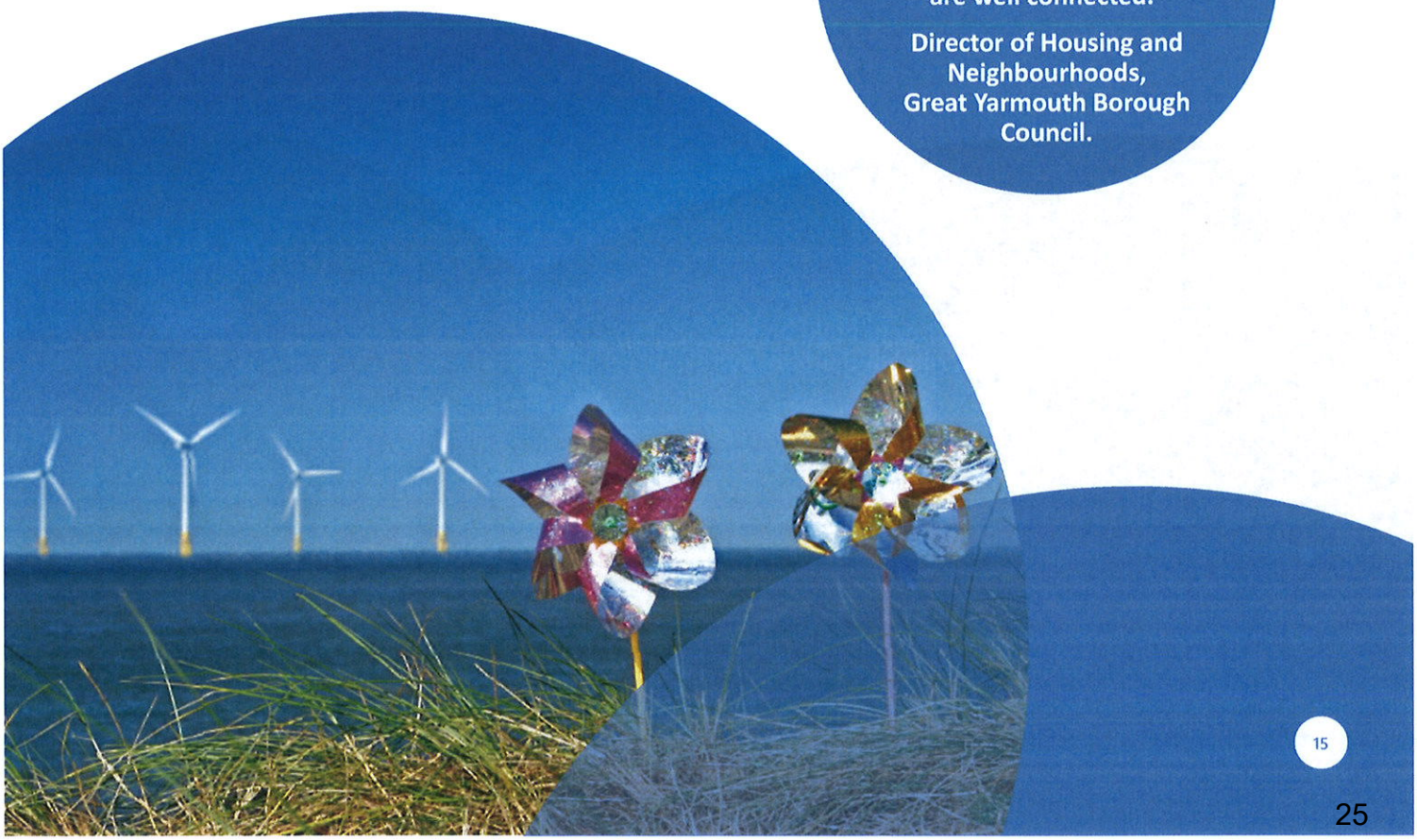
- **Increasing community resilience.**
- **Improving the responsiveness of voluntary sector support services.**
- **Increasing the participation of communities in driving forward sustainable economic development.**

The vision is to work with local residents to build stronger communities- focussing on people, neighbourhoods, and the things that matter most. Community Development approaches are used to work with local people in the places they live to identify and act upon things that matter most to communities.

The project builds upon 10+ years of work in Great Yarmouth building on existing and award winning community development infrastructure - incorporating engaged local residents, neighbourhood boards and a variety of diverse community and voluntary based organisations.

**"Our starting point is that communities are full of people who can provide the connections that make their neighbourhood stronger. People thrive in communities that are well connected."**

**Director of Housing and Neighbourhoods, Great Yarmouth Borough Council.**



# 3 Tackling Inequalities in Communities - Case Study

## Arts and Culture for health and wellbeing

**Collaboration between Norfolk's arts, culture, health and social care sectors** is well established with some major successes in attracting investment to deliver effective joint programmes.

Norfolk County Council's award-winning **Culture & Heritage, Communities, Information and Learning Services** including museums, libraries, archives, arts, community learning and sports play a key role in supporting local health and wellbeing priorities through the provision of: collaborative programmes; volunteering; learning and skills development; provision of welcoming and enriching spaces and professional development for arts, health and social care professionals.

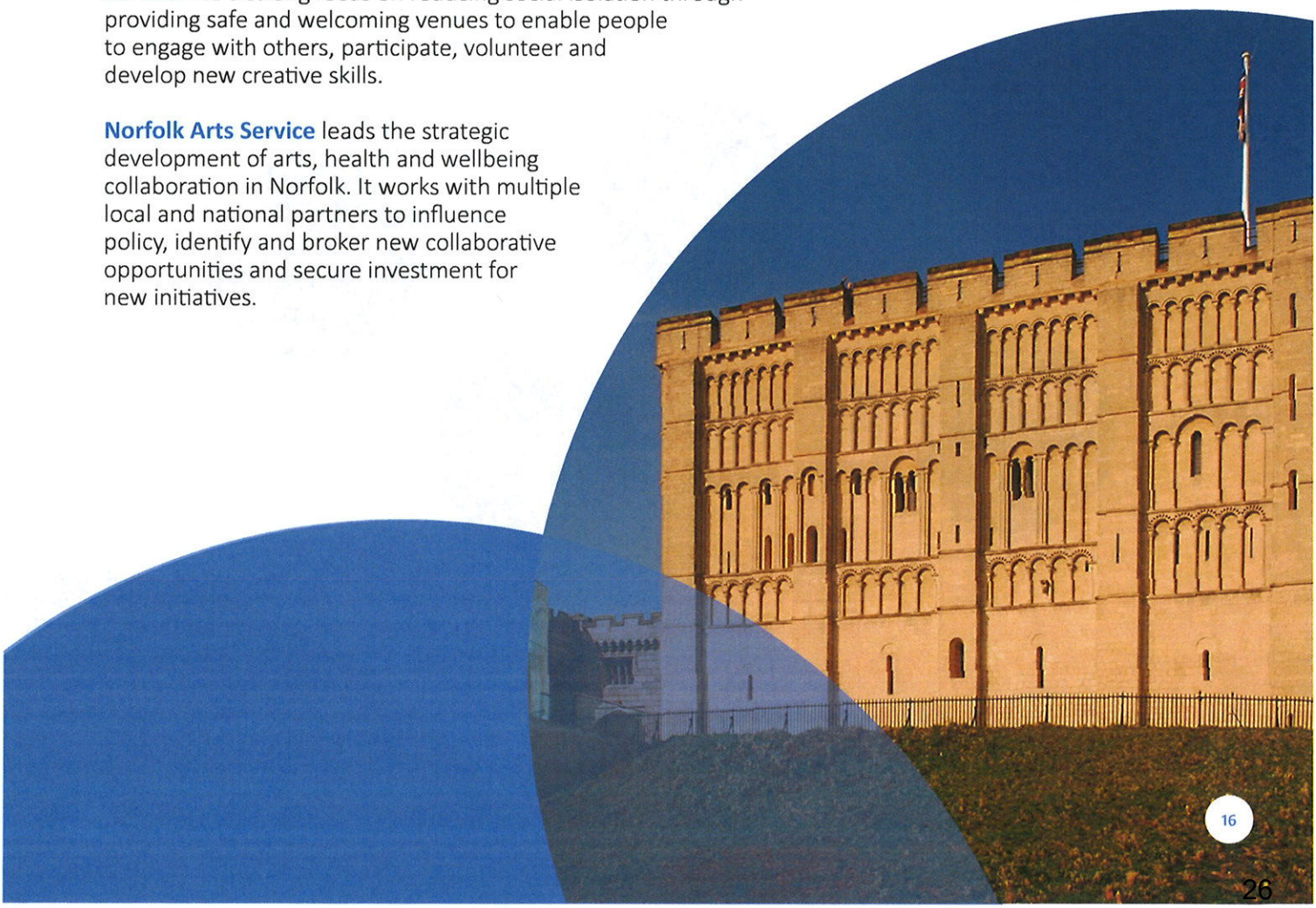
**"There is growing evidence that engagement in activities like dance, music, drama, painting and reading help ease our minds and heal our bodies. It is most encouraging to see just how much potential and ambition there is for joined-up action on this vital work in Norfolk."**

**Sir Nicholas Serota, Chair, Arts Council England.**

With ten outstanding museums, **Norfolk Museums Service** is strongly embedded in our local communities, providing excellent and ongoing support for health and wellbeing priorities through its extensive public programmes and targeted projects.

With 47 community libraries, **Norfolk Library and Information Service** has a strong focus on reducing social isolation through providing safe and welcoming venues to enable people to engage with others, participate, volunteer and develop new creative skills.

**Norfolk Arts Service** leads the strategic development of arts, health and wellbeing collaboration in Norfolk. It works with multiple local and national partners to influence policy, identify and broker new collaborative opportunities and secure investment for new initiatives.



# 4 Integrating Ways of Working

**Collaborating in the delivery of people centred care.**

## Living Independently in Later Life

Whilst life expectancy has risen only half of our retirement years are spent in full health. We will see the largest increases in the number of people over 65 years old.

There are 14,000 people living with dementia now- this is forecast to almost double to 25,000 by 2037 and most of these new cases will be in people aged over 85.

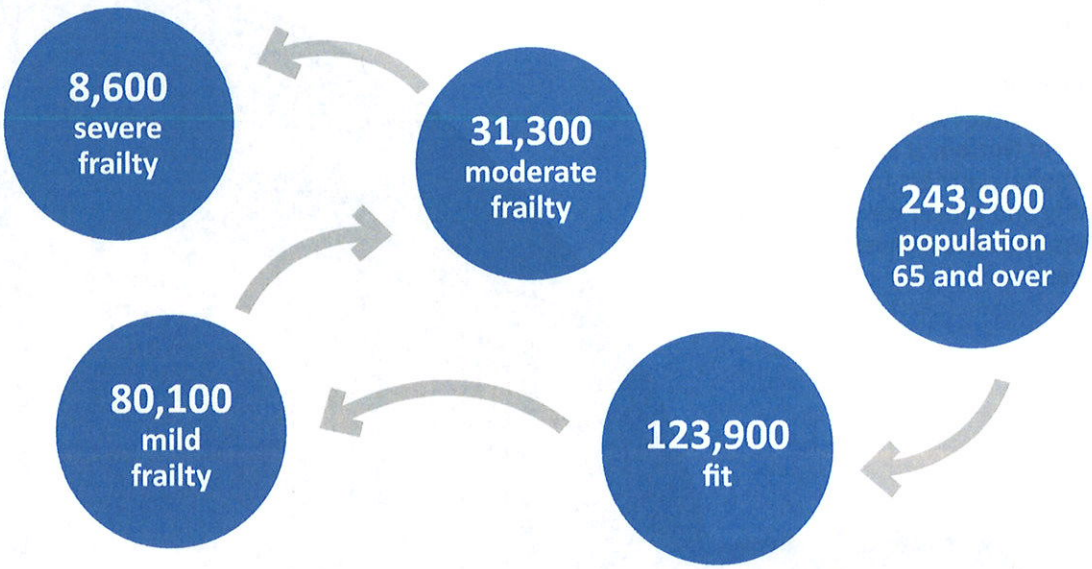
An estimated 23,200 people provide 50+ hours of unpaid care a week.

## Mental health and wellbeing

About 1 in 7 people in Norfolk and Waveney experience a common mental health disorder with long term mental ill health being higher than the average for England.

- 8% of adults were recorded as having depression.
- 1,712 emergency hospital admissions were for intentional self harm in 2016/17.
- About 110 people die each year from suicide.

**The number of ill health conditions an individual has contributes to the complexity of how to manage, and increases the cost of health and social care.**



# 4 Integrating Ways of Working - Actions

## What's important strategically?

We are seeing increasing demand with an ageing population. It is only by working together, in an integrated way, that we can meet the needs of people with more complex health and care challenges, managing with reducing or level budgets.

We want vulnerable people of all ages to live as long as possible in their own homes and to be independent, resilient and well- having access to early help and person centred care when needed. Long term mental ill health is associated with significantly poorer physical health and shorter life expectancy.

Working together with and within communities is important to promote good mental health support and wellbeing. It is also important to recognise the contribution of carers and the support they need.

### Key Challenges

- We are seeing increasing demand with an ageing population.
- Disease patterns are changing: multiple morbidity, frailty in extreme old age, and dementia are becoming more common.
- Ensuring parity of approach between physical and mental health.

### Key Measures

**Each HWB organisation can clearly report to the HWB how they are:**

1. Prioritising promoting independence and healthy later life both at a policy level and in decision-making.
2. Contributing to the Sustainability & Transformation Partnership's Strategy.

### Priority actions

**We will ensure integrated ways of working by:**

- Collaborating in the delivery of people centred care to make sure services are joined up, consistent and makes sense to those who use them.
- Working together to promote the important role of carers and the support they may also require.
- Embedding integrated approaches in policy, strategy and commissioning plans.

# 4 Integrating Ways of Working - Case Study

## History of dementia partnerships in Norfolk

Dementia as a priority for Norfolk has been championed by a series of partnership groups over the years: The Norfolk Older People's Strategic Partnership, the Dementia Strategy Implementation Board, the Norfolk and Waveney Dementia Partnership and more recently the Dementia Academy.

## Areas of focus continue to include:

- Early diagnosis and a gap free pathway for people with dementia and their carers.
- Improving advice and Information.
- Launch of **www.dementiafriendlyNorfolk.com**.
- Support for employers with a resource pack – addressing an ageing workforce, early onset dementia and more of us becoming carers.
- Medication advice – a leaflet detailing medication effects.
- Life stories as a resource to support stages of dementia.
- Prevention – research and evidence-based approaches to prevent and delay the onset of dementia.
- Involvement as a 'critical friend' in the dementia subgroup of the Norfolk and Waveney Sustainability & Transformation Partnership's Mental Health work stream.

# 4 Integrating Ways of Working - Case Study

## Promoting independence in older age

Physical activity has been introduced into Norwich care settings by **Active Norfolk** through the Mobile Me scheme.

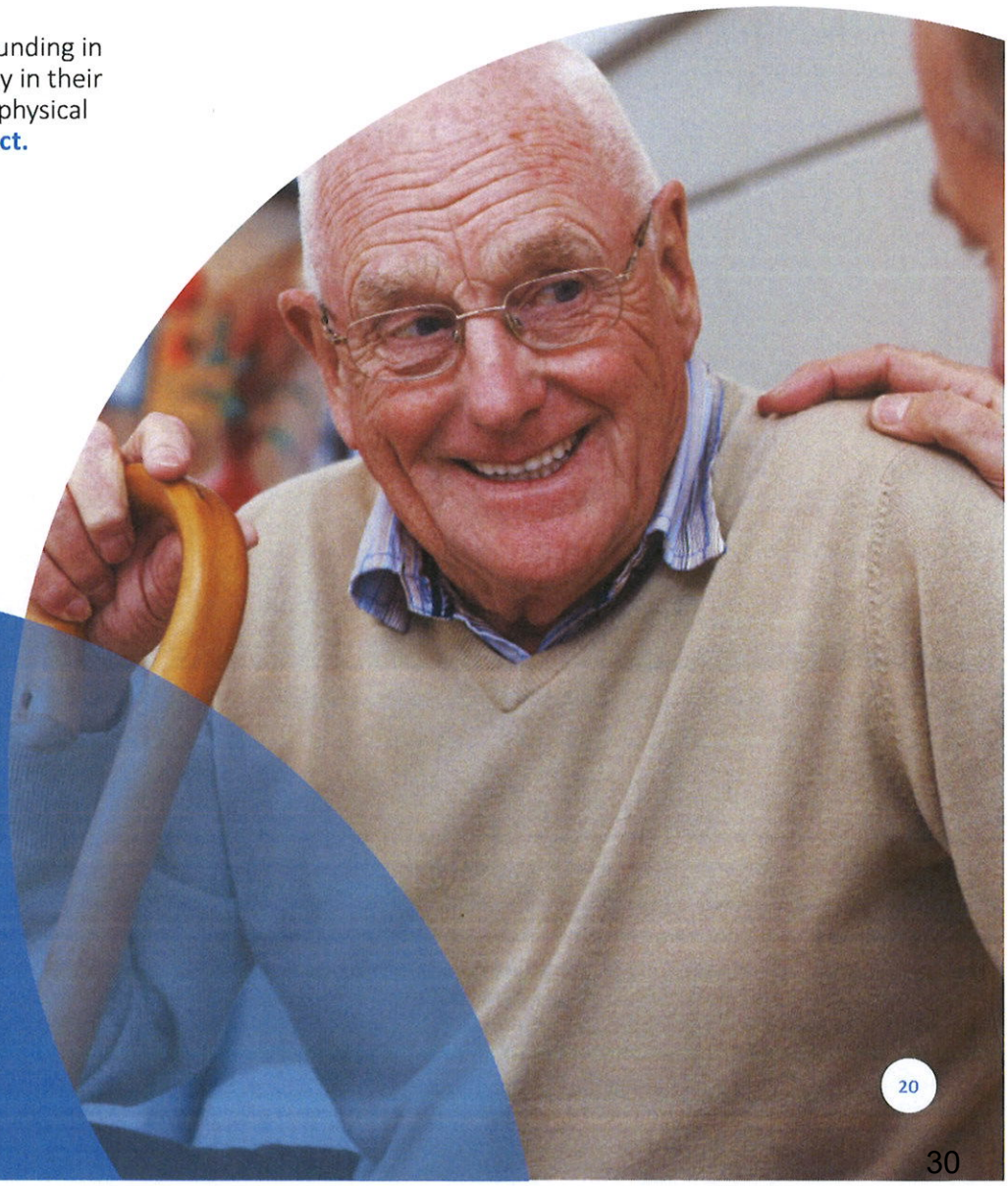
Jack, in his 90s, lives in an area where there is little interest in socialising as a community. He was inactive and rarely left his flat. Through Mobile Me Jack is now playing a sport he enjoyed in his youth.

**"I feel better in myself as I can play table tennis again. I'm surprised I still have the touch"**

**Norse Care** employs a physical activity coordinator for their housing schemes.

**"We have seen an increase in physical abilities, improvements in confidence and general wellbeing. There are also new social groups forming"**

Cotman Housing has secured funding in order to embed physical activity in their homes. Age UK has integrated physical activity into the **Agewise project.**



# 4 Integrating Ways of Working - Case Study

## Improving mental health and wellbeing

Norwich Theatre Royal's **Creative Matters** includes performances and workshops to think about important societal and personal issues. This included sessions on men's mental health, stigma, and male suicide- sessions on dementia and homelessness are planned for 2018/9.

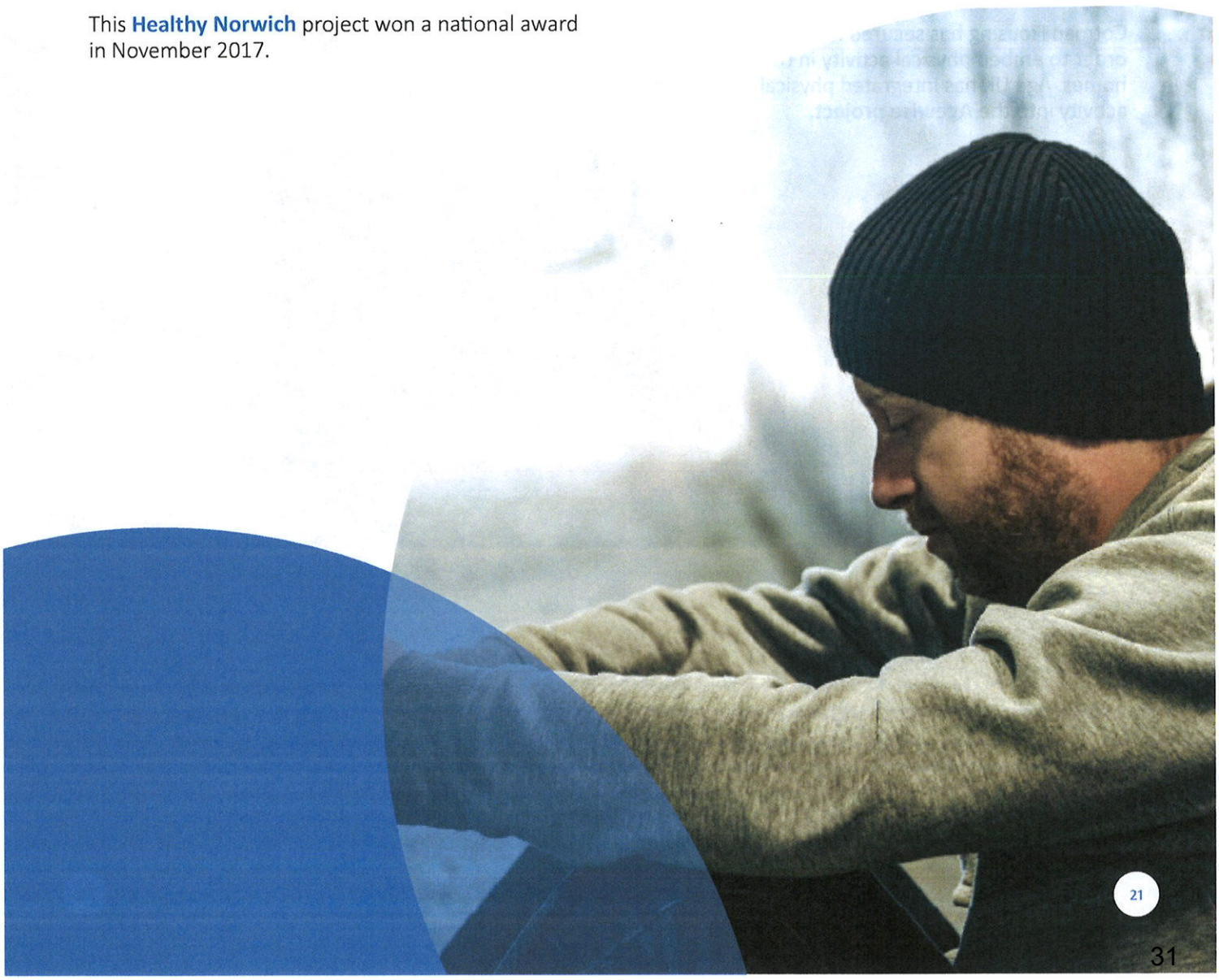
**MensNet** in Norfolk brings together organisations with a strategic interest in mental health. All to Play For is aimed at men struggling with mental health issues. John, 24, participates weekly:

**"It has been very beneficial for me dealing with my mental health, boosting my confidence,and helping improve my people skills".**

The **12th Man** project identified barber shops as positive spaces where discussions could happen.

Barbers are trained in Mental Health First Aid and subtle prompts are used to encourage these discussions.

This **Healthy Norwich** project won a national award in November 2017.



# Implementing our Strategy

## Working together to achieve joint outcomes

### We commit to:

- **Identifying the actions** that each Health and Wellbeing Board partner will take in delivering our strategy, either through partners' existing plans or new initiatives.
- **Developing an implementation plan** so we can focus on the important things we have agreed to do together.
- **Holding ourselves to account** and be an accountable public forum for the delivery of our priorities.
- **Monitoring our progress**- reviewing data and information which impact on our agreed outcome measures.
- Carrying out in-depth reviews to **understand the impact** we are making.
- Reporting on our progress to the Health and Wellbeing Board – **challenging ourselves** on areas where improvements are needed and supporting action to **bring about change**.
- **Keeping our Strategy live** – reflecting the changes as we work together towards an integrated system.

# Partner organisations involved in the Health and Wellbeing Board – Norfolk and Waveney

Health and Wellbeing Board
Norfolk & Waveney

- Healthwatch Norfolk
- Broadland District Council
- NHS Great Yarmouth and Waveney CCG
- Voluntary Community and Social Enterprise Sector representatives
- Police and Crime Commissioner's Office
- Norfolk and Suffolk NHS Foundation Trust
- Breckland Council
- NHS North Norfolk CCG
- Norfolk and Norwich University Hospitals NHS Foundation Trust
- East Coast Community Healthcare Community Interest Company
- Great Yarmouth Borough Council
- Norfolk Independent Care
- Borough Council of King's Lynn and West Norfolk
- Norwich City Council
- NHS West Norfolk CCG
- North Norfolk District Council
- Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust
- South Norfolk Council
- Waveney District Council
- Norfolk and Waveney Sustainability Transformation Partnership
- Norfolk County Council
- NHS Norwich CCG
- Norfolk Constabulary
- NHS South Norfolk CCG
- James Paget University Hospitals NHS Foundation Trust
- Norfolk Community Health & Care NHS Trust

HELP US HELP YOU
STAY WELL THIS WINTER

in good health

NHS 70 YEARS OF THE NHS 1948 - 2018

# Winter 2018/19 - investing to improve services

Winter always brings additional pressures on health and social care services. It always has. It is the same across the country and Norfolk and Waveney is no different.

**This year we expect pressures over the winter to be just as great as ever. So we have planned well ahead with more services, more capacity and more support for local people and patients.**

**This year we're asking everyone: 'Help Us Help You'**

- Use local pharmacies where appropriate and walk-in or minor injury units if it's more serious and urgent
- Seek advice for serious health problems early, to stop them getting worse
- Be a good friend or neighbour if they need a little more support

## What's different this year?

**More beds, more services**

**Extra £3 million NHS money**

**Extra £4.1 million (Norfolk) and £3.2 million (Suffolk) for social care, to speed discharge from hospitals**

**Learning from last winter and changing the approach for 2018-19**

**See centre and back pages**

How some staff got to work last winter

## Why winter is a challenge

- Demand is rising
- We have more older and frail people
- Winter makes breathing illnesses worse
- Flu and norovirus always strike

## Our people: Our biggest and best asset

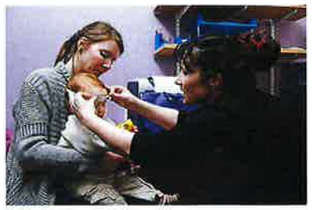

Make no mistake, staff and volunteers working across health and social care in Norfolk and Waveney are our best asset.

Over winter, many agree to work longer, harder and take on more shifts. Day after day they provide dedicated and compassionate care and support for people in our communities, going the 'extra mile' when they can.

We thank them and ask everyone to appreciate their hard work too. Here are some facts about demand in our area:

- More ambulances arriving per day at the Norfolk and Norwich University Hospital than any other hospital in East Anglia - and significant increases in people attending A&E departments across our area.
- As many as 40,000 calls to 111 a month
- More than 1,800 weekend and evening GP appointments per week

# These are just some of the additional services or capacity we are introducing to reduce pressures on urgent and emergency services, and look after people



## West Norfolk area plans include:

- Enhanced and enlarged discharge lounge at the Queen Elizabeth Hospital to help people return home sooner
- Six more community beds, more provision around end of life care.
- Nurse-led clinic to support homeless people, reducing their reliance on hospitals.
- Continued funding for SOS bus.
- Increase in Mental Health Liaison cover in hospital.
- Increase weekend Discharge Planning Team to help patients get back home as soon as appropriate.
- More use of on-call consultants to avoid admissions
- Greater use of day surgery
- Surgical Emergency Ambulatory Care launched

## Across all of Norfolk and Waveney

- Flu vaccinations
- Provision to manage outbreaks of flu within care homes
- Six more ambulance rapid response vehicles staffed with paramedics who can treat people at the scene and save them a trip to hospital
- Ambulance service will hire in more ambulances if it needs to
- Ambulance Patient Safety Intervention Teams as required, to ensure patients awaiting handover to hospital are well looked after and assesse.
- 1800 weekend and evening GP/nurse appointments per week
- More people safely assisted and managed in their first call to 111 (more call handlers and more clinicians in the Clinical Assessment Service)
- More therapy resource in hospitals and community teams to help people get home sooner and live as independently as possible at home
- Social care Trusted Assessor Facilitators are working with residential homes to help people return to their home from hospital
- Local authorities are training some of their staff and volunteers to support older people and carers in the community.

## Great Yarmouth and Waveney area plans include:

- Enhanced ambulatory care unit at the James Paget University Hospital (pictured below), providing prompt assessment and treatment to help reduce patients' time in hospital and prevent admissions. The new facility is more than double the size of the old unit, with capacity to see many more patients.
- Early Intervention (falls) Vehicle - ambulance and community staff respond to people who have fallen to prevent hospital admission
- Ensuring enough therapists to undertake discharge assessments at JPUH.
- More re-ablement and specialist beds in the community
- More home-based re-ablement to help people remain safely at home

## Central Norfolk area plans include:

The Norfolk and Norwich University Hospital's 8-point plan includes:

- 57 additional beds
- New discharge suite (artist's impression right) for up to 28 people to improve the patient's experience 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 - care at home for up to 30 patients at a time, who are medically well enough to leave hospital.
- Additional Physiotherapy and Occupational Therapy Resource

- Hospital Ambulance Liaison Officers help speed up handovers in the NNUH Emergency Department, releasing crews as soon as possible
- More appointments at the Rouen Road Walk in Centre
- GP surgeries providing welfare checks to 'high risk' patients to help them remain safe and well at home
- 'Admission avoidance' teams will extend working to 7 days a week, (ie the Norwich Escalation Avoidance Team and the Supported Care Services in North/South Norfolk). They arrange multi-agency packages of health and care support, for people at home.
- Up to ten more 're-ablement' beds in the community
- Mental Health night hub in Norwich - enhanced crisis response
- Care homes: Support and training on falls management and new ways of hydrating residents to keep residents out of hospital; more short-term mental health beds to help avoid hospital admission and help people return home
- Early Intervention (falls) vehicle

## Boost for social care

In October, the Health and Social Care Secretary Matt Hancock pledged an extra £4.1 million for Norfolk and £3.2 million for Suffolk. This will go to our local social care teams, to help them do even more to support local people get home and stay well at home.

Mr Hancock said: "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."

# Our strategy for winter

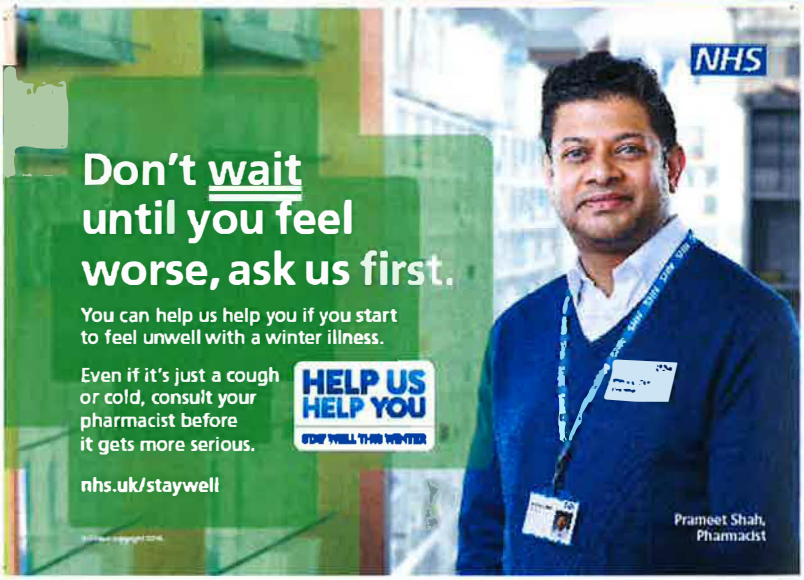
We have been drawing up our winter plans since last winter. All of the initiatives listed in the centre pages - and many more - have been put in place to:

- Provide the people of Norfolk and Waveney with health and care services when needed, closer to home where possible because the best bed is your own bed
- Reduce pressures on our ambulance and hospitals

HELP US HELP YOU
STAY WELL THIS WINTER

## Help yourself to stay well this winter

- **Make sure you get your flu jab**
- **Keep your home at 18°C (65°F) or higher if you can**
- **Make sure you order repeat prescriptions in time, so you don't run out (but only order what you need)**
- **Look out for neighbours and friends who may need extra help during the winter.**




# Be a germbuster: don't spread diseases

### Norovirus (sickness and diarrhoea)

You can catch it by close contact with someone with norovirus, touching surfaces or objects that have been touched by someone with norovirus, eating food that has been prepared or handled by someone with norovirus

- **Wash your hands frequently**
- **Wash surfaces and towels**
- **Do not come back to school, work public spaces or use public transport for 48 hours after the last symptom**

### Flu

Flu is spread by germs from coughs and sneezes, which can live on hands and surfaces for 24 hours. You are more likely to give it to others in the first 5 days.

- **Wash your hands often, with warm water and soap**
- **Use tissues to trap germs when you cough or sneeze**
- **Put used tissues in a waste bin as quickly as possible**

# Homes and Health

Report of the Health and Wellbeing Board District Councils' Group

**Jamie Sutterby**
**Director of Communities & Wellbeing**
**South Norfolk Council**

## Core Services


Homelessness


Planning


Building control


Environmental Services


Housing


Community Protection


Leisure


Food Safety & Licensing


Community Engagement


Elections


Refuse Collection


Economic Development

**Keeping residents healthy**

Sport and leisure – Broadly Active, leisure centres, community sports, Fit 4 Life

Supporting local and national events – Tour de Norfolk

Energy advice – Warm Homes Fund

**Supporting our older population**

Maintaining independence - Handyperson schemes

Keeping active – Reducing loneliness, Fit 4 Life, Silver Social

Dementia Friendly Neighbourhoods

Supporting hospital discharge

LILY (living Independently in Later Years)

**Encouraging the best start in life**

Early Help hubs

Kids Clubs

Hardship funding, Debt advice, FIRST officers

HONOR programme

Jobs Clubs and apprenticeships

**Warm and healthy homes:** to work in partnership and build on existing initiatives such as promoting winter wellness, providing energy and money saving advice and installing central heating systems to fuel poor households

## Programme Summary

**Category 1 - Urban**

- Private Sector 150 Gas boilers
- Social Housing 15 gas boilers
- Project Support/EPCs

**Category 2 - Rural**

- Private Sector 250 Oil/LPG boilers
- Social Housing 118 Air source heat pumps
- Project Support/EPCs

**Category 3 – Energy Efficiency and Health**

- Emergency funds
- Training/evaluation
- Direct 1:1 support
- Marketing, admin and programme management
- Health and Housing data mapping

Discharge Hubs

Local Councils

Direct marketing

Agencies and self referrals

**Triage**
Age, benefits, health, income, tenure, excess cold, heating system and fuel type,

Further advice

1:1 Support

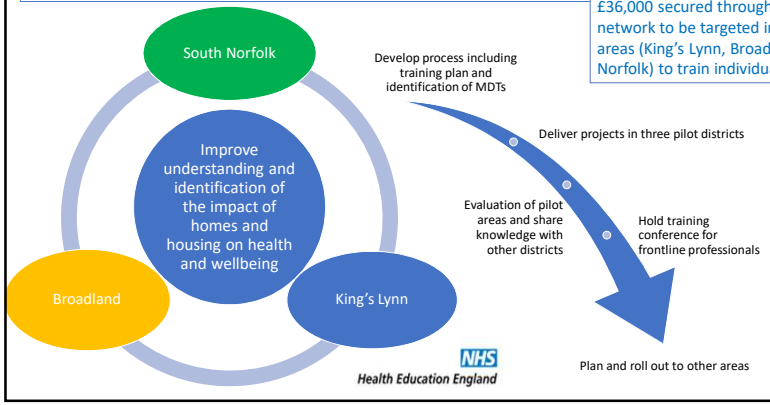
Emergency Funds

Insulation/ FTCH

Referral → Assessment → Delivery

**Integration with MDTs:** Integration with Multi-Disciplinary Team activities in localities to identify need and any value added district offer

£36,000 secured through Health Education network to be targeted in three district areas (King's Lynn, Broadland and South Norfolk) to train individual health




**Discharge from hospital:** Coordinate and share learning on working with the three acute hospitals to help find a sustainable model and consider extending the district offer to acute patient flow to include discharge from mental health and community hospitals

**Queen Elizabeth Hospital Trust** KL&WN Council are funding a 12-month pilot using the District Direct model as a proof of concept

Community hospitals

**Norfolk & Norwich University Hospital** – 3 District Direct officers based within the integrated discharge until July 2019. Funding through 4 District Councils, ASC & 3 CCGs

**James Paget Hospital** – Healthy homes assistance undertaking works within a patient's property to facilitate safe discharge.

Hellesdon hospital

**Aims**:

- Alleviate winter pressures
- Reduction in delayed discharge
- Fewer re-admissions
- Delayed need for formal health and social care packages

# HWB is asked to agree:

1. To focus on Homes and Health as a priority for HWB member organisations. While there is a breadth of ongoing activity in this area, in order to focus our collective efforts and to see system wide improvements, it is further proposed that the HWB agrees:

- To build on existing initiatives on **warm homes** such as sourcing cheaper energy, securing debt and money advice, and working in partnership to maximise the efficacy of the recently won £3M capital investment programme
- **Integration with Multi-Disciplinary Team activities** in localities to identify need
- **Discharge from hospital** – coordinate and share learning on working within the three acute hospitals and consider extending initiatives to include discharge from mental health and community hospitals

2. Support cross partner activity, coordinated by staff from the organisations above, to explore ways in which (a) short term improvements can be made to support work on winter pressures for this year and (b) longer term system changes to support working with residents and their homes to improve health and wellbeing.

| | |
|---|---|
| **Report title:** | **Our Joint Health and Wellbeing Strategy 2018-22 – Implementation planning** |
| **Date of meeting:** | **13 February 2019** |
| **Sponsor (H&WB member):** | **Dr Louise Smith, Director of Public Health, Norfolk County Council** |

## Reason for the Report

In 2018, the Health and Wellbeing Board (HWB) agreed its Joint Health & Wellbeing Strategy 2018-2022 and all HWB partner organisations have confirmed their formal sign up to it. The focus has now moved to implementation planning - identifying and developing the specific actions that the Board, subgroups and each HWB partner will take in delivering our Strategy, either through existing plans or new initiatives. This report updates on partners' progress.

## Report summary

This paper provides a draft high-level **Implementation Framework**, based on our agreed Strategic Framework, and outlines next steps.

## Recommendations:

HWB partners are asked to:

1. Agree the draft high level Implementation Framework
2. Agree to develop an Implementation Action & Delivery Plan
3. Commit to action to take this work forward

## 1. Background

1.1 In 2018, the Health and Wellbeing Board (HWB) agreed its Joint Health & Wellbeing Strategy for 2018-22. During the autumn 2018, all HWB partners took the Strategy back to their individual organisations' governing bodies/boards for formal sign up, to ensure governance arrangements were fully in place in preparation for implementation.

1.2 Our Joint Health and Wellbeing Strategy 2018-22 outlines:

- The HWB's vision for **A single sustainable health and wellbeing system**
- Our strategic priorities - **Prioritising prevention**, **Tackling inequalities in communities** and **Integrating ways of working**
- Our values – **Collective accountability**, **simplification of systems**, **promoting engagement and involvement**, **based on evidence of needs**.
- How we bring together **existing strategies** and agree to work together to achieve joint outcomes

## 2. Implementing our Strategy

### Our HWB Annual Conference – developing our strategic vision

2.1 Working together as system leaders, we launched our Joint Health and Wellbeing Strategy 2018-22 at the Annual Health and Wellbeing Board Conference on 5 December 2018 to over a hundred wider partners and stakeholders.

2.2 Conference speakers emphasised the importance of focusing on, and strengthening, connections and relationships - working together as systems leaders to create the right environment for an integrated sustainable system, bringing about whole system change and fostering a creative and innovative environment to impact on health and wellbeing outcomes.

2.3 Through discussion and debate in workshops and plenary partners obtained insights about the opportunities and challenges involved in delivering the Strategy. The conference also highlighted how, as joint and accountable stakeholders, all had a part to play in developing and implementing solutions.

### Implementation planning - collaboration and added value

2.4 The focus for our implementation planning is on collaboration and the specific added value that the HWB can bring, with actions and prioritisation informed by our collective strategic plans. A draft **Implementation Framework (Appendix A)** has been drawn up based on the agreed Strategic Framework, which forms part of our Strategy.

2.5 The Implementation Framework takes our vision and priorities, identifying priority actions and key measures. It focuses, at a high level, on how HWB partners will address the challenges facing the system collectively and individually to drive forward improvement in health and wellbeing outcomes. It also outlines commitment to evaluate and report progress so as to demonstrate how together as system leaders we are achieving our vision of a Single Sustainable System.

2.6 HWB partners have committed to working together, through the Joint Health and Wellbeing Strategy, to achieve joint outcomes. The work to support implementation of priority actions will be progressed by individual and groups of HWB partners through a variety of means, including holding workshops, setting up task & finish groups, carrying out in-depth reviews/deep dives, setting up rapid action teams, engaging through focus groups or the use of social media, highlighting national good practice as well as innovation across the county, bringing reports to HWB meetings to challenge ourselves/the system on areas that are not progressing or where system leaders need to act and support action to bring about change.

2.7 This will be outlined in an **Implementation Action & Delivery Plan** which will sit beneath the high level Implementation Framework, outlining the timeline for the actions and the HWB partner(s) who will take responsibility for leading the work. Over the course of the year, HWB partners will need to prepare to contribute to the Board's evaluation by bringing **an annual report** back to the HWB at the end of the first year of the Strategy to demonstrate improvements and allow a refresh of strategic ambitions to keep the strategy live and relevant

2.9 Key actions starting during the first year of our Strategy will include:

- Developing, in partnership, a systematic approach for **Children and Young People's** support and provision - starting with a workshop on 13 Feb 2019 and a focus on mental health

- Delivering the **Health and Homes work programme** – led by the HWB District Councillors Sub Committee

- **Joint working with the STP** to support the development and providing oversight of the integration of the Health and Social Care local system **-** helping to ensure appropriate governance and robust accountability

- Launching the new **Joint Strategic Needs Assessment** to inform planning and policy and developing the HWB's website pages as the essential source of latest information for the health and wellbeing strategy work programme

- **Workplace health** – developing a strategy addressing mental and physical ill health in our workforce including emphasis on mental health first aid training for all key sectors and mental health champions maintaining the focus on the importance of good mental health

- Agreeing a **Carers Strategy** for Norfolk and beginning implementation

- Launching the HWB Chairman's Awards at the next HWB Annual Conference – **recognising good practice and innovation** and demonstrating the best use of our shared knowledge

2.10 HWB partners are asked to agree the draft high level Implementation Framework and to take this work forward to by developing an Implementation Action & Delivery Plan.

## 3. Next steps

3.1 Next steps for HWB partners include:

- Developing an **Implementation Action & Delivery Plan** – so we can be clear about what we need to do, when we will need to do it, and who will take the lead.

**Officer Contact**

If you have any questions please get in touch with:


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

# Joint Health and Wellbeing Strategy: Our Implementation Framework

## How we are working towards our vision

### A Single Sustainable System

- Sharing our thinking, planning, opportunities and challenges – informing **new ways of working and transformation**
- Engage with and **listen to service users**, residents and communities to inform our understanding and planning
- Providing **joint accountability** so that as a system we are preventing, reducing and delaying needs and associated costs
- Undertake **needs assessments**, including the JSNA, to help us keep our Strategy on track and understand its impact
- Develop mechanisms such as risk stratification tools and the sharing of information to **target care where it is needed most**
- Use partners' existing plans – building on the priorities partners are already working hard to address, identifying the added value that **collaboration** through the HWB's Strategy can bring

## The actions we are taking

### Prioritising Prevention

- Developing in partnership a systematic approach for **children and young people's** support and provision
- Embedding **prevention** across all organisational strategies and policies.
- Providing **joint accountability** so that as a system we are preventing, reducing and delaying needs and associated costs
- Promoting and supporting **healthy lifestyles** with our workforces

### Tackling Inequalities in Communities

- Promoting alignment and consistency in local delivery partnerships to plan for, and with, their local community
- Providing and using the **evidence** to address needs and inequalities
- Addressing the impact of **crime, violence and injuries**.
- Joining up **housing** and **development planning** by working with those with planning responsibilities

### Integrating Ways of Working

- **Collaborating** in the delivery of people centred care, through partnerships and newly forming care systems, to make sure services are joined up, consistent and makes sense to those who use them.
- Working together to promote the important role of **carers** and the support they may also require.
- Embedding integrated approaches in policy, strategy and commissioning plans

## Key Measures - How we will know we are achieving

- Delivering the agreed priority actions, in partnership, for **children and young people**
- Holding partners to account for **prioritising prevention** in policies and decision-making
- Developing a mental health strategy including mental and physical ill health in **our workforce**

- Coordinated delivery across local partnerships helping communities to live well
- Reduced **crime, injuries and accidents** to minimise the impact on health and wellbeing in our most deprived areas

- Delivering the agreed priority actions, in partnership, for **Promoting independence** and helping people to age well
- Supporting and having oversight of the Sustainability & Transformation Partnership

## How we will know we are making a difference

**Evaluation** **Impact** **Outcomes** **System Change** **Efficient processes**

HWB partner organisations have aligned strategies, make collaborative decisions and, where appropriate, work through pooled fund arrangements to deliver a single sustainable system.

We will know we are making a difference by evaluating how we are:

- Contributing to **financial sustainability** and an integrated system
- Reviewing the impact of strategy and **outcomes**
- **Using the evidence intelligently** – including evidence from service users - in our discussions and our planning
- Working in partnership with others to **support delivery** of partners' transformation plans
- Using **source data** available (including from the JSNA) to inform strategic plans

| | |
|---|---|
| **Report title:** | **NHS Long Term Plan - Briefing** |
| **Date of meeting:** | **13 February 2019** |
| **Sponsor:** | **Dr Louise Smith, Director of Public Health** |

## Reason for the Report

The Health and Wellbeing Board (HWB) provides oversight and strategic leadership across many complex organisations and systems, and commissioning across the NHS, social care and public health and will be concerned with the implications of the NHS Long Term Plan for the local system as a whole.

## Report summary

This report outlines the key messages from the NHS Long Term Plan (LTP) which was published in January 2019, setting out a strategy for the health service for the next ten years and providing a framework for local systems to develop plans, building on existing plans and based on collaboration.

## Recommendations:

The HWB is asked to:

1. Discuss the implications of the NHS Long Term Plan for our local health and wellbeing system

## 1. Background

1.1 In June 2018m, the Prime Minister announced a new five-year funding settlement for the NHS: a 3.4 per cent average real-terms annual increase in NHS England's budget between 2019/20 and 2023/24 (a £20.5 billion increase over the period). To unlock this funding, national NHS bodies were asked to develop a long-term plan for the service. Following a consultation, the resulting document - the NHS Long-Term Plan - was published on 7 January 2019 www.longtermplan.nhs.uk.

1.2 The NHS Long Term Plan (LTP) provides a comprehensive action plan and set of national priorities for how the NHS will use the additional 3.4 per cent a year over the next five years to improve health and address health inequalities, redesign the model of care and support and to ensure the financial sustainability of the NHS.

1.3 It provides a framework for local systems to develop plans based on collaboration.

## 2. NHS Long Term Plan – key messages

2.1 The NHS Long Term Plan (the Plan) is split into 7 chapters and the key points from each chapter are summarised below:

**Chapter 1: A new service model for the 21st century**

2.2 The NHS Long Term Plan sets out the pathway for a new service model fit for the 21st century. The aim is for patients to receive more options, better support and properly joined-up care at the right time in the optimal care setting.

2.3 The first aim of the new service model is boosting out-of-hospital care. It is based upon three years of testing alternative models in the Five year forward view through integrated care vanguards and integrated care systems (ICSs) and promises to 'finally dissolve the historic divide between primary and community health services'. This aim is backed by a commitment to increase investment in primary medical and community health services as a share of the total national NHS revenue spend across the five years from 2019/20 to 2023/24, meaning at least a £4.5 billion more will be spent on these services in five years' time.

2.4 **Emergency care services will also be expanded and reformed** to help ensure patients get the care they need faster, relieve pressure on A&E departments and better offset pressures in demand over winter months. This includes fully implementing the urgent treatment centre model by autumn 2020, enabling all localities to have a consistent offer for out of hospital urgent care and the option of appointments booked through a call to NHS 111.

2.5 Over the next five years the NHS intends to increase support for people so that they have **more** control over their own health and more personalised care when they need it. This will start with diabetes prevention and management, asthma and respiratory conditions, maternity and parenting support, and online therapies for common mental health problems. It includes the roll out of the NHS personalised care model across the country and the acceleration of personal health budgets.

2.6 In order to improve access to advice and care, it is intended that **digitally-enabled primary and outpatient care** will go mainstream across the NHS. A digital NHS 'front door' through the NHS App will provide advice, check symptoms and connect people with healthcare professionals. Outpatient services will also be fundamentally redesigned over the next five years in order to avoid up to a third of face-to-face outpatient appointments. This is expected to remove the need for up to 30 million outpatient visits a year. In order to facilitate this, there will be dedicated funding to capitalise on the opportunities provided by advances in digital technology, detailed in Chapter 5.

2.7 The Plan promises to focus on population health, enabled by ICSs covering the whole country by April 2021. 'Every ICS will need streamlined commissioning arrangements to enable a single set of commissioning decisions at system level. This will typically involve a single CCG for each ICS area'.

2.8 The move to ICSs will be supported by NHS Improvement taking a more proactive role in supporting collaborative approaches between trusts, and also by reforms to funding flows and contracting arrangements. A new ICS accountability and performance framework will provide a consistent and comparable set of performance measures and system-wide objectives will be agreed with the relevant NHS England/ NHS Improvement regional director.

2.9 The Plan also includes a commitment to support local approaches to blending health and social budgets where councils and CCGs agree it makes sense. There is a plan to review the better care fund (BCF) in early 2019.

**Chapter 2: More NHS action on prevention and health inequalities**

2.10 Alongside the important role played by local government The NHS long term plan sets out new commitments for action that the NHS itself will take to improve the prevention of ill-health. The renewed NHS prevention programme includes the following programmes:

- **To cut smoking**: By offering NHS funded tobacco treatment services to all hospital admitted patients who smoke, expectant mothers and their partners, long term users of specialist mental health services and learning disability services.
- **To reduce obesity**: Through measures including targeted support for patients with type 2 diabetes or hypertension with a BMI of 30+. There is also a commitment to double the NHS diabetes prevention programme funding over the next five years and also increase the profile of nutrition in professional education training.
- **To limit alcohol related A&E admissions**: Over the next five years hospitals with the highest rate of alcohol dependence-related admissions will be supported to establish alcohol care teams.
- **To lower air pollution**: Through the redesign of care, including a greater use of virtual appointments, the NHS aims to cut business mileages and fleet air pollution emissions by 20% by 2023/24.

2.11 These measures are designed to contribute to the government's ambition of five years of extra healthy life expectancy by 2035.

2.12 In addition to preventing ill-health, The NHS long term plan takes a more concerted and systematic approach to previous plans in addressing unwarranted variations in care and reducing health inequalities. NHS England will continue to target a higher share of funding (£1 billion by 2023/24) towards geographies with high health inequalities and during 2019 all health systems will be expected to set out how they will reduce health inequalities by 2023/24 and 2028/29. The Plan aims to ensure that action to drive down health inequalities is central to everything the NHS does, including:

- continuity of carer models for the most vulnerable mothers and babies and specialist smoking cessation support offered to all women who smoke during pregnancy
- ensuring at least 390,000 people living with severe mental health problems have their physical health needs met by 2023/24
- ensuring people with learning disability and/ or autism get better support investing up to £30 million extra on meeting the needs of people experiencing homelessness
- continuing to support carers and their health needs, particularly those from vulnerable communities and young carers
- expanding NHS specialist clinics to help more people with serious gambling problems.

**Chapter 3: Further progress on care quality and outcomes**

2.13 Although performance in all major conditions is now measurably better than a decade ago, there remains a degree of unmet need and unwarranted variation for the biggest killers and disablers of the population, coupled with increasing opportunities for further medical advances.

2.14 The NHS long term plan sets out two clear areas for further progress on care quality and outcomes, firstly enabling a strong start in life for children and young people and secondly providing better care for major health conditions.

2.15 **Children and young people** represent a third of the population. The Plan sets out measures to address their current and future needs including: maternity and neonatal, mental health, learning disability, autism and cancer.

2.16 The Plan also goes further on the *NHS five year forward view'*s focus on cancer, mental health, diabetes, multi-morbidity and healthy ageing including dementia and extends to providing **better care for major health conditions** such as cardiovascular and respiratory conditions, learning disability and autism, among others.

2.17 Some improvements in these services have been framed as ten-year goals due to the extent of time required to expand capacity and grow the workforce.

**Chapter 4: NHS staff will get the backing they need**

2.18 The Plan makes it clear that workforce growth has not kept up with need, partly due to increasing demands on the NHS and partly because the NHS has not been a sufficiently flexible and responsive employer. Staff are feeling the strain, particularly due to substantial and unsustainable vacancies.

2.19 As recognised in the Plan, 'the challenge is substantial, but there are real opportunities to make improvements. More people want to train to join the NHS than are currently in education or training. Many of those leaving the NHS would remain if they were offered improved development opportunities and more control over their working lives'.

2.20 The NHS workforce implementation plan is due to be published later in the year when the education and training budget for Health Education England (HEE) is set. The Plan does include some actions that can be taken now, across eight key areas:

**1. A comprehensive new workforce implementation plan:** a workforce implementation plan will be published later in 2019 and NHS Improvement, HEE and NHS England will establish a
national workforce group to ensure that workforce actions agreed are delivered quickly.

**2. Expanding the number of nurses, midwives, AHPs and other staff:** the national workforce group will agree action to increase supply to improve the nursing vacancy rate to 5% by 2028, including expanding the number of undergraduate places, increased funding for clinical placements, on-line nursing qualification, apprenticeships, 'earn and learn' support, a new post qualification employment guarantee and national recruitment campaigns.

**3. Growing the medical workforce:** As well as increasing medical school places from 6,000 to at least 7,500 per year and committing to a new state-backed GP indemnity scheme from April 2019, the workforce implementation plan will build on the *General practice forward view* with the aim to move from a dominance of highly specialised roles to a better balance with more generalist ones.

**4. International recruitment:** The workforce implementation plan will set out new national arrangements to support recruiting overseas, which will be particularly important in the short term before increased domestic training has an impact. NHS England and NHS Improvement will also directly monitor NHS staffing flows post-Brexit to consider consequential actions.

**5. Supporting our current NHS staff:** The proportion of HEE's total budget spent on workforce development will increase and respect, equality and diversity will be central to the workforce implementation plan. The NHS chief people officer, working with the national workforce group, will take action for all NHS staff in a number of areas such as improving wellbeing, supporting flexibility and enabling staff to move more easily across NHS employers.

**6. Enabling productive working:** Improved technology, including electronic roster or e-job plans, will be used to support staff. A review of NHS workforce data will also be commissioned to ensure it supports both day-to-day and strategic workforce decision making.

**7. Leadership and talent management:** a new NHS leadership code will set out the cultural values and leadership behaviours of the NHS and will be used to underpin everything from recruitment practices to development programmes. The national workforce group will also look at options for improving the NHS leadership pipeline.

**8. Volunteers:** The aim is to double the number of NHS volunteers over the next three years and as part of this at least £2.3 million of NHS England funding will be provided to the Helpforce programme to scale successful volunteering programmes across the country.

**Chapter 5: Digitally-enabled care will go mainstream across the NHS**

2.21 Technological advances are expected to provide new possibilities for prevention, care and treatment. Progress has already begun in recent years with the introduction of the NHS App, Electronic Prescription Service, NHS e-referral service and the Global Digital Exemplar Programme.

2.22 Technology will play a crucial role and in ten years' time, it is expected that the existing model of care will look markedly different. The NHS will offer a 'digital first' option for most, allowing for longer and richer face-to-face consultations with clinicians where patients want or need it. Primary care and outpatient services will have changed to a model of tiered escalation depending on need. Senior clinicians will be supported by digital tools, freeing trainees' time to learn. When ill, people will be increasingly cared for in their own homes, with the option for their physiology to be effortlessly monitored by wearable devices. People will be helped to stay well, to recognise important symptoms early, and to manage their own health, guided by digital tools'.

2.23 The NHS long term plan sets out the approach to technology across the five key areas – empowering people; supporting health and care professionals; supporting clinical care; improving population health; and improving clinical efficiency and safety.

2.24 Recognising that digital advances will require time, infrastructure and the right environment to thrive, The Plan sets out key principles and milestones (Table 1). The principles include the need to create a digitally literate workforce, ensuring compliance with published open standards and clear development requirements that meet NHS wide needs and allow for future development.

**Table 1**

| | |
|---|---|
| **2019** | Introduce controls to ensure new systems purchased by the NHS comply with agreed standards, including those set out in *The Future of Healthcare8.* |
| **2020** | Five geographies will deliver a longitudinal health and care record platform linking NHS and local authority organisations. (Three additional areas will follow in 2021) |
| **2020/21** | People will have access to their care plan and communications from their care professionals via the NHS App; the care plan will move to the individual's local health care record (LHCR) across the country over the next five years. |
| **2021** | By summer 2021, there will be 100% compliance with mandated cyber security standards across all NHS organisations in the health and care system |
| **2021/22** | We will have systems that support population health management in every ICS in England, with a chief clinical information officer or chief information officer on the board of every local NHS organisation |
| **2022/23** | The Child Protection Information system will be extended to cover all health care settings, including general practices. |
| **2023/24** | Every patient in England will be able to access a digital first primary care offer. |
| **2024** | Secondary care providers in England, including acute, community and mental health care settings, will be fully digitised, including clinical and operational processes across all settings, locations and departments. Data will be captured, stored and transmitted electronically, supported |

**Chapter 6: Taxpayers' investment will be used to maximum effect**

2.25 Long term modelling underpinning the Plan is based on using the additional £20.5 billion for the NHS by 2023/24 for three areas: current financial pressures; continuing demand growth; and new priorities. To put the NHS on a sustainable financial path, the Plan sets out five 'stretching but feasible' commitments as covered below.

**Test 1: The NHS (including providers) will return to financial balance**

2.26 Over the next five years, NHS organisations must meet the following three objectives:

1. continue to balance the NHS' books nationally across providers and commissioners
2. reduce the aggregate provider deficit each year, with provider sector balance by 2020/21
3. reduce, each year, the number of NHS organisations individually in deficit with all NHS organisations in balance by 2023/24

2.27 The Plan sets out a number of changes (Table 2) including changes to payment arrangements; 2019/20 rebased control totals; an accelerated turnaround process; earned financial autonomy for ICSs; and a new financial recovery fund (FRF). The FRF will mean the end of the control total regime and provider sustainability fund for all trusts that deliver against their recovery plans by 2021 at the latest.

**Table 2**

| | |
|---|---|
| **Payment arrangements** | To take better account of the costs of delivering efficient services locally an updated market forces factor will be phased in over the next five years. There will be a move to a blended payment model, beginning with urgent and emergency care, with a single set of financial incentives. The revised approach will remove, on a cost neutral basis, two national variations to the tariff: the marginal rate for emergency tariff and the emergency readmissions rule, which will not form part of the new payment model. |
| **Reforms to the payment system** | Reforms will move funding away from activity-based payments and ensure a majority of funding is population-based. An appropriate level of volume related payments for elective care will remain for now, alongside new incentives for improvements in quality (including patient experience). |
| **2019/20 rebased control totals** | 2019/20 control totals will be rebased, with a neutral aggregate impact, to take account of distributional effects from price relativities, the market forces factor and national variations to the tariff. There will also be greater flexibility for all STPs and ICSs to agree financially neutral changes to control totals within their systems. |
| **Accelerated turnaround** | Turnaround deployed for the 30 worst financially performing trusts. |
| **Increased system autonomy** | To support the move to system shared decisions about financial planning and prioritisation, local health systems will be given greater control over resources based on a track record of strong financial and performance delivery, assessed in part through the new ICS accountability and performance framework. |
| **Financial Recovery Fund (FRF)** | As a result of the FRF, it is expected that the number of trusts reporting a deficit in 2019/20 will reduce by half and by 2023/24 will be nil. The FRF will reduce in size over five years, replaced by recurrent efficiency improvements. Multi-year financial recovery plans will be agreed with NHS England and NHS Improvement. This will mean the end of the control total regime and provider sustainability fund for all trusts which deliver against their recovery plans by 2021 at the latest. |

**Test 2: The NHS will achieve cash-releasing productivity growth of at least 1.1% per year**

2.28 The NHS has been set an objective of making efficiency and productivity gains of at least 1.1% a year over the next five years, to be retained and reinvested in the NHS. The Plan recognises that waste does remain in the system and there are opportunities for efficiency. Over the next two years the efficiency and productivity programme will focus on ten priority areas:

1. **Improving the availability of clinical workforce, further reducing bank and agency costs**: By 2021, all clinical staff working in the NHS will be deployed using an electronic roster or e-job plan. By 2023, all providers will be able to use evidence-based approaches to determine how many staff they need on wards and in other care settings.

2. **Procurement**: By 2022, the volume of products bought through Supply Chain Coordination Limited (SCCL) will double to 80%, the number of nationally contracted

products will be extended and the way local and regional procurement teams operate will be consolidated.

3. **Pathology and imaging networks**: By 2021, all pathology services across England will be part of a pathology network and, by 2023 diagnostic imaging networks will be introduced.

4. **Community health services, mental health and primary care**: The GIRFT programme has already started work in mental health and will be extended across to community health services and primary care from April 2019.

5. **Medicines**: Over the next five years, all providers will be expected to implement electronic prescribing systems to reduce errors by up to 30%.

6. **NHS administrative costs**: Further efficiencies will save over £700 million by 2023/24, comprising £290 million from commissioners and over £400 million from providers.

7. **Land, buildings and equipment**: National work with providers will reduce the amount of non-clinical space by a further 5% and by 2020, the aim is to reduce the NHS carbon footprint by a third from 2007 levels.

8. **Non-clinically effective interventions**: The NHS needs to ensure that the least effective interventions are not routinely performed, or only performed in more clearly defined circumstances; freeing up scarce professional time and allowing resources to be reinvested into patient care.

9. **Improving patient safety**: Measures include a new patient safety incident management system by 2020; a shared and consistent patient safety curriculum; and the development of a network of senior patient safety specialists.

10. **Patient, contractor, payroll, or procurement fraud**: The NHS Counter Fraud Authority will continue to tackle this including large scale patient eligibility checking services.

**Test 3: The NHS will reduce the growth in demand for care through better integration and prevention**

2.29 Chapters one to three of The NHS long term plan describe in detail how this is being done.

**Test 4: The NHS will reduce unjustified variation in performance**

2.30 As set out in the Plan, ‘reducing unwarranted variation will be a core responsibility of ICSs. We expect all ICSs, supported by our national programmes, to bring together clinicians and managers to implement appropriately standardised evidence-based pathways’. Further detail is provided in chapters two and three of the Plan.

**Test 5: The NHS will make better use of capital investment and its existing assets to drive transformation**

2.31 In 2017, the government announced an additional allocation of £3.9 billion to accelerate estates transformation, tackle critical backlog maintenance issues and support efficiency. The chancellor has confirmed that NHS long-term capital

investment will be considered in the 2019 Spending Review. In return, the NHS has committed to maximise the productivity benefits generated from its estate such as through improving utilisation of clinical space; sustainable build and maintenance; improving energy efficiency; and releasing properties not needed. A number of reforms to the NHS capital regime are also being considered and these will be set out alongside the Spending Review capital settlement.

**Chapter 7: Next steps**

2.32 The Plan sets out major reforms to the NHS architecture, payment systems and incentives, providing a long-term strategic framework for local planning. Building on the approach taken in developing it, a new operating model must be based on co-design and collaboration.

2.33 2019/20 is a transitional year with each NHS organisation to agree a single year organisational operating plan and contribute to a single year local health system-level plan by April 2019. By Autumn 2019, local five year plans should be published. These should build on existing plans and be based on engagement with the local communities; a comprehensive assessment of population need; the national list of essential interventions; and take account of the clinical standards review and the national implementation framework due to be published in the spring. To support this, local health systems will receive five-year indicative allocations for 2019/20 – 2023/4.

2.34 Local plans should be brought together in a detailed national implementation programme by autumn 2019. This will also take account of the government's Spending Review setting out details of the NHS capital budget, funding for education and training and the local government settlement to cover public health and adult social care services.

2.35 The Plan does not require changes to the law to be implemented. However, it recognises that amendment to legislation would significantly accelerate progress on service integration, administrative efficiency and public accountability.

2.36 ICSs will be central to the delivery of the plan with the aim that ICSs cover all of the country by April 2021. National support will be provided to each developing system to produce and implement a clear development plan and timetable. NHS England and NHS Improvement will implement a new shared operating model designed to support delivery of the Plan, based on a supportive and collaborative culture. NHS organisations too will be encouraged to support each other with a 'duty to collaborate'.

2.37 Building on the consultative approach taken in developing the Plan, an NHS Assembly will be established in early 2019, bringing together a range of organisations and individuals at regular intervals as a 'guiding coalition' to implement the plan.

**Conclusion**

2.38 The NHS long term plan sets out ambitious improvements for patients over the next ten years. Building on work already started, the challenge is for local NHS organisations to work with their partners to develop and implement local plans for their local population. These plans must overcome the challenges that the NHS faces, such as staff shortages and growing demand for services. The workforce

implementation plan and social care green paper due to published later this year will be key to realising these ambitions. While the scale of change required cannot be underestimated, the aim is to make the NHS fit for purpose for patients, their families and staff.

*(Summary courtesy of the Healthcare Financial Management Association).*

**Officer Contact**

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


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


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.

**Item 9**

| | |
|---|---|
| **Report title:** | **Norfolk and Waveney Sustainability and Transformation Partnership (STP) update** |
| **Date of meeting:** | **13 February 2019** |
| **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 October 2018.

## Action/decisions needed:

Members of the Health and Wellbeing Board are asked to:

1. Assist with building awareness of the three levels our Integrated Care System will have within their organisations, in order to build a consistent and shared understanding of how the system will work together to improve health and care.

2. Consider the role that partners could play, both collectively and individually, in the development and implementation of our 20 Primary Care Networks across Norfolk and Waveney.

3. Support the continued involvement of service-users, carers, staff and other stakeholders in the implementation of our mental health strategy.

4. Commit to supporting the development of the Norfolk and Waveney five year plan.

in good health

## 1. Creating an Integrated Care System for Norfolk and Waveney

1.1 On 7 January 2019, the NHS published its Long Term Plan, which lists a number of important ambitions for the next few years. Central to the delivery of all of them will be the need for people to work together – whether that's GP surgeries teaming up with each other, as well as community and mental health services and social care, so they can care for people more effectively, or whole health and care systems coming together to plan and deliver improvements for patients. The Long Term Plan says that by April 2021 integrated care systems (ICS) will cover the whole country, growing out of the current network of Sustainability and Transformation Partnerships (STPs).

1.2 Over the past few months a significant amount of work has been done to develop our ICS through our involvement in the Aspirant ICS Programme and engagement with a

broader group of colleagues, including CCG governing bodies and provider boards, as well as local voluntary and community sector organisations and patients.

1.3 Our ICS will operate at three levels: at "neighbourhood" level, place level and across Norfolk and Waveney. We have been considering what we could do differently at these three levels to better integrate services and provide more joined-up care:

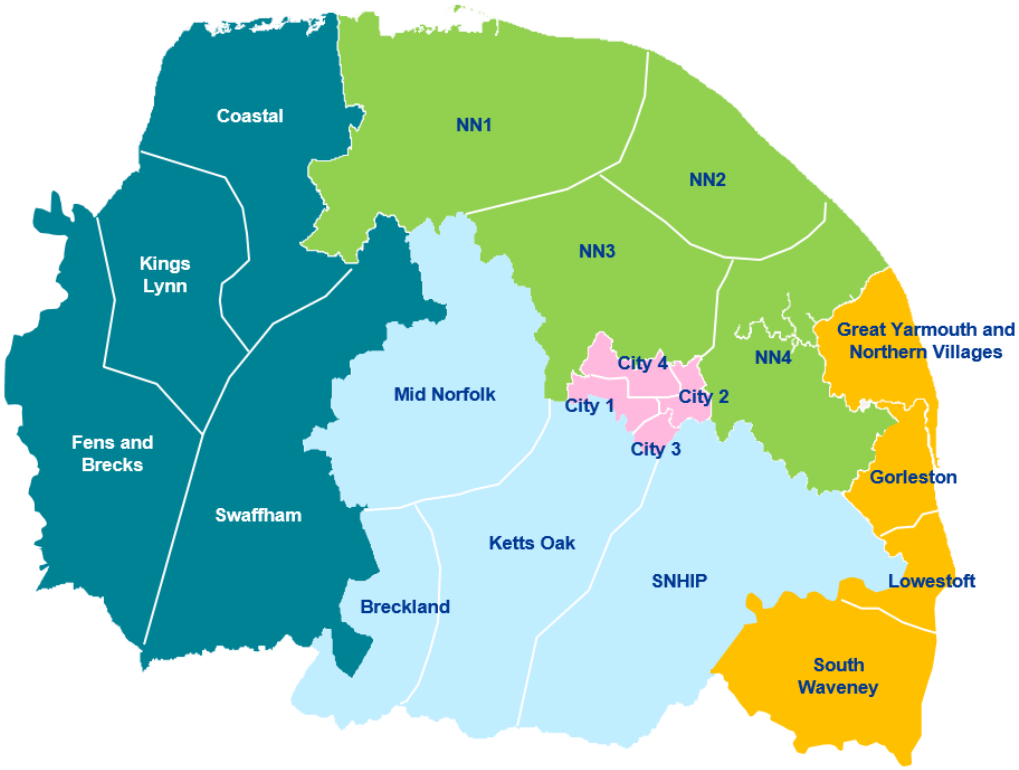
**At "neighbourhood" level**

1.4 We will create 20 "neighbourhoods" – four in each CCG area, serving a population of between 25,000 and 70,000 people. At this neighbourhood level we have some really exciting ideas about how we can transform care, based on what the most effective GP practices are already doing.

1.5 In each neighbourhood we want to create primary care networks – teams based around groups of GP practices and made up of professionals from a range of different backgrounds, for example there would be an adult social care lead and team, mental health workers and community healthcare colleagues.

1.6 These multi-disciplinary teams will work closely with local voluntary and community groups and other statutory services; social prescribing will be a key tool for helping tackle the underlying causes of ill-health. We've just been awarded £535,000 from NHS England to develop our primary care networks. This video explains more about primary care networks and the benefits they'll bring to people living in Norfolk and Waveney.

1.7 Here is a map showing the 20 primary care networks we are developing:




**At place level**

1.8 We have five CCG areas which are very different from each other in many ways. For example Norwich is urban and has a much younger population than rural North Norfolk, and so there are some instances when we need to adapt services to meet the needs of

each area. We are creating local delivery groups in each of the five places, involving the district council(s) and other key partners including the voluntary and community sector.

**Across Norfolk and Waveney**

1.9 There are times when it makes sense for us to make decisions and provide services for the whole area or 'system', particularly to remove the unwarranted variations in quality and care that still exist. We need to be clear about when this is the case and equally to understand when we'd be better to make a decision at a more local level.

1.10 We have started to draft a vision and strategy for our system, together with a financial strategy, contracting arrangements, an approach to population health management and a plan for how we can strengthen our primary care networks.

1.11 We expect NHS England to notify us of the application process for becoming an ICS by the end of February. Governing bodies, provider boards and the Health and Wellbeing Board will be notified of this process as soon as possible. In due course governing bodies, provider boards and the Health and Wellbeing Board will be invited to discuss the expression of interest within the timescales set by NHS England.

1.12 As a system we will also be working together over the coming months - and engaging widely with local people - to determine what the NHS Long Term Plan will mean for people in Norfolk and Waveney. In the autumn we will publish our local five year plan, setting out how we will be implementing the NHS Long Term Plan.

## 2. Draft mental health strategy for Norfolk and Waveney published

2.1 On 10 December 2018, we published the draft Mental Health Strategy for Norfolk and Waveney, which is available to read here: https://www.healthwatchnorfolk.co.uk/ingoodhealth/stp-mental-health. Our draft strategy has been developed with input from thousands of local people and professionals. Based on what we have heard so far, our vision is to develop and deliver 'place based' services wrapped around primary care through integrating mental and physical health in each of our localities: Great Yarmouth and Waveney, North Norfolk, Norwich, South Norfolk and West Norfolk.

2.2 Six pillars have been identified for future work and we are co-designing the detailed plans that sit behind each of these. The pillars are worth highlighting as these come straight from what we have heard about where current services need to be improved:

- Focus more on prevention and wellbeing
- Ensure clear routes into and through services and make these transparent to all
- Support the management of mental health issues in primary care settings
- Provide appropriate support to those in crisis
- Ensure effective in-patient care for those that really need it
- Ensure the system is focused on working in an integrated way to care for patient

2.3 Throughout January and into early February we have been asking people what they think of our draft strategy, to help us refine it into the final document. We are currently analysing this feedback and an updated version of the strategy will be presented to the Joint Strategic Commissioning Committee on 19 February for sign-off. We'll continue to engage and involve service users, carers, staff and stakeholders in the implementation of our strategy once it has been finalised.

2.4 As a partnership we are committed to working together to respond to NSFT's recent CQC report and to make the improvements to mental health care that we need to. We are working closely with our national NHS colleagues, our counterparts in Suffolk and NSFT itself to ensure that the necessary short-term changes take place quickly and effectively while we're developing a new model of care, based on prevention, primary care and community.

## 3. Review of child and adolescent mental health services

3.1 We have also reviewed child and adolescent mental health services (CAMHS). The review has produced a set of recommendations to create a much more integrated children's system, with consistent system-wide strategic leadership for children and young people's mental health.

3.2 As with our review of adult mental health services, this work has been driven by engagement with young people, their parents / carers, professionals and others. The review has looked at a range of aspects of our Local Transformation Plan and our wider ambitions for these important services. This has included commissioning arrangements, leadership and governance, service models, performance, the provider landscape, and the many interfaces these services need to have with other parts of the system.

## 4. Focusing on children and young people

4.1 In addition to reviewing child and adolescent mental health services, we have also given some thought to the wider integration of children's services. We want a greater emphasis in our STP on the needs of children and young people and so we have agreed to create a new STP workstream to channel future transformation work. This will enable us to collectively make the biggest difference to the lives of children and young people living locally, and will support, for example, the implementation of the recommendations from the review of CAMHS.

## 5. Demand and capacity review

5.1 Over the past few months we've undertaken a significant piece of work 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.

**What did the review tell us?**

5.2 The review identified key challenges for our partnership:

- A growing and ageing population
- Primary care working to capacity, with a shrinking GP workforce
- Acute inpatient bed capacity cannot meet demand
- Community services cannot meet demand from acutes
- Social care related delayed transfers of care (DToCs) are high and there is a lack of home care capacity
- The system has significant financial challenges.

5.3 Whilst these challenges were not unknown to us, the review has helped to quantify them in more detail so that we understand more about the scale of the challenges facing us, the causes and some potential solutions.

5.4 For example, the review highlighted that if we do not implement the many schemes already in the pipeline and if we do not develop more, the mismatch in demand for services and our capacity to care for those people would result in a deficit of 500 beds by 2023. Together with improving outcomes for patients, this is why we are focused on developing more integrated services for people before they need hospital treatment.

5.5 The review is also clear that the issues we face cannot be addressed by any single organisation – only collective interventions across the system will create a sustainable position.

**Next steps**

5.6 The demand and capacity issues could potentially be covered by any one of these workstreams: Acute Transformation, Urgent and Emergency Care or Primary and Community Care. However the issues fall across the whole system and none of those workstreams can cover the whole problem.

5.7 So we have agreed to establish a new Demand and Capacity workstream to take forward the findings from the review. The workstream will establish a short, medium and long term plan, with a significant part of its work to focus on the longer term strategy. The Director of Strategy at the James Paget University Hospitals NHS Trust will be the programme director for this work.

## 6. Financial planning

6.1 In January all the NHS organisations involved in our partnership received their 2019/20 control totals and allocations and we have been working together to analyse these. This is a good example of how we are working differently. In the past, each organisation would have looked at their own finances and considered what any changes meant for them. This year we are working much more closely together and sharing information so that we understand the impact of any changes on the finances of our system.

6.2 Last year our collective deficit was £65 million and we are currently forecasting a deficit of over £90 million for 2018/19. We have agreed as a partnership that our ambition is to halve this in the next financial year. The additional funding we're receiving as part of the investment announced with the Long Term Plan will help with this, however it will not solve the problem. We need to identify further savings or ways to make our system more efficient.

6.3 Through our involvement in the Aspirant ICS Programme, we have developed three system finance documents which will now be presented to CCG governing bodies and trust boards for approval:

- **Financial Strategy:** This sets out the behavioural principles and framework under which the system will operate. In doing so our collective focus will be on managing the system within the total available resource, rather than from any single organisations perspective, and thus manage financial risk collectively.

- **Contracting Arrangements:** This sets out the principles and method under which the system will contract in order to drive collaboration and a cost focus across the system. In doing so this will reduce the transactional activity, freeing up resources to deliver transformation. The focus on cost will ensure that increased activity, which the system can't afford, isn't incentivised.

- **Memorandum of Understanding:** This sets out the STPs partners' agreement on the basis of the financial principles of collaboration, financial governance structures, and roles and responsibilities. In doing so this signals partners desire to operate collaboratively to achieve our vision for the system.

## 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

**Item 10**

| | |
|---|---|
| **Report title:** | **CCG Annual Reports** |
| **Date of meeting:** | **13 February 2019** |
| **Sponsor (H&WB member):** | **Tracy Williams, Vice Chair, Health and Wellbeing Board** |

## Reason for the Report

NHS Clinical Commissioning Groups must include a narrative in their Annual Reports about how they have contributed to the delivery of Health and Wellbeing Board priorities. The Board must also be consulted in the preparation of these narratives.

## Recommendations

Each CCG in Norfolk and Waveney has submitted a draft narrative, prepared for their 2018/19 Annual Reports, about how they have supported and contributed to the delivery of Health and Wellbeing Board priorities.

The HWB is asked to:

- Agree the narratives / indicate what changes it would recommend
- Welcome the move to a single management team in 2019

## 1. Background

1.1 Under the Health and Social Care Act 2012, Clinical Commissioning Groups (CCGs) are required to consult the Health and wellbeing Board (HWB) about the part of their Annual Report which sets out the CCG's contribution towards delivery of the JH&WBS and each year the CCGs provide the extract of their Annual Reports for comment. The Board may also give directions as to the form and content of an Annual Report and, at the outset, the HWB gave direction that the overall form and content of the Annual Reports should be succinct and clear for the public.

## 2. The draft narratives

2.1 Each of the five CCGs in Norfolk and Waveney have submitted narratives for inclusion in their Annual Reports for 2018/19 about how they have contributed to the delivery of Health and Wellbeing Board priorities. The narratives are attached as follows:

Appendix A - Great Yarmouth & Waveney CCG
Appendix B - North Norfolk CCG
Appendix C - Norwich CCG
Appendix D - South Norfolk CCG
Appendix E - West Norfolk CCG

2.2 It must be stressed that CCG Annual Reports are not due to be submitted to NHS England until 18 April 2019 and these narratives remain draft and subject to minor changes up to that point, to fulfil the requirements of Governing Bodies and NHS England.

**Contact**

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

| **Name** | **Email** |
| --- | --- |
| Tim Curtis (NHS CCG Communications) | Tim.curtis2@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.**

# NHS Great Yarmouth & Waveney CCG
# Draft extract of Annual Report 2018-19

The CCG is a member of the Health and Wellbeing Board and has contributed to the Health and Wellbeing Strategy. The strategy has four priorities in place which are;

- A Single Sustainable System
- Prioritising Prevention
- Tackling Inequalities in Communities
- Integrating Ways of Working

The CCG has been helping to deliver these priorities in the following ways:

1. A key member of the Great Yarmouth Local Delivery Group which is accountable to the STP Primary and Community Care Programme Board and crucial to the successful delivery of the Sustainability and Transformation Plan (STP) at a local level.

2. Completed a successful procurement process to commission East Coast Community Health to provide Adult Community Health and Specialist Palliative Care Service from April 2019. The outcome base specification designed, is fully aligned to the Health and Wellbeing Board priorities to deliver improvements in the following;

   a. Peoples experience of health and care
   b. Peoples health and wellbeing
   c. Efficiency and value for money of services
   d. Integrated services across the system including primary, community and social and secondary care
   e. Self-care

3. Led and supported integrated working across organisations in the local area, to put in place services that facilitate improved discharges from the James Paget University Hospital and enable people to go home. Initiates include the development of the Integrated Discharge Hub at the JPUH and the development of reablement services to help a person to regain as much independence as possible

The CCG is a partner in the Norfolk and Waveney Sustainability and Transformation Partnership (STP), which is aspiring to become a Wave 3 Integrated Care System (ICS). See page xxx

The CCGs of Norfolk and Waveney are creating a single management team, which began with the appointment of a Chief Officer and Chief Finance Officer in early 2019. See page xxx.

# NHS North Norfolk CCG
# Draft extract of Annual Report 2018-19

## Health and wellbeing strategy

NHS North Norfolk CCG is an active member of the Health and Wellbeing Board.

Decades of improvements in life expectancy and forecasts for future population growth mean that an increasing proportion of our population are elderly, have multiple illnesses and need care and support as they become frail in extreme old age. Common causes of death such as heart disease are decreasing and being replaced with conditions such as dementia. [1]

The Health and Wellbeing Strategy has four key priorities which the CCG has worked to support:

| Health and Wellbeing Board Vision/ Priority | How the CCG is supporting the HWB priorities |
|---|---|
| **Vision- A Single Sustainable System** | The CCG is a partner in the Norfolk and Waveney Sustainability and Transformation Partnership (STP), which is aspiring to become a Wave 3 Integrated Care System (ICS). See page xxx<br><br>The CCGs of Norfolk and Waveney are creating a single management team, which began with the appointment of a Chief Officer and Chief Finance Officer in the spring of 2019. |
| **Priority- Prioritising Prevention**<br><br>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. | The CCG has supported patients to access the 'Broadly Active' exercise referral scheme. The activity programme is aimed at those with stable long term medical conditions who would benefit from physical activity and comprises a supervised 12 week exercise programme individually tailored to patients and working with participants to find long term sustainable exercise opportunities that fit with individual's lifestyle and medical condition. See page xxx<br><br>The CCG also actively supports Public Health prevention priorities such as smoking cessation; It is the lead commissioner for a Tier 3 weight management service for tier 3 patients from the Norfolk and Norwich University Hospital for the 3 CCGs in central Norfolk. It has rolled out the National Diabetes Prevention Programme, offering targeted intervention to people most at risk of contracting diabetes. See page xxx |

[1] Director of Public Health Annual Report 2018, Norfolk County Council

| | |
|---|---|
| **Priority- Tackling Inequalities in Communities**<br><br>Providing support for those who are most vulnerable in localities using resources and assets to address wider factors that impact on health and wellbeing. | In September 2018 the CCG worked with NHS South Norfolk CCG to launch guidance to help GP Practices to become "dementia friendly". See Page xxx<br><br>A new CAN Connect Service is being delivered by Community Action Norfolk (CAN) in the North Norfolk area. Life Connectors and volunteers help people realise life goals and so tackle loneliness and isolation.<br><br>Social prescribing has been rolled out across all practices, whereby patients are signposted to the right community support services to tackle the root cause of their ill health.<br><br>The CCG also commissions a team based at CityReach to support people who frequently attend A&E but whose health concerns are not accidents or emergencies. |
| **Priority- Integrating Ways of Working**<br><br>Collaborating in the delivery of people centred care to make sure services are joined up, consistent and makes sense to those who use them. | The CCG has developed the North Norfolk Escalation Avoidance Team (NEAT), a multi-disciplinary team that puts an integrated package of care in place for people who develop a health crisis.<br><br>The CCG has invested in 'Hospice at Home' an enhanced palliative care service working in partnership with community staff, GP Practices and palliative care specialists.<br><br>The Norfolk and Waveney 'Winter Room' and 'System Operation and Resilience Groups' are integrated teams of staff drawn from all NHS and social care teams to co-ordinate urgent and emergency care. |

The Norfolk Health and Wellbeing Board has been consulted over the contents of this section of the report. It was sent to the February 2019 meeting of the Board and (more to follow…)

# NHS Norwich CCG
# Draft extract of Annual Report 2018-19

## Health and wellbeing strategy

The CCG is an active participant in the leadership and work of the Board and contributes towards the delivery of the 2018-2022 Health and Wellbeing Strategy for Norfolk. The Chair of NHS Norwich CCG, Tracy Williams, is one of the two Vice-Chairs of the Health and Wellbeing Board.

The Health and Wellbeing Strategy has four key priorities which the CCG has worked to support:

| Health and Wellbeing Board priority | How the CCG is supporting the HWB priorities |
|---|---|
| **A Single Sustainable System** | The CCG is a partner in the Norfolk and Waveney Sustainability and Transformation Partnership (STP), which is aspiring to become a Wave 3 Integrated Care System (ICS). See page xxx<br><br>The CCGs of Norfolk and Waveney are creating a single management team, which begins with the appointment of a Chief Officer and Chief Finance Officer in the spring of 2019. |
| **Prioritising Prevention**<br><br>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. | The CCG's Healthy Norwich programme continues to help people in the Norwich area lead healthier lives. This is a partnership with Norwich City Council, Broadland District Council and Public Health. Activities have included:<br><br>• Healthy Norwich grants programme to support community initiatives<br>• Smokefree Sidelines campaign<br>• 0-4 years accident prevention in the home project<br>• Promoting the Daily Mile in schools<br>• Breastfeeding Friendly scheme in GP Practices<br>• Working with practices to diagnose dementia in patients earlier, so they can access treatments and support to improve symptoms and slow down the progress of the disease<br><br>Full details of Healthy Norwich activities are on page xxx<br><br>The CCG actively supports Public Health prevention |

| | |
|---|---|
| | priorities such as smoking cessation; it commissions weight loss and activity programmes for patients who are overweight to prevent diabetes and CVD ill health. It has rolled out the National Diabetes Prevention Programme in Norwich, offering targeted intervention to people most at risk of developing diabetes. |
| **Tackling Inequalities in Communities**<br><br>Providing support for those who are most vulnerable in localities using resources and assets to address wider factors that impact on health and wellbeing. | The Healthy Norwich partnership has supported initiatives that target communities where there are identified health inequalities:<br>Funding for the Heartsease Healthy Living initiative to support seven community projects.<br>The Healthy Norwich partnership works to deliver the Norwich affordable warmth strategy to reduce fuel poverty – one of the wider determinants of health.<br><br>Social prescribing has been rolled out across all practices, whereby patients are signposted to the right community support services to tackle the root cause of their ill health.<br><br>Voluntary Norfolk has been commissioned to pilot a health coaching scheme to support people to manage their<br>long-term health conditions.<br><br>Age UK is commissioned to run a Promoting Independence scheme, working closely with GPs and other health professionals to support people over the age of 65 to improve their wellbeing.<br><br>NHS England commissions the CityReach service for people who are homeless, or otherwise do not engage with the NHS. The CCG is also piloting a team based at CityReach to support people who are frequent attenders at A&E.<br><br>*One*Norwich is developing a pilot service to engage and support patients with severe and multiple disadvantages. |
| **Integrating Ways of Working**<br><br>Collaborating in the delivery of people centred care to make sure services are joined up, consistent and makes sense to those who use them. | Norwich CCG and partners have developed the Norwich Escalation Avoidance Team (NEAT), a multi-disciplinary team that puts an integrated package of care in place for people who are experiencing a health or social care crisis.<br><br>The CCG has developed an enhanced case management model called Community FICS (Fully Integrated Care and Support), being piloted in the City 2 area of Norwich.<br><br>The CCG has invested in an enhanced palliative care service working in partnership with community staff, |

| | |
|---|---|
| | GP Practices and palliative care specialists. Referrals are made via NEAT.<br><br>The CCG commissioned HomeWard, our hospital at home service, which has dedicated social care resources.<br><br>The Norfolk and Waveney 'Winter Room' and 'System Operation and Resilience Groups' are integrated teams of staff drawn from all NHS and social care teams to co-ordinate urgent and emergency care. |

The Norfolk Health and Wellbeing Board has been consulted over the contents of this section of the report. It was sent to the February 2019 meeting of the Board and (more to follow…)

# NHS South Norfolk CCG
# Draft extract of Annual Report 2018-19

## Health and wellbeing strategy

NHS South Norfolk CCG is an active member of the Health and Wellbeing Board.

Decades of improvements in life expectancy and forecasts for future population growth mean that an increasing proportion of our population are elderly, have multiple illnesses and need care and support as they become frail in extreme old age. Common causes of death such as heart disease are decreasing and being replaced with conditions such as dementia. [1]

The Health and Wellbeing Strategy has four key priorities which the CCG has worked to support:

| Health and Wellbeing Board vision/priority | How the CCG is supporting the HWB priorities |
|---|---|
| **Vision - A Single Sustainable System** | The CCG is a partner in the Norfolk and Waveney Sustainability and Transformation Partnership (STP), which is aspiring to become a Wave 3 Integrated Care System (ICS). See page xxx<br><br>The CCGs of Norfolk and Waveney are creating a single management team, which began with the appointment of a Chief Officer and Chief Finance Officer in the spring of 2019. |
| **Priority - Prioritising Prevention**<br><br>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. | The CCG has supported patients to access the 'Broadly Active' exercise referral scheme. The activity programme is aimed at those with stable long term medical conditions who would benefit from physical activity and comprises a supervised 12 week exercise programme individually tailored to patients and working with participants to find long term sustainable exercise opportunities that fit with individual's lifestyle and medical condition. See page xxx<br><br>The CCG also actively supports Public Health prevention priorities such as smoking cessation; It commissions with the 3 CCGs in central Norfolk a Tier 3 weight management service for tier 3 patients from the Norfolk and Norwich University Hospital. It has rolled out the National Diabetes Prevention Programme, offering targeted intervention to people most at risk of contracting diabetes. See page xxx |
| **Priority - Tackling Inequalities in Communities**<br><br>Providing support for those who are most vulnerable in | In September 2018 the CCG worked with NHS North Norfolk CCG to launch guidance to help GP Practices to become "dementia friendly". See Page xxx<br><br>The Better Together Service is being delivered by |

| | |
|---|---|
| localities using resources and assets to address wider factors that impact on health and wellbeing. | Voluntary Norfolk in the South Norfolk area where volunteers help people realise life goals and so tackle loneliness and isolation.<br>Social prescribing has been rolled out across all practices, whereby patients are signposted to the right community support services to tackle the root cause of their ill health.<br><br>The CCG also commissions a team based at CityReach to support people who frequently attend A&E but whose health concerns are not accidents or emergencies. |
| **Priority - Integrating Ways of Working**<br><br>Collaborating in the delivery of people centred care to make sure services are joined up, consistent and makes sense to those who use them. | The CCG has developed the South Norfolk Escalation Avoidance Team (NEAT), a multi-disciplinary team that puts an integrated package of care in place for people who develop a health crisis.<br><br>The CCG has invested in 'Hospice at Home' an enhanced palliative care service working in partnership with community staff, GP Practices and palliative care specialists.<br><br>The Norfolk and Waveney 'Winter Room' and 'System Operation and Resilience Groups' are integrated teams of staff drawn from all NHS and social care teams to co-ordinate urgent and emergency care. |

The Norfolk Health and Wellbeing Board has been consulted over the contents of this section of the report. It was sent to the February 2019 meeting of the Board and (more to follow…)

# NHS West Norfolk CCG
# Draft extract of Annual Report 2018-19

## Health and wellbeing strategy

The CCG is an active participant in the work of the Board and contributes towards the delivery of the 2018-2022 Health and Wellbeing Strategy for Norfolk.

The Health and Wellbeing Strategy has four key priorities which the CCG has worked to support:

| Health and Wellbeing Board priority | How the CCG is supporting the Health and Wellbeing Board priorities |
|---|---|
| **A Single Sustainable System**<br>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. | The CCG is a partner in the Norfolk and Waveney Sustainability and Transformation Partnership (STP), which is aspiring to become a Wave 3 Integrated Care System (ICS). See page xxx<br>The CCGs of Norfolk and Waveney are creating a single management team, which began with the appointment of a Chief Officer and Chief Finance Officer in early 2019. See page xxx |
| **Prioritising Prevention**<br>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. | A focus on prevention and helping people to stay well is a priority for the CCG, its partners and the wider STP.<br>The CCG has rolled out the National Diabetes Prevention Programme across West Norfolk practices, offering targeted intervention to people most at risk of developing diabetes.<br>The CCG has also led on the development of a new five-year diabetes strategy for Norfolk and Waveney STP 2018-2023.<br>NSFT and WNCCG have jointly commissioned a 'Mental Health Hub' (provided by West Norfolk Mind) to help support people with mental health issues before they reach crisis point.<br>West Norfolk CCG has invested additional funding in the Norfolk First Support 'reablement' service which is provided by Norfolk County Council and helps older people to regain their mobility and confidence, for example after hospital care, which enables people to remain living independently.<br>Additional investment has been made with CCGs across Norfolk in the Community Epilepsy service, helping to reduce the need for hospital services and providing improved care. |
| **Tackling Inequalities in Communities**<br>Providing support for those who are most vulnerable in localities | WNCCG has supported Norfolk County Council colleagues in rolling out 'Social Prescribing' across all practices. This is supporting patients to access the right community support services that |

| | |
|---|---|
| using resources and assets to address wider factors that impact on health and wellbeing. | are best able to support them with non-medical issues.<br>WNCCG has also invested in a Nursing Clinic to support homeless people in King's Lynn, working with the Southgates GP Practice and Homeless Charity (Purfleet Trust).<br>NHS England and West Norfolk CCG have worked with colleagues across Norfolk and via a local West Norfolk Dementia Network to support improved dementia services. This has included a pilot project to support patients attending 7 GP Practices, delivered by the Alzheimers Society. This has also included promotion of dementia services and support via the 'Lily' service (provided by the Borough Council of King's Lynn and West Norfolk in conjunction with a consortium of local voluntary sector organisations). |
| **Integrating Ways of Working**<br>Collaborating in the delivery of people centred care to make sure services are joined up, consistent and makes sense to those who use them. | As part of the work to transform health and care services across Norfolk and Waveney, five Local Delivery Groups (LDGs) have been established, with one in West Norfolk. The LDG meets on a monthly basis in King's Lynn.<br>Partners include:<br>• NHS West Norfolk CCG<br>• Norfolk County Council<br>• Norfolk Community Healthcare NHS Trust<br>• Norfolk and Suffolk NHS Foundation Trust<br>• Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust<br>• Borough Council of King's Lynn and West Norfolk<br>• West Norfolk Healthcare Ltd<br>• Healthwatch<br>• Community Action Norfolk<br>The purpose of the LDG is to implement and monitor local delivery of transformational service initiatives identified by the STP programme.<br>Work is moving at pace and will involve the use of population health modelling to redesign how we deliver health and care services in West Norfolk. As part of this work, WNCCG, working with its partners, is currently piloting the West Norfolk Escalation Avoidance Team – West (NEAT), a multi-disciplinary team that puts an integrated package of care in place for people who develop a health crisis. |

| | |
|---|---|
| | WNCCG has worked with Norfolk County Council to deliver Accommodation Based Reablement services, which provide support to patients who require support in a care home to regain independent living skills before returning home.<br>WNCCG has commissioned a new In-Patient Unit, provided by Norfolk Hospice Tapping House, to deliver high quality palliative and end of life care. This works closely with our West Norfolk Integrated Palliative Care Service, which also includes Norfolk Community Health and Care, Norfolk County Council, Macmillan and Marie Curie.<br>There has been additional investment in the 'Improving Access to Psychological Therapies' service (provided by Norfolk and Suffolk Foundation Trust) to support people with anxiety and depression, with a particular focus recently on ensuring that this support is offered to people with Long Term Conditions (such as Diabetes), in association with acute and community service providers. |

The Norfolk Health and Wellbeing Board has been consulted over the contents of this section of the report. It was sent to the February 2019 meeting of the Board for information and comment.

| Report title: | Prevention Concordat for Better Mental Health |
|---|---|
| Date of meeting: | 13 February 2019 |
| Sponsor (H&WB member): | Louise Smith, Director for Public Health |

## Reason for the Report

To share with the Health & Wellbeing Board the context and principles set out in the Prevention Concordat for Better Mental Health and ask them to sign up to a cross sector approach.

## Report summary

The Prevention Concordat for Better Mental Health led by Public Health England provides a consensus statement whereby local authority, NHS, education settings, voluntary sector and employers pledge to align their mental health prevention approaches to the priorities stated.

The ambition of the concordat is to bring together these organisations to provide a prevention approach to improving public mental health and to achieve a more equitable community.

The focus on prevention to increase joint cross-sector action, work collaboratively and build workforce capacity and capability links with the Health and Wellbeing strategy & partnership 2018-22.

## Recommendations

The HWB is asked to:

1. To review, agree and sign up to the set of statements, listed below.
2. To agree to work together to develop a shared system action plan for better mental health

## 1. Background

1.1 In 2018 Public Health England set out the expectations and principles in a document called The Prevention Concordat for Better Mental Health which is underpinned by an understanding that taking a prevention-focused approach to improving the public's mental health is shown to make a valuable contribution to achieving a fairer and more equitable society.

1.2 The NHS Five Year Forward View outlines and promotes a public mental health informed approach to prevention along with a range of relevant guidance and evidence-based interventions and delivery approaches.

1.3 The concordat promotes evidence-based planning and commissioning to increase the impact on reducing health inequalities. The sustainability and cost-effectiveness of this approach will be enhanced by the inclusion of action that impacts on the wider determinants of mental health and wellbeing.

## 2. Prevention Concordat for Better Mental Health

2.1 In 2018 the Norfolk and Waveney Sustainability & Transformation Partnership (STP) commissioned a review of adult mental health services which has resulted in a 10-year strategy and provides an opportunity to strengthen the prevention and wellbeing approach across the county.
https://www.healthwatchnorfolk.co.uk/ingoodhealth/stp-mental-health/

2.2 The Prevention Concordat for Better Mental Health intends to provide a focus for cross-sector development and action to deliver a tangible increase in taking a public mental health approach in Norfolk.

2.3 In agreeing to the consensus statement, organisations agree to incorporate the following statements/principles into their mental health prevention work.

2.3.1 To transform the health system, we must increase the focus on prevention and the wider determinants of mental health. We recognise the need for a shift towards prevention-focussed leadership and action throughout the mental health system; and into the wider system. In turn, this will impact positively on the NHS and social care system by enabling early help using a range of upstream interventions.

2.3.2 There must be joint cross-sectoral action to deliver an increased focus on the prevention of mental health problems and the promotion of good mental health at local level. This should draw on the expertise of people with lived experience of mental health problems, and the wider community, to identify solutions and promote equality.

2.3.3 We will promote a prevention-focused approach towards improving the public's mental health, as all our organisations have a role to play.

2.3.4 We will work collaboratively across organisational boundaries and disciplines to secure place-based improvements that are tailored to local needs and assets, in turn increasing sustainability and the effective use of limited resources.

2.3.5 We will build the capacity and capability across our workforce to prevent mental health problems and promote good mental health, and Workforce Development Framework Call to Action.

2.3.6 We are committed to supporting local partners to adopt this Concordat and its approach.

2.4 In summary we ask the Health & Wellbeing Board members to agree and sign up to the six statements shown above.

2.5 Further information can be found at the link below:

https://www.gov.uk/government/publications/prevention-concordat-for-better-mental-health-consensus-statement/prevention-concordat-for-better-mental-health#about-the-concordat

**Officer Contact**

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


| Name | Tel | Email |
|---|---|---|
| Sally Hughes | 01603 638361 | Sally.hughes@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.