Norfolk Health & Wellbeing Board

with Norfolk and Waveney Health and Care Partnership (NWHCP) Oversight Group Members

Date: **Wednesday 01 December 2021**
Time: **9.30am**
Venue: **Council Chamber, County Hall, Martineau Lane, Norwich**

Representing	Membership	Substitute
Cabinet member for Adult Social Care, Public Health and Prevention, Norfolk County Council	Cllr Bill Borrett*	
Cabinet member for Childrens Services and Education, NCC	Cllr John Fisher*	
Leader of Norfolk County Council (nominee)	Cllr Lana Hempsall	
Adult Social Services, NCC	James Bullion	Debbie Bartlett
Borough Council of King's Lynn & West Norfolk	Cllr Sam Sandell	Cllr Elizabeth Nockolds
Breckland District Council	Cllr Alison Webb	Cllr Sam Chapman-Allen
Broadland District Council	Cllr Fran Whymark	Cllr Roger Foulger
Cambridgeshire Community Services NHS Trust	Matthew Winn	
Children's Services, Norfolk County Council	Sara Tough	Sarah Jones
Director of Public Health, NCC	Dr Louise Smith	
East Coast Community Healthcare CIC	Ian Hutchinson	Tony Osmanski*
East of England Ambulance Trust	Terry Hicks	
East Suffolk Council	Cllr Mary Rudd	Cllr Alison Cackett
Great Yarmouth Borough Council	Cllr Emma Flaxman-Taylor	Cllr Donna Hammond
Healthwatch Norfolk	Patrick Peal	Alex Stewart
James Paget University Hospital NHS Trust	Anna Hills	Anna Davidson*
NHS Norfolk & Waveney CCG	Tracy Williams	
NHS Norfolk & Waveney CCG	Dr Anoop Dhesi*	
Norfolk Community Health & Care NHS Trust	John Webster	Geraldine Broderick*
Norfolk Independent Care	Dr Sanjay Kaushal	
Norfolk Constabulary	ACC Nick Davison	Supt Chris Balmer
Norfolk & Norwich University Hospital NHS Trust	David White*	Sam Higginson
Norfolk & Suffolk NHS Foundation Trust	Stuart Richardson	
North Norfolk District Council	Cllr Virginia Gay	Cllr Emma Spagnola
Norwich City Council	Cllr Beth Jones	
Police and Crime Commissioner	Giles Orpen-Smellie	Dr Gavin Thompson
Queen Elizabeth Hospital NHS Trust	Caroline Shaw	Prof Steve Barnett*
South Norfolk District Council	Cllr Alison Thomas	Cllr Florence Ellis
Norfolk and Waveney Health and Care Partnership (Chair)	Rt Hon Patricia Hewitt*	
Norfolk and Waveney Health and Care Partnership (Executive Lead) & NHS Norfolk & Waveney CCG	Melanie Craig*	
Voluntary Sector Representative		Pete Boczko
Voluntary Sector Representative	Dan Mobbs	Hilary MacDonald
Voluntary Sector Representative	Alan Hopley	Daniel Childerhouse

Additional NWHCP Oversight Group members invited as guests:

Suffolk Health and Wellbeing Board	Cllr Beccy Hopfensperger	

**Joint members of the NWHCP Oversight Group and Health and Wellbeing Board*

For further details and general enquiries about this Agenda please contact the Committee Administrator:

Jonathan Hall on 01603 679437 or email: committees@norfolk.gov.uk

Norfolk Health & Wellbeing Board

Wednesday 01 December 2021
Agenda
Time: 9:30am

1.	Apologies	Committee Officer	
2.	Chair's opening remarks	Chair	
3.	To approve the minutes of the meeting held 29th September 2021	Chair	(Page 3)
4.	Actions arising	Chair	
5.	Declarations of interests	Chair	
6.	Public Questions (How to submit a question) Deadline for questions: **9am, Monday 29 November 2021**	Chair	
7.	Urgent arising matters	Cllr Bill Borrett	
8.	Delivering our Joint Health and Wellbeing Strategy	James Bullion	(Page 11)
9.	Health Inequalities data in Norfolk Part A – Health Inequalities data in Norfolk **(presentation)** Part B – System progress and next steps **(presentation)**	Louise Smith Tracy Williams / Howard Martin	(Page 24) (Page 26)
10.	Developing our Integrated Care Partnership	James Bullion	(Page 31)
11.	All Age Carers Strategy for Norfolk and Waveney 2022 - 25 Progress Report **(presentation)**	James Bullion / Sharon Brooks	(Page 36)
12.	Norfolk Better Care Fund 2021/2022 Submission **(presentation)**	James Bullion / Nick Clinch / Bethany Small	(Page 39)
13.	Adult Social Care Winter Plan **(presentation)**	James Bullion / Chris Scott / Rachel Peacock	(Page 73)

Further information about the Health and Wellbeing Board can be found on our website at:
About the Health and Wellbeing Board

Health and Wellbeing Board
with Norfolk and Waveney Health and Care Partnership (NWHCP) Oversight Group Members
Minutes of the meeting held on 29 September 2021 at 09:30am
in Council Chamber, County Hall Martineau Lane Norwich

Present:	**Representing:**
Cllr Bill Borrett*	Cabinet member for Adult Social Care, Public Health and Prevention, Norfolk County Council
James Bullion	Adult Social Services, NCC
Cllr Elizabeth Nockolds	Borough Council of King's Lynn & West Norfolk
Cllr Alison Webb	Breckland District Council
Cllr Fran Whymark	Broadland District Council
Sara Tough	Children's Services, Norfolk County Council
Dr Louise Smith	Director of Public Health, NCC
Terry Hicks	East of England Ambulance Trust
Cllr Alison Cackett	East Suffolk Council
Cllr Emma Flaxman-Taylor	Great Yarmouth Borough Council
Patrick Peal	Healthwatch Norfolk
Jonathan Barber	James Paget University Hospital NHS Trust
Cllr Lana Hempsall	Leader of Norfolk County Council (nominee)
Tracy Williams	NHS Norfolk & Waveney CCG
Dr Anoop Dhesi*	NHS Norfolk & Waveney CCG
ACC Nick Davison	Norfolk Constabulary
David White	Norfolk & Norwich University Hospital NHS Trust
Oli Matthews	Norfolk & Suffolk NHS Foundation Trust
Melanie Craig*	Norfolk and Waveney Health and Care Partnership (Executive Lead) & NHS Norfolk & Waveney CCG
Cllr Virginia Gay	North Norfolk District Council
Cllr Beth Jones	Norwich City Council

** Joint members of the NWHCP Oversight Group and Health and Wellbeing Board*

Officers Present:

Hannah Bailey	Public Health Policy Manager
Tom Bassett	Partnerships Board Transformation Manager
Michael Bateman	AD SEND Strategic Improvement Learning & Inclusion
Jonathan Hall	Committee Officer
Nicola LeDain	Committee Officer
Heather Roach	Chair Norfolk Safeguarding Adults Board
Chris Robson	Chair of the Norfolk Safeguarding Children Board
Walter Lloyd-Smith	Board Manager, Norfolk Safeguarding Adults Board
Stephanie Tuvey	Advanced Public Health Officer (Health & Wellbeing Board)

1. Apologies

1.1 Apologies were received from Peter Boczko, Cllr John Fisher, Rt Hon. Patricia Hewitt, Ian Hutchison, Dan Mobbs, Alan Hopley, Giles Orpen Smellie, Josie Spencer, Matthew Winn, Cllr Sam Sandell (Cllr Elizabeth Nockolds substituting), Sam Higginson (David White substituting) Anna Hills (Jonathan Barber substituting), Cllr Mary Rudd (Cllr Alison Cackett substituting) and Caroline Shaw (Dr Claire Fernandez substituting).

1.2 Also absent was Dr Sanjay Kaushal.

2. Election of Chair

2.1 Cllr Bill Borrett was proposed by Cllr Alison Webb and seconded by Cllr Emma Flaxman-Taylor.

2.2 Cllr Bill Borrett was **duly elected** as Chair of the Health and Wellbeing Board for the ensuing Council year.

3. Election of Vice-Chairs

3.1 Cllr Alison Thomas was proposed by Cllr Fran Whymark and seconded by David White.

3.2 Tracy Williams was proposed by Dr Anoop Dhesi and seconded by Melanie Craig.

3.3 Cllr Alison Thomas was **duly elected** as Vice-Chair of the Health and Wellbeing Board for the ensuing Council year.

3.4 Tracy Williams was **duly elected** as Vice-Chair of the Health and Wellbeing Board for the ensuing Council year.

4. Declarations of Interests

4.1 None

5. Minutes

5.1 The minutes of the meeting held on 10th March 2021 were agreed as an accurate record and signed by the Chair.

6. Chair's Opening Remarks

The Chair welcomed members and substitutes to the meeting which was the first meeting back in person since the start of the pandemic. The Board had not met since March 2021, given the important work undertaken by members in dealing with the pandemic. The Chair thanked all members and substitutes for their attendance.

7. Actions arising

7.1 None

8. Public Questions

8.1 Two questions had been received and the responses had been published on the County Council's website.

9. Health and Wellbeing Board Governance Update

9.1 The Health and Wellbeing Board received the report which was introduced by James Bullion. The Chairman took the opportunity to welcome the new members of the Board. David White from Norfolk and Norwich University Hospital NHS Trust outlined that the Trust felt it more appropriate going forward for the Chairman to be a member of the HWB as opposed to the CEO of the Trust.

9.2 The Health and Wellbeing Board **AGREED** to**:**

a) Note that Norfolk County Council has amended its constitution to include East of England Ambulance Trust Membership for the HWB.
b) Note the changes to HWB representation from organisations and officially welcome new members to the Board.
c) Note the HWB attendance record for April 2020 – April 2021 (Appendix A).
d) Delegate further discussions around the governance arrangements for the Health and Wellbeing Board and Integrated Care Partnership to James Bullion and Melanie Craig, with a formal proposal brought to the Board for endorsement.
e) Support the proposal to invite the Chair of the Norfolk and Waveney VCSE (Voluntary, Community and Social Enterprise sector) Health and Social Care Assembly to be a member of the Health and Wellbeing Board, under the membership for the VCSE sector.
f) Note the changes to representation for the Norfolk and Norwich University NHS Trust.

9.3 Cllr Lana Hempsall joined the meeting.

10. Delivering our Joint Health and Wellbeing Strategy

10.1 The Health and Wellbeing Board received the report, which was introduced by James Bullion. The report outlined the statutory requirement for all Health and Wellbeing Boards to produce a local, Joint Health and Wellbeing Strategy and looked back on progress against the strategy's priorities during 2020/2021.

The report then outlined the need to drive improvements and refocus the Board's vision in a different landscape to when it was originally launched, and so a review and refresh of the Joint Health and Wellbeing strategy was recommended.

10.2 ACC Nick Davison joined the meeting.

10.3 The following points were discussed and noted:

- Greater focus was required on wellbeing aspects in addition to health. The strategy needed to be more holistic to include prevention, education and environmental health works.
- The term prevention needs to be clearly defined at all health and care levels and in the context of demand.
- The effects of domestic abuse are very influential within wellbeing, with a fifth of all recorded crimes relating to the issue. In addition, it was acknowledged that much domestic abuse goes unreported.
- The refresh of the strategy also needs to align with that of the ICS and take in to account the needs of patients, as the sector comes out of the pandemic and deals with the backlog of treatment required.
- Addressing inequalities, funding the increase of mental health demands, and promoting the need for prevention were also thought to be key issues for the refreshed strategy.
- Work had been commissioned with Britain Thinks to ascertain what the public understand by prevention and what interventions they can currently access. .
- HealthWatch Norfolk have also been asked to undertake a literature review and small programme of engagement as to what provides good health, wellbeing and prevention.
- The proposed Health and Wellbeing Board Awards and Conference Programme would be an important opportunity to recognise the dedication of the workforce during the pandemic and bring wider partners together in commitment to the

refreshed strategy.

10.4 The Health and Wellbeing Board **AGREED** to:.

a) Endorse the progress against the JHWBS vision and priorities for 2020 /2021 (Appendix A).
b) Endorse the proposal for reviewing and refreshing the JHWBS for 2022 and commit to engaging with the process on behalf of Member organisations.
c) Comment on the joint commitments that could be strengthened through the review and refresh process.
d) Support the re-launch of the HWB Awards and Conference and agree that this activity is focussed on prioritising prevention.

11. Developing Norfolk & Waveney's Integrated Care System

11.1 The Health and Wellbeing Board received a report which was presented by Melanie Craig. The report updated the Board on progress with developing Norfolk and Waveney's Integrated Care System (ICS) since March 2021.

11.2 The following points were discussed and noted:

- The prevention theme is a high priority for the new ICS as well as the wider concerns of wellbeing. Ensuring staff are protected and valued will mean that patients receive the highest care possible.
- The changes involve a measure of devolution and were welcomed. The 'place' level arrangements are complex and required further thought and discussions with organisations and partners. It was felt it was important to obtain a local view to investigate how services could be delivered which will involve more community engagement in the process. Duplication at the place level should be avoided.
- Transition had been happening more slowly than previous reorganisations as the last three years had demonstrated. The process will be completed by April 2022 although not all changes will have happened by then.
- The transition in Norfolk and Waveney had been smoother because the direction of travel had been acted upon earlier by the merger of five CCGs in to one.
- The pandemic had proven that greater collaboration amongst service providers had been very fruitful, the Covid 19 vaccination programme had been a good example of this.
- The objectives of the Integrated Care Board and the Integrated Care Partnership do need to align.. The Integrated Care Partnership will have a core focus on prevention. The 'place' partnerships on district council boundaries will be helpful to provide focus to the key objectives.
- It was important to ensure the momentum is not lost as services are restored and the crisis of the pandemic eases.
- The goal of "telling your story once" was essential particularly for patients moving from primary to secondary care. The patient sees health care as one, not different sectors.
- Implementation of the new system will be complex. The system is not dismantling the current architecture but over laying it with the new ICS arrangements. The implementation stage is a golden opportunity to ensure that collaboration is key

rather than competition.

- A simplified and practical approach to the relationship between the Health and Wellbeing Board and the Integrated Care Partnership was desirable, albeit within the statutory constraints It would be important to avoid duplication, streamline and reduce bureaucracy.
- The acute hospitals were working together to develop processes to have a single waiting list, albeit this was a long-term aim as the current backlog is an enormous challenge.
- District Councils were ready and willing to help support the ICS if delegation and resource was passed down.
- The transfer of direct and specialised commissioning raises the challenge of access to GPs and especially access to dentistry, both of which were difficult. Unfortunately, the new arrangements by April 2022 will not make access easier as in the case of dentistry, the budget has been reduced dramatically and dentists have no incentive to take on NHS work due to the national policy and contract. Lobbying was required at a national level and members were advised to pursue this to help drive improvements to the dentistry service.
- The integration of Childrens Services within the new ICS governance should be considered so there is no duplication or disruption of services. Schools within the local level are important in the role of children's health, wellbeing and safety as the recent pandemic had proven.
- The James Paget Hospital is on the new hospital build programme. This placing is not to replace the current hospital but as system capacity which provides the ICS with a good opportunity to utilise this extra resource.
- Reducing health inequalities was a key ambition of the new ICS. The 'place' based arrangements, together with the five alliances and the district councils, are ideally situated to tackle that work which would need to see a delegation of responsibility, decision making and resource from the ICS.

11.3 The Health and Wellbeing Board **AGREED** to:

a) support the continued development of the Norfolk and Waveney Integrated Care System.

12. Norfolk Autism Partnership Board Update, Autumn 2021

12.1 The Health and Wellbeing Board received a report and presentation (see appendix A) from Tom Bassett. The presentation outlined the progress made by the Norfolk Autisum Partnership Board since the last report to the Health and Wellbeing Board in 2019.

12.2 The following points were discussed and noted:

- James Bullion advised that the annual report from the partnership had been received in 2019 where it was agreed it would continue to be presented to the Board annually. The latest report had been discussed at a recent Chair and Vice Chair's meeting.
- The Board were pleased to see the high number of staff who had undertaken the training with over 4500 NCC staff having undertaken the e learning and 1000 staff participated in the day course.The eLearning is also available for free on the Norfolk Autism Partnership website, with 300+ people accessing the training and 12 organisations trained to deliver the day course. The Chairman encouraged any staff or member who has not yet undertaken the training to do so. Those members that had undertaken the training advised it was very useful in understanding and improving communication with Autistic people.

- It was reminded that Autism is a syndrome and the pathway to diagnosis did not have a single diagnostic test. For many people the diagnosis wasn't as important as the support, understanding and considerations required for their day to day living.

12.3
- Autism diagnosis waiting times whilst improving are still very challenging. Many people do not receive a diagnosis until later in life.

The Health and Wellbeing Board **AGREED** to continue to:

a) Signpost organisations to the Autism eLearning on the NAPB website to work towards a more inclusive Norfolk.
b) Support in the wider engagement activities of the NAPB by offering resource, time or links to relevant parties.

12.4 Cllr Beth Jones left the meeting

13. Norfolk Area Special Educational Needs & Disability (SEND) Strategy

13.1 The Health and Wellbeing Board received the report highlighting the need to endorse and support the implementation of the strategy. The Area SEND Strategy was a self-contained strategic document setting out Norfolk's current 4 priorities for SEND and the associated high level action plan and key performance indicators. The report was presented by Maxine Blocksidge.

13.2 The following points were discussed and noted:

- It was important for members to not only endorse the strategy but to own it as an area and to provide the necessary leadership for its implementation.
- There are three areas in the written statement of action that arose from the inspection; timeliness and quality of education health and care plans, communication and co-production, and adequate provision for young people as

13.3 they move into adulthood. Each priority has a Board sat around it with the presence of NHS England and the DFE to give added oversight.

- The transition to employment from education for the age group 18 to 25 years olds was being supported by a 'preparation for adult life group' which starts working with children from age 14. There are other groups which work with children for preparation of adult life. Within the strategy itself there are clear elements to support the transition such as providing work experience opportunities.

The Health and Wellbeing Board **AGREED** to

a) Endorse the refreshed Area SEND Strategy for Norfolk.

b) To provide leadership to the implementation of the Area SEND Strategy to ensure that all agencies, partners and stakeholders are aware of the priority actions and support these equally in the strategic and operational work of the children's 'system' across Norfolk.

14. **Norfolk Safeguarding Annual Report for 2020-21: Safeguarding adults during a global pandemic**

14.1 The Health and Wellbeing Board received the report which was presented by Heather Roach. The report summarised the work of the Norfolk Safeguarding Adults Board (NSAB) and the wider partnership's adult safeguarding activity during 2020/21. It set out the work done to safeguard those at risk of abuse and harm in very challenging and fast changing circumstances of the response to the Covid-19 pandemic.

14.2

The following points were discussed and noted.

- The Board welcomed the report and the positive outcomes that had been achieved over the pandemic.
- The Domestic Abuse Partnership Perpetrator Approach (DAPPA) programme was working well because of additional funding added to the domestic abuse support and because of the strong working relationship with Norfolk Constabulary.
- Two routes were available within the DAPPA programme for offenders. The first being a diversionary pathway and the second, for those who are non-compliant and refusing to engage, there was a disruption pathway.
- The domestic violence disclosure scheme gives individuals the right to be aware of offenders and their previous behaviour.
- It was suggested that an item around preventative approaches for addressing Domestic Violence was brought to the Health and Wellbeing Board at a future meeting.

14.3

Heather Roach provided a verbal update on the recommendations on the Cawston Park Hospital review.

- Many of the main issues raised by the review were already in progress through a multi-agency action plan
- All remaining patients were removed from Cawston Park Hospital.
- A review of the commissioning arrangements was in place to consider ethical commissioning as well as the removal of medical admissions and social care discharges.
- Issues concerning racism towards patients with cognitive impairments were being addressed.
- National recommendations such as the review of corporate governance of private companies had received support from Jerome Mayhew MP, who was to attend a meeting with the NSAB and the Law Commission in October 2021.
- Meetings had taken place with NHS England to ensure CCGs were aware of what services they were commissioning. In addition, reviews of placements for individuals were also to be considered to ensure physical and mental wellbeing was appropriate for that patient.
- NSAB had met with CQC who responded by advising they are looking to get more families and patients involved in their processes, shorter and more frequent inspections and more tools and training for their staff.
- In future the joint commissioning between Adult Social Services and the CCG will focus on a strengthened single approach with a hoped single funding scheme aimed at providing solutions solely for the individual patient.

14.4 The Health and Wellbeing Board **AGREED** to:

a) Agree the contents of the annual report 2020/21.
b) Promote the work of NSAB to HWB partner organisations and stakeholders.
c) Use its media profile to support the work of NSAB and partners agencies in protecting those adults at risk of abuse and harm.

15. Norfolk Safeguarding Children Partnership Annual Report

15.1 The Board heard a presentation by Chris Robson Chair of the Norfolk Safeguarding Children Board (see Appendix B) who also provided the Children's version of the report for members. The Norfolk Safeguarding Children Partnership (NSCP) Annual Report summarises the local arrangements for safeguarding children, which includes governance and strategic overview; Norfolk's response to Covid-19; independent scrutiny; progress against NSCP priorities; learning from Serious Case Reviews/Safeguarding Practice Reviews; training and workforce development; and the voice of the child.

15.2 The following points were discussed and noted:

- The report was well received by the Board and Chris Robson was thanked for his involvement.
- The genuine engagement and involvement of young people in the report was commended.
- The three strands of the partnership (Norfolk County Council, NHS and Norfolk Constabulary) had a very strong relationship and meet at least 4 times a year as well as frequent informal engagement. Such a strong partnership was not common across the country and the value this provided should not be underestimated.
- Chris Robson's role is independent and provides a check and balance for the Board members reassurance.
- The multi-agency training that has been delivered and the children's version of the NSCP's annual report are finalists in the LGC awards.

15.3
- The Safeguarding campaign undertaken through the pandemic period is also a finalist in the forthcoming public sector public relations award.

15.4 The Health and Wellbeing Board provided comment on the contents and **AGREED** to:

a) endorse the report.

The Chairman thank all those who attended the meeting and reminded members of the Board's Development Session to be held on October 27th 2021.

Meeting concluded at 12.13pm

Bill Borrett, Chair,
Health and Wellbeing Board

Report title: Delivering our Joint Health and Wellbeing Strategy

Date of meeting: 01 December 2021

Sponsor (HWB member): James Bullion, Executive Director Adult Social Services

Reason for the Report

There is a statutory requirement for all Health and Wellbeing Boards (HWB) to produce a local, Joint Health and Wellbeing Strategy (JHWBS). It is important that the Board continues to take collective accountability for reviewing progress against our JHWBS and to agree next steps in driving forward the delivery of our commitments.

Report summary

Following the Board's agreement in September to beginning a process of reviewing and refreshing the Joint Health and Wellbeing strategy, this report will update Members on progress and outline next steps.

Recommendations

The HWB is asked to:

a) Consider and review the feedback so far from stakeholder interviews and research from BritainThinks. Agree to the next steps, as set out in section 3 below which aim to ensure a strong effective relationship between the development of both the Joint Health and Wellbeing Strategy, and the Health and Care Strategy.

1. Background

1.1 Late 2018 saw the launch of the Joint Health and Wellbeing Strategy, visit our Joint Health and Wellbeing Strategy (JHWS) page to learn more. It sets out a vision of a single, sustainable health and wellbeing system - prioritising prevention, tackling inequalities in communities and integrating ways of working - and stands as our system-wide, shared commitment to taking collective accountability for the health, care and wellbeing of our communities.

1.2 At the last meeting of the Health and Wellbeing Board, Members agreed to support a process of reviewing and refreshing the strategy so that it can continue to drive improvement and refocus our vision in a different landscape to when it was originally launched.

1.3 Work has been underway on some key activity to support this process and this report updates Members, asks for continued support and outlines next steps.

2. Progress

2.1 **Health and Wellbeing Board Member 121 Interviews:** A programme of 121 interviews with HWB Members has been conducted to understand the impact organisations have had during the pandemic, how organisations have supported delivery of the current strategy, where the strategy has been making a positive impact and what could be strengthened and improved in the refresh process.

Participation in the interviews has been excellent with Member engagement offering a range of rich feedback to support the refresh of the strategy. We are very grateful for people finding time to take part.

2.2 A total of 27 interviews have been completed and Appendix A details**: A high level summary of key findings:** Responses to the questions asked in the interviews have been themed to present the key emerging themes from HWB Members.

2.3 Engaging with our communities:

2.4 Alongside the stakeholder interviews we also commissioned research and engagement to help understand better the impact of the strategy and gain insight into people's understanding of and attitudes to prevention. The strategy refresh offers the opportunity to re-align our aspirations for prevention, so that as system leaders we can provide a consistent framework for our workforce and organisational delivery plans and a meaningful vision for our communities. Healthwatch Norfolk and BritainThinks have been commissioned to support this work, and progress is as follows:

2.4.1 **Healthwatch Norfolk:**
Healthwatch Norfolk is carrying out a program of work aligned to the three prevention priorities of the original strategy to inform the refresh.
The three priorities are:

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

Healthwatch Norfolk **will achieve these objectives through a three-phase approach**:

- **A desk based practice review** – review of best practice in prevention initiatives in health and social care at local and national level, focussing on areas demographically similar to Norfolk and Waveney.
- **Focus groups with service users** – topics currently being defined but likely to include exploration of people's attitudes towards prevention, testing their understanding, establishing the type of prevention interventions people have taken up or would like to take up and their reflections on the accessibility and usefulness of these interventions.
- **Survey work** – to be defined but will test prevalence in wider population of themes which emerge from focus groups.

  Reporting will be ongoing with final outputs tailored to audience as appropriate including public facing report on Healthwatch Norfolk website.

  The **timescale for this work is October 2021- April 2022.**

2.4.2 **BritainThinks**
The **primary objective of the research** led by BritainThinks is to 'Understand the public's starting point on prevention: How they understand it; how important it is to them; the extent to which they engage with prevention interventions and recognise them as such'. Secondary objectives are to: 'Support the development of a definition of prevention for the strategy that is meaningful to people' and 'Generate real-world case studies showing where prevention has had an impact on participants' quality of life'.

BritainThinks will achieve these objectives through a four-phase approach:

- An initial immersion phase to understand the Joint Health and Wellbeing Strategy priorities.
- Phase 2 - ten x two-hour online focus groups of approximately six participants each focus group, plus four x 45-minute in depth interviews with people who are less digitally enabled.
- Phase 3 – fourteen follow-up case study interviews.
- Phase 4 - reporting including PowerPoint presentation, pen portraits and an opportunity for an online briefing.

Phases one and two are complete and the key points from the interim findings are found below:

Key Findings

1. Participants tend to draw a distinction between what it means to be 'healthy', and what it means to be 'well' – the former more strongly associated with physical health, the latter interpreted more holistically including a greater focus on mental health. Taking care of both health and wellbeing is seen as a greater priority now than it did pre-pandemic.

2. While physical health has always been considered important, mental health is increasingly being prioritised too. Participants expressed a perception that mental health problems are more common than they have ever been, and increasingly prevalent – both at a national and local level.

3. Norfolk is generally seen as 'healthy' place to live. The natural geography allows for many opportunities to feel healthier both physically and mentally, including fresh, clean air (and low levels of pollution) and access to green space. However, local health and care services are felt to struggling to consistently meet the needs of residents, as evidenced by services being suspended and difficulties getting appointments.

4. Prevention is broadly understood as a concept (i.e., the idea that you take action earlier on to stop things going wrong / getting worse) although it has relatively low salience in the context of health and wellbeing. When prompted, most default to thinking about interventions by healthcare professionals and/or measures focussing on physical health.

5. Definitions of prevention that are focused on offering early help to promote physical and mental health, and which are seen to prioritise people's health and wellbeing (rather than reducing demand on services) resonate most strongly. However, given some felt that they might be unlikely to accept early help in reality, and deprioritise issues they feel are minor until they become more serious, any definition needs to work harder to land the message of *why* prevention is important (e.g., focusing on longer-term benefits).

The **timescale for this work is September - December 2021**.

The findings from both pieces of research will be presented to the Health and Wellbeing Board as part of a workshop in the New Year.

3. Next Steps

3.1 Since the work to review the health and wellbeing strategy began, there has been more detailed guidance published about the expectations of the ICS as a whole and the ICP, in particular. This includes the requirement for a Health and Care Strategy developed and

overseen by the ICP, which will need to have a clear relationship with Joint Health and Wellbeing Strategy. It is therefore suggested that in the New Year a workshop is held which reviews the engagement findings to date, alongside any further guidance on the health and care strategy. This will be an opportunity to take soundings on how best to progress both strategies so we have the most effective strategic and delivery framework for the Health and Wellbeing Board and the Integrated Care Partnership.

Officer Contact

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

Name	Tel	Email
Debbie Bartlett	01603 303390	Debbie.Bartlett@norfolk.gov.uk

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

Appendix A
Joint Health and Wellbeing Strategy Refresh –
Summary of key findings from HWB member discussions

1. The main impacts organisations have made during the Covid-19 pandemic:

- **Joint working leading to new ways of working**

For many organisations the pandemic brought the need to find new ways of working to deliver services to support Norfolk and Waveney communities. This involved breaking down some of the organisational barriers to support one another and move resources accordingly. It was all about bringing the whole system together to use collective resources and share duties and responsibilities to make sure resources were used to their best effect. HWB members recalled the benefits sharing resources brought with many organisations redeploying staff to support other organisations such as the James Paget Hospital staff being redeployed in the Norfolk and Norwich University Hospital, Environmental Health Officers supporting the Track and Trace efforts and co-ordinating leisure staff across district councils to provide on the ground support.

Many noted that this accelerated organisations to work collaboratively with partners and in doing so has really boosted working relationships and innovation across the system. It was felt that the HWB has built up relationships amongst partners and of particular value during the pandemic was the relationship between the NHS and local government, and the need for this to be built upon with future changes across the system.

In turn some members reported the significant impact the pandemic had on their ways of working and the need to change at pace to look to work very differently to manage the demands. This was seen to have a positive impact and was something members felt should be held onto moving forwards and not revert back to old ways of working. For example, in the NHS virtual consultations increased in 5 weeks rather than 5 years as the NHS plan set out originally which has led to progress on working together as a system, yet it was recognised that there is still too often working in silos. The push to use technology proved a success with investment on hardware and software, yet the willingness was always there to do this in the future.

One example noted that many services moved to telephone triage such as Smoke Free and as a result existing pressures on that service were released. Home swabbing was another example of new ways of working before operations could take place alongside supporting patients with Learning Difficulties with accessible information which they could understand explaining the reasons why home swabbing was important.

- **Supporting communities**

HWB members expressed the need to support and protect vulnerable people across Norfolk. It was clear there was lots of communities that needed support with basic needs such as food and medication. District councils delivered food parcels, made wellbeing calls making sure people were ok and remained connected within their

community, supported by co-ordination from Norfolk County Council (NCC). This work led to further advocacy work in supporting people who had become more vulnerable because of the pandemic. For many partners there was an increasing concern of poverty and inequalities across Norfolk and Waveney and ensuring people were identified who were seen as falling through the gaps.

- **System Leadership:**

HWB members spoke of the key role system leadership took throughout the pandemic noting local resilience arrangements, establishing system wide arrangements for children and young people and the need to understand what was happening in response to the Covid-19 outbreak by providing clear messages and communication with communities, partners and members. This leadership was described as bringing early understanding of impact of covid on our population and deepened partnerships and joint working both at an operational level and commissioning level.

The Covid Vaccination programme was cited as one example of this, standing up that programme quickly with volunteer support meant that Norfolk was the first in the country to set up assessable clinics for people with learning difficulties and or autism. Work was undertaken with families to understand what would support these individuals to get their vaccine and this was put into practice.

2. The main impacts we have seen on our communities as a result of the Covid-19 pandemic:

- **Impact on workforce**

HWB members highlighted the unprecedented intense pressures the health and care system has experienced during the pandemic and is currently still experiencing today. The rising pressures on families has brought pressures for staff working within the health and care system. All organisations continue to manage the changes brought about by the pandemic and as a result noted seeing the impact on colleagues and staff. They are exhausted, stressed, unwell, tired and stretched and as staff shortages continue the pandemic is still not over and many recalled only now seeing the real impacts as colleagues remained working throughout which has had an impact on their mental health and wellbeing as the pressure has not lifted. HWB members expressed the need to support our workforce to ensure resilience going forwards into winter and beyond.

- **Effect on individual's health and wellbeing**

Many expressed the toll the pandemic has had on people's health particularly with regard to mental health, for many mental health issues are now coming to the fore and have been exacerbated during this difficult time. Many impacts were attributed to this increase in the need for mental health support such as fear, financial worries, employment worries, health worries and isolation. The mix of these complex factors has created vulnerabilities in families that would not have previously identified themselves as vulnerable, coupled with the additional complexities of having children at home, home schooling, and working from home there has been many changes to juggle.

It was noted that the highest increase in need for mental health support has been in children aged 6-10 highlighting the impact on children and young people too. The closure of schools has had a significant impact on children and young people which has disrupted their education and affected their ability to socialise with their peers, as a result some are now reported to have experienced long-term issues because of this.

For many across Norfolk and Waveney their health conditions have worsened and waiting lists for elective procedures has considerably lengthened. HWB members expressed their concern about the effect the pandemic has had on people's ability to lead their lives, to be social and to access health and care services. An example of this is the presentation of some individuals with type 2 diabetes whose control of their condition has deteriorated which in turn will have longer impacts going forwards. Others have become frailer and unhealthier during this period of time with the need to be indoors and lack of exercise has made many feel isolated and cut off from communities, again this will have a lasting impact on people. People have also not accessed services as many services were closed and there is now a rise in presentations and often people are presenting late will illnesses that may have been prevented. Confusion on accessing services during the pandemic has meant many have held on to pain and not wanted to bother services, particularly at this scary time where for some it has felt harder to access help. Patient experience has deteriorated with many left feeling frustrated about length of time they are having to wait.

- **Widening Health Inequalities is evident**

HWB members highlighted that during the pandemic health inequalities had been exacerbated and many members reported seeing magnification of differences in how populations across Norfolk and Waveney have managed during the pandemic. They pointed to widening gaps and areas of concern which had now deepened with some communities being neglected. More than ever, it was felt there was the need to focus specifically on targeting areas of deprivation to provide support and ensure changes to services were made to ensure equity of access for all. HWB members noted that economic deterioration from the pandemic has resulted in changes in peoples home positions and employment which has resulted in families needing wider help with debt, employment, housing, grief and domestic violence to name a few, many of which are linked to Covid19. HWB members spoke of the rising level of poverty people and families are living across Norfolk, especially those in work. They noted that some of the poorest communities didn't benefit from working from home or the furlough scheme as so many were key workers, many families remain impacted by long covid bringing further difficulties.

3. Where the current strategy has had a positive impact:

- **Overarching Framework with relevant priorities**

Fundamentally members saw the Joint Health and Wellbeing Strategy (JHWS) as a good overarching framework that helps guide people and sets a direction of travel to ensures organisations collaborate and work towards the same goals. Many saw it as by coming together as a system we can be greater than the sum of our parts but recognised the importance of organisations owning the strategy's priorities to play their role within the system and contribute. Some felt that the onus is on members actions within their own organisations to build on the strategy, this is what really counts. HWB members expressed agreement that the current priorities of the strategy remain relevant today and may be the right ambitions for the system, but they highlighted that some areas have been heightened by the pandemic. An example of this was the focus around health inequalities and how these have deepened during the pandemic and become far more evident. It was noted that the priorities may mean different things to different organisations, so they need to remain meaningful to all partners of the HWB during the refresh of the strategy. The building blocks are in place these need to be reenergised to build upon our work as a system.

Led to stronger working relationships and joint working

Health and wellbeing were identified as not only the prerogative of the NHS and Social Care but should be everyone's prerogative, as there are many other factors that can affect these such as social interaction, being in employment and having a suitable safe home to live in and therefore health and wellbeing needs to be addressed as a collective whole system. The place of the HWB and the strategy were highly valued by members who noted the success they have brought in working together, in developing a place where open conversations can be held focusing on collaboration rather than competition. It was felt the role of the HWB was strongly valued as it has enabled stronger good working relationships to be built across the system and that with the development of the ICS this should continue to enhance this work. HWB members noted the strength of its partnership and highlighted that still better engagement across counties with other HWBs bringing wider partners together should be sought.

4. Where and how the strategy could be improved:

- **Have a more focused approach for the strategy**

It was strongly conveyed that the refreshed strategy needs a more focused and planned approach that acknowledges what the Board is doing on the fundamental things that affect people's health and wellbeing in Norfolk. There needs to be more emphasis on what the role of the HWB is and what the system wants to achieve with a clear vision, priorities and objectives. Concern was expressed that in the past the strategy has tried to do too much and that as a system we can't do everything. It needs clear commitments on what it means for organisations working to the implementation and delivery of the strategy that focus on action rather than just talking about it, so that organisations can plan their activities to take the system in that direction. However, they noted that people need to acknowledge that in taking a

more focussed approach there are some areas that will not be captured in the strategy.

HWB members articulated the need to focus more on the strategy at the HWB meetings and be mindful of returning to it to reflect on what we have done and are doing on the strategy. They felt it should be more visible and driving our work whilst giving us opportunities to check in on the progress throughout its lifetime, whilst remembering the benefits of having everyone around the table.

It also needs to be recognised that people may need different support following the pandemic and that specific focus on key areas was needed in the strategy refresh. The following areas were mentioned in the view that these need to be a strong focus of the JHWS: Carers, Children and Young People, Mental Health, Obesity and Social Care.

- **Engage with communities on the strategy and focus on our population needs**

HWB members highlighted the importance of engaging with communities across Norfolk and Waveney as it was felt that without genuine engagement, the system could not make a genuine difference to peoples lived experiences. It was those lived experiences that can take you to a whole new level and areas we may not have thought about as a system. Communities need to be able to understand the JHWS, it needs to be written in such a way that means something to the public. To achieve this the strategy must be written using understandable language such as plain English. The JHWS needs to acknowledge what is important to the people of Norfolk and Waveney and make sure that it is reflective of what people want. It was thought that the strategy would only come alive to people if it was made easily accessible and real-life examples were used throughout so they could understand what it means for them and their family.

It was seen that the JHWS needs to be based very clearly on our populations needs and as a system we need understand those needs. It was highlighted that we need to make better use of assets such as the Joint Strategic Needs assessment (JSNA) build strong evidence to tackle things early and focus on long term change. HWB members highlighted the importance of a having a shared understanding of our population and communities using intelligence that provides us with the understanding of what our communities actually look like and need. This would then aid the process pf prioritising the most important areas.

- **More opportunities to build on working relationships**

Whilst HWB members recalled the strong working relationships the board has forged they did note that there can always be more done to help build on those relationships and improve our ability to work together, to really understand each other better and our individual organisations. The Strategy has done a lot to understand the role of the HWB partnership and develop a culture of coproduction and willingness to engage on working together as a system. Some reported that more opportunities to come together as a board informally could really help boost our work especially when discussing ideas and reviewing collaborative solutions.

5. Key learning the system needs to take from Covid-19:

- **Continue joint working to embrace a single sustainable system**

It was noted despite the complexities of the pandemic one positive that was clearly expressed was the progress that was made in such a short timeframe. Barriers were broken down and levels of bureaucracy were reduced due to the urgency of needing to work together as a whole system. HWB members felt it was clear we were all on the same side supporting our population and made it known that our communities do not worry where the help and support comes from as long as they receive the support they need. Good examples were given of teams working well together and a big improvement in integrated ways of working across the system.

HWB members highlighted the importance of not losing sight of our learning around joint working and innovations since the Covid19 pandemic and that the momentum must be maintained by all within the system to move forward, with new ways of working. It was seen that with the developing Integrated Care System (ICS) and changes ahead this was the optimal time to enhance our new ways of working collaboratively across the system and try to embrace the goal of a single sustainable system as we are a long way off that. It was hoped that in light of such long standing barriers being broken down, as a result of the pandemic, there was the willingness there to be embraced and reenergised.

- **Need to focus on health inequalities**

The pandemic has shown that there are many areas that can have a big impact on health and wellbeing such as poor housing and employment. There was strong belief that the pandemic has not caused new problems in relation to health inequalities it has just widened the gaps and therefore as a system it should be a priority of focus that all in the system agree to work on, in partnership. It was felt there needs to be the acknowledgement that in focusing on health inequalities there may be other areas we are unable to focus on. It was highlighted that when working together a more coherent plan could be established and have quite a targeted approach and focus on how we as system where and how we will work better together.

HWB members felt that if the system really wants to reduce and improve outcomes on deprivation and health inequalities the focus is no longer about equitable access, but the focus should be on having the right access to improve health outcomes for the most deprived. It was conveyed that in order to achieve this, as a system we need to focus on doing things differently to create equity for different communities. It was believed this may involve taking services to communities much more than previously.

- **Continue to focus on new ways of working**

Upon reflection of the pandemic HWB members noted the greater impact organisations had and opportunities as a system to actively collaborate with one another in a controlled and manageable way. This was all whilst not feeling that any organisation was more important than another and working at extreme pace. Many felt that the flexible way of working and delivery of services helped to change things for the better, including working attitudes, culture and behaviours towards working together, which must not be lost. An example of this referenced was the need to

work differently with distribution of money across the system and be braver in regard to this. There were calls to keep this ‘can do’ attitude and spirit to keep the agility going and not falling to old habits.

- **Take time to reflect on learning from the pandemic**

From discussions with HWB it was clear they saw the value in reflecting on the pandemic and the need to learn from activity during this time, but many felt that now was too early to do this particularly due to the momentous experience it has been. It was described as an important task we should not shy away from but should be reviewed as a system and evaluate what has happened. It was noted that depending on where you are within the wider system you’ll see one area of the system and ‘see it under your lens’, whereas there may be data used in other areas that could really benefit sharing across the system. It was highlighted that as a system there has not been the time and space to evaluate our experiences yet, as we are still living in the pandemic. Time should be put aside for this in the future and is something the HWB as a forum could perhaps help facilitate.

One example was given of the need to recognise what has gone well, not so well and how we want to work together in the future. For example, it was suggested that remote services have worked well for some outpatients so this approach could be used in the future, but consideration of additional resources to support this would be required as the remote working does have a knock-on effect to other services. HWB members believed strong working relationships across the Norfolk and Waveney system enabled organisations to react as best they could in response to the pandemic but in that wider reflection it was also noted the need for wider emergency planning as a collective system.

6. What we need to do for a renewed and collective effort on prevention:

- **Prevention needs to be embedded in Education**

Many recognised the importance of focusing on prevention across the system, they noted in the past prevention has always been seen as taking place in an ideal world so a shift in our thinking is required, brining action and a long-term plan for the system. It was stated that prevention must start with children and Young people (CYP), setting good foundations to live well into adulthood as this is where the system can have the biggest impact, therefore investment in prevention is vital. The focus should be on how we make a difference to someone’s life. Knowing that children are the most vulnerable in society it was strongly conveyed that that is where we should be focusing on, to make a difference in the long term. It is too late once they start school aged 5. Prevention is a long term commitment that must start in Education, HWB members noted that running public campaigns on prevention would only reach so far and this is where education and prevention need to be brought together, strengthened and taught on the curriculum. There was the

recognition that interventions need to happen earlier with the right messaging to the right people and at the right time.

- **A focused understanding of prevention with agreed priorities as a system**

It was portrayed that there was a lot of rhetoric around prevention and questions were raised regarding the genuine understanding on what it means, and the impact prevention could have if time was dedicated to it. As a system it was noted that there needs to be clarity of what is meant by prevention and an agreement forged on this. It was expressed that detailed conversations on prevention are limited, yet it was seen as a major priority that needs thoughtful and specific refocusing on the prevention agenda noting what we as a system will prioritise in the coming years. Without this it was deemed that the system would have limited impact. It was felt a general blanket approach was not acceptable and refinement was needed to set an ambition for prevention as a system and discuss the specific actions needed to undertake this work. This should be a whole system approach particularly as the NHS focus on treating disease rather than preventing disease so we need to consider the additionality the system can bring and help embed prevention into all areas of the wider system.

What the word prevention means to the public and the communities of Norfolk and Waveney was also seen of upmost importance. Particularly so that communities can understand their role in prevention and what it means for them. It was conveyed that as a system often lots of messages are put out to communities which can become confusing. It was deemed important to engage in the right way with communities on the topic of prevention focusing on coproduction with a clear explanation of prevention that communities will understand in plain English.

- **Concern on pressure in the system – getting the balance on prevention**

HWB members identified the need for consistency in funding to support the prevention agenda but noted the considerable strain the system is currently under and the reality of the financial sustainability of it. The realities today highlight the financial deficit the system is in with increasing demands that results in the inability to divert funding to prevention due to the immediate pressures that are faced. It was highlighted that this may be the case for health and social care meaning they may be unable to give prevention the same focus as wider partners such as voluntary sector organisation so there is a need to invest and to collaborate on this area.

7. How we can better monitor success:

- **Work smarter to link the JHWS to other strategies across the system**

In order to monitor the JHWS it was stated that there needs to be greater and smarter alignment between strategies across the system, there needs to be a constant thread that runs through the strategies to allow them to become more integrated. One strategy reference by many was the Integrated Care Partnership (ICP) and the ability to align that and the JHWS together in the best way possible or

even make them one and the same. HWB member noted that in making strategies meaningful to partners they need to form part of what they are doing as an organisations and it was noted that the timing of strategies was also of vital importance particularly in development of the ICS.

- **Culture shift to monitoring – focus on working together as a system**

It was noted that the HWB has two key roles to have a broad partnership understanding of the needs of our population and a culture of collectivism in working to address those population needs. It was suggested that the whole system has moved in a direction and the focus should be focussed on how we work together as a system and our culture rather than specific outcomes, but we do need to be able to check in and ask ourselves how well are we working? Are things improving or worsening for the communities of Norfolk and Waveney? This led to further conversations on new ways to monitor the refreshed strategy and ensuring that a monitoring industry is not created. HWB members were of the view that we must be able to say what we are doing and almost act as a self-assessment in relation to the strategy and what partners are doing together, something simple that doesn't duplicate efforts elsewhere in the system.

Suggestions were made on possible activity towards monitoring the refreshed strategy. One suggestion made was the use of a Health and Wellbeing Strategy group to bring people together or smaller working groups on how the strategy and activity align itself particularly with the development of the ICS. Case studies from organisation on what they have been doing was also mentioned alongside the use of strategy champions focusing on the different strands. Another suggestion came to use the UEA to tap into the long-term research and look at how we are improving things across Norfolk with a critical eye approach on what's worked and what could work better. A simplistic approach of 'you said, we did' was also seen a valued approach but it was noted that monitoring of the strategy has to work for the individual organisations and the strategy itself must reflect that different organisations collect and monitor data in different ways.

- **Clear ownership of the JHWS**

HWB members highlighted the need for greater ownership of the JHWS and therefore needs to be seen as part of all organisations core business within the partnership. It was felt in the past this has not always been the case as there was not always the clarity and understanding of the role of the HWB. The role of the HWB needs to be focused on the health and wellbeing of our population and to aid this process it was noted that better understanding of each organisations input to the JHWS was vital. It was expressed that the board need to be able to hold each other to account and focus on a small number of things that we as a system can impact upon in a combined effort, ie common goals. These goals should be regularly reviewed and the strategy driving the work of the HWB to make a difference to the population of Norfolk and Waveney. For ownership of the strategy, it was believed that organisations that form the HWB, would need to bring the this refreshed strategy through their own governance process, to their own boards to form a commitment to the strategy and note how they will take the priorities forwards.

Norfolk Health and Wellbeing Board

Item 9

PART A

Report title: Health Inequalities data in Norfolk

Date of meeting: 01 December 2021

Sponsor (HWB member): Dr Louise Smith, Director of Public Health

Reason for the Report

To share an update of health inequalities data in Norfolk and Waveney, highlighting the geographical areas with the 20% most deprived population, in the context of the NHS Health Inequalities "Core 20 PLUS 5" initiative.

Report summary

Tackling health inequalities in our communities is one of the main priorities of the Health and Wellbeing Board. This report provides an opportunity to update the Health and Wellbeing Board members on health inequalities in Norfolk. It highlights the 42 communities across Norfolk and Waveney forming the 20% most deprived areas which will be targeted in the NHS Health Inequalities "Core 20 PLUS 5" initiative.

Recommendations

The HWB is asked to:

a) Receive a presentation on Health Inequalities data in Norfolk.

1. Methodology

1.1 Tackling health inequalities in our communities is identified as a key priority in the Joint Health and Wellbeing Strategy 2018 – 2022 – *"Providing support for those who are most vulnerable in localities using resources and assets to address wider factors that impact on health and wellbeing".*

1.2 The HWB District Council sub-committee has also received an inequalities deep dive report jointly presented by Public Health and Norfolk and Waveney CCG, in January 2021.

2. Health Inequalities data in Norfolk and Waveney

2.1 Tackling health inequalities in our communities is one of the main priorities of the Health and Wellbeing Board.

2.2 This report provides an opportunity to update the Health and Wellbeing Board members with a summary of health inequalities in Norfolk and provide a focus on the communities in Norfolk and Waveney where the largest health inequalities are identified- in areas of the highest deprivation.

2.3 The report highlights the 163,800 people living in 42 communities across Norfolk and Waveney forming part of the 20% most deprived areas nationally (as defined through the Index of Multiple deprivation [IMD]) which will be targeted in the NHS Health Inequalities "Core 20 PLUS 5" initiative.

2.4 The NHS Core 20 PLUS 5 Initiative has been developed to drive targeted health inequalities improvements. This will focus on the most deprived 20% of our population, plus other

population groups experiencing significant health inequalities identified by local population health data. The initiative will also target five clinical areas.

Officer Contact

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

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

Norfolk Health and Wellbeing Board

Item 9

PART B

Report title: System progress on Health Inequalities

Date of meeting: 01 December 2021

Sponsor (HWB member): Tracy Williams, Clinical Governing Body Member Norfolk and Waveney CCG. Clinical Lead for: Health Inequalities, Children Young People & Maternity

Reason for the Report

The following report is to provide the Health and Wellbeing Board (HWB) with an overview of the approach adopted by Norfolk & Waveney (N&W) Clinical Commissioning Group (CCG) to support the Covid-19 vaccination inequalities programme and our resulting lessons learned from collaborative system working. The report will describe how the insight from the methods and approaches taken to increase vaccination uptake and address inequalities, has provided opportunities to embed new ways of collaborative working within our Integrated Care System (ICS) with system partners. In addition, the report will explain how these experiences will be used to foster innovative working methods between ICS partners as well as improve partnership arrangements, to achieve collective ambitions in tackling wider health inequalities for our N&W residents.

Report summary

At the commencement of the Covid-19 vaccination programme it was starkly apparent that a proportion of our local population were more vulnerable to and at increased risk from contracting Covid-19. The pandemic had both nationally and locally illuminated far reaching health and socioeconomic inequlaties within our society.

Those impacted most, included individuals with protected characteristics such as older age or ethnic minority status; people with underlying health conditions and those who have more common conditions like obesity; as well as individuals experiencing specific socioeconomic factors, including certain occupation groups, inclusion health groups and those living in deprivation. All of which consequently makes some individuals more vulnerable to catching and having poor outcomes from Covid-19.

N&WCCG recognised the importance of ensuring equal access to the national vaccination programme for all residents and the need to provide tailored solutions to suit the needs of specific identified vulnerable communities and groups. We recognised to positively improve our ability to reach into communities and increase vaccination uptake for some of our most vulnerable residents, health colleagues needed to collaborate widely with VCSE organisations, Social Care, Public Health, and Local Government colleagues.

Forging such new relationships to deliver direct health care provision, was necessary to better understand the needs of our communities and be able to work together to co-develop solutions to help to reduce inequalities in Covid-19 vaccine uptake. The following report will identify the significance of this way of collaborative working; demonstrate the importance of adopting a data led and evidence-based approach to inform our collective understanding of need; and will provide examples of specific actions taken to tackle the varied inequality challenges faced in the vaccine programme. The report will subsequently demonstrate our intention to build on these ways of working, to maximise the opportunity to improve health outcomes and address inequalities especially significant as ICS partners are working against a backdrop of rising health inequalities due to the health and economic outcomes of the pandemic.

Recommendations

The HWB is asked to:

1.3 Consider the collaborative approach being recommended to help shape our future ways of working to tackle health inequalities, to endorse the approach and to provide comments on the ambitions and future opportunities we have in N&W ICS to further embed collective action.

1. Methodology

1.1 The HWB District Council sub committee has previously received an inequalities deep dive report jointly presented by Norfolk Public Health and N&WCCG, in January 2021. The report provided a summary position of the impact of the pandemic on health inequalities and set out the planned approach to addressing health inequalities with use of the Tackling Health Inequalities guidance documentation and toolkit developed by Public Health teams at both Norfolk and Suffolk County Councils. Subsequently, in July 2021 each district and borough council provided a summary report, detailing the work underway to address health inequalities and plans in place at each local council area. This report builds on these previous insight, place-based tools and collaborative work between partners.

2. Health Inequalities

2.1 **National context**

Covid-19 has highlighted the urgent need to prevent and manage ill health in groups that experience health inequalities, as outlined in the NHS Long Term Plan. To help achieve this, NHS England and NHS Improvement issued guidance as part of its response to the pandemic, setting out eight urgent actions for tackling health inequalities. Systems are now asked to focus on five priority areas, from the eight actions.

2.2 These are:

- **Priority 1: Restore NHS services inclusively**. Systems are required use their data to plan the inclusive restoration of services, guided by local evidence. This approach should be informed by ethnicity and deprivation intelligence, as evidence suggests these are the areas where heath inequalities have widened during the pandemic.
- **Priority 2: Mitigate against digital exclusion.** Systems are asked to ensure provision between face-to-face services and remote provision is balanced by level of need and accessibility, and that insight is captured into users of virtual and face to face means and the impact of digital consultation channels on patient access is well understood.
- **Priority 3: Ensure datasets are complete and timely.** Systems are asked to continue to improve the collection and recording of ethnicity data across all service provision.
- **Priority 4: Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes**. This priority has further been developed by NHSE/I, Health Inequalities and Improvement Team's, Core20Plus5 initiative.
- **Priority 5: Strengthen leadership and accountability.** Systems and providers are required to have an executive board-level lead for tackling health inequalities and should access training made available by the Health Equity Partnership Programme.

2.3 To support these 5 priority areas, NHSE/I's Health Inequalities and Improvement Team will be working with other national programmes and policy areas to support the national vision of exceptional quality healthcare: ensuring equitable access, excellent experience, and optimal outcomes for all.

2.4 **The approach and lessons learned from the Vaccine Inequalities programme in Norfolk and Waveney**.

2.5 To support the Covid-19 vaccination programme, a N&W Vaccine Inequalities Oversight Group (VIOG) was formed in January 2021. With wide-ranging partner wide representation, one of the main functions of VIOG was to utilise data-led insight to inform the design of local vaccine provision. Up-to-date vaccine uptake data compiled by the Insight & Analytics team at Norfolk County Council was shared weekly and supported partner understanding of any concerns in vaccine uptake in any areas of our ICS and in any population groups, also indicated levels of vaccine hesitancy.

2.6 Vaccine hesitancy is recognized as complex and context specific and is influenced by many factors including complacency, convenience, and confidence. Data demonstrating vaccine uptake rates amongst our community segmented into a number of different groups including, protected characteristics, LSOA, ethnicity, people with learning difficulties, SMI and health inclusion groups was used to inform local need. By working in partnership, stakeholders were able to use the data information, combined with local intelligence about possible reasons for vaccine hesitancy, lower uptake levels to collaboratively design services and local engagement responses.

2.7 The planned responses by VIOG partners supported the outcome of Norfolk and Waveney having the highest rates of dose 1 and 2 uptake across the Eastern Region and included:

2.7.1 Protect NoW covid vaccination calling: The Protect NoW call handler team used motivational interviewing techniques to maximise uptake within priority groups and used data to target our most vulnerable community members. This project involved letters, online support and telephone contact to try and encourage engagement and gather insight to inform future actions to increase uptake.

2.7.2 Roving model: To support ease of access and community engagement, N&W procured two vaccine buses. They visits specific community settings, workplaces, attend community events and colleges, as directed by need evident from data insight. Over 4000 N&W residents have received their Covid-19 vaccination via the roving model, which also has an additional ‘worry’ bus as part of the offer, providing people the time to talk through any fears and concerns they have with a health professional.

2.7.3 Inclusion Health Groups: Bespoke offers for our homeless populations, sex workers with outreach hostel pop ups and community venues. Targeted engagement with our Gypsy Roma traveller community through trusted communicators, pop ups to mosques and our Asylum seeker and refugee communities.

2.7.4 Community Engagement: VIOG has been supported by a comprehensive comms and engagement response, to enable to effective engagement, education, and awareness campaigns, such as ‘I’ve Had Mine’ to encourage vaccine uptake. In addition to the system wide social media and public comms, each district council utilised their covid marshals to undertake community engagement activities, including door knocking and working with communities where uptake was of significant concern. Under the COPI notice sharing of data, VIOG gained agreement for data sharing between the GP Practices and Councils for the explicit purpose of supporting vaccine uptake. This has been a game changer and a new way of working in collaboration.

2.7.5 NHSE/I Health Equalities Partnership (HEP) programme. Through Hep funding Anglia Ruskin University, were commissioned to lead an insight gathering research exercise, working with VCSE organisations and the local community. A key finding from the research was the importance of developing a network of trusted communicators to engage communities and promote key health messages. This insight was crucial in supporting a newly formed VCSE grant fund and was used by system partners to inform their own work as part of our system-wide effort to support the vaccination campaign.

2.7.6 Community Champion: With national funding from MHCLG, Gt Yarmouth Borough Council, has established a Community Champions' Programme. The programme aims to develop new networks of trusted local champions who can help support those most at risk from Covid-19, building trust and communicating accurate health information to the grass-roots level to help boost vaccine take-up. VIOG have worked closely with the Borough Council, ensuring the Champions programme received regular data intel to support their community engagement activities and shared wider intel.

3 Next steps

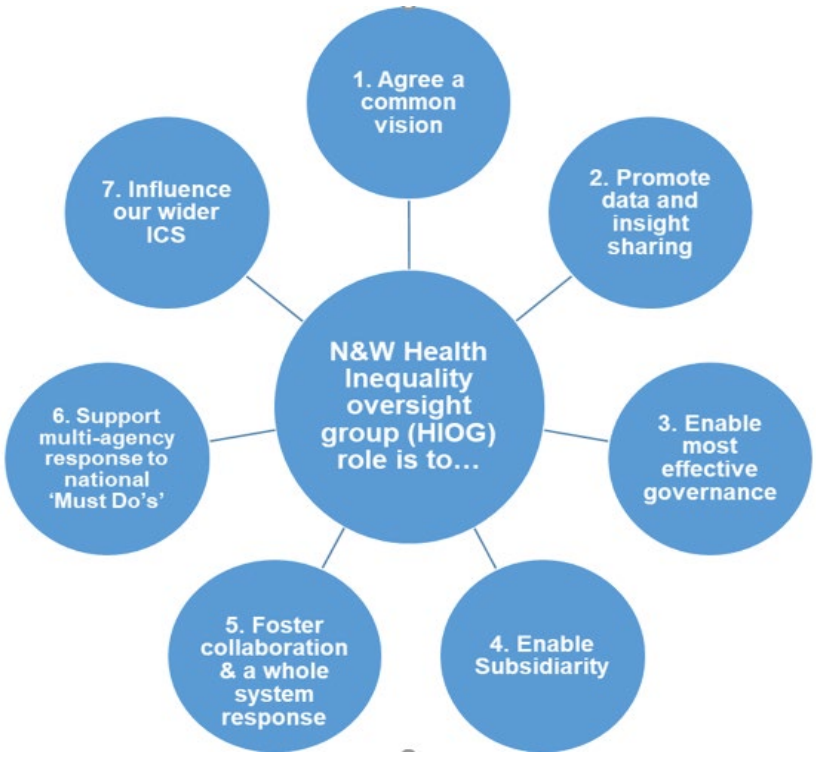
3.1 N&W ICS received funding of £193,500 to develop and deliver a county wide engagement model for vaccine promotion in communities in the ICS area, which will build on the community champion programme in Gt Yarmouth. Additionally, £26,500 was secured for the James Paget University Hospital to pilot a pregnancy uptake engagement programme. Both projects are expected to be set up and delivery underway by March 2022.

3.2 **Maternity Vaccination pilot**: has provided an opportunistic model of vaccination for pregnant people, via the James Paget University Hospital Trust. It has been designed with a focus on improving uptake, giving good patient experience and providing an innovative way to target vaccine delivery to improve health outcomes for families in some of our socially and economically deprived areas.

3.3 **Scaling up of the Community Champions** programme across the N&W system and working in partnership with the VCSE sector to reach our most vulnerable communities and build our understanding about how we can engage them in healthcare.

3.4 **A proposal for embedding an approach in support of addressing wider health inequalities**

3.5 Building on the learning from VIOG, planning is underway into the development of a Health Inequality Oversight Group (HIOG) for the ICS. Provisional partner discussions have confirmed the following core seven functions of HIOG (as described in the visual below) and the need for strategic system leadership to form the membership of HIOG.



3.6 The functions are HIOG have been built up from the insight of the vaccination programme and include the following specifics for each of the seven functions:

- Define our ICS vision and understanding to address the Health inequalities (HI) and unwarranted variation in outcomes & access to care.
- Promote a data-led approach, to drive collective ICS action. The scale of challenge and opportunities to make an impact will only be clear through data sharing, collective insight and sharing good practice.
- To provide strategic leadership to existing initiative and workstreams across the ICS, ensuring everyone is connected in this targeted work.
- To recognise the role of place-based partnership to drive operational action in support of addressing HI and maximise the use of tools available to support this – for example the Public Health Norfolk/Suffolk toolkit.
- Recognise to address HI we must develop a 'whole Systems approach'. No one part of the system can make a lasting impact in isolation.
- Support national partner 'Must Do's'' as required eg NHSE/I; PCN Health Inequality DES requirements; role of place-based partnerships; CORE20+5.
- To foster long-term, system-level change to reduce HI. E. g N&W ICS clinical strategy, alongside initiatives such as the role of Anchor Institutions.

3.7 HIOG is current working with partners to build on the lessons learnt from VIOG and consider the most appropriate governance arrangements to facilitate appropriate system action of the health inequality challenges. At our ICS place-level we are seeing strong engagement by partners in the public health, Tackling Health Inequalities toolkits which advocate for a robust and systematic approach to understanding the level of health inequalities experience by the local communities with a data led approach; to drive community engagement and encourage a whole system approach to design local interventions.

3.8 In addition, N&W place-based arrangements are emerging with a clear remit of our local Health and Care Alliances to focus on addressing inequalities in access to health and care services and outcomes. Whilst the local Health and Wellbeing partnerships will focus on tackling wider inequalities that contribute to people's health and wellbeing.

3.9 HIOG is recognised as providing a leadership function to our activity being driven at our place-level in the ICS. As a consequence, HIOG will lead our strategic understanding of the approaches to be adopted by our system and provide clear support to delivery transformational activity to address health inequalities across our neighbourhoods, places and for the N&W system.

Officer Contact

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

Name	Email
Rachel Hunt	rachel.hunt6@nhs.net

Report title: Developing our Integrated Care Partnership

Date of meeting: 01 December 2021

Sponsor (HWB member): James Bullion, Executive Director for Adult Social Services, NCC

Reason for the Report

The Health and Wellbeing Board (HWB) plays a vital role in the planning, coordination and governance of our health and care system, including in development of our Integrated Care Partnership. This report is intended to outline the next steps in the development of the Integrated Care Partnership.

Report summary

This paper provides a summary of key points from the HWB workshop on developing our Integrated Care Partnership (ICP) held on 11 November, and outlines the timeframe and next steps in the development of the ICP.

Recommendations

The HWB is asked to:

a) Review the summary of the workshop outcomes
b) Agree the next steps to:

- Develop the governance arrangements, taking account of the statutory and legislative framework for HWBs and ICPs, for a 'joint' ICP and HWB, with common membership and streamlined arrangements for holding meetings **(January 2022).**
- Develop the process for appointing an ICP chair designate, taking account of national guidance on functions and ensuring there is a transparent and jointly supported decision-making process **(February 2022).**
- Work through the HWB District Sub-Committee, to engage local partners in developing the approach to place-based health and wellbeing partnerships **(January 2022).**

1. Methodology

1.1 The government has brought forward proposals in its Health and Care Bill to implement statutory arrangements for Integrated Care Systems (ICSs) with two components:

- The first component is the **Integrated Care Partnership, or ICP**: a broad alliance of organisations and representatives concerned with improving the care, health and wellbeing of the population, jointly convened by local authorities and the NHS.
- The second component is a statutory body, **the Integrated Care Board, or ICB**: the ICB will be responsible for the commissioning of healthcare services in that ICS area, bringing the NHS together locally to improve population health and care.

1.2 This report focuses on the development of ICP in the Norfolk and Waveney ICS. The ICP is a critical part of our ICS and the journey towards better health and care outcomes for our communities.

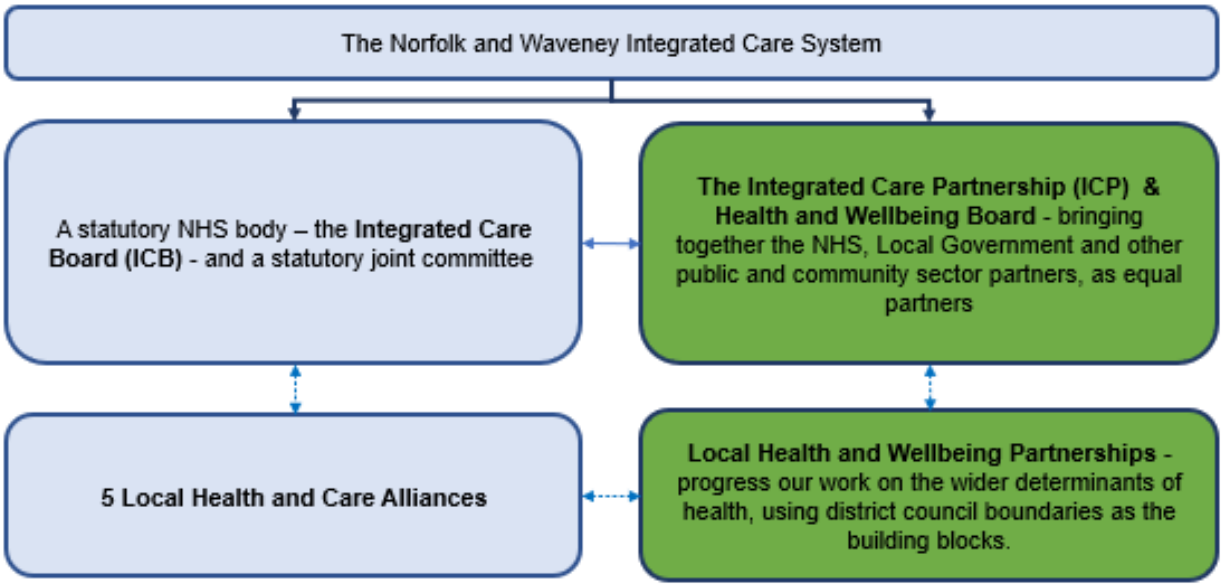
1.3 The ICP will provide a forum for NHS leaders and local authorities (LAs) to come together, as equal partners, with important stakeholders from across the system and community to highlight where coordination is needed on health and care issues and challenge partners to deliver the action required.

1.4 Together, the ICP will generate an integrated care strategy to improve health and care outcomes and experiences for their populations, for which all partners will be accountable.

1.5 They should support place-based partnerships and coalitions with community partners which are well-situated to act on the wider determinants of health in local areas.

2. Introduction

2.1 Work has been underway to develop the proposed architecture and design of the Norfolk and Waveney statutory ICS. As per the statutory arrangements, our ICS will be made up of two parts, with a proposed approach to working together locally mirroring the two elements which make up the ICS:



2.2 Subject to the passage of the Health and Care Bill through Parliament, our ICP will be in place from April 2022. In developing the ICP, we are seeking to build understanding and consensus on the role, membership and ways of working of the partnership, taking as the starting point the five expectations:

a) ICPs are a core part of ICSs, driving their direction and priorities.

b) ICPs will be rooted in the needs of people, communities, and places.

c) ICPs create a space to develop and oversee population health strategies to improve health outcomes and experiences.

d) ICPs will support integrated approaches and subsidiarity.

e) ICPs should take an open and inclusive approach to strategy development and leadership, involving communities and partners to utilise local data and insights.

3. Outcomes from the HWB ICP development session

3.1 On 11 November 2021, the members and substitute members of the HWB came together in a workshop to set out our strategic approach to developing a Norfolk and Waveney ICP. Discussions were framed around three key areas:

- The relationship between the existing Norfolk HWB and the ICP.
- The approach to working together at 'place', through local Health and Wellbeing Partnerships.
- An exploration what we as a system want to get out of the ICS.

3.2 **Key outcomes from the workshop included:**

3.2.1 Simplicity of the system

- We need simplicity in system governance arrangements and to avoid duplication in the health and wellbeing system as a whole. The focus should be on using and building on existing structures, including the HWB.
- There was **consensus for bringing together the Norfolk and Waveney ICP and the existing Norfolk HWB** – including common membership of the ICP and the HWB (with the membership of the HWB providing a good basis for the ICP) and streamlined arrangements for holding meetings.
- We should **capitalise on the refresh of the JHWBS to streamline the approach to developing the ICP Integrated Care Strategy** - exploring the added value that a coordinated approach to the JHWBS and Integrated care strategy can bring to reduce duplication within the system, build on the priorities partners have collectively agreed upon, and achieve our agreed, shared outcomes.

3.2.2 Place-based approach

- We should focus our collective energy and efforts into working effectively at a local level and support the principle of subsidiarity.
- There was support for **building on the existing interfaces and structures based around District Council footprints to establish local, place-based Health and Wellbeing Partnerships**, chaired by district councils and involving a broader range of public sector partners, VCSE and citizens to tackle wider determinants of health and wellbeing.
- There was recognition that whilst the relationship between the overarching ICB and ICP is clear, the place-based Health and Wellbeing Partnerships and Health and Care Alliances will need to develop their working arrangements.
- The Health and Wellbeing Board District Sub-Committee will extend its invitation to the Chairs of the Health & Care Alliances to support collaboration and coordination at this level.

3.2.3 Joint working

- We have a sound track record of system-wide partnership working and the essential foundations are already in place to meet the vision and outcomes described in the guidance to date.
- Joint working has been our best weapon against Covid. We should **agree a set of principles, including a commitment to equal partnership, which builds on this foundation to support new ways of working,** which resolve long standing health and wellbeing challenges.

3.2.4 Whole system prevention and early intervention

- We should strengthen our collective approach to **address health challenges that the health and care system cannot address alone**, especially those that require a longer timeframe to deliver, such as tackling health inequalities and the underlying social determinants that drive poor health outcomes. For example, across education, housing, environment, transport, employment, and community safety.
- We should enable the shift in focus to a whole system prevention approach and make a shared commitment to prevention and early intervention across the health, care and wellbeing system to achieve our agreed, shared outcomes. To achieve this we need to be ambitious and take collective responsibility, as system leaders, for our role in ensuring that prevention and early intervention forms part of policy, strategy and commissioning plans beyond organisational boundaries.

3.2.5 An integrated, innovative system

- We need to work together as system leaders to **drive and enhance integrated approaches and collaborative behaviours at every level of the system**, where these can improve planning, outcomes and service delivery.
- This should promote the mobilisation of resources and assets in the community and system, and across the place-based partnerships.

3.2.6 Based on evidence of needs

- Our priorities should be informed by local population needs, and the specific communities identified through population health management data. We have the opportunity to use our wealth of system data and information, including our JSNA, intelligently - making evidence-based decisions to improve health and wellbeing outcomes.

4. Next steps

4.1 The next steps will be to:

- Develop the governance arrangements, taking account of the statutory and legislative framework for HWBs and ICPs, for a 'joint' ICP and HWB, with common membership and streamlined arrangements for holding meetings **(January 2022)**.
- Develop the process for appointing an ICP chair designate, taking account of national guidance on functions and ensuring there is a transparent and jointly supported decision-making process **(February 2022).**
- Work through the HWB District Sub-Committee, to engage local partners in developing the approach to place-based health and wellbeing partnerships **(January 2022).**

5. Timeline for implementation

5.1 **Integrated Care Partnership** - For April 2022, we expect to have:

- An agreed Interim Partnership with the minimum statutory membership and other key representatives to reflect those involved in addressing the wider determinants of health.
- A Chair Designate, Terms of Reference and a set of agreed partnership principles to frame the work of the Partnership going forward.
- A target date for the formal convening of the ICP, which will be dependent on the establishment of the ICB.
- A clear relationship between the ICP and local place-based arrangements.

- An agreed forward programme for the year.
- Agreed programme and approach to developing and agreeing the Health and Care Strategy.

5.2 **Health and Wellbeing Partnerships** would commence in April 2022.

5.3 Joint sign-off and agreement to the ICP arrangements will be sought through Norfolk and Suffolk County Councils' respective cabinets, the Health and Wellbeing Board and the Norfolk and Waveney interim ICS Partnership Board.

Officer Contact

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

Name	Tel	Email
Hannah Shah	01603 223165	Hannah.shah@norfolk.gov.uk

Report title: **All Age Carers Strategy for Norfolk and Waveney 2022 - 25 Progress Report**

Date of meeting: 01 December 2021

Sponsor (HWB member): **James Bullion, Executive Director, Adult Social Services, NCC**

Reason for the Report

- To provide an update to the Board on the development of an All Age Carers Strategy for Norfolk and Waveney including preparation of the carers survey.
- To request support of the Board in promotion of the survey and to inform future lines of enquiry.

Report summary

The report provides an overview of engagement activities being used to support the development of an All Age Carers Strategy for Norfolk and Waveney. The work is being coordinated by the independent charity Carers Voice Norfolk and Waveney and includes a survey of carers. The survey has been co-produced with carers and comprises 20 questions covering topics such as access to services and impact of caring roles on health, education and employment.

The survey represents one part of a suite of activities that includes focus groups and interviews. Findings from the survey will be analysed during January. These will help to identify extra lines of enquiry, to be pursued during the first quarter of 2022, with a view to producing a first draft of the strategy in April. It is hoped that co-production will continue to evolve so that it becomes an integral part of monitoring and delivering the strategy.

Recommendations

The HWB is asked to:

a) Support the launch of the survey and development of an All Age Carers Strategy by:
   - Promoting the survey to relevant stakeholders and networks.
   - Endorsing co-production as part of strategy development.
   - Providing insight to support additional lines of enquiry.

b) Agree to receive the Carers Engagement Report and Strategic Recommendations for the Carers Strategy in 2022.

1. Methodology

1.1 At the meeting of the Health and Wellbeing Board on 17 July 2018 the Board agreed to the development of a Norfolk and Waveney Carers Strategy which is overseen and monitored by the Health and Wellbeing Board (HWB).

1.2 The previous carers strategy for Norfolk expired in 2017 and work on the new strategy covers both Norfolk and Waveney. It also extends the age group to all carers, whereas the previous strategy focussed on adults. The new strategy is timely as it incorporates the ongoing impact of Covid-19. It is proposed that the new strategy will run until 2025, although co-production will support longer term impact.

2. Our Approach to the Carers Strategy

2.1 A carer is anyone who cares, unpaid, for a friend or family member who, due to illness, disability, a mental health problem or an addiction, cannot cope without their support. Often these relatives or friends find it difficult to think of themselves as carers and look for support for their caring role only when they reach a crisis. However, if help and support are given early this enables both the carer and the person they care for, to have improved health and wellbeing outcomes.

2.2 In 2018, the HWB agreed our ambitions to take forward an approach to the strategy that:

- Puts the voice of carers central to how partners in Norfolk & Waveney take forward their approach to identify and support carers in staying well themselves and those they care for.
- Uses a mix of co-production activities as well as evidence already collated from previous, local, co-production events to develop a plan for Norfolk & Waveney.
- Co-production will be based around a meaningful framework which supports the development of a plan for Norfolk & Waveney to ensure:
    - The most is gained from co-production - makes co-production realistic yet ambitious for all involved.
    - Due regard is given to the duties required by the Care Act 2014 and the Children and Families Act.
    - Local stakeholders and representatives from local organisations who have a role and responsibility in providing 'An integrated approach to identifying and assessing Carer health and wellbeing' are able to contribute.

2.3 To provide this robust evidence for the new strategy, the following engagement activities are being used:

- Co-production with carers leading to the development and launch of a Carers Survey in November 2021. This includes an easy read version.
- Interviews and focus groups with carers and support agencies.
- A survey of agencies supporting carers (January 2022).
- Analysis of all of the initial data collected, which will lead us to extra lines of enquiry.
- The development of an evidence base for the first draft of strategy (April 2022).

2.4 We were also keen to ensure the survey was as relevant and informative as possible. Co-production of the Carers Survey took place between July and September 2021. This was supported by engagement with Carers Groups using direct conversations, social media, and online meetings.
These groups included:

- Young Carers and Families,
- Young Adult Carers,
- Adult Carers,
- Parent Carers,
- Former Carers,
- Bereaved Carers,
- Carers Ambassadors.

2.5 This has resulted in a co-produced survey, which is now live and will remain open until the end of January 2022. The work undertaken to involve Carers in its development will help to promote the survey to smaller self-help groups and Carers who are hidden from mainstream services. As part of this, Carers Voice have been reaching out and building trust with minority groups with additional input from local support agencies.

2.6 The results from the carers survey will form a critical part of the evidence base for developing the Carers Strategy. As such, it is important for this survey to reach as many individuals and groups as possible, including people who are more isolated from services. To support promotion, a press release has been produced and groups will be encouraged to include the survey as part of their meetings, informal gatherings, and social media. Posters and other templates have been developed to support wider engagement.

2.7 Once we have the results of the survey and the other engagement activities, the next step is to produce a Carers Engagement Report, which will include Strategic Recommendations for the Carers Strategy in 2022. At this point we would like to come back to the Health and Well Being Board to discuss the Strategic Recommendations and agree next steps for creating the All Age Carers Strategy for Norfolk and Waveney.

Officer Contact

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

Name	Email
Bethany Small	Bethany.small@nhs.net

IN TRAN communication for all

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

Report title: Norfolk Better Care Fund 2021/2022 Submission

Date of meeting: 01 December 2021

Sponsor (HWB member): James Bullion, Director of Adult Social Care

Reason for the Report

In 2021/2022, as part of the Better Care Fund Planning Requirements, we are required to jointly agree a plan between health and social care for the delivery and spend of the pooled Better Care Fund (BCF). This plan must be reviewed and signed off by the Norfolk Health and Wellbeing Board.

For 2021/2022 the BCF Submission includes:

- A narrative plan, describing our approach to integration, discharge, housing and health inequalities (Appendix A).
- An excel template, describing the BCF income and expenditure, our planned performance against the five key metrics, and affirmation that we are meeting the national conditions as set out in the current BCF Planning Requirements (Appendix B).

Report summary

The BCF is a nationally mandated programme, aiming to join up health and care services so people can manage their health and wellbeing and live independently in their communities for as long as possible. A key priority of the Health and Wellbeing Board (HWB) has been to lead a review of Norfolk's BCF. Based on local and national direction, there is an opportunity to shape a future BCF to further deliver local priorities, act as a strengthened delivery arm of joint commissioning and service design, and focus strategy and funding on some of the most important emerging priorities for integration.

Norfolk County Council (NCC) and Norfolk and Waveney Clinical Commissioning Group (NWCCG) have worked in partnership to lead an initial review with partners of the Core BCF, identifying the following key themes for consideration in the future design of our BCF:

- Services funded within the Core BCF largely tie back to current national BCF aims and fund a range of services that provide extensive benefit to Norfolk's population.
- There is significant opportunity to use the BCF to support other increasingly important local areas of joint health and care working, including prevention and inequalities. The BCF is also currently system focused, with opportunities to align with place priorities and processes.
- Good organisational joint working on the future of the BCF is now in place, with partners seeing it as a key delivery arm of future integrated priorities between health and care.
- Services within the BCF often account for only a small proportion of their total funding, challenging tie-back to directly attributable better outcomes.

The Health and Wellbeing Board (HWB) have agreed that Norfolk's BCF is reshaped with the following delivery priorities, that reflect key local strategic direction, including emerging place-based priorities:

- Inequalities and support for wider factors of wellbeing,
- Prevention,
- Sustainable system (including Admissions Avoidance),

- Person centred care and discharge and
- The DFG and housing sits as a theme across all of these priorities.

To align with this approach, it was also agreed that:

- The BCF is re-baselined, to create a series of 'buckets' that contain the funding pots for services/projects based around the recommended Norfolk BCF priorities, improving joint financial working and drivers for integration and focus on system & place priorities.
- The BCF is developed to encompass both system and place priorities and processes.
- An Integrated Commissioning Steering Group, which has driven the BCF Review work, establish an overview of the BCF programme going forward, reporting to the HWB.

Recommendations

The HWB is asked to:

a) Support the progress of the Better Care Fund (BCF) Review.
b) Sign off the BCF submission for 2021/22, including the BCF Narrative Plan and the BCF Excel Template.

1. Methodology

1.1 In March 2021 we presented a paper to the Board, "Norfolk's Better Care Fund: Opportunities for the Future", which detailed our planned priorities for the Better Care Fund programme moving forward and proposed a set of principles for how the BCF should be developed in the future. This paper was agreed, and the report summary above details the decisions made.

2. Better Care Fund Review

Background

2.1 The Better Care Fund (BCF) is a nationally mandated programme, launched in 2013 with the aim of joining up health and care services, so that people can manage their own health and wellbeing and live independently. Delivered locally under a statutory requirement of Health and Wellbeing Board (HWB), it is executed through three key funding streams under the BCF 'banner':

- Core BCF (subject of phase one of the BCF review) - bringing Local Authorities (Las) and NHS partners together to agree integrated priorities, pool funding and jointly agree spending plans.
- Disabled Facilities Grant (DFG) - Help towards the costs of making changes to a person's home so they continue to live there, led by District Councils in Norfolk.
- iBCF - Available social care funds for meeting adult social care needs, ensuring that the social care provider market is supported, and reducing pressures on the NHS.

2.2 Partners in Norfolk have long utilised the BCF to fund and develop critical services that support the health and wellbeing of our population, including care from the provider market, key health and care operational teams, and community based support from the VCSE sector.

2.3 Following a pause in the review arising from COVID-19, NCC and NWCCG have worked in partnership to lead an initial review of the Core BCF, engaging with partners across the system. With the aim of developing an ambitious BCF programme which meets the future needs of, work so far has included:

- Reviewing the Core BCF programme key metrics and model.
- Reviewing the current finances and how the Core BCF is spent across Norfolk, including its role alongside wider budgets and financial plans.

- Reviewing monitoring arrangements to ensure return on investment and outcomes focus.
- Developing recommendations on how the BCF is used in Norfolk, aligned with emerging national and local strategy and exploring options for a place focused model.

Understanding Impact

2.4 Alongside this, we had also identified that many of the projects and workstreams within the BCF were only part funded by it. In 2021/2022, as far as possible we have wholly funded projects within the BCF. This will allow us to have greater oversight of the programme as a whole and better understanding of the impact the BCF has in Norfolk.

2.5 To support this, we have developed an initial Impact Review assessment which we will be doing for all of the projects within the BCF. This will allow us to understand what the aims of the funding are, how we can expect this to be measured and monitored, and when we can be updated on the progress. This will enable us to more comprehensively understand our BCF programme and what we are achieving through it.

3. BCF Delivery Priorities in 2021/2022

3.1 For 2021/2022 we are asked to submit two documents to NHSE&I split across a narrative plan and an excel template. The contents are summarised below.

Narrative Plan

3.2 The BCF Narrative Plan (Appendix A) follows the template given to us by NHSE&I and details:

- How we engaged stakeholders in developing and preparing the plan.
- Our priorities for 2021/2022 and key changes made to the previous BCF Plans.
- The governance routes for the BCF.
- Our overall approach to integration in Norfolk, including: joint priorities; joint commissioning; supporting people to remain independent at home; and how BCF funded services are support this.
- Our overall approach to discharge in Norfolk, including: the approach in our area to improving outcomes for people being discharged from hospital; and how BCF funded services are support safe, timely and effective discharge.
- Our approach to the Disabled Facilities Grant and wider housing services.
- Our priorities for addressing health inequalities and equality for people with protected characteristics (under the Equality Act 2010).

Excel Template

3.3 The Excel Template (Appendix B) takes a more detailed look at the income and expenditure associated with the BCF, and our expected performance against the metrics.
A summary of the information included within each tab is:

- **Tab 1 Guidance:** Guidance to completing the document.
- **Tab 2 Cover:** A cover page for the document, including who is submitting the return and contact details of key stakeholders.
- **Tab 3 Summary:** A brief summary of the information within the template document
- **Tab 4 Income:** Details of the BCF income for 2021/22, including the core Better Care Fund, improved Better Care Fund, and Disabled Facilities Grant.
- **Tab 5a Expenditure:** A very detailed summary of the services and projects funded by the income on Tab 4, including where the money has come from, a description of the schemes being funded, which sector the commissioner and provider come from, and the category of the scheme being delivered.

- **Tab 5b Scheme Type:** Details the scheme types that can be picked, and how to allocate them on Tab 5a. This tab has been given to us by the Better Care Fund National Team.
- **Tab 6 Metrics:** Looks at the five key metrics, our past performance against these, and our expected performance moving forward.
- **Tab 7 Planning Requirements:** Asks us to confirm that we have met the National Conditions set out in the BCF Planning Requirements document.

3.4 For 2021/2022 there are three new metrics within the Better Care Fund. These metrics are:

- **Avoidable admissions:** Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i).
- **Length of Stay:** Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for:
  i) 14 days or more
  ii) 21 days or more
  As a percentage of all inpatients.
- **Discharge to normal place of residence:** Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence.

3.5 There are also two metrics which have remained the same as in previous years:

- **Residential Admissions:** Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population.
- **Reablement:** Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services.

Officer Contact

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

Name	Tel	Email
Nick Clinch	01603 223329	nicholas.clinch@norfolk.gov.uk

BCF narrative plan template

This is an optional template for local areas to use to submit narrative plans for the Better Care Fund (BCF). These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

Although the template is optional, we encourage BCF planning leads to ensure that narrative plans cover the headings and topics in this narrative template.

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 15-20 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

Cover

Health and Wellbeing Board(s)

Norfolk Health and Wellbeing Board

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, district councils)

How have you gone about involving these stakeholders?

A key priority for 2020/21 of the Health and Wellbeing Board and has been to lead a review of Norfolk's BCF. Based on local and national direction, there is an opportunity to shape a future BCF to further deliver local priorities, act as a strengthened delivery arm of joint commissioning and service design, and focus strategy and funding on some of the most important emerging priorities for integration in our system.

Working in partnership to jointly develop our future priorities to the Better Care Fund, Norfolk County Council (NCC)and Norfolk and Waveney Clinical Commissioning Group (N&WCCG) have worked in partnership to lead an initial review with partners of the Core BCF engaged with a wide range of system and Place stakeholders to ensure their views were included from the beginning. This included attending Place-based fora across the county to directly engage with representatives from:

- Norfolk and Norwich University Hospital NHS Foundation Trust
- Queen Elizabeth Hospital Kings Lynn NHS Trust
- James Paget University Hospitals NHS Foundation Trust
- Norfolk Community Heath and Care NHS Trust
- Norfolk and Suffolk Foundation Trust
- Primary Care Networks
- General Practice Partnership Organisations
- VCSE Representation Organisations
- District Councils
- Norfolk County Council (NCC)
- Norfolk & Waveney Clinical Commissioning Group (N&WCCG)
- Norfolk Pharmacies

Conversations with stakeholders included:

- reviewing the Core BCF programme key metrics and model,
- the current finances and how the BCF is spent across Norfolk, including its role alongside wider budgets and financial plans,
- Reviewing monitoring arrangements to ensure return on investment and outcomes focus.
- Developing recommendations on how the BCF is used in Norfolk, aligned with emerging national and local strategy and exploring options for a place focused model.

The engagement had the core aim of developing an ambitious BCF programme which meets the future needs of our system and our population – including creating a BCF set for the future that considers the role of ICS' through the Health and Social Care Bill White

Paper (Feb 2021) and emphasises the BCF's role in future joint working particularly as a key component of place partnerships.

The priorities were then agreed at our newly established Integrated Commissioning Steering Group (ICSG), that brings together membership from Norfolk County Council, Norfolk & Waveney CCG and Suffolk County Council.

The priorities were also signed off by our Norfolk Health and Wellbeing Board with membership from:

- District Councils
- Clinical Commissioning Croups (CCGs)
- Healthwatch Norfolk
- Norfolk and Waveney Sustainability and Transformation Partnership (STP)
- Representatives from the voluntary, community and social enterprise (VCSE) sector
- Norfolk police and the Police and Crime Commissioner (PCC)
- Main providers of health and care services in Norfolk

District Councils were also specifically engaged and involved in developing priorities and plans for the Disabled Facilities Grant.

Executive Summary

This should include:

- Priorities for 2021-22
- key changes since previous BCF plan

In 2018 our Health and Wellbeing Board launched a joint Health and Wellbeing Strategy which detailed its key priorities:

- A single sustainable system – working together, leading the change, and using our resources in the most effective way.
- Prioritising prevention – supporting people to be healthy, independent, and resilient throughout life. We'll offer help early to prevent and reduce demand for specialist services.
- Tackling inequalities in communities – providing support for those who are most in need and address wider factors that impact on wellbeing, such as housing and crime.
- Integrating ways of working – collaborating in the delivery of people-centred care to make sure services are joined-up, consistent and make sense to those who use them.

The priorities remain relevant in 2021-22, as we recover from the COVID pandemic, and seek to support all of Norfolk's residents to live happy, healthy, and independent lives at home for as long as possible.

Norfolk and Waveney are also in the process of becoming an Integrated Care System, and have developed a common purpose and aims to support people in Norfolk:

- To make Norfolk and Waveney the best place to work in health and care
- To make sure that people can live as healthy a life as possible
- To make sure you only have to tell your story once

These remain the overall priorities of our system. However we have also developed a specific set of priorities for our Better Care Fund programme based on the lesson's learned from our previous BCF programmes, but also discussions with partners from across Norfolk. As part of the Norfolk BCF review we have utilised the key strategies and policies that affect the system both nationally and locally, including the Joint Health and Wellbeing Strategy, Integrated Care System aims, Aging Well, Promoting Independence and local emerging place priorities. These priorities meet the national BCF directives, whilst also reflecting key local direction from our Joint Health & Wellbeing Strategy and align with other key system strategies, emerging place priorities and other individual organisational strategies:

- Prevention
- Sustainable Systems inc. Admission Avoidance
- Person Centred Care and Discharge
- Inequalities and Support for Wider Factors of Wellbeing
- Housing, DFGs, and overarching pieces of work

We also established a number of principles for developing our BCF Programme this year, to help us develop further direct impact of the fund on our priorities and Integration across the system. This included:

- Creating an Integrated Commissioning Steering Group, made up of senior staff from NCC, the CCG, and SCC, to support the BCF Review, provide strategic

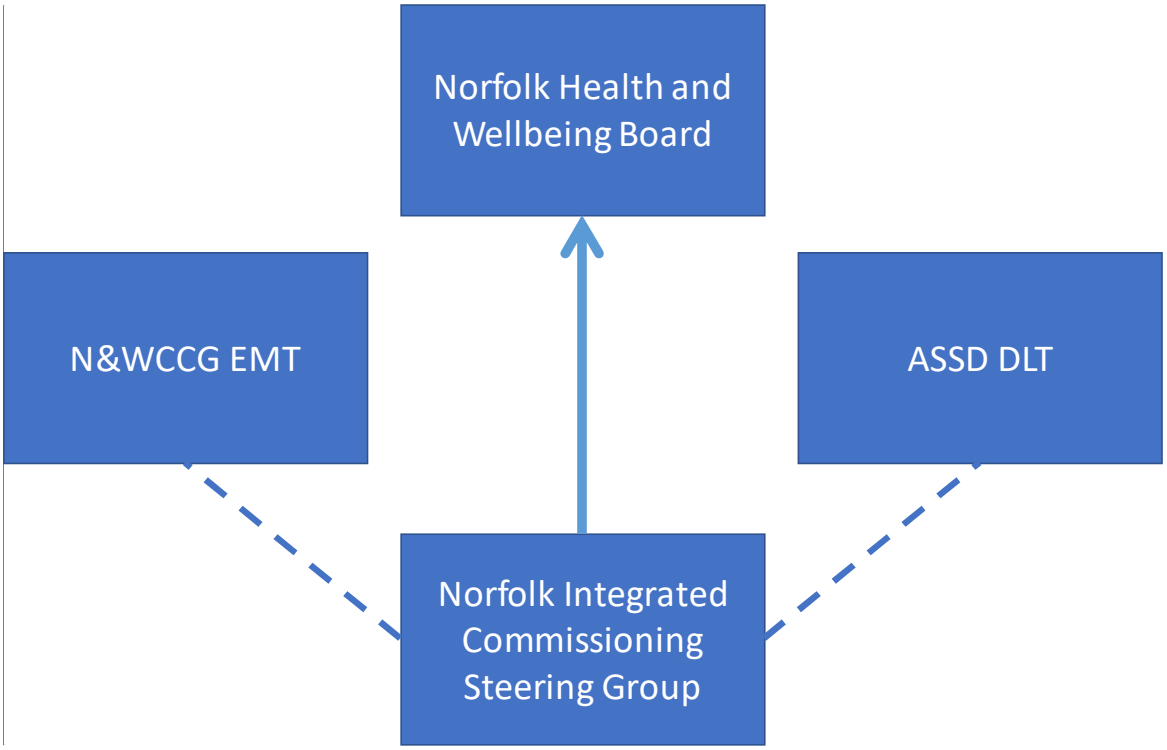
leadership of the BCF under the HWBB, and develop processes to strengthen joint commissioning at System and Place within the opportunities provided by the BCF.

- Funding programmes which benefitted from joint funding and had joint impact across health and social.
    - We also included some programmes which benefit from joint oversight of health and social care, though they may not be joint funded currently.
- Funding fewer whole services, so we could more closely monitor their impact on the system
- Creating an Impact Review, which detailed the aims, KPI's and expected benefits of each BCF funded service.
    - In 2022/23 we are aiming to have a BCF dashboard reporting on these services, which is reported to the Integrated Commissioning Steering Group.

In this way we have a more cohesive Better Care Fund programme which better reflects Norfolk's integration priorities and will help us understand the impact the fund is having on achieving this in Norfolk. This will further strengthen a BCF that acts as a key delivery arm of system and place priorities for integrated health and care working. Focussing on these four priority areas the BCF programme will be targeted towards projects and workstreams which will best achieve the aims of the local health and social care system.

Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.



The Better Care Fund in Norfolk is governed by our Joint Health and Wellbeing Board, who agree our approach to the BCF and sign off our plans and submissions.

The development of the approach, plan and submission sits within our Integrated Commissioning Steering Group. The ICSG brings together Council and CCG commissioners and finance colleagues to make integrated financial and commissioning decisions, engaging with partners across the health and social care system in those decisions. This includes developing our priorities for the Better Care Fund, which form the core of this plan. To facilitate this the ICSG has membership from Norfolk County Council, Norfolk and Waveney CCG and Suffolk County Council. Membership from Suffolk also now ensures that Norfolk has a forum to strengthen joint working within our ICS footprint that includes two separate BCF plans (Norfolk and Suffolk)

As the ICSG isn't currently a decision making board, the BCF is also governed in the CCG Executive Management Teams and NCC Adults Social Services Directorate Leadership Team. These groups include our CCG Chief Executive, Melanie Craig, and Director of Adult Social Care, James Bullion, respectively.

Overall approach to integration

Brief outline of approach to embedding integrated, person centred health, social care and housing services including

- Joint priorities for 2021-22
- Approaches to joint/collaborative commissioning
- Overarching approach to supporting people to remain independent at home, including strengths-based approaches and person-centred care.
- How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2020-21.

Our Joint Priorities:

To build our BCF Programme for 2021/22 we worked with partners across health and social care to look at what our priorities were as a system. We agreed five key priorities:

- Prevention
- Sustainable Systems inc. Admission Avoidance
- Person Centred Care and Discharge
- Inequalities and Support for Wider Factors of Wellbeing
- Housing, DFGs, and overarching pieces of work

We also agreed to focus our BCF on projects that were either jointly funded, would benefit strongly from integrated oversight, or had outcomes that impacted the health and social care system.

Our BCF Programme was then built with these priorities in mind.

Alongside this Norfolk and Waveney are in the process of becoming an Integrated Care System and have developed a common purpose and aims to support people in Norfolk:

- To make Norfolk and Waveney the best place to work in health and care
- To make sure that people can live as healthy a life as possible
- To make sure you only have to tell your story once

As the ICS develops and becomes a statutory body, we expect this to support the development of joint priorities and build stronger collaborative commissioning links, as the BCF is seen as a key vehicle to drive integration within the ICS.

Approaches to joint/collaborative commissioning

In Norfolk we have been committed to integrated working and joint commissioning across the health and social care system. This is reflected in both our governance routes, but also in the number of joint funded and cross organisational teams we have.

One of the longest running examples we have of this is our jointly management structure for NCC and NCH&C operational teams.

We also have a jointly funded Social Care and Health Partnerships Team and jointly funded Quality Assurance and Market Development functions. These teams work across health and social care to commission and monitor services.

In 2020 we developed the new Integrated Commissioning Steering Group, which aims to improve joint commissioning and decision making. The purpose of the group is to:

- offer a place to agree, develop, jointly fund, and deliver joint commissioning projects and/or posts that will benefit the system through improved outcomes for users and/or value for money.
- review and comment on projects or services being developed in Norfolk and Waveney that will alter, improve, or change the provision of integrated delivery including projects funded by BCF and those not funded by BCF but with an impact on both aforementioned partners.
- will hold a list of key programmes requiring either its significant oversight and input, those it must be consulted on, and those it needs to be informed of.
- monitor the BCF and other integration projects to assess impact and return on investment for these, including the High Impact Change Model

Overarching approach to supporting people to remain independent at home and how BCF services are supporting this approach.

Norfolk's overarching approach to supporting people to remain independent at home focuses on three key ambitions:

- Promoting Independence – supporting people to stay at home for longer through linking in with their communities
- Preventing Crisis – offering additional targeted and tailored interventions to prevent crises occurring
- Rapid Response – taking action to divert people away from hospital or long-term care admissions.

In Norfolk we have a strong focus on supporting people to make links into their communities to enable them to stay at home for longer. As part of the BCF we fund both community connector roles, and universal services to support people to remain independent. This includes:

- Integrated Care Coordinators – ICCs work differently across each Place according to the local need. For example, in North Norfolk ICC's will receive referrals, primarily from GPs, for people who need community services to meet their needs. ICC's will work with the person to look at their strengths and needs, and refer or signpost them to appropriate community resources.
- Social Prescribing – A community wellbeing service that focuses on improving wellbeing. A free and confidential service that provides support to get healthier and feel better.
- Carers' Support Services – Our key service Carers Matter Norfolk offer information, advice, and assessment to unpaid carers.
- Norfolk Volunteer Services – Encourages and enables people to use their time, skills, and talents to volunteer and to find meaningful and enjoyable volunteering roles, for their own benefit and for the benefit of their local community.
- Transport schemes – Due to Norfolk's rural nature we fund transport services to support people to attend health, social care, and wellbeing appointments.

We also work in multi-disciplinary teams to identify people who would benefit from more targeted and tailored interventions. Our Early Help Hubs, GP led MDT's, NEAT and Discharge Hubs are all multi-disciplinary teams that sit at different stages of our system with people referred to them for support based on their needs. We also fund

specific services aimed at preventing an escalation of need. Some of these services include:

- Assistive Technology and Integrated Community Equipment – by providing assistive technology and equipment into people's own homes we can help them and the people that care for them to manage their health and social care needs and hopefully prevent this escalating into a crisis need.
- Specialist Dementia Nurses – Specialist dementia nurses who give expert practical, clinical, and emotional support to families living with dementia.
- Community Nursing and Occupational Therapy – Community nurses and OTs working in the community to help maintain quality of life and live as independently as possible.
- Community Stroke Support Services – a variety of services to support people to recover after a stroke and prevent the recurrence of further strokes.

Where crisis does occur, rapid response and intervention can prevent a hospital admission and enable people to recover with additional support at home. Where these services don't prevent admission, they can limit length of stay through earlier intervention during the crisis. Our Network Escalation Avoidance Teams are multidisciplinary teams which can coordinate services around an individual to avoid hospital admission in a crisis. Some of the services they, and people in our communities, can draw on are:

- Swifts and Night Owls – a 24-hour service directly accessible by residents in Norfolk who have an urgent, unplanned need at home that doesn't require traditional emergency services.
- Non-injury falls – Norfolk First Response can support people who have a fall that doesn't require attention from emergency services, with specialist lifting equipment and help, support, and reassurance.
- In My Place Carers Emergency Planning – Unpaid Carers can register a contingency and emergency plan with NCC. This both prepares them for what to do if they have an emergency or crisis, but also supports carers in case they have an emergency which leaves them unable to care. This reduces the number of cared for people entering hospital or emergency respite care in a crisis.
- Assistive Technology – assistive technology can be used to alert family, friends or call aid services to a crisis developing in someone's home, allowing them to intervene more quickly to prevent a hospital admission.

Supporting Discharge (national condition four)

What is the approach in your area to improving outcomes for people being discharged from hospital?

How is BCF funded activity supporting safe, timely and effective discharge?

As part of the Better Care Fund over previous years, Norfolk has been implementing the High Impact Change Model – Transfers of Care. We are transforming the integrated Discharge Hubs at each of the three acute hospitals to become multi-disciplinary teams focussed on the promotion of a 'home first' ethos.

The Better Care Fund has enabled us to bring our District and Borough Council partners into the Home First Hubs. They have knowledge of and access to very local community services as well as helpful services of their own. This includes things like: assisted bin collection schemes, warm homes services and handy man services. They also bring key knowledge on housing in Norfolk, and lead our Disabled Facilities Grant schemes, which offers adaptations that can be key to getting people home and helping them live independently there.

The Better Care Fund is also creating capacity for discharge, for example through:

- Norfolk First Response – this service offers free reablement services to people returning to their own homes for up to six weeks. As part of this reablement support they can offer personal care and other home support services, and will also support people to link into their relevant community, health and social care services. This will include identifying what ongoing home support services will be necessary.
- Short Term Offer – we also offer a variety of bed based services, where people can go to access reablement and rehabilitation services with an aim to supporting people back to their previous residence.
- Our existing Trusted Assessment Facilitator model is in the process of being revised based on learning from the last 4 years and an identified need for all staff involved in discharge to build stronger relationships between themselves and with the care provider market.

Alongside this the Better Care Fund is also supporting people home through our:

- Home from Hospital Services - This service supports hospital staff in the safe discharge of patients by ensuring that homes are safe and warm to return to, that there is food available and that the patients' neighbours, family networks and local community, where appropriate, have been informed that the person has been discharged. Each of our acutes also have services which call and check in on patients post discharge to ensure they have settled and are receiving the right support.
- Integrated Community Equipment Services – this service offers people the loan of equipment they need to support them post discharge, either temporarily to support reablement or to support with a longer term need.

For each hospital system, there is a plan including discharge planning, which starts at the front door with our admissions avoidance teams. We strive to have an estimated discharge date set withing 48 hours of someone being admitted to the hospital to support discharge planning starting as early as possible. To support this work we are implementing an integrated 'Transfers of Care' Form for use across Norfolk and Waveney, by health and social care partners, promoting a 'description of needs' rather than prescribing needs model which is followed up by assessment in the place someone has been discharged to, be it their own home or a short term bed.

A new Adverse Discharge is being developed and will be promoted with the care sector and operational staff. The process will incorporate a feedback loop to providers and learning to improve the quality of discharges across the system.

As part of our drive for timely and safe discharge we have also established a Community Capacity Cell, which brings together partners weekly to look at capacity in our post discharge support services. In this way we can work together to manage this capacity and coordinate planning to improve the Care Market to meet our needs.

As people are discharged from hospital along their D2A pathway there are a number of services they can access to ensure the discharge is safe and effective. These services will look different for every patient depending on what their needs are at point of discharge, and some differ across the three acutes in Norfolk, however all of them will be focussed on reablement, supporting someone back into their home and helping them access the right services to keep them independent at home. In this way our discharge approach links directly back into our admission prevention model, with both ending and starting with linking people back into their communities and the support and services around them.

Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

Disabled Facilities Grant:

Historically individual CCGs and NCC Commissioners have liaised on seven district based plans. The merger of five CCGs to one and the restructure of NCC commissioning teams presented the opportunity for greater clarity and focus of the strategic steer to the LHAs and potential to better align services and reporting

The formulation of plans for 2021/22 has been undertaken and key principles have been agreed which will overlay the district-based plans. These principles will support more effective reporting, delivery, and performance.

The key principles are as follows:

- Operation in line with the DFG Protocol
- An ambition to increase and regularise services and processes across the county
- A unified approach to reporting performance and demonstrating outcomes
- Importance of having housing as part of the MDT approach – early identification of potential adaptations to support independence
- Exploring the role of Carers – ability to support carers more directly – if the caring role can be sustained the cared for person has better quality of life and greater potential for staying in their own home

The Integrated Housing and Adaption Teams Prevention and Promoting Independence plan for 2021/22 is attached and details the overarching objectives for the DFG programme and locality delivery.

Integrated Housing and Adaption Teams

Equality and health inequalities.

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

- Changes from previous BCF plan.
- How these inequalities are being addressed through the BCF plan and services funded through this.
- Inequality of outcomes related to the BCF national metrics.

Our Health and Wellbeing Board's joint Health and Wellbeing Strategy details "tackling inequalities in communities – providing support for those who are most in need and address wider factors that impact on wellbeing, such as housing and crime" as one of its key priorities.

Alongside this the High Impact Change Model for prevention asks us to use Population Health Management to identify which population groups are at risk of preventable admissions and assess the effects of health and wider inequalities and local levels of deprivation on admission rates.

As part of this our Local Delivery Groups, which bring together partners across each of the five Places in Norfolk, have been focussed on identifying the specific health inequalities experienced in their area, and how the demography, geography and community support is affecting this. This work is still in its early stages of development but is why it was so important for us to include our Places in developing our BCF priorities.

Currently, as part of our BCF programme we have specific information and advice services targeted at those with protected characteristics or those we know experience health inequalities, including people with disabilities, older people, and unpaid carers. As the locality work on health inequalities develops this will influence a more comprehensive targeting of BCF services towards tackling these inequalities.

Our services are also developed with Equality Impact Assessments, which aim to understand and mitigate the potential inequalities experienced by people with protected characteristics as a result of new services or service changes. Many of our services, such as those detailed above, seek to target these inequalities by offering additional support to people with protected characteristics.

We are also developing a more comprehensive dashboard on the impact of our BCF programme, as detailed in the 'Executive Summary'. This alongside the 2021 census data, once it is published, will enable us to better identify and evidence any inequality of outcomes related to the BCF national metrics and our locally expected impacts.

Better Care Fund 2021-22 Template

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

For a more optimal view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance sheet for readability if required.

The details of each sheet within the template are outlined below.

Checklist (click to go to Checklist, included in the Cover sheet)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be completed before sending to the Better Care Fund Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover (click to go to sheet)

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net
(please also copy in your respective Better Care Manager)

4. Income (click to go to sheet)

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2021-22. It will be pre-populated with the minimum CCG contributions to the BCF, Disabled Facilities Grant (DFG) and improved Better Care Fund (iBCF). These cannot be edited.
2. Please select whether any additional contributions to the BCF pool are being made from local authorities or the CCGs and as applicable enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources when planning expenditure. The fields for Additional contributions can be used to include any relevant carry-overs from the previous year.
3. Please use the comment boxes alongside to add any specific detail around this additional contribution including any relevant carry-overs assigned from previous years. All allocations are rounded to the nearest pound.
4. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net

5. Expenditure (click to go to sheet)

This sheet should be used to set out the schemes that constitute the BCF plan for the HWB including the planned expenditure and the attributes to describe the scheme. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting and to particularly demonstrate that National Conditions 2 and 3 are met.
The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and CCG minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:
1. Scheme ID:
- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.
2. Scheme Name:
- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.
3. Brief Description of Scheme
- This is a free text field to include a brief headline description of the scheme being planned.
4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 5b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important to our understanding of how BCF funding is being used and levels of investment against different priorities.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.
5. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "CCG minimum" then the planned spend would count towards National Condition 2.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.
6. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and CCG/NHS and enter the respective percentages on the two columns.
7. Provider:
- Please select the 'Provider' commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.
8. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the CCG or Local authority
- If the scheme is funding across multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

9. Expenditure (£) 2021-22:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)
10. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

This is the only detailed information on BCF schemes being collected centrally for 2021-22 and will inform the understanding of planned spend for the iBCF grant and spend from BCF sources on discharge.

6. Metrics (click to go to sheet)

This sheet should be used to set out the HWB's performance plans for each of the BCF metrics in 2021-22. The BCF requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for the last two quarters of 2021-22.
The previous measure of Non Elective Admissions is being replaced with a measure of Unplanned Admissions for Chronic Ambulatory Care Sensitive Conditions. Performance data on this indicator up to 2019-20, by local authority can be found at:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/february-2021/domain-2-enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

A data pack showing breakdowns of data for new metrics (discharge and avoidable admissions) is available on the Better Care Exchange.

For each metric, systems should include a narrative that describes:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- how BCF funded schemes and integrated care will support performance against this metric, including any new or amended services.
1. Unplanned admissions for chronic ambulatory sensitive conditions:
- This section requires the area to input a planned rate for these admissions, per hundred thousand people for the year. This is the current NHS Outcomes Framework indicator 2.3i.
- The numerator is calculated based on the expected number of unplanned admissions for ambulatory sensitive conditions during the year.
- The denominator is the local population based on Census mid year population estimates for the HWB.
- Technical definitions for the guidance can be found here:
https://files.digital.nhs.uk/A0/76B7F6/NHSOF_Domain_2_S.pdf

2. Length of Stay.
- Areas should agree ambitions for minimising the proportion of patients in acute hospital who have been an inpatient for 14 days or more and the number that have been an inpatient for 21 days or more. This metric should be expressed as a percentage of overall patients.
- The ambition should be set for the HWB area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions. Ambitions should be set as the average percentage of inpatient beds occupied by patients with a length of stay of 14 days and over and 21 days and over for Q3 2021-22 and for Q4 2021-22 for people resident in the HWB.

- Plans should be agreed between CCGs, Local Authorities and Hospital Trusts and areas should ensure that ambitions agreed for 21 days or more are consistent across Local Trusts and BCF plans.

- The narrative should set out the approach that has been taken to agreeing and aligning plans for this metric
3. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay.

- The ambition should be set for the healthand wellbeing board area. The data for this metric is obtained from the Secondary Uses Service database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions. Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.

4. Residential Admissions (RES) planning:
- This section requires inputting the information for the numerator of the measure.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care) for the Residential Admissions numerator measure.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.
5. Reablement planning:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

7. Planning Requirements (click to go to sheet)

This sheet requires the Health & Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2021-22 for further details.
The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.
The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select ‘Yes’ or ‘No’ to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is ‘No’, please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

Better Care Fund 2021-22 Template

2. Cover

HM Government

NHS

Version 1.0

Please Note:
- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.
- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".
- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2021-22.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Norfolk
Completed by:	Nick Clinch
E-mail:	nicholas.clinch@norfolk.gov.uk
Contact number:	01603 223329

Please indicate who is signing off the plan for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	
Name:	

Has this plan been signed off by the HWB at the time of submission?	No
If no, or if sign-off is under delegated authority, please indicate when the HWB is expected to sign off the plan:	Wed 01/12/2021

<< Please enter using the format, DD/MM/YYYY
Please note that plans cannot be formally approved and Section 75 agreements cannot be finalised until a plan, signed off by the HWB has been submitted.

	Role:	Professional Title (where applicable)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	County Councillor	Bill	Borrett	bill.borrett.cllr@norfolk.gov.uk
	Clinical Commissioning Group Accountable Officer (Lead)	Chief Executive, NHS	Melanie	Craig	melaniecraig@nhs.net
	Additional Clinical Commissioning Group(s) Accountable Officers	Director of Primary &	Mark	Burgis	mark.burgis@nhs.net
	Local Authority Chief Executive	Head of Paid Service	Tom	McCabe	tom.mccabe@norfolk.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)	Executive Director of	James	Bullion	james.bullion@norfolk.gov.uk
	Better Care Fund Lead Official	Director of Commissionin	Gary	Heathcote	gary.heathcote@norfolk.gov.uk
	LA Section 151 Officer	Executive Director,	Simon	George	simon.george@norfolk.gov.uk
Please add further area contacts that you would wish to be included in official correspondence -->	Assistant Director, Social Care & Health Partnership Commissioning	Assistant Director	Nicholas	Clinch	nicholas.clinch@norfolk.gov.uk
	Commissioning Manager, Social Care & Health Partnership Commissioning	Commissioning Manager	Bethany	Small	bethany.small@nhs.net

**Only those identified will be addressed in official correspondence (such as approval letters). Please ensure all individuals are satisfied with the information entered above as this is exactly how they will appear in correspondence.*

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Please see the Checklist below for further details on incomplete fields

	Complete:
2. Cover	No
4. Income	Yes
5a. Expenditure	Yes
6. Metrics	Yes
7. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2021-22 Template

3. Summary

Selected Health and Wellbeing Board: Norfolk

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£9,157,782	£9,157,782	£0
Minimum CCG Contribution	£69,119,908	£69,119,908	£0
iBCF	£38,453,693	£38,453,693	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	**£116,731,383**	**£116,731,383**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum CCG allocation

Minimum required spend	£19,603,939
Planned spend	£33,906,128

Adult Social Care services spend from the minimum CCG allocations

Minimum required spend	£34,116,638
Planned spend	£44,378,059

Scheme Types

Assistive Technologies and Equipment	£6,099,107	(5.2%)
Care Act Implementation Related Duties	£3,982,505	(3.4%)
Carers Services	£31,172	(0.0%)
Community Based Schemes	£9,965,125	(8.5%)
DFG Related Schemes	£9,189,482	(7.9%)
Enablers for Integration	£1,547,458	(1.3%)
High Impact Change Model for Managing Transfer of	£514,016	(0.4%)
Home Care or Domiciliary Care	£8,374,177	(7.2%)
Housing Related Schemes	£377,720	(0.3%)
Integrated Care Planning and Navigation	£4,086,688	(3.5%)
Bed based intermediate Care Services	£8,722,855	(7.5%)
Reablement in a persons own home	£11,829,299	(10.1%)
Personalised Budgeting and Commissioning	£0	(0.0%)
Personalised Care at Home	£944,249	(0.8%)
Prevention / Early Intervention	£2,322,454	(2.0%)
Residential Placements	£1,168,945	(1.0%)
Other	£47,576,131	(40.8%) !!! Please try to keep 'Other' t
Total	**£116,731,383**	

Metrics >>

Avoidable admissions

	20-21 Actual	21-22 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	802.9	984.9

Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients	LOS 14+	11.6%	11.7%
	LOS 21+	5.9%	6.1%

Discharge to normal place of residence

	0	21-22 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	0.0%	92.1%

Residential Admissions

		20-21 Actual	21-22 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	554	551

Reablement

		21-22 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	84.8%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Plan for improving outcomes for people being discharged from hospital	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2021-22 Template

4. Income

Selected Health and Wellbeing Board: Norfolk

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Norfolk	£9,157,782
DFG breakerdown for two-tier areas only (where applicable)	
Breckland	£1,329,644
Broadland	£1,013,705
Great Yarmouth	£1,348,045
King's Lynn and West Norfolk	£1,782,807
North Norfolk	£1,354,615
Norwich	£1,293,541
South Norfolk	£1,035,425
Total Minimum LA Contribution (exc iBCF)	**£9,157,782**

iBCF Contribution	Contribution
Norfolk	£38,453,693
Total iBCF Contribution	**£38,453,693**

Are any additional LA Contributions being made in 2021-22? If yes, please detail below	No

Local Authority Additional Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional Local Authority Contribution	**£0**	

CCG Minimum Contribution	Contribution
NHS Great Yarmouth and Waveney CCG	£8,505,324
NHS North Norfolk CCG	£13,671,793
NHS Norwich CCG	£16,028,559
NHS South Norfolk CCG	£16,619,084
NHS West Norfolk CCG	£14,295,148
Total Minimum CCG Contribution	**£69,119,908**

Are any additional CCG Contributions being made in 2021-22? If yes, please detail below	No

Additional CCG Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional CCG Contribution	**£0**	
Total CCG Contribution	**£69,119,908**	

	2021-22
Total BCF Pooled Budget	**£116,731,383**

Funding Contributions Comments Optional for any useful detail e.g. Carry over
N/A

See next sheet for Scheme Type (and Sub Type) descriptions

Better Care Fund 2021-22 Template

5. Expenditure

Selected Health and Wellbeing Board: Norfolk

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£9,157,782	£9,157,782	£0
Minimum CCG Contribution	£69,119,908	£69,119,908	£0
iBCF	£38,453,693	£38,453,693	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	**£116,731,383**	**£116,731,383**	**£0**

Please note:

Scheme Types categorised as 'Other' currently account for approx. 41% of the planned expenditure from the Mandatory Minimum. In order to reduce reporting ambiguity, we encourage limiting this to 5% if possible.
While this may be difficult to avoid sometimes, we advise speaking to your respective Better Care Manager for further guidance.

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum CCG Contribution (on row 31 above).

	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£19,603,939	£33,906,128	£0
Adult Social Care services spend from the minimum CCG allocations	£34,116,638	£44,378,059	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes

Sheet complete

						Planned Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	Advocacy Service	Free advice lines with info to help older people.	Integrated Care Planning and Navigation	Care navigation and planning	Information, Advice and Advocacy	Social Care		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£29,700	Existing
2	Part funding of Carers Support	To support carers to maintain their caring role up to 12 months	Care Act Implementation Related Duties	Carer advice and support	Carers Matter Norfolk - Assessment	Social Care		CCG			Local Authority	Minimum CCG Contribution	£167,800	Existing
3	Community Nursing and Occupational	Community nurses and OTs working in the community to help	Community Based Schemes	Multidisciplinary teams that are supporting		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£9,901,451	Existing
30	Dementia/Alzheimers Support	Specialist dementia nurses who give expert practical, clinical and	Integrated Care Planning and Navigation	Care navigation and planning	Admiral Nuses	Community Health		CCG			Local Authority	Minimum CCG Contribution	£219,506	Existing
5	Early Help hub	Provided by Gt Yarmouth Borough Council	Integrated Care Planning and Navigation	Care navigation and planning		Social Care		CCG			Local Authority	Minimum CCG Contribution	£28,000	Existing
4	Dementia/Alzheimers Support	Support & advice service and funds support workers.	Integrated Care Planning and Navigation	Care navigation and planning	Information, advice and support service	Social Care		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£246,901	Existing
7	HomeWard	Planned discharge care (including cancer care)	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£1,441,472	Existing

8	RATS & Virtual Ward	Planned discharge care (including cancer care)	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£1,830,928	Existing
9	ICES	To facilitate people to live at home, with the aid of equipment, and to	Assistive Technologies and Equipment	Community based equipment		Social Care		CCG			Private Sector	Minimum CCG Contribution	£5,398,675	Existing
10	Intergrated Care Co-Ordinators	A first point of contact for professionals in health and social care.	Integrated Care Planning and Navigation	Care navigation and planning		Primary Care		CCG			Local Authority	Minimum CCG Contribution	£553,083	Existing
11	Intermediate Spot Purchase Beds	Accomodation based commissioning.	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Community Health		CCG			Private Sector	Minimum CCG Contribution	£1,591,069	Existing
32	Together	The Health and Wellbeing Volunteer Service will be available	Reablement in a persons own home	Preventing admissions to acute setting		Mental Health		CCG			Local Authority	Minimum CCG Contribution	£392,500	Existing
13	Early Interv. & Discharge Liaison Teams & Co-	Admission avoidance, early intervention and inpatient discharges	Integrated Care Planning and Navigation	Care navigation and planning		Acute		CCG			NHS Community Provider	Minimum CCG Contribution	£962,126	Existing
14	Home from Hospital, Medical Loans Service &	The services will support hospital staff in the safe discharge of patients by	Assistive Technologies and Equipment	Community based equipment		Primary Care		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£189,432	Existing
15	Domiciliary Care	Home Care support	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		CCG			Private Sector	Minimum CCG Contribution	£1,487,047	Existing
16	NCC Meds Management	Arden and GEM Commissioning Support Unit funds advice, help	Other		Information and advice on managing	Community Health		CCG			Local Authority	Minimum CCG Contribution	£368,800	Existing
17	Equal Lives	A disability rights organisation supporting people to empower	Integrated Care Planning and Navigation	Care navigation and planning	Information, Advice and Advocacy	Other	Primary and Social Care	CCG			Local Authority	Minimum CCG Contribution	£145,213	Existing
33	NEAT	Network of Escalation Avoidance Team	Integrated Care Planning and Navigation	Assessment teams/joint assessment		Other	Acute and Social Care	CCG			Local Authority	Minimum CCG Contribution	£660,872	Existing
19	Norfolk Volunteer Services	Encourages and enables people to use their time, skills and talents to	Enablers for Integration	Voluntary Sector Business Development		Social Care		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£220,149	Existing
20	Palliative Beds & Hospice	Accomodation based commissioning.	Residential Placements	Nursing home		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£798,945	Existing
34	Discharge Practitioner Services	Funding of practitioners to support multi-agency discharge teams.	High Impact Change Model for Managing	Multi-Disciplinary/Multi-Agency Discharge		Acute		CCG			Local Authority	Minimum CCG Contribution	£135,016	Existing
22	Part funding of Reablement Service	NFR Reablement services, offering six weeks reablement in a	Reablement in a persons own home	Reablement to support discharge - step down	incl. District Direct	Social Care		CCG			Local Authority	Minimum CCG Contribution	£1,148,799	Existing
23	Safe at Home	Handy person service in Great Yarmouth and Waveney	DFG Related Schemes	Handyperson services		Social Care		CCG			Local Authority	Minimum CCG Contribution	£31,700	Existing
24	Weight Management Scheme	Scheme to support people at risk of further health conditions due to	Prevention / Early Intervention	Risk Stratification		Primary Care		CCG			Private Sector	Minimum CCG Contribution	£390,495	Existing
35	Staff recharges - GP's & Ass. Practitioners	Work focussed on healhier communities, better healthcare for	Care Act Implementation Related Duties	Other	Staffing charges for GP's and AP's.	Other	Primary and Social Care	CCG			Local Authority	Minimum CCG Contribution	£121,705	Existing
26	Neuro Cardiac & Pulmonary Support Services	Specialist Community Nurses - Neuro Cardiac & Pulmonary Support	Personalised Care at Home	Physical health/wellbeing		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£470,054	Existing

27	Specialist Nursing Teams	Specialist Nursing Teams to support people in the community	Personalised Care at Home	Physical health/wellbeing		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£474,195	Existing
36	SOS Bus	Provides a first point of contact, support and first aid to people who	Prevention / Early Intervention	Other	Information, advice and support focussed	Primary Care		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£122,559	Existing
37	Social Prescribing	A community wellbeing service that focus' on improving wellbeing. A	Prevention / Early Intervention	Social Prescribing		Primary Care		CCG			Private Sector	Minimum CCG Contribution	£846,919	Existing
38	Eating Disorders	To provide a range of services to support clients with an eating	Prevention / Early Intervention	Risk Stratification		Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£120,847	Existing
39	Voluntary Sector MH Services	works in partnership with over 20 voluntary and community groups	Enablers for Integration	Voluntary Sector Business Development		Mental Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£622,309	Existing
40	West Norfolk Carers Project	Independent charity supporting unpaid family carers & creating	Carers Services	Other	Information, advice and support service	Social Care		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£31,172	Existing
41	Care Navigators	Supports older people to 'navigate' their way around health, social	Integrated Care Planning and Navigation	Care navigation and planning		Other	Primary and Social Care	CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£68,039	Existing
42	Day Centres / Daycare	Marion Road Day (norwich)Centre & Glaven Day Centre	Home Care or Domiciliary Care	Other	Day Care Centres	Social Care		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£68,730	Existing
43	Wellfamily Services	Well Family is a one stop health and wellbeing service comprising a	Prevention / Early Intervention	Risk Stratification		Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£76,341	Existing
44	St. Martin's Hub	Provides emergency accommodation and support for rough	Housing Related Schemes			Mental Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£198,720	Existing
45	West Norfolk Disability Information	Provides a range of information and support to all disabled people,	Integrated Care Planning and Navigation	Care navigation and planning	Information, advice and support service	Social Care		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£13,248	Existing
46	GP / Medical cover for Intermediate Care	GP medical cover to intermediate care services help people to	Bed based intermediate Care Services	Other	GP cover of our bed based intermediate	Primary Care		CCG			Private Sector	Minimum CCG Contribution	£31,786	Existing
22	Equipment at home (BOC)	Oxygen at home service	Prevention / Early Intervention	Risk Stratification		Community Health		CCG			Private Sector	Minimum CCG Contribution	£81,288	Existing
22	Swifts and Nightowls	24-hour service you can call if you have an urgent, unplanned need	Reablement in a persons own home	Rapid/Crisis Response - step up (2 hr response)		Social Care		CCG			Local Authority	Minimum CCG Contribution	£1,300,000	Existing
22	NFS Referrals	Provides intensive support in own home for up to 6 weeks to	Reablement in a persons own home	Reablement service accepting community and		Social Care		CCG			Local Authority	Minimum CCG Contribution	£1,328,000	Existing
47	ASD / ADHD / Asperger's Support	offers personal, friendly assistance for everyone with Asperger syndrome	Prevention / Early Intervention	Risk Stratification		Mental Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£364,025	Existing
31	Mid Norfolk Heartwork	To provide a structured, supervised exercise scheme which will	Prevention / Early Intervention	Risk Stratification		Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£8,258	Existing
31	Norfolk & Norwich Scope Association	Improving children's physical and cognitive skills	Prevention / Early Intervention	Risk Stratification		Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£15,809	Existing
31	Norfolk Deaf Association	Aims to relieve the Audiology depts workload as well as help	Prevention / Early Intervention	Risk Stratification		Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£71,413	Existing

31	Sensing Change	Social Work Practice providing a range of services including social	Prevention / Early Intervention	Risk Stratification		Social Care		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£7,500	Existing
31	Stroke Assocation	Provides a range of community stroke support services in the	Prevention / Early Intervention	Risk Stratification		Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£117,000	Existing
48	Transport Plus	Provision of transport using volunteer drivers to enable access to	Community Based Schemes	Other	Transport	Community Health		CCG			Local Authority	Minimum CCG Contribution	£37,660	Existing
49	West Norfolk Community Action Norfolk	CAN is the leading organisation for engagement with the	Enablers for Integration	Voluntary Sector Business Development		Other	Spend is across all areas of health and social	CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£40,000	Existing
50	West Norfolk Community Transport	To provide day to day management of a bank of drivers, and to	Community Based Schemes	Other	Transport	Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£26,014	Existing
51	Enhanced Home Support Service	Supports hospital discharge by offering home support packages	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge		Social Care		LA			Private Sector	Minimum CCG Contribution	£1,200,000	Existing
52	Rapid Response (part of Swifts and NightOwls)	Rapid response service for people with short term, unplanned, care	Reablement in a persons own home	Preventing admissions to acute setting		Acute		LA			Local Authority	Minimum CCG Contribution	£250,000	Existing
53	Age UK Advocacy Service	Older Persons Advocacy service	Integrated Care Planning and Navigation	Care navigation and planning	Information, Advice and Advocacy	Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£202,000	Existing
22	NFR Reablement	NFR Reablement services, offering six weeks reablement in a	Reablement in a persons own home	Reablement to support discharge - step down		Social Care		LA			Local Authority	Minimum CCG Contribution	£7,410,000	Existing
55	Independent Mental Health Advocacy and	Mental Health Advocacy	Integrated Care Planning and Navigation	Care navigation and planning	Information, Advice and Advocacy	Mental Health		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£826,000	Existing
56	District Direct	District Council expertise in our acute Home First Hubs	High Impact Change Model for Managing	Housing and related services		Acute		LA			Local Authority	Minimum CCG Contribution	£105,000	Existing
57	Dementia Support SLA	Support for people with Dementia	Prevention / Early Intervention	Risk Stratification		Social Care		LA			Private Sector	Minimum CCG Contribution	£100,000	Existing
2	Carers	To support carers to maintain their caring role up to 12 months	Care Act Implementation Related Duties	Carer advice and support	Carers Matter Norfolk - Assessment	Social Care		LA			Private Sector	Minimum CCG Contribution	£1,150,000	Existing
9	ICES	To facilitate people to live at home, with the aid of equipment, and to	Assistive Technologies and Equipment	Community based equipment		Social Care		LA			Private Sector	Minimum CCG Contribution	£511,000	Existing
60	Out of Hospital / Short Term Offer	Bed based reablement offer and hospital social work teams	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Social Care		LA			Local Authority	Minimum CCG Contribution	£7,100,000	Existing
61	Integrated Care Coordinators	A first point of contact for professionals in health and social care.	Integrated Care Planning and Navigation	Care navigation and planning		Primary Care		LA			Local Authority	Minimum CCG Contribution	£65,000	Existing
62	Social Care and Health Partnership	Joint Commissioning Team across NCC & CCG	Enablers for Integration	Joint commissioning infrastructure		Social Care		LA			Local Authority	Minimum CCG Contribution	£240,000	Existing
63	Integrated Quality Team	Joint Quality Team across NCC & CCG	Enablers for Integration	Joint commissioning infrastructure		Social Care		LA			Local Authority	Minimum CCG Contribution	£250,000	Existing
64	LD, MH and Autism Packages of Care	Care services for people with LD, MH and Autism	Other		Home based and residential packages of care	Social Care		LA			Private Sector	Minimum CCG Contribution	£14,600,638	Existing

65	Disabled Facilities Grant	Spend on DFG's by our district and borough councils	DFG Related Schemes	Adaptations, including statutory DFG grants		Social Care		LA			Local Authority	DFG	£9,157,782	Existing
66	Home from Hospital SLA	The services will support hospital staff in the safe discharge of patients by	High Impact Change Model for Managing	Housing and related services		Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£107,000	Existing
70	ASC Core Care Services (underlying spend	Covering market pressures	Other		Covering market pressures	Social Care		LA			Local Authority	iBCF	£21,999,693	Existing
71	Younger Adults Residential Price Uplift for those	Residential placements for younger adults	Residential Placements	Care home		Social Care		LA			Private Sector	iBCF	£370,000	Existing
72	Home Care Framework and Rate increase	Home care services across Norfolk.	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Private Sector	iBCF	£2,202,000	Existing
73	Older People Cost of Care Exercise 2018/20	Covering market pressures	Other		Covering market pressures	Social Care		LA			Local Authority	iBCF	£3,827,000	Existing
74	Younger Adults Demography and Pressures 2019/20	Covering market pressures	Other		Covering market pressures	Social Care		LA			Local Authority	iBCF	£1,680,000	Existing
75	Hard to Reach Homecare services	Home Care services targeted at hard to reach areas.	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Private Sector	iBCF	£144,000	Existing
76	DOLS	Deprivation of Living Safeguards	Care Act Implementation Related Duties	Other	Deprivation of Living Safeguards	Social Care		LA			Local Authority	iBCF	£225,000	Existing
77	Enhancement to Social Care Capacity 2018	Additional Social Work Capacity	Care Act Implementation Related Duties	Other	Additional Social Work Capacity	Social Care		LA			Local Authority	iBCF	£2,118,000	Existing
78	Former Protection of Social Care	Protection of Social Care	Other		Protection of Social Care	Social Care		LA			Local Authority	iBCF	£5,100,000	Existing
79	MH Capacity (evolve and practitioners)	MH Capacity	Care Act Implementation Related Duties	Other	MH Capacity	Social Care		LA			Local Authority	iBCF	£200,000	Existing
80	Trusted Assessors	Trusted Assessment model in our acute hospitals, supporting	High Impact Change Model for Managing	Trusted Assessment		Social Care		LA			Local Authority	iBCF	£167,000	Existing
81	The Old Maltings service provision	Housing with Care service	Housing Related Schemes			Social Care		LA			Private Sector	iBCF	£179,000	Existing
82	Practice Educator Lead	Practice Educator Lead to support good practice.	Enablers for Integration	Workforce development		Social Care		LA			Local Authority	iBCF	£54,000	Existing
83	Autistism Diagnostic Service	Autistism Diagnostic Service	Integrated Care Planning and Navigation	Assessment teams/joint assessment		Social Care		LA			Local Authority	iBCF	£67,000	Existing
84	Technology for agile working	Support agile working for SW Teams	Enablers for Integration	Workforce development		Social Care		LA			Local Authority	iBCF	£80,000	Existing
85	Winter Co-ordination role	Coordinating Winter Planning for ASC	Enablers for Integration	Programme management		Social Care		LA			Local Authority	iBCF	£41,000	Existing

2021-22 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Telecare 2. Wellness services 3. Digital participation services 4. Community based equipment 5. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Carer advice and support 2. Independent Mental Health Advocacy 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the CCG minimum contribution to the BCF.
3	Carers Services	1. Respite services 2. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services shoukld be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG - including small adaptations 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate
6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. Community asset mapping 7. New governance arrangements 8. Voluntary Sector Business Development 9. Employment services 10. Joint commissioning infrastructure 11. Integrated models of provision 12. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Domiciliary care workforce development 4. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services	1. Step down (discharge to assess pathway-2) 2. Step up 3. Rapid/Crisis Response 4. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups. Four service models of intermediate care are: bed-based intermediate care, crisis or rapid response (including falls), home-based intermediate care, and reablement or rehabilitation. Home-based intermediate care is covered in Scheme-A and the other three models are available on the sub-types.
12	Reablement in a persons own home	1. Preventing admissions to acute setting 2. Reablement to support discharge -step down (Discharge to Assess pathway 1) 3. Rapid/Crisis Response - step up (2 hr response) 4. Reablement service accepting community and discharge referrals 5. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
14	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
15	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
16	Residential Placements	1. Supported living 2. Supported accommodation 3. Learning disability 4. Extra care 5. Care home 6. Nursing home 7. Discharge from hospital (with reablement) to long term residential care (Discharge to Assess Pathway 3) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
17	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Better Care Fund 2021-22 Template

6. Metrics

Selected Health and Wellbeing Board: Norfolk

8.1 Avoidable admissions

	19-20 Actual	20-21 Actual	21-22 Plan	Overview Narrative
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	Available from NHS Digital (link below) at local authority level. Please use as guideline only	802.9	984.9	For 2020/21 we saw a reduction in avoidable admissions, mainly attributable to COVID. We believe this figure will increase in 2021/22, however using the lessons learned during the pandemic regarding admissions avoidance, and our condition specific and more general admission avoidance schemes, will mitigate against a return to 2019/20 levels. These services include: assistive technology and ICES; community nursing and OT; dementia support services; community stroke services and cardiac services.

Please set out the overall plan in the HWB area for reducing rates of unplanned hospitalisation for chronic ambulatory sensitive conditions, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

>> link to NHS Digital webpage

8.2 Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan	Comments
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients (SUS data - available on the Better Care Exchange)	Proportion of inpatients resident for 14 days or more	11.6%	11.7%	We have seen higher rates in H1 this year compared to H1 in 2019/20, we have also historically seen higher rates in Q3 and Q4, so we expect a higher full year effect this year overall. Our approach to reducing length of stay focuses on early coordinated discharge planning, including a new integrated "Transfers of Care" Form promoting a 'description of needs' which is understood across health and social care. We also seek to reduce length of stay through our District Direct service, which brings our District and Borough Council partners in to the Home First Hubs, who have knowledge of the key services in their area which might help a person home sooner. This works well in tandem with Home from Hospital services which ensure people have a safe and warm home to return to. For people being discharged into residential care, our Trusted Assessment Facilitators model is currently being revised based on the learning from the past four years. It has identified a need for all staff in discharge teams to build stronger relationships with the care provider marker, which will in turn reduce length of stay. As these new or revised services embed we would expect to see a reduction in LOS from 2022/23.
	Proportion of inpatients resident for 21 days or more	5.9%	6.1%	

Please set out the overall plan in the HWB area for reducing the percentage of hospital inpatients with a long length of stay (14 days or over and 21 days and over) including a rationale for the ambitions that sets out how these have been reached in partnership with local hospital trusts, and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.

8.3 Discharge to normal place of residence

	21-22 Plan	Comments	
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	92.1%	The percentage of people discharged to their normal place of residence in the first half of 2021/22 was 92.3%, however we expect this to reduce marginally over winter. We have a number of services in the BCF aiming to support people back to their normal place of residence, including our reablement schemes, aimed at helping people to be as independent as possible: Short Term Offer, bed based reablement scheme; and Norfolk First Response, home based reablement scheme. We also seek, where possible, to ensure people's normal place of residence is adapted to any new support needs they may have post discharge. Two ways of doing this are through our Disabled Facilities Grants, making adaptations to their home, and our Integrated Community Equipment services putting in new or	**Please set out the overall plan in the HWB area for improving the percentage of people who return to their normal place of residence on discharge from acute hospital, including a rationale for how the ambition was reached and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.**

8.4 Residential Admissions

		19-20 Plan	19-20 Actual	20-21 Actual	21-22 Plan	Comments
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	572	555	554	551	2020/21 saw significant numbers of people discharged into Care Homes due to the COVID Scheme 1 arrangements. Many of these became long term occupiers of residential and nursing beds towards the end of 2020/21 and into 2021/22, who in other circumstances may have returned home. At the same time we are aware that during the same 12 month period, people tried to stay out of care due to the perceived COVID risk. This measure is currently under review due to the exceptional circumstances experienced over the last 12-18 month period.
	Numerator	1,274	1,235	1,248	1,265	
	Denominator	222,661	222,666	225,343	229,546	

Please set out the overall plan in the HWB area for reducing rates of admission to residential and nursing homes for people over the age of 65, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		19-20 Plan	19-20 Actual	21-22 Plan	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	87.1%	85.9%	84.8%	D2A is significantly re-shaping demands on reablement and home support within Pathway 1, with Norfolk's reablement services (funded via BCF) playing a critical role in supporting people in the community. Volumes of discharges into reablement services increased from 946 to 1880 last year with a slight increase expected to year end this year. This increased volume has impacted on the proportion of older people who were still at home 91 days after discharge from hospital into reablement services, although we are expecting the service volumes to stablise due to overall capacity and along with it the outcomes to begin to improve again.
	Numerator	626	813	1,636	
	Denominator	719	946	1,930	

Please set out the overall plan in the HWB area for increasing the proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Better Care Fund 2021-22 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Norfolk

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it
NC1: Jointly agreed plan	**PR1**	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between CCG(s) and LA; been submitted? Has the HWB approved the plan/delegated approval pending its next meeting? Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned?	Cover sheet Cover sheet Narrative plan Validation of submitted plans	Yes	Narrative plan: Page 2 describes how we engaged with partners across the system and the conversations we have had with them about the BCF over the past year as part of our BCF review work.		
	PR2	**A clear narrative for the integration of health and social care**	**Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes:** • How the area will continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally. • The approach to collaborative commissioning • The overarching approach to support people to remain independent at home, and how BCF funding will be used to support this. • How the plan will contribute to reducing health inequalities and inequalities for people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered, - Changes to local priorities related to health inequality and equality, including as a result of the COVID 19 pandemic, and how activities in the BCF plan will address these	Narrative plan assurance	Yes	We have used the given narrative plan template which has guided us through each of these sections.		
	PR3	**A strategic, joined up plan for DFG spending**	**Is there confirmation that use of DFG has been agreed with housing authorities?** • Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home? • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory Disabled Facilities Grants? or - The funding been passed in its entirety to district councils?	Narrative plan Confirmation sheet	Yes	This is detailed on page 12 of the narrative plan, and in the further document "Integrated Housing and Adaption Teams Prevention and Promoting Independence plan for 2021/22" which we attached to our submission.		
NC2: Social Care Maintenance	**PR4**	**A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the CCG minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC3: NHS commissioned Out of Hospital Services	**PR5**	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the CCG minimum BCF contribution?**	Does the total spend from the CCG minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC4: Plan for improving outcomes for people being discharged from hospital	**PR6**	**Is there an agreed approach to support safe and timely discharge from hospital and continuing to embed a home first approach?**	• Does the BCF plan demonstrate an agreed approach to commissioning services to support discharge and home first including: - support for safe and timely discharge, and - implementation of home first? • Does the expenditure plan detail how expenditure from BCF funding sources supports this approach through the financial year? • Is there confirmation that plans for discharge have been developed and agreed with Hospital Trusts?	Narrative plan assurance Expenditure tab Narrative plan	Yes	Yes, this begins on page 12 of our Narrative Plan, and specifically details some of the BCF services that support us in delivering safe and timely discharge with a Home First focus.		

Agreed expenditure plan for all elements of the BCF	**PR7**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	• Do expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated) • Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (see paragraphs 32 – 43 of Planning Requirements) (tick-box) • Has funding for the following from the CCG contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement?	Expenditure tab Expenditure plans and confirmation sheet Narrative plans and confirmation sheet	Yes			
Metrics	**PR8**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	• Have stretching metrics been agreed locally for all BCF metrics? • Is there a clear narrative for each metric describing the approach locally to meeting the ambition set for that metric, including how BCF expenditure will support performance against each metric? • Are ambitions across hospital trusts and HWBs for reducing the proportion of inpatients that have been in hospital for 21 days aligned, and is this set out in the rationale? • Have hospital trusts and HWBs developed and agreed plans jointly for reducing the proportion of inpatients that have been in hospital for 14 days or more and 21 days or more?	Metrics tab	Yes			

Report title: Adult Social Care Winter Plan

Date of meeting: 01 December 2021

Sponsor (HWB member): James Bullion, Executive Director for Adult Social Services, NCC

Reason for the Report

In response to the increased demands and challenges for winter 2021/2022 Adult Social Services have produced a local Winter Action Plan for Norfolk. This action plan will set out not only the unprecedented challenges faced by Social Services at this time, but the practical solutions being put in place to manage these challenges.

Report summary

The plan builds upon the strong contingency processes developed during the height of the Covid pandemic and is based on continued strong collaborative working with our partners and providers. We provide many of the most vulnerable individuals in Norfolk with care and support and this Winter Plan will put in a place a system of resilience that will help our staff focus limited resources where they are most needed. We want to ensure that high quality, safe, and timely care is provided to all those that need it. The Winter Plan will be presented to Cabinet on 6th December 2021.

Recommendations

The HWB is asked to:

a) Consider and Agree the Adult Social Care Winter Plan for 2021/2022.

1. Background and Purpose

1.1 Adult Social Services have faced and continue to face its greatest challenge. We have met extreme pressures on health and social care during the height of the Covid epidemic and this has not only continued but is increasing.

1.2 An ageing population combined with increasing numbers of people with long-term health conditions means that demand for both health and social care is increasing and we know that these pressures increase during winter months, particularly across the urgent care system. Traditionally, winter is not considered an unusual event but recognised as a period of increased pressures due to demand in both the complexity of people's needs and the capacity demands on resources within social care. As we head into winter with an already pressured position across the Norfolk wide system, this winter will prove challenging for all stakeholders.

1.3 Winter 2021/2022 continues to present greater challenges and the strain placed on the system by Covid continues to be felt. Building on last year's Adult Social Care Winter Plan through Covid, we will set out the key elements of this year's Plan which will focus resources on the key areas that contribute towards building and maintaining a stable system for winter 2021/2022.

1.4 Adult Social Services is committed to working with, and supporting, the wider health and social care system but understanding that there is a need to have a single view of how the

Department will marshal its resources and prioritise interventions.

1.5 Norfolk Adult Social Services face a level of unprecedented challenge in 2021/2022 with national and local workforce shortages, rising demand in hospitals and the community, increase in Pathway 1 and 2 demand, with the infection risk posed by COVID-19 as well as other recurring respiratory viruses.

1.6 Recruiting and keeping people in the care workforce is a major challenge to the care industry. On any one day there are 14,000 vacancies in the care sector in Norfolk. Care providers often find themselves competing with retail and hospitality sector to attract and keep staff. We continually need to support independent care providers to promote caring as a valued, meaningful and fulfilling career in health and social care.

1.7 We will continue to support people in Norfolk to be independent, resilient, and well, through our Promoting Independence Strategy and the implementation of the Winter Plan. We will continue to strengthen social work so that it prevents, reduces and delays need. We will continue to be strong partners for integration working, be a strong partner to our providers, accelerate the use of technology and safeguard people with strong management of finance and performance.

2. Health and Social Care Context

2.1 We are committed to delivering a good service to our residents. We have already achieved a great deal in our journey towards Promoting Independence and we are committed to continuing this work to ensure we provide support for people who need it. As well as managing a difficult winter period, with the support of a focused Winter Plan, we will continue to provide support to residents of Norfolk when they need it most.

2.2 We will continue to promote prevention and early help through our Promoting Independence Strategy. This is the bedrock of prevention across the county, supporting more people to stay independent, resilient, and well. This ranges from community development, community connectors, general and specialist information and guidance, through to targeted early help and reablement. We will continue using Living Well as our Norfolk model of social work, based on 3 Conversations. Living Well was co-produced as a basis for promoting independence in Adult Social Care using social prescribing, employment support, money management, carers support, as well as new mobile technology for front line staff. We have rolled out the new approach to more than 600 practitioners.

2.3 Adult Social Services in Norfolk support's 18,616 people every year with 109,156 contacts for social care received in a year to Norfolk County Council. In the period April to October 2021, our front line SCCE service received 20,279 calls requesting help. This unprecedented demand for support continues to rise with 9,400 more people contacting SCCE for support than four years ago. Residents are contacting Adult Social Services for a wide range of services and help. Residents requesting information numbered 2,375 with 2,263 people requesting a financial service. Mental Health Services saw 1,686 requests for an assessment.

2.4 In the period 1st April to 31st October 2021, Adult Social Services carried out 32,500 Care Act assessments. Assessments on average take 17 days to complete. This means that 6% of the Norfolk population received assessments in the past seven months with 41% of these assessments leading to a service being provided. Assessments could be a formal 'Care Act' assessment, assessments around carers, Assistive Technology, Safeguarding and more. In addition to these formal assessments, we conducted 12,762 existing case reviews. Reviews include a review of the 'Care Act' or unplanned reviews resulting in a change of circumstance.

2.5 Reablement services from April to October 2021 saw 4,852 referrals with 45% in the 80–90-year-old age bracket.

2.6 Swifts made over 9000 visits for people in the community with unplanned urgent needs in the rolling year between 2020 and 2021. There were 7,107 referrals to Swifts in the period April to October 2021.

2.7 In Quarter 2 of 2021 Adult Social Services had 13,212 people access Norfolk County Council Commissioned Services including Day Care, Home Care, Residential Services, Nursing, Equipment, Supporting Living Transport and more. This total included 7,033 Older People, 2,743 Learning Disabilities, 1,553 Physical Disabilities, and 1,262 in Mental Health.

2.8 We will continue to deliver Extra Care Housing as part of the Independent Living Programme. Cabinet agreed a £29 million capital fund to facilitate the development of new extra care housing across Norfolk. The first scheme is underway in Fakenham consisting of 66 flats, a mix of one and two beds offering affordable rent and shared ownership.

2.9 We will continue to help young people prepare for adult life through our Preparing for Adult Life (PfAL) service, focusing on the needs of young people 10 to 14. This service facilitates stronger relationships with families and ensures a smooth transition into adulthood.

2.10 We will continue to safeguard adults against harm. We received 9,480 safeguarding enquiries in the period April 2021 to October 2021. We will continue strengthening our safeguarding work by ensuring our professionals have the right training, and multi-agency working is at the heart of the programme.

2.11 Assistive Technology (AT) - in the year from November 2020 to October 2021, the AT Team did around 2700 assessments for Assistive Technology to support people to live independently at home and to support carers to continue caring. AT has already reached over 7,000 homes and we continue to review our AT offer to ensure the benefits to prevent, reduce and delay the need for formal care, is fully integrated into practice across Adult Social Services.

2.12 We will continue to support our carers when they are needed now more than ever. There are 99,419 unpaid and 336 paid carers in Norfolk supporting family and friends. We are committed to continuing to support our vital carers.

2.13 We have together already achieved much in our journey towards Promoting Independence and supporting our residents through one of the most difficult periods. We will continue to support people in Norfolk to be independent, resilient, and well through our Promoting Independence Strategy. This work will continue as a core part of the way we work. The additional support of the Winter Plan will look to manage unprecedent pressures that we expect to experience this winter.

2.14 Working in partnership with the Health system: It is important that there is clear system join up and partnership working with Health. The following is a summary of the action that is being taken and the join up that is happening across Health and Social Care.

2.15 The Norfolk and Waveney system has undertaken an evidence based and inclusive approach to winter planning across health and care pathways. The process is dynamic and will evolve as additional information becomes available. The following established Key Lines of Enquiry (KLOEs) have been used to provide a framework to collate information and provide assurance that the winter planning is structured and robust: Demand, Capacity, Exit Flow, Workforce, External and Communications.

2.16 Winter plans are compiled by the System Resilience team within the CCG's Urgent and Emergency Care Strategic Commissioning Team, on behalf of the system, in the form of live shared system document Norfolk and Waveney Winter Assurance Pack, overseen by the Norfolk and Waveney Urgent and Emergency Care Strategic Transformation Steering Group (UEC STSG). Winter resilience activities underpin a broader programme of transformation work which is delivering the National and Regional UEC agenda to improve access to services and outcomes for patients.

2.17 Provider level information forms the first 'Line of Defence' in the NHS National Winter Planning process. Individual winter plans have been gathered from key health and care organisations and demand profiles cross referenced to build a comprehensive understanding of pressures and plans throughout the UEC pathways. The NHS must balance competing demand between the elective and UEC pathways providing services for the significant backlog of cases that built during the Covid pandemic.

2.18 The Winter Planning process coordinates forecast demand for the winter period with assurance that individual organisational plans are in place. The plans have enabled identification of gaps in provision which, along with national and regional health and care priorities, have been used as the underpinning rationale for allocation of additional winter funding.

2.19 Key areas of concern for the N&W system centre around hospital exit flow and workforce. This presents as a high number of inpatients that do not meet the 'Criteria to Reside' and longer lengths of stay. Exit flow issues result from provider care market workforce shortages which have reduced both residential and home care availability. This has created a back log with upstream impact on hospital flow and ambulance handover delays.

2.20 System level Winter Planning information provides the 'Second Line of Defence'. A high degree of collaboration at system level is in place supporting centralised initiatives for example, coordinated Norfolk and Waveney 'Winter Campaign' communications strategy, Workforce Mutual Aid agreement and collaborative bank, health and care staff vaccination programme. Additional winter schemes are being developed across the Norfolk and Waveney system to increase virtual ward and bed-based capacity, improve hospital discharge pathways and reduce ambulance handover delays at hospital.

3. Winter Plan Proposal

3.1 Norfolk Adult Social Services plays a critical role in ensuring the health and social care systems run as effectively as possible. The pressure placed on the system has increased to an unprecedented level during winter 2020/21 and winter 2021/22.

3.2 This report asks Cabinet members to agree the Norfolk Adult Social Services Winter Plan which sets out, in a single view, the department's arrangements for the winter period. The Plan prepares the organisation to maintain Adult Social Care services during winter whilst at the same time, supporting system partners in maintaining good patient flow and safety.

3.3 The Winter Plan will prepare the department to maintain safe service provision during this period. The plan has been developed with commissioning colleagues and focuses on the 'must do' key areas of work that will prepare us for winter. To support the health and social care system to meet the challenges, this winter we are:

a) Maintaining and expanding capacity to support people at home or, where appropriate, in short term residential settings,
b) Prioritisation of people's care needs on the Interim Care List,
c) Providing wrap-around support for care settings,
d) Improving pathways that are there to meet people's care and support needs,
e) Deploying Assistive Technology,
f) Social Care recruitment campaign,
g) Improving capacity in NFS,
h) Supporting our Front Door service, SCCE and
i) Supporting our Mental Health Services.

3.4 The Winter Plan is made up of five key workstreams with a focus on increasing capacity through winter 2021/22. These are detailed below along with specific examples of the work contained in each workstream. The detailed Winter Plan can be made available by contacting the officer named on this paper.

3.5 **Workstream 1: Meeting People's Needs.** To ensure we meet people's needs through winter as part of our plan we will maintain and expand capacity to support people at home or, where appropriate, in short term residential settings. We will also explore the use of Direct Payments and Personal Assistants to meet people's identified care and support needs. Work is underway to prioritise the care and support needs on the Interim Care List through the setting up of a Multi-Disciplinary Team to oversee the plan, prioritise care and proactively manage packages of care that have been handed back to the Local Authority.

3.5.1 As part of this workstream we will look to extend current block contracts with the Home Support market to provide capacity that will support people who need to be discharged from hospital, back home.

3.5.2 We have also re-opened the Home Support Framework, with more providers being approved for NCC to commission care with. We are also working with the Voluntary Sector to understand how provision could be better connected with people who have identified support needs.

3.6 **Workstream 2: Supporting the Provider Market.** We will ensure we provide the provider market with strong support during winter. We will do this by providing wrap around support and leadership for care providers, focusing on quality and risk management. We will proactively support care providers and have reinstated regular calls with Home Support providers, to understand any issues and support they might need.

3.7 We are expanding the Short-Term Beds team to provide rapid assessment of people entering a Short-Term Bed, to support people to return home, when they are ready and able to. We are focusing on quality and risk management by developing an escalation approach for Quality risk threshold that will enable risk management of cases where there is no care.

3.8 We will deploy Assistive Technology where appropriate. We are currently sending out 100 video care phones to homes.

3.9 We have installed a system called iStumble to support people in their homes with falls. The first round of training on iStumble for NFS workers has now been completed, with all North

based workers trained in the devices and the referral process and they have had the app for actioning video calls downloaded onto their work phones.

3.10 **Workstream 3: Supporting a resilient and functioning system.** We will ensure our decision making and processes enable responsive social care during winter and we will support to support our workforce.

3.11 We will ensure there is a strong link between the Adult Social Services brokerage function and the Discharge Hubs in each of the three hospitals. This will ensure we have a robust and timely response when referrals for care packages or placements are received.

3.12 We are committed to supporting our existing workforce and building a future workforce for Norfolk. We will look to do this by extending the NHS staff bank to enable deployment across social care and exploring the benefits of a peripatetic team.

3.13 A major risk we face during this winter is a staff shortage. With critical funding from government, we are working on an ambitious recruitment campaign. The Workforce Capacity Grant will also help us work to support providers to recruit and retain staff. We will launch a Well-Being service for new and existing staff, and we will work with local colleges and places of Higher Education to establish a Norfolk Care Academy.

3.14 **Workstream 4: Supporting Norfolk First Response (NFS) Business Continuity.** We will review all areas of activity to aid flow and improve capacity in NFS. We will review the reablement care and support being given to people to ensure that resources will be deployed in the most efficient way to support people. A number of initiatives are also focused on reducing the number of Domiciliary Care packages the service holds, to increase capacity for reablement support.

3.15 **Workstream 5: Supporting Mental Health Services.** Mental Health services are under considerable strain. We will look at implementing three new Mental Health Step Down Services. We will also look to establish five additional Mental Health residential care discharge beds. We will continue to address blockages as a priority. We will also extend the District Direct housing post into the Mental Health Discharge Team. We will provide Social Work roles to support timely hospital discharge in Mental Health.

4. Impact of the Proposal

4.1 The 2021/22 Winter Plan will help us ensure that high quality, safe and timely care is provided to everyone who needs it.

4.2 Across operational and commissioning teams, planning for winter is being built into the heart of ongoing service planning and we have been strengthening our collaborative working between local partners and providers. We want to continue to build on this collaboration, so we are best prepared to face this winter's challenge.

4.3 This document details Norfolk County Council's Adult Social Services Winter Action Plan. The purpose of the plan will be to prepare the department to maintain high quality and safe service provision during winter and supporting system partners. This document details the key themes and actions guiding our work.

5. Performance Management and Risk Assessment

5.1 The Plan will be measured using a robust performance management framework with regular reporting to the Departmental Leadership Team. We have also developed a SCOPEL (Social Care Operational Pressures Escalation Level) reporting system for adult social care. This is based on a similar model to the NHS OPEL system. SCOPEL provides a single daily view of the pressures on our social care teams and the care market using a simple 1 to 4

scoring system. It will be used to assess and report on the pressures at any given time during the winter and will inform senior management decisions if the pressures escalate up through the levels. While the plan is a robust and considered approach to managing existing pressures and looking to ensure we provide the right level of services through winter, the success of this Winter Plan and our ability to deliver may be met with a number of risks.

5.1.1 Risk 1 - Recruitment, retention, and wellbeing:
Sustaining staffing levels over winter in the whole care sector is vital, together with staff wellbeing which minimises short-term sickness absence. Arrangements are in place for all Norfolk County Council front-line social care staff to have a free flu vaccination. Nationally, there is provision for all care home staff and home care staff to access Covid and flu vaccinations. A recruitment campaign is underway to attract new staff.

5.1.2 Risk 2 - Market capacity:
The majority of delays attributed to Adult Social Services have been people waiting for a support package. Homecare continues to be difficult to access across Norfolk, a situation which is reflected nationally.

5.1.3 Risk 3 - Holding lists:
The department has made good strides in reducing the holding lists over the last year; however, urgent demand from acute hospitals to support people back home can increase workloads for community teams and allow less urgent requests to build up.

5.1.4 Risk 4 - Maintaining our strategy:
At peak periods, the very high numbers of people seeking urgent medical care puts strain on the capacity we have to prevent and reduce the need for formal care. We know from previous years that increased numbers of people are admitted to residential and nursing care during winter months, and whilst for many this will be the right outcome, there could be those for whom alternatives might have been possible.

5.1.5 Risk 5 – Financial:
At times of pressure, there is a risk that, through winter, more intensive packages of support are needed for people due to an increase in complexity. There is a risk that we build in greater dependency for care which may impact on our ability to make savings.

5.1.6 Risk 6 – Reputation:
It is important for the confidence of people who use our services, that the contribution of Adult Social Care is not overlooked, and we are provided with the support and resources to maintain and deliver a high-quality level of care and support to people living within Norfolk.

6. Alternative Options

6.1 None identified

7. Financial Overview

7.1 The Adult Social Care budget at NCC still remains under pressure and is likely to require the usage of Business Risk Reserves in order to maintain a balanced outturn for 2021/22.

7.2 It is important however to recognise the critical interventions required by us during Winter in order maintain Adult Social Care over what is likely to be a period of enormous pressure. Given the financial position, investment has been targeted at those areas likely to have the biggest impact and/or fully harness external funding. The above actions to be undertaken during Winter, where they attract additional costs, are to be funded from a combination of Adult Social Care held Covid-19 reserves, Health and Social Care Hospital Discharge

Funding or the newly announced Adult Social Care Workforce Recruitment and Retention fund.

Officer Contact

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

Name	Email
Claire Sullivan	Claire.sullivan2@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.