Norfolk Health & Wellbeing Board

Date: **Wednesday 29 April 2015**

Time: **9:30am to 1pm (Please note start time)**

Venue: **Edwards Room, County Hall**

Membership	Substitute	Representing
William Armstrong	Alex Stewart	Chair, Healthwatch Norfolk
Cllr Brenda Arthur	Phil Shreeve	Norwich City Council
Cllr Yvonne Bendle	Cllr Lisa Neal	South Norfolk Council
Stephen Bett	Jenny McKibben	Norfolk's Police and Crime Commissioner
Harold Bodmer	Catherine Underwood	Director Community Services
Dr Jon Bryson	Ann Donkin	South Norfolk Clinical Commissioning Group
Pip Coker	Dan Mobbs	Voluntary Sector Representative
T/ACC Nick Dean	C/Sup Jo Shiner	Norfolk Constabulary
Ruth Derrett		NHS England, East Sub Region Team
Dr Anoop Dhesi	Mark Taylor	North Norfolk Clinical Commissioning Group
Richard Draper	Dan Mobbs	Voluntary Sector Representative
Andy Evans	Kate Gill	Great Yarmouth & Waveney Clinical Commissioning Group
Cllr John Lee	Cllr Annie Clausen-Reynolds	North Norfolk District Council
Joyce Hopwood	Dan Mobbs	Voluntary Sector Representative
Cllr James Joyce		Chairman, Children's Services Committee, Norfolk County Council
Cllr Penny Linden	Cllr Marlene Fairhead	Great Yarmouth Borough Council
Sheila Lock		Director Children's Services
Dr Ian Mack	Sue Crossman	West Norfolk Clinical Commissioning Group
Lucy Macleod		Interim Director of Public Health
Cllr Elizabeth Nockolds		King's Lynn and West Norfolk Borough Council
Dr Chris Price	Jonathon Fagge	Norwich Clinical Commissioning Group
Cllr Andrew Proctor	Cllr Roger Foulger	Broadland District Council
Cllr Daniel Roper		Norfolk County Council
Dr Wendy Thomson		Managing Director, Norfolk County Council
Cllr Lynda Turner	Cllr Trevor Carter	Breckland District Council
Cllr Sue Whitaker	Cllr Elizabeth Morgan	Chair, Adult Social Care Committee, Norfolk County Council

Persons attending the meeting are requested to turn off mobile phones.

For further details and general enquiries about this Agenda please contact the Committee Administrator:
Nicola LeDain on 01603 223053
or email committees@norfolk.gov.uk

Business items

1	**Apologies**	Chair	
2	**Minutes**	Chair	(Page **3**)
3	**Members to Declare any Interests**	Chair	
4	**Any urgent business**	Clerk	
5	**Clinical Commissioning Groups' plans 2015/16**	CCGs x 5	(Page **33**)
6	**Norfolk Better Care Fund – Delivering the Plan**	Harold Bodmer/ CCGs x 5	(Page **36**)
	Short break – at the Chairman's discretion		
7	**Annual Report of the Independent Chair of Norfolk Safeguarding Children Board 2013-14**	David Ashcroft, Chair NSCB	(Page **68**)
8	**Children's Services Improvement & Performance** a) Improvement & Performance report b) LAC Health report	Sheila Lock/ Helen Wetherall/ Don Evans	(Page **128**)
9	**Voluntary Sector Engagement Project Final report**	Linda Rogers Head of Operations Voluntary Norfolk	(Page **180**)
10	**Healthy Communities – Evaluation report**	Lucy Macleod	(Page **189**)
11	**CCG's draft Annual Reports**	CCGs x 5	(Page **199**)
12	**NHS England's 5 year Forward View**	NHS England East Sub-Region Team	(Page **210**)
	Minutes of meetings		
13	**Healthwatch Norfolk minutes of the meeting held on 19 January 2015**	William Armstrong	(Page **216**)
14	**Norfolk Health & Overview Scrutiny Committee minutes of the meeting held on 15 January 2015**	Chair	(Page **220**)

Norfolk County Council
at your service

Health and Wellbeing Board
Minutes of the meeting held on Wednesday 4 February 2015 at 9.30am
in Edwards Room, County Hall, Norwich

Present:
Mr D Roper, Norfolk County Council – Chairman

Cllr Brenda Arthur	Norwich City Council
Harold Bodmer	Director of Community Services, NCC
Dr Jon Bryson	South Norfolk Clinical Commissioning Group
Tracey Cogan	NHS England, East Anglia Area Team
Pip Coker	Voluntary Sector Representative
T/ACC Nick Dean	Norfolk Constabulary
Richard Draper	Voluntary Sector Representative
Jenny McKibben	Norfolk's Deputy Police and Crime Commissioner
Joyce Hopwood	Voluntary Sector Representative
Dr Ian Mack	West Norfolk Clinical Commissioning Group
Lucy Macleod	Interim Director of Public Health
Dr Chris Price	Norwich Clinical Commissioning Group
John Stammers	Great Yarmouth & Waveney Clinical Commissioning Group
Alex Stewart	Healthwatch Norfolk
Mark Taylor	North Norfolk Clinical Commissioning Group
Dr Wendy Thomson	Managing Director, Norfolk County Council
Cllr Lynda Turner	Breckland District Council
Cllr Sue Whitaker	Chair, Adult Social Care Committee, NCC

1 Apologies

1.1 Apologies were received from Cllr James Joyce, Cllr Andrew proctor (substituted by Cllr Roger Foulger), Cllr Penny Linden, Cllr Yvonne Bendle, and Cllr Elizabeth Nockolds.

2 To agree the minutes

2.1 The minutes of the Health and Wellbeing Board (HWB) held on the 22nd October 2014 were agreed as a correct record and signed by the Chair.

3 Declarations of Interests.

3.1 Those members of the Clinical Commissioning groups who practiced dispensing (John Stammers and Anoop Dhesi) declared an 'other' interest in respect of Item 7.

4 To receive any items of urgent business

4.1 There were no items of urgent business.

5 Norfolk Joint Health and Wellbeing Strategy 2014-17 Implementation – workshop

5.1 The Norfolk Health and Wellbeing Board Strategic Plan was approved by the Board in May 2014 and a sub group of the Board had been tasked with steering the work forward. The report aimed to give Members an update on the progress and issues arising to date. The Board split into three groups, each identified by the Health and Wellbeing Boards'

priorities.

5.2 This item was taken as a workshop, and the notes from this workshop is attached at appendix A.

5.3 The Board **RESOLVED** to;

- Note the progress and work underway by partners and to feed this back to their respective officers in the organisations they represent to encourage participation.
- Comment on the immediate forward plans for each theme
- Consider how the larger challenges within the Strategy could be addressed.

6. Launch of the Norfolk Better Care Fund

6.1 The Norfolk Better Care Fund Plan was approved with conditions in October 2014. It was resubmitted with the additional requirement in December and the Board heard that the Plan was now approved. The presentation that the Board received is attached at appendix B.

6.2 Congratulations were given to all those concerned for their fortitude in seeing through the implementation of the Better Care Fund, as there had been hurdles to overcome throughout the process.

6.3 It will provide an opportunity to work together with communities in reducing admissions to hospital and the creation of a joint post of Director of Integrated Care (Norfolk County Council and Norfolk Community Health and Care NHS Trust) and would provide a good platform to work from.

6.4 The Board **RESOLVED** to;

- Note the resubmission of Norfolk's Better Care Fund plan to the national assurance programme and its subsequent approval.

7. Norfolk Pharmaceutical Needs Assessment (PNA) 2015

7.1 Health and Wellbeing Boards (HWBs) must publish a pharmaceutical needs assessment (PNA) by 1 April 2015. The PNA will be used by NHS England when making decisions

7.2 It was suggested by members of the Board that consideration be given to how the work around safeguarding might relate to this given the central role that pharmacies might have and it was confirmed that safeguarding requirements were included when services were commissioned from pharmacies. It was also suggested that the preventative agenda could be developed further with pharmacies as a community resource.

7.3 The issue of a quality assurance process was raised and it was confirmed that the new PNA was would be refreshed every three years.

7.4 It was noted that there was no mention of dementia and as it was a priority of the Board it should be included. It was confirmed that this was picked up through the Healthy Living Pharmacies work.

7.5 The Board **RESOLVED** to;

- Agree that the Director of Public Health will act as accountable officer with responsibility for ensuring that the HWB's duties in accordance with the Regulations (2013) are met.

- Note the requirements of the Regulations (2013) to publish a PNA by 1 April 2015 that will be used by NHS England in determine applications for the provision of pharmaceutical services and maintain the PNA so that it is kept up-to-date.
- Approve and publish the Pharmaceutical Needs Assessment 2015-2018 to ensure that the legal requirement to publish an up-to-date PNA by 1 April 2015 is met.

8. Children's Services Improvement and Performance Update

8.1 The report provided an update on Children's Services improvement and performance. The Board were presented with an update which provided details of the Social Care Performance Overview Dashboard as at December 2014.

8.2 It was reported that the Assistant Director team in Children's Services had been appointed to which was important in enabling a sustainable Children's Services for the future and meant that other posts could now be filled.

8.3 The Board noted that, in terms of general health indicators, the health of Norfolk's Looked After Children was generally good but that problems occurred when children were placed out of County. There were approximately 20% out of county. Children's Services was looking closely on a locality basis to better understand the issues and it was agreed that a report would be brought to the next H&WB meeting on the health of Looked after Children.

8.4 The Board **RESOLVED** to;

- Note the report

9. The Report into Rotherham – Implications for Norfolk (presentation)

9.1 The Board received a presentation (attached at appendix C) from T/ACC Nick Dean and Sheila Lock, Interim Executive Director Children's Services which outlined the strategic approach in Norfolk to tackling child sexual exploitation and some of the lessons learnt of the investigation into Rotherham.

9.2 It was reported that there had been an unprecedented rise in the numbers of people coming forward about child abuse across the country over the last 18 months and that agencies nationally and locally were working together to overcome the issues that had arisen. It was estimated that 5% of children would be affected by CSE (Child Sexual Exploitation) in their lifetime.

9.3 The Board sought assurance that agencies in Norfolk were clear about where they should be looking and how best to target efforts to identify areas of concern. It was considered important for all agencies across the Board to make sure they know about the approach in Norfolk, to support it and to be fully committed to it.

9.4 The Board **RESOLVED** to;

- Note the presentation

10. Forward Plan, Review and Development

10.1 The report set out the draft forward plan and enabled the Board to review and comment on its programme of work for the coming year. The report also outlined initial proposals for the Board to conduct a review of its current working arrangements, including

reflecting and testing itself on whether it is focused on the right things, working effectively, and adding value, and through this identifying areas for development.

10.2 In terms of the Forward Plan, it was suggested that it was important for the Board to be able to give more focus to mental health. It was also suggested that rather than updates the Board needed to be clear about how it was making a difference, for example, through an impact outcomes framework.

10.3 In terms of the H&WB review, disappointment was expressed that the formal external review was not until 2016 and that the proposed timetable was not challenging enough. It was, however, recognised that Health and Wellbeing Boards could potentially have a change of governance and role after the general election.

10.4 There was a preference for the Board to carry out its own 'active' internal review, sharing ideas and reviewing best practice, and Board members could get on with implementing the outcomes. There would inevitably be some unanswered questions arising from this work which could then be used for a peer review. It was suggested that external challenge could be engaged along the way to strengthen this first stage of the review.

10.5 It was agreed that the review timetable be revised so the Board could achieve as much as possible, as soon as possible.

10.6 The Board **RESOLVED** to;

- Note the report
- Agree the forward plan for the year ahead
- Decide how best to progress a review of the Health and Wellbeing Board

11. NHS England – verbal update

11.1 The Board received a short update from the representative of NHS England, which explained that there had been a restructure at area team level. It was hoped that by 1st April, all the positions in the new structure would be filled. There would be a more detailed update at the next meeting.

11.2 CCG assurance meetings had been arranged which would follow similar to previous years. NHS England were also working alongside CCG colleagues to provide operational and resilience plans.

11.3 Work had been carried out with the CCG to alleviate the situation arising from the Watton Surgery. Lessons had been learnt and new models of care practice implemented.

12. Healthwatch Norfolk minutes of the meetings held on 22 September and 17 November 2014

12.1 The Board received and **NOTED** the minutes of the meetings of Healthwatch Norfolk which took place on 22nd September 2014 and 17th November 2014.

13. Norfolk Health and Overview Scrutiny Committee minutes of meetings held 16 October and 27 November 2014

13.1 The Board received and **NOTED** the minutes of the meetings of the Norfolk Health and Overview Scrutiny Committee meetings which took place on 27 November 2014 and 15 January 2015.

The next meeting would take place on **Wednesday 29 April 2015** at 9.30am. The venue would be confirmed.

The meeting closed at 1.30pm

Chairman

Joint Health and Wellbeing Board meeting 4th February 2015 – Workshop

Dementia Priority – Making Norfolk a better place for people with dementia and their carers

Present: Joyce Hopwood (Dementia Champion), Brenda Arthur (Norwich City Council), Sue Whitaker (Adult Social Care Committee), Harold Bodmer (Adult Social Services), Anoop Dhesi (North Norfolk CCG), Ian Mack (West Norfolk CCG), William Armstrong (Healthwatch Norfolk), David Wright (James Paget Hospital), Nicola Gregory (Public Health, Dementia Priority Coordinator)

Major changes and challenges for the Board

- The Board is too big to be effective as a decision making body. Other HWB's across the country are smaller. The Board is instead a place to 'unblock' problems.
- A locality board exists in Norwich, a small strategic group which has achieved a lot. A representative from here could sit on the Board.
- Effective sub groups could link into the Board.
- Looking at other HWB's across the country could be helpful, with a view to a peer review taking place.
- One problem is that HWBs were designed with unitary councils in mind.
- A concern is that the Board becomes irrelevant to CCGs.

Challenges and progress around the Dementia Priority

- Norwich City Council are keen to make Norwich more dementia friendly (e.g. dementia adaptation grants, HandyVan Service) and work with local businesses and services regarding advice and support around this area, but beyond dementia friendly training it's a challenge how to proceed.
- There have been improvements regarding dementia awareness but there needs to be earlier involvement from the public sector around dementia friendly communities work.
- More private sector involvement in dementia work is needed. Local businesses are however involved in the Safer Places Scheme.
- There is the argument that there is a reluctance to diagnose dementia as services are not available to people following diagnosis, but a diagnosis can also enable an individual to access services and empower them to make certain decisions, such as POA.
- West Norfolk CCG have developed a SPECAL approach towards dementia.
- The voluntary sector plays a large part in providing resources but this is dwindling. The West Norfolk Alliance brings together the public sector and aims to focus on this gap in resources.
- The quality of home care and standard of dementia training needs to be focussed on.
- Norfolk could pay more attention to best practice outside of the county. Healthwatch could undertake a piece of work around this. ***Action - Bill Armstrong to liaise with Sue Whitaker.*** There are also examples abroad, for instance Scandinavia, of forward thinking pieces or work around older people maintaining their independence.

- Work around healthier lifestyles and prevention runs alongside dementia (as well as the other two priority areas). The Public Health department could be utilised more.

Practical steps to be taken

- It would be helpful if a few key areas were identified that each locality could focus on. Suggested areas were:

  - Healthy lifestyle messages linked to prevention, this links in with the focus of the Care Act.
  - 'Switching on' local support networks around diagnosis.
  - Local information available to all at the right time is crucial, social housing tenants were highlighted as an important group.
  - De-medicalisation of dementia.
  - The dementia pathway in each area needs to be clearly identified.
  - Look at doing something more creative with Continuing Care funding, there is a good case for pooled budgets.
  - Greater involvement from private businesses. ***Action - Brenda Arthur will take this proposal to the next Business Improvement meeting.***

Notes from Joint Health & Wellbeing Board workshop 04.02.15

Preventing / Reducing Obesity Priority

Table: Dan Roper (NCC), Lucy MacLeod (Public Health), Pip Coker (Voluntary Sector), Tracey Cogan (NHS England), Martyn Swann (South Norfolk Council), John Stammers (Gt Yarmouth CCG), Caroline Money (NCC) and Lara Williamson (PH). Alex Stewart (Healthwatch).

Discussion topics in bold

Mental Health & Obesity, the challenges of:

1. medication & weight gain
2. unwillingness to take up healthy activities (barriers if activities not tailored)
3. sector perception of localities seeming unwilling to commission enough tailored/targeted activities

Examples of good practice: Voluntary sector provision of mountain walking programme for clients with mental health issues – this was a positive intervention. Green Care projects have been effective.

Suggested actions

Ensuring range of tailored physical activities programmes available.

HWB to recommend to Housing providers to include 'health-added value' into all commissioning.

Confidence building - to overcome barriers around engaging in activity on offer & increase community resilience

Examples of good practice: South Norfolk Council Early Help scheme. Ensuring use of Making Every Contact Count at all points of contact.

Suggested actions

Increase/support/promote Community or Family Connectors/ Buddy schemes; MECC training: target areas of need identified in JSNA data.

Collaborations needed to strengthen positive effects of actions

Examples of good practice: South Norfolk Council working with CABs on pathways. Public Health linking Physical Activity with other strands of Healthy Weight programmes

Suggested actions

HWB to strengthen working collaboratively in any area to respond to local needs – greater integration of services, as committed to in cross cutting theme.

Businesses could be appealed to for support with activities, for example to provide equipment or sponsorship for activities

Suggested action: HWB and partners to link into business networks

Primary Prevention: Need attention on this – ie tackling causes of preconditions (upstream) such as obesogenic environment, need to 'manage upwards'

Concern at availability of foodstuffs (high in Sugar, Salt & Saturated Fats) & fast food outlets near schools/ within hospitals/ advertising permits.

Suggested action

HWB to lobby for change - reflecting groundswell of concern on need for regulation of food. Working with services/ food industries/ businesses to improve health options in food procurement; Economic Development Unit to work with producers; use of planning laws.

Workforce health & wellbeing

Examples of good practice: Fit4Work projects. Employers leading by example – incentive: healthier workforce

Suggested action: HWB Strategy promoted to employers to incorporate in their planning for workforce

Offender Health

Examples of good practice: Health initiatives such as Garden Organic schemes in prisons

Discussion of need for the companies running probation services to take Holistic approach

Other points raised:

HWB work with LEP on how they can contribute to the inequalities agenda

Podiatry & Biomechanics – how orthotics can help overcome certain barriers to engaging in physical activities, and the need for this information to be promoted.

Summary

Copies of an extract from the HWB Strategy citing the ten reducing obesity intentions, and the executive summary of the Tackling Obesity HNA for Norfolk, were circulated to all at the table to add clarity to current practical actions planned. There was useful discussion on the challenges and progress around the reducing obesity priority with contributions including suggestions for practical actions that do fit within and add insight to strands of the identified recommendations and intentions.

Health and Wellbeing Board

Workshop

Preschool Priority

4th February 2015

Definitions for Social and Emotional Wellbeing presented to the group.

“A positive state of mind and body, feeling safe and able to cope, with a sense of connection with family, communities and the wider environment”

(Better Mental Health Outcomes for Children and Young People)

Or

- Emotional wellbeing – this includes being happy and confident (~~and not anxious or depressed~~)
- Psychological wellbeing – this includes the ability to be autonomous, problem solve, manage emotions, experience empathy, be resilient and attentive
- Social wellbeing – has good relationships with others (~~and does not have behavioural problems, that is, they are not disruptive, violent or a bully~~)

(NICE 2014)

Comments:

- Language is important – the definition has to be easily understood by all.
- The simpler the better
- It should be accepted in a broader sense, not just from the health perspective i.e. effects of poor housing, poverty, attainment
- The second definition is too health and outcomes focussed
- Achievement, values and self-esteem were also felt to be important
- That this should be seen more as an ‘ambition’ than a ‘definition’
- Preference very much for the first one

The final version of the ambition for the social and emotional wellbeing of 0-5s

“A positive state of mind and body, feeling safe, resilient and able to cope, with a sense of connection with family, communities and the wider environment”.

This lead to a brief discussion on readiness for school.

Comments:

- It was recognised that there has been some debate regarding this issue. Nurture and play both important.

- At the moment this is measured by the Early Years Foundation Stage Profile and Personal, social and emotional is part of this.
- There has been recommendations around formalising a definition for Norfolk.

The preschool priority intentions handed out.

Comments:

- It is important to emphasise the cross cutting goals of tackling inequalities, prevention and integration.
- Better referral pathways are required to improve integration
- It was felt that intention 3 (below) is driven by health and should have a broader approach.

Develop arrangements for integrated commissioning of universal and targeted services for children aged under 5. This includes services offered by general practice, maternity, health visiting, school nursing and all early years providers. The aim is to ensure:

- vulnerable children at risk of developing (or who are already showing signs of) social and emotional and behavioural problems are identified as early as possible by universal children and family services
- targeted, evidence-based and structured interventions are available to help vulnerable children and their families – these should be monitored against outcomes
- children and families with multiple needs have access to specialist services, including child safeguarding and mental health services.

- There followed a discussion around the reshaping of the Children's Strategic Partnership. This could influence other agencies. Currently no one involved in the Children's Partnership is looking at children's health.
- Communities should be encouraged and enabled and develop a strategic approach.
- There should be a focus on the needs of service users
- Parent education seen as key
- Are universal services delivering what is expected by commissioners, providers and service users? What does this look like?
- Attachment training is seen as evidence based and provides outcomes that have a long term impact on outcomes for young people.
- Concern was raised regarding tackling inequalities, is enough targeted work being done?
- Useful to go back to the JSNA to ensure focus is correct.
- What are the actions and what is the impact? This must translate into something meaningful. Are there broader outcomes, not just health?
- It was felt strongly that co-commissioning would be the obvious way to move forward.
- It was felt that implementation of the Health and Wellbeing Board Strategy could be a perfect opportunity to start working in different ways.
- This must be about action and not just discussion and reporting.

- This is about the Health & Wellbeing Board holding members and providers to account.
- There is a need to ensure that what service users are experiencing is informing commissioners and providers.
- There is a need to address disparity of provision both geographically and with regard access to specialist services.

Actions

- Action plans to be drawn up for the Strategy intentions.
- Develop a questionnaire for focus groups/parents forums to engage with providers and service users.
- Involvement of Health and Wellbeing Board early years coordinator and the Board Champion in the Children's Strategic Partnership.
- Revisit JSNA to ensure correct focus.
- Include information regarding reducing inequalities into action plans.
- Research attachment training for a consistent Norfolk wide approach and other appropriate multiagency workforce development.

Norfolk's Better Care Fund: the vision

Norfolk Health and Wellbeing Board

February 2015

Norfolk County Council/Norfolk's CCGs

BCF Requirements

- A pooled budget between NCC and the CCGs under Health and Wellbeing Board
- Minimum £65 million pooled for Norfolk
- Performance measures:

  Avoidable hospital admissions

  – Residential admissions

  – Delayed transfers of care

  – Effective reablement

  Local priority:

  – Dementia assessments
- Requires national assurance

Norfolk's Better Care Fund vision: an enabler to integrated care

- People will be able to access effective and co-ordinated care which is delivered at home or in their local community
- Services will be shaped around the individual
- People will be supported to manage their own care and wellbeing
- Primary care we be the heart of care co-ordination
- Planning should start at a local level

Key projects across Norfolk:

- Integrated and co-ordinated teams around GP practices
- Risk stratification to identify individuals at risk
- Self-care and self-management
- Re-ablement and rehabilitation
- Assistive technology and falls prevention
- Dementia services and mental health
- Services at end of life
- Carers support

What difference will this make?

- Services which feel integrated to use
- Avoiding unnecessary escalation of need and crisis admissions
- More preventative and targeted approaches; less duplication
- Better use of the Norfolk health and care £
- Addressing the HWBB priority for integration
- The beginning of a much wider programme?

Where are we now?

- The Norfolk Better Care Fund plan has now been formally approved
- The pooled fund starts from April 2015
- Local governance and delivery plans are in place
- Delivery underway on priority areas
- HWBB oversight will continue.

Child Sexual Exploitation

‘It isn’t hidden – you just haven’t looked for it.’

Definition of Child Sexual Exploitation:

*'Sexual exploitation of children and young people under 18 involves **exploitative situations**, contexts and relationships where young people (or a third person or persons) receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and/or another or others performing on them, sexual activities.*

Child sexual exploitation can occur through the use of technology without the child's immediate recognition; for example being persuaded to post sexual images on the Internet/mobile phones without immediate payment or gain.

In all cases, ***those exploiting the child/young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources. Violence, coercion and intimidation are common, involvement in exploitative relationships being characterised in the main by the child or young person's limited availability of choice*** *resulting from their social/economic and/or emotional vulnerability.'*

Key Vulnerabilities?

- Chaotic or dysfunctional household
- History of abuse
- Recent bereavement or loss
- Attending school with young people who are sexually exploited
- Learning disabilities
- Queries over their own sexual orientation
- Friends with young people who are sexually exploited
- Homelessness
- Lacking friends from the same age group
- Living in residential care / hostel accommodation
- Low self-esteem or self-confidence
- Young carer
- Gang association or neighbourhood

Signs for Concern?

Missing from home or care
Physical injuries
Drug or alcohol misuse
Involvement in offending
Repeated **sexually-transmitted infections, pregnancy and terminations**
Absence from school
Evidence of sexual bullying
Vulnerability through the internet / social networking sites
Estranged from their family
Receipt of gifts from unknown sources
Recruiting others into exploitative situations
Poor mental health
Self-harm
Thoughts of or attempts at suicide

Norfolk's Approach

- Key priority for NSCB
  - Dedicated sub group
  - Multi agency focus and support
- Multi Agency strategy
- Dedicated CSE team within the Multi Agency Safeguarding Hub (MASH)
  - Children's Services
  - Police
  - The Magdalen Group – The ROSE Project
- Referral process
- Intervention options document

Norfolk's Approach

- Training and Awareness Raising
  - Conference held 7th November
  - Chelsea's Choice
  - Media and Communications Work Streams
    - Parents/ carers and professionals
    - Children and young people
    - Victims
  - Involvement of young people

Seven Principles:

- The child's best interests must be the top priority
- Participation of children and young people
- Enduring relationships and support
- **Comprehensive problem-profiling**
- Effective information-sharing within and between agencies
- Supervision, support and training of staff
- **Evaluation and review**

Norfolk's Strategic Response:

- High level Strategy mtgs. with senior partners
  - Involving children and young people in the county response to CSE
  - Providing Leadership and Working in Partnership
  - Training and awareness raising
  - Identification and understanding of risk through problem / geographic profiling
  - Engagement, intervention and supporting victims
  - Disrupting and Prosecuting offenders

The Current Picture?

- Total live CSE Cases – 163 (includes all referrals therefore children at risk and those already being exploited)

- Current High Risk – 17 HIGH

- Total CSE Referrals in last Financial Year (Since April 2014 – to date) – 494

- Total Online CSE in last Financial Year (Since April 2014 – to date) – 103 – (20.9%) – of these 21 both contact and online

Rotherham?

- High level meeting coordinated by CC and DCS
- HMIC – Child Protection
- NSCB oversight –PIQAG Audit
- Barnados' Audit
- Children's Services Internal Audit
- Peer Review- College of Policing

The Next Twelve Months:

- Refresh Multi Agency Strategy
- Revisit ToR for CSE sub group
- Revisit structure of CSE sub group (op vs strategic)
- Communications strategy
- Training and awareness raising
- Geographic profiling
- Re- evaluation

Report to Norfolk Health and Wellbeing Board
29 April 2015
Item 5

Clinical Commissioning Groups: Operational plans 2015-16

What is the role of the HWBB in relation to this paper?

The Health and Social Care Act 2012 sets out a number of legal responsibilities for the Health and Wellbeing Board, including a:

- Duty to provide an opinion as to whether the CCG commissioning plan has taken proper account of the Health and Wellbeing Strategy and what contribution has been made to the achievement of it

Key questions for discussion

Q.1 To what extent are the CCGs' refreshed plans aligned to the overarching goals* and priorities** in the JH&WBS 2014-17?

Q.2 What is their overall contribution towards delivering the Strategy, including addressing health inequalities, including inequalities suffered by those with mental ill health?

Q.3 How do the plans support promoting independence through good community health and social care services?

***Overarching Goals:**

- Integration
- Reducing inequalities
- Prevention

****Priorities:**

- Social and emotional wellbeing of pre-school children
- Reducing obesity
- Making Norfolk a better place for people with dementia and their carers

Actions/Decisions needed

The Board is asked to:

- Note the CCGs plans
- Comment on the engagement/alignment with and contribution towards delivering the Board's priorities
- Agree its role in relation to breaking down barriers, mitigating risk and driving forward the improvements identified locally

Clinical Commissioning Groups: Operational plans 2015-16

Report by Norfolk's Clinical Commissioning Groups

Summary

This item provides an opportunity for the Health & Wellbeing Board to consider key elements of Norfolk's Clinical Commissioning Groups (CCGs) plans for the period 2015 to 2016. Representatives from each of the CCGs will present key elements of their plans at the Board meeting.

Action
The Board is asked to:
- Note the CCGs plans
- Comment on the engagement/alignment with and contribution towards delivering the Board's priorities
- Agree its role in relation to breaking down barriers, mitigating risk and driving forward the improvements identified locally

1. Background

1.1 The Health and Social Care Act 2012 sets out a number of legal responsibilities for the Health and Wellbeing Board, including a duty to:

- Provide an opinion as to whether the CCG commissioning plan has taken proper account of the Health and Wellbeing Strategy and what contribution has been made to the achievement of it

1.2 At its meeting in May 2014, the Health & Wellbeing Board received the 2 year operational plans 2014/15 and 5 year strategic commissioning plans 2014/19 from each of Norfolk's CCGs. Members considered the extent to which they were aligned with the overarching goals and priorities in the Joint Health and Wellbeing Strategy (JH&WBS) and how they were contributing towards the delivery of them.

1.2 During the course of that discussion it was noted that integration was a strong theme common to all and that the CCGs were working hard with County Council and the districts to be able to implement an integrated care system. The Better Care Fund would clearly be important within this and would radically change the way we work. Members also recognised that this would be hugely challenging over the next few years and some very difficult decisions would need to be made, within tight timescales.

1.3 There was discussion of some of the key challenges faced by all CCGs and agreement that the key role of the Health and Wellbeing Board was in bringing partners together. There was a suggestion that the Board could use the JH&WBS's three overarching goals to look at this - ie view it through the lens of prevention, integration and reducing inequalities and try to track them to see how our collaborative working was making a difference.

2. This years' annual planning round

2.1 At this time each year the Board considers the extent to which CCGs' plans are taking proper account of the Joint Health & Wellbeing Strategy (JH&WBS). It is an opportunity to review the extent of engagement and alignment with the JH&WBS and to consider the contribution being made towards achieving it. For the purposes of today's discussion, the CCGs have been invited to present key elements of their plans for 2015 to 2016.

2.3 As part of their presentations to the Board, the CCG's have been asked to draw out the parts of their plans which demonstrate the extent to which the CCG is using the JSNA and embedding the Board's other strategic priorities - in particular, how the CCG is fulfilling its statutory duty to reduce inequalities including plans for monitoring access to services and equitable provision for protected groups.

2.4 Mental health has been identified by the Board as the "golden thread" underpinning all aspects of the Strategy and CCGs have also been asked to highlight those elements of their plans which seek to address the inequalities suffered by those with mental ill health and which address parity of esteem in service commissioning.

2.5 Driving integration of health and social care system, and wider, is a primary concern of the H&WB and this is reflected in the overall aims of the Strategy. With this in mind the CCGs have also been asked to lead a discussion with Board members on integration across Norfolk and to highlight some of the key issues that the Board could help with.

3. Action

3.1 The Board is asked to:

- Note the CCGs plans
- Comment on the engagement/alignment with and contribution towards delivering the Board's priorities
- Agree its role in relation to breaking down barriers, mitigating risk and driving forward the improvements identified locally

Officer Contact

If you have any questions about Norfolk CCG's commissioning plans then please get in touch with:

Name	CCG	Email
Sue Crossman, Chief Officer	West Norfolk CCG	sue.crossman@nhs.net
Ann Donkin, Chief Officer	South Norfolk CCG	ann.donkin@nhs.net
Kate Gill, Director of Operations	Great Yarmouth & Waveney CCG	kate.gill1@nhs.net
Jo Smithson, Chief Finance Officer	Norwich CCG	jo.smithson@nhs.net
Mark Taylor, Chief Officer	North Norfolk CCG	Mark.taylor25@nhs.net

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Report to Norfolk Health and Wellbeing Board

29 April 2015

Item 6

Norfolk Better Care Fund – Delivering the Plan

Cover Sheet

What is the role of the HWBB in relation to this paper?

The Health and Wellbeing Board is the body accountable for the Norfolk Better Care Fund. This paper makes proposals for future monitoring and reporting of integration and the BCF to provide assurance and to support the Board in leading the transformation of health and social care services in Norfolk needed to deliver the BCF Plan. It also provides the Board with information about NHS England's recent detailed 'Guidance for the Operationalisation of the BCF in 2015/16' together with proposals for meeting these specific requirements.

Key questions for discussion

Q.1 Will the proposed arrangements provide the assurance the Board requires and support it Board in realising its vision for the BCF for Norfolk?

Q. 2 Does the Board have any further questions in relation to this latest Guidance and its responsibilities in relation to it?

Action needed

The Board is asked to:

- Note the national Guidance
- Agree arrangements going forward to support the Board in leading the transformation of health and social care services needed to deliver our vision for the BCF plan for Norfolk (proposals outlined in paras. 2.5 and 3.5)

Norfolk Better Care Fund – Delivering the Plan

Report of the Director of Community Services, Norfolk County Council
Chief Officer of NHS Great Yarmouth and Waveney Clinical Commissioning Group
Chief Officer of NHS North Norfolk Clinical Commissioning Group
Chief Officer of NHS Norwich Clinical Commissioning Group
Chief Officer of NHS South Norfolk Clinical Commissioning Group
Chief Officer of NHS West Norfolk Clinical Commissioning Group

Summary
This paper makes proposals for future monitoring and reporting of the BCF to provide assurance and to support the Board in leading the transformation of health and social care services needed to deliver the BCF Plan. It also provides the H&WB with information about NHS England's recent detailed 'Guidance for the Operationalisation of the BCF in 2015/16' together with proposals for meeting these requirements.

Action required:

The Board is asked to:

- Note the national Guidance
- Agree arrangements going forward to support the Board in leading the transformation of health and social care services needed to deliver our vision for the BCF plan for Norfolk (proposals outlined in paras. 2.5 and 3.5)

1. Background

1.1 At its meeting on 4 February 2015, the Health and Wellbeing Board was informed that the Norfolk Better Care Fund Plan met all the requirements set out by the Department of Health and had been approved on 23 January 2015. A copy of the approved plan is available on-line at the following link. The Health and Wellbeing Board is the body accountable for delivering the Norfolk Better Care Fund.

2. Delivering the Better Care Fund Plan

2.1 The BCF plan in Norfolk involves a £65m pooled commissioning fund for the provision of integrated health and community care services. It has a priority purpose of reducing unplanned admissions to hospital and performance measures have been agreed for avoidable hospital admissions, residential admissions, delayed transfers of care, effective reablement and a local priority of dementia assessments.

2.2 Our vision for the BCF is as an enabler to integrated care:

Norfolk's Better Care Fund vision: an enabler to integrated care

- People will be able to access effective and co-ordinated care which is delivered at home or in their local community
- Services will be shaped around the individual
- People will be supported to manage their own care and wellbeing
- Primary care we be the heart of care co-ordination
- Planning should start at a local level

2.3 The purpose of the Better Care Fund is to build better health and social care services. This is in line with the Board's priorities and underpins much of what we are working to deliver through our Joint Health & Wellbeing Strategy. Having overseen the development of the BCF plan, the Board now moves into its strategic role in delivering the plan. This is for the Board working in its role as 'systems leader' ie:

- Providing the overall strategic direction
- Monitoring the impact of integration through the BCF, and
- Securing sustainable improvement on the ground in Norfolk

2.4 Delivering the BCF plan relies on a transformation of health and social care services in Norfolk and re-configuring community services in Norfolk will be an important part of getting it right. The Board will wish to assure itself that the necessary transformation of services is addressing the challenges and delivering the outcomes needed and proposals for this are as follows:

Impact of integration through the BCF – proposal 1

2.5 The H&WB will continue to have a regular item on the agenda about the impact of integration in Norfolk, including the BCF. Starting with the next Board meeting this will focus on:

- Looking at what is being delivered - illustrated, for example, via case studies and/or showcasing initiatives which are examples of good practice
- Identifying any barriers to progress or blockages in the system and agreeing how to tackle them

- Reviewing trends in BCF performance
- Evaluating what overall is being achieved
- Agreeing what further action is needed by partners and/or the Board as a whole to meet our strategic aims for Norfolk

3 Recent national Guidance

3.1 On 20 March 2015, the National Director of Commissioning Operations, NHS England, wrote to the Chairs of all Health & Wellbeing Boards about the publication of detailed guidance on the operation of the Better Care Fund in 2015/16 including reporting and monitoring requirements for the fund and how progress against conditions of the fund will be managed.

3.2 The letter to the Chairman of the Norfolk H&WB is attached as Appendix A, the Guidance as Appendix B and the sample quarterly reporting template as Appendix C.

3.3 A key expectation for the H&WB, as outlined in para 14 of the Guidance, is that

"HWBs are a valuable forum for stakeholders to come together to review performance of the BCF and consider future work. The expectation is that HWBs will continue to oversee the strategic direction of the BCF and the delivery of better integrated care, as part of their statutory duty to encourage integrated working between commissioners."

3.4 The new Guidance outlines an expectation for quarterly reporting to NHS England based on a standard template (Appendix C), which will cover income and expenditure, payment for performance, the supporting metrics and the national conditions. Whereas much of the performance monitoring, assurance, and performance management will be at CCG level, the process for submission of these quarterly reports includes final sign off at the end of the process by the H&WB. There are a series of deadlines for submissions as follows:

- 29 May 2015 – for the period January to March 2015
- 28 August 2015 – for the period April to June 2015
- 27 November 2015 – for the period July to September 2015
- 26 February 2016 – for the period October – December 2015
- 27 May 2016 – for the period January – March 2016

Standing arrangement – proposal 2

3.5 In order to meet these specific requirements for regular, reporting nationally of metrics in the BCF a standing arrangement is proposed as follows:

- Final sign off of quarterly reporting template on the BCF be delegated to a sub-group of the H&WB comprising:
  - Chair of the H&WB
  - Vice Chairs of the H&WB x 2
  - Executive Director of Adult Social Care
  - Director of Public Health

- That the quarterly reporting template is circulated to the H&WB as a whole once signed off by the sub-group

- That where the standing sub-group consider that an issue needs escalating to the whole of the H&WB that an urgent, extra-ordinary meeting be called

4 Existing governance arrangements

4.1 The following outlines the key elements of the governance arrangements which are already in place to support the process.

4.2 **Pooled Funds**

- The pooled funds are secured through a legal agreement under section 75 of the National Health Service Act 2006 (s75 agreement). The County Council has a s75 agreement with each of the five Clinical Commissioning Groups in Norfolk

- Each s75 agreement articulates the local governance arrangements for each for the individual pooled funds and is managed by a **designated Pooled Fund Manager** (the existing integrated post of Head of Commissioning for the locality).

- Each s75 agreement has the H&WB at the head of its governance arrangement

4.3 **Local partnerships boards**

- The overall local performance of the BCF will be managed via partnership boards between the Council and each of the CCGs. Each board will contain officers of the respective organisations

4.4 **Norfolk Better Care Fund Programme Group**

- During 2014, a Norfolk BCF Programme Group was developed with the purpose of providing a 'light touch' programme management infrastructure to support the development and delivery of the BCF Plan at Norfolk level and to avoid duplication with local delivery boards. It also provides a structure to ensure shared requirements across the county are met.

- The delivery programmes for the BCF continue under the local partnership boards within each CCG area and with the oversight of the Norfolk Better Care Fund Programme Group.

- Membership of the BCF Programme Group currently includes the Director of Integrated Commissioning (Chair), Heads of Integrated Commissioning for each CCG area (ie **designated Pooled Fund Managers),** a finance lead representing the CCGs and one from NCC, a Chief Officer representing the districts (in relation to the Disabled Facilities Grant), a performance lead representing the CCGs and one from NCC, a Public Health lead, a workforce lead representing the CCGs and one from NCC, and a H&WB officer support

4.5 **Health & Wellbeing Board**

- The Health and Wellbeing Board is the body responsible for developing the strategic plan for the BCF and is accountable, overall, for the Norfolk Better Care Fund
- Recognising this, each s75 agreement has the H&WB at the head of its governance arrangement

- The H&WB has a regular item on its agenda – which has previously focused on the BCF development and progress through the national assurance process

4.6 Robust arrangements are in place for operational oversight of the BCF together with strategic oversight for Norfolk as a whole. The arrangements outlined in paragraph 2.5 and 3.5 above will further strengthen that strategic oversight from the H&WB perspective and will provide a formal mechanism for the purposes of the required quarterly reporting.

5. Action required

5.1 The Board is asked to:

- Note the national Guidance
- Agree arrangements going forward to provide assurance and support the Board in leading the transformation of health and social care services needed to deliver the Better Care Fund plan for Norfolk (proposals outlined in paras. 2.5 and 3.5)

Officer Contact

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

Catherine Underwood 01603 224378 catherine.underwood@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.

Department of Health

Department for Communities and Local Government

Local Government Association

NHS England

20 March 2015

Dear Health and Wellbeing Board Chair

BETTER CARE FUND: OPERATIONALISATION GUIDANCE AND NON-ELECTIVE ADMISSIONS AMBITIONS

I am writing to advise you of the publication of detailed guidance on the operation of the Better Care Fund in 2015/16. The *Guidance for the Operationalisation of the BCF in 2015/16* published today sets out in detail the reporting and monitoring requirements for the fund, how progress against conditions of the fund will be managed, and the future role of the Better Care Support Team (which will succeed the current BCF Taskforce). I hope you and colleagues will find this further guidance helpful as we move into the implementation of the BCF.

The guidance also provides further advice to areas around the alignment of BCF targets for reducing non-elective admissions with the planning assumptions included in final CCG operational plans. It confirms that BCF plans should continue to include ambitious 'stretch' targets that aim to accelerate progress on reducing admissions – and therefore that the stretch ambitions in BCF plans may be higher than assumptions included in operational plans.

However as set out in the BCF Operationalisation Guidance, where the existing BCF target is significantly higher than the operational plan target, HWBs will be able to take the opportunity to consider amending the BCF target to align more closely and ensure it remains credible and deliverable. The guidance specifically confirms that:

- we do not expect any change in the BCF target where it is already within two percentage points of the operational plan target; and
- where a HWB chooses to revise their BCF target, this will be subject to the approval of NHS England in consultation with Ministers.

Operation and Funding of the Payment for Performance Sum

Any changes to BCF stretch targets agreed at local level will need to be reflected in the size of the overall nominal payment for performance sum, which is dependent on the size of the final BCF stretch target. The size of the payment for performance sum will also need to be updated in light of final baseline data which is now available. To help areas work this

through, the BCF Taskforce have published an analytical planning tool alongside the Operationalisation Guidance.

As set out in the BCF Operationalisation Guidance the nominal payment for performance sum will be equivalent to the number of reduced non-elective admissions in the BCF target paid at tariff. The actual payment will be dependent on the actual level of reduction achieved.

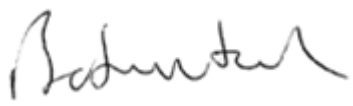
Each CCG will be expected to have budgeted for a payment for performance sum consistent with the operating plan reduction in admissions. Where the BCF plan includes a greater level of reduction, and where this reduction is achieved, CCGs will therefore need to ensure that their contracts are sufficiently sophisticated and granular to ensure that where the stretch target is achieved, the money is available for payment for performance in line with the BCF plan.

To be clear, where contracts with acute providers are based on a marginal rate rather than full tariff the source of funding for the resulting payment will be as follows:

- a reduction in payment to acute provider at the agreed marginal rate; and
- the balance to full tariff which is currently withheld by the CCG and used for investment in services to relieve pressure on A&E services by the System Resilience Group (SRG). Any such money must not be committed beyond the date at which it would need to be released into the payment for performance pot, unless there is express prior agreement of all parties through the Health and Wellbeing Board that this investment would be deemed a suitable use of the payment for performance pot and as such could continue to be invested in that scheme as part of the performance reward.

I hope this guidance is helpful. If you have any queries please discuss with your local NHS England team or contact the Better Care Support Team directly by emailing *england.bettercaresupport@nhs.net*.

I have copied this letter and the guidance to local authority chief executives and CCG accountable officers, and would grateful if you could share with other local colleagues as necessary.



Dame Barbara Hakin
National Director: Commissioning Operations
NHS England

NHS England Publications Gateway Reference 03001

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Better Care Fund Task Force

Better Care Fund:

Guidance for the Operationalisation of the BCF in 2015-16

The Better Care Fund

Contents

PURPOSE

1. This document provides local partners to Better Care Fund plans – Clinical Commissioning Groups (CCGs), Local Authorities (LAs), and Health and Wellbeing Boards (HWBs) – with guidance on the operationalisation of these plans in 2015-16.

2. In particular it sets out:
    - the Care Act legislation underpinning the BCF;
    - the accountability arrangements and flows of funding;
    - the reporting and monitoring requirements for 15-16;
    - arrangements for the operation of the payment for performance framework;
    - how progress against plans will be managed and what the escalation process will look like; and
    - the role of the BCF Task Force / Better Care Support Team going forward.

3. There are a number of annexes that this document should be read alongside, as well as the policy framework[1] for the fund, published by the Department of Health (DH) and Department of Communities and Local Government (DCLG).

4. This guidance has been co-developed across the national organisations on the BCF Task Force with input from Local Authorities and Clinical Commissioning Groups.

LEGAL POWERS FROM THE CARE ACT (2014)

5. Under s.223G of the NHS Act 2006 (as amended most recently by the Care Act 2014), NHS England has the power to set conditions around the payment of funds to CCGs. In relation to the BCF allocation, section 223GA states that this must include a condition that funds are paid into a section 75 pooled fund, and may include (but is not limited to) conditions relating to:

    - the preparation and agreement of a spending plan by the CCG(s) and local authority party to the pooled fund;
    - the approval of the plan by NHS England;
    - the inclusion of performance objectives in a spending plan – i.e. the non-elective admissions reduction target; and
    - the meeting of any performance objectives included in a spending plan or specified by NHS England – i.e. payment proportional to performance as per the BCF Technical Guidance.

6. Where a condition is not met, s.223GA of the NHS Act 2006 (as amended most recently by the Care Act 2014) enables NHS England to:
    - ***withhold the payment*** (insofar as it has not been made);
    - ***recover the payment*** (insofar as it has been made);

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/381848/BCF.pdf

- ***direct the CCG(s) as to the use*** of the designated amount for purposes relating to service integration or for making payments under s.256 of the 2006 Act.

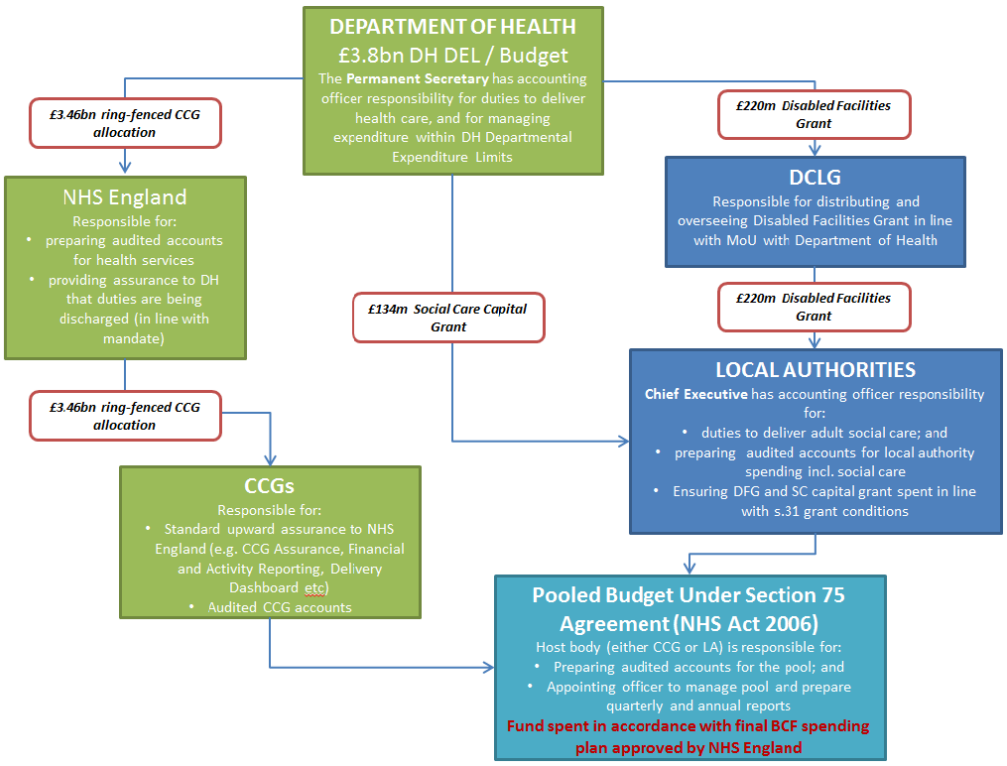
7. The three powers of intervention set out above where a condition is not met apply to the £3.46bn of the BCF that is being routed through CCGs. The powers do not apply to the remaining £354m (social care capital grant and disabled facilities grant) which will be paid by DH and DCLG directly to local authorities under s.31 of the Local Government Act 2003.

8. These powers are only triggered once the Secretary of State for Health uses his powers to include in the mandate a requirement for NHS England to ring-fence some of its funding to fund integration. The mandate for 15/16 was published on 11 December 2014 with the relevant requirements around the BCF.

9. The mandate requires that NHS England consult with the Department of Health and Department for Communities and Local Government before exercising its powers in relation to the failure to meet specified conditions.

ACCOUNTABILITY STRUCTURES AND FUNDING FLOWS IN 15-16

10. One of the recommendations of the 2014 NAO report[2] on the BCF was to develop clear accountability structures for the fund, including how accounting officers will gain assurance on how local areas spend the Fund. Below is a diagram setting out the accountability arrangements and flow of funding for the BCF.



[2] http://www.nao.org.uk/wp-content/uploads/2014/11/Planning-for-the-better-care-fund.pdf

11. In summary, at national level:
    - the full £3.8bn of funding will be part of DH's budget so overall accountability to Parliament will sit with the DH Permanent Secretary;
    - DCLG will retain policy responsibility for the Disabled Facilities Grant (DFG);
    - the NHS England Accounting Officer is accountable for the effective use of the £3.46bn of the fund which constitutes revenue grant;
    - the £3.46bn will pass from NHS England to CCGs through 15/16 allocations, and then from CCGs to pooled budgets (via section 75 agreements);
    - the capital grant monies will flow directly to LAs (from DH for the £134m Adult Social Care Capital Grant and from DH to DCLG and then to LAs for the £220m DFG), and then into the pooled budget via s.75; and
    - the monies will then be spent on services in line with their approved BCF plan.

12. At local level:
    - CCGs (Accountable Officers) will be the accountable body for their share of the £3.46bn of the BCF allocated to them by NHS England (and any additional monies they plan to voluntarily add to the pooled fund), and will be held to account by NHS England for the appropriate use of BCF resources locally; and
    - local authorities (s.151 officers) will be the accountable body, under the terms of their grant agreements, for the £354m of funding that is paid directly to them by DH and DCLG (and any additional monies they plan to voluntarily add to the pooled fund).

13. At a local level, as legal recipients of the funding, CCGs and LAs are the accountable bodies for the respective elements of the BCF allocated to them, and therefore responsible for ensuring the appropriate use of the funds. This means that they retain responsibility for spending decisions and monitoring the proper expenditure of the fund in accordance with the approved plan. At present these tasks cannot be delegated by them to the HWB. However, local authorities may be able to delegate such tasks to the HWB in the future as new regulations broadening the role of HWBs are being consulted upon[3]. LAs should check the DCLG website for progress.

14. HWBs are a valuable forum for stakeholders to come together to review performance of the BCF and consider future work. The expectation is that HWBs will continue to oversee the strategic direction of the BCF and the delivery of better integrated care, as part of their statutory duty to encourage integrated working between commissioners. Given they are a committee of the LA, HWBs are accountable to the LA and ultimately to the LA's electorate. HWBs also have their own statutory duty to help commissioners provide integrated care that must be complied with[4]. Particularly where members of a HWB include providers delivering care that is or could be commissioned under BCF, care will need to be taken to ensure that any conflicts of interest are appropriately dealt with.

[3] https://www.gov.uk/government/consultations/proposed-local-authorities-functions-and-responsibilities-england-regulations-2015

[4] Section 195 of the Health and Social Care Act 2012

15. In terms of operational oversight of the BCF, the regulations[5] governing s.75 agreements require the agreement to set out (amongst other provisions):
    - the arrangements for monitoring the delivery of the services that it covers;
    - who the "host" organisation is that will be responsible for accounting and audit; and
    - who the "pool manager" is that will be responsible for submitting to the partners quarterly reports, and an annual return, about income and expenditure from the pooled fund, and other information by which partners can monitor the effectiveness of the pooled fund arrangements.

16. Therefore, arrangements for monitoring delivery, accounting and audit should be governed by the local s.75 agreement, in addition to the separate reporting and accountability arrangements each partner organisation will have for their share of the funding being pooled.

17. The BCF Task Force released guidance and support[6] for local areas in developing their local s.75 agreements in September which included a template s.75 agreement accompanied by an explanatory memorandum. The explanatory memorandum provides support for local areas considering their local governance and oversight arrangements. Traditionally, s.75 agreements are governed by a partnership board made up of the bodies that are signatories to the agreement. Each of those signatories should be authorised to act on behalf of their employing organisation, so the partnership board is able to make joint decisions.

18. In order for the HWB to review performance of the BCF and consider future work, it would need to have the appropriate information reported to it from a partnership board. HWBs can require CCGs that are represented on the HWB and the LA that established the HWB to provide it with relevant information, for example the quarterly reports and annual report. This can be done under section 199 of the Health & Social Care Act 2012. For the purposes of the BCF, there should be a partnership board with minimum representation across the relevant CCG(s) and LA(s) – many localities will already have a partnership board in place and where this is the case there is no need to set up one specifically for the BCF.

19. ***NHS England recommends to CCGs:***
    - ***that a partnership board is in place to govern the s.75 agreement;***
    - ***that a clause is included in the s.75 agreement that sets out what information should be included in the host partner's quarterly reports and annual reports to ensure the ability to monitor the effectiveness of the pooled fund arrangements and provide assurance to NHS England as to the appropriate use of the fund (this is explained in more detail in the next section with template reports); and***
    - ***that a clause is included to ensure the quarterly reports and annual returns are signed off by the HWB.***

[5] NHS Bodies and Local Authorities Partnership Agreements Regulations 2000

[6] http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/risk-sharing/

REPORTING AND MONITORING IN 15-16

20. The BCF will be embedded into business as usual processes in NHS England for planning, performance monitoring, assurance, and performance management[7] as far as possible. However, on the most part, this will be at CCG level rather than HWB level.

21. As previously agreed, and reflected in the assurance outcome letters, every CCG will have the following standard conditions on its BCF funding using powers under s.223G of the NHS Act 2006:
    - The fund being used in accordance with their final approved plan and through a section 75 pooled budget agreement; and
    - The full value of the element of the fund linked to non-elective admissions reduction target will be paid over to CCGs at the start of the financial year. However, CCGs may only release the full value of this funding into the pool if the admissions reduction target is met as detailed in the BCF Technical Guidance[8]. If the target is not met, the CCG(s) may only release into the pool a part of that funding proportionate to the partial achievement of the target. Any part of this funding that is not released into the pool due to the target not being met must be dealt with in accordance with NHS England requirements. Full details are set out in the BCF Technical Guidance.

22. As part of the enforcement of the first condition, NHS England can require CCGs to:
    - explain the governance arrangements they have in place; and
    - report on spending and provide evidence that it has been spent in a particular way (in accordance with their approved plan).

23. As part of the enforcement of the payment for performance condition, NHS England can require CCGs to report on their non-elective admissions, how much money has been released into the pooled fund, and if any element has been held back (in accordance with the technical guidance) what that has been spent on. Contained in annex 1 is a summary of the guidance, including information on the baseline, data source, and dates of performance and related payment. ***This information should be included in the quarterly reports and annual reports, and the s. 75 agreement should require it.***

24. The size of the final Payment for Performance pot linked to the non-elective admissions reduction ambition is likely to change from the figures reported in October in the NCAR meta-analysis[9] for the following reasons:
    - Updated baseline data to reflect actual performance for Q1-3 in 14/15, and any changes to Q4 2013/14 figures resulting from 12 month routine data revisions in MAR (Monthly Activity Return);

[7] Such as: NHS England Board Performance Report, Regional Operations and Delivery Directors report, Delivery Dashboard, Finance and Activity Report, CCG Assurance Framework

[8] http://www.england.nhs.uk/wp-content/uploads/2014/08/bcf-technical-guidance-v2.pdf

[9] http://www.england.nhs.uk/wp-content/uploads/2014/11/bcf-ncar-results-analysis.pdf

- areas who were 'approved with support', 'approved subject to conditions' or 'not approved' may have had an action on the back of their NCAR review requiring them to resubmit a revised plan with an amended non-elective admissions ambition; and
- any changes to targets agreed and approved in line with the further guidance on alignment of BCF targets with operational plan targets set out in the Payment for Performance section below.

25. An analytical tool has been published on the Better Care Fund webpage, which aims to support areas understand the impact of the revised baseline on their non-elective admissions plan, the resulting impact on the size of the payment for performance pot, and therefore the balancing minimum required amount to be invested in NHS commissioned out of hospital services. The tool will also help areas considering reviewing their BCF non-elective admissions target as part of the NHS operational planning process.

26. If there are any disputes locally between CCG(s) and LA(s) regarding the non-elective admission ambition and payment for performance, this should be managed locally and you should refer to your risk sharing agreement agreed as part of your BCF plan. If the dispute cannot be resolved locally, please then refer to your relevant NHS England sub-region, and Local Government regional peers for assistance. If there are any disagreements on data issues, this should be handled through the usual MAR revisions process.

27. The Better Care Fund Task Force has produced standard reports that will fulfil both local reporting obligations and the minimum national reporting obligations against the key requirements and conditions of the Fund. The standard reports aim to fulfil both the quarterly reporting and annual reporting requirements referred to earlier in this guidance document under the s.75 regulations. Using the standardised reports ensures there is a mechanism in place to monitor the totality of the fund at HWB level, i.e. the planning footprint of the BCF.

28. ***The joint BCF Task Force ask CCGs and LAs to use the quarterly reporting template (example contained in annex 2), as well as an annual reporting template which is currently in development and will be released in due course. The template covers reporting on: income and expenditure, payment for performance, the supporting metrics, and the national conditions. It is suggested that these reports are discussed and signed-off by HWBs given their lead role in the BCF as part of discharging their duty under s.195 of the Health and Social Care Act (2012) to encourage commissioners to provide health and social care services in an integrated manner***[10]. ***Furthermore, NHS England recommends to CCGs that this approach is built into their local s.75 agreements, and require CCGs to report back on this which should also include confirmation that the HWB has signed it off.***

[10] Section 95 of the Health & Social Care Act 2012

29. The draft Year-End reporting guidance and an annual report template is in development across NHS England and LGA, and will build on the quarterly reporting. There are some outstanding queries around accounting and audit being worked through before these can be finalised and issued. Once finalised the template and guidance will be available on the Better Care Fund webpage.

PAYMENT FOR PERFORMANCE

30. As detailed in the quarterly reporting template and guidance in annex 1, the reports are due for submission at 5 points in the year:

    - 29 May 2015 – for the period January to March 2015
    - 28 August 2015 – for the period April to June 2015
    - 27 November 2015 – for the period July to September 2015
    - 26 February 2016 – for the period October – December 2015
    - 27 May 2016 – for the period January – March 2016

31. The reason the reporting commences from January 2015, is due to the baseline for the quarterly Payment for Performance schedule, linked to the non-elective admissions ambition. This is detailed in the BCF planning guidance and technical guidance published in the summer of 2014, and summarised in annex 1.

32. We understand that Health and Wellbeing Boards may wish to consider the alignment of BCF targets with the planning assumptions included in final CCG operational plans. In some cases, differences might arise when a broad range of planning factors are taken into account, including:

    - actual performance in the year to date, particularly through the winter;
    - the actual outturn for 2014/15; or
    - progress with contract negotiations with providers.

33. BCF plans should continue to represent ambitious stretch targets that aim to accelerate progress on reducing non-elective admissions. It is therefore expected that the target included in the BCF plan may be higher than operational planning assumptions. A difference between these does not mean that the BCF target needs to be amended.

34. However, Health and Wellbeing Boards may feel that the emergence of large differences begins to affect the credibility of the BCF ambition. In these circumstances they may wish to amend the BCF target to more closely align with the CCG operational plan. If so we expect that:

    - there will be no change to the targets included in BCF plans where these are within 2 percentage points of assumptions in operational plans. For example, where the BCF target is for a 4% reduction in non-elective admissions, provided the operational plan target is for a 2% (or greater) reduction, the BCF target

should not change. In these HWB areas there will be no further central plan review and assurance; and

- where the target in BCF plans is greater than 2 percentage points away from assumptions in operational plans (for example a BCF target of 6% and an operational plan target of 1%), the HWB may, at its discretion, amend the BCF target where it believes this change is required to ensure it remains credible and realistic. Any changes will need to be agreed by the HWB and will be subject to approval by NHS England (in consultation with Ministers).

35. Any review or change to BCF targets around non-elective admissions should be undertaken within the partnership approach underpinning local BCF planning and agreed by the HWB.

36. If, through this process, the planned level of improvement is reduced the HWB must also approve a balancing increase in the amount to be invested in NHS commissioned out-of-hospital services, in line with the BCF planning guidance (unless that level of investment already exceeds the required minimum). Where any balancing increase is necessary, HWBs will need to ensure that this change does not impact on their ability to meet the national BCF conditions, in particular on the protection of social care. NHS England will be seeking assurance on this point as part of the approval process of any proposed changes to BCF targets.

37. The payment for performance element of the Fund will be linked to the performance of local areas in reducing non-elective admissions in line with the trajectory agreed in their BCF plan. This performance element of the Fund will be paid by CCGs into the pooled fund in four quarterly instalments, and payment will be proportionate to actual performance (as per annex 1). The first of these will be made in May 2015, based on performance in the fourth quarter of 2014/15. The first quarterly performance target will continue to be based on the trajectory for improvement set out in the BCF plan approved in October (or approved subsequently for plans initially not approved or approved subject to conditions). Any amendments which are approved to targets as a result of the process set out above will only affect the three remaining quarterly targets.

38. The nominal payment for performance sum will be equivalent to the number of reduced non-elective admissions in the BCF target paid at tariff, and an analytical tool has been published on the Better Care Fund website to help areas calculate the sum (and update the figure following final baseline data and any changes to targets agreed and approved by NHS England as set out above). The actual payment will be dependent on the actual level of reduction achieved.

39. Each CCG will be expected to have budgeted for a payment for performance sum consistent with the operating plan reduction in admissions. Where the BCF plan includes a greater level of reduction, and where this reduction is achieved, CCGs will need to ensure that their contracts are sufficiently sophisticated and granular to

ensure that where the stretch target is achieved, the money is available for payment for performance in line with the BCF plan.

40. Where contracts with acute providers are based on a marginal rate rather than full tariff the source of funding for the resulting payment will be as follows:

- a reduction in payment to acute provider at the agreed marginal rate; and
- the balance to full tariff which is currently withheld by the CCG and used for investment in services to relieve pressure on A&E services by the System Resilience Group (SRG). Any such money must not be committed beyond the date at which it would need to be released into the payment for performance pot unless there is express prior agreement of all parties through the Health and Wellbeing Board that this investment would be deemed a suitable use of the payment for performance pot and as such could continue to be invested in that scheme as part of the performance reward.

BETTER CARE SUPPORT TEAM IN 15-16

41. A joint Better Care Support Team with representation across NHS England, LGA, DH and DCLG will continue into 15-16 and will focus on the below, working through the NHS England and Local Government Regions:

- Supporting local areas with the implementation of their BCF plans;
- Monitoring progress with the delivery of plans through the quarterly and annual reporting processes set out in this document;
- supporting the performance management and escalation processes for the BCF, including the enactment of Care Act powers where relevant; and
- reporting progress to the national BCF Programme Board and Cross-Ministerial Board.

MANAGING PROGRESS AND WHAT THE ESCALATION PROCESS WILL LOOK LIKE

42. Performance management for the BCF will be led by NHS England and the local government regions, with the joint Better Care Support Team providing support and advice. Working with the Better Care Support Team, NHS England and the Local Government regions will monitor progress against plans from the quarterly monitoring process described above, and will determine whether areas are continuing to meet the standard conditions of the Fund as detailed in the BCF plan assurance letters:
    1. That the Fund is pooled under a s.75 agreement
    2. That the Fund is used in accordance with their final approved plan
    3. That they continue to meet the requirements around the payment for performance framework

43. In addition to the standard conditions of the Fund above, the NHS England and Local Government regions will work with the Better Care Support Team to monitor progress around the delivery of the national conditions. The national conditions were a key focus of the Nationally Consistent Assurance Review (NCAR) process. Areas will have been approved on the basis of having a satisfactory plan to achieve the national conditions – as access to the funds was conditional upon the plan satisfactorily meeting the national conditions.

44. If an area fails to meet any of the standard conditions of the Fund, including if the funds are not being spent in accordance with the plan with the result that delivery of the national conditions is jeopardised, the Better Care Support Team may make a recommendation to NHS England that they should initiate an escalation process. The key steps of the escalation process are detailed below – with the main principle being that intervention should be appropriate to the risk identified. The process ultimately leads to the ability for NHS England to use its powers of intervention provided by the Care Act legislation, in consultation with DH and DCLG as the last resort. Note that the quarterly reporting templates allow for any variation in spending from the plan to be explained.

45. The below table sets out the proposed escalation process which will normally be initiated if any of the conditions of the Fund are not met following the return of the quarterly reports. The Better Care Support Team will support this process, making recommendations to NHS England for decision where necessary. The process may be adapted to accommodate local circumstances. Local stakeholders will be notified if this is the case. It may also be updated to reflect learning from experience.

1 – Assurance meeting	The assurance meeting is the opportunity to use national and local insight to drive a discussion about areas of concern. It would be the first formal opportunity to raise concerns. It is expected that in line with the principle of 'no surprises', issues will have been raised through ongoing relationships via Regions, Area Teams and local government regional peers. The meeting would be an opportunity to discuss the concerns and agree actions and next steps, including whether support is required.
2 – Formal letter and clarification of agreed actions	The CCG(s) will be issued with a letter summarising the assurance meeting and clarifying the next steps agreed, timescales, and how this will be monitored and by whom. If support was requested by the CCG(s), an update on what support will be made available to them will be included. This may be support from regional or national teams.
3 – Regular monitoring of agreed actions	The agreed actions will be monitored by a named point of contact to track progress.
4 – Consideration of intervention options	If it is found that the concern is so deep set or serious (or the agreed actions do not take place satisfactorily) that intervention may be appropriate, then the

	implications of doing so will be considered carefully. The principle must be that the consequences of the intervention action for patients is at the very least no worse than the status quo of not intervening.
5 – Regional and national consistency	It will be important to ensure that peer review is sought through the assurance consistency process to ensure that the rationale for intervention is robust.
6 – Consultation with ministers	NHS England consults with DH and DCLG in accordance with the 2015/16 Mandate
7 – Summary report and directions drafted for committee approval	Finally, the relevant evidence and legal wording needs to be submitted to NHS England's Assurance and Development Committee for consideration. Once approved the documentation, including any directions, will be passed to the Chief Executive for signature.

ANNEXES

Annex 1 – Summary of Payment for Performance Guidance

Annex 2 – Example Quarterly Report Template and Guidance

ANNEX 1 – SUMMARY OF PAYMENT FOR PERFORMANCE GUIDANCE

1. The performance-related funding will be made on the basis of performance over the final quarter of 2014/15 and the first three quarters of 2015/16, against the trajectory as set out in the plans. HWBs are therefore required to set an annual target (from Q4 2014/15 until end of Q3 2015/16), with quarterly milestones, in the finance and activity plan template.

2. Assessments of how suitable the locally set targets are will be made by HWBs and through the NCAR assurance process. Payments will be made in arrears as set out below:
   - May 2015 (based on Q4 2014/15 performance)
   - August 2015 (based on Q1 2015/16 performance)
   - November 2015 (based on Q2 2015/16 performance)
   - February 2016 (based on Q3 2015/16 performance)

3. At each 'payment point', CCGs will release money into the BCF pooled fund on the basis of performance to date, against plan. Each quarterly payment will be proportionate to the level of improvement achieved so far (calculated as a proportion of the planned full-year reduction against the baseline). The relationship between payment and progress toward target will be directly linear (e.g. achieving 30% of the target will release 30% of the funding). There will be no additional payment for performing beyond the target.

4. The steps to calculating the quarterly payment are:

   a. take the cumulative activity reduction against the baseline at quarter end and divide it by the cumulative Q3 2015/16 target reduction;
   b. multiply that by the size of the performance pot available; and
   c. subtract any performance payments made for the year to date.

5. The minimum payment in a quarter is £0 (there will not be a negative payment or 'claw back' mechanism) and the maximum paid out by the end of each quarter cannot exceed the planned cumulative performance pot available for release each quarter.

6. Although we are asking areas to plan on the basis of the baseline being actual Q4 13/14 outturn, and planned Q1, Q2, Q3 14/15 outturn, for the purposes of assessing performance in 15/16, for quarters 1-3 in 14/15 areas will be assessed against their actual outturn. Through the technical guidance we asked areas to ensure any financial risk associated with this is managed appropriately and articulated in plans.

7. The data source for non-elective admissions data is Monthly Activity Returns (MAR) data. For the 15/16 planning round, both MAR and SUS (Secondary Uses Service) data will be collected with the aim that these data sources should begin to align.

ANNEX 2 – EXAMPLE HWB QUARTERLY REPORTING TEMPLATE

1. The example quarterly reporting template (attached as a spreadsheet) is to provide local areas with an early indication of what the report will cover.

2. The actual quarterly reporting templates will be accessible via the UNIFY system as soon as the MAR data has been released for each relevant quarter.

3. The template in UNIFY will pre-populate the baseline data and actual performance data at each quarter.

Notes for Completion

The template requires the HWB to track through the high level metrics from the HWB plan.
The template will require completion on a quarterly basis and submitted to **bettercarefund@dh.gsi.gov.uk**
The deadline for submitting the returns are as follows:
Q4 14/15 - 29/05/2015
Q1 15/16 - 28/08/2015
Q2 15/16 - 27/11/2015
Q3 15/16 - 26/02/2016
Q4 15/16 - 27/05/2016
The template return will require sign off by the HWB.
The template is based on the BCF plan template (part 2). Therefore the guidance for the part 2 template may help in completing this form.
To accompany the quarterly report we will require the HWB to submit a written narrative to explain any changes to plan and any material variances against the plan.
The template should be completed in line with relevant accounting standards. The guidance published by CIPFA and HFMA will give further details.

The template consists of four sheets:
1) Cover Sheet
2) I&E - this tracks through the funding and spend for the HWB and the expected level of benefits
3) P4P - this details the Payment for Performance calculation
4) Non Elective - tracks through the changes to non-elective activity
5) Support Metrics - details the other metrics included within the HWB plan.
6) National Conditions - checklist against the national conditions as set out in the Spending Review.

Yellow cells require input, blue cells do not.

1) Cover Sheet
On the cover sheet please enter the following information:
Health and Well Being Board
The Quarter to which this report relates to
Who has completed the report, email and contact number in case any queries arise
The cover sheet will also indicate whether the quality checks have been met and provide details of which areas need reviewing
Please detail who has signed off the report on behalf of the Health and Well Being Report.

2) I&E

Anytown HWB	Q1 2015/15 Report

Completed by:

Email:

Contact Number:

Quality Checks Cleared?

Signed off on behalf of the HWB:

Submission Gudiance

The template will require completion on a quarterly basis and submitted to **bettercarefund@dh.gsi.gov.uk**

The deadline for submitting the returns are as follows:

Q4 14/15 - 29/05/2015
Q1 15/16 - 28/08/2015
Q2 15/16 - 27/11/2015
Q3 15/16 - 26/02/2016
Q4 15/16 - 27/05/2016

Anytown HWB	Q1 2015/15 Report

Income and Expenditure Summary
Figures in £000

Summary of Total BCF Funding	Year to Date			Forecast Outturn		
Local Authority Social Services -Minimum Contribution	2015/16 Plan	2015/16 Forecast	2015/16 Variance	2015/16 Plan	2015/16 Forecast	2015/16 Variance
AnyTown	500	500	-	2,000	2,000	-
<Please select Local Authority>			-			-
<Please select Local Authority>			-			-
<Please select Local Authority>			-			-
<Please select Local Authority>			-			-
<Please select Local Authority>			-			-
<Please select Local Authority>			-			-
Total Local Authority Minimum Contribution	**500**	**500**	**-**	**2,000**	**2,000**	**-**
Additional Local Authority Contribution						
AnyTown	1,000	1,000	-	4,000	4,000	-
<Please select Local Authority>			-			-
<Please select Local Authority>			-			-
<Please select Local Authority>			-			-
<Please select Local Authority>			-			-
<Please select Local Authority>			-			-
<Please select Local Authority>			-			-
Total Additional Local Authority Contribution	**1,000**	**1,000**	**-**	**4,000**	**4,000**	**-**
CCG Minimum Contribution						
NHS Anytown	2,000	2,000	-	8,000	8,000	-
<Please Select CCG>			-			-
<Please Select CCG>			-			-
<Please Select CCG>			-			-
<Please Select CCG>			-			-

<Please Select CCG>			-			-
<Please Select CCG>			-			-
Total Minimum CCG Contribution	**2,000**	**2,000**	**-**	**8,000**	**8,000**	**-**
Additional CCG Contribution						
NHS Anytown	1,000	1,000	-	4,000	4,000	-
<Please Select CCG>			-			-
<Please Select CCG>			-			-
<Please Select CCG>			-			-
<Please Select CCG>			-			-
<Please Select CCG>			-			-
<Please Select CCG>			-			-
Total Additional CCG Contribution	**1,000**	**1,000**	**-**	**4,000**	**4,000**	**-**
Total Contribution	**4,500**	**4,500**	**-**	**18,000**	**18,000**	**-**

Summary of Total BCF Expenditure

BCF Expenditure						
Acute			-			-
Mental Health	500	500	-	2,000	2,000	-
Community Health	500	500	-	2,000	2,000	-
Continuing Care	500	500	-	2,000	2,000	-
Primary Care	1,000	1,000	-	4,000	4,000	-
Social Care	2,000	2,000	-	8,000	8,000	-
Other			-			-
Total	**4,500**	**4,500**	**-**	**18,000**	**18,000**	**-**
Contribution less Expenditure	**-**	**-**	**-**	**-**	**-**	**-**

CCG Share of £1.1bn Contribution to Social Care						
NHS Anytown	500	500	-	2,000	2,000	-
<Please Select CCG>			-			-
<Please Select CCG>			-			-
<Please Select CCG>			-			-
<Please Select CCG>			-			-
<Please Select CCG>			-			-
Total Minimum CCG Share of £1.1bn Contribution to Social Care	**500**	**500**	**-**	**2,000**	**2,000**	**-**

CCG Share of £2.4m Minimum Contribution						
NHS Anytown	1,500	1,500	-	6,000	6,000	-
<Please Select CCG>			-			-
<Please Select CCG>			-			-
<Please Select CCG>			-			-
<Please Select CCG>			-			-
<Please Select CCG>			-			-
Total CCG Share of Minimum £2.4bn Contribution	**1,500**	**1,500**	**-**	**6,000**	**6,000**	**-**

Summary of NHS Commissioned out of hospital services spend from MINIMUM BCF Pool						
Mental Health			-			-
Community Health	1,000	1,000	-	4,000	4,000	-
Continuing Care	500	500	-	2,000	2,000	-
Primary Care	500	500	-	2,000	2,000	-
Social Care			-			-
Other			-			-
Total	**2,000**	**2,000**	**-**	**8,000**	**8,000**	**-**

Summary of Benefits						
Reduction in permanent residential admissions			-			-
Increased effectiveness of reablement			-			-
Reduction in delayed transfers of care			-			-
Reduction in non-elective (general + acute only)	(112)	(112)	-	(447)	(447)	-
Other			-			-

Total	**(112)**	**(112)**	**-**	**(447)**	**(447)**	**-**

Has the housing authority received its DFG allocation?	
Have the funds been pooled via a s.75 pooled budget arrangement?	

Anytown HWB	

Payment for Performance

	Plan	Forecast	Variance against Revised Plan
1. Reduction in non elective activity			
Baseline of non elective activity	20,100	20,100	-
Change in non elective activity	(400)	(700)	(300)
% change in non elective activity	-2.0%	-3.5%	-1.5%
2. Calculation of performance and NHS commissioned ringfenced funds			
Financial value of non elective saving / performance fund	596,000	1,043,000	447,000
Combined total of performance and ringfenced funds	3,900,000	3,900,000	-
Ringfenced funds	3,304,000	2,857,000	(447,000)
Value of NHS commissioned services	6,000,000	6,000,000	-
Shortfall of contribution to NHS commissioned services	0		-

	Q4 14/15 Revised Plan	Q1 15/16 Revised Plan	Q2 15/16 Revised Plan	Q3 15/16 Revised Plan
Cumulative quarterly baseline of non elective activity	5,000	10,100	15,000	20,100
Cumulative change in non elective activity	(200)	(300)	(200)	(400)
Cumulative % change in non elective activity	-4.0%	-3.0%	-1.3%	-2.0%
Financial value of non elective saving / performance fund (£)	148,259	151,224	145,294	151,224
Value of payment made over to BCF	148,259	-	-	-
Variance	(0)	151,224	145,294	151,224
Commentary on Variance		Payment not due	Payment not due	Payment not due

Anytown HWB	Q1 2015/15 Report

Non - Elective admissions (general and acute)

Plan

Metric		Baseline				Pay for performance period				
		Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Q4 (Jan 15 - Mar 15)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population	*Quarterly rate*	2,500	2,550	2,450	25,500	2,376	2,475	2,475	2,426	2,402
	Numerator	5,000	5,100	4,900	5,100	4,800	5,000	5,000	4,900	4,900
	Denominator	200,000	200,000	200,000	20,000	202,000	202,000	202,000	202,000	204,000

P4P annual change in admissions *-400*
P4P annual change in admissions (%) *-2.0%*
P4P annual saving *£596,000*

Please enter the average cost of a non-elective admission: £1,490

Peformance against plan

Metric		Baseline				Pay for performance period				
		Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Q4 (Jan 15 - Mar 15)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population	*Quarterly rate*	2,500	2,550	2,450	25,500	2,327	2,426	2,426	2,426	2,353
	Numerator	5,000	5,100	4,900	5,100	4,700	4,900	4,900	4,900	4,800
	Denominator	200,000	200,000	200,000	20,000	202,000	202,000	202,000	202,000	204,000

P4P annual change in admissions *-700*
P4P annual change in admissions (%) *-3.5%*
P4P annual saving *£1,043,000*

Please enter the average cost of a non-elective admission: £1,490

Variance against plan

Metric		Baseline				Pay for performance period				
		Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Q4 (Jan 15 - Mar 15)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population	*Quarterly rate*	-	-	-	-	50	50	50	-	49
	Numerator	-	-	-	-	100	100	100	-	100
	Denominator	-	-	-	-	-	-	-	-	-

Anytown HWB	Q1 2015/15 Report

Residential admissions

Plan

Metric		Baseline (2013/14)	Planned 14/15	Planned 15/16
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Annual rate*	664	663.4	635.5
	Numerator	130	130	125
	Denominator	19,600	19,597	19,669
	Annual change in admissions		*0*	*-5*
	Annual change in admissions %		*0.0%*	*-3.8%*

Performance against plan

Metric		Baseline (2013/14)	Planned 14/15	15/16 Performance
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Annual rate*	664.0	663.4	635.5
	Numerator	130	130	125
	Denominator	19,600	19,597	19,669
	Annual change in admissions		*0*	*-5*
	Annual change in admissions %		*0.0%*	*-3.8%*

Variance against plan

Metric		Baseline (2013/14) Variance	14/15 Variance	15/16 Variance
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Annual rate*	-	-	-
	Numerator	-	-	-
	Denominator	-	-	-

Reablement

Plan

Metric		Baseline (2013/14)	Planned 14/15	Planned 15/16
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Annual %*	#REF!	89.3	90.0
	Numerator	#REF!	125	135
	Denominator	#REF!	140	150
	Annual change in admissions		*#REF!*	*10*
	Annual change in admissions %		*#REF!*	*8.0%*

Performance against plan

Metric		Baseline (2013/14)	Planned 14/15	15/16 Performance
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Annual %*	#REF!	89.3	90.0
	Numerator	#REF!	125	135
	Denominator	#REF!	140	150
	Annual change in admissions		*#REF!*	*10*
	Annual change in admissions %		*#REF!*	*8.0%*

Variance against plan

Metric		Baseline (2013/14)	Planned 14/15	Planned 15/16
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Annual %*	#REF!	-	-
	Numerator	#REF!	-	-
	Denominator	#REF!	-	-

Delayed transfers of Care

Metric		14/15 plans				15-16 plans			
		Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Q4 (Jan 15 - Mar 15)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).	*Quarterly rate*	**357.3**	**360.1**	**433.8**	**338.0**	**357.0**	**359.8**	**433.4**	**337.8**
	Numerator	500	504	607	482	509	513	618	491
	Denominator	139,942	139,942	139,942	142,593	142,593	142,593	142,593	145,357

Performance against revised plan

Metric		14/15 plans				15-16 performance			
		Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Q4 (Jan 15 - Mar 15)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).	*Quarterly rate*	**357.3**	**360.1**	**433.8**	**338.0**	**357.0**	**359.8**	**433.4**	**337.8**
	Numerator	500	504	607	482	509	513	618	491
	Denominator	139,942	139,942	139,942	142,593	142,593	142,593	142,593	145,357

Variance against revised plan

Metric		14/15 variance				15-16 variance			
		Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Q4 (Jan 15 - Mar 15)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).	*Quarterly rate*	-	-	-	-	-	-	-	-
	Numerator	-	-	-	-	-	-	-	-
	Denominator	-	-	-	-	-	-	-	-

Patient / Service User Experience Metric

Plan

Metric		Baseline Apr'13-Mar'14	Planned 14/15 (if available)	Planned 15/16
Proportion of people with LTC who feel supported to manage their condition (as measured through national GP patient survey)	*Metric Value*	56.3%	58.0%	61.4%
	Numerator	680	724	793
	Denominator	1,207	1,249	1,292
Improvement indicated by:				

Performance against plan

Metric		Baseline Apr'13-Mar'14	Planned 14/15 (if available)	15/16 Performance
Proportion of people with LTC who feel supported to manage their condition (as measured through national GP patient survey)	*Metric Value*	56.3%	58.0%	61.4%
	Numerator	680	724	793
	Denominator	1,207	1,249	1,292
Improvement indicated by:				

Variance against plan

Metric		Baseline Apr'13-Mar'14	14/15 Variance	15/16 Variance
Proportion of people with LTC who feel supported to manage their condition (as measured through national GP patient survey)	*Metric Value*	-	-	-
	Numerator	-	-	-
	Denominator	-	-	-

Local Metric

Plan

Metric		Baseline Apr'12 to Mar'13	Planned 14/15 (if available)	Planned 15/16
Prevention of Falls (per 100,000)	*Metric Value*	1721.0		1471.0
	Numerator	447		377
	Denominator	19,855		19,855
Improvement indicated by:				

Performance against plan

Metric		Baseline Apr'12 to Mar'13	Planned 14/15 (if available)	15/16 Performance
Prevention of Falls (per 100,000)	*Metric Value*	1721.0		1471.0
	Numerator	447		377
	Denominator	19,855		19,855
Improvement indicated by:				

Variance against plan

Metric		Baseline Apr'12 to Mar'13	14/15 Variance	15/16 Variance
Prevention of Falls (per 100,000)	*Metric Value*	-	-	-
	Numerator	-	-	-
	Denominator	-	-	-

Annual Report of the Independent Chair of Norfolk Safeguarding Children Board

Cover Sheet

What is the role of the H&WB in relation to this paper?

From Working Together 2015:

- The Chair must publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in the local area. The annual report should be published in relation to the preceding financial year and should fit with local agencies' planning, commissioning and budget cycles. The report should be submitted to the Chief Executive, Leader of the Council, the local police and crime commissioner and the Chair of the health and well-being board.

Key questions for discussion

The Health & Well Being Board is requested to assure itself that the improvements noted external review activities in spring 2014, i.e. the Peer Review and the DfE Strategic review, are reflected in the NSCB annual report. More specifically,

- How effectively do partners work together to meet the needs of vulnerable children in Norfolk?
- Is safeguarding children reflected in commissioning arrangements?
- Is the Health & Well Being Board satisfied that services are having a positive impact on outcomes for children?

Actions/Decisions needed

The Board is asked to:

- Note the report and that it has also been reported to the Children's Services Committee, Norfolk County Council's Managing Director and to partner agencies.

Annual Report of the Independent Chair of Norfolk Safeguarding Children Board

Summary
This Annual Report from the Norfolk Safeguarding Children Board reports on activities for the year 2013-14, and is presented to the Health & Well Being Board as part of the accountability of the NSCB in discharging its responsibilities to co-ordinate safeguarding work and to ensure the effectiveness of partnership arrangements.

It records a challenging year when considerable progress was made to strengthen the Board. We can be confident that the NSCB is now working more effectively and can evidence the impact it has on the well-being and safety of children and young people across the County.

Since the end of the year covered by this Annual Report there has been further substantive and measurable progress which provides a foundation for continuing improvement.

Action
The Health and Wellbeing Board is asked to:

- Note the report and that it has also been reported to the Children's Services Committee, Norfolk County Council's Managing Director, the Police Crime Commissioner and to partner agencies.

1. Background

1.1 This Report is for information. The Independent Chair of the NSCB will be attendance to answer questions or respond to points raised.

2. Annual Report 2013-14

2.1 Under statutory guidance and Working Together 2013 the Independent Chair of the NSCB is required to prepare an Annual Report on the work of the Board. The Annual Report 2013-14 is at Appendix A.

3. Key issues

3.1 In summary, there are a number of areas where the Board is continuing to strengthen its work and ensure continuous improvement. In addition to the improvements made specifically within Children's Services, the Board has:

- Strengthened its governance and leadership arrangements
- Established clear priorities with sign up across the partnership to identify and tackle neglect, child sexual abuse and child sexual exploitation
- Published a business plan and a learning & improvement framework to support continuous development
- Clearly identified the risks and opportunities in place.

3.2 The risks as reported to the Department for Education are:

- Recruitment of new senior Children's Services management team
- Scale and pace of leadership demands on new postholders
- Implementation of new structure for Children's Services
- Capacity to sustain effective joint working at both local and county levels
- Level of health engagement in children's services
- Significant reform required of key services, including LADO, MASH

3.3 The opportunities are:

- Signs of Safety
- Whole system leadership groups and reestablishment of Children's Strategic Partnership
- Clear political and management leadership commitment across partners to tackle key issues
- Effective learning from serious cases and other audit and quality assurance processes
- Regular communication to all Children's Services staff through newsletter, emails and face to face events about progress on the improvement agenda.
- Section 11 audit and performance challenge for all LSCB partners
- Key strategies and practice tools on priority areas such as neglect

4. Action

4.1 The Health and Wellbeing Board is asked to:

- Note the report and that it has also been reported to the Children's Services Committee, Norfolk County Council's Managing Director, the Police Crime Commissioner and to partner agencies.

Officer Contact

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

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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.

Annual Report

1 April 2013 - 31 March 2014

Norfolk Safeguarding Children Board

www.nscb.norfolk.gov.uk

September 2014

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Foreword from Chair

I am pleased to present this Annual Report on the work of Norfolk Safeguarding Children Board. It records a challenging year when considerable progress was made to strengthen the Board. We can be confident that the NSCB is now working more effectively and can evidence the impact it has on the well-being and safety of children and young people across the County.

Since the end of the year covered by this Annual Report there has been further substantive and measurable progress which provides a foundation for continuing improvement. The NSCB has contributed to:

- Encouraging improvements in front-line practice through a strong training and development programme;
- Disseminating the lessons from serious case reviews, audits and good practice across the county;
- Developing the Early Help offer;
- Consolidating and reporting the evidence of improved performance;
- Introducing strategies for responding to neglect, child sexual exploitation and the impact of obesity on safeguarding;
- Developing clear leadership across the whole children's system.

I would like to record my thanks to Colin Chapman as previous NSCB Chair, and to all colleagues and partners who have contributed to the work of the Board over the past year.

1: Introduction

Norfolk has undergone a period of change and challenge in 2013 – 14. The Board and its partners started the financial year addressing the weaknesses identified in the Ofsted inspection of local authority arrangements for the protection of children, which judged safeguarding as inadequate. This was followed by inspections of Norfolk County Council's arrangements for supporting school improvement in June 2013 and looked after children services in July 2013, which were judged as ineffective and inadequate, respectively.

The Department for Education issued Norfolk County Council a Directions Notice and an Improvement Board was established to address some of the serious issues that emerged from the collective inspection findings. With this, there was a change of leadership within Children's Services and a corresponding change of chairing arrangements for the Norfolk Safeguarding Children Board (NSCB).

This has been a challenging year for Norfolk, however, the Board has embraced the challenge and is committed to improving the partnerships' safeguarding arrangements and outcomes for children and young people. With change comes opportunities to build on our strengths and address our weaknesses. The Board now benefits from stronger leadership focus and direction and is supported by improved intelligence. Clear priorities have been established and the governance and impact of the Board's work has improved.

2: NSCB Change Programme (2013 - 14)

By the time the Directions Notice was received, the Board had implemented a change programme under the leadership of the then Chair, Colin Chapman. The proposal for the change programme was brought to Board in September 2013 in a paper which set out proposals to improve the structure and governance arrangements for the NSCB, with a view to ensuring that the NSCB provides an increased level of scrutiny and challenge to safeguarding children arrangements in Norfolk. This was a direct response to the Ofsted judgements of safeguarding arrangements which stated

> *"The work of the NSCB is underdeveloped…..Progress in ensuring a cohesive multi-agency approach and response to safeguarding has been slow; governance arrangements have taken a long time to become embedded and some partners report poor accountability and inefficient working, which is leading to inactivity."*

The proposal was set out alongside the work being undertaken with the Improvement Board to ensure that all partners were committed to the improvement journey and clear about their roles and responsibilities.

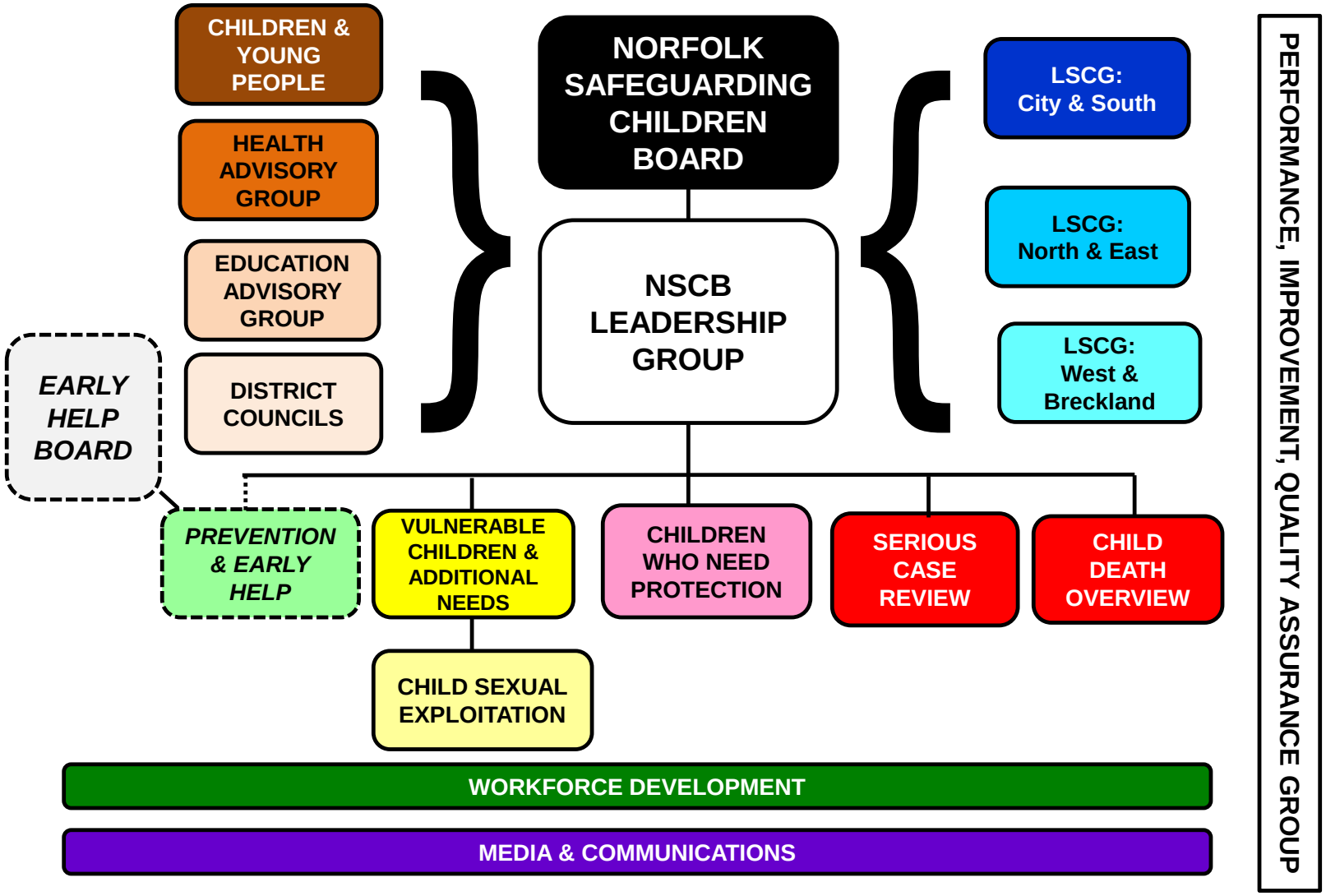
The change programme was implemented in Sept 2013 and with it a review of all the subgroups and the Board's structure.

2.1 The NSCB Board Structure

One of the key elements of the change programme was to review the Board structure to better align its strategic objectives with business management. This has led to a much improved focus on partnership arrangements, including setting Board priorities and improved governance and performance management arrangements. The significant changes to the new structure are:

- An established leadership group that meet on a regular basis between Board meetings
- The review of the Monitoring and Evaluation Group, which is now rebranded as the Performance, Improvement and Quality Assurance Group (PIQAG).
- The establishment of discrete advisory groups covering Health, Education and District Councils

The Board Structure



NSCB Governance Arrangements from 2013 - 2014

In addition to the Board's quarterly meetings, two extraordinary meetings were held in May 2013 and March 2014. The May meeting was arranged to co-ordinate the partners' response to the Ofsted inspection findings from the Board's perspective and to begin the planning for the revised structure, above. From the outset, it was clear that the governance arrangements needed to be strengthened, with greater clarity about partners' roles and responsibilities as well as challenging their commitment and capacity to make the necessary changes to improve safeguarding arrangements for children.

The Leadership Group has been an extremely effective mechanism for supporting the change programme and developing governance arrangements. Sitting on this group are:

- The Chair of the NSCB
- The Director of Children's Services
- The Norfolk Constabulary's Head of Vulnerability and Partnerships (from April 2014 Head of Safeguarding and Harm Reduction)
- Norfolk & Waveney Clinical Commissioning Group's Director of Quality Assurance - Chair of Health Advisory Group
- Norwich City Council's Head of Local Neighbourhood Services - Chair of District Council Advisory Group
- Primary School Headteacher – Chair of Education Advisory Group
- Chief Executive of Momentum, Norfolk's umbrella organisation for Voluntary and Community sector organisations that work with young people
- The NSCB Business Manager

The Leadership Group's first task was to ensure that the subgroups were working effectively, with appropriate chairing arrangements and membership. It was agreed that all subgroups would be chaired by Board members, or appropriate deputies, such as Children's Services Assistant Director. The exceptions to this are the Workforce Development Group and the Media and Communications Group, which are chaired by experts in those fields.

The other significant shift is the reporting arrangements: the Leadership Group are responsible for setting the agenda and take direction from PIQAG on the issues arising from data and audit/case review activity. As a result, all partners have fed back that the Board meetings are much more business-focused and productive, which in turn reinforces their commitment to the Board.

Colin Chapman took up post as Chair in April 2013 and came to Norfolk with a strong background in chairing multi-agency partnerships, performance management and equality and diversity. Between April 2013 and January 2014, his leadership skills brought new direction to the Board and partners welcomed his refreshing and challenging approach. However, throughout this period Colin was conscious of his relative lack of experience in the safeguarding arena, particularly in light of the significant challenges faced by Norfolk. After leading the Board successfully through its governance review, Colin recognised that Norfolk needed a different set of skills and increased capacity for the next stage of the journey to outstanding. The priority

for the Board is to ensure that we get it right for the children and young people. Colin, therefore, took the difficult decision to stand down as Chair in order to ensure that the Board moves forward under the leadership of someone with a proven track record in improving safeguarding performance and standards.

Arrangements for an Interim Chair were put in place and David Ashcroft, current chair of South Tyneside Local Safeguarding Children Board, was appointed. David has worked with several Boards in Local Authorities judged to be inadequate and came to the role with a track record of success in improving frontline safeguarding and child protection services.

David formally started at the end of January 2014. In the last two months of the 2013 – 14 financial year, David and Colin worked jointly during a formal handover period, which ensured that the transition arrangements were smooth and robust. One of the key focuses during this period was to further strengthen the Board's governance and an extraordinary meeting was held in March 2014. The key outcomes of this meeting were to agree the Board's priorities, publish a Governance Handbook and enable David to report to the Department for Education on the progress the Board had made in improving safeguarding arrangements in Norfolk.

NSCB subgroups – purpose and priorities

With the change programme, all the subgroups reviewed their Terms of Reference to re-establish their purpose and priorities. A brief summary of each subgroup is below. Further detail on the outcomes and achievements of each subgroup is included in Sections 3 and 4 of this report.

Leadership Group
Chair: Independent Chair of the Board

The Leadership Group sits between the subgroups and the Board. The purpose of the Leadership Group is:

- To develop and embed the Board's vision and values so that all children and young people in Norfolk can expect high standards in safeguarding
- To develop the NSCB Business Plan and Change Delivery plan for approval by the Board
- To monitor the implementation of the NSCB Business Plan and Audit Programme
- To identify national and local issues relevant to the responsibilities of the Board and progress as appropriate
- To commission additional work streams not previously included in the Business Plan
- To develop the NSCB meeting agenda
- To review & monitor single and multi agency audit activity.
- To maintain regular overview of budget and enable better decision making at Board on income and expenditure
- To enable Board partners to meet their statutory duties as laid out in Working Together 2013

Performance Improvement & Quality Assurance Group (PIQAG)
Chair: Head of Safeguarding and Harm Reduction Departments, Norfolk Constabulary

The Performance Information & Quality Assurance Group (PIQAG) is effectively the 'engine room' of the Board. The group is made up of all the Subgroup Chairs to enable the Chair to maintain an overview of all the Board's work and the impact that it is having on children.

PIQAG is responsible for developing and implementing the NSCB's audit framework and monitoring and evaluation strategy with a focus on:

- Enabling the NSCB to be confident that it is effective in meeting its statutory obligations as outlined in Working Together 2013 (Chapter 3).
- Ensuring that the Local Authority and Board partners, and the Board, have clear and mutual understandings of key information about safeguarding issues and activities.
- Ensuring that the NSCB is effective in respect of activities for which it has some coordination or monitoring responsibility.
- Ensuring that new or revised policy and guidance is effectively developed and embedded.

In addition the PIQAG is responsible for;

- Developing and implementing a SMART work plan in order to address the prioritised issues as allocated to the group by the Leadership Group or those identified by the group through analysis of data
- Monitoring the implementation of the recommendations (recorded in the Composite Action Plan) developed in the context of Serious Case Reviews and Multi Agency Reviews in coordination with the Serious Case Review Group.
- Evaluating the impact of these recommendations and review the sustainability of any improvements as a result.
- Improving countywide cohesiveness in NSCB's work through commissioning, guidance and close working relationship with LSCGs
- Establishing performance monitoring arrangements for NSCB, including
    - developing and finalising a set of key performance indicators
    - identifying areas of performance where there are concerns and directing audit activity to review them
- Evaluating multi-agency working identifying the quality of practice and lessons learnt in terms of both multi-agency and multi-disciplinary practices
- Presenting recommendations and findings from review, assessments and audits to the Leadership Group and to highlight any activity required
- Identifying best practice, and make information available on this to the NSCB and its sub-groups and committees.

PIQAG reports directly to the Leadership Group who use the information provided to set the agenda for Board meetings.

Workforce Development Group
Chair: Independent Chair, UEA

The WDG supports the NSCB fulfilling its responsibilities to ensure that the workforce is well trained in safeguarding arrangements and legal requirements. The WDG is responsible for ensuring:-

- both single and inter-agency training is delivered to a consistently high standard, and that a process exists for evaluating the effectiveness of training and
- that all individual members of the workforce who have contact with children, families or parents are recruited and trained to a standard that facilitates effective safeguarding of children, and
- that partner agencies have robust processes and procedures for addressing concerns about the suitability of employees to work with children.

Currently the NSCB delivers three types of training:

- Multi-agency training – There are a range of courses being delivered and the main contractor for this is Barnardo's. Within this arrangement, the WDG can commission additional training in response to recommendations from serious case reviews, multi-agency audits and national trends.
- The Safer Training programme is for personnel working either in the voluntary and private sector or for statutory organisations who come into infrequent contact with children and young people such as the Fire Service. There are a range of courses offered and the WDG monitors the training outcomes and oversees the quality assurance for this programme.
- The Early Years programme has been commissioned by the Norfolk Early Years team to provide a range of courses specifically aimed at practitioners working in the Under 5s sector. Again the WDG oversees and monitors this.

NSCB Best Practice Group (sitting beneath WDG)
Chair: NSCB Workforce Development Officer

Sitting beneath the WDG is the Best Practice Group. The NSCB holds quarterly workshops on particular safeguarding issues with multi-agency operational and strategic managers to consider key safeguarding issues and new legislation and guidance. Workshops topics relating to the Board priorities, with a focus on learning from serious case reviews.

In addition to Best Practice workshops, the group also runs smaller roadshow programmes across the county normally in response to a training need identified through case reviews.

Media and Communication Group
Chair: Customer Service and Communications Manager, Norfolk County Council

Media and Comms supports the NSCB in fulfilling one of its key functions in raising awareness of safeguarding issues by communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising awareness of how this can best be done, and encouraging them to do so.

Future developments to this group include closer working with the Adults Safeguarding Board for a more joined up approach to raising awareness around community safety

Vulnerable Children Group
Chair: Head of Norfolk Youth Offending Team

In March 2012 the Board approved the creation of a new sub-group focusing on particularly vulnerable children, to include:

- Privately Fostered children
- Children whose Parents Misuse Substances
- Children Missing From Education
- Young Offenders
- Children who have been exposed to Domestic Abuse or Violence

Each meeting has a lead professional who produces a report for discussion, based on 'Turning the Curve' methodology.

Children at risk of sexual exploitation and abuse (CSE)
Chair: Head of Vulnerability and Partnerships (from April 2014 Safeguarding and Harm Reduction), Norfolk Constabulary

Children at risk of Sexual Exploitation (CSE) subgroup form a distinct category of vulnerable children, although many of them will also fall within the groups identified above. This subgroup meets bi-monthly to consider prevention, education and different approaches/responsibilities to protecting children at risk of sexual exploitation in Norfolk. There are four distinct workstreams to this subgroup including: data & mapping; referral and assessment; training and awareness raising; developing practical intervention.

Child Protection Group
Chair: AD Social Care, Children's Services

This subgroup did not meet in 2013 – 14, however, the focus of the subgroup was agreed in response to the need to improve multi-agency working around children in Section 47, including initial child protection conferences, review conferences and core groups. The subgroup will also monitor the rate of re-referrals and the length of time children spend on CP plans.

Serious Case Review Group
Chair: Independent Chair of NSCB

The SCRG makes all decisions regarding conducting serious case reviews under Chapter 4 of the guidance Working Together to Safeguard Children 2013, where

children have died or been seriously injured as a result of abuse or neglect. Where criteria to undertake a Serious Case Review are not met, the SCRG may agree to conduct single and multi-agency management reviews.

The primary purpose of undertaking these reviews is to ensure that lessons are learned and safeguarding practice is improved. The recommendations from the reviews are incorporated into a single Composite Action Plan, which is reviewed by all agencies, both as individual organisations and at PIQAG. Actions are RAG rated to monitor progress towards improved safeguarding practice.

Child Death Overview Panel
Chair: Designated Doctor

The CDOP undertakes an overview of deaths of all children up to the age of 18 in Norfolk. It also has responsibility for the Rapid Response Team which provides support and scrutiny when a child dies unexpectedly at home. This is a paper based review, based on information available from those who were involved in the care of the child, both before and immediately after the death, and other sources including, perhaps, the coroner.

CDOPs are subject to guidance in Chapter 5 of Working Together to Safeguard Children, 2013, including:

- reviewing all child deaths up to the age of 18, excluding those babies who are stillborn and planned terminations of pregnancy carried out within the law
- collecting and collating information on each child and seeking relevant information from professionals and, where appropriate, family members;
- discussing each child's case, and providing relevant information or any specific actions related to individual families to those professionals who are involved directly with the family so that they, in turn, can convey this information in a sensitive manner to the family
- determining whether the death was deemed preventable, that is, those deaths in which modifiable factors may have contributed to the death and decide what, if any, actions could be taken to prevent future such deaths;
- making recommendations to the LSCB or other relevant bodies promptly so that action can be taken to prevent future such deaths where possible;
- identifying patterns or trends in local data and reporting these to the LSCB;
- where a suspicion arises that neglect or abuse may have been a factor in the child's death, referring a case back to the LSCB Chair for consideration of whether an SCR is required;
- agreeing local procedures for responding to unexpected deaths of children
- co-operating with regional and national initiatives – for example, with the National Clinical Outcome Review Programme – to identify lessons on the prevention of child deaths.

Advisory Groups

As part of the governance review in 2013 – 14, it became clear that the Board need to improve communication in three sectors: Health, Education and District Councils, which was an issue highlighted in Ofsted inspection report published Feb 2013. In

each of these areas, there is often variation in the way services are delivered and/or lack of understanding from partner agencies to the significance of the variations. It was also recognised that in a county the size of Norfolk requires additional co-ordination to ensure that the large and geographically challenged workforce are supported with clear and consistent messages around safeguarding priorities.

Health Safeguarding Advisory Group
Chair: Great Yarmouth & Waveney CCG, Director of Quality & Safety

The Health Safeguarding Advisory Group (HSAG) meets quarterly and includes all the local and regional health partners:

- 5 CCGs and the Designated Team
- NHS England: regional commissioner
- 3 Acutes
- 2 Community Health Care Providers
- Norfolk & Suffolk Foundation Trust (Mental Health)
- Public Health
- Ambulance Services

The HSAG is an opportunity for the health professionals, both providers and commissioners, to convene and discuss safeguarding issues from a purely health perspective and advise the Board on themes emerging, such as increased incidents of self harm. Representation on the Board can be streamlined as the number of providers and commissioners can give assurances that the views of all in their sector are represented through HSAG.

Education Advisory Group
Chair: NSCB Norfolk Primary Headteacher Association (NPHA) representative

The Education Advisory Group (EAG) meets termly to review actions specifically for schools and develop strategies for ensuring that the safeguarding agenda is taken forward by their colleague headteachers and governors. The EAG has representatives from:

- Primary schools
- Secondary Schools
- Special Schools
- Independent Schools
- Where appropriate, managers from Children's Services also attend.

There are 450 schools and academies in Norfolk. The EAG are key to supporting effective communication with this largely autonomous universal service, ensuring that the Board has a mechanism through which to reach them and get their feedback on issues such as children missing education and promoting awareness of child sexual exploitation.

District Council Advisory Group
Chair: Head of Local Neighbourhood Services, Norwich City Council

The District Council Advisory Group (DCAG) convened in Nov 2013 and includes representatives from all seven district councils. The purpose of the group is to recognise the variations, for example, housing arrangements and ensure consistency in safeguarding children. The DCAG is committed to ensuring that all Norfolk's District Councils are meeting their duties and obligations under the Children Act 2004 and Working Together 2013 and increasing the visibility of the district council functions in the work of the NSCB.

Children and Young People Shadow Board

The Board is also supported by a Children & Young People Shadow Board. They report regularly to Board and are key to highlighting safeguarding issues that matter to them. Their feedback is crucial for all members to know that we are getting it right across the spectrum, from direct service delivery to the production of literature and promotional material. This group was established in 2013 – 14 and will in the future take an active role in LSCB business planning events.

Local Safeguarding Children Groups

There are three LSCGs, reflecting the operational divisions within Norfolk County Council. These are North & East, City & South and West & Breckland Local Safeguarding Children Groups. LSCGs operate within the broader remit of the NSCB and promote the safeguarding agenda within their respective areas.

Chairs	
North & East	Cathy Mouser, Children's Services Operational Manager Ali Jennings, Named Nurse East Coast Community Health Jane Worsdale, Headteacher (Primary)
City & South	Paul Corina, Children's Services Operational Manager
West & Breckland	Ann McKendrick, Children's Services Operational Manager

LSCGs deliver the strategic vision and objectives of the Board at a tactical level, that is:

- promoting and enabling co-ordination and co-operation between agencies working with children and families
- undertaking local level evaluations of effectiveness
- proactively taking the lead on safeguarding issues to promote the welfare of children in the respective local areas

LSCGs ensure effective front line coordination of agencies to safeguard and promote the welfare of children and act as a key link in ensuring that knowledge and intelligence from the local groups informs Board policy making and decisions.

3: Working Together to Safeguard Children

Working Together was reissued on 21 March 2013, so this financial year the changes were embedded into practice. The Board's effectiveness in working together can be summarised in terms of:

- Engagement and Participation
- Section 11 compliance
- Learning and Improvement
- Multi-Agency Training and Workforce Development
- Policy and procedure
- Financial arrangements

3.1- Engagement and Participation

This year marked the establishment of an NSCB Shadow Board to better enable children and young people to get involved with the work of the Board. The Shadow Board is made up of a range of young people with direct experience of safeguarding practice, including:

- teen disability with reference to the CAFs – now Family Support Process of FSP - and social work involvement)
- the Norfolk In Care Council (NICC)
- the Mancroft advice project, including experience of child protection conferences and teenage parenting
- young people from the disabled parents' network with reference to CAF/FSP

In August 2013, the group undertook a structured training programme around:

- The function of the NSCB
- What is safeguarding
- Confidentiality and personal boundaries
- A shortened version of the Safer training course
- A session around resilience and personal wellbeing

Phase two of the implementation of the Shadow Board started in September 2013, when it became operational. This involved continued training around co-production, presentation skills and other practical skills relevant to the work. These were practical pieces of work and did not require separate training sessions. The outcome of this was a Shadow Board presentation to the board in December 2013, where the group addressed the issue of child sexual exploitation (CSE). The young people reported on progress with their practical sessions and requested feedback from Board members on how they can contribute in the future.

There are ongoing challenges about recruitment and retention of Shadow Board members, however, with a set project on raising awareness of CSE in 2014 – 15 and other projects proposed, the forecast is good for continuing engagement.

The value that the young people place in this work was recognised when the Norfolk In Care Council (NICC) awarded the NSCB Business Manager, Abigail McGarry, an Inspirational Adult Award in April 2014. They said:

Abigail has complete faith in us and for our first piece of work asked us to look at child sex exploitation. Few managers would have thought that we could deal with such a horrible subject but actually we did and we think we did well. We as part of the shadow board have offered advice on how to handle a marketing campaign, how and who it should be targeted at. We have also been able to look at it from a looked after child's perspective and identify some things we believe makes us more vulnerable and have offered recommendations on how to address some of these… She made sure we were well protected during this work and is one of the few managers that is not scared to give constructive criticism. This alone shows she values us; so many managers are scared to criticise our work but she gets that that is how we learn and that is how discussions happen and that is how mutually respectful relationships are made.

Engagement at senior leadership level has improved, particularly with the establishment of the Advisory Groups, however, further work is required. Attendance at Board remains variable.

Organisations/ Agencies	Total attendance	Total meetings
NSCB Independent Chair	3	4
Children's Services	4	4
Adult Social Care	2	4
King's Lynn District Council	0	4
Breckland District Council	1	4
North Norfolk District Council	2	4
Great Yarmouth District Council	2	4
Broadlands District Council	1	4
Norwich City Council	4	4
South Norfolk District Council	1	4
Special Schools rep	3	4
Primary Schools rep	4	4
Secondary schools rep	3	4
NCC YOT	4	4
Norfolk Constabulary	4	4
Norfolk & Suffolk Probation Trust	3	4
CAFCASS	4	4
NHS England	1	2
Acute Hospital Trusts	4	4
Community Health Care Providers	3	4
East Coast CCG: children safeguarding CCG lead	3	4
Norfolk & Suffolk Foundation Trust (Mental Health)	4	4
East of England Ambulance Service NHS	1	4
Public Health Services	0	1
Momentum – Voluntary Sector	2	4

On average 66.3% of statutory partners attended over the course of the year. Attendance continued to be an issue in 2013 – 14, largely due to the significant number of District Councils in Norfolk and low attendance from some areas. This issue was addressed towards the end of the financial year, with the establishment of the District Council Advisory Group. Partners from District Councils have fed back that this structure improves their engagement as they can give and receive messages to Board, while at the same time focusing on safeguarding issues, such as homelessness, welfare reform and licensing, in a more meaningful way with the DCAG. The Chief Executives fully endorsed this as a way forward and have renewed their commitment to the NSCB by supporting the development of the DCAG.

Attendance is an area that the Chair will be addressing in 2014 – 15. Some apologies were noted due to changes of leadership, for example, in the voluntary sector.

The structure and agendas of meetings have improved and partners have reflected that the Board meetings are more focused, which has contributed to increased commitment to attend Board, with partners taking more active roles.

Attendance at Leadership Group has been 100% since it was established. Advisory Groups are well attended to support communications to and from the Board to the sectors represented, i.e. Health, Education and District Councils.

Leadership Group has also reviewed the membership, roles and responsibilities of agencies at subgroups.

3.2 Agency Section 11 compliance

The Section 11 returns showed that all agencies' compliance with safeguarding has improved between 2012 – 13 and 2013 – 14. Comparator diagrams and agencies' RAG rating is included as Appendix 1.

Over the last three years, the direction of progress for most of the statutory agencies appears to be positive. Partners' self-assessment against staff training, inter-agency working and involvement of children and families, is reported as progressing. Developing appropriate policy procedures, and ensuring safe staffing via recruitment and training have been prioritised and improved. There have also been greater efforts towards effective inter-agency working practice and information sharing.

Progress across partner agencies, however, is inconsistent: Some agencies have used the S11 self-assessment process extremely effectively and have focused on areas of improvement and made excellent efforts to improve. The improvement plans have been monitored by senior level staff within the agency and have been internally reviewed by single executive committees. For some others it has not been given appropriate significance and the improvement action plans have not been implemented effectively.

In February 2014, the PIQAG agreed that the NSCB approach to S11 needed developing to make it more challenging: From the beginning the role of the NSCB

S11 in the self-assessment process stressed facilitating improvement by agencies' self-scrutiny and taking on the role of 'critical friend'. Though the NSCB can drive improvement it does not sufficiently allow the opportunity to hold partner agencies accountable to each other. Currently, a sense of accountability is not in evidence. Therefore, there is a need for a stricter approach to the process of self-assessment and for the NSCB to scrutinise organisations' self-assessments and o hold agencies accountable when improvement is not made. Changes to the way the S11 process is proposed to be carried out in the future include:

- Developing a S11 assessment tool so that, in addition to a more comprehensive 'single agency compliance', a supplementary section on evidence of improvement on SCR and other multi-agency audit recommendations is also included
- The NSCB will carry out S11 standards audits across agencies to triangulate self-assessments as well as independently verify and establish levels of standards across agencies
- The NSCB Chair will hold the agencies to account based on the evidence provided in the S11 returns through structured "challenge" meetings. The outcome of these meetings will be reported to Board so that the statutory partners can maintain an overview of the self-assessment process and provide further challenge as appropriate

3.3 Learning and Improvement

A Learning and Improvement Framework went to the then Monitoring and Evaluation Group (now PIQAG) in Jul 2013 and was agreed at Board in Sept 2013. This document outlines the NSCB's approach to learning and improving across the safeguarding system, which is to:

- Create a 'learning' culture
- Define ways of knowing
- Establish the types of information the NSCB gathers, including how and what it is used for
- Establish performance management arrangements across the partnership
- Outline processes for disseminating learning
- Outline the Board's process for monitoring and evaluating the impact of learning and improvement on safeguarding arrangements

The challenge for the NSCB was – and still is - to establish mechanisms for sharing information around both good practice and challenging poor practice to and from the Board consistently. The work of the sub groups was recognised as an opportunity to gain a wider perspective on the system. Clearly many lessons can be learned through serious case reviews, but the Board has a wealth of data, case audits and local intelligence to draw from and the voice of the child must be central to all our learning.

The NSCB needs to demonstrate how well partners work together to safeguard children. The ways of knowing, i.e. the evidence the Board requires, include:

- quantitative information, underpinned by an agreement which identifies what data will be shared, by whom and how often
- qualitative information, drawn from serious case reviews and audits
- outcomes from feedback and surveys of both children and their families as well as the workforce on the frontline
- reference to national research

Quantitative Information: Data

The Board's progress in terms of gathering and using data has been slow. In Jul 2013, a workshop was held with key partners from Children's Services, Health and the Police, including the relevant data officers, to agree a performance scorecard. This was identified as a key weakness in the Ofsted inspection. Progress has been hampered, initially by Children's Services and subsequently by some partners' inability or unwillingness to share information against the agreed indicators.

Towards the end of the 2013 - 14, the Board made a significant step change in the quality of data it had access to, when Children's Services Interim Senior Leadership Team resolved their internal performance management issues. By March 2014, the Board had high quality, reliable data relating to Children's Social Care, which has enabled the Board to identify a number of core issues relating to contacts, referrals and the application of threshold guidance. With the emergence of this information, come challenges to partners, not only in terms of how the safeguarding arrangements and risks are managed, but also about the way they gather and monitor intelligence within their own agencies.

Further drilldown into data in terms of the Child's Journey is included in Section 4, below. The NSCB will continue to develop its scorecard in 2014 – 15, with a view to establishing a dashboard of indicators to be tabled as a standing item at Board meetings.

Serious Case Reviews and Multi-Agency Reviews

The Board commissioned two Serious Case Reviews (SCRs) in 2013 – 14, Case L and Case M, which are due to be published in August 2014 and February 2015, respectively. Case M is of some significance as it was previously investigated as a Multi-Agency Review (MAR) as Child J; the findings from that were taken to Board in March 2013 and the MAR was officially signed off in April 2013. There are a number of reasons that the case came back to the Serious Case Review Group (SCRG), namely that an incident of abuse re-occurred despite the MAR taking place, which indicates significant challenges to the Board in terms of implementing the learning. This has been picked up in the current SCR's Terms of Reference.

In addition to Child J, two further Multi-Agency Reviews (MAR) were signed off in 2013 – 14, Child I and Child K. Child K was completed within nine months, which is an improvement from previous MARs, and was presented to Board in Sept 2013. More work is required in the timeliness of conducting the reviews. The NSCB Business Manager rewrote the guidance for SCR processes, which were signed off by SCRG in Sept 2013.

The common themes for these MARs were:

- neglect and sexual abuse remain ongoing issues for Norfolk (see Section 5 below on Board priorities)
- poor understanding of thresholds and when to refer/re-refer
- poor information sharing places barriers on partners working effectively together
- losing sight of the child

Dissemination of this learning was undertaken through a series of roadshows (see 3.4 below). As much of the review process undertaken in recent years has been discretionary, i.e. conducted as Multi-Agency Reviews rather than SCRs, the reports have not been published and this has inhibited effective sharing. This issue is being addressed in the current Case M SCR.

The SCRG regularly monitors the progress against the recommendations from previous SCRs and MARs in its Composite Action Plan (CAP). A significant number of recommendations were evidenced as implemented and embedded during the course of 2013 – 14. The quantity has fluctuated as more recommendations were added, but overall there has been a reduction from 61 to 44. The recommendations marked as amber in the traffic light system have not shifted as quickly and the multi-agency recommendations have increased.

The tables below show where the activity has shifted in terms of agency's ownership and themes emerging. There has been a significant shift within themes: historically, there has been a pattern that at between a third and a half of all recommendations are related to policies and procedures. At the end of this year, that had reduced to just over a quarter (27%), while there has been a significant increase in recommendations around practice standards moving from 16% (10/61) in April 2013 to nearly 39% (17/44) at year end.

Current CAP recommendations by agency								
	Apr-13	Mar-14	Apr-13	Mar-14	Apr-13	Mar-14	Apr-13	Mar-14
	RED	RED YEAR END	AMBER	AMBER YEAR END	GREEN	GREEN YEAR END	TOTALS	TOTALS YEAR END
City Council	1	0	1	1	2	0	**4**	**1**
Children's Services	6	0	1	7	7	3	**14**	**10**
Education	0	0	2	1	3	0	**5**	**1**
Health	0	0	1	0	1	2	**2**	**2**
LSCB/NSCB	1	0	14	2	4	0	**19**	**2**
Multi-Agency	5	5	9	9	1	4	**15**	**18**
Police	0	0	0	7	2	1	**2**	**7**
CPS	0	1	0	0	0	0	**0**	**1**
DASVB	0	0	0	1	0	0	**0**	**1**
TOTALS	**13**	**6**	**28**	**28**	**20**	**10**	**61**	**44**

Current CAP recommendations by theme								
	Apr-13	Mar-14	Apr-13	Mar-14	Apr-13	Mar-14	Apr-13	Mar-14
	RED	RED YEAR END	AMBER	AMBER YEAR END	GREEN	GREEN YEAR END	TOTALS	TOTALS YEAR END
Policy/ Procedures	6	3	14	7	4	2	**24**	**12**
Practice Standards	5	2	1	12	4	3	**10**	**17**
Early Intervention/FSP	0	0	0	1	6	1	**6**	**2**
Learning and Improvement	0	1	2	1	2	0	**4**	**2**
Traiing	2	0	7	3	2	1	**11**	**4**
Audit	0	0	4	2	2	3	**6**	**5**
Audit (single -agency)	0	0	0	2	0	0	**0**	**2**
TOTALS	**13**	**6**	**28**	**28**	**20**	**10**	**61**	**44**

By year end, we had reduced our red traffic lights by over a half, from 13 to 6, however the amber traffic lights have remained static. The challenges for the Board are to improve our response to multi-agency recommendations and agree actions to move the amber traffic lights forward at a greater pace.

The CAP has gone regularly to Board and each agency has been asked to continue to provide evidence of progress. This will be further supported with the development of the S11 self-assessment process.

Qualitative Information: Audit and Evaluation Activity

Audit and evaluation activity focused on four key areas:

- audit of child protection conferences: organisation, administration, reports and attendance
- evaluation of the effectiveness of the pre-birth protocol
- audit of the Journey of the Child, focusing on cases of re-referrals
- audit of Child Sexual Abuse investigations that ended in No Further Action (NFA)

The audit of child protection conferences resulted in four key recommendations linked to: agencies taking responsibility for quality assuring the reports that go to conference; ensuring that the social work reports capture the voice of the child; ensuring that the independent chairing service is consistent across the county; and evaluating the attendance of multi-agency partners at conference. The recommendations were picked up by the Independent Chairing Service Manager and a subsequent audit is planned to monitor how effectively they have been implemented.

The pre-birth protocol was picked up as an issue in the Ofsted inspection. The evaluation activity focused on how well the protocol was understood by staff, rather than the quality of its implementation. The evaluation was positive on three counts: dissemination, awareness raising and facilitating good practice. This is an area that will need to be revisited as part of ongoing audit planning.

The Journey of the Child audit was a significant piece of work. The audit was commissioned as a result of ongoing monitoring and analysis of the rate of re-referrals in Norfolk, which has increased steadily, in contrast to the statistical neighbour average which is decreasing. This trend raised questions about the effectiveness of multi-agency interventions to safeguard and protect in relation to

achieving sustainable positive outcomes for children and young people in Norfolk. The multi-agency audit was carried out to explore what can be learnt from these cases to improve practice.

The audit resulted in a number of recommendations:

- improving the way we identify high risk re-referral cases which will alert workers to deal with complex cases
- Social workers' reports should incorporate full chronology, including identified risk factors in the past and how many times particular types of interventions were tried, not only for the child under concern, but also others in the family. Also the number of times CP was carried out and what outcomes were achieved
- The NSCB template which is used by other agencies to provide single agency conference reports should be revised
- Timeliness of sending reports to the conference chair needs to improve
- CP conference should be more focused on risk factors
- The CP plan must be a SMART document with specific time scales and expected outcomes. It must also include dates of the meeting, identified risks, children's needs and expected outcomes, and not just list a number of actions. Dates should be specific to achieve expected outcomes.
- Use of written agreements must be reviewed by Children's Services and used only when they can be monitored
- Categorisation of complex cases should be reviewed
- An effective step down must be ensured before children are de-registered. At the first review conference for complex cases (which repeatedly comes back to the social services) exceptions should be made to consider sustainability before deregistering
- NSCB should provide guidance for managing complex cases to allow some exceptional practice for sustaining positive outcomes for children
- There should be more effective and regular attempts to ascertain children's wishes and feelings and evidencing that the focus is on the child rather than on parental needs. The voice and needs of the child are paramount
- Better joint working and communication between professionals is needed throughout a child's journey and not only when a child is on Section 17 or 47. All agencies must encourage and maintain professional communication whilst keeping the child's safeguarding in focus
- Conference attendees' list must include all agencies working with the family. A record of name, agency, phone number and e-mail contact must be kept
- Work shadowing could break down the barriers between teams and agencies and lead to more shared understanding of thresholds, etc.

Implementation for some of these recommendations has already begun; they will be monitored regularly by the newly established Child Protection Group and incorporated into a Composite Action Plan for RAG rating in the future.

The audit Child Sexual Abuse investigations that ended in NFA was commissioned in response to the Multi-Agency Reviews. The audit process started in February 2014 and findings will go to PIQAG in 2014 – 15.

Local Authority Designated Officer (LADO) report

The LADO report went to Board in Dec 2013 to enable the NSCB to monitor how well we deal with allegations against professionals. This was a retrospective report relating to 2012 – 13.

Out of 385 referrals, the number of all LADO allegations which resulted in initial meetings (160 strategy and Management Evaluations Meetings or MEM meetings) is 41.6%. Nearly half of all the referrals that met the criteria may have been dealt with by the agency/employers dealing with the allegations through their internal management processes, and some may have been No Further Action

In 2013 – 14, the staffing team have worked together to develop an effective electronic case management system, however, challenges remain around capturing collection of digital information, which would give easy identification of themes, i.e. types of employment, allegations of harm, categories of harm.

The LADO team has raised their profile by providing training for other agencies, both statutory and third sector agencies. They have made links with the Early Years Senior Management Team, which led to improved outcomes for young children in Early Years settings by increasing the understanding of the LADO role. Co-working with Education Safeguarding Adviser has enabled schools to feel more confident in the role of the LADO, evidenced by some of the positive comments received from Heads who contacted the team. It also allowed for informed discussions on the more complex cases where a discussion is required as to the "best way forward" for both the young person and adult subject to an allegation.

Working with Human Resources has improved and there is now on-going dialogue between disciplinary issues and the LADO, using the Guidance for Safer Working Practice for Adults who work with Children and Young People as the framework for discussion. This was supported by the Board's revisions to Safer Staffing.

Links with the Roman Catholic Diocese of East Anglia Safeguarding Commission resulted in a number of referrals relating to those working within the church community.

In 2013 – 14, the LADO team started making greater use of teleconferencing, thus allowing participants to attend meetings without having to travel great distances, and enabling a greater participation and subsequent protection of young people.

The LADO report also detailed ongoing challenges around:

1. Chairing of Strategy meetings by Senior Managers has, at times, been difficult to organise due to their competing demands. This was resolved in January 2014 when LADOs started chairing their own Strategy meetings.
2. A small number of allegations regarding foster carers have been very complex and time consuming due to the need for legal advice or to contribute to Court proceedings.
3. A number of issues were identified around private health resources, who provide resources to very vulnerable young people, both from with Norfolk and from other counties across the country. By working closely with

colleagues within health, these issues are being challenged together and outcomes for young people are improving. Issues related to inappropriate restraints and restrictions on young people movements within the establishments.

4. Historical allegations: There was an increase in the number of historical allegations of abuse where the alleged perpetrator does or did work with children and young people. These cases generally involve police investigations and take longer to resolve.
5. Young adults: There was a small increase in the number of young people who leave education and then immediately return to the establishment as a member of staff. These difficulties led to advice and work with schools to ensure that they have appropriate induction courses for staff and clear expectation about all staff behaviour with pupils. Staff need to be aware of the potential consequences of breaching some guidelines.

The Board has requested that the data from LADO investigations is improved and brought back in 2014 – 15 to enable partners to assess whether the issues noted above are being addressed effectively.

3.4 Multi-Agency Training and Workforce Development

There are four broad areas relating to multi-agency training and workforce development as follows:

- NSCB commissioned multi-agency training courses
- Best Practice events, including roadshows to disseminate learning from Serious Case Reviews and Multi-Agency Reviews
- The impact and reach of the NSCB's Safer Training Programme
- Learning events organised by the Local Safeguarding Children Groups

In addition, the NSCB joined forces with the Family Justice Board in March 2014 to hold a joint conference on safeguarding children at home and in the courts. Feedback from this event was extremely positive. One delegate commented that it was an *'excellent partnership event, demonstrating Norfolk's commitment to safeguarding best practice'*. Further events of this kind are planned for 2014 – 15.

NSCB training

The NSCB commissions the majority of its multi-agency training through Barnardo's. Throughout 2013 – 14 the Workforce Development Group (WDG) monitored the attendance and feedback of this training at its quarterly meetings. A full summary of attendance can be found at Appendix 2. There is a slight increase from 2012-13 to 2014, from 1201 to 1339 places filled, however, with an increase of training on offer the overall number of places available has reduced from 74% to 73%.

Barnardo's provided the WDG with feedback from training, starting from the type and number of training courses and linking this information with training evaluation. In total, there were 13 subject areas totalling 64 training courses delivered across the year; including additionally commissioned training around Graded Care Profile

(GCP). The full rollout of the GCP training was deferred to 2014 – 15 to align with the implementation of the Neglect Strategy. (See Section 5, Board priorities, below).

Course Title	Duration (days)	No. of courses delivered
Awareness of Challenges when working with parents	1	3
Child sexual exploitation	1	6
Domestic Abuse	1	6
Emotional Harm	1	6
Graded Care Profile (GCP[1])– No evaluations	1	1
GCP Train the Trainer – No evaluations	1	2
Making multi agency assessments work	1	12
Neglect	1	6
Physical Harm	1	3
Safeguarding Disabled Children (Non specialist professionals)	1	3
Sexual Abuse	1	6
Understanding Children & Young People who engage in sexually abusive behaviour	1	6
Supervision Skills	3	4

Collective analysis of evaluation samples

Item	% Participants who were confident or very confident	
	Pre training	Post training
Learning Outcomes	25%	91%
Relevance to role	7%	93%
Further professional development needs	6%	94%
Level training pitched	5%	95%
Knowledge of trainer	9%	91%
Materials and handouts	5%	95%
Booking and administration	8%	92%
Location of venue	4%	96%
The facilities at venue	11%	89%
Percentage of all courses rated as Good or Excellent	89%	

Overall, the training has had very positive feedback, with a significant rise in confidence with people who attended, although consideration must be given as to whether or not the pre-training aspect of the evaluation forms was completed in full. There are a number of challenges that the Board must still address, however, including:

- Unfilled training spaces: at 73% we are not training to capacity and need a better understanding of why spaces are not being taken up.
- Linked to the above, the WDG continue to struggle to get an accurate training needs assessment and workforce sufficiency data from key partners.
- The longer term impact of multi-agency training, combined with staff churn, requires ongoing monitoring
- The Barnardo's contract comes to an end in 2014 – 15: the tendering process is in place but a change in provider may bring additional challenges.

The chairing of the WDG changed early in 2014 – 15 and with it, we now have the expertise of the University of East Anglia, to provide greater direction to workforce development moving forward.

NSCB Best Practice events & SCR Road Shows

The NSCB continues to hold quarterly events for middle managers on key safeguarding issues. This year, the events focused on multi-agency assessments, Child Sexual Exploitation and Private Fostering. The focus in the final quarter was disseminating learning from Serious Case Reviews and Multi-Agency Reviews. The Board recognised that these messages needed to go beyond middle managers and reach the frontline so a series of five roadshows was organised across the county to support the learning. Attendance by agency is laid out in table below.

	MA Assessments	Child Sexual Exploitation	Private Fostering	learning from SCRs & MARs	TOTAL
Acute Hospitals	2	4	1	14	**21**
CAFCASS	1	1	0	8	**10**
Children Centres	3	0	0	12	**15**
Children's Services	20	23	17	57	**117**
Community Health	11	8	5	73	**97**
District Council	5	4	0	8	**17**
Early Years	0	0	0	12	**12**
Faith Groups	1	1	0	1	**3**
Further Education	1	0	0	0	**1**
Health	1	1	2	4	**8**
Home Office	0	1	1	0	**2**
Housing	3	0	0	10	**13**
Mental Health	3	1	4	6	**14**
Police	1	6	2	8	**17**
Probation	4	2	1	4	**11**
Schools	2	1	1	13	**17**
Voluntary Sector	5	8	3	58	**74**
YOT	0	1	1	14	**16**
TOTALS	**63**	**62**	**38**	**302**	**465**

All of the Best Practice events include presentations from relevant agencies and workshop exercises to promote learning and discussion. The PowerPoints are posted on the NSCB website so attendees can take the learning back to their teams and organisations for further dissemination.

All events have clearly defined learning objectives, for example, the objectives for the Best practice events and roadshows were to:

- Understand the Serious Case Review and Multi-Agency Review Process
- Have knowledge of the current Child Protection situation issues in Norfolk
- Understand the key learning points from recent Norfolk Multi-Agency Reviews
- Have considered the implications of this learning on practice
- Have considered how 'systems' impact on practice and the potential consequences of this impact
- Have an awareness of how NSCB Policies and Procedures relate to good practice

Up until spring 2013, the NSCB sought feedback using survey monkey, however, attendees often did not use this facility so we were not capturing the information. From Jul 2013, the NSCB improved its evaluation processes and started collecting feedback manually. Attendees were invited to complete an evaluation form at the end of the session and provide comments on the content. The NSCB uses this information for future planning. Feedback in 2013 – 14 was very positive.

The Session:	MA Assessments	CSE	Private Fostering	learning from SCR & MAR
met its learning outcomes	not collected	100%	100%	97.3%
was well organised		100%	100%	98.9%
included relevant information		97.7%	100%	98.2%
encouraged my participation		97.8%	100%	97.8%
increased my confidence in applying learning points to practice		97.8%	100%	98.1%
group discussions were focused		91.4%	100%	98.1%
RESPONSES OVERALL		**96.3%**	**100%**	**97.9%**

The NSCB's Workforce Development Officer now regularly follows up three to six months after the Best Practice events to assess what longer term impact the session had on practice.

In addition to the CSE Best Practice event, four further sessions were held for schools in Sept 2013. These sessions were tailored to ensure that schools awareness of the warning signs and indicators was raised as well as their understanding of resources available to promote health relationships. In total 117 people attended. Feedback on the effectiveness of the learning showed the sessions were 'very clear and informative'. Particular mention was made in relation to:

- The changes to the PSHE curriculum
- Young people's perceptions of relationships.
- Understanding where to go to access support and help.

Plans are in place for further awareness raising in schools in 2014 – 15.

NSCB Safer Programme

The NSCB Safer Programme continues to develop and meet the safeguarding procedural, policy and training needs of the voluntary, community and private sector of Norfolk. The Board considers the work of the Safer Programme to be a vital part of its overall commitment to the safeguarding and welfare of all children and young people in Norfolk, and will continue to ensure its successful operation. Since 2010, the programme has generated income to ensure that it is self sufficient.

The voluntary, community and private sector is very active in working to safeguard children and young people with whom they work and provides a key role in providing information and resources to the wider public about the needs of children. Safer is an inclusive programme aimed at all groups and organisations in the wide and diverse area of the voluntary, community and independent sector. The programme works closely with partner agencies in the statutory and voluntary sector to publicise resources and training. Information sheets are distributed throughout the County by a variety of means.

Organisations recognise their roles and responsibilities to children and young people in their care via a number of routes. They acknowledge the need to implement policies and procedures to safeguard children and promote their welfare. These organisations contact the Programme and register for an annual membership fee of £30.00. Once registered the group receives a free comprehensive resource Safer Pack. This covers all aspects of risk assessment for child protection issues. The pack includes a certification process, after the group has met pre-set standards through proof of documentation and verification; this is key to quality assuring safeguarding arrangements. The initial membership fee also carries two free initial training places and a further two free places after three years of continuous membership.

The Safer Certification process offers reassurance to parents/carers knowing the group has actively engaged with the Norfolk Safeguarding Children Board to ensure their setting is a safer environment.

The training offered by the NSCB Safer Programme has expanded significantly in the past four years. It now offers introduction level (group 1 and 2) courses around Designated Child Protection Officer, E-Safety, Safeguarding Children and Mental Health, Substance Misuse and Safeguarding and Understanding Domestic Abuse and Safeguarding.

Other training offered includes Core Programme level Child Protection training (group 3) for voluntary and independent agencies. This must be completed to access the further NSCB multi agency courses.

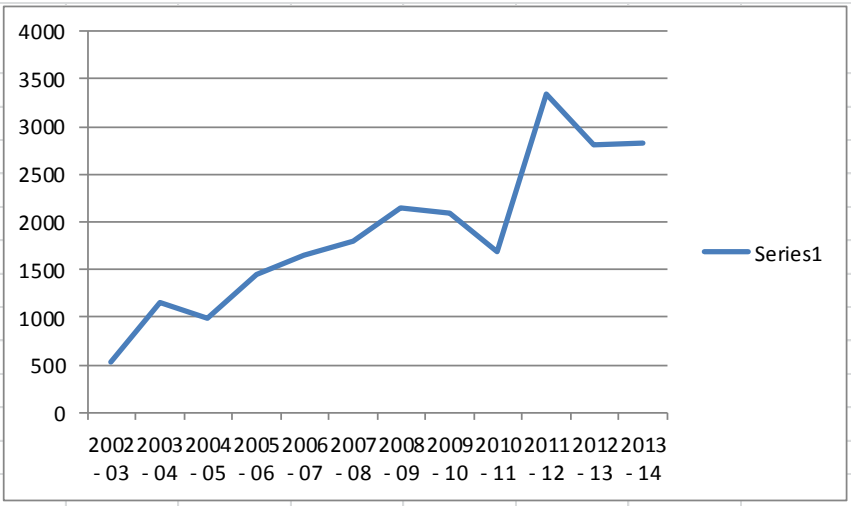
The NSCB Safer Programme has also delivered bespoke training packages, such as the Safeguarding Lead Practitioner training to all Early Years settings in Norfolk. This was developed in partnership with Early Years, Norfolk County Council and is delivered according to agreements with Early Years. This amounts to on average 10 two day sessions per term.

The impact of the NSCB Safer Programme can be measured by the effective partnership working with Momentum, Voluntary Norfolk, Norfolk Voluntary Sector Forum and its satellite groups, as well as statutory and private agencies. It is accessible to the whole voluntary, community and private sector whatever the size or nature of the group/organisation and, in addition, providing the vital training and resources required, it follows the guidance set out in Working Together to Safeguard Children 2013.

The NSCB Safer Programme, contributes to capacity building in the voluntary and community sector. This enables those groups and organisations in Norfolk working with children to develop the necessary skills and knowledge in child protection and policy production that will better place them to deliver preventative services. It also empowers them to achieve a quality threshold that they lack and which would prevent them entering into a service level agreement.

In the last 12 years, Safer has trained 22,479 people, of which 2833 were trained in their financial year, Sept 2013 – Aug 2014.

Sept - Aug Financial Year	Numbers trained
2002 - 03	525
2003 - 04	1163
2004 - 05	988
2005 - 06	1452
2006 - 07	1646
2007 - 08	1795
2008 - 09	2143
2009 - 10	2102
2010 - 11	1691
2011 - 12	3338
2012 - 13	2803
2013 - 14	2833
TOTALS	**22479**



Local Safeguarding Children Groups events

The NSCB funds the LSCGs to hold learning events each year. They determine the topic(s) based on local need. A summary of their activity:

LSCG	Date	Learning focus	Number attended
City & South	Oct 13	Early Help Workshops x 2	110
North & East	Nov 13	Safeguarding Week- 6 x workshops on: • Eating disorders x 2 • CEOP: "Think you know" for professionals x 2 • CEOP: Internet Safety for parents and carers x 1 • Sexual Abuse x 1	134
West & Breckland	Jan 14	Domestic Abuse Workshops x 3	180

Each LSCG evaluates the impact and effectiveness of these events by seeking feedback from the attendees. The information is used to plan future learning activity.

The LSCGs also support general communication by disseminating information on national and local updates and promoting training opportunities.

3.5 Multi-agency policy procedures

The Norfolk Threshold Guidance was produced in accordance with Working Together 2013 and signed off by Board in September. This document replaced the Norfolk Priority Matrix and was well received by partners as an improvement to the way we understand and assess need. Hard copies were provided for all schools and the LSCGs. The guidance was included in all multi-agency training, including the Safer programme.

Over the course of the year, however, the evidence from data and case reviews has challenged the Board and the guidance requires further development to better support frontline practice and partnership working. In 2014 – 15, the Board plans to not only review the guidance but also to improve the way it is rolled out and

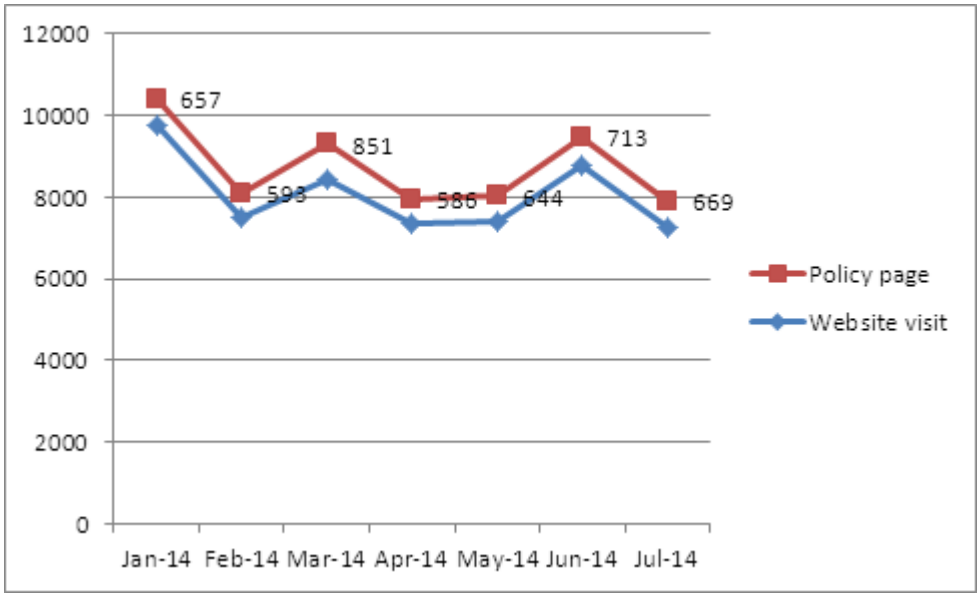
embedded. All partners agree that the best way to safeguard children is to have a consistent understanding of the thresholds. Moving forward, frontline staff and decision makers will be included in discussions about how we assess need and appropriate step up and step down procedures. This will be supported by road show type events where partners will be asked to consider the thresholds, not as barriers, but as vantage points to make the best decisions about how we keep children safe.

Alongside the Threshold Guidance, a multi-agency Practice Standards document was tabled at Board in Dec 2013. This document clearly sets out the standards expected of all practitioners on the child's journey. The formal publication was deferred so that it coincides with the revisions to the Threshold Guidance.

2013 – 14 also saw an intensive overhaul of all the multi-agency policies and procedures. In March 2013, the Board agreed to commission Tri-X to host its policy manual and from Apr to Jul 2013 a small multi-agency task and finish group reviewed 67 policies. The online manual went live in Sept 2013 and is now regularly reviewed and updated.

The policy manual was promoted to frontline staff during the roadshows that focused on learning from SCRs and MARs. At that point in time over a third of the recommendations from our SCRs and MARs related to policy and procedure so it was a good opportunity to stress the importance of following the policy and feeding back on how well they worked. Particular emphasis was placed on the Resolving Professional Disagreement policy to encourage staff to challenge each other in their practice and to signpost them to the procedures to support effective challenge.

Since the manual went live, the Board has been monitoring the website more closely to track hits. From the roadshows in Jan 2014, the activities and visits on the NSCB webpage has been monitored. There is no significant changes recorded and an average time visitors have been spending on the site is 1 min 20 secs.



Source: Google analyst

A survey link is also placed for feedback and to date a small number (12) of feedback have been received. All of this feedback has been positive, however, at

Board it was agreed to invest in improving the layout of the website to ensure it is user friendly. This work is planned for 2014 – 15.

3.6 Financial information

The Board's financial position remains stable and is supported by income generated through the Safer Programme. Some monies from previous underspends have been reviewed at Leadership Group. It was agreed to hold some in reserve in anticipation of future SCR activity and to invest in the future in improvement activities linked to the Board's agreed priorities.

There was significant spend this year against SCR activity, with final invoices for two MARs conducted in 2012 – 13, the Child K MAR and payment for Case L SCR up to the end of the financial year.

Staffing costs remain stable, however, with some maternity cover there was a minor overspend. There was also minor overspend to Chair costs, due to the changes in leadership.

A full breakdown is included in the tables below.

Income

NSCB Position 2013/14 — **As at March 2014**

Funded by:	Income Budget	% Income budget	Income To Date	Forecast	Variance	Narrative
Norfolk County Council	£119,048	24.21%	£120,148	£120,148	-£1,100	Includes Children's Services £78,710, Childrens Services Training £8,000, SEN £18,952 and YOT £5,386 services in Norfolk County Council, £8,000 ASSD contribution
Health	£80,621	16.39%	£80,621	£80,621	£0	
Police	£48,611	9.88%	£48,611	£48,611	£0	
District Councils	£35,525	7.22%	£35,525	£35,525	£0	
CAFCASS	£550	0.11%	£550	£550	£0	
Probation	£3,945	0.80%	£3,945	£3,945	£0	
Training Income	£193,500	39.35%	£177,034	£177,034	£16,466	Training Income Generated by NCC for external safeguarding courses
Annual Membership	£10,000		£11,520	£11,520	-£1,520	SAFER subscriptions Generated Externally
Use of reserves	£0		£3,863	£3,863	-£3,863	
Income	**£491,800**	**100%**	**£481,817**	**£481,817**	**£9,983**	

Expenditure

NSCB Activities	Expenditure Budget	Spend to Date	Forecasted Spend	Variance	Narrative
Staffing Costs					
Management Support	£153,500	£123,449	£123,449	-£30,051	Monitoring & Evaluation Officer post, Workforce Development Officer post and other Management Support (via Dreamkey).
Business Support	£68,000	£67,375	£67,375	-£625	Business Support for NSCB, Child Death Overview, SAFER and Training.
Training staff	£63,500	£70,714	£70,714	£7,214	Part of SAFER Training Programme. Posts include a Training Officer and Programme Coordinator
Employee Transport and Subsistence	£6,500	£10,592	£10,592	£4,092	
Staffing Costs	**£291,500**	**£272,129**	**£272,129**	**-£19,371**	
Chairperson	£45,000	£47,500	£47,500	£2,500	
Training, Media and subgroup conferences	£95,000	£73,569	£73,569	-£21,431	Multi-Agency Training Programme agreed with Barnardo's for c£60k pa signed Feb 12
Legal	£2,500	£2,436	£2,436	-£64	
Serious Case and Multi Agency Reviews	£25,000	£49,566	£49,566	£24,566	
Office Expenses	£7,500	£8,676	£8,676	£1,176	Includes printing, stationery and other office expenses
Meetings	£25,300	£27,940	£27,940	£2,640	Primarily for Multi-Agency Training venues
Overall Expenditure	**£491,800**	**£481,817**	**£481,817**	**-£9,983**	
Current Forecast Overspend/(Underspend)			**£0**		

Section 4: The Child's Journey

4.1 Norfolk Demographic Information and Background (from JSNA)

The information from the Joint Strategic Needs Assessment (JSNA) continues to provide valuable information to the Board. The JSNA is written in two parts looking at 0 – 10 year olds and 11 – 19 year olds. The information below is based on the 2012 – 13 data and focuses on family related issues:

- **Domestic abuse**: There were 6,305 incidents of domestic abuse which involved 7,709 different children: most incidents were in Norwich, Great Yarmouth and King's Lynn.

- **Parental substance and drug misuse**: Around 12,000 children and young people (0-19) in Norfolk are affected by parental drug use or are living with dependent drinkers. Approximately 1,900 children live with adults in substance misuse treatment but many more live with adults who are not in structured treatment programmes and so the full picture remains unknown.

- **Parental mental health**: It is not known how many children and young people in Norfolk live with parents experiencing mental health problems.

- **Young carers**: 2001 Census figures indicate there were approximately 400 carers aged under 11 in Norfolk and this figure is expected to rise to around 460 when the 2011 Census figures are released. There are approximately 329 under-11s providing 1-19 hours of care a week, 21 providing 20-49 hours and 47 spending more than 50 hours a week caring for dependents.

- **Teenage parents**: In Norfolk, the under-18 conception rate is 35.1 compared to the average for England which is 38.1: the figure for Norfolk is significantly better than the England average. Data is not routinely collected about teenage parents so the most detailed information derives from the Family Nurse Partnerships which shows that young parents often experience multiple social, economic, health and education disadvantages.

- **Safeguarding**: There is evidence of increases in referrals and children becoming the subject of a child protection plan. The range of reasons for increases including increased public and professional awareness, implementation of the Common Assessment Framework, better promotion of safeguarding, rise in domestic abuse, economic downturn, substance misuse and mental health issues. Additional agency hours required to resource undertaking Child Protection meetings. The effect of the forecasted population increase.

- **Looked after children**: There is evidence of increases in the number of looked after children, especially those aged 16 and 17. The range of reasons for increases include rise in domestic abuse, economic downturn, substance misuse and mental health issues. Additional agency hours required to resource undertaking placements for LAC. The effect of forecasted population increase.

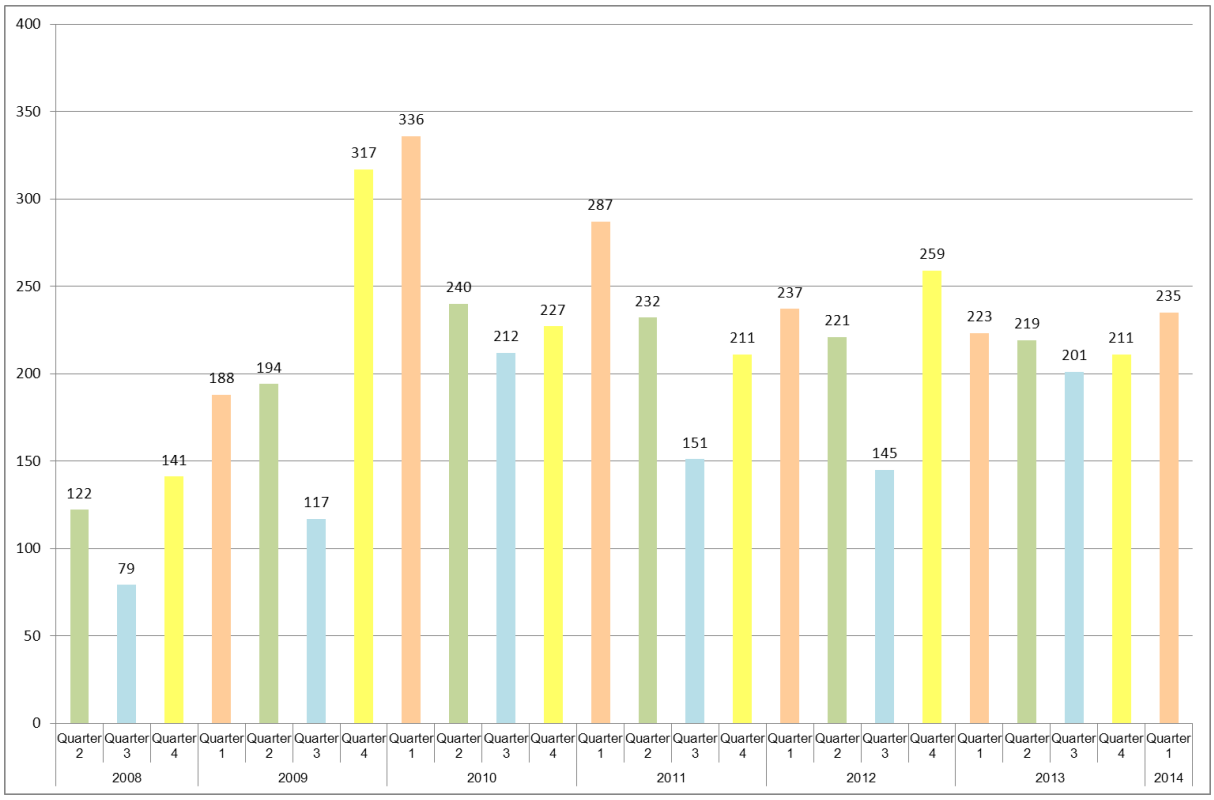
4.2 Early Intervention and Prevention

In 2012 – 13, an Early Help Programme Board (EHPB) was established to develop operational arrangements. In the Feb 2013 Ofsted inspection report it was recommended that the receipt of timely early intervention services for vulnerable children and their families should be implemented within six months, by accelerating the development and dissemination of a coherent and shared early help offer. The NSCB has monitored this development, for example, the Business Manager sits on the EHPB and ensures that the information on early help is fed back to the Board on a regular basis.

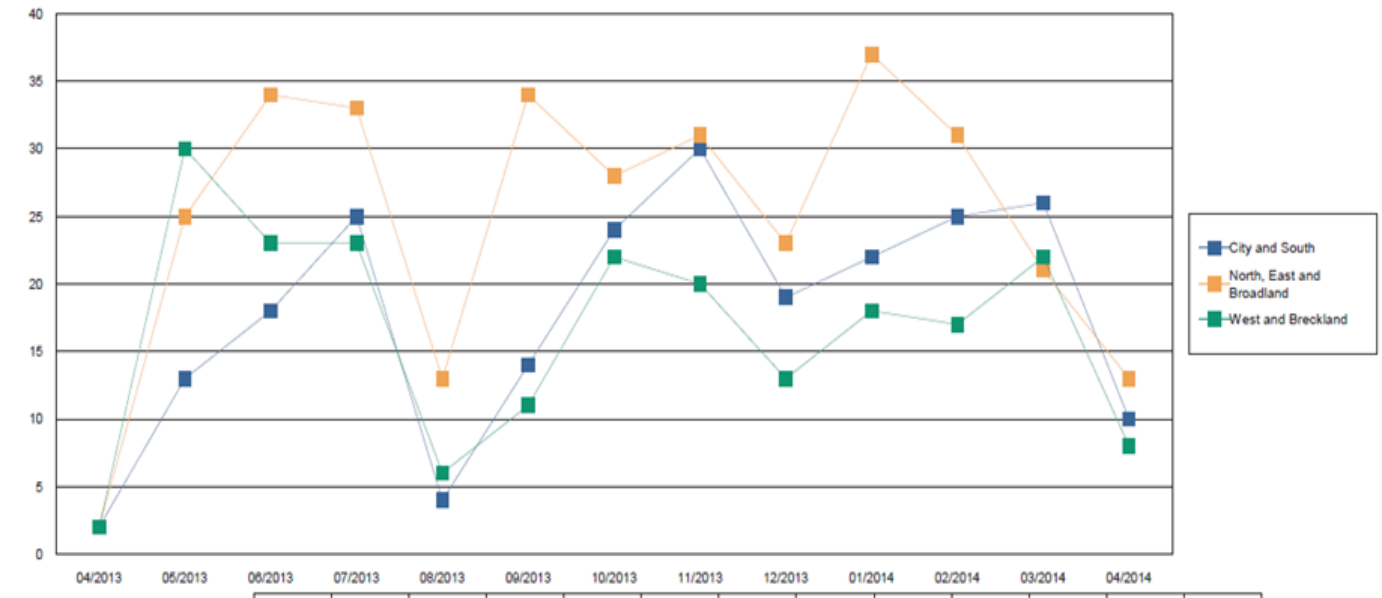
In 2013 – 14, the EHPB took the decision to rebrand the Common Assessment Framework (CAF) and relaunch it as Norfolk's Family Support Process (FSP). This was achieved by Sept 2013 and the Board funded the publicity material for children and families to support their understanding of the offer.

FSPs initiated in Norfolk year on year

The table below shows the year on year and quarterly (Jan-Mar = Quarter 1) FSP figures since 2010. Quarter 3 2013 shows a 9.94% increase in FSPs initiated compared to the same period in 2012, and a 6.8% increase compared to Q3, 2011



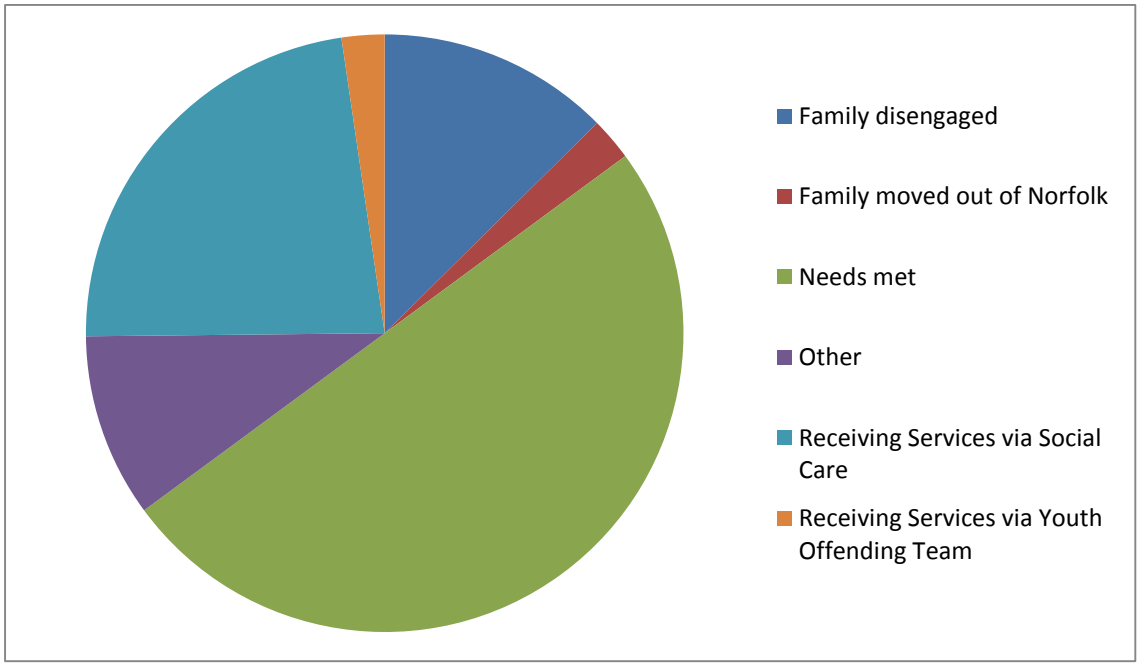
FSPs initiated Countywide by month and Operational Division



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
City and South	2	13	18	25	4	14	24	30	19	22	25	26	10
North, East and Broadland	2	25	34	33	13	34	28	31	23	37	31	21	13
West and Breckland	2	30	23	23	6	11	22	20	13	18	17	22	8

FSPs closed and outcomes achieved

IN 2013 – 14 a total of 302 cases were closed across the county, of which exactly 50% (151) record that the family's needs were met.



This figure was consistent in most of the county, however, there was a higher rate of disengagement in the North & East.

Outcome recorded	City & South	North & East	West & Breckland	NORFOLK TOTALS
Family disengaged	7	26	5	**38**
Family moved out of Norfolk	2	3	2	**7**
Needs met	39	53	59	**151**
Other	11	13	6	**30**
Receiving Services via Social Care	22	26	21	**69**
Receiving Services via Youth Offending Team	1	1	5	**7**
TOTALS	**82**	**122**	**98**	**302**

Norfolk recognises that more work needs to be done to ensure that the early help offer is accessible and effective. In 2014 – 15, the pace of improvement has been stepped up with the opening of two Early Help Hubs, where innovative early help programmes are being piloted. Early indications show that children and families are benefitting from these arrangements. Plans are in place to conduct an audit to assess the effectiveness of these new arrangements.

In the last quarter of 2013 – 14, Children's Services analysis of Family Support Plans resulted in the needs of the family being met, with less than a fifth escalating to the threshold of social care. While the numbers of Family Support Plans being initiated may appear to be falling, much of the apparent decline can be attributed to a delay in recording FSPs on the central database.

4.3 Children's Social Care

The Interim Children's Services Leadership Team (CSLT) have worked hard to address the serious issues in performance management arrangements reported by Ofsted in its 2013 inspection report. With the appointment of an Interim Assistant Director for Performance and Quality Assurance, there has been a significant culture shift across the service, with regular scrutiny and challenge meetings to drill down into performance information. This was supported by a complete overhaul of the data collection mechanisms, for example, revising the forms on CareFirst. As a result, Children's Services had robust data from Dec 2013 against which it could assess its own performance and ask questions of partner agencies. This information is presented every month to the Improvement Board and feeds into the NSCB scorecard. From 2014 – 15, the presentation of social care data has further developed with the production of a succinct dashboard.

Some of these developments happened relatively late in the financial year, however. While future arrangements are secure and robust, the overall data from 2013 – 14 was patchy due to the inadequacies picked up by Ofsted. For example, the council did not complete its Children in Need census last year. Notwithstanding, the CSLT did a retrospective analysis of the CiN cohort and through regular internal challenge have addressed their needs. In the last quarter, the CiN data showed:

Section 17 Children in Need in CIN & CWD Teams with an up-to-date* CIN Plan:

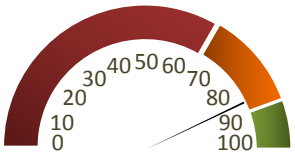
	Jan-14	Feb-14	Mar-14
No. s17 Children in Need	1,336	1,385	1,354
No. s17 with CIN Plan	663	1,005	990
No. s17 without a CIN Plan	673	380	364
% with a CIN Plan	49.6%	72.6%	73.1%
No. CWD Children in Need	345	350	346
No. CWD with CIN Plan	48	116	123
No. CWD without a CIN Plan	297	234	223
% with a CIN Plan	13.9%	33.1%	35.5%

* To count as having a CIN Plan, any existing plan must have been started or reviewed within the last 30 working days

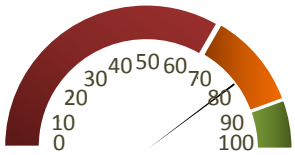
Children in Need Allocated to a Qualified Social Worker:

	Jan-14	Feb-14	Mar-14
No. Children in Need (not CP or CLA)	3299	3371	2745
No. Allocated to Qualified Worker	2842	2702	2463
% Allocated to Qualified Worker	86.1%	80.2%	89.7%

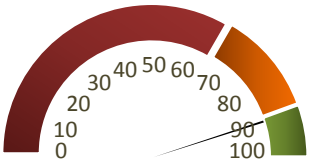
Children in Need Allocated to a Qualified Social Worker, cont.



Jan-14 = 86%



Feb-14 = 80%



Mar-14 = 89%

Rate of Children in Need per 10,000 Under-18 Population:

	Jan-14	Feb-14	Mar-14
Norfolk (Current)	354.6	336.8	316.7
England 12/13		332.2	
Statistical Neighbours 12/13		304.0	

At year end, 1,079 CiN cases were not held in S17 CiN or CWD teams. 557 were being assessed in Duty teams, and 401 were in Child Protection teams, over half of which were recently stepped-down from Child Protection Plans. Sixty are receiving services from Adoption Support, 30 are allocated to Looked-After Children teams

with the final 19 cases held in the Specialist Social Work, Diverse Communities team.

Children's Services are planning a restructure in 2013 – 14 to ensure that the right cases are held in the right teams.

The number of S17 Children in Need who do not have a current CiN Plan almost halved in the last Quarter. Of the 364 CiN without an up-to-date plan, over 150 had their plan reviewed between 31 and 40 working days ago. There are currently 80 Section 17 CiN with no CiN Plan.

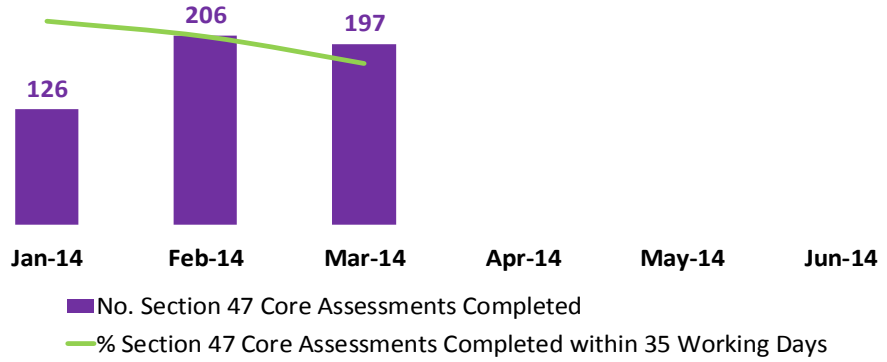
CiN in Children with Disabilities teams were required to review plans on a 30 working-day cycle since January. While there is still considerable improvement required, it was encouraging that almost three times as many CWD Children in Need had plans when comparing March data to January..

The Child Protection data is also secure for the last quarter and shows progress. For example, the percentage of children on CP plans with an allocated social worker has averaged out at 99%. The very slight drop in allocations in March shown in the chart below is related to cases being transferred to Child Protection teams at the point at which the data was sourced.

Children in Child Protection Teams Allocated to a Qualified Social Worker:

	Jan-14	Feb-14	Mar-14
No. Children on CP Plan	502	537	538
No. Allocated to Qualified Social Worker	497	537	527

Section 47 Core Assessments Completed in Timescales:

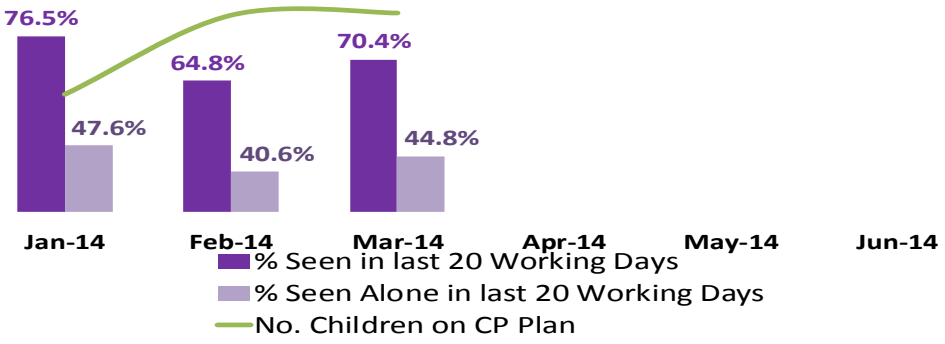


	Jan-14	Feb-14	Mar-14
No. Section 47 Core Assessments Completed	126	206	197
No. Section 47 Core Assessments Completed within 35 Working Days	116	180	156
% Section 47 Core Assessments Completed within 35 Working Days	92.1%	87.4%	79.2%

Rate of Children on a CP Plan per 10,000 Under-18 Population:

	Jan-14	Feb-14	Mar-14
Norfolk (Current)	30.3	32.4	32.4
Norfolk 12/13		33.1	
England 12/13		37.9	
Statistical Neighbours 12/13		35	

Social Worker visits to Children on a Child Protection Plan in Timescales:



	Jan-14	Feb-14	Mar-14
No. Seen in last 20 Working Days	384	348	379
No. Seen Alone in last 20 Working Days	239	218	241

Children on a CP Plan for 18 months & Over and Children Starting a CP Plan for a Second/Subsequent Time:

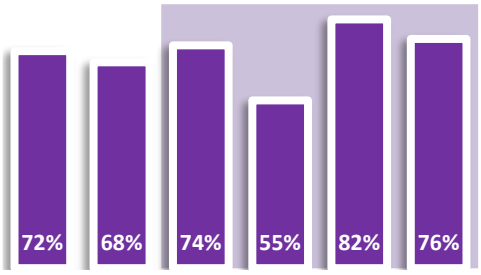
	Jan-14	Feb-14	Mar-14	England 12/13	Statistical Neighbours 12/13
No. on CP Plan for 2+ Years	12	12	13		
% on CP Plan for 2+ Years	2.4%	2.2%	2.4%	3.2%	3.5%
No. on CP Plan for 18 months - 2 Years	6	15	12		
% on CP Plan for 18 months - 2 Years	1.2%	2.8%	2.2%	Not Available	
No. Children Starting CP Plan for 2nd/Subesequent Time	13	13	9	Not Available	
% Children Starting CP Plan for 2nd/Subesequent Time	20.3%	18.3%	12.9%	14.9%	15.6%

Percentage of Re-Referrals:

Re-Referrals	Mar-14	Apr-14	May-14
Norfolk	27.6%		
England 2012/13	24.9%		
Statistical Neighbours 2012/13	20.8%		
East of England 2012/13	23.4%		

ICPCs within 15 Working Days of Strategy Discussion:

The shaded area of the chart shows performance since the implementation of the new forms in CareFirst



	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Total ICPCs	95	78	68	76	78	78
Within 15 Working days	68	53	50	42	64	59
Over 15 Working Days	27	25	18	34	14	19

4.4 Vulnerable children

Other data on vulnerable cohorts and child deaths is included in the table below:

Measure	Performance		
	2011/12	2012/13	2013/14 YEAR END
Number of LAC missing from care for over 24 hours	19	21	14
Number of children missing in local area	539	895	1167
Number of children identified as at risk of CSE, referred through the MASH (cumulative)	N/A	N/A	131
Number of recommendations from 'Who's Looking Out For the Children' RAG rated as green	Not published	Not available	12 Green
Children Missing Education: total number of referrals (end of academic year)	5113	4531	5253
Children Missing Education: total number of Children with no educational destination (end of academic year)	146	143	151
Domestic violence and abuse incidents where children are present.	1562	1529	1743
Domestic violence and abuse incidents (non crime) where children are present.	4901	4952	5437

Measures on vulnerable cohorts, cont.	2011 – 12	2012 – 13	2013 - 14
Rate of violent and sexual offences against children 0-17 per 10,000 U18 population	110.2	88.4	104.3
Number of notifications of new private fostering arrangements received during the year	30	48	48
Rate of hospital in patient admissions caused by unintentional and deliberate injuries by CYP aged 0 -17 per 10,000	124	118	129.9*
Number (%) of recommendations from SCRs/MARs RAG rated as red	Not available	27.2% (year end)	6 (16%) (year end)
Number (%) child deaths from child death overview panel that had modifiable features (preventable or potentially preventable)	12.0%	17.9%	11.1%
Number of children killed or seriously injured in road traffic accidents in the period	34 (0-15) and 46 (16-19) in 2011	22 (0-15) and 39 (16-19) in 2012	27 (0 - 15) and 43 (16-19) in 2013

*Estimated from proxy a proxy indicator of all admissions for injury and poisoning

Vulnerable Children Group

The Vulnerable Children Group (VCG) and the Child Sexual Exploitation Subgroup monitor the vulnerable cohorts regularly. The VCG met four times in 2013 – 14 to drilldown into data and intelligence relating to:

- Parents with substance misuse issues;
- Young Offenders and Children in Custody;
- Children Missing Education (CME); and
- Domestic Violence

The topics covered the impact of the presenting issues on outcomes for children and recommendations for improvement. Some of the actions completed were:

- Feedback to commissioners on drug and alcohol misuse programmes to better ensure that the treatment plans are joined up and child focused as appropriate (data on number of parents in programmes not yet available).
- Improved links between the Youth Offending Team and the police to implement the recommendations for safeguarding young people in custody: these arrangements were judged to be outstanding in a subsequent inspection of the Constabulary.
- Inclusion of CME data on the scorecard, linked to the work of the Education Advisory Group. Closer monitoring of persistent absenteeism and exclusions has since been agreed.
- Agreed buy-in with Countywide Community Safety Partnership to work collectively to tackle domestic abuse, resulting in more joined up working with partnership boards.

A further meeting on Private Fostering had to be cancelled due to changes in Chairing arrangements; the Private Fostering annual report went to Board in March 2014. The report demonstrated sustainable performance, however the number of notifications did not rise during the year despite the production of publicity materials and the Best Practice events. Performance in terms of private fostering arrangements that began BEFORE 1 April (previous year) that were continuing on 1 April (current year) where scheduled visits in the survey year were completed in the required timescale was 85%: a significant improvement to previous year's (64%), better than our Statistical neighbours and close the national average (67% and 91% respectively).

Child Sexual Exploitation Subgroup

The CSE Subgroup was established as a Strategic Development Group with a view to being incorporated into the VCG programme when the strategy is fully embedded. The work of the CSE was steady throughout 2013 – 14. Its main achievements were:

- Ensuring that a discrete CSE team in the Multi-Agency Safeguarding Hub (MASH) was established to triage all cases relating to children going missing, and/or assessing the risk of children indicating they were vulnerable to exploitation
- Collecting data and reporting on cases of children at risk, with the development of a comprehensive data monitoring tool; this in turn enabled Norfolk to contribute to national data collections with more robust, quality assured information
- Raising awareness through Best Practice Group events and tailored events in schools
- Revising the CSE Strategy in line with national publications such as the Office of Children's Commissioner Inquiry into CSE in Gangs and Groups.

The Chair of the CSE Subgroup reports regularly to Board. In March 2014, a summary of the achievements above was put forward to Board as well as challenges to the way we respond to CSE moving forward. There is a real and pressing need to start using the intelligence and data we have collected more proactively in order to improve the way that we problem profile in Norfolk. The report stated 'Whilst the Police have secured an officer to work on intelligence gathering and research, his ability to profile locations and 'hot spots' is limited. This is clearly work for an analyst with access to all agency systems who could overlay relevant data to ensure key locations were identified for target hardening and education / awareness raising. There is no analytical capacity within the MASH or the CSE team at present and this is identified by the subgroup as a significant gap.' As a result, the Board is looking at capacity building around data analysis.

Children missing is a standing item at all CSE subgroup meetings and the Missing Persons Co-ordinator sits within the CSE team in the MASH. The increase in numbers of children going missing is of concern, however, this is in part due to better reporting and recording.

Children With Disabilities Subgroup

A second Strategic Development Group was also in operation, under the remit of the VCG, looking at how well we safeguard Children With Disabilities. The multi-agency Subgroup met every other month throughout 2013 – 14 to review the recommendations made by the government for LSCBs in the 'Safeguarding Disabled Children' Practice Guidance (2009). There were 15 areas to review and a total of 61 recommendations. Each of these was RAG rated based on the knowledge and experience of the multi-disciplinary membership (including parents). In addition to amber, the group also rated some recommendations as yellow to indicate that they are further along the road to improvement.

32% of the recommendations were deemed to be RED, i.e. underdeveloped and requiring improvement. The most significant areas were:

- consulting with, listening to and encouraging the participation of disabled children amongst all services;
- appropriate training concerning safeguarding disabled children;
- awareness raising of the particular safeguarding needs of disabled children;
- supporting families & carers to provide the best care possible for disabled children and young people;
- strategic links between children and adult services; and
- robust monitoring, auditing and recording systems.

The majority of recommendations (36%) were yellow, i.e. there is scope for rapid improvement. However, only a very small number (5.5 out of 61 or 9%) could be confidently RAG rated as green.

It was agreed at Board in March 2014 that the work of the Strategic Development Group was complete: the actions would be taken forward with Children's Services leading and progress would be reported regularly to the Board through the VCG.

Licencing (premises)

The NSCB recognises the importance of a robust and effective licencing process to ensure the safety of children and aims to improve the current arrangements. The group plans to do this by:

- better co-ordination between the Board and the District Councils (who are the licensing authorities in Norfolk)
- improved information across agencies and between District Councils
- improved consistency of reporting
- greater understanding of staff in different agencies who are involved in the licencing application and the enforcement process
- ensure effective and robust licensing policies and procedures

The Board also intends to extend the monitoring of licencing from premises to transport (taxis) as it has critical significance for Chid Sexual Exploitation (one of the key priorities of the Board).

The NSCB has been acting as one of the Responsible Authorities for child protection in the process of any licencing application to check the premises applications (new and variation). Upon receiving the applications checks are made specially of the section N and P(e) of the application 'the protection of children from harm'. A close scrutiny is done by checking the intention of the applicants about how the protection for children from herm will be done. A database is maintained which contains details of these applications.

The table below presents the details of applications by quarters in the year 2013-2014

2013 - 2014 Licence Applications Stats

	Applications received (new or variation of existing liscencs)				Liscencs reviewed by Trading Standards	Concerns reported by Liscencing enforcement officer	Objections received from member of public
District Cou	Q1	Q2	Q3	Q4			
Breckland	5	11	5	13			
Broadland	11	9	1	4	1		
Gt Yarmout	11	10	15	8	1		
Kings Lynn	11	9	8	9			
North Norfol	5	1	1	2			2
Norwich Cit	14	19	15	11	1		
South Norfo	3	2	1	11		1	
Totals	**60**	**61**	**46**	**58**	**3**	**1**	**2**

Concerns (1)
Raised by Licensing & Enforcement Officer detailing concerns of childs involvement at the premises. Education safeguarding advisor have been informed as the child does not attend school, home educated

Reviews by TSA (3)
- Received from Trading Standards Service documents to review the licence for Sale of alcohol to underage children

- Received from Norwich City Council documents to review premises licence for following a high number of incidents involving violence and intoxication at the premises

- Received from Norfolk Constabulary Licensing Team documents to review licence for the prevention of crime and disorder, public safety, the prevention of public nuisance and the protection of children from harm

Copies of Objections Received from the member of public (2)
- Email received detailing concerns and objection to a licence being approved for a chip shop. No comments was made by the NSCB on the application to the liscencing authority, the applicant or the objector, NSCB chair responded to that effect.

- Emails received detailing concerns and objections for a caravan site to be re-located adjacent to a Primary and Pre-School, no comments were made from NSCB.

Plans are in place to impove the monitoring arrangements of licenced premises through the District Council Advisory Group. From 2014 – 15 the Performance Indicators in relation to licencing data will include.

- Number of applications received (source NSCB)
- Number of applications refused on the bases of Safeguarding concern/reasons (source DC)
- Number of licences revoked on the basis of safeguarding concerns (Source DC)
- Number of complaint /reviews from trading standard agency (Source NSCB)
- Number of complaint / objections received from members of public (Source NSCB/DC)

The DCAG will receive quarterly data from the NSCB and it will form a regular part of DCAG meeting agenda. The DCAG will report regularly to the Board via PIQAG of any concerns etc.

4.5 Child death and serious injuries

The Child Death Overview Panel (CDOP) met ten times throughout 2013 – 14 and agreed classification on 27 deaths. Our national returns showed that three deaths were deemed to have modifiable features, although none of these met the criteria for a Serious Case Review. The categories of death are in the table below:

Category	Number of child deaths with modifiable factors recorded under this category of deaths	Number of child deaths with no modifiable factors recorded under this category of deaths	Number of child deaths where there was insufficient information to assess if there were modifiable factors
Deliberately inflicted injury, abuse or neglect	0	0	0
Suicide or deliberate self-inflicted harm	0	0	0
Trauma and other external factors	3	3	1
Malignancy	0	2	0
Acute medical or surgical condition	0	0	0
Chronic medical condition	0	1	0
Chromosomal, genetic and congenital anomalies	0	3	0
Perinatal/neonatal event	0	11	0
Infection	0	1	0
Sudden unexpected, unexplained death	0	2	0
TOTAL	**3**	**23**	**1**

Two thirds of the children were under the age of 1 and had life limiting conditions; (40.7%) were caused by perinatal or neonatal events.

The deaths with modifiable features were caused by trauma and/or other external factors, for example road traffic incidents. There was insufficient information to assess if one death, a road traffic fatality, could have been prevented. A breakdown of the deaths by age is include in the table below:

Age of child	modifiable factors	no modifiable factors	insufficient information
0-27 days	0	13	0
28 days- 364 days	0	5	0
1 year-4 years	1	1	0
5-9 years	1	2	0
10-14 years	0	2	0
15-17 years	1	0	1
Unknown	0	0	0
TOTAL	**3**	**23**	**1**

Road safety data shows that this is a continuing area of concern, particularly in rural Norfolk.

Number of children killed or seriously injured in road traffic accidents in the calendar year.

Year on Year	2011	2012	2013
Aged 0 - 15	34	22	27
Aged 16 - 19	46	39	43
TOTALS	**80**	**61**	**70**

2013 by quarter	Jan - Mar 2013	Apr - Jun 2013	Jul - Sept 2013	Oct - Dec 2013
Aged 0 - 15	8	5	8	6
Aged 16 - 19	9	9	19	6
TOTALS	**17**	**14**	**27**	**12**

The casualty numbers are those from the STATS19 data. This is the dataset recorded and held by Norfolk Constabulary. This records injury accidents occurring on the public highway, within the County boundary, which the Police are made aware of. It doesn't include accidents on private land or accidents involving a Norfolk resident which occur outside of Norfolk.

The numbers have increased since 2012, however there are on average 70 road traffic incidents involving children over a three year period. The numbers spiked over the summer months for 16 – 19 year olds.

The Road Traffic Safety Group are scheduled to come to CDOP in 2014 – 15 to assess how well we are raising awareness of RTIs and what more we can learn from these incidents to better protect Norfolk's children and young people.

Section 5: NSCB Priorities

The Board's priorities in 2013 – 14 have largely been covered in the report above, that is to:

- Review and improve governance arrangements through a strategic change programme
- Review and improve the way the quality and timeliness of the data provided by partners in order to effectively monitor and challenge deficiencies in front line child protection practice
- Establish the Children & Young People's Shadow Board to ensure young people's voices are heard
- Agree Board's future priorities and develop a Business Plan against which the Board can monitor its impact and effectiveness

While the Board has addressed each of the above, the pace of change has some times been slow. Board members undertook a self assessment in February 2014 to feedback to the newly appointed Chair on their views of the Board's strengths and weaknesses. The responses were taken forward through the Board's Development Day, held in March 2014, where a number of the issues were addressed. The purpose of the day was to consolidate and confirm the Board's progress. More specifically:

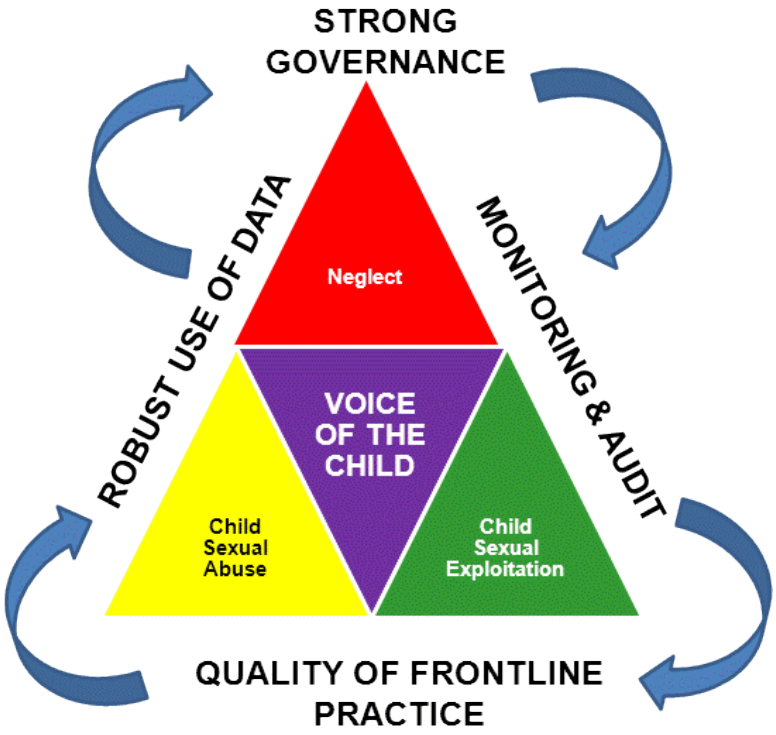
- *To provide context for* national and local perspectives
- To establish expectations and enable members to assess the Board's performance
- To ensure the NSCB can measure the difference it makes to ensuring safeguarding and promoting well being
- To provide a strategic framework and an overview of the improvement agenda
- To set priorities for 2014 onwards and develop the work of the Board

The Chair's focus was on getting the Board to work together in terms of thinking, learning, challenging and acting and achieving. Feedback showed that partners agreed that the day met its objectives.

The Board reviewed the information available with a specific focus on learning from recent Multi-Agency Reviews. Priorities were identified for work on **neglect; sexual abuse** of children; and **child sexual exploitation**, as areas of critical vulnerability for children and young people in Norfolk, together with scrutiny of the **consistency and quality of front-line practice**, and hearing the **voice of the child**. Together these provide a focus for the work of the Board in challenging the overall pace of improvement and ensuring that there is a measurable impact on the experience and quality of service for children and young people and their families.

The Board recognises that in order to effectively identify and tackle the priority issues, the voice of the child must be at the heart of safeguarding arrangements. Improvement will be evidenced by data, audit and, crucially, service user feedback. All of the Board's work is child-centred and as such is underpinned by consistent high quality frontline practice.

The Board is continuing to address the weaknesses identified by Ofsted. A draft outline of the Business Plan went to Board in March 2014 and was subsequently signed off in 2014 – 15. This business plan will further strengthen the Board's governance arrangements with clear lines of accountability linked to each priority area. Alongside this, the performance scorecard developed in 2013 – 14 will ensure that the Board has sufficient high quality information so that it can effectively monitor and challenge deficiencies in front line child protection practice.



These clear improvement priorities will enable partners to assess whether they are fulfilling their statutory responsibilities to help protect and care for children and young people and challenge each other if not. The delivery plan below identifies clear, measurable outcomes for children and young people, against which the Board can measure and report on its effectiveness.

Work has already begun on providing strategic direction and challenge to the identified priorities. The revised CSE Strategy was signed off in March 2014 and the draft Strategy to Identify and Tackle Neglect was agreed in principle in early 2014 – 15. The newly formed Child Protection Group has been tasked with producing a Strategy for the Eradication and Prevention of Child Sexual Abuse this financial year.

Appendix 1: S11 Comparator diagrams 2010 - 2013

Figure 1: Distribution of Standards and RAG Scores 2013

(data from 17 statutory agencies)

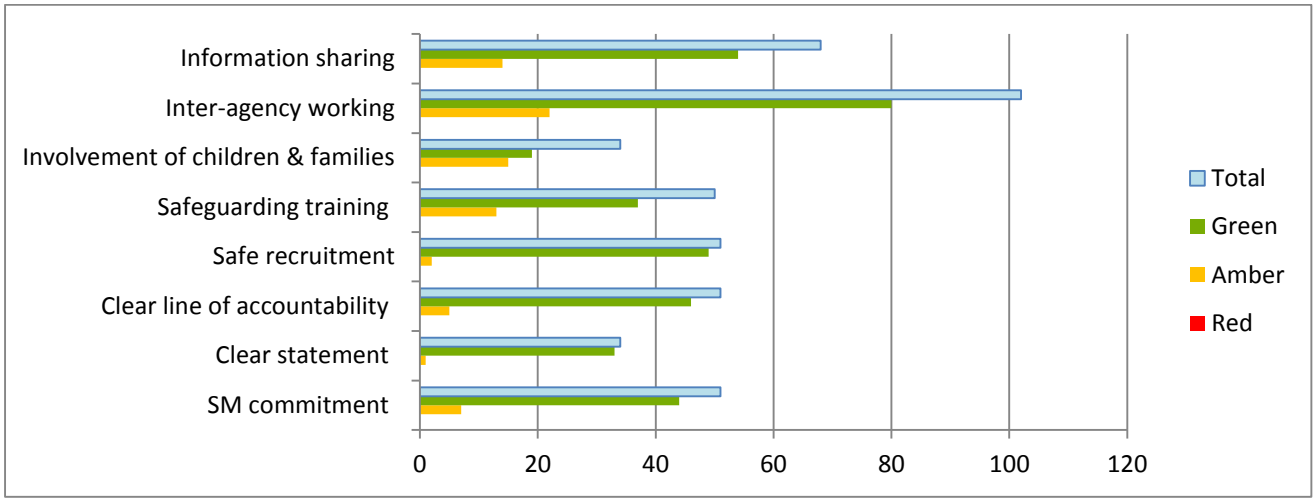


Figure 2: Distribution of Standards and RAG Scores 2010

(data from 17 statutory and 8 voluntary agencies)

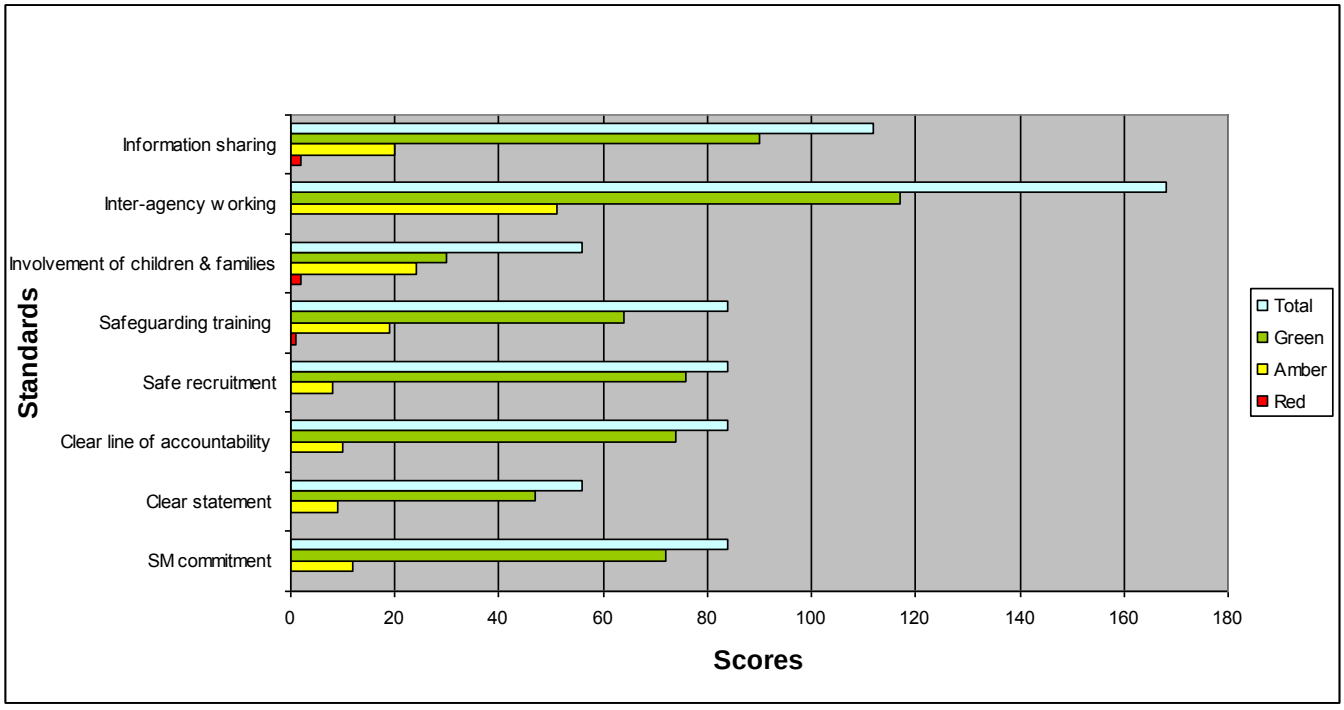


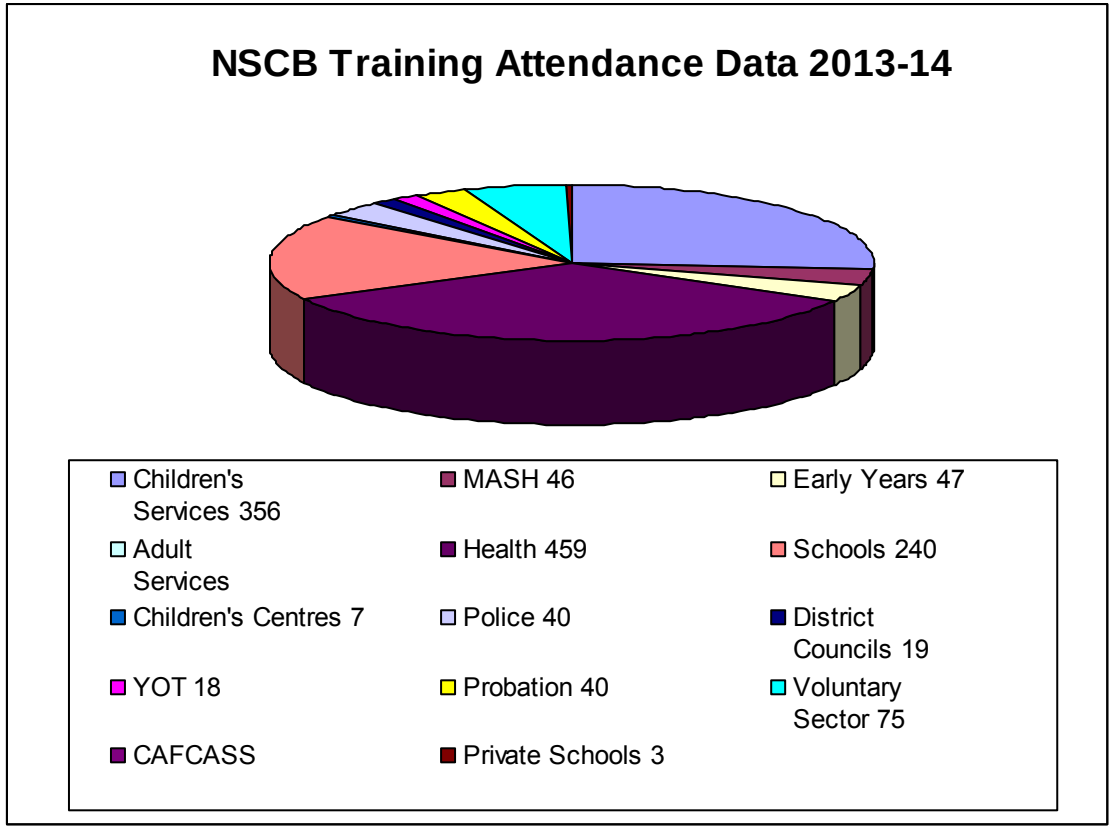
Figure 3: Distribution of Standards and RAG Scores 2013

S 11 RAG at a glance 2013																							
	STANDARDS																						
Agencies	Senior management commitment			Clear statement of agency's responsibilities			Clear line of accountability			Safer recruitment			Staff training			Views of children and families			Effective inter-agency working			Information sharing		
	Red	Amb	Green	Red	Ambe	Green	Red	Ambe	Green	Red	Ambe	Green	Red	Ambe	Green	Red	Ambe	Green	Red	Ambe	Green	Red	Ambe	Green
Children's Services - Social Care		2	1			2		1	2			3			3		1	1		2	4		2	2
Children's Services - YOT			3			2			3			3			3		2			6			4	
Norfolk Constabulary			3			2			3			3		3			2				6			4
Norfolk Sullfolk Probation Trust		1	2			2			3			3		1	2		1	1			6		2	2
NNUH			3			2			3			3			3			2		3	3			4
JPUH		1	2			2			3			3			3		2			4	2			4
QEUH			3			2			3			3		1	2		1	1		3	3			4
NSFT			3			2			3			3		1	2			2		2	4			4
NNCH			3			2			3			3			2		1	1			6		1	3
ECCH			3			2			3			3		1	2			2			6		2	2
Norwich City Council			3			2			3			3			3		2				6			4
Broadland District Council			3			2			3			3			3			2			6			4
South Norfolk District Council		1	2			2		2	1			3			3			2			6		1	3
North Norfolk District Council			3			2			3			3			3		2				6			4
Breckland District Council		2	1		1	1		2	1		2	1		3				2		2	4		2	2
GYM BC			3			2			3			3		2	1		1	1			6			4
Kingslynn Borough Council			3			2			3			3		1	2			2			6			4

Appendix 2: NSCB Multi Agency Training Attendance Data

Financial Year 2013-14 – Final Data

Course	Number of courses/ Places available	Total Attendees	Percentage of places used	Total number of attendees per agency													
				Children's Services	MASH	Early Years	Adult Services	Health (Total)	Schools	Children's Centres	Police	District Councils	YOT	N&S Prob	Vol Sector	CAFCASS	Private Schools
Supervision Skills - 2 day course	4 / 80	67	84%	11		6		33				1	1	1	12		
Supervision Skills - Follow up Day 3	4 / 80	61	83%	9		5		33				1	1	1	11		
Substance Misuse	5 / 100	74	74%	31	3			20	12		1			3	4		
Physical Harm	4 / 100	47	47%	16	3			20	6	1				1	1		
Neglect	7 / 175	144	82%	42	6	1		67	31	2	1			2	1		
MAPPA - 1/2 day course	2 / 40	25	63%	2	1			12					1	10	1		
Emotional Harm	6 / 150	109	73%	33	5			38	27		1			1	4		
Domestic Abuse	6 / 150	101	67%	27	6	1		40	18	1				2	5		
CP Conference	4 / 80	77	96%	16		8		21	15		5	3	1		9		
Sexual Abuse	5 / 125	70	56%	21	4			22	14		2	1	1	4	1		
MA Assessment	12 / 300	207	69%	24	5	25		61	65	3	1	5	2	1	10		3
Sexually Abusive Behaviour	6 / 150	113	75%	46	6			35	15			1	3	5	3		
CSE	5 / 125	114	91%	28	5	0	0	27	16		25	2	4	4	3		
Disabled Children	4 / 100	44	44%	22	1			9	8			1		1	4		
Warner Training	2 / 24	22	92%	7	0	1		5	2			2	3		2		
Working with Parents	3 / 75	64	85%	21	1			16	11		4	2	1	4	4		
TOTALS	**78 / 1834**	**1339**	**73%**	**356**	**46**	**47**		**459**	**240**	**7**	**40**	**19**	**18**	**40**	**75**		**3**


NSCB Training Attendance Data 2013-14
Children's Services 356
MASH 46
Early Years 47
Adult Services
Health 459
Schools 240
Children's Centres 7
Police 40
District Councils 19
YOT 18
Probation 40
Voluntary Sector 75
CAFCASS
Private Schools 3

Health Data Broken Down

Course	Community Health		Acute Trusts (Hospitals)			Mental Health	Other	TOTALS
	ECCH	NCH&C	JPUH	NNUH	QEH	NSFT	NHS Norfolk	
CP Conference		14	1		1	5		21
CSE	1	2	8	7		7	2	27
Disabled Children		8				1		9
Dom Abuse		14	6	1	2	17		40
Em Harm	1	16	1			20		38
MA Assessment	3	29	4	1		23	1	61
MAPPA		1				11		12
Neglect	2	31	6		1	27		67
Phys Harm	1	15			1	3		20
Sexual Abuse		7		3		12		22
Sexualised Behav		12	1	1		21		35
Subs Misuse		11	1			8		20
Sup Skills	2	21	2	2	1	5		33
Sup Skills Day 3	2	23	2	1		5		33
Warner		5						5
Working with Parents		13				3		16
TOTALS	**12**	**222**	**32**	**16**	**6**	**168**	**3**	**459**

District Councils Data Broken Down

(aligned with LSCG structure)

Course	City & South		North & East			West & Breckland		TOTALS
	Nch City	S Norfolk	N Norfolk	Broadland	GYBC	KL &WN	Breckland	
CP Conference	1					1	1	**3**
CSE	2							**2**
Disabled Children	1							**1**
Dom Abuse								**0**
Em Harm								**0**
MA Assessment	2					1	2	**5**
MAPPA								**0**
Neglect								**0**
Phys Harm								**0**
Sexual Abuse	1							**1**
Sexualised Behav	1							**1**
Subs Misuse								**0**
Sup Skills	1							**1**
Sup Skills Day 3	1							**1**
Warner				2				**2**
Working with Parents	2							**2**
TOTALS	**12**	**0**	**0**	**2**	**0**	**2**	**3**	**19**

Children's Services Performance Monitoring Report

Cover Sheet

What is the role of the H&WB in relation to this paper?

The Health and Wellbeing Board has asked for an update on Children's Services Improvement and Performance as a standing item at each of the Board's meetings.

The following report has been prepared for NCC's Children's Services Committee and is put before the Board as a reference point. The Executive Director Children's Services will highlight at the meeting where partners and the wider community can play a part in improving outcomes.

Key question for discussion

Q. Does the Board have any questions or comments about the contents of the report?

Actions/Decisions needed

The Board needs to:

- Consider and comment on the report

Children's Services Performance Monitoring Report

Report of the Interim Director of Children's Services, Norfolk County Council

Summary
This report provides an update on operational performance within children's Services including Support for School Improvement and Social Care and Safeguarding.

Support for School Improvement
Performance targets have been revised to reflect a heightened ambition for better outcomes. A district breakdown supports the targeted work to reduce variation in pupil and school outcomes.
For Early Years Foundation Stage, the latest predictions indicate a 1% improvement overall in the percentage of children achieving a 'Good Level of Development'
At Key Stage 2, schools are predicting a 2% rise on 2014 outcomes overall and similarly for Free School Meals pupils.
At Key Stage 4 the schools in the Great Yarmouth district are predicting the biggest improvement at 6% above the 2014 outcome and a 7% increase for Free School Meal pupils.
Ofsted inspection outcomes for Norfolk schools judged good or better improved by 2% for Primary phase schools by December 2014 from July 2014. The percentage judged good or better for secondary phase schools dropped by 2%. Both outcomes are below the national average. Special schools remain in line with the national average.
The refreshed LA education improvement plan - 'A Good School for Every Norfolk Learner (AGSfENL): Phase 2 Embedding the Strategy to Support School Improvement' - focuses on the key actions to be taken to address the LA strategic aims and meet Ofsted inspection priorities for improvement.

Social Care and Safeguarding
The number of contacts fell by 13% in January compared to December and the number of referrals fell by just over 1%.
The timeliness of initial assessments (IAs) is still poor (44% compared with 49% reported to Committee last time) however social care teams are taking a risk-based approach to prioritising their initial assessments.
Rates of re-referral to Children's Social Care services in Norfolk are very slightly below the average for the whole of England
The first monthly performance report produced by the Norfolk Early Help Family Focus Team (NEHFF) shows:
a 21% increase above the last 6 month average ongoing work is needed to continue implementing key learning and improving practice across the whole of the multi-agency partnership
A majority of requests for support came from schools with concerns of attendance, exclusions or an equivalent level of concern
Of the 53 cases referred in January, most were from the North, then south, East, City and then West with the fewest.
There are currently 380 active cases open to practitioners; with some of these cases jointly worked (i.e. 2 workers in one locality working with the same family) due to the nature of their needs.
Practitioners are working with families for an average of 250 days (8 months).

Families are able to access on-going support once their agreed outcomes have been met. This support has led to a very low (1%) re-referral rate. 80% of the 2264 families who have benefitted from the programme in total have had their needs met and outcomes achieved
Almost 80% of Initial Child Protection Conferences conducted were within 15 working days of a strategy discussion, an improvement on the previous 2 months.
Fewer Section 47 Core Assessments are being conducted within timescales with performance dropping from around 80% in November and December to 64% in January.
The rate of children on Child Protection plans is lower than is seen across England and among statistical neighbours.
LAC numbers have risen slightly since December but overall the trend continues to be downwards.
Recent CQC reports have revealed that health providers in Norfolk have been late in conducting LAC health assessments
There has been a gradual shift over the year (2014) from 'Inadequate' cases to 'Requires Improvement' cases (previously categorised by Ofsted as 'Satisfactory'), as judged by the Social Care Audit Team.
Increased numbers of social workers' reports are being received for LAC reviews (from 59% in October 2014 to 71% in December 2014).
Increased numbers of young people are being made aware of the promise (from 48% in October 2014 to 71% in December 2014).
Notifications to IROs of changes to children's circumstances have improved slightly from 89% in September 2014 to 90% in December.
In January the referral rate for Children's advocacy services was 90% and take-up was also 90%. H
High caseloads for Independent Chairs and Independent Reviewing Officers is a long-standing issue that remains a challenge.

Action
The Health and Wellbeing Board is asked to:

- Consider and comment on the report

1. Background

1.1 Norfolk Children's Services continues its intensive and extensive improvement activities under the direction of the Children's Services Committee and the independently chaired Norfolk Education Challenge Board and Norfolk Safeguarding Children Board. Committee Members have stated that they wish to diligently oversee these improvements to ensure that all elements of Children's Services operations are increasingly evidencing greater effectiveness and efficiency.

The increasingly sophisticated performance and challenge functions being put in place are ensuring that there is an array of detailed evidence available to ensure that Members are sighted on all aspects of Children's Services Improvement as they progress. Accordingly Members will see progress on a range of indicator and trend data and areas of variance such as over or under performance. Alongside the Task and Finish Groups and fact-finding activities planned for Members, these reports are assisting Committee Members in their strategic decision-making. This report includes data and information that demonstrates further development of performance reporting capacity within the service.

2. Impact of Support for School Improvement

Education performance

2.1 Predictions for 2015 outcomes continue to be collected from those Norfolk schools identified by the Local authority (LA) as 'causing concern' or 'requiring improvement'. From February 2015, schools that are assessed as being 'good' or better will also be asked to submit progress data on a half-termly basis. The colour coding in the scorecard has been revised to reflect a heightened ambition for better outcomes. Furthermore, a district breakdown has been added to support the targeted work in districts to reduce variation in pupil and school outcomes.

2.2 For Early Years Foundation Stage, the latest predictions indicate a 2% improvement overall in the percentage achieving a 'Good Level of Development'. (Appendix A Scorecard p.3) The predictions show a significant potential improvement in outcomes for pupils eligible for Free School Meals, which would take the percentage to in line with the national average for 2014. Most districts are predicting improvement and the biggest increase is predicted in North Norfolk at +8% improvement on the 2014 outcomes and a 5% rise for Free School Meals pupils.

2.3 At Key Stage 2, schools are predicting a 2% rise on 2014 outcomes overall and a 4% rise for Free School Meals pupils. (Appendix A – Scorecard p.4) Kings Lynn and West Norfolk schools are predicting the biggest rise overall at 3% improvement on 2014 outcomes. For Free School Meals pupils, Kings Lynn and West Norfolk schools are predicting a 6% improvement on 2014.

2.4 At Key Stage 4 the predictions indicate a 4% rise in outcomes, for the percentage of pupils achieving five good GCSEs including English and mathematics. (Appendix A – Scorecard p.5) The schools in the Great Yarmouth district are predicting the biggest improvement at 7% above the 2014 outcome and an 8% increase for Free School Meal pupils.

2.5 The predictions have been followed up by the Education Achievement Service and every school has received an individual letter in response. Beyond this, the predictions for all 'schools causing concern' are followed up by the Education Intervention Service to check their accuracy and to challenge where this indicates under-performance. Some schools assessed as 'requiring improvement' will be individually followed up where their predicted data is not showing improvement.

2.6 Ofsted inspection outcomes for Norfolk Early Years settings continue to be broadly similar to the national average. For primary schools the percent judged good or better improved by 2% by December 2014 from July 2014. Since then for schools with a published outcome the percentage has risen by a further percent to 73%. (Appendix A – Scorecard p. 6) The percentage judged good or better for secondary phase schools dropped by 2% by December 2015 but has since risen by 4% and is now 64%. Both outcomes are below the national average in these measures. Special schools remain in line with the national average at 3%. During the autumn term 2014 39 schools were inspected, compared to 54 in the autumn term in 2013. 24 out of the 39 schools were judged good (62%), 11 were judged RI (28%) and 2 out 39 (5%) were judged to require special measures.

2.7 From May 2015 the Education Performance Scorecard will include measures from the Inclusion Service performance framework. This will include data about Children Missing Education (CME), Pupils Missing from Education (PME), attendance, exclusions and young people Not in Education Employment or Training (NEET).

2.8 The refreshed LA education improvement plan - 'A Good School for Every Norfolk Learner (AGSfENL): Phase 2 Embedding the Strategy to Support School Improvement' - focuses on the key actions to be taken to address the LA strategic aims and meet Ofsted inspection priorities for improvement. This is described further in the paper 'A Good Education for Every Norfolk Learner' that is being presented separately to Committee.

3. Impact of Child Protection Services and Services for Looked After Children and Early Help

3.1 At Appendix B is the February 2015 dashboard of quantitative indicators showing the latest trends in statutory and non-statutory processes associated with children's social care. The following points are worthy of note:

Contacts, Referrals and Initial Assessments

- The number of contacts fell by 13% in January compared to December and the number of referrals fell by just over 1%. Whilst it is not advisable to draw any conclusions on one month's data this would be a pleasing trend to see over the next few months. It represents a reduction in workload for front-line social care staff and a better conversion rate from contacts to referrals. It also represents a more discerning approach to contacts from partners. The slightly more favourable conversion rates indicate that this is the case. (22% in January compared with 20% in the previous month).

- The timeliness of initial assessments (IAs) is still poor (44% compared with 49% reported to Committee last time). Analysis of the data shows that social care teams are taking a risk-based approach to prioritising their initial assessments. 90% of IAs where the outcome was to conduct a strategy discussion were completed in timescales, however this dropped to only 27% where the outcome was for a Core Assessment or Children In Need Plan. Operational managers have been written to requesting explanations for current performance levels in this area. Managers continue to insist that assessments are completed to a good standard which is also impacting upon timescales. It is worth noting that 60% of all IAs were completed within 15 working days.

- Rates of re-referral to Children's Social Care services in Norfolk are very slightly below the average for the whole of England.

Children in Need (CIN) and Early Help

- A lack of a central recording and case management system means that there is often late notification of Family Support Plans initiated to the central team, which in turn creates the impression that fewer FSPs are being conducted. A new system has been procured and is scheduled to be operational from Spring 2015 and will enable new FSPs to be

recorded in a much timelier manner. In the meantime, at Appendix C is the first monthly report produced by the Norfolk Early Help Family Focus Team (NEHFF).

- Highlights from this report are that:

  - In January 2015, there was a 21% increase above the last 6 month average in requests for support to the NEHFF service
  - The use of the FSP for families needing early help to prevent risks escalating remains uneven across the county. The quality of FSPs is too variable, for teams directly managed through Norfolk County Council, Norwich Families Unit and Stonham there are quality assurance processes in place, ensuring key learning and reflective practice. However ongoing work is needed to continue implementing key learning and improving practice across the whole of the multi-agency partnership.
  - A majority of requests for support came from schools with concerns of attendance, exclusions or an equivalent level of concern.
  - Of the 53 families referred in January
    75% of families were a single parent family.
    89% of families had a child(ren) historically known to social care
  - Of the 122 children registered as part of a family:
    10 children were above 18
    86 children were of school age and
    26 children were pre-school age.
  - Of those needing a multi-agency targeted support service, 87 anti-social behaviour incidents occurred across the 33 families, with ten being the most and 1 being the least. There were 7 incidents of youth crime across the 4 families with the highest being 4 and 1 being the least. A majority of families met the education criteria due to poor attendance
  - Of the 53 cases referred in January, most were from the North, then South, East, City and then West with the fewest.
  - There are currently 380 active cases open to practitioners; with some of these cases jointly worked (i.e. 2 workers in one locality working with the same family) due to the nature of their needs.
  - Practitioners are working with families for an average of 250 days (8 months).
  - Families are able to access on-going support once their agreed outcomes have been met. This support has led to a very low (1%) re-referral rate.
  - 80% of the 2264 families who have benefitted from the programme in total have had their needs met and outcomes achieved
  - Two case studies are included in the report at Appendix C and demonstrate the impact that this programme can have on the whole family.

- Technical issues on reporting from Carefirst have been identified and are impacting on Children in Need Performance. This has been identified as part of the forensic analysis of the monthly performance data that takes place on an on-going basis relying on practitioners, Business Intelligence and Performance Service (BIPS) colleagues and Performance and Challenge staff in Children's Services working closely together. Measures are being taken to rectify the identified issues and we will be able to provide a much more accurate picture of current performance from March 2015.

Child Protection

- Performance around social worker visits to children on Child Protection Plans is improving slowly and analysis of performance at the end of December highlighted that the actual performance is much higher than is reported, this is due to delays in recording

and authorising the activity. All Operational Managers are provided with explanations for each individual case where visits are not completed within timescales.

- Almost 80% of Initial Child Protection Conferences conducted were within 15 working days of a strategy discussion, an improvement on the previous 2 months.

- Fewer Section 47 Core Assessments are being conducted within timescales with performance dropping from around 80% in November and December to 64% in January. This will need further investigation to fully understand the issues that have caused this decline.

- The rate of children on Child Protection plans is lower than is seen across England and among statistical neighbours. It is expected that this rate will increase as LAC numbers further reduce and risk is managed more appropriately within communities.

Looked After Children (LAC)

- LAC numbers have risen slightly since December but overall the trend continues to be downwards. This slight rise indicates that Children's Services will continue to accommodate children where it is the right thing to do and in the best interests of the child/ren.

- While it appears that the proportion of looked-after children who receive timely health assessments is in line with national and statistical neighbour averages, recent CQC reports have revealed that health providers in Norfolk have been late in conducting these assessments. There continue to be delays in requesting health assessments for children who have been looked-after for less than 12 months. This is something that Children's Services and health colleagues are pursuing with vigour.

- Although there has been a slight decrease in the percentage of eligible care leavers with an up-to-date Pathway Plan, the overall trend is still one of improvement in performance compared to April 2014, when less than 50% were completed.

3.2 At Appendix D is an analysis of the qualitative (audit) data for the calendar year 2014.

3.3 There has been a gradual shift over the year from 'Inadequate' cases to 'Requires Improvement' cases (previously categorised by Ofsted as 'Satisfactory'). This shows gradual and sustained improvement over time. The audit team are strictly adhering to high standards and thresholds when evaluating social care work. We are confident that any erring is on the side of being over self-critical in, what is a subjective discipline but which is also subject to strict moderation by the audit team. This approach has been previously commended by both Peer Review and DfE Strategic Review teams.

3.4 At Appendix E is a detailed monthly analysis of performance of the Independent Reviewing Service for Looked-After Children. (This report also contains information on the performance of the Independent Child Protection Conference Chairs.) Highlights from this report include:

- Increased numbers of social workers' reports being received for LAC reviews (from 59% in October 2014 to 71% in December 2014).

- Increased numbers of young people being made aware of the promise (from 48% in October 2014 to 71% in December 2014).

- Notifications to IROs of changes to children's circumstances have improved slightly from 89% in September 2014 to 90% in December.

- Advocacy for children and young people in the child protection process is provided by Coram/Voice. In January the referral rate was 90% and take-up was also 90%. This has improved greatly and shows that use of the advocacy service is becoming embedded.
- Feedback forms for children and young people, for parents and for professionals who attend child protection conferences were introduced from 1st September 2014. A report based on the first six months will be produced and actions considered – in the light of changes that Signs of Safety will bring.

- Caseloads for Independent Chairs and Independent Reviewing Officers is a long-standing challenge. Recently there have been attempts to increase the number of sessional staff both from within Children's Services and from neighbouring authorities. How this affects performance will be reported in future reports.

4. Issues, risks and innovation

4.1 Appendix F shows the children's services corporate risks and mitigations. This is the latest version of the register.

4.2 These risks are regularly reviewed by both the CS Leadership Team and the Chief Officer group and are reported and reviewed at each Audit Committee meeting.

4.3 **Equality Impact Assessment (EqIA)**
This report deals with equality issues throughout.

5. Conclusions

5.1 Improvement in Children's Services continues to be given a high priority by the Council with determined focus on safeguarding and support and challenge for schools. Our first priority is to make sure that all children are safe and achieve the best possible educational outcomes. We will then build dynamic, self-assured, forward thinking, sustainable services that are valued and recognised as outstanding by all service users, staff, auditors and inspectors. We will increasingly work with all our partners to ensure we provide a consistently high quality service that achieves the best possible positive outcomes and impact for children and families. We will get it right for every child every time.

5.2 This report summarises our improvement progress using performance measures contained in scorecards and associated information and data to demonstrate impact and highlight issues. The report also demonstrates mitigations against the four corporate risks that children's services are currently reporting which are shown above.

6. Action

6.1 The Health and Wellbeing Board is asked to:

- Consider and comment on the report.

Officer Contact

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

Name	Tel	Email
Helen Wetherall	01603 224368	helen.wetherall@norfolk.gov.uk

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

Norfolk County Council

February 2015

Norfolk Children's Services Education Improvement Plan Scorecard

A Good School for Every Norfolk Learner
2014 – 2015

Phase 2 – Embedding the Local Authority Strategy for Supporting School Improvement

SCORECARD

The Local Authority has 4 key strategic aims which underpin the support provided to settings, schools and colleges. The support for school improvement sits within a broader ambition of 'A Good Education for Every Norfolk Learner'. The four key aims are to:

Aim 1: Raise Standards at all Key Stages
Aim 2: Increase proportion of schools judged good or better
Aim 3: Improve leadership and management
Aim 4: Improve monitoring and evaluation of impact

(This scorecard reflects measurable data for Aim 1 and Aim 2 for routine monitoring purposes)

Performance Monitoring – Against LA High Level Strategic Targets for Improvement

Aim 1: Raise Standards at all Key Stages

Data is collected each half term from Norfolk schools that are identified through the LA risk assessment as schools causing concern (SCC) including Academies, and those already judged to require improvement or those at risk of requiring improvement (RI). The data collected from these schools is analysed school by school by the Education Achievement service and an interpretation is sent back to the school with comments.The Education Intervention Service then follow up with schools of concern to quality assure the data provided.

Each school's data is aggregated to calculate an overall percentage in order to monitor whether all SCC and all RI are on track to meet 2015 targets. This data is then further aggregated with the 2014 outcomes for the remaining schools (ie those that are risk assessed as good or better) to see the impact of intervention and support on the overall trajectory to meet 2015 targets.

Aim 2: Increase the proportion of schools judged good or better

Outcomes from school inspections are monitoried weekly. A report is provided to the Assistant Director of Children's Services showing the impact of Norfolk inspections on our trajectory towards our 2014 targets. Further analysis is undertaken to show the impact of intervention, challenge and support on inspection outcomes by LA risk category.

Key		
Green	Performance is in line with national or better	*Latest – represents the latest value and rating available at the time of reporting
+	Performance above national	
Amber	Performance is off-track (up to 4% below national)	
Red	Performance is well below national (more than 4% below national)	
↑ / ↓	Improvement / decline from 2014 Norfolk outcomes	
Frequency	Frequency of reporting is given against each measure - available Monthly [M], Quarterly [Q], Bi-annually [B] or Annually [A], some measures with © against are cumulative figures so data cannot be compared month to month as numbers will always increase.	

Aim 1: Raise Standards at all Key Stages

1.1 Improve Early Years outcomes

Percentages represent the percentage of pupils.

FSM = Pupils eligible for Free School Meals at any point in the last 6 years

All = All pupils in the cohort

2015 predictions are derived from half termly report card data for schools where outcomes are not good, combined with 2014 outcomes for good and outstanding schools who are not required to submit half termly data.

				2015 Predictions					
		2013	2014	Aut 1	Aut 2	Spr 1	Spr 2	Sum 1	Sum 2
Norfolk	All	46	58 ↑	58	60 ↑				
	FSM	32	43 ↑		45 ↑				
Breckland	All	41	58 ↑	55 ↓	58				
	FSM	28	49+ ↑		42 ↓				
Broadland	All	52	60 ↑	61+	62 +↑				
	FSM	37 +	41 ↑		46 + ↑				
Great Yarmouth	All	40	57 ↑	56 ↓	62 +↑				
	FSM	32	48+ ↑		51 + ↑				
Kings Lynn & West	All	47	61+ ↑	61+	62 +↑				
	FSM	34	43 ↑		48 +↑				
Norwich	All	38	51 ↑	52 ↑	49 ↓				
	FSM	28	38 ↑		39 ↑				
North	All	48	57 ↑	59 ↑	65+ ↑				
	FSM	37+	45 ↑		50+ ↑				
South	All	55+	60 ↑	59 ↓	61				
	FSM	32	42 ↑		44↑				
National	All pupils	52	60						
	FSM	36	45						

In order to trackthe progress in closing the gap with national averages - the colour codingrelates to the Norfolk gaps to national average .

We have not collected FSM data in autumn term 1 (Schools should compare the FSM gap with pupils who are not FSM – and <u>not</u> to the average for All children. So it is advisable not to calculate the gap between FSM and All children)

1.2: Improve Outcomes at Key Stage 2

Percentages represent the percentage of pupils.

FSM = Pupils eligible for Free School Meals at any point in the last 6 years

All = All pupils in the cohort

2015 predictions are derived from half termly report card data for schools where outcomes are not good, combined with 2014 outcomes for good and outstanding schools who are not required to submit half termly data.

				2015 Predictions					
		2013	2014	Aut 1	Aut 2	Spr 1	Spr 2	Sum 1	Sum 2
Norfolk	All	71	74 ↑	75 ↑	76 ↑				
	FSM	55	59 ↑	62 ↑	63 ↑				
Breckland	All	64	68 ↑	68	69 ↑				
	FSM	48	51 ↑	57 ↑	55 ↑				
Broadland	All	78+	82+ ↑	83+ ↑	84 +↑				
	FSM	67+	69+ ↑	70+ ↑	73 +↑				
Great Yarmouth	All	65	74 ↑	72 ↓	74 ↑				
	FSM	55	62 ↑	58 ↓	65 ↓				
Kings Lynn & West	All	69	73 ↑	73	76 ↑				
	FSM	53	58 ↑	64 ↑	64 ↑				
North	All	72	75 ↑	75	76 ↑				
	FSM	56	63 ↑	64 ↑	63				
Norwich	All	66	72 ↑	72	74 ↑				
	FSM	57	60 ↑	63 ↑	64 ↑				
South	All	79+	82+ ↑	82+	82 +				
	FSM	60	63 ↑	63	65 ↑				
National	All pupils	76	**79**						
	FSM	63	**67**						

In order to track the progress in closing the gap with national averages - the colour coding relates to the Norfolk gaps to the national average .

(Schools should compare the FSM gap with pupils who are not FSM – and <u>not</u> to the average for All children. So it is advisable not to calculate the gap between FSM and All children.)

1.3: Improve outcomes at Key Stage 4

Percentages represent the percentage of pupils.

FSM = Pupils eligible for Free School Meals at any point in the last 6 years

All = All pupils in the cohort

2015 predictions are derived from half termly report card data for schools where outcomes are not good, combined with 2014 outcomes for good and outstanding schools who are not required to submit half termly data.

				2015 Predictions					
		2013	2014	Aut 1	Aut 2	Spr 1	Spr 2	Sum 1	Sum 2
Norfolk	All	55	52 ↓	55 ↑	56 ↑				
	FSM	31	30 ↓	33 ↑	35 ↑				
Breckland	All	50	52 ↑	54 ↑	55 ↑				
	FSM	26	33 ↑	34 ↑	34 + ↑				
Broadland	All	60	58+ ↓	60+ ↑	64 + ↑				
	FSM	34	33 ↓	38+ ↑	42 + ↑				
Great Yarmouth	All	48	44 ↓	51 ↑	51 ↑				
	FSM	30	29 ↓	37+ ↑	37+ ↑				
Kings Lynn & West	All	54	45 ↓	47 ↑	45				
	FSM	34	24 ↓	23	27 ↑				
North	All	57	59+ ↑	62+ ↑	61 +↑				
	FSM	34	42+ ↑	42+	41+↓				
Norwich	All	46	49 ↑	50 ↑	51 ↑				
	FSM	26	28 ↑	30 ↑	27 ↓				
South	All pupils	66+	61+ ↓	62+ ↑	64 + ↑				
	FSM	43+	32 ↓	35 ↑	38 + ↑				
National	All pupils	60	**55***						
	FSM	41	**36****						

The 2014 results are FIRST and cannot be compared to 2013 results

In order to track the progress in closing the gap with national averages - the colour codingrelates to the Norfolk gaps to the national average .

(Schools should compare the FSM gap with pupils who are not FSM – and <u>not</u> to the average for All children. So it is advisable not to calculate the gap between FSM and All children)

* Unvalidated data from RAISEonline
** NCER calculated National, not officially published

Aim 2: Increase the proportion of schools judged good or better

Shown as a percentage of schools, the number of settings or schools is shown in brackets.The denominator represents the current number of schools that have an Ofsted judgement.

		July 2012		July 2013		July 2014		December 2014			April 2015			July 2015			
		Norfolk Actual	National (June 2012)	Norfolk Actual	National (June 2013)	Norfolk Actual	National	Norfolk Actual	Norfolk Target	National	Norfolk Actual	Norfolk Target	National	Norfolk Actual	Norfolk Target	National	Latest Norfolk
% should increase	%Early Years settings judged good or better	78%+	74%	78%+	77%	78%+	77%										
	%Primary phase schools judged good or better	60%	69%	64% ↑	78%	70% ↑	81%	72% ↑									73%↑
	%Secondary phase schools judged good or better	47%	66%	63% ↑	72%	62% ↓	70%	60%↓									64% ↑
	%Special schools judged good or better	91%	81%	82% ↓	87%	91% ↑	90%	91%									91%
% should decrease	Reduce % of schools in an Ofsted category	3%	3%	4% ↑	3%	4%	3%	4%									3% ↓
	Reduce % of schools judged to Require Improvement	37%	28%	32% ↓	19%	25% ↓	17%	25%									25%

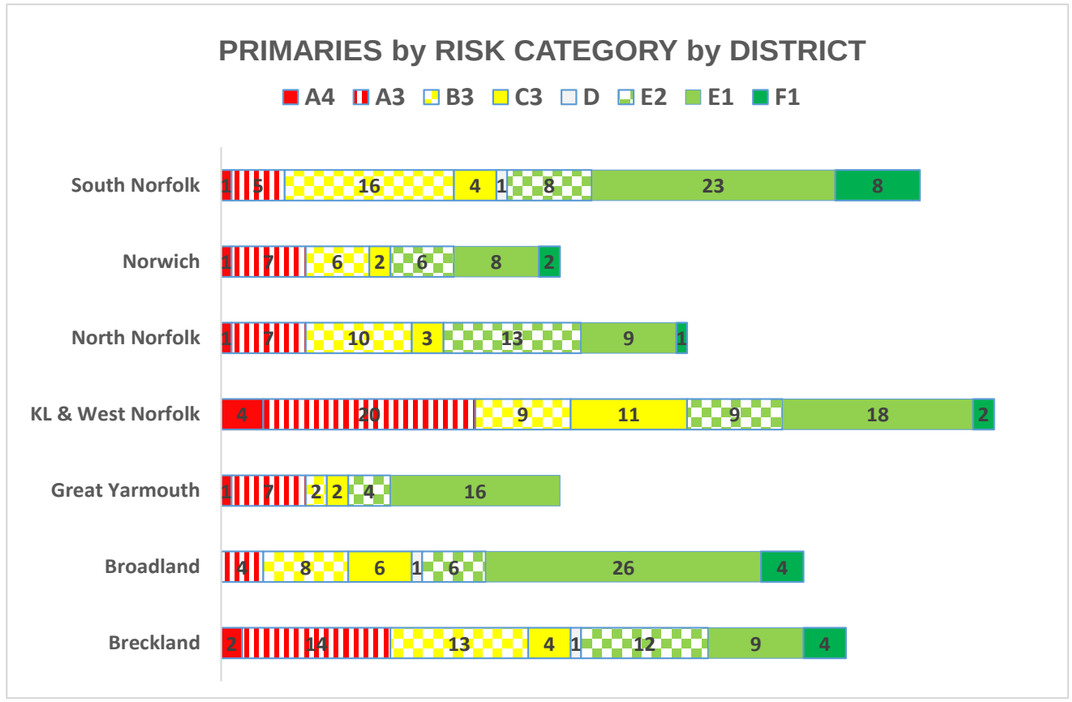
Reduction in District Variation: Percentage of all schools, percentage of schools judged good or better :

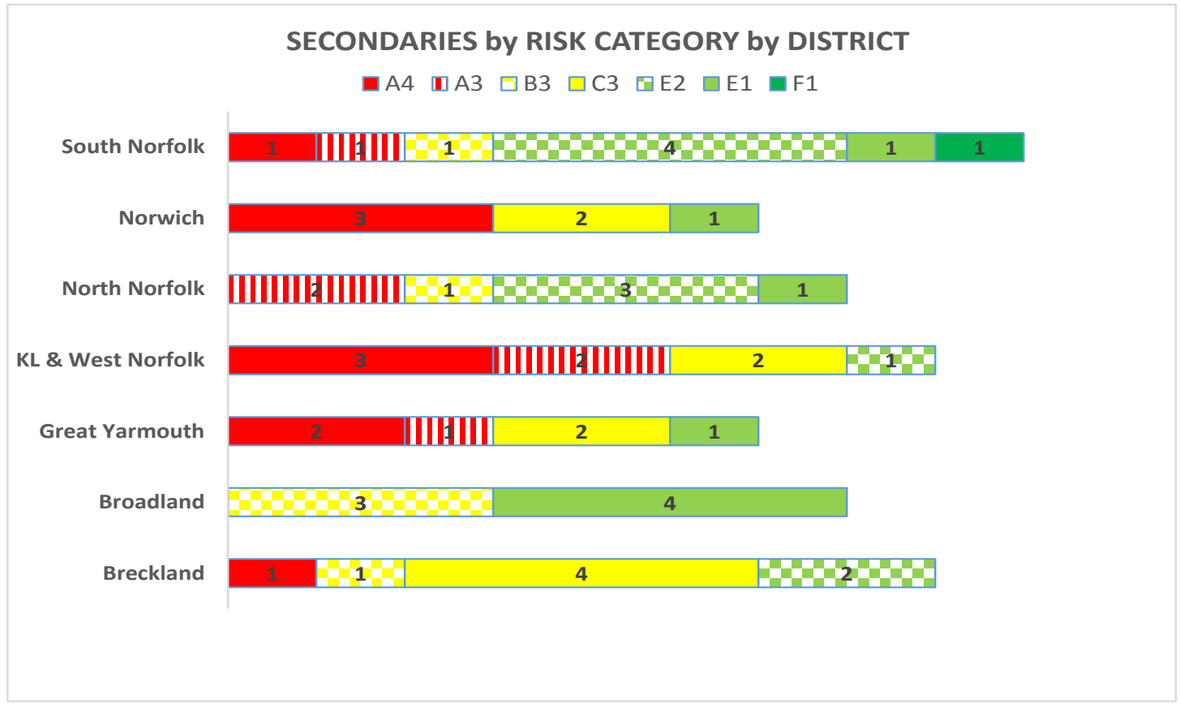
	Autumn 2013	July 2014	December 2014	April 2015	July 2015	Norfolk Latest
Norfolk	66% (270/409)	70% (287/403) ↑	72% (283/396)			72% (285/399) ↑
Breckland	64% (41/64)	69% (44/64) ↑	66% (42/64) ↓			68% (43/64) ↓
Broadland	77% (46/60)	75% (45/60) ↑	77% (46/60) ↓			75% (45/59) ↑
Great Yarmouth	56% (20/36)	65% (22/34) ↑	67% (22/33) ↑			69% (22/32) ↑
Kings Lynn & West	52% (51/79)	63% (49/77) ↑	64% (47/73) ↑			64% (46/73) ↓
Norwich	66% (27/41)	70% (28/40) ↑	69% (27/39) ↓			72% (28/40) ↑
North	65% (35/54)	73% (39/54) ↑	75% (40/53) ↑			77% (40/55) ↓
South	80% (59/74)	81% (59/73) ↑	81% (59/73)			81% (59/73)
National (Data View)		81%				

In order to track the progress in closing the gap with national averages - the colour coding relates to the Norfolk gaps to the national average .
(Numerator is number of schools inspected, denominator is number of schools with an inspection status. The denominator changes as schools become sponsored Academies)

Aim 2: - Increase the proportion of schools judged good or better

The LA risk assessment of schools is designed to provde the appropriate relationship between the LA and a school in order to challanege achievement, target service activity, intervene and broker relevant support. This risk assessment is revised termly (or sooner if a school becomes of concern to the LA). It is not a prediction of an Ofsted ouctome, but a judgement on published achievement outcomes – which could put the school at risk of a similar judgement in an Ofsted inspection. (In a small number of cases schools are risk assessed as of concern to the LA for reasons other than achieviement – e.g. significant staffing issues including poor leadership and governance which has capacity to affect provision and outcomes for pupils).





Key - Schools are risk assessed into 3 broad bands, made up of 6 categories shared with schools, and 8 internal LA categories for differentiated intervention, challenge and support.

3 broad bands of schools	Confidential risk shared with school	LA internal risk categories
A = School of Concern	A schools	A4 = school of concern
		A3 = school of concern – and improving1
	D schools	D = temporary school of concern
B / C = Requiring Improvement	B schools	B3 = Requires Improvement (RI) or risk of RI but stuck and declining)
	C schools	C3 = Requires Improvement (RI) or risk of RI but improving)
E /F = Good and Outstanding schools schools	E schools	E2 = Good , but some minor issues which might affect good judgement
		E1 – solidly good
	F schools	F1 - Outstanding

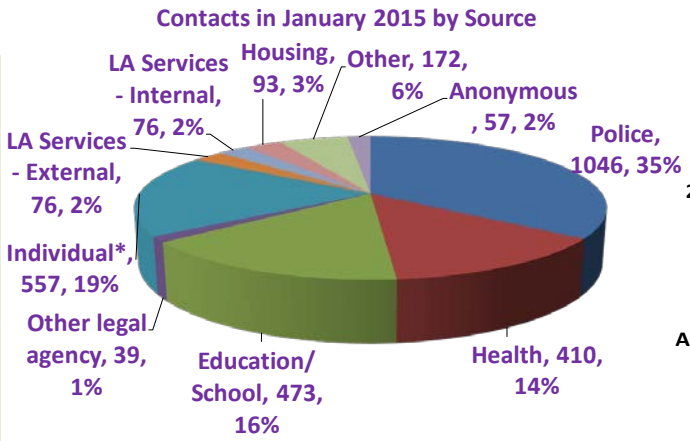
Norfolk Children's Services Social Care Performance Overview Dashboard – January 2015 Data

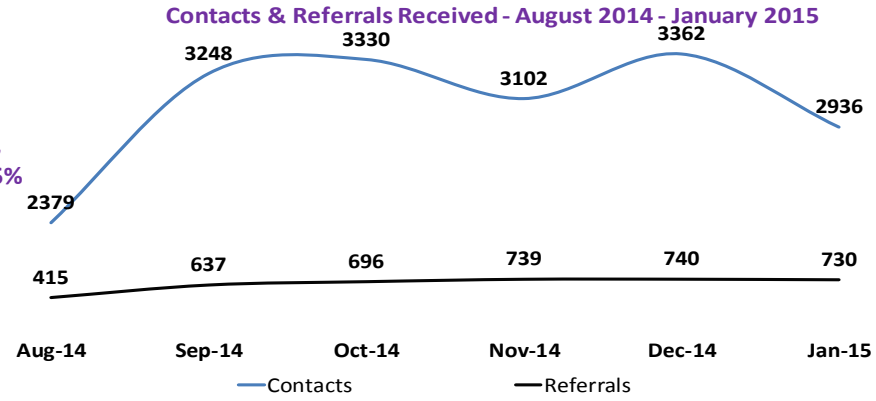
Contacts and Initial Assessments:

Initial Contacts by Source:

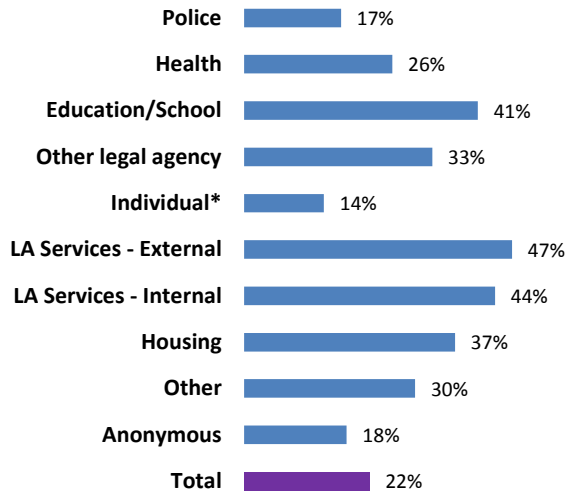
	Nov-14	Dec-14	Jan-15
Police	1021	1380	1046
Health	457	465	410
Education/ School	522	410	473
Other legal agency	84	104	39
Individual*	543	502	557
LA Services - External	52	107	76
LA Services - Internal	58	62	76
Housing	87	99	93
Other	218	198	172
Anonymous	60	35	57
Total	**3102**	**3362**	**2999**

* Individuals are comprised of: Stranger/Family/Carer/ Neighbour/Self





Conversion of Contacts to Referrals by Source:

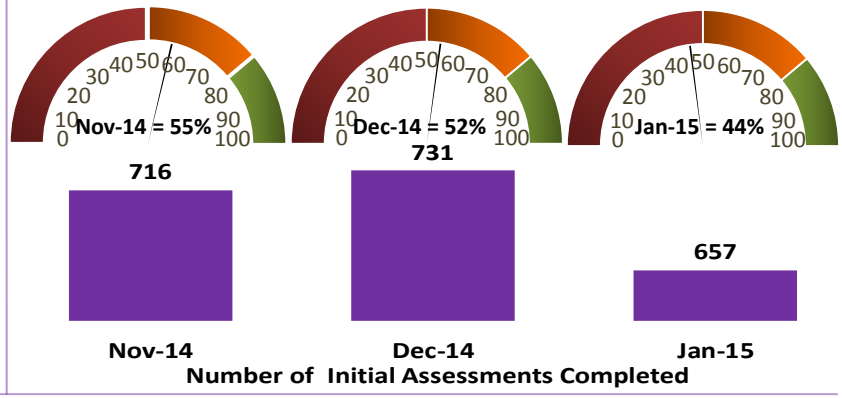


* Individuals are comprised of: Stranger/Family/Carer/ Neighbour/Self

Percentage of Re-Referrals:

Re-Referrals	Nov-14	Dec-14	Jan-15
Norfolk	22.6%	28.1%	22.6%
England 2013/14	23.4%		
Statistical Neighbours 2013/14	26.1%		
East of England 2013/14	22.4%		

Initial Assessments Completed in Timescales:



Commentary:

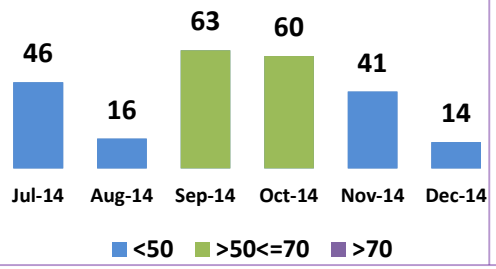
While the number of contacts reduced by almost 10% in January, compared with December which is a traditionally a peak month, the number of referrals has remained fairly constant, resulting in a slight increase in the conversion rate. The proportion of re-referrals has reduced from a high in December and is in line with the England and statistical neighbour averages.

It is unacceptable that only 44% of Initial Assessments were completed within the 10 working day timescale. Further analysis of the data shows that 90% of Initial Assessments where the outcome was to conduct a strategy discussion were completed in timescales, however this dropped to only 27% where the outcome was for a Core Assessment or CIN Plan. Operational managers have been written to requesting explanations for current performance levels in this area. Managers continue to insist that assessments are completed to a good standard which is also impacting upon timescales. 60% were completed within 15 working days.

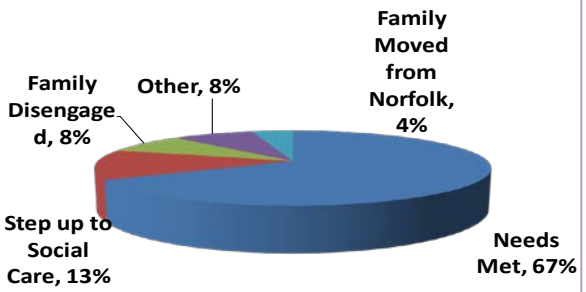
Norfolk Children's Services Social Care Performance Overview Dashboard – January 2015 Data

Early Help & Children in Need:

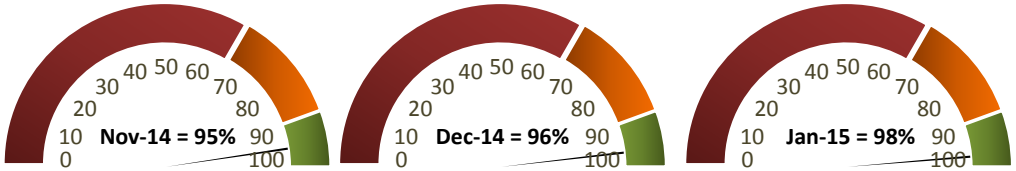
Family Support Plans Initiated:



Outcomes of Family Support Plans closed 1st January – 31st December 2014:



Children in Need Allocated to a Qualified Social Worker:



Section 17 Children in Need in CIN & CWD Teams with an up-to-date* CIN Plan:

	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
No. s17 Children in Need	1364	1270	1157	1117	1063	1028
No. s17 with CIN Plan	593	587	512	518	578	600
No. s17 without a CIN Plan	771	404	645	599	485	428
% with a CIN Plan	**43.5%**	**46.2%**	**44.3%**	**46.4%**	**54.4%**	**58.4%**
No. CWD Children in Need	335	322	317	304	299	292
No. CWD with CIN Plan	135	132	252	257	245	239
No. CWD without a CIN Plan	200	190	65	47	54	53
% with a CIN Plan	**40.3%**	**41.0%**	**79.5%**	**84.5%**	**81.9%**	**81.8%**

* To count as having a CIN Plan, any existing plan must have been started or reviewed within the last 30 working days

Rate of Children in Need per 10,000 Under-18 Population:

	Nov-14	Dec-14	Jan-15
Norfolk (Current)	307.2	306.5	336.3
England 13/14		346	
Statistical Neighbours 13/14		339.0	

CIN Reviewed within Timescales:

	Reviewed in Timescales		
	In Time	Out of Time	% In Time
CIN Teams	629	399	**61.2%**
CWD Teams	245	47	**83.9%**
Other Teams	303	703	**30.1%**

Ethnicity & Gender of S17 Children in Need:

Ethnicity	Female	Male	Unborn	U/K	Total	% Cohort
Any other ethnic origin	12	13	1		26	1.1%
Any other mixed background	22	20			42	1.8%
Arab	2				2	0.1%
Asian - any other background	3	6			9	0.4%
Bangladeshi		4			4	0.2%
Black - any other background	7	9			16	0.7%
Black African	8	11			19	0.8%
Black Caribbean			1		1	0.0%
Chinese	1				1	0.0%
Indian	4	1			5	0.2%
Not yet Available / Unknown	23	26	19		41	1.8%
White - other background	85	85	2		172	7.4%
White and Asian	2	2			4	0.2%
White and Black African		8	1		9	0.4%
White and Black Caribbean	5	10			15	0.6%
White British	880	1006	41	1	1928	82.9%
White Irish	2	3			5	0.2%
Total	**1056**	**1204**	**65**	**1**	**2326**	**100%**

Commentary:

A lack of a central recording & case management system means that there is often late notification of Family Support Plans initiated to the central team, which in turn creates the impression that fewer FSPs are being conducted. A new system has been procured and is scheduled to be operational from Spring 2015 which will enable new FSPs to be recorded in a much timelier manner.

Reporting issues around identifying the true CIN cohort for non- Children in Need teams artificially suppresses their performance in terms of reviews being conducted within timescales. Measures are being taken to rectify these issues and we will be able to provide a much more accurate picture of current performance in March 2015.

The apparent increase in the rate of Children in Need will also be, in part, linked to the reporting issue outlined above. Again, it is anticipated that this will be rectified in March 2015.

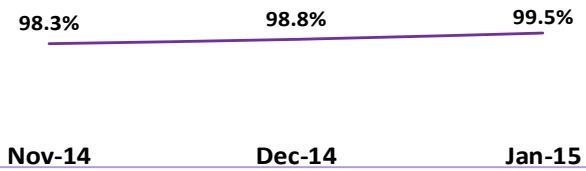
The gender split of Section 17 Children in Need (53% Male, 47% Female [excluding unborn & unknown]) does not significantly differ from the overall Norfolk 0-17 population of 51% Male / 49% Female.

Norfolk Children's Services Social Care Performance Overview Dashboard – January 2015 Data

Child Protection:

Children in Child Protection Teams Allocated to a Qualified Social Worker:

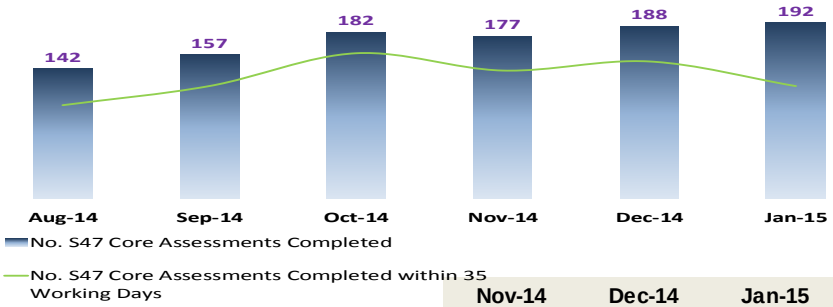
	Nov-14	Dec-14	Jan-15
No. Children on CP Plan	529	570	558
No. Allocated to Qualified Social Worker	520	563	555
% Allocated to Qualified Social Worker	98.3%	98.8%	99.5%



Rate of Children on a CP Plan per 10,000 Under-18 Population:

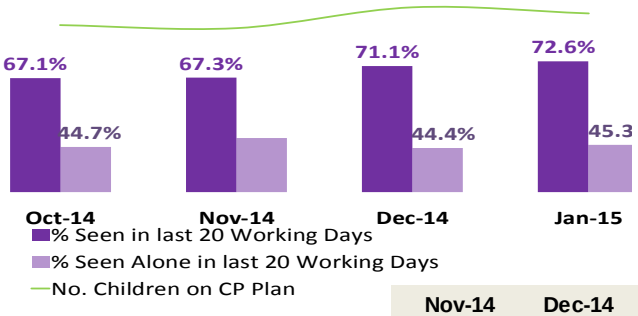
	Nov-14	Dec-14	Jan-15
Norfolk (Current)	31.9	34.4	33.6
Norfolk 13/14		32.3	
England 13/14		42.1	
Statistical Neighbours 13/14		45	

Section 47 Core Assessments Completed in Timescales:



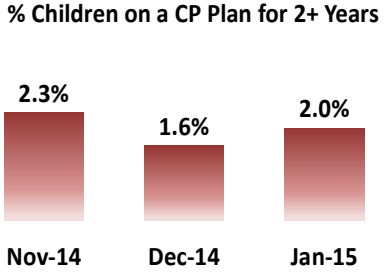
	Nov-14	Dec-14	Jan-15
No. Section 47 Core Assessments Completed	177	188	192
No. Section 47 Core Assessments Completed within 35 Working Days	140	150	123
% Section 47 Core Assessments Completed within 35 Working Days	79.1%	79.8%	64.1%

Social Worker visits to Children on a Child Protection Plan in Timescales:

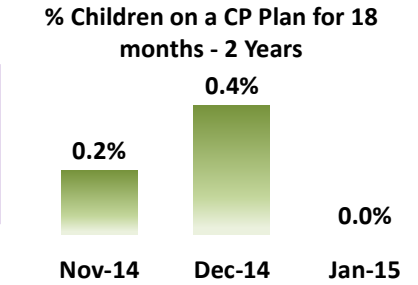


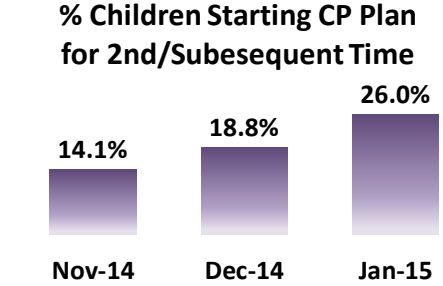
	Nov-14	Dec-14	Jan-15
No. Seen in last 20 Working Days	356	405	449
No. Seen Alone in last 20 Working Days	252	253	285

Children on a CP Plan for 18 months & Over and Children Starting a CP Plan for a Second/Subsequent Time:



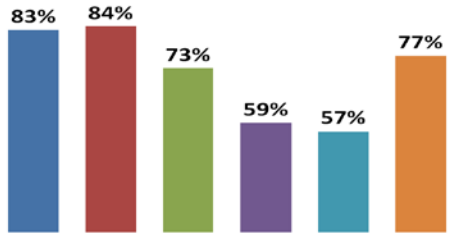
England 13/14 = 2.6%; Stat Nbr = 3.1%





England 13/14 = 15.8%; Stat Nbr = 17.4%

ICPCs within 15 Working Days of Strategy Discussion:



	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
Total ICPCs	60	83	101	90	113	64
Within 15 Working days	50	70	74	53	64	49
Over 15 Working Days	10	13	27	37	49	15

Commentary:

Performance around social worker visits to children on Child Protection Plans is improving slowly and analysis of performance at the end of December highlighted that the actual performance is much higher than is reported, this is due to delays in recording and authorising the activity. All Operational Managers are provided with explanations for each individual case where visits are not completed within timescales.

Almost 80% of ICPCs conducted were within 15 working days of a strategy discussion, an improvement on the previous 2 months.

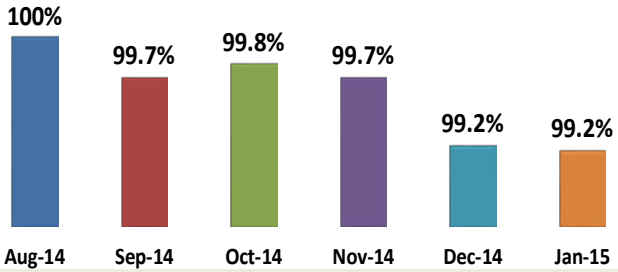
Fewer Section 47 Core Assessments are being conducted within timescales with performance dropping from around 80% in November & December to 64% in January. This will need further investigation to fully understand the issues that have caused this decline.

The rate of children on Child Protection plans is lower than is seen across England & among statistical neighbours. It is expected that this rate will increase as LAC numbers further reduce and risk is managed more appropriately within communities.

Norfolk Children's Services Social Care Performance Overview Dashboard – January 2015 Data

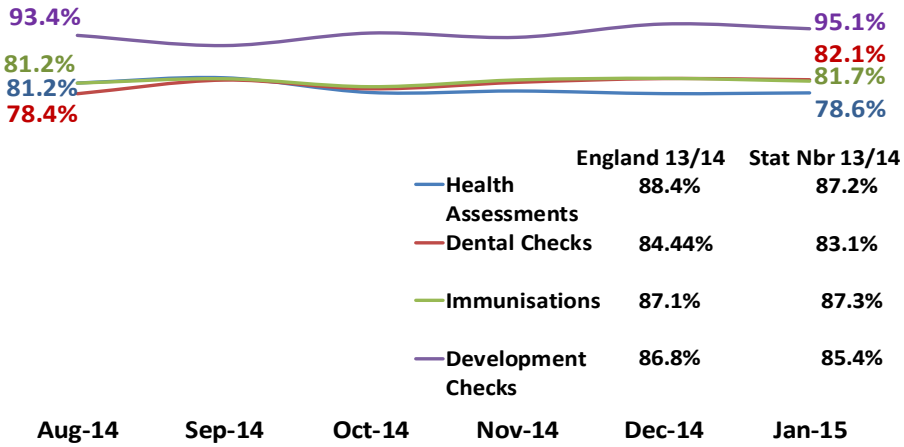
Looked-After Children:

Looked-After Children allocated to a Qualified Social Worker:



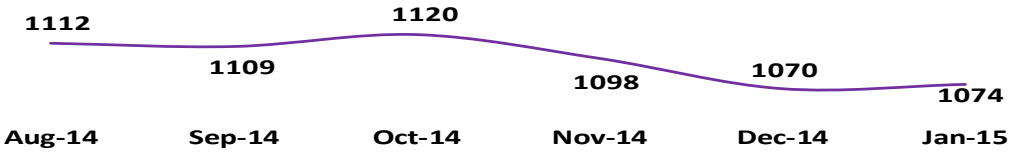
	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
Number	1090	1106	1118	1095	1061	1065

Health of Looked-After Children:

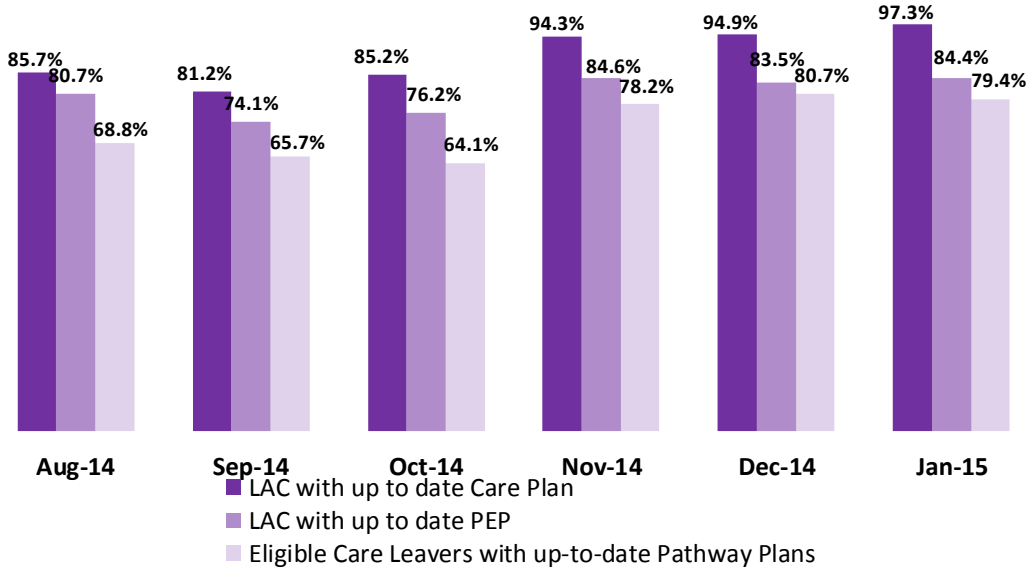


	England 13/14	Stat Nbr 13/14
Health Assessments	88.4%	87.2%
Dental Checks	84.44%	83.1%
Immunisations	87.1%	87.3%
Development Checks	86.8%	85.4%

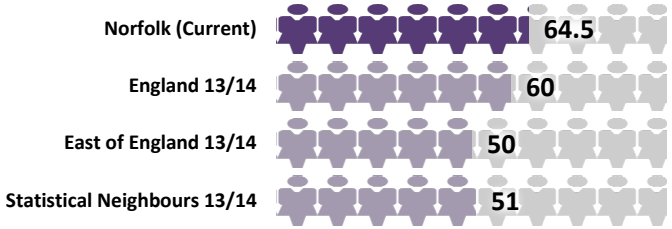
Number of Looked-After Children:



Care Plans, Pathway Plans & Personal Education Plans:



Rate of LAC per 10,000 Under-18 Population



Commentary:

LAC numbers have risen slightly since December but overall the trend continues to be downwards.

While it appears that the proportion of looked-after children who receive timely health assessments is in line with national and statistical neighbour averages, recent CQC reports have revealed that health providers in Norfolk have been late in conducting these assessments. There continue to be delays in requesting health assessments for children who have been looked=after for less than 12 months.

Although there has been a slight decrease in the percentage of eligible care leavers with an up-to-date Pathway Plan, the overall trend is still one of improvement in performance compared to April 2014, when less than 50% were completed.

Norfolk Early Help Family Focus
January 2015

Performance Report: County Overview

From 1st March 2015 a Monthly Locality Report will be prepared as part of this document

Content

Summary

Families Identified

Referrals

Allocations

Monitoring

Outcomes Achieved, Closures & Score Card

Customer Journey

Case Studies

Area Reports (to follow)

1. City
2. North
3. East
4. South
5. West

Any queries regarding this report please contact officers:

Elizabeth Broadhurst (Head of Service and Partnership) or

Tracey Walton (Norfolk Early Help Family Focus Project Manager)

Summary

OfSTED (February 2013) identified that the early help offer for children and their families was underdeveloped. With some aspects of early help provision strengthened by the re-commissioning of children's centres, which now focus more clearly on vulnerable families.

Norfolk has encountered some difficulties getting the Troubled Families programme (Norfolk Family Focus) off the ground, in addition our OfSTED report noted that we needed to 'ensure the receipt of timely early intervention services for vulnerable children and their families by accelerating the development and dissemination of a coherent and shared early help offer to ensure that there is consistent offer across the county'. The Norfolk Early Help Strategy pulled together partners to create an approach that ensures children receive the right support at the earliest point of identified need as this continues to be a challenge in Norfolk.

Therefore with these challenges in mind it was decided and agreed that we need to proceed with plans to realign the *Family Support Programme* and *Norfolk Family Focus, bringing them together in to one offer*. Aiming to establish one joined up process to deliver support to those families who have an identified and targeted need. In late 2014 teams expanded from 3 to 5 localities including a significant increase of frontline practitioners.

In January 2015, the Norfolk Early Help Family Focus (NEHFF) and Family Support data was brought together to provide a picture of early intervention or step down from specialist support (CIN/CP) services across the county.

Operational teams have been working hard to build up the profile of this expanded offer, by meeting with partners, schools and other key stakeholders. Referrals are increasing at a steady rate. However there is an ongoing need to raise the Early Help profile and build trust amongst stakeholders and families around the offer.

This report is the start of producing robust performance management reports.

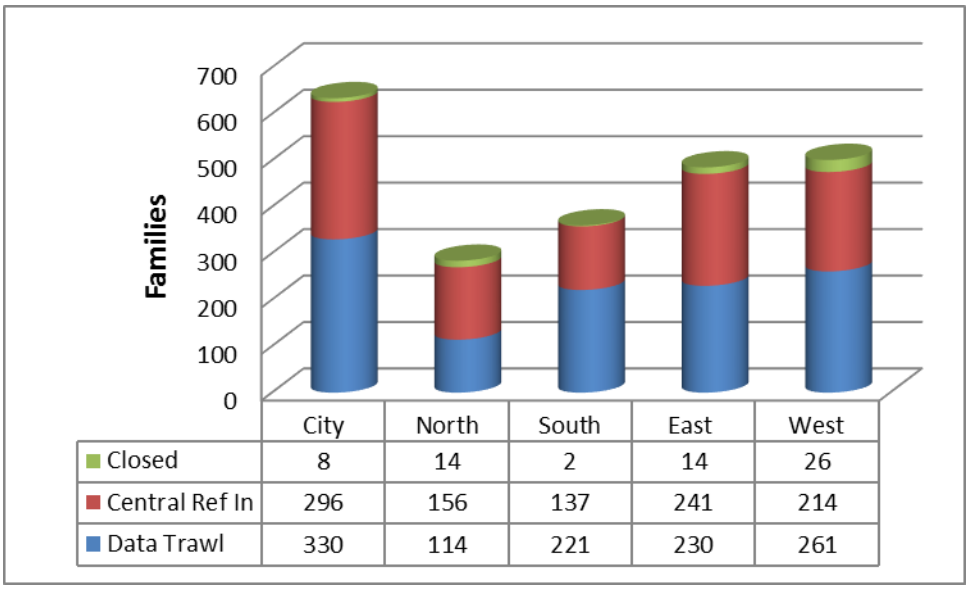
1. Families Identified

1.1 Families Identified

The Norfolk Early Help Family Focus (NEHFF) and Family Support data has been brought together to provide a picture of early intervention or step down from specialist support (CIN/CP) services across the county.

In April 2012, the Government launched the Troubled Families Programme: a £448 million scheme to incentivise local authorities and their partners to turn around the lives of 120,000 troubled families by May 2015. Norfolk's contribution was to identify, work with and turn around the lives of 1700 families.

At the end of January 2015 there were 2428 active Family Support Assessments. To date Norfolk has identified 2264 families who meet the troubled families criteria.



	City	North	South	East	West
Closed	8	14	2	14	26
Central Ref In	296	156	137	241	214
Data Trawl	330	114	221	230	261

Figure 1

These figures may be incorporated those families who meet the troubled families criteria as the family support process is incorporated within the approach.

2. Referrals

2.1 Requests for Support

The service saw 53 cases referred into Norfolk Early Help Family Focus (NEHFF) in January 2015 for support. The figures for January only, include all requests for support (R4S) and Family Support Process (FSP) uploads.

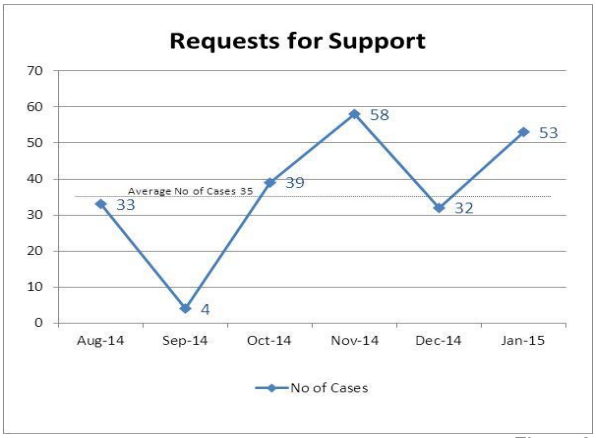


Figure 3

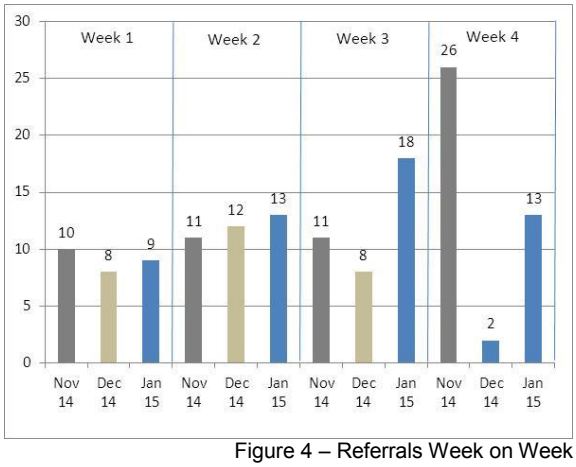


Figure 4 – Referrals Week on Week

In January 15 NEHFF received 43 referrals into the service and 10 uploaded FSP's. This means in January there was a 21% increase above the last 6 month average in request for support to the NEHFF service. Figure 3 & 4 includes FSPs uploaded in January only[1]. As FSPs are part of the central referral in process they will be recorded as part of the data set with enhance recording and future analysis.

It is likely once the FSP data is migrated and analysed for post January, it will show a decrease in FSPs. This is in part to the change in role (Locality CAF Leads became part of the Interim Team Managers across the county) together with Schools and partner agencies reporting that they are unable to complete FSPs without the support of CAF Leads. However, in many instances this function is now being fulfilled by Family Practitioners from within NEHFF service and we expect there to be an increase in the FSP's as it is a mandatory tool across the early help offer.

Figure 4 demonstrates the number of referrals coming into the service week on week, it appears to show that, Christmas notwithstanding, there appears to be a surge in week four. Resources are aligned within the central referral in team to meet the demand during this period.

Referrers[2] took on average 9 working days to complete the paperwork and for the NEHFF service to receive the request for support.
The longest period of time was 66 days and the shortest being 0 (receipt same day as referrer signed paperwork). The reasons for the long delays are being identified and will be reported in the next report.

The use of the FSP for families needing early help to prevent risks escalating remains uneven across the county. The quality of FSPs is too variable, for teams directly managed through Norfolk County Council, Norwich Families Unit and Stonham there are quality assurance processes in place, ensuring key learning and reflective practice. However ongoing work is needed to continue implementing key learning and improving practice.

We expect the newly procured case management system to tell us the journey throughout the family support process in addition to the data we already collect.

[1] *We are unable to include historic FSP data into this report as there is a potential to double count.*

[2] *Referrers includes partner organisations therefore creating a difficulty around the ability to performance manage.*

2.2 Types of Referrals

The NEHFF service accepts referrals from established Help Hubs, Self Referrals, NEHFF Requests for Support, Uploaded FSP's, Mash Requests for Support and Steps downs from Social Care.

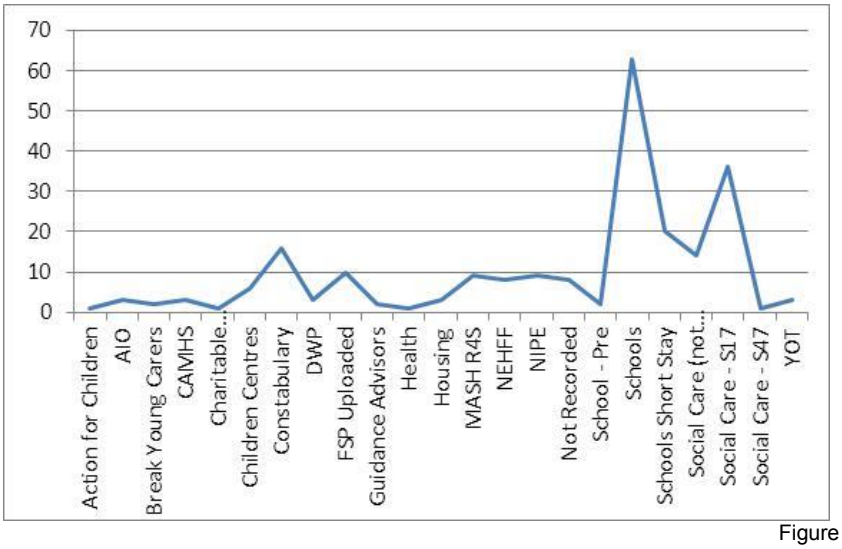


Figure 5

A majority of requests for support came from schools with concerns of attendance, exclusions or an equivalent level of concern.

Figure 5 demonstrates the referrals received from providers month on month.

	Action for Children	AIO	Break Young Carers	CAMHS	Charitable Organisation	Children Centres	Constabulary	DWP	FSP Uploaded	Guidance Advisors	Health	Housing	MASH R4S	NEHFF	NIPE	Not Recorded	School - Pre	Schools	Schools Short Stay	Social Care (not defined)	Social Care - S17	Social Care - S47	YOT
Total	1	3	2	3	1	6	16	3	10	2	1	3	9	8	9	8	2	63	20	14	36	1	3
Jan-15	1	1	1	1			2		10				4	3	2	4		14	3	4	5		
Dec-14							2						1	2		2	1	13	3	2	9	1	2
Nov-14						1	6	1		2		2		3	4	1	1	16	3	7	5		1
Oct-14		2		1	1	1	3						1		1			11	6		9		
Sep-14						3		1					1		2	1		2	3	1	5		
Aug-14			1	1		1	3	1			1	1	2					7	2		3		

Figure 6

8 cases were stepped down from social care. Each locality holds a monthly transfer meeting between CiN, CP, NIPE and Early Help. These meetings are in their infancy but there are areas of best practice emerging, Broadland CiN and the NEHFF team have been able to demonstrate strong practice in this area.

In the coming weeks and months a renewed focus needs to be targeted around embedding the case transfer process between specialist services and Early Help.

Operational teams have communicated with schools as the main source of identifying children in need of a multi-agency response and schools request for support regarding the family support process. The NEHFF service works closely with operational partnership teams (OPTs) and has Police Constable Support Officers (PCSO) embedded within most of the teams. Work at a regional level is ongoing with DWP to increase employment referrals and support. As defined within the Early Help Approach document, and actions with the communications plan, there is much work to do and planned regarding communications with our wider partners and ensuring our offers is clearly understood, that will increase appropriate referrals.

2.3 Family Information at Point of Referral

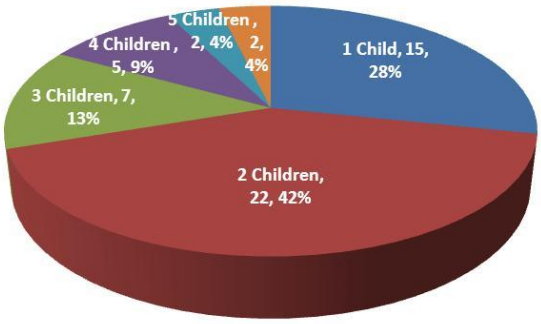


Figure 7

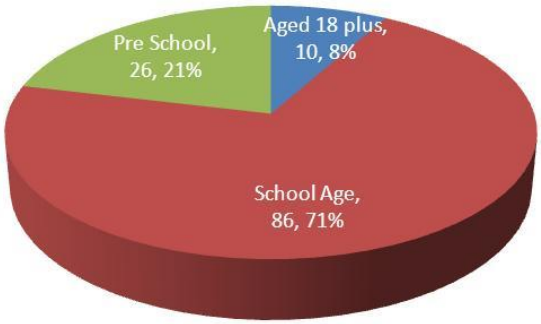


Figure 8

Of the 53 families referred in Jan 15

- 75% of families were a single parent family.
- 89% of families had a child(ren) historically known to social care (8 current families).

Of the 122 children registered as part of a family:

- 10 children were above 18, registered with other siblings in the family,
- 86 children were of school age and
- 26 children were pre-school age.

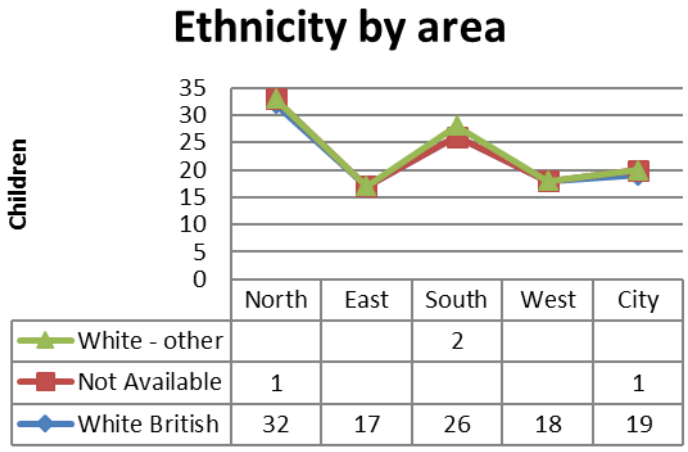


Figure 9

For the most part, the ethnicity was recorded as White British. In the South, there is a small pocket of Lithuanian and Portuguese families.

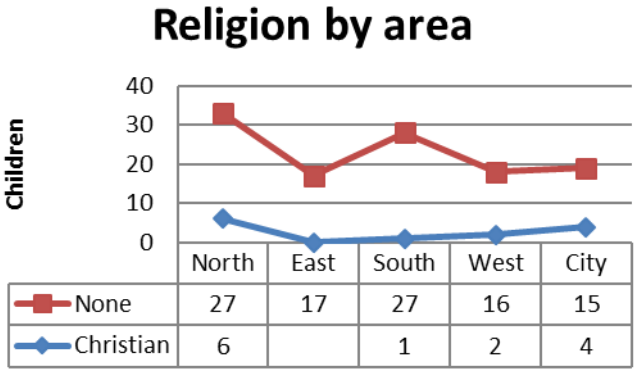


Figure 10

Most families in all area's either declared no religion or failed to answer the question.

Of religions declared, an even split of Church of England and Catholic were noted.

2.4 Families needs at the point of Referral

Of those requesting support 2 FSPs did not meet the troubled families' criteria.
51 were split as figure

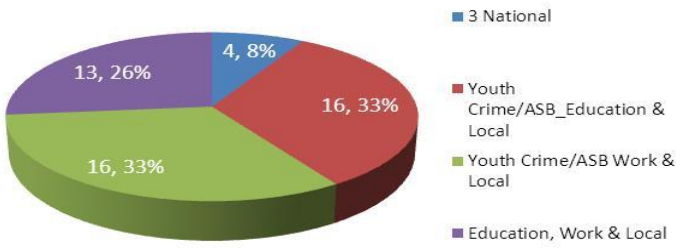


Figure 11

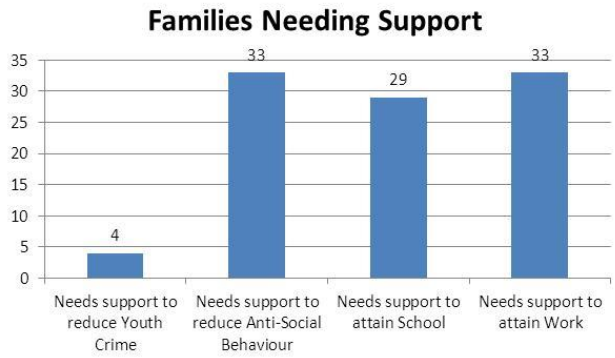


Figure 12

Of those needing a multi-agency targeted support services, 87 anti-social behaviour incidents occurred across the 33 families, with ten being the most and 1 being the least.
There were 7 incidents of youth crime across the 4 families with the highest being 4 and 1 being the least.
A majority of families met the education criteria due to poor attendance.

In advance of developing the CMS system we have started to records the needs of the family on entering the programme to record this from March onwards, which is also in readiness for the cost savings calculator[3].

3 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/68744/The_Cost_of_Troubled_Families_v1.pdf

3 Allocations

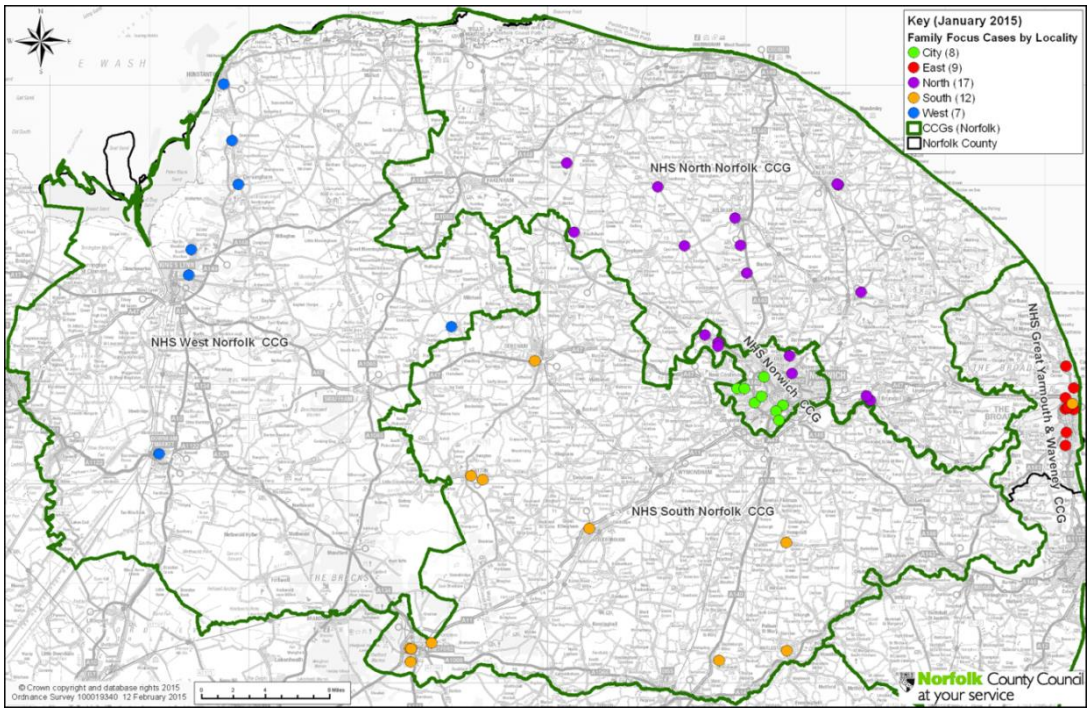


Figure 13 - NEHFF New families January 2015

3.1 **Intervention Type**

Of the 53 cases received in January, the following were allocated to the NEHFF operational teams.

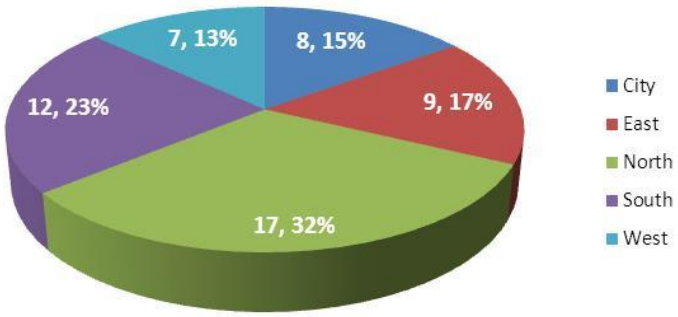


Figure 14

3.2 Active Caseload to the Norfolk Early Help Family Focus Operational Teams

There are 380 active cases open to practitioners; with some of these cases jointly worked (i.e. 2 workers in one locality working with the family) due to the nature of their needs. Practitioners are working with families for an average of 250 days (8 months)[4].

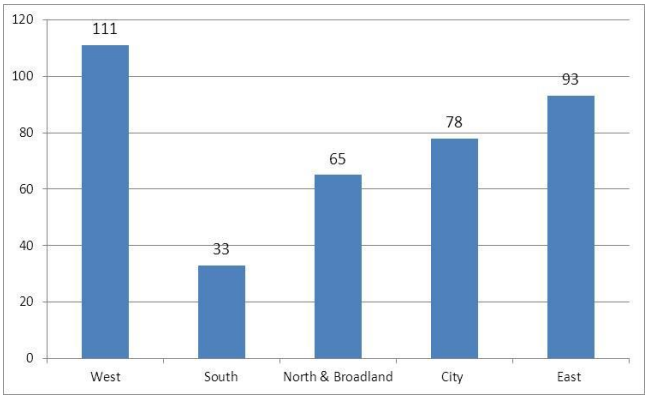


Figure 15

4. Monitoring (essential element of Troubled Families framework)

Once face to face interventions end and families are on their journey to achieving lasting change, NEHFF offers a monitoring service to families. This service supports families with their plan over the phone at agreed intervals over an agree period of time. It provides families with a point of contact for information and advice and enables a conversation to reassure families that their plan is on track and they are continuing to achieve their outcomes, sustaining lasting change. If family's need change they are able to reach out and obtain the support in a timely response to ensure they continue on their journey rather than these problems escalating and require a more targeted intense intervention. It also provides a route into evidencing significant and lasting change as required by the DCLG (eg evidence of adults still in work, not claiming benefits that would otherwise be hard to identify by other means).

An important success of this element is that it currently has a 1% re-referral rate back in to NEHFF service.

4.1 **Referrals to the Monitoring Service as at 31st January 2015**

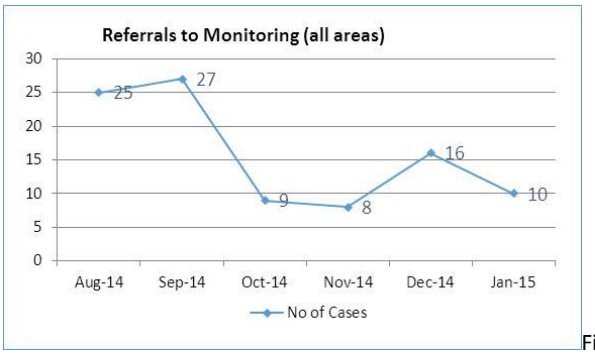


Figure 16

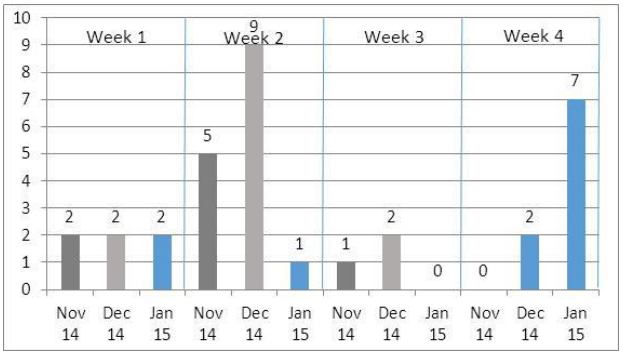


Figure 17 progress weeks on week

Total referrals into the monitoring service from all operational teams.

The monitoring service saw a large influx of referrals at the end of August following a programme team restructure. The influx in august resulted in a trickle in the following

[4] From the date the case is allocated to a worker to the date the case is referred to central monitoring or closed.

month from the East and other areas with an influx from December and January 2015. On average the monitoring service sees two referrals into the service each week.

What we can also see in figure 17 is the progress average over the initial 4 weeks. This records our plan of actively working and showing progress in those vital first four weeks to embed last change.

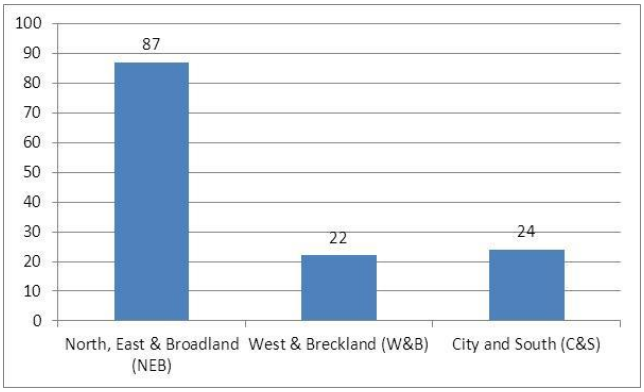


Figure 18

The monitoring service is currently active with 133 families.

Following direct intervention with the operational teams, families generally agree to a call once a month. On average families are worked with in monitoring for a 127 days (4.2 months).

4.2 **Referrals closed to Monitoring as at 31st January 2015**

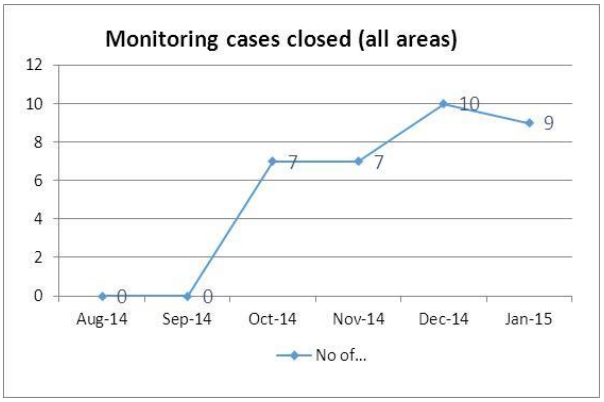


Figure 19

Cases were monitored during Aug and Sept however none were closed due to staff changes.

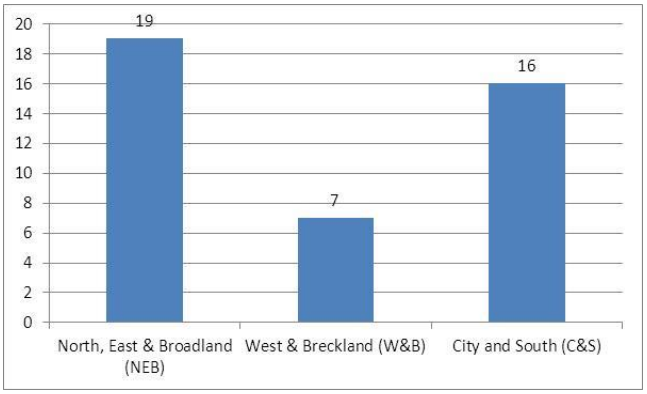


Figure 20

The monitoring service has closed 42 families in January 2015

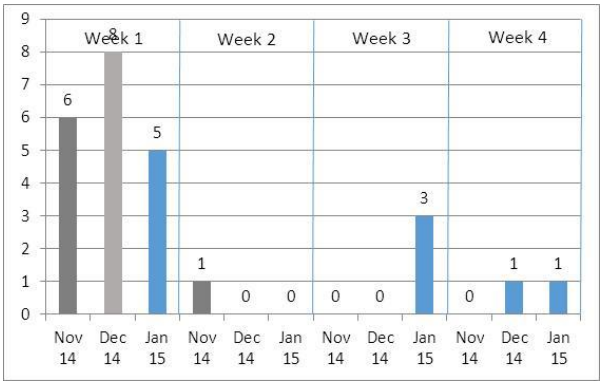


Figure 21

<u>Reasons for Closure to monitoring</u>

The success of direct intervention and value of the monitoring function is evidenced by only 1% of families overall returning to the service for support

10% (4) families moved out of area

19% (8) families closed, no longer needed support achieving their outcomes

71% (30) families naturally progressed to the universal pathway no longer needing support.

5. Outcomes Achieved and Closures

Of those 2264 families identified, 4% have been closed from the Norfolk troubled families register. Of the 4% closed, of the prevailing child:

- 34 moved out of county,
- 20 became a looked after child,
- 9 went on to state correction and
- 1 child died

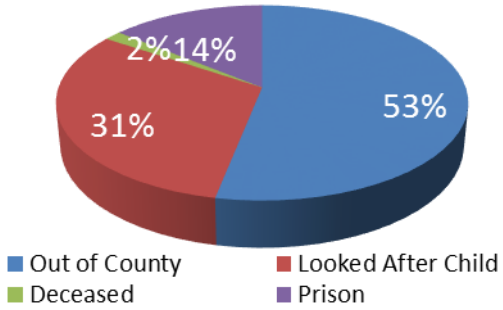


Figure 22

Of those families in receipt of a family support process the reasons for closure are:

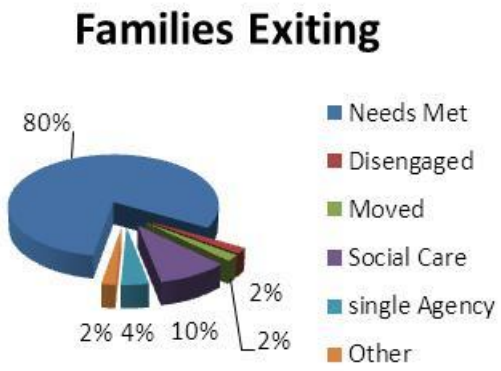
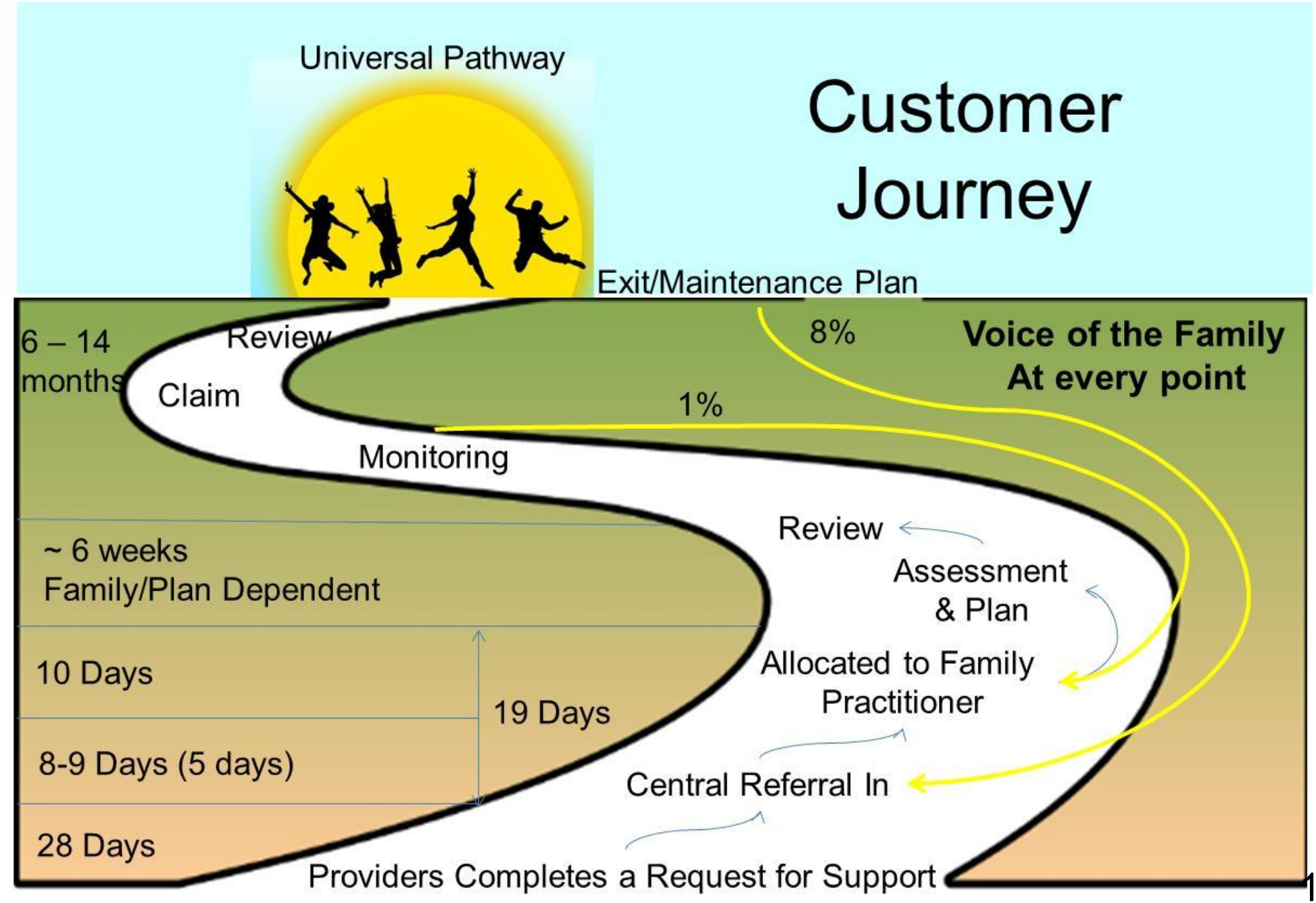


Figure 23

80% have progressed to enter the universal pathway, with their needs met:

- 1 family disengaged from the programme in January and
- 1 family moved out of county.
- 7 families moved onto another form of support such as Social Care.


Universal Pathway
Customer Journey
Exit/Maintenance Plan
6 – 14 months
Review
Claim
Monitoring
8%
1%
Voice of the Family
At every point
~ 6 weeks
Family/Plan Dependent
10 Days
8-9 Days (5 days)
28 Days
19 Days
Review
Assessment & Plan
Allocated to Family Practitioner
Central Referral In
Providers Completes a Request for Support

Lasting Change & Scorecard

Norfolk Early Help Family Focus Score Card – January 2015

The score care is under development and will be expanded to include wider criteria and an operational split.

At the end of January, the data team completed a post PbR activity that meant Norfolk verified an additional 358 families who had achieved their outcomes in the areas of youth crime, anti-social behaviour and education. Therefore at the end of January the unofficial (not reported to the DCLG until the February 2015 verification window), turned around figures was 68%. This means the target of 75% by February 2015, in order to go through to Phase II, Wave 3 of the programme, is more achievable.

	Identified To date	Active								Worked With	Families "Turned Around" 31st January 2015 68%		
			Timeframe	No	No	No	Timeframe	No	No				
	Troubled Families Register: No of Families identified for Support	Family Support Process	Provider to NEHFF Referral In	Requests for Support	Cases Stepped down from Social Care (SC)	NEHFF cases referred back into the service for support	Central Referral In to Allocation	Cases waiting allocation to date	Cases Worked with by operational teams	Troubled Families Register: No of Families worked with by NEHFF/partners	Youth Crime/ASB/Education	Progress to Work	Full Employment
	Not exclusive												
County	2264	2428	9 days	53	8	21	9.2	94	380	2200	1120	312	39

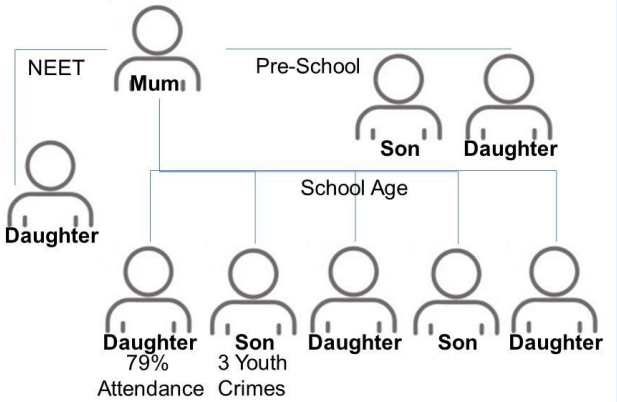
Norfolk Early Help Family Focus Case Study

Customer

Family involved with multiple services and Children Services since 2009, stepped down to a CAF/FSP in 2012.

Family behaviours impacted on the community and family life with offending behaviour, domestic violence, anti-social behaviour, lack of household routines, school attendance issues resulting in the presentation of a chaotic lifestyle.

Key Worker: FIP



Needs

- Support to reduce domestic violence within the home.
- Support with parenting technics and maintenance.
- Support to access appropriate benefits and manage finances
- Support to access appropriate housing.
- Support to manage parental/family mediation
- Support to enable the family to engage with court/youth offending pathways.
- Support to enable the family to engage positively with schools and transition between schools.

Activity

Engagement with Norfolk Family Focus and the Family Intervention programme to offer targeted support to the whole family around the identified needs. This involved support to the family to build relationships, manage benefits, rules and boundaries for when behaviour in children escalated (ASB), management of transition of schools and enable and empower mum to have her voice heard.

Post court case the key worker from the FIP worked intensively with the family supporting court agreed visitation, aggressive behaviour and reflective parenting.

NFF worked alongside the family to coordinate support with other agencies to deliver the good outcomes.

A Troubled Family Employment Advisor (TFEA) worked with mum to identify the family is on the correct benefit and explore working opportunities.

Health Visitor to monitor lice and vaccinations.

So what?

The needs of the family have been managed through the Family Support Process that resulted in:

- 2 post school children in college, no longer NEET, working towards breaking the cycle of inter-generational workless benefits.
- Reduced Youth Crime resulting demand reduction and better community participation.
- Reduced anti-social behaviour in the home resulting in improved family and community relationships.
- All children attending school on a regular basis and achieving B+ across subjects.
- Adult planning to return to work with continued engagement from TFEA.
- Health appointments attended with all vaccinations up to date, resulting in healthy children and young people.
- The NFF and partners managed risks within the FSP process that prevented the family being re-opened to social care and demand reduction across the partnership.

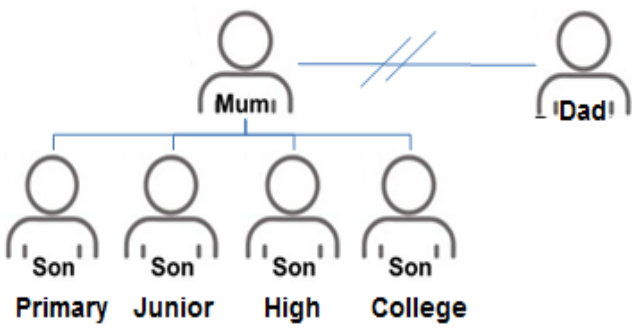
Norfolk Early Help Family Focus Case Study

Customer

Family stepped down from the Child In Need Team. Anti-Social Behaviour displayed between family members in-particular challenging behaviour from the two oldest sons.

History of domestic violence within the family.

Poor communication between parents resulting, in persistent arguing, lack of respect from children towards mother. A "nothing is going to work to change us" attitude from all.



Needs

- Support with managing ASB in the school and family home
- Support mum with her Mental Health issues
- Support child with mental health issues and ADHD
- Support to improve school attendance and encourage positive engagement
- Support mum and dad with parenting skills, using a joined up approach.

Activity

Norfolk Family Focus supported mum throughout the marriage break-down, this involved weekly visits and regular telephone calls. This enabled mum to recognise the abusive nature of her relationship.
Together we arranged an outreach session with Leeway and prompted regular visits to the GP to enable a change in medication for the mum's depression.
Although the primary concern is always the children and their needs the parents are crucial in providing the care and home environment so empowering them and ensuring they are receiving the right support is a massive part of the work needed.
One of the children engaged in MAP Positive activities which gave an outlet to talk about what was good/bad about school life and home life. This enabled the child to choose appropriate friendships to be built within the local community.
Mum supported another of the children with the police regarding issues of steeling.
Mother approached the police for support when physically attacked by eldest son & father, and was supported with appropriate models to prevent the behaviour reoccurring.
Support was also provided from MAP (Mancroft Advice Project) to prompt a positive change in attitude and from supported the school via the Benjamin Foundation 'Time for You' practitioner for one of the children.

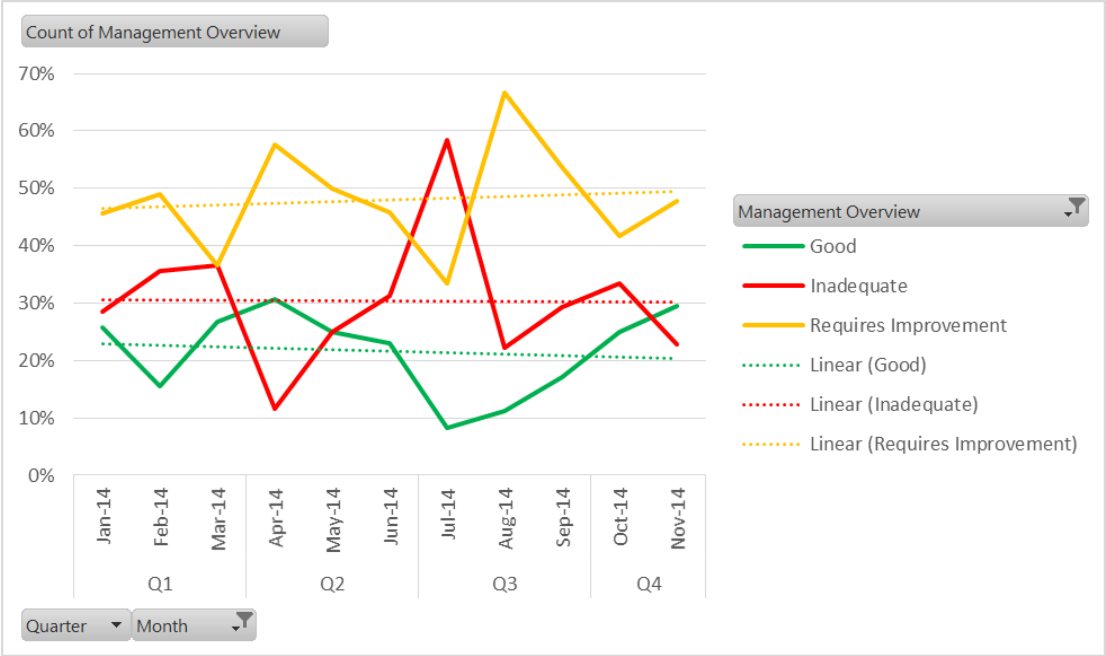
So what?

- All children are in employment or education with good attendance.
- ASB in the home has significantly reduced.
- Mums mental wellbeing has improved having sourced appropriate support.
- The ongoing support from Norfolk Family Focus and its wider partners prevented the family from needing more specialist provision.
- The marriage breakdown resulted in improved relationships across the whole family with tension reduced and a calmer home environment. Dad continues to have contact.
- One of the children has joined the Army and when he returns mum sees him as a positive influence to the younger children.
- NFF worked alongside mum to access services (eg Leeway) that would otherwise not have occurred. This enabled her to recognise the abusive nature of her relationships and enabled her to move positively forward.
- Family Support Meetings enabled difficult conversations between the parents in a controlled environment. Discussions around what was working well and what needed to change were held and ways to move forward were agreed by the family and all professionals. This meant everyone involved was up-to-date and a co-ordinated, family orientate plan was in place continuously.

Audit improvement

Difficulties in identifying improvement due to different case types / children being audited at different times of the year. However there are some themes…

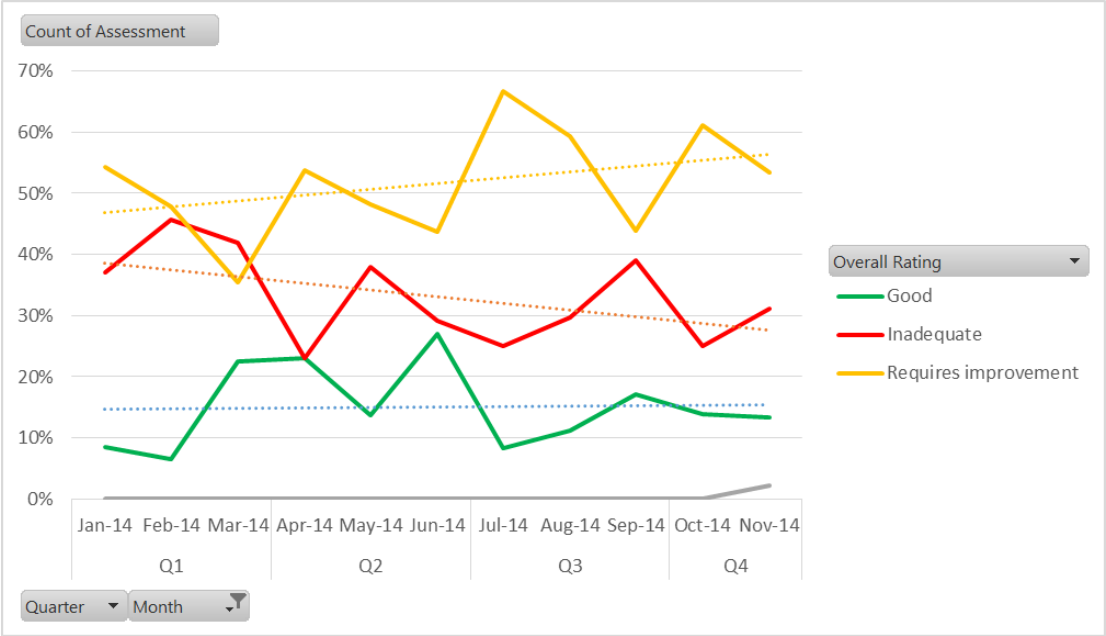
Management Overview



General trend is an increase in "Requires Improvement" and decrease in "Inadequate" cases over the past 12 months. However in the last 6 months the number of Good cases has increased significantly, as shown above.

CIN cases have shown the most significant improvement.

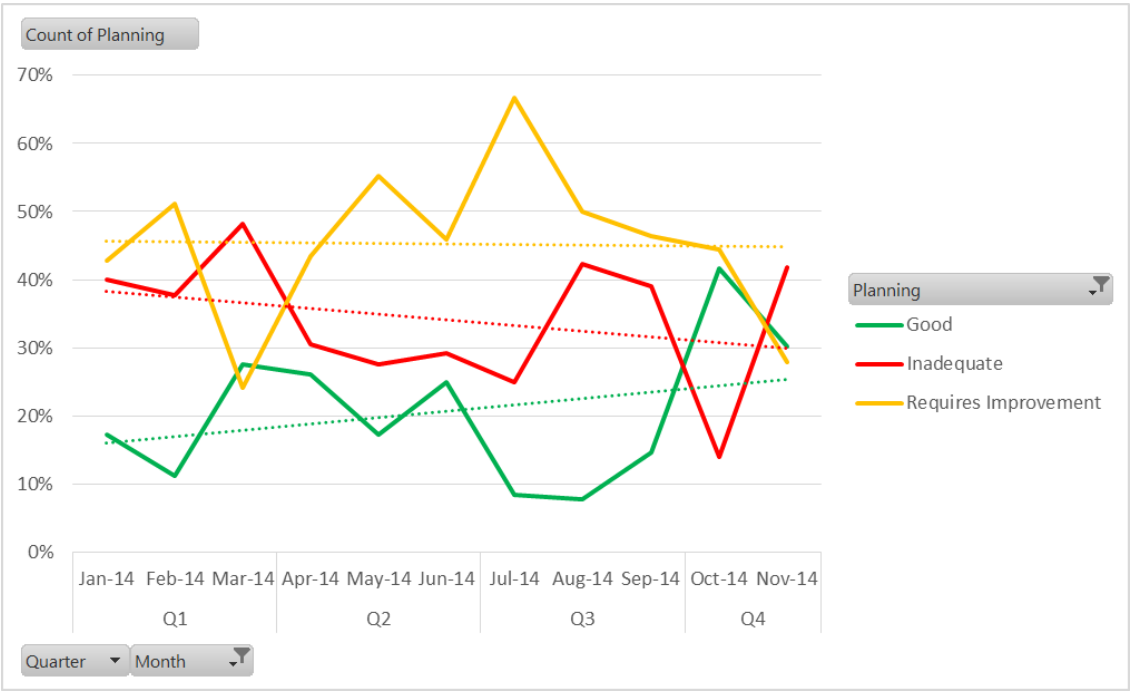
Assessment



General trend is an increase in “Requires Improvement” and decrease in “Inadequate” cases over the past 12 months. The number of Good is consistent.

CIN cases have shown the most improvement in Assessment work (33% in Jan, 47 % in June & 67% in December of cases rated as Outstanding, Good or Requiring Improvement), with child protection cases decreasing from 100% in June to 88% In November.

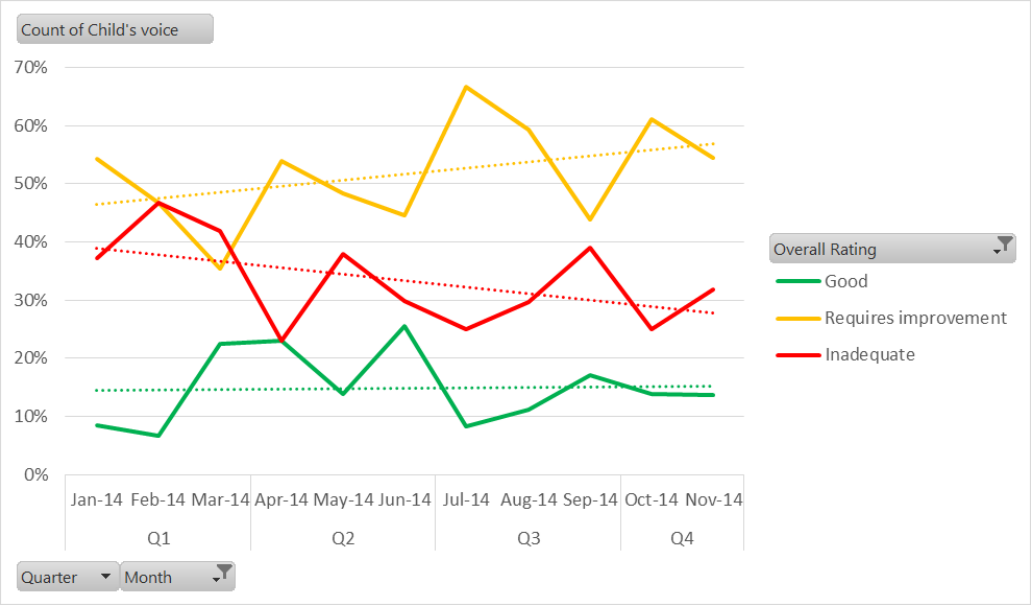
Planning



General trend is an increase in “Good” and decrease in “Inadequate” cases over the past 12 months. The number of cases Requiring Improvement around Planning is consistent. The spike in ‘Inadequate’ plans coincides with the shift to more intensive oversight of LAC cases by Audit.

CP cases have improved from 69% to 89% of cases rated as Outstanding, Good or Requiring Improvement for Planning.

Child's Voice



General trend is an increase in "Requiring Improvement" and decrease in "Inadequate" cases over the past 12 months. The number of cases "Good" around capturing the Child's Voice is remaining consistent.

CIN cases has shown significant improvement from 36% to 67%.

Independent Chairing Service

Report: February 2015

1. Analysis of QA Reports – LAC October-December

The QA reports collect a substantial amount of information. This report will highlight areas of improvement and issues which remain of concern.

- **Reviews in timescale : October 91.3% November 97.1% December 92.5%**
  The reasons for reviews going out of timescale are recorded by the IRO and followed up as necessary.
  Please note that this measurement is whether the current review has been held within timescale from the previous one; it is not the performance indicator measure. However, if we can continue with this high figure, then the KPI figure will improve once historical failings are overcome.
  Potential risk: caseloads are high (see below) and it is increasingly difficult to cover sickness absence etc.

- **Social workers' reports for reviews**
  The September figure was 59.3% and the October one 59.4%. However, in November this improved to 74.1% and in December was 71%.

- **Children and young people's knowledge of the 'Promise'**
  In October, of those children and young people who were asked by IROs whether they knew about Norfolk County Council's 'Promise' to them, only 47.6% said they did. This figure improved to 70.5% in December. Under 4s are not included in this figure.

- **Had IROs been made aware of significant changes between reviews?**

  The figures show that IROs are increasingly being made aware of significant changes. There were 53 reviews (out of 256) in September when IROs should have been made aware of changes but had not been. In October this had reduced to 27 out of 244. In December the figure was 24 out of 235.

- **IROs' communication with child/young person between reviews**

  The October report highlighted this as a potential area of weakness in Norfolk, where IRO caseloads are too high to permit visits between reviews. This is not a statutory requirement but has been an expectation in recent Ofsted inspections. IROs endeavour to undertake visits where this is particularly necessary, or to communicate with the child/young person by other means. For example, for October reviews, 24 children/young people had been seen between their reviews and 7 had been contacted in other ways (phone, letter). 8 had been offered additional contact but this had been declined.

- **Participation of children and young people in their reviews**

  This is reported to the DfE against a mandatory set of participation codes. Children under 4 are not included in this measure. In December 14.8% of the children reviewed were under 4. Children and young people 'attending and communicating for themselves' was 46.3%. Those who 'did not attend but communicated by other means' was 32.7%. The list of those children and young people who did not attend is used for supervision purposes to ensure that every effort is made to encourage actual attendance.

- **Equality and diversity**

  IROs report on any unmet needs and explain what action is being taken to address these.

2. Other QA activity

- The performance of IROs and ICs is RAG-rated against a number of measures in their monthly supervision sessions.
- Monitoring of the timeliness of CP Plans and Chairs' Reports is in place.
- Monitoring of the timeliness of LAC Chairs' reports has not been in place due to lack of Business Support time. However, this has been set up and should start in March.
  The backlog of LAC review chairs' reports which was reported on in October 2014 has been addressed.
- IROs and ICs take two of their LAC reports/CP plans to each supervision session.
- The Assistant Service Manager for the ICs has continued to observe conferences.
- The Assistant Service Manager for the IROs and the Service Manager are starting observations of all the IROs.
- A QA framework is being developed to give structure to the QA activity which is over and above the individual QA of child protection and care planning.
- IROs and ICs are starting to contribute information to the newly introduced 'Divisional Accountability Days'.

3. Signs of Safety

All IROs and ICs have had the two-day introductory training. In February and March they will have 4 days of training specific to their role. The fifth and final day will be in May. Discussions are underway about the introduction of Signs of Safety in child protection conferences and a pilot will be planned.

Representatives from the service will join the Practice Leads Group.

4. Voice of the Child and Service User Feedback

- Advocacy for children and young people in the child protection process is provided by Coram/Voice. In January the referral rate was 90% and take-up was also 90%. This has improved greatly and shows that the advocacy service is becoming embedded.
- Feedback forms for children and young people, for parents, and for professionals who attend child protection conferences were introduced from 1st September 2014. A report based on the first six months will be produced and actions considered – in the light of changes that Signs of Safety will bring.
- The chairing service is involved, alongside a senior operational manager, with the Eastern Region 'Research in Practice' initiative on promoting the 'Voice of the Child in child protection'. Work streams have been identified. Norfolk is joining the work on 'voice of the child' practice leads/champions.
- The 'review of LAC reviews' has taken place and the Participation Officer is collating the findings. This is specifically to ensure that a review is the child/young person's meeting, not an adult-focused one.

5. LAC Reduction Activity

IROs have increased their activity in tracking plans for children and making sure these are progressed in a timely way.

They provide information and views as required, including for the 'thinking differently' meetings which have been taking place to look at the cases identified by the Ingson consultants.

6. Caseloads

Caseloads have risen now that we no longer have agency staff. All IROs have 95+ cases, going up to 103 and 109. The statutory guidance states that caseloads should be between 50 and 70. The workloads are as pressured for child protection conference chairs. The number of days on training for Signs of Safety significantly reduce availability of both ICs and IROs. This is an area of high risk. Not only does it mean that timescales may not be met (e.g. due to lack of cover for sickness absence), but it also has an impact on how much tracking and monitoring of cases the IROs and ICs can do.

New statutory guidance is awaited on long-term foster care. This will introduce the concept of proportionality in terms of visiting and reviewing requirements for children/young people who are placed long-term. However, this guidance has not yet been introduced and we do not know the detail.

7. NSCB Priorities

The IROs and ICs and their managers continue to be engaged in the work on the 3 priorities of: neglect; child sexual abuse; and child sexual exploitation.

8. Regional Group

One of the Assistant Service Managers continues to attend the Eastern Region IRO Managers' Network, which feeds into the national IRO managers' project group with the DfE.

9. Training

The main focus of training at the moment is, of course, Signs of Safety.

There are also definite plans now for the training module specifically designed for IROs and ICs, provided through Birmingham University, to be run in the region.

10. Annual Report

There is a statutory requirement for an Annual Report to be produced for an IRO service. In Norfolk this will cover the joint IRO and IC service.

Wendy Dyde

Risk Register - Norfolk County Council

Risk Register Name	Corporate Risk Register
Prepared by	Steve Rayner
Date updated	December 2014
Next update due	March 2015

High	Red
Med	Amber
Low	Green
	Met

CDGSTP	Area	Risk Number	Risk Name	Risk Description	Date entered on risk register	Current Likelihood	Current Impact	Current Risk Score	Tasks to mitigate the risk	Progress update	Target Likelihood	Target Impact	Target Risk Score	Target Date	Prospects of meeting Target Risk Score by Target Date	Risk Owner	Reviewed and/or updated by	Date of review and/or update
C	Children's Services	RM14147	Failure to improve at the required pace.	CS Teams do not show the improved performance at the speed which is acceptable to DfE and Ofsted.	01/12/2013	2	5	10	Additional capacity in leadership and management in place with 'grow our own' model for sustaining social worker capacity in place. Additional social worker capacity in place. Robust and systematic performance management structures and processes established and beginning to embed. System leadership priorities to be agreed.	**SOCIAL CARE:** Improvement board has completed its work as part of NCC CS Phase 1 improvement. NCC and DfE are working together on the model for further challenge and support to assure and ensure pace and range of improvement activities. System leadership discussions are continuing with key partners' CEOs and are led by NCC MD. Signs Of Safety has been adopted as the philosophy of social work across NCC CS and partner services . Evidence from QA and Performance reports shows that improvements continue in the right direction. Recruitment to NIPE is complete and additional capacity is being offered through this initiative. NFF cotinues strong and rapid progress towards targets. SUPPORT FOR SCHOOL IMPROVEMENT: Ofsted inspection evidences that LASSI is effective. Overall - the restructure of children's services will ensure that structures are more strongly aligned with strategic priorities and new ways of working.	1	4	4	31/01/2016	Green	Sheila Lock	Helen Wetherall	01/12/2014
C	Children's Services	RM14148	Overreliance on interim capacity	Overreliance on interim capacity at leadership and management levels and in social worker teams leads to unsustainable performance improvement.	01/12/2013	3	5	15	Succession Planning. Skills and knowledge transfer from interim to permanent staff in place and showing positive impact. Need for permanent replacement to interim senior leadership team.	NIPE initiative is providing significant additional capacity and is showing signs of improving performance in teams were deployed. New structure has been pubished for consultation. Advertisements for DCS and ADs have been published and processes are moving forward to timescale and plan.	2	4	8	30/06/2015	Amber	Sheila Lock	Helen Wetherall	01/12/2014
C	Children's Services	RM13906	Looked After Children overspends	The number of LAC continues to increase so that the Looked After Children's budget could result in significant overspends that will need to be funded from elsewhere within Children's Services or other parts of Norfolk County Council	18/05/2011	5	5	25	LAC Reduction Strategy agreed by CSLT and being applied. LAC Panel now in place, chaired by DCS. Target reunification given to all LAC Teams and IRO's	Interim team targets have been profiled over the next year and a tracker to be produced. Interim additional management in place to drive performance to achieve targets. Private sector (Ingson's) reviewing every LAC case to address performance issues and identification of re-unification opportuities. work etc	2	4	8	30/06/2016	Amber	Sheila Lock	Helen Wetherall	01/12/2014
D	Children's Services	RM14157	Lack of Corporate capacity and capability in particular ICT and BIPS reduces the ability of Children's Services to	Lack of NCC capacity and infrastructure to support the back-office functions that Children's Services needs in particular ICT is becoming a limiting factor for improvement as DNA improvements are awaited.	13/03/2014	5	5	25	COG involvement to ensure pace of improvement is maintained over protracted timescale. Decentralisation of services for schools report to Education Challenge Board. More robust client side function.	Restructure brings a new post and team 'Clientside manager and team' - will ensure that the needs of the service are srongly expressed as part of all shared services planning in the future.	4	5	20	31/03/2015	Red	Sheila Lock	Helen Wetherall	01/12/2014

Report to Norfolk Health and Wellbeing Board
29 April 2015
Item 8 b)

Children's Services Improvement and Performance Update

Cover Sheet

What is the role of the H&WB in relation to this paper?

The Health & Wellbeing Board has asked for an update on the performance concerns around Health Assessments for Looked After Children. This is in the context of improvement and a previous Ofsted report that was critical of services for LAC and the role of partners

Key questions for discussion

Q.1 Why is the performance in relation to LAC health assessments challenging?

Q.2 What should be reasonably expected in terms of performance from all providers?

Q.3 What collective action can be taken to ensure the improvements required are delivered in a timely and sustainable way?

Actions/Decisions needed

The Board is asked to:

- Acknowledge the poor historical performance and significant decline in year to date performance in this key area

- Offer a view on the way forward to improve performance in this area

Children's Services Improvement and Performance Update

Report of the Interim Director of Children's Services, Norfolk County Council

Summary

At its last meeting the Health & Wellbeing Board asked for an update on the performance concerns around Health Assessments for Looked After Children. This report provides an overview of performance on the provision of Health Assessments for Looked After Children (LAC).

Action required
The Board is asked to:

- Acknowledge the poor historical performance and significant decline in year to date performance in this key area
- Offer a view on the way forward to improve performance in this area

1. Background

1.1 Health outcomes for LAC

1.1.1 At its last meeting the Health & Wellbeing Board asked for an update on the performance concerns around Health Assessments for Looked After Children. This is in the context of improvement and a previous Ofsted report that was critical of services for LAC and the role of partners.

1.1.2 The impacts of abuse and neglect ensure that LAC are far more likely to experience health problems than their peers. In addition to the human costs of these poorer outcomes, the long-term costs to statutory services of these health impacts can be significant.

1.1.3 A national survey found two thirds of all looked after children have at least one physical health complaint.

1.1.4 LAC have higher incidences of speech and language problems, bedwetting, co-ordination difficulties and eye or sight problems.

1.1.5 LAC are on average four times more likely than their peers to have a mental health disorder - rising to seven times more likely for LAC placed in residential settings.

1.1.6 Care leavers are four or five times (depending on which study you read) more likely to commit suicide in adulthood than their peers.

1.2 Corporate Parenting Responsibilities

1.2.1 Norfolk Children's Services (NCS) Corporate Parenting Strategy states that for all LAC Norfolk Children's Services and partner organisations assume the role of corporate parents. This means that together we will:

- Take responsibility for all children in the care of Norfolk Children's Services including those children who may require specialist placements outside Norfolk
- Prioritise the needs of all Looked After Children
- Strive to achieve the same outcomes as any good parent would want for their own child.

1.2.2 The Children Act 1989 was the first legislation to place responsibility for the safety of Looked After Children with Local Authorities. Section 27 of the Act requires partner organisations including health, housing and education services to provide help, support and services through their role as Corporate Parent.

1.2.3 The Children Act 2004 re-emphasised the importance of partnership working and collaborative service agreements to provide appropriate services for children and young people.

1.3 Specific Agency Responsibilities in Relation to Health Assessments

1.3.1 Local authorities are responsible for making sure a health assessment (HA) of physical, emotional and mental health needs is carried out for every child they look after, regardless of where that child lives. Regulation 7 of the *Care Planning, Placement and Case Review (England) Regulations, 2010* requires the local authority that looks after them to arrange for a registered medical practitioner to carry out an initial assessment of the child's state of health and provide a written report of the assessment.

1.3.2 CCGs, NHS England and NHS service providers have a duty to comply with requests from local authorities in support of their statutory requirements. Where a looked-after child is placed out of area, the receiving CCG is expected to cooperate with requests to undertake health assessments on behalf of the originating CCG.

1.4 Current Performance Concerns

1.4.1 The performance in relation to completion of HAs (both initial and review) is a cause for some concern and it is vital for the health of Norfolk's Looked After Children (LAC) that action is taken to address that position. The Position has been 'stuck 'for too long.

2. LAC Health Coordinator

2.1 Since 1st April 2012 NCS has provided funding of c£30k per annum towards the cost of a LAC Health Coordinator post, which is shared across the CCGs. The purpose of which is to facilitate effective administration of IHA and HA requests.

2.2 A number of KPIs are attached to the post including 100% completion within timescales of both IHA's and HA's.

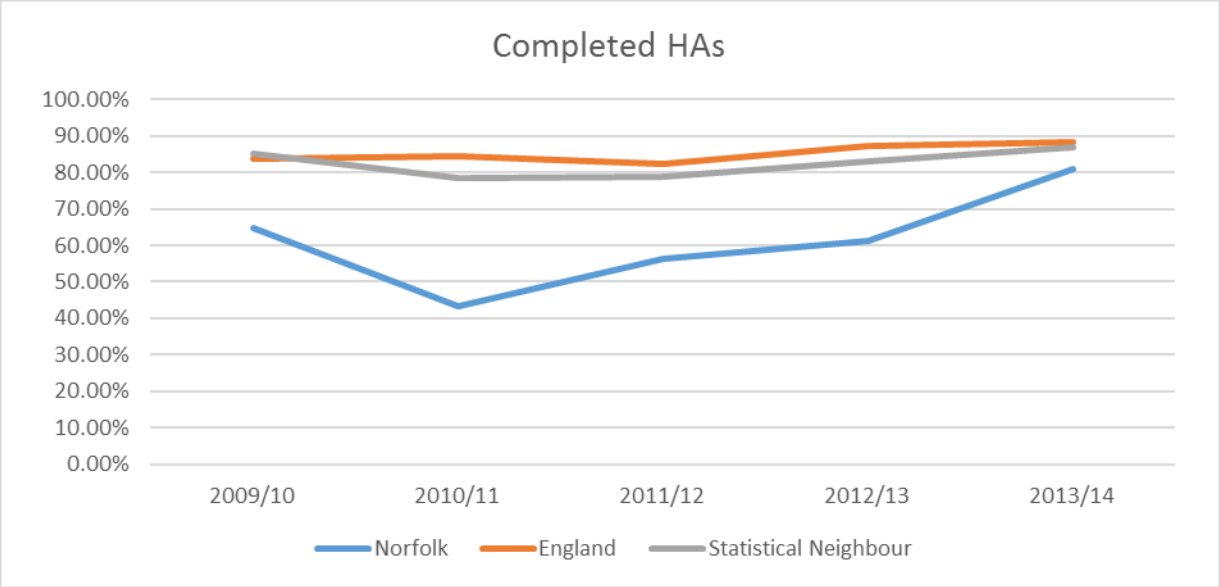
2.3 The role has not met its objectives and should be reviewed as a matter of urgency, particularly given the current service level agreement (SLA) is due to terminate on 31st March 2015. However, despite considerable

effort, NCS has not been able to illicit any proactive engagement from the contracts department at NCH & C in reviewing the job description/performance indicators for the role. As a result, the funding for the SLA from 1st April 2015 has not yet been approved by NCS.

3. Performance Data

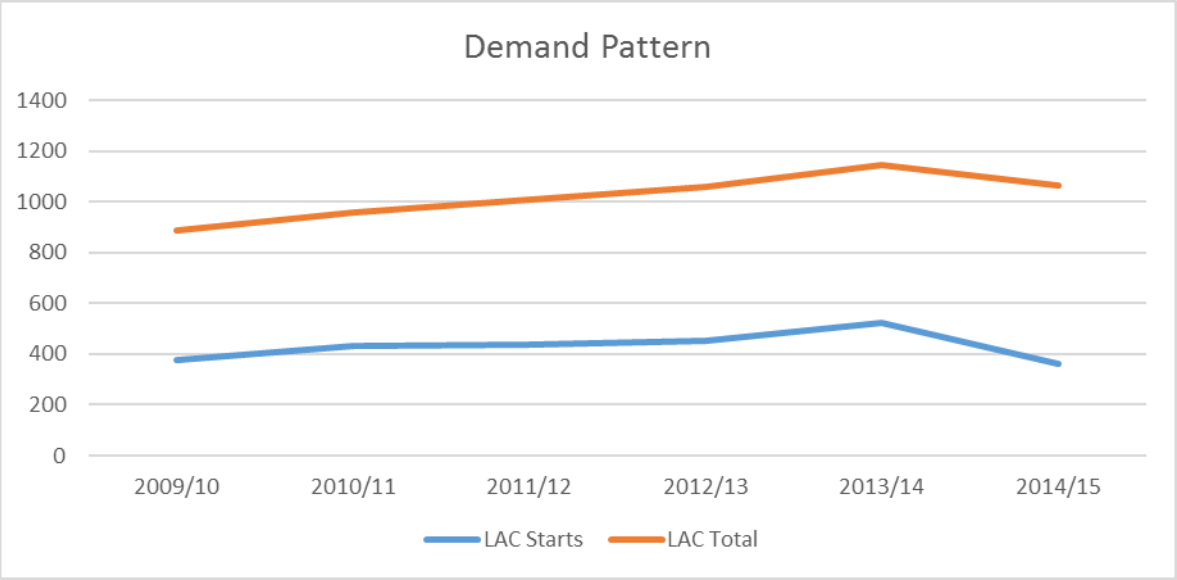
3.1 The numbers of LAC with a HA in timescale had increased significantly since its low point in 2010/11 with a notable jump across 2013/14, coinciding with the arrival of the interim Children's Services Leadership Team. However, performance remained below both the statistical neighbour and England averages across that period.

Table 1



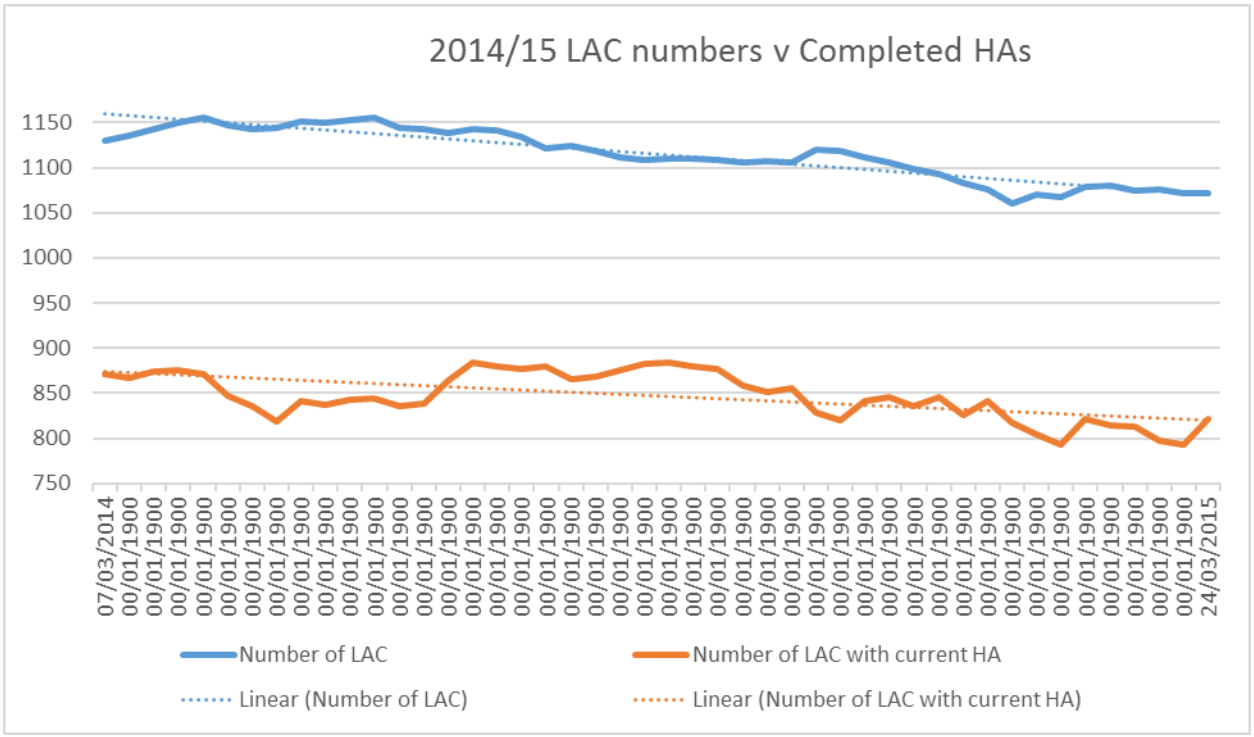
3.2 It is concerning to note that performance has dropped across 2014/15 particularly in light of the reduction in demand which is a function of both lower LAC starts and lower total LAC numbers (table 3).

Table 2



3.3 Table 3 shows that the number of completed Health Assessments has fallen at a similar rate to total LAC numbers. As a result, the percentage of LAC with a Health Assessment has remained relatively static across 2014/15. Children's Services has previously reported on this KPI as a percentage, effectively masking the decline in performance.

Table 3



3.4 NCS is constantly reviewing its data to ensure we fully understand performance and we recognise it will be important to analyse any variation in performance between IHAs and HAs, which we cannot easily segment at this time. However, it remains the case that we are seeing an evidential decline in the number of completed Health Assessments.

4. Action required

4.1 The Board is asked to:

- Acknowledge the poor historical performance and significant decline in year to date performance in this key area
- Offer a view on the way forward to improve performance in this area

Officer Contact

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

Sheila Lock 01603 222601 sheila.lock@norfolk.gov.uk

Voluntary Sector Engagement Project (VSEP) Final Report, March 2014- March 2015

Cover Sheet

What is the role of the H&WB in relation to this paper?

Building on earlier work by partners, the Health & Wellbeing Board commissioned a Voluntary Sector Engagement Project (VSEP) to support the active engagement of the voluntary sector into the changing landscape of the health and social care agenda and the Health and Wellbeing Board.

Key questions for discussion

Q.1 How can partners/the Board help sustain the Project's achievements and legacy?

Q.2 What can the partners/the Board do to mitigate the impact of the closure of the Project?

Action needed

The Board needs to:

- Note the content of this report and the achievements of the VSEP
- Consider the impact of the closure of the Project in relation to on-going vcs engagement
- Consider how it might take forward the recommendations suggested to address these gaps.

Voluntary Sector Engagement Project (VSEP) Final Report, March 2014- March 2015

Report by the Head of Operations, Voluntary Norfolk

Summary

This is the Final Report from the Voluntary Sector Engagement Project (VSEP) whose funding from the Health & Wellbeing Board ended on March 31st. The Report highlights some of the main achievements of the Project's work in bringing the active engagement of the voluntary sector into the Health and Wellbeing Board and the wider health and wellbeing agenda. It also identifies gaps which have been left behind as a result of the Project's closure and concludes with some recommendations.

Action

The Health and Wellbeing Board is asked to:

- Note the content of this report and the achievements of the VSEP
- Consider the impact of the closure of the Project in relation to on-going vcs engagement
- Consider how it might take forward the recommendations suggested to address these gaps.

1. Background

1.1 Through commissioning the VSEP, the Health & Wellbeing Board has supported the engagement of the voluntary and community sector (VCS) in the changing landscape of health and wellbeing structures and drivers. The project developed from related work with the Norfolk County Strategic Partnership. Using Second Homes Council Tax monies the Board took over responsibility for the project in 2012. The project was delivered by Voluntary Norfolk.

1.2 In 2013 the Board set up a VSEP Steering Group drawn from Board members. The Steering Group has met four times. Its last meeting (4 Dec 2014) considered the Project's Exit Plan and was attended by Debbie Bartlett, Chris Price, Richard Draper, Daniel Harry, Debbie Elliott and Linda Rogers and Claire Collen (Voluntary Norfolk).

1.3 Whilst the Steering Group was able to acknowledge the very positive outcomes and successes of the VSEP, two areas of activity were highlighted by the VSEP Manager as being particularly impacted by the Project's closure:

a) The loss of a dedicated VCS officer post able to provide a direct communication and engagement route between the Board's work and the wider VCS;
b) The impact on two VCS specialist forums - the Mental Health Forum and the Learning Disabilities Forum – of the loss of input and support from the VSEP.

1.4 It is hoped that the Board will consider the impact of the loss of support to these areas of work and what might be done to support them in the future.

2. Overview of the VSEP and Legacy

2.1 The VSEP has offered an effective link to the voluntary sector for the Health and Wellbeing Board and its partner organisations. This has provided added value to Board activity because it has benefited from the expertise, front-line knowledge and understanding of a sector working closely with vulnerable individuals and communities most at risk of inequality.

2.2 Whilst VCOs differ in their capacity and desire to engage at a strategic and policy development level, the VSEP has been able to support and facilitate engagement by interpreting policies and issues in a voluntary sector relevant way. The sector's impact on the health and wellbeing of Norfolk residents goes far deeper than simply through the delivery of commissioned health and wellbeing services. Voluntary and community action is integral to the County's vitality.

2.3 The VSEP's engagement routes include those into various VCS networks, forums and the wider sector which has enabled that contribution to be more closely aligned to the work and priorities of the Board. Good examples are engagement by the Mental Health Forums and the Learning Disabilities Forum. The VSEP has offered a focused pro-active communication channel to stimulate mutual understanding and appreciation of the context within which both the Board and voluntary sector organisations are working to improve the lives of residents.

2.4 In closing off the Project, and to ensure that work is still available and can be accessed in the future, a new Engagement Resources page has been set up on Voluntary Norfolk's website: **Engagement Resources**. The resources include sector directories, outcomes from events, reports and the Compact case study and are outlined below:

a) Effective engagement with Health & Wellbeing Board - Norfolk Compact Case Study (2015)

Shortlisted for a Compact Award this short case study illustrates how Board discussions and Board partners have benefitted from voluntary and community sector experience and expertise. It shows the various ways the VSEP has been able to draw in VCS engagement to shape and influence discussion at the Board, as well as facilitate dialogue and contribution outside of Board meetings. It gives examples of work undertaken through the VSEP on welfare reform, mental health and the Joint Strategic Needs Analysis. The Case Study can be seen **here**.

b) Directory of VCS Mental Health Services (2015)

The Directory profiles the wide and diverse range of services offered by members of the Norfolk's Mental Health Provider Forum - a forum of voluntary/not-for profit organisations.

c) Directory of Norfolk's voluntary sector forums (revised 2015)

The Directory provides information about the main county-wide voluntary sector forums working in specialist fields like mental health, social welfare and children and families. The forums are led by voluntary sector provider organisations – although many involve the public sector. The Directory's purpose is to increase awareness about the specialist nature of the forums, give an idea of who the member organisations are, and provide key contact details.

d) Norfolk's Health & Wellbeing Board - Summaries for the VCS

Part of VSEP's role was making sure the wider sector had access to Board proceedings. Produced within days of the Board meetings, summaries of Board meetings, highlighting aspects of particular significance for the voluntary sector were circulated to over 100 CEOs/senior staff in the VCS, and also sent to about 70 public sector leads who found them of value in giving an insight to VCS perspectives. The last four Summaries are: **4 February 2015**; **22 October 2014**; **16 July 2014**; **6 May 2014**

e) Voluntary Sector Representatives to the Health & Wellbeing Board - Job description

A job description outlining the role, remit and routes of accountability for the three VCS Reps was first developed in 2012 and can be found here. (The VSEP ran the election process for these positions.)

f) Tackling Health Inequalities – Role of the VCS

Using reducing the harm caused by smoking as an example, a model of three different approaches helps illustrate how the VCS contributes to mitigating health inequalities through *direct interventions, indirect support or diversionary interventions*. The 2-page model can be found **here**.

g) Event - Understanding the Joint Strategic Needs Analysis (JSNA) 2015

The VCS can help shape the local agenda by sharing front-line knowledge and expertise through the JSNA. A workshop for the sector, delivered jointly between the JSNA Manager and the VSEP, illustrated the breadth and variety of public data held and showed how VCS intelligence can help build an understanding of the complex relationships between needs, problems and service gaps experienced by service users. Slides from the presentation can be accessed **here**.

h) Report - Closing the Gap: Priorities for essential change in mental health in Norfolk - August 2014

In January 2014 the government published Closing the Gap: priorities for essential change in mental health setting out 25 aspects of mental health care and support where tangible changes, such as waiting times and the Crisis Care Concordat, could be expected within a relatively short time frame. To get a 'take' on Norfolk's MH priorities, the VSEP supported the Mental Health Provider Forum to work with the Integrated MH & LD Commissioning Team to deliver a joint workshop with public sector commissioners and voluntary sector providers identifying what those gaps were. The report **Norfolk Closing the Gap Priorities (Aug 2014)** pulls together common concerns as well as identifying existing and planned activity.

i) Event - Updating the Current Environment for Mental Health and Learning Difficulty (cross-sector conference) - September 2013

Working across sector boundaries is relatively undeveloped in Norfolk, but over 100 participants from across the voluntary and independent sectors came together for this event. It was both an opportunity to hear from commissioners about the drivers impacting on the commissioning, and to identify and share common concerns between providers. An invigorating event which also produced some good networking, a joint Action Plan was developed identifying key priorities to improve service delivery at both a strategic and operational level.

The event was co-produced between the voluntary sector MH Provider Forum (supported by the VSEP), Norfolk Independent Care, County Council Integrated MH & LD Commissioning Team, and the MH Trust. A copy of the Action Plan is available **here**.

j) Event – Welfare Reform Workshop (June 2013)

The VSEP took the lead in running a multi-agency workshop for a number of HWB partners, along with other key players such as senior Housing Officers, the Constabulary and the Probation Service, to raise awareness about the impact of welfare cuts and identifying actions to reduce the likely repercussions for people already experiencing high levels of inequality in Norfolk.
Key findings included:

- Welfare reform is causing greater inequality because it is disproportionately cutting income from the poorest households
- Evidence shows inequality is the biggest determinant of health and wellbeing problems
- Targeting inequality will lead to the biggest increases in health and wellbeing for all and presents the best value for money
- To tackle these issues effectively there needs to be integrated commissioning at all levels
- The Health and Wellbeing Board needs to provide strategic leadership to enable this to happen

The subsequent report: **Welfare Reform - understanding and mitigating the impacts in Norfolk on health and wellbeing, 10 July 2013** that went to the Health and Wellbeing Board in July generated much debate and interest and was well **reported in the local press** the following day.

3. Impact of Project Closure

3.1 As mentioned above, two areas of activity are particularly impacted by the closure of the Project:

a) The loss of a dedicated VCS officer post able to provide a direct communication and engagement route between the health and wellbeing agenda, the Board's work and the wider VCS;

b) The loss of support to two VCS specialist forums: the Mental Health Forum and the Learning Disabilities Forum.

Taking each in turn:

Re: a) Loss of direct communication & engagement route with wider VCS

Gap – engagement of the wider VCS in Board working groups

3.2 The VSEP Manager has been active in both the HWB Strategy Implementation Group and the JSNA Officers Group. Although two of the HWB VCS Reps are very engaged in the Implementation Group, the focus, quite understandably, tends to be within their own specialist fields. That has become even more the case with the development of their roles as Priority Champions. However, the broader intelligence and overview that the VSEP has been able to bring to the Implementation Group, for example identifying the contribution of a wide and diverse range of VCS partners to the HWB agenda, will now be less readily available.

3.3 None of the HWB Reps are involved in the JSNA officer group. This will make it more difficult to access, garner and gather understanding from VCS sources of front-line service gaps and needs.

Gap – Communication and horizon-scanning:

3.4 The VSEP bulletins, updates and website have helped raise awareness about current health, social care and wellbeing issues which has kept the Board's health and wellbeing agenda real and relevant for the VCS. For key colleagues in the public sector, many of whom received the bulletin, it has also offered insight into current VCS thinking and drivers.

Gap - Strategic voice and advocacy

3.5 Through the VSEP, the views of the wider VCS have been gathered providing background for the three VCS Representatives at Board meetings and also informing activity in other areas. Examples includes engagement with forums of specialist organisations (whose voice is not represented on the Board), feedback from a variety of VCS events and day to day contact with a large number of different organisations. All these links and relationships developed through the VSEP have been opportunities for drawing in data and providing the coordinated information to support the VCS input to Board discussion and activity outside of Board meetings.

Gap – Supporting the work of the VCS Board Representatives.

3.6 The VSEP has worked closely with the VCS Representatives – all of whom are highly experienced and more than capable of advocating their own corners. The VSEP's role has been primarily to liaise and co-ordinate with the Reps in advance of Board meetings. As mentioned earlier, for two of the Reps the role has expanded considerably as Priority Champions (in this they are supported by Public Health staff).

3.7 Whilst all are currently able to continue their involvement with the Board, this is may change in the not too distant future. At some point a process for electing/inviting new representatives will need to be developed. In terms of accountability and routes out to the wider sector, there is currently no mechanism or overarching VCS body to deliver that, or run a process for replacing existing Representatives.

Re b) Loss of support to the Mental Health & Learning Disabilities Forums

3.8 One of the most effective ways to engage with the VCS is through forums and networks where organisations (large and small) with a common specialist interest come together to tackle cross-cutting issues, offer mutual support, exchange information and explore opportunities for joint working. They are key routes for

articulating collective voices and provide transparent structures through which partners can identify shared and common agendas, as well as engage in strategic conversations with commissioners. For commissioners they offer a valuable, and time-efficient, opportunity to build constructive dialogue with a range of organisations, share commissioning intentions and get a 'sense check' from the sector.

3.9 A key dimension of the VSEP's work has always been to work closely with the forums because of the added value it brings. The project fairly early on identified that one forum, the Mental Health Forum, was in danger of sliding backwards when the support it had been receiving [1] ended. A decision was made to work with the Forum to build its capacity so as to move forward on pressing mental health issues impacting on the VCS members and their service users. (This included the emerging agenda around personalisation and personal budgets.) Since then the Forum has grown in strength, membership and ability to inform decision-making processes. Examples of work undertaken with the Forum are detailed above (Section 2). It is recognised by the NCC/CCG Integrated MH & LD commissioners as a highly appropriate route for engagement with the voluntary sector.

3.10 Modelled on the approach used by the MH Forum, in January 2014 the VSEP convened, and has since helped establish a successful Learning Disabilities Forum. For some time the VSEP had been concerned about the lack of a supporting network for LD organisations. Initially consideration was given to opening up the MH Forum to the LD sector. However, it was felt this would not be helpful for either group of specialists because of the different service needs of service users as well as the organisational needs of LD providers. That has proved the right decision given important agenda drivers like Winterbourne.

3.11 Whilst the LD Forum has fewer members (there are fewer VCS organisations working in this field and they tend to be quite small), during its first year the Forum has:

- Enabled members to understand more about each other's work through organisational presentations and holding bi-monthly meetings in each other's venues.
- Started to share good practice (for example outcome based-assessment for care planning).
- Developed good engagement with the LD commissioner.
- Made representation on the Winterbourne work and has secured a Forum place on the Winterbourne Project Board.
- Developed links with the LD Partnership Board (two of the Forum members are already involved).
- Made a submission to NCC on the 2014 transport budget proposals.

4. Impact of the Forum's activity

4.1 These two Forums have been able to demonstrate a number of mutual benefits to both their members and public sector partners.

4.2 VCS providers invest their time and energy in contributing to the dialogue because it helps them in meeting the needs of their service users in several ways. It means they are:

[1] It used to receive some administrative and policy support from Space East (with funding from NCC), but that ceased in July 2012.

- better informed about the strategic context in which they operate (particularly beneficial for smaller organisations who might otherwise not have access to this sort of information)
- able to identify areas of cross-cutting concern and work together to progress action
- better placed to contribute frontline knowledge and specialism to service planning and delivery
- more knowledgeable about ways their services currently do, or could be designed to meet local and national MH & LD priorities
- more equipped to spot and engage with opportunities as they arise
- effectively, transparently and accountably represented on strategic forums.

4.3 Public sector partners, particularly commissioners have:

- access to a ready-made network of organisations of different sizes, specialities, geographic location and capacity
- a more developed understanding of the way VCS organisations contribute to meeting mental health and learning difficulty needs in Norfolk
- improved dialogue with VCS organisations to improve service planning and delivery through meaningful co-production
- a route to strategic co-ordination of sector input into key areas of service development and activity
- a recognised route for communicating and engaging directly with the VCS
- the benefit of expertise and insight from engaging with a collective voice (as opposed to individual contract negotiations which may be fraught).
- the ability to collect front-line intelligence on the impact of service gaps and needs
- additional flexibility to respond to commissioning opportunities
- opportunities for collective evaluation exercises and developing a collective evidence base

4.4 Despite these positive outcomes, it is highly probable that in the absence of an equivalent level of input the VSEP has been able to give in the last 3 years, both Forums will be unable to maintain momentum at the same level. In the case of the MH Forum it is likely that it will revert back to meetings only with very little activity taking place to effect change in between. In the case of the LD Forum, its development into a strong network of support and influence for members will probably not happen. The chairs of both Forums have said they simply do not have the capacity to give the amount of time needed to ensure continuity as effective voices for the sector. Concern about the sustainability and effectiveness of the forums has also been expressed by the commissioners who have built such positive relationships with them.

4.5 Whilst there are other forums in the county bringing together specialist voluntary organisations, for example advice agencies, carers and children & young people, each of these has a dedicated funded post to co-ordinate activity and work - either as part of a contract with Norfolk County Council/CCGs, or through independent funding. [2] The lack of any dedicated funding to support the work of these two forums feels inherently unfair.

[2] The Specialist Advice Services Group includes a Co-ordinator post as part of the NCC contract. Carers organisations delivering the NCC contract are members of the Carers Agency Partnership which again includes a Co-ordinator post. The Voluntary Sector Forum for Children & Young People is supported by Momentum - a specialist infrastructure organisation funded by NCC through the new VCS Engage Project. The Older People's Strategic Partnership is supported through a post located within Norfolk Age UK and funded by NCC.

5. Recommendations

5.1 The Board is asked to consider how it wishes to respond to the gaps left behind as a consequence of the closure of the VSEP, in particular to the two strands set out below:

a) Loss of direct communication & engagement with the wider VCS

- To consider commissioning a piece of work from the VCS that relates specifically to consolidating, maintaining and developing the routes for engagement and communication between the wider VCS and the work of all partners to the HWB.

- Within this to consider how direct communication will be facilitated in the future between the HWB Strategy Implementation Group and the JSNA Officers Group with the wider VCS.

b) Support for MH & LD Forums

- The Board is asked to reflect on the value it attaches to vibrant forums that bring together VCS organisations working with some of the most vulnerable of service users – particularly in light of the focus on achieving parity of esteem between physical health and mental health with regard to funding, services and market development. The Board is asked to continue supporting this work by exploring with relevant partners to the Board possible sources of funding that can enable this to happen.

- An Outline Proposal for a post to work with the MH & LD Forums, including a role description, has been prepared. Copies are held by Voluntary Norfolk, the Chairs of both forums and the lead MH/LD Commissioner.

6. Action

6.1 The Health and Wellbeing Board is asked to:

- Note the content of this report and the achievements of the VSEP
- Consider the impact of the closure of the Project in relation to on-going vcs engagement
- Consider how it might take forward the recommendations suggested to address these gaps.

Officer Contact

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Community Led Health Improvement Healthy Communities Report

Cover Sheet

What is the role of the H&WB in relation to this paper?

In 2012, the Health & Wellbeing Board agreed to set up a community- led health improvement work programme in Norfolk which was place-based, had achieved a positive impact and could be considered for wider implementation across Norfolk. This is a report on the final, external evaluation of the Healthy Communities project.

The key findings of the evaluation were:

1.1 The Healthy Communities project has undoubtedly contributed to the health and wellbeing of the communities served

1.2 Health improvement projects in the county of Norfolk should be much more closely integrated, with all mutually supporting each other and promoted under a single brand.

1.3 Closer integration with the work of Clinical commissioning groups is highly desirable.

1.4 It might be even better to direct programmes at Districts. District councils have more resources and also power (such as planning powers) to improve many of the determinants of health.

1.5 Local health activists need to be regularly reminded of existing and new resources and services available from Public Health Departments to support them. Norfolk's Living Well Health and Wellbeing e-newsletter is distributed widely and highlights some services each month.

Key questions for discussion

- Are community led health improvement projects an effective tool for supporting the Health and Wellbeing Boards priorities?

- Has the 'Healthy Communities' model had an impact and achieved its intended outcomes? (Please see section 1.2)

Actions/Decisions needed

The Board is asked to:

- Acknowledge the report and the closing of the Healthy Communities project.
- Agree how partners can build on learning from the model developed and take it forward to support the Health and Wellbeing Board strategy in the future.
- Discuss the impact of the Healthy Communities project and if this, or a similar Asset Based Community Development project, could be supported in the future.

Community Led Health Improvement Healthy Communities Report

Report of the Interim Director of Public Health, Lucy Macleod

Summary

This paper will update the board on the progress and final evaluation of the Healthy Communities Project, summarise key activity since the last report (July 2014) and make recommendations on further development.

Action
The Health and Wellbeing Board is asked to:

- Acknowledge the report and the closing of the Healthy Communities project.
- Agree how partners can build on learning from the model developed and take it forward to support the Health and Wellbeing Board strategy in the future.
- Discuss the impact of the Healthy Communities project and if this, or a similar Asset Based Community Development project, could be supported in the future.

1. Background

1.1 In 2012, the Health & Wellbeing Board agreed to set up a community- led health improvement work programme, using two approaches used in Norfolk which were place-based, had achieved a positive impact and could be considered for wider implementation across Norfolk (Healthy Towns and Ageing Well). The Board also endorsed a proposal that the programme should be supported by part of the County Council's share of 2nd homes monies for 2012-13.

1.2 In setting up this programme Members noted that the community-led approach to health improvement was concerned with supporting communities to:

1. Identify and define what was important to them about their health and wellbeing
2. Identify the factors that impacted on their wellbeing, and to
3. Take the lead in identifying and implementing solutions.

1.3 The H&WB agreed the overall approach for implementation with the 10 communities identified from the health evidence base. Those communities are Fakenham, Cromer, Wymondham, Diss, North Walsham, Downham Market, Hunstanton, one ward in Kings Lynn and two wards in Great Yarmouth. The original steering group for the project in its development stages was replaced with a locality implementation group, to co-ordinate roll-out.

1.4 The Board has received regular reports on the progress being made and the most recent report to the H&WB meeting in July 2014 can be accessed on the County Council's website at the following link.

1.5 The Healthy Communities project ends at the end of March 2015, this paper serves as a final report and evaluation on the project.

1.6 The external evaluation referenced in this update was carried out by JK Public Health Consulting Ltd. John Kemm is director and lead consultant for the firm, he retired from the NHS after twenty years working in senior public health posts. His evaluation was carried out between October and December 2014. Please see the key points below but a copy of the full report can be found in the link at point 3.

2. Outline of key activities and outcomes

2.1 *Report based on the project ending and key evaluation points.*

This update is based on the Healthy Communities project coming to an end based on the agreed funding period March 2015. This report includes the main findings and recommendations for future Community led health improvement initiatives. The key evaluation points being to support communities to identify and define what is important to them about their health and wellbeing, Identify factors that impacted on their wellbeing, and to take the lead in identifying and implementing solutions.

Update of key activity since the July 2014 Report.

Since the last report to the Board in July 2014 the project has seen an increase in community based activity, training, and a small grants programme. It has also supported community resilience by connecting community members and groups with existing services and assets to support health and wellbeing.

The key activity since July has been:

- The increase in grants allocated to support local community groups to deliver Health and wellbeing projects and associated activities. *See appendix 1*
- The training provision in all areas supporting the upskilling of general public and community groups. *See appendix 2*
- The increase of the Healthy Communities team at health fairs and health events - raising awareness and signposting local people to local services. *See appendix 3*
- There was also an increase in the delivery of Dementia Friends information sessions with targets being met and exceeded. *See appendix 2*

Another area of note is that two members of staff left their posts during the project and one new member of staff was brought in on a part time basis. This increased workload on remaining staff from October until end of project.

2.2 *Enabling Healthier communities - See below for the evaluation of the key outcomes*

2. Identify and define what was important to them about their health and wellbeing

We organised, promoted and hosted a series of 12 engagement events supported with the use of data collection tools, used to gather information direct from local residents prioritising what they feel is important to them in regards to health and wellbeing. These events were also used to inform the allocation of available grants and relevant training needs. *See table 1.1*

1.1

Town	***District***	***Date of event***	***Number attending***
Cromer	*North Norfolk*	*24/7/13*	*42 **
Diss	*South Norfolk*	*15/11/13*	*31*
Downham Market	*West Norfolk*	*27/3/14*	*25*

Fakenham	*North Norfolk*	*18/7/13*	*85 **
Hunstanton	*West Norfolk*	*29/1/14*	*41*
Kings Lynn	*West Norfolk*	*11/3/14*	*38*
North Walsham	*North Norfolk*	*4/3/14*	*27*
Wymondham	*South Norfolk*	*21/11/13*	*50*
Great Yarmouth	*Great Yarmouth*	*Special Arrangements*	

Two sessions held in these areas

3. Identify the factors that impacted on their wellbeing,

Community led health improvement projects aim to support and enable local community drivers to take the lead in finding solutions to the issues identified, preferably with local health services. The development of shared actions plans or network opportunities offers an element of sustainability, whilst also being able to identify suitable training and allocation of grants. Mechanisms were put in place to identify and assess local services that impact on resident's health. Identified support given to develop new or support existing services and activities in local area based on the need of the local communities. Please see table 2.1 that details the health and wellbeing issues communities raised at these events.

2.1

	Cromer	**North Walsham**	**Fakenham**	**Hunstanton**	**Kings Lynn**	**Downham Market**	**Wymondham**	**Diss**
Transport	X	X	X	X	X	X	X	X
Access to health information	X	X	X	X	X	X	X	X
Community togetherness	X	X		X	X	X	X	X
Mental health issues		X		X	X		X	X
Opportunities for Physical activity & exercise				X	X	X	X	X
GP services	X			X	X	X		
Support for children & young people		X		X		X	X	X
Healthy eating							X	X
Living with disability		X	X					X
Services for older people		X					X	X
Sexual health		X						

4. Take the lead in identifying and implementing solutions.

We established a forum, network meeting or action group to collate the health issues facing the target area and to identify and implement suitable solutions using the existing health assets available. Health groups have been set up or supported by the Healthy Communities in South Norfolk, North Norfolk, West Norfolk and Great Yarmouth and plans have been confirmed to sustain delivery of these meetings beyond the Healthy Communities funding period of March 2015.

2.3 *Community Engagement*

6,145 people engaged in the project over the 10 communities through engagements, events, meetings and training. Training including Mental health First Aid, Dementia Friends, Understanding Health Improvement and Grants training. Events included Health fairs and Health related events and engagement included

meetings, workshops and presentations. Key issues coming from our engagement events included transport, community togetherness and access to health information. Slipper swaps were one of our more successful events with 610 pairs of slippers being distributed to support the falls prevention and Warm and Well campaigns.

2.4 *Cases studies.*

During the course of the project there were a number of case studies from partners and members of the public, here are a few taken from the independent evaluation:

'Andrew, an ambulance first responder spotted the Mental Health First Aid course run by Healthy Communities listed in his local paper. He was keen to increase his knowledge of this topic and attended the course which he found very helpful; He went on to attend a dementia friends information seminar and found this "thought provoking and a real eye opener". He then went on to attend a further course in Norwich and to become a Dementia Friends champion'.

'Bruce had suffered from various mental health issues ranging from panic attacks, anxiety, depression, obsessive compulsive disorder and physical conditions brought on by severe stress since he was ten years old. Visits to his GP and referral to psychologists helped but he still lacked self-confidence and self-esteem. When he saw an IFS self-defence course supported by Healthy Communities and advertised in Great Yarmouth he thought it might help. He found the six week course had a profoundly positive effect on him. He liked the way the programme took place in a fun, friendly and relaxed atmosphere. The team had lots of time and patience and allowed people to do things at their own pace matched to their age, fitness and abilities'.

Great Yarmouth

Arrangements in Great Yarmouth were slightly different from those in the other healthy communities. Since the borough council had already established a lively community development programme, the healthy community project was embedded in the day to day development activity of the council. The project was led by a neighbourhood manager employed by Great Yarmouth Council who already had good networks for engaging the community. This approach also supports the Health and Wellbeing board second homes funding allocated to district councils for Community led health improvement

2.5 *Key achievements*

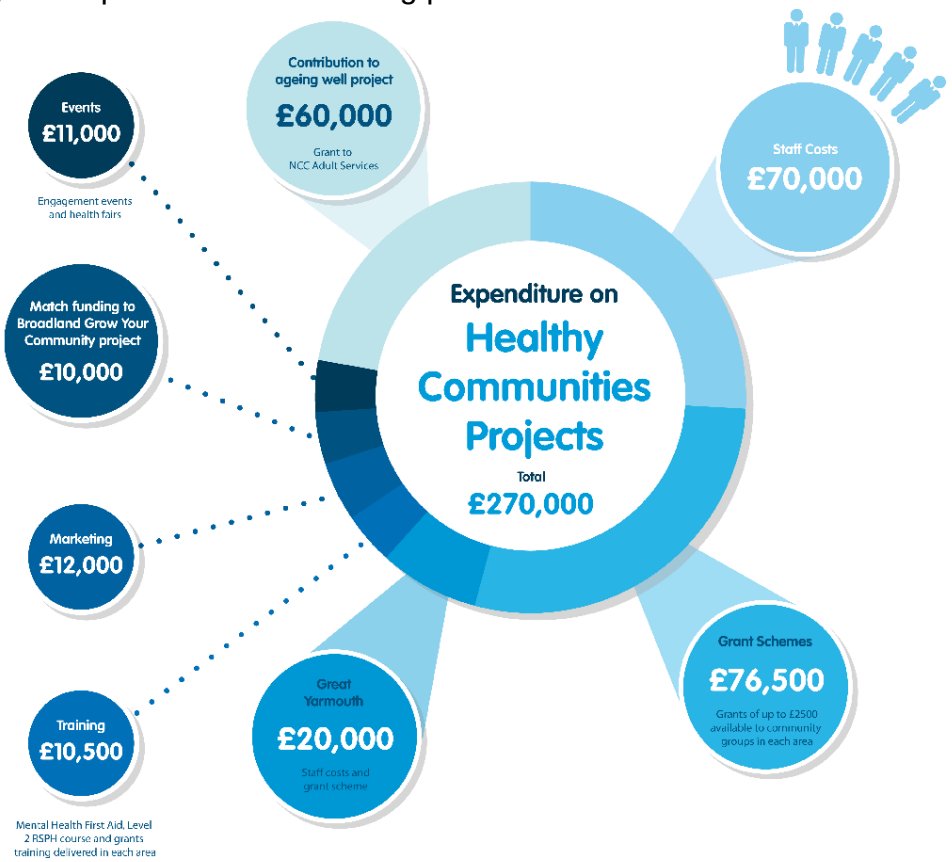
The below points are key achievements as reported by our independent evaluator:

- The project delivered start up workshops, training programmes, health fairs and the establishment of local health groups as specified in the PID.

- Those who have contact with healthy communities' project value it highly, particularly for strengthening networks and improving communications between the different organisations operating in each town.
- Healthy community project activity made contact with a large number of people. In all and over 6,000 people have had high level contact with the project although it is expected that many more benefited from secondary contact.
- The project has been particularly successful in creating dementia awareness through the roll out of the Dementia Friends programme, which raises awareness of one of the board's top priorities.
- The development of Community Asset Based Inventories for each community was completed and distributed with a mechanism in place for ensuring relevant and accurate data is kept up to date
- The project has engaged with professional and community workers within identified areas which impacted on the person in the street by enabling these workers to empower their community members and users. This was evident in the grant programme where a selection of various local, valued services were supported to expand their offer in communities.

2.6 *Financial Summary*

The independent evaluation report states that it is clear that there are indications that the money was well spent and offers value in terms of 10 stronger better informed communities in the identified towns. This can be deduced from the way the project supported community networks, allowing health organisations to come together to work more efficiently and the upskilled workforce of local organisations and general public with the training provided



3. Key recommendations for future work

These are some of the recommendations taken from the full report, which is available here: Full Evaluation Report.

4.1 The Healthy Communities project has undoubtedly contributed to the health and wellbeing of the communities served

4.2 Health improvement projects in the county of Norfolk should be much more closely integrated, with all mutually supporting each other and promoted under a single brand.

4.3 Closer integrating with the work of Clinical commissioning groups is highly desirable.

4.4 It might be even better to direct programmes at Districts. District councils have more resources and also power (such as planning powers) to improve many of the determinants of health.

4.5 Local health activists need to be regularly reminded of existing and new resources and services available from Public Health Departments to support them. Norfolk's Living Well Health and Wellbeing e-newsletter is distributed widely and highlights some services each month.

4. Action

4.1 The Health and Wellbeing Board is asked to:

- Acknowledge the report and the closing of the Healthy Communities project.
- Agree how partners can build on learning from the model developed and take it forward to support the Health and Wellbeing Board strategy in the future.
- Discuss the impact of the Healthy Communities project and if this, or a similar Asset Based Community Development project, could be supported in the future.

Officer Contact

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

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Appendix 1 – Grant allocation

Town	Applicant	Project	Grant
North Lynn	Forward Day Centre	Vegetable growing for adults and children with learning disabilities –who will eat the vegetables when grown	£2,500
North Lynn	North Lynn Discovery Centre	Free local community gym to be used by NEET and other disadvantaged young people	£2,460

North Lynn	Matthew project	Drop in service on drugs and alcohol providing information and referral	£675
North Lynn	West Norfolk Mind	Gardening for health allotment – funds for support worker, raised beds and publicity	£2.500
Hunstanton	Norfolk Rural Community Council	Good neighbour scheme meeting to recruit volunteers – train volunteers	£2,500
Hunstanton	Sustrans	Active explorer scheme– map and publicity to encourage adults and children to cycle/ walk to recreational venue	£2,500
Hunstanton	West Norfolk Befriending	Recruit volunteers to befriend isolated carers	£2,500
Downham Market	Sustrans	Active explorer scheme– map and publicity to encourage adults and children to cycle/ walk to recreational venue	£2,500
Downham Market	West Norfolk Befriending	Recruit volunteers to befriend isolated carers	£1,042
Gt Yarmouth (Nelson)	Pathways Cafe	Free 3 course meal twice a week for homeless clients – General support to increase health and self-worth	£5,000
Gt Yarmouth (Central & Northgate)	Pedal the prom	Free weekly signposted and marshalled cycle ride for all ages. Supported by cycle mechanics and coaches	£5,000
Gt Yarmouth (Nelson)	Fox's Passage Residents Assoc.	Community garden for local residents to maintain and enjoy. Tools will be supplied	£1,250
Gt Yarmouth (Nelson)	Go Ahead Club	Social club to provide safe and friendly place for people with learning difficulties to come together and have fun.	£2,500
Gt Yarmouth (Nelson)	IFS Motivational Defence	Sessions to teach people self-defence skills and improve fitness – 3 courses each course 6 weekly one hour sessions	£964
Gt Yarmouth (Central & Northgate)	YMCA	Health and wellbeing programme using alternative sports and ways of engaging hard to reach young people	£2,500
Fakenham	Fakenham Area Partnership	GIFT community gardening project on 3 sites – Training and information on growing own food	£2,500
Fakenham	Norfolk Rural Community Council	Good neighbour scheme - meeting to recruit volunteers – train volunteers	£2,500
Fakenham	Recreation Ground Charity	Outdoor gym equipment – organise sessions for keep fitters	£2,500
Fakenham/ N. Walsham/ Cromer	North Norfolk Fit together	Expenses for volunteer walk leaders	£2,500
North Walsham	The Atrium	Toddler dance sessions-publicity and recruit and train volunteer leaders	£2,500
North Walsham	Norfolk Rural Community Council	Good neighbour scheme - meeting to recruit volunteers – train volunteers	£2,500
North Walsham	North Walsham Multisports	Summer multisports club –camp to teach sporting techniques and develop social skills and general fitness of 5-12 year olds	£2,406
North Walsham	Dementia group, Griffin Area Partnership	Additional twice monthly session for people with dementia and their carers	£2,485
Cromer	Cromer Youth Football Club	Purchase of sun shelters – promotion of sun awareness to [layers and supporters	£890
Diss	Dove Dementia Cafe	Start up costs for new Dementia cafe as part of Diss dementia Friendly Initiative	£1,500
Diss	Smoothie bike project	Static bike coupled to smoothie maker – promote healthy eating	£4,000
Diss	Good Neighbour scheme	Expand scheme to additional areas of Diss	£1,000
Diss	Diabetes Exercise Programme	Pilot exercise course for people with diabetes referred from GP	£1,000
Diss	What the doctor	Event for carers to enable them to try out several relaxation techniques –	£500

	ordered	Talk by GP and staff in informal setting	
Diss	Dementia Friendly Community	Support for launch of dementia friendly initiative and to train businesses	£500
Wymondham	Good Neighbour scheme	Expand scheme to additional areas of Wymondham	£1,000
Wymondham	What the doctor ordered	Event for carers to enable them to try out several relaxation techniques – Talk by GP and staff in informal setting	£500
Wymondham	Wymondham Pabulum Cafe	Enable set up of Pabulum picture Palace and Singing Cafe and purchase of books and promotional materials	£3,000
Wymondham	Sing Your Heart Out	Running costs of a therapeutic singing group for people with learning disabilities and mental health problems	£2,000
Wymondham	Wymondham Martial Arts Centre	Start after school club to promote healthy lifestyles to children and young people	£2,000
		Total	**£74,172**

Appendix 2 – Training provision

	Mental Health First Aid		**Dementia Friends**		**Understanding Health Improvement**		**Applying for grants**	
	Course	Part.	Course	Part.	Course	Part.	Course	Part.
Cromer	2	14	4	73	1	13	1*	15
North Walsham	2	14	3	41	2	12		
Fakenham	1	14	3	23	1	12		
Hunstanton	2	10	1	12			1	12
Kings Lynn	1	8	6	48	1	10	1	11
Downham market	1	9	1	14	1	12	1	14
Wymondham	2	27	2	16	1	14	1	12
Diss	1	8	1	8	1	13	1	15
Great Yarmouth	1	14	1	35	1	21	2	25

Appendix 3 – Events

Area	Event type	Month	Year	No. of High level Contacts
Fakenham	ABCD Workshop	July	2013	55
Fakenham	ABCD Workshop	July	2013	30
Cromer	ABCD Workshop	July	2013	27
Cromer	ABCD Workshop	July	2013	15
Fakenham	Community event	August	2013	50
Fakenham	Community event	September	2013	20
Cromer	Community event	August	2013	60
Fakenham	Community event	August	2013	10
Hunstanton	Community event	October	2013	12
King's Lynn	Community event	September	2013	30
Cromer	Health Fair	October	2013	27
North Walsham	Other	October	2013	70
Cromer	Health Fair	November	2013	60
Downham Market	Community event	September	2013	15
Hunstanton	ABCD Workshop	January	2014	41
King's Lynn	ABCD Workshop	March	2014	38

Downham Market	ABCD Workshop	March	2014	27
North Walsham	ABCD Workshop	March	2014	27
Fakenham	Other	March	2014	14
North Walsham	Health Fair	March	2014	120
Fakenham	Community event	April	2014	80
Fakenham	Health Fair	June	2014	25
Diss	ABCD Workshop	November	2013	31
Wymondham	ABCD Workshop	November	2013	50
Wymondham	Community event	January	2013	15
Wymondham	Community event	November	2013	40
Wymondham	Community event	March	2014	15
Diss	Other	April	2014	9
Diss	Other	May	2014	8
Wymondham	Community event	June	2014	15
Diss	Community event	June	2014	85
Cromer	Community event	June	2014	45
North Walsham	Network Meeting	July	2014	11
Great Yarmouth	Health Fair	June	2014	120
Cromer	Community event	August	2014	30
Fakenham	Community event	August	2014	45
North Walsham	Community event	August	2014	25
Hunstanton	Community event	August	2014	100
King's Lynn	Network Meeting	August	2014	7
King's Lynn	Community event	September	2014	200
Great Yarmouth	Community event	July	2014	176
King's Lynn	Health Fair	October	2014	100
North Walsham	Network Meeting	October	2014	10
Cromer	Community event	October	2014	100
Downham Market	Community event	October	2014	100
Great Yarmouth	Other	August	2014	176
Downham Market	Community event	December	2014	135
Wymondham	Community event	December	2014	45
King's Lynn	Community event	December	2014	62
Diss	Community event	December	2014	70
Great Yarmouth	Community event	January	2015	51
Hunstanton	Health Fair	January	2015	150
Hunstanton	Community event	January	2015	87

Report to Norfolk Health and Wellbeing Board
29 April 2015
Item 11

Clinical Commissioning Groups: Extracts from Draft Annual Reports 2014 -15

What is the role of the HWBB in relation to this paper?

The Health and Social Care Act 2012 sets out a number of legal responsibilities for the Health and Wellbeing Board, including a:

- Duty to provide an opinion as to whether the CCG commissioning plan has taken proper account of the Joint Health and Wellbeing Strategy and what contribution has been made towards the achievement of it
- Duty to assess how well the CCG has discharged its duties to have regard to the JSNA and JH&WBS

Key questions for discussion

Q.1 What has been the overall contribution of each of the CCGs towards delivering the priorities of the Joint Health and Wellbeing Strategy?

Q.2 Is this reflected appropriately in the reviews in the CCGs draft Annual Reports?

Actions/Decisions needed

The Board is asked to:

- Comment on the extracts provided of the CCGs draft Annual Reports 2013/14
- Make any other general comments as to form and content of the CCGs Annual Reports

Clinical Commissioning Groups: Extracts from Draft Annual Reports 2014 -15

Report by Norfolk's Clinical Commissioning Groups

Summary

This report provides relevant extracts of the Clinical Commissioning Groups (CCGs) draft Annual Reports 2014/15. It brings together the reviews prepared by each of the CCGs of the extent to which the CCG has contributed to the delivery of the joint health and wellbeing strategy. The report provides an opportunity for the Board to comment directly on these draft reviews and, if it wishes to do so, more generally on the form and content of the CCGs draft annual reports.

Action

The Board is asked to:

- Comment on the extracts provided of the CCGs draft annual reports 2013/14
- Make any other general comments as to form and content of the CCGs annual reports

1. Background

1.1 Clinical Commissioning Groups (CCGs) are required to publish an annual report in accordance with directions issued by NHS England. The NHS England Annual Reporting Guidance states that, amongst other things, the annual reports must contain a review of the extent to which the CCG has contributed to the delivery of the joint health and wellbeing strategy. The Guidance also states that in preparing this review the CCG must consult the Health and Wellbeing Board (H&WB).

1.2 In addition, the Guidance states that the Board may give directions to clinical commissioning groups as to the form and content of an annual report and that the CCGs must give a copy of its annual report to the Board.

2. CCGs Draft Annual Reports 2014-15

2.1 The CCGs are currently drafting their annual reports in accordance with the detailed Guidance and these will be published in due course.

2.2 For the purposes of today's discussion, each of the CCGs were invited to submit the relevant extract from their draft Annual Report which covers the extent to which the CCG has contributed to the delivery of the joint health and wellbeing strategy. These extracts from the draft annual reports are attached in the appendices as follows:

- Great Yarmouth & Waveney CCG – Appendix A
- North Norfolk CCG – Appendix B

- Norwich CCG – Appendix C
- South Norfolk CCG – Appendix D
- West Norfolk CCG - Appendix E

2.3 In terms of the overall form and content, each CCG has drafted its annual report in accordance with detailed NHS guidance. The breadth of the annual report is potentially wide and in many cases the CCGs have taken the approach that 'less is more' in order to keep the size of the document manageable. At this stage, it may be that the Board would wish to offer comments in general about overall form, content, etc.

3. Action

3.1 The Board is asked to:

- Comment on the extracts provided from each of the CCGs draft annual reports 2014/15
- Make any other general comments as to form and content of the CCGs annual reports

Officer Contact

If you have any questions about CCG's draft Annual Reports please get in touch with:

Name	CCG	Email
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Ann Donkin, Chief Officer	South Norfolk CCG	ann.donkin@nhs.net
Andy Evans, Chief Officer	Great Yarmouth & Waveney CCG	andy.evans2@nhs.net
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Great Yarmouth & Waveney CCG

Health and Wellbeing Boards

The CCG has been a full participant in working with our partners across the Norfolk and Suffolk Health and Wellbeing Boards in the development of the Joint Health and Wellbeing Strategies. This has included participation in discussion at full Health and Wellbeing Board meetings, as well as a number of sub groups established to assist in working on the finer detail of the plans. The CCG's commissioning intentions support the aims of both the Norfolk and Suffolk Joint Health and Wellbeing Strategies.

Suffolk Health and Wellbeing Strategy is available here: http://www.suffolk.gov.uk/your-council/decision-making/committees/suffolk-health-and-wellbeing-board

Norfolk Health and Wellbeing Strategy is available here: http://www.norfolk.gov.uk/download/healthwell060514agendapdf

North Norfolk CCG

The CCG's Chair, Dr Anoop Dhesi, and the Chief Officer, Mark Taylor, are members of the joint **Health and Wellbeing Board** with Norfolk County Council officials and other strategic partners, including voluntary groups and charities. The Board met on 5 occasions during the year ended 31st March 2015, in April, May, July, October and February; attendance by the CCG was very good.

The Board leads the development of the Joint Health and Wellbeing Strategy, which is informed by the Joint Strategic Needs Assessment and describes the county's current and future health and wellbeing needs. The Board drives the integration of health, social care and other public sector services. In May 2014 the Board agreed three main priorities for supporting everyone in Norfolk to live '*healthy, happier lives for longer'* by:

- promoting the social and emotional wellbeing of pre-school children;
- reducing obesity; and
- making Norfolk a better place for people with dementia and their carers.

Activity to achieve each of the priorities is designed to achieve the cross-cutting goals of:

- providing help and support at an earlier stage before problems become acute; and
- reducing inequalities in health and wellbeing.

Promoting the social and emotional wellbeing of pre-school children is led by Public Health England (PHE) through its Healthy Child Programme (HCP). The CCG is working with PHE to co-produce the transition of current service delivery to the HCP pathway, ensuring that the pathway follows national guidance and best practice and that service users can access services from the acute setting closest to their home wherever possible.

To support the delivery of its dementia priority, the Health & Wellbeing Board created the Norfolk Dementia Strategy Implementation Board in the autumn of 2014, of which NHS North Norfolk CCG is a member**.** The CCG fully supports the Board's aims, which are to:

- build an integrated approach to dementia;
- promote awareness of dementia;
- improve the managed dementia care pathway;
- support independent living in the community; and
- improve services for those unable to live independently.

These aims closely reflect the aims of the CCG's 'Living Well with Dementia programme, which was established in 2013. Having identified a need for advice and information, the CCG has been working in partnership with stakeholders to produce information packs for people newly diagnosed with dementia and the learning from this work is being shared with the Implementation Board's Information Group.

Norwich CCG

[Note – the extracts are from two sections of the Draft Annual Report – one extract is in a section about the reporting year and the second part is in a 'looking ahead' section.]

Section: Integrated Commissioning

The CCG actively pursues an integrated approach to its work with partner organisations such as Norfolk adult and children's services, public health, Norwich City Council and Broadland District Council. They are represented on the Your Norwich Board and in appropriate Task and Finish Groups. At a strategic level, discussions take place at the multi-agency Norwich Locality Board, chaired by the Leader of Norwich City Council and there is important joint work with Norwich City Council and Public Health on the Healthy Norwich programme.

The Norfolk Health and Wellbeing Board strategy was agreed in May 2014 and the CCG's work programme, in particular the Healthy Norwich and YourNorwich programmes, are fully aligned with its priorities. During 2014/15, arrangements for the Better Care Fund were put in place including the identification of priority spending areas and strategic direction. The Fund comes into existence in 2015/16 – see page X.

The priorities of the Norfolk Health and Wellbeing Board, to which the CCG's work programme are aligned, are:

- Promoting the social and emotional wellbeing of pre-school children - a detailed work programme for is being developed. Norfolk County Council is the lead agency
- Reducing Obesity – which the CCG contributes to via the Healthy Norwich programme
- Making Norfolk a better place for people with dementia and their carers - the CCG has established a multi-stakeholder working group for an integrated approach in Norwich to meet the needs of patients with dementia and their carers. Funding has been identified for an Admiral Nurse for 2015/17.

The co-location of an integrated commissioning team within the CCG's offices ensures health and social care commissioning is coordinated and more effective.

Section: Looking Ahead

The focus of the CCG in 2015/16 will be to maintain the pace of delivery envisaged and embarked upon during 2014/15. Service improvements such as our virtual ward and weight management programmes will continue to be embedded and developed. The YourNorwich, Healthy Norwich and Quality workstreams will be central to this.

In 2015/16 the CCG will contribute £12.2 million towards the Norfolk Better Care Fund (BCF). This is a scheme that transfers NHS resources into a pooled fund under the overall control of Health & Wellbeing Boards. The total value of the Better Care Fund for Norfolk is £62.4 million, from April 2015. The diagram, on page xx, shows how we plan to spend BCF money in Norwich.

Norfolk County Council at your service

NHS Norwich Clinical Commissioning Group

NORWICH BETTER CARE FUND PLAN ON A PAGE

INTEGRATED CARE MODEL	INTEGRATION SCHEMES		PERFORMANCE INDICATORS
Primary Care Development	Development of primary care localities	Risk stratification and targeted interventions	Reduced permanent admissions of older people to residential and nursing care
Community Health and Care Services	Integrated teams in localities	Care co-ordination teams	Increased proportion of older people still at home 91 days after discharge into reablement/rehab
	7 day case management for complex needs	Falls prevention	
	7 day social care assessment and care management	Integrated end of life care	Reduced delayed transfers of care from hospital
	Integrated dementia care		
	Integrated support for people with long-term conditions	Integrated community mental health	Reduced avoidable emergency admissions
Intermediate care	7 day supported discharge and intermediate care management		Increased proportion of people feeling supported to manage their long-term condition
Community assets	Supporting self care	Support for carers	Better patient experience of care
	Voluntary and community intervention fund	Housing and housing related support	

South Norfolk CCG

Annual Report submission to Norfolk Health and Wellbeing Board

Integrated Commissioning

South Norfolk CCG works with a range of strategic partners and stakeholders from across the statutory, community and voluntary sectors. The CCG works closely with the following local government organisations:

- Norfolk County Council Adult Social Services / Children's Services & Public Health Norfolk
- South Norfolk Council
- Breckland District Council

The above organisations regularly engage with the CCG across a range of for a, and, through 'Better Care for South Norfolk', share collegiate responsibility to strategically plan integrated commissioning priorities for the South Norfolk area.

During 2014/15, arrangements for the Better Care Fund were put into place including the identification of priority spending areas and strategic commissioning intentions. The Fund comes into existence in 2015/16 – more details can be found on page XX.

The CCG has a strong Integrated Commissioning team that leads the coordination of out of hospital health and social care commissioning effectively, which is clinical and practitioner led.

South Norfolk CCG has aligned its strategic intentions to compliment the Norfolk Health and Wellbeing Board strategy, which was agreed in May 2014. The priorities of the Norfolk Health and Wellbeing Board, to which the CCG's work programmes are aligned involve:

- **Promoting the social and emotional wellbeing of pre-school children:** The CCG is supporting Norfolk County Council (as the lead agency) in the development of a comprehensive work plan locally which will encompass the Children and Families Act, and the specific details relating to pre-school children within the Act

- **Reducing Obesity:** The CCG continues to work with Public Health Norfolk in the development of its county-wide Obesity strategy, as well as continuing to develop a South Norfolk-specific programme with a range of stakeholders. The CCG is also reviewing its commissioning intentions for a Tier 3 Weight Management Service.

- **Making Norfolk a better place for people with dementia and their carers:** Through the aims of 'Better Care for South Norfolk', and the Integrated Commissioning workstreams for out of hospital and mental care,, the CCG has made significant progress in the commissioning of services available for people with dementia and their carers. More details can be found on page XX

Plan for 2015/16

Over 2015-16, the CCG will focus on the following key areas of delivery:

- Continuing to review support for people with dementia and their carers locally, and

ensuring that Primary Care continues to drive the dementia agenda alongside key stakeholders across health, social care and the voluntary sectors.

- Commence the delivery of South Norfolk's End of Life Strategy

- Focus on improving the quality of care pathways of priority Long Term Conditions for patients in South Norfolk, with particular emphasis on the integrated elements of delivery

- Support the development of the multi-disciplinary 'Early Help' Hub model in the South Norfolk District

'Better Care in South Norfolk' - Plan for 2015/16

As part of the agreed delivery of the Norfolk Better Care Fund in 2015/16, the CCG will contribute £14 million into the Fund. The total value of the Fund for Norfolk is £62.4 million, from April 2015.

Priorities for 'Better Care in South Norfolk' are as follows:

- Development and roll-out of Integrated Primary Care Teams across South Norfolk, focusing on the sharing of appropriate information between health and social care services
- Support and monitoring of the 'Information and Support' Service pilot, delivered by Age UK Norfolk at 14 surgeries across South Norfolk
- Continuation of a range of integrated support services for people with dementia, including continued funding for the Admiral Nurse service in South Norfolk

West Norfolk CCG

Working with the Norfolk Health & Wellbeing Board

Health & Wellbeing Boards were established under the Health and Social Care Act 2012 to act as a forum in which key leaders from the health and care system could work together to improve the health and wellbeing of their local population and to promote integrated services.

WNCCG recognises the Norfolk Health and Wellbeing Board as a key vehicle to engage strategic leaders from health and care on a county-wide basis and is an active participant in the Board, the WNCCG representative Dr Ian Mack being vice chair of the Board.

WNCCG has mirrored this collaboration at local West Norfolk health and care system level, through the West Norfolk Alliance of health and care providers and commissioner partners at Chief Executive level, committed to innovation in health and care delivery and via the development of a West Norfolk Health and Wellbeing strategy led by WNCCG and Kings Lynn Borough Council.

The Norfolk Health and Wellbeing Board developed and agreed shared intentions to drive forward health and care integration and reduce inequalities, and to deliver this with focus on 3 local priorities;

- Promoting the social and emotional wellbeing of pre-school children
- Reducing obesity
- Making Norfolk a better place for people with dementia and their carers

In responding to these priorities three overarching goals were also identified:

- Prevention – providing help and support at an earlier stage before problems become acute
- Reducing inequalities in health and wellbeing
- Integration – partners working together to provide effective, joined up services

Examples of WNCCG's contribution to deliver improvements in these areas during 2014/15 included:

- Continued work to progress integrated commissioning and service delivery, as a nationally identified Integrated Pioneer - one of a select few areas identified. This status has offered national government support to accelerate integration through sharing of expertise, resource and offering ability to test established process and regulations;

- Work to implement a West Norfolk Dementia strategy, commissioning a range of pathway initiatives to support early identification, assessment and dementia diagnosis supported by appropriate and timely treatment. This has included piloting of a Dementia Complexity in Later Life (DCLL) pathway, Dementia Admiral Nurses, and work with providers to develop Dementia Champions to promote dementia care

- Work to review the obesity pathway for the population of West Norfolk, to ensure that appropriate interventions at all levels are available, and that early support and prevention is promoted through the Norfolk's 'Living Well' Health Trainer service;

- Work to lead improvements in commissioning of children's services, driving change in service provision through the CCG Chief Officer's role as Chair of the Norfolk-wide Women and Children's Commissioning Board. Work within West Norfolk included work with healthcare partners to improve integration of acute and community paediatric provision and to enhance paediatric acute urgent care over the winter period via additional investment;

- Targeted commissioning with Public Health colleagues to reduce inequalities, via the commissioning of health and wellbeing services tailored to particular population groups with specific access and health needs.

NHS Five Year Forward View: New Models of Care

Cover Sheet

What is the role of the H&WB in relation to this paper?

The Five Year Forward View sets out a vision for the future of the NHS, and articulates why change is needed, what that change might look like, and how it can be achieved. The FYFV and supporting guidance are key to delivery of the HWB's statutory duties, in particular:

- Preparation of the Joint Strategic Needs Assessment and Health and Wellbeing Strategy
- Duty to encourage integrated working between commissioners of health and social care services
- HWB opinion in relation to CCG commissioning plans, in relation to the Health and Wellbeing Strategy.

Key questions for discussion

The Health and Wellbeing Board is asked to note and discuss the key issues within the Five Year Forward View and to frame its local response.

NHS Five Year Forward View

Report of the Locality Director, East Sub Region Team, NHS England

Summary

The NHS Five Year Forward View was published in October 2014 and sets out a vision for the future of the NHS. It has been developed by the partner organisations that deliver and oversee health and care services including NHS England, Public Health England, Monitor, Health Education England, the Care Quality Commission and the NHS Trust Development Authority.

The purpose of the Five Year Forward View is to articulate why change is needed, what that change might look like and how we can achieve it. It describes various models of care which could be provided in the future, defining the actions required at local and national level to support delivery.

The Forward View covers such areas as disease prevention, new, flexible models of service delivery tailored to local populations and needs; integration between services; and consistent leadership across the health and care system.

Action
The Health and Wellbeing Board is asked to note and discuss the key issues within the Five Year Forward View and to frame its local response.

1. Background

1.1 The purpose of the Five Year Forward View (FYFV) is to articulate why change is needed, what that change might look like and how we can achieve it. It describes various models of care which could be provided in the future, defining the actions required at local and national level to support delivery.

1.2 FYFV identifies three themes or gaps that must be addressed and are interlinked:

- Health and wellbeing – requiring a radical upgrade in prevention
- Care and quality – requiring new models of care
- Funding – requiring efficiency and investment.

2. Executive Summary

2.1 The NHS has dramatically improved over the past fifteen years. Cancer and cardiac outcomes are better; waits are shorter; patient satisfaction much higher. Progress has continued even during global recession and austerity thanks to

protected funding and the commitment of NHS staff. But quality of care can be variable, preventable illness is widespread, health inequalities deep-rooted. Our patients' needs are changing, new treatment options are emerging, and we face particular challenges in areas such as mental health, cancer and support for frail older patients. Service pressures are building.

2.2 The 'Forward View' sets out a clear direction for the NHS – showing why change is needed and what it will look like. Some of what is needed can be brought about by the NHS itself. Other actions require new partnerships with local communities, local authorities and employers. Some critical decisions – for example on investment, on various public health measures, and on local service changes – will need explicit support from central government.

2.3 The first argument made in the Forward View is that the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health.

2.4 The NHS will back hard-hitting national action on obesity, smoking, alcohol and other major health risks. We will help develop and support new workplace incentives to promote employee health and cut sickness-related unemployment. And we will advocate for stronger public health-related powers for local government.

2.5 When people do need health services, patients will gain far greater control of their own care – including the option of shared budgets combining health and social care. The 1.4 million full time unpaid carers in England will get new support, and the NHS will become a better partner with voluntary organisations and local communities.

2.6 The NHS will take decisive steps to break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, between health and social care. The future will see far more care delivered locally but with some services in specialist centres, organised to support people with multiple health conditions, not just single diseases.

2.7 England is too diverse for a 'one size fits all' care model to apply everywhere. Different local health communities will instead be supported by the NHS' national leadership to choose from amongst a small number of radical new care delivery options, and then given the resources and support to implement them where that makes sense.

2.8 One new option will permit groups of GPs to combine with nurses, other community health services, hospital specialists and perhaps mental health and social care to create integrated out-of-hospital care – the **Multispecialty Community Provider**. Early versions of these models are emerging in different parts of the country, but they generally do not yet employ hospital consultants, have admitting rights to hospital beds, run community hospitals or take delegated control of the NHS budget.

2.9 A further new option will be the integrated hospital and primary care provider – **Primary and Acute Care Systems** – combining for the first time general practice and hospital services, similar to the Accountable Care Organisations now developing in other countries too.

2.10 Across the NHS, urgent and emergency care services will be redesigned to integrate between A&E departments, GP out-of-hours services, urgent care centres, NHS 111, and ambulance services. Smaller hospitals will have new options to help them remain viable, including forming partnerships with other hospitals further afield, and partnering with specialist hospitals to provide more local services. Midwives will have new options to take charge of the maternity services they offer. The NHS will provide more support for frail older people living in care homes.

2.11 The foundation of NHS care will remain list-based primary care. Over the next five years the NHS will invest more in primary care, while stabilising core funding for general practice nationally over the next two years. GP-led Clinical Commissioning Groups will have the option of more control over the wider NHS budget, enabling a shift in investment from acute to primary and community services. The number of GPs in training needs to be increased as fast as possible, with new options to encourage retention.

2.12 In order to provide the comprehensive and high quality care people want, Monitor, NHS England and independent analysts have previously calculated that a combination of growing demand if met by no further annual efficiencies and flat real terms funding would produce a mismatch between resources and patient needs of nearly £30 billion a year by 2020/21. So to sustain a comprehensive high-quality NHS, action will be needed on all three fronts – demand, efficiency and funding.

2.13 The NHS' long run performance has been efficiency of 0.8% annually, but nearer to 1.5%-2% in recent years. For the NHS repeatedly to achieve an extra 2% net efficiency/demand saving across its whole funding base each year for the rest of the decade would represent a strong performance – compared with the NHS' own past, compared with the wider UK economy, and with other countries' health systems. The Forward View considers that it is possible – perhaps rising to as high as 3% by the end of the period – provided we take action on prevention, invest in new care models, sustain social care services, and over time see a bigger share of the efficiency coming from wider system improvements.

2.14 On funding scenarios, flat real terms NHS spending overall would represent a continuation of current budget protection. Flat real terms NHS spending per person would take account of population growth. Flat NHS spending as a share of GDP would differ from the long term trend in which health spending in industrialised countries tends to rise as a share of national income.

2.15 Depending on the combined efficiency and funding option pursued, the effect is to close the £30 billion gap by one third, one half, or all the way. Delivering on the transformational changes set out in the Forward View and the resulting annual efficiencies could – if matched by staged funding increases as the economy allows – close the £30 billion gap by 2020/21.

3. KEY ISSUES FOR FURTHER EXPLORATION OR FOR DISCUSSION

3.1 The *Forward View* into Action guidance is particularly relevant to the work of health and wellbeing boards in the following ways:

- The emphasis on a radical new approach to public health and prevention with CCG and local authorities asked to set and share quantifiable levels of ambition to reduce local health and healthcare inequalities and improve outcomes for health and wellbeing. These should be supported by agreed actions to achieve these, such as specifying behavioural interventions for patients and staff, in line with NICE guidance, with respect to smoking, alcohol and obesity, with appropriate metrics for monitoring progress. Further guidance is anticipated and the approach should be specified in the Health and Wellbeing Strategy.

- The encouragement to all local areas to develop a shared vision of health and care for their populations in the context of the strategic choices outlined by the *Forward View*. There is a call for partners to look afresh at their medium-term strategies so that the explore opportunities to create the conditions for rapid early adoption of the new models described in the *Forward View*.

- CCGs are to lead a major expansion in 2015/16 in the offer and delivery of personal health budgets to people, where evidence indicates they could benefit.

- The ambition for the level of improvement agreed by CCGs and Councils in Better Care Fund (BCF) plans should be reviewed if there is a material change in their assessment of the risk to delivery, taking into account:
  - actual performance in the year to date, particularly through the winter;
  - the likely outturn for 2014/15;
  - progress with contract negotiations with providers.

- Any such review should be undertaken within the partnership underpinning local BCF planning and approved by the Health and Wellbeing Board.

- The Health and Wellbeing Board will be asked to endorse a refreshed CCG operating plan. The refreshed plan should reflect any updated Health and Wellbeing Strategy.

3.2 The Health and Wellbeing Board is asked to note and discuss the key issues within the Five Year Forward View and to frame its local response.

ACTION

4.1 The Health and Wellbeing Board is asked to note and discuss the key issues within the Five Year Forward View and to frame its local response.

Officer Contact

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

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Minutes of Board Meeting

Monday 19 January 2015

	Attendees: William Armstrong (WA) – Chair Graham Dunhill (GD) – Community member Mary Ledgard (ML) – Community member Diane DeBell (DD) – Community member Pa Musa Jobarteh (PMJ) – Co-opted member (BridgePlus) Fiona Poland (FP) – Co-opted member (University of East Anglia Jon Clemo (JC) – Provider member (Norfolk Rural Community Council) **Officers in attendance:** Christine MacDonald (CM) – Operations Manager Chris Knighton (CK) – Communications Manager Sam Revill (SR) – Research Manager Ann Stephens (ASt) – Engagement Officer Stephanie Tuvey (ST) – Research Intern **Guests** Lynda Tarpey – NHS England
	Questions from the general public
	No questions were submitted from the general public
1.	**Apologies for absence and introductions**
	Apologies: Alex Stewart (AS) Roan Dyson (RDy) – Provider member (POWhER) Nick Baker (NB) – Co-opted member (North Norfolk District Council)
2.	**Declarations of Interest**
	ML advised that she attends the Norfolk Older People's Strategic Partnership Board on behalf of HWN. Previous declarations are as follows: ML is a patient governor of the Norfolk Community Health and Care NHS Trust. WA is a trustee of Voluntary Norfolk.
3.	**Minutes of the meeting held on the 17 November 2014**
	The minutes of the Healthwatch Norfolk (HWN) Board meeting held on Monday 17 November 2014 were confirmed as a correct record of the meeting with the addition under item 5. of reference to the requirement for Standing Orders to be drafted and circulated to the Board. WA suggested that HW England, other local Healthwatches or Norfolk County Council may be a source of examples of Standing Orders.
4.	**Matters Arising not covered by the agenda**
	There were no matters arising not covered by the agenda.
5.	**Presentations**
	I. HWN Children, Young People and Families Project

CK provided a high level progress report on the work to date. He explained the background to the project in terms of the change from LINk (who had not remit for health and social care for children) to Healthwatch which includes health and social care provision for children within the remit of Healthwatch.
The project consists of four main strands and there is cross over with other HWN work around maternity services.
ASt outlined the achievements to date:

- 36 detailed focus interviews have taken place with adoptive parents
- Plan to engage with Looked After Children directly on line
- Attended 2 foster carer groups

Early indications are the need for timely post adoption support both therapeutic and health.

In response to a query from PMJ, CK confirmed that ethnic monitoring of all groups involved in the project will be undertaken. He also confirmed that this information will be available in future reports on HWN engagement.

HWN had queried the lack of information and evidence available from Children's Services commissioners.

426 pupil responses to the survey which represents over 50% of that age group. The survey identified an opportunity for face to face counselling to be available for all students in schools.
HWN is keen to recruit young volunteers and to date 60+ have expressed an interest via the on line survey which WA felt to be very encouraging.

An update was provided to the steering group last week which was attended by the Director of Children's services, and other key stakeholders. DDB attended on behalf of the Board.

CK congratulated his colleagues Ann Stephens and Stephanie Tuvey on the fantastic work they have achieved and concluded that there is an opportunity for HWN to make a difference. A further report will come back to the Board on this work.

II. Timber Hill Walk in Centre

LT explained that NHS England has commissioned Enable East to carry out work on assessing the contract for the walk in centre which is about to move location. NHS England is therefore taking stock of the monies being used to fund this service. LT advised that figures indicate attendance at the walk in centre is dropping year on year which might be a reflection of improvement in other areas eg. GP appointments, community pharmacies.
ML confirmed her involvement in the setting up of the walk in centre which is GP led as opposed to the previous walk in centre at Dussindale which was nurse led. The original aim was for the centre to be open 7.00 am – 9 pm, 365 days a year.
ML also advised that the attached GP surgery was included to provide viability to the project. Accessibility to the centre of the city is good and transport is clearly a major issue for residents of Norfolk.

	The Board suggested several reasons for drop off in attendance – shorter opening hours, talk in the local press of closing the walk in centre, problems with shortage of GPs at the centre, waiting times, less publicity since the closure of the Primary Care Trust and inclusion of these issues in political papers. DDB suggested that it would be helpful to have further details of the context within which figures are dropping. PMJ confirmed that the centre is convenient for BME groups in the city centre. SR confirmed that 33% of the enquiries and comments received by HWN is about GP services and particularly about access. Other work by HWN identified 25% of A&E attendances are self-presenting. There is no walk in centre in West Norfolk. Currently the Clinical Commissioning Groups have not commissioned community pharmacy minor ailment services in Norfolk. LT will contact SR directly outside of the meeting about information held by HWN. CK confirmed that social media could be used as a means to ask questions of the public about using the walk in centre. LT confirmed that a public consultation will take place should NHSE decide to make any changes to the service and the consultation will include statistical data on uptake of the service. LT is to complete her report by mid February 2015.
6.	**Items for information and discussion**
6.1	**Updated risk register (board paper)** Presented for information only. No new risks had been added to the register. The paper was noted by the Board.
6.2	**QC1 Panel Report (board paper)** ML presented the paper to the board and summarised developments in HWN's project work taken to QC1 since the last board meeting. In ML's summary the following points were raised: • The Panel has aligned dates of its meetings with Board meetings • The completed questionnaires on mental health services have highlighted a number of themes although the number of responses is disappointing • The Panel recommends that the veterans project should be undertaken, possibly in partnership with another Healthwatch e.g. Essex • The Panel had agreed to funding a data inputter for the questionnaire on the take up of flu vaccinations • The Panel had approved the proposal for the UEA to do further work on CAMHS
6.3	**2014-15 Qtr 3 Finance Report (board paper)** Paper noted for information by the Board
6.4	**General correspondence received (verbal)** None noted
6.5	**Highlights of meetings attended by Chair/CEO (verbal)** WA – Meetings attended by the chair 18 November - HOSC 28 November - Sweethearts (art therapy) 16 December - meeting with Gary Page (chair of Norfolk and Suffolk NHS Foundation Trust) 8 January - mentally disabled offenders (police and crime commissioner) 9 January - Chaired Palliative Care Forum

6.6	**The Kings Fund Annual Conference (verbal)** This item held in abeyance as unfortunately MG not present.
7	**Any Other Business** There was no other business.
8	**Dates of future board meetings (2015/16)** The Board briefly discussed the merits of Board meetings being held in different venues throughout the county. In view of the very small numbers of public attending the Board suggested that more needs to be done in advertising the meetings to include posters to be prepared, hosting of future venues e.g. by local town council. It was concluded that the next meeting should take place in Dereham as scheduled but that this item should be added to the agenda for discussion at the next Board meeting on 16 March 2015.

Norfolk County Council
at your service

NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE
MINUTES OF THE MEETING HELD AT COUNTY HALL, NORWICH
On 15 January 2015

Present:

Mr C Aldred	Norfolk County Council
Mr R Bearman	Norfolk County Council
Mr J Bracey	Broadland District Council
Mr M Carttiss (Chairman)	Norfolk County Council
Mrs J Chamberlin	Norfolk County Council
Michael Chenery of Horsbrugh	Norfolk County Council
Mrs A Claussen-Reynolds	North Norfolk District Council
Mr D Harrison	Norfolk County Council
Mr R Kybird	Breckland District Council
Dr N Legg	South Norfolk District Council
Mrs M Somerville	Norfolk County Council
Mrs S Weymouth	Great Yarmouth Borough Council
Mr A Wright	King's Lynn and West Norfolk Borough Council

Substitute Member Present:
Ms S Bogelein for Mrs Wollard, Norwich City Council

Also Present:

Catherine Underwood	Director of Integrated Commissioning, Norfolk County Council
Debbie Olley	Director of Integrated Care (Interim), Norfolk Community Health and Care / Norfolk County Council
Laura Clear	Deputy Director Integrated Care and Systems Lead, Norfolk Community Health and Care / Norfolk County Council
Dr Anoop Dhesi	Chairman of North Norfolk Clinical Commissioning Group
John Everson	Head of Integrated Commissioning, North Norfolk Clinical Commissioning Group
Mark Burgis	Head of Clinical Pathway Design, North Norfolk Clinical Commissioning Group
James Joyce	Norfolk County Councillor
Sue Whitaker	Norfolk County Councillor
Chris MacDonald	Healthwatch Norfolk
Chris Walton	Head of Democratic Services
Maureen Orr	Democratic Support and Scrutiny Team Manager
Tim Shaw	Committee Officer

1 Apologies for Absence

Apologies for absence were received from Mr B Bremner and Mrs C Woollard.

2. Minutes

The minutes of the previous meeting held on 27 November 2014 were confirmed by the Committee and signed by the Chairman.

3. Declarations of Interest

There were no declarations of interest.

4. Urgent Business

There were no items of urgent business.

5. Chairman's Announcements

5.1 Mr Richard Bearman and Mrs Shirley Weymouth

The Chairman welcomed back onto the Committee Mr Richard Bearman. He also congratulated Mrs Shirley Weymouth on becoming Mayor-elect of Great Yarmouth Borough Council.

5.2 Congratulations to Norfolk Community Health and Care NHS Trust on a 'Good' rating by the Care Quality Commission

The Chairman said that the Member Briefing for January 2015 referred to the Care Quality Commission's latest inspection of Norfolk Community Health and Care NHS Trust for which they received a 'Good' rating. The CQC had said that it was quite an achievement for a community healthcare trust to receive a 'Good' rating in its new inspection regime. The Committee joined the Chairman in congratulating NCH&C on this result.

5.3 Members Visit to Norfolk Police Headquarters Control Centre at Wymondham December 9th 2014

5.4 The Chairman said that on 9 December 2014 a group of five Members of the Committee had visited the Police Control Centre at Wymondham to observe the service provided to people who needed support because of mental health issues rather than Police intervention.

5.5 At the request of the Chairman, Margaret Somerville updated the Committee on what the group of Members had learnt from the visit. She said that the group was impressed by the care and compassion shown by Police Officers and the Integrated Mental Health Team. She said that in April 2014, the first integrated Mental Health Team in the country was established in the Police Control Centre at Wymondham. Funding for this initiative had followed a bid to the Home Office Innovation Fund to establish an Integrated Mental Health Team. Norfolk County Council had provided bridge funding, pending the second innovation bid that was

agreed in July 2014 for the next two years.

5.6 Mrs Somerville went on to say that the group was informed that 15-25% of police time was engaged with people with mental health issues. This was both time consuming and inappropriate when what was really needed was a mental health intervention. There was a lack of understanding about how to access appropriate mental health services and they were often unavailable in crisis situations. There was difficulty in making referrals and inconsistent partnership working or data sharing with timely support, and the rural nature of Norfolk added to this difficulty. Mrs Somerville added that to have a dedicated team within the Police Control Centre who not only understood the mental health conditions, but also knew how to evaluate, refer or reassure those with mental health needs with their professional expertise, had proved invaluable. In one month before Christmas, calls included 106 people experiencing a psychotic episode, 27 potential suicide or self -harm, 89 with personality disorders and in 110 cases, there were concerns for safety. Several were repeat callers, with 77 previously known and 194 currently active. Repeat callers traditionally took at least 10-15 minutes but now these calls went directly to the mental health team and did not tie up the 999 service. Many of the callers were previously unknown to the service suggesting that they had problems as yet undiagnosed. In the month before Christmas the new arrangements had saved on the deployment of Police Officers on 22 occasions. Normally two Police Officers would have been deployed on a 999 response. Fifteen Section 136 calls were averted. A Section 136 effectively kept Police Officers away from frontline work but by averting the need for a S136, the team had reduced the pressure on the Mental Health Trust while at the same time giving those with mental health needs immediate support and a better quality of care. Those with serious mental health issues were not detained in padded police cells but were taken to Hellesdon, or a place of safety, to await assessment and a suitable bed wherever that might be.

5.7 The Chairman thanked Mrs Somerville for her detailed comments and said that a further opportunity for Committee Members to visit the Police Control Centre would be arranged for the end of January / February 2015. Those who would like to take part were asked to contact Maureen Orr.

6 Integration of Health and Social Care Services, Central and West Norfolk

6.1 The Committee received a suggested approach from the Democratic Support and Scrutiny Team Manager on progress with integration of health and social care services in central and west Norfolk in 2014-15 and plans for the future.

6.2 The Committee received evidence from Catherine Underwood, Director of Integrated Commissioning, Debbie Olley, Interim Director of Integrated Care and Laura Clear, Deputy Director Integrated Care and Systems Lead Norfolk County Council / Norfolk Community Health and Care who updated the Committee on integrated commissioning and operational plans across central and west Norfolk in 2015-16. The Committee also received a presentation from Dr Anoop Dhesi, Chairman of North Norfolk CCG, about the effectiveness of integrated services developed in North Norfolk in 2014-15.

6.3 In the course of discussion the following key points were made:

- The witnesses said that for the foreseeable future integration would continue to be a key theme for both health and social care services. Norfolk County Council and Norfolk Community Health and Care NHS Trust

(NCH&C) had entered into a formal agreement to create a single management arrangement for social care and community nursing and therapies across Norfolk, except for the Great Yarmouth and Waveney CCG area which would be looked at separately by the Great Yarmouth and Waveney Joint Health Scrutiny Committee in due course.

- Very strong progress had been made in ensuring that people had a joined up experience of health and social care but there were significant decisions still to be made, not least because of the requirements of the new Better Care Fund (BCF) for the pooling of health and social care resources.
- The establishment of the BCF for 2015 onwards would provide a national push towards much greater integration than had been achieved by the pilot schemes of the past.
- It was pointed out that there were now in effect five integration plans for Norfolk based on the five CCG areas, however, there was much in common between these plans.
- The Committee received a detailed presentation from Dr Anoop Dhesi, Chairman of North Norfolk CCG, about the effectiveness of integrated services developed in North Norfolk in 2014-15. This could be found on the Committee papers website.
- The revenue funding for 2015/16 for each of the CGCs was set out in the report from the Director of Integrated Commissioning and Interim Director of Integrated Services at paragraph 5.2.
- The biggest challenge for Social Care Services was the constant need to provide effective services to increasing numbers of older people and people with complex needs in the context of very significant pressure on County Council funding.
- Health and Social Care Services had appointed to a new senior management structure for integrated services across its organisations at no additional management cost.
- The witnesses said that health and social care commissioners and providers were concentrating on the integration of services for adults, however, the needs of young people and the needs of carers of young people, to access services in a way that would be of benefit to them in planning for the services that were needed in adulthood was very important.
- As well as integration with social care, new methods of integrated working between different parts of the NHS (e.g. primary and community care; community care and acute care; acute care and primary care) were being tried across the county.
- Mental Health Services were seen as an important aspect of an integrated health and social care services. A partnership board had been established to provide leadership and to provide joint work on mental health issues.

6.4 It was **agreed** that the Committee might wish to invite commissioners and providers to report back in 12 months on progress with health and social care integration.

7 NHS Workforce Planning for Norfolk

7.1 The Committee received a report from the Democratic Support and Scrutiny Team Manager that asked Members to make the appointments to a task and finish group to scrutinise NHS workforce planning for Norfolk and to agree on the terms of reference for that group.

7.2 The Committee **agreed** the terms of reference for the task and finish group to scrutinise NHS workforce planning for Norfolk that were set out in the report.

7.3 The Committee **agreed** to appoint the following Members to serve on that group:-

Michael Chenery of Horsbrugh
Alexandra Kemp
Robert Kybird
Nigel Legg
Margaret Somerville

7.4 It was also **agreed** that Alex Stewart of Healthwatch Norfolk should be invited to join the group on a co-opted, non-voting basis and that Chris MacDonald could substitute for him at the early meetings.

8 Forward work programme and appointment of substitute link members with local NHS Trusts and Clinical Commissioning Groups

8.1 The Committee considered the appointment of **substitute** link members with local NHS Trusts, where vacancies existed.

8.2 The Committee **agreed** to nominate the following Members as **substitute** link Members with NHS bodies:-

North Norfolk CCG – Michael Chenery of Horsbrugh
Great Yarmouth and Waveney CCG – Jenny Chamberlin
West Norfolk CCG – Tony Wright
James Paget University Hospital NHS Foundation Trust – Margaret Somerville

8.3 Maureen Orr was asked to email Members of the Committee for nominations to fill the vacancies that remained for substitute link members:-

Norwich CCG
Norfolk and Suffolk NHS Foundation Trust

8.4 The Chairman said that Emma Corlett, the County Council's Member Champion for Mental Health, had written to him to ask that the Committee consider looking at the situation regarding out of area placement of mental health patients and the overall effects of the radical redesign of services brought about by NSFT's 2012-16 Service Strategy.

8.5 The Committee **agreed** the current forward work programme that was set out in the officer report subject to the following changes:-

For the 16 April 2015 agenda – add an item concerning the Norfolk and Suffolk NHS Foundation Trust to cover:-

(a) An update on out of area placement of mental health patients
(b) The effect of changes to mental health services on support for homeless people
(c) The effect of the changes to mental health services on policing
(d) Disparity in the services available to mental health patients in different localities
(e) The numbers of adults in mental health residential care establishments in Norfolk compared to other parts of England.
(f) The levels of caseloads for NSFT staff
(g) Performance monitoring of the overall effects of the changes to mental

health services

For the 16 April 2015 agenda- add an item about 'Service given to patients with mental health issues in A&E following attempted suicide or self-harm episodes'.

8.6 The Committee also **agreed** that Dr Ian Mack, Chairman of Norfolk Stroke Network, should be asked to provide a report for the Member Briefing in April 2015 on the action taken to address the Care Quality Commission's (CQC) comments about access to the stroke care pathway for incomers to Norfolk. (It was noted that CQC's comments were made in its report about the latest inspection of Norfolk Community Health and Care NHS Trust, published in December 2015).

Chairman

The meeting concluded at 11.40 am

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