Health & Wellbeing Board

Date: **Wednesday 2 May 2018**

Time: **9:30am in private (workshop)**

11:00am - in public

Venue: **Edwards room, County Hall, Norwich**

Representing	Member	Substitute
Adult Social Care Committee, Norfolk County Council (NCC)	Cllr Bill Borrett	Cllr Shelagh Gurney
Adult Social Services, NCC	James Bullion	Debbie Bartlett
Borough Council of King's Lynn & West Norfolk	Cllr Elizabeth Nockolds	Cllr Sam Sandell
Breckland District Council	Cllr Paul Claussen	Cllr Trevor Carter
Broadland District Council	Cllr Andrew Proctor	Cllr Roger Foulger
Children's Services Committee, NCC	Cllr Penny Carpenter	Cllr Stuart Dark
Children's Services, Norfolk County Council	Sara Tough	Sarah Jones
Director of Public Health, NCC	Dr Louise Smith	
Great Yarmouth Borough Council	Cllr Andy Grant	Cllr Emma Flaxman-Taylor
Healthwatch Norfolk	William Armstrong	Alex Stewart
NHS England, East Sub Region Team	Simon Evans-Evans	
NHS Great Yarmouth & Waveney CCG	Dr Liam Stevens	
NHS Great Yarmouth & Waveney CCG	Melanie Craig	
NHS Norwich CCG	Tracy Williams	
NHS Norwich CCG	Jo Smithson	
NHS North Norfolk CCG	Dr Anoop Dhesi	
NHS North and South Norfolk CCG	Antek Lejk/Helen Stratton	
NHS South Norfolk CCG	Dr Hilary Byrne	
NHS West Norfolk CCG	Dr Paul Williams	
NHS West Norfolk CCG	John Webster	
Norfolk Constabulary	ACC Paul Sanford	ACC Nick Davison
Norfolk County Council	Cllr David Bills	
Norfolk County Council	Dr Wendy Thomson	
North Norfolk District Council	Cllr Maggie Prior	
Norwich City Council	Cllr Kevin Maguire	Adam Clark
Police and Crime Commissioner	Lorne Green	Dr Gavin Thompson
South Norfolk District Council	Cllr Yvonne Bendle	Cllr Florence Ellis
Voluntary Sector Representative	Dr Joyce Hopwood	Laura Bloomfield
Voluntary Sector Representative	Dan Mobbs	Elly Wilson
Voluntary Sector Representative	Dr Janka Rodziewicz	Jon Clemo
Standing invitation to attend Board meetings:		
East Coast Community Healthcare CIC	Jonathan Williams	Tony Osmanski
James Paget University Hospital NHS Trust	Christine Allen	Anna Davidson
Norfolk Community Health & Care NHS Trust	Roisin Fallon-Williams	Geraldine Broderick
Norfolk Independent Care	John Bacon	
Norfolk & Norwich University Hospital Trust	Mark Davies	John Fry
Norfolk & Suffolk NHS Foundation Trust	Julie Cave	Gary Page
Queen Elizabeth Hospital	Jon Green	Edward Libbey
Sustainability & Transformation Partnership (Chair)	Rt Hon Patricia Hewitt	
Waveney District Council	Cllr Mary Rudd	

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

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

Hollie Adams on 01603 223 029 or email committees@norfolk.gov.uk

Health & Wellbeing Board
Agenda

Time: 11:00am

1	Apologies	Clerk	
2	Chairman's opening remarks	Chair	
3	Minutes	Chair	(Page 3)
4	Action points arising from the minutes	Chair	
5	Members to declare any interests	Chair	
6	Norfolk & Waveney Sustainability and Transformation Partnership (STP): • Update on integrating health and care services	Patricia Hewitt/ Antek Lejk	(Page 9)
7	Norfolk & Waveney Sustainability and Transformation Partnership (STP): • Update on the Acute Care Workstream	Christine Allen/ Jon Barber	(Page 12)
8	Integration – a vision for Norfolk Adult Social Services and review of the Better Care Fund 2017/18	James Bullion	(Page 21)
9	Health and Wellbeing Board Governance	Linda Bainton	(Page 99)

Information updates

- **The All Age Autism Partnership Board** - has been formerly constituted and will be holding its first meeting on Wednesday 30 May 2018
- **Further information about the Norfolk Health and Wellbeing Board** – can be found on our website at: About the Health and Wellbeing Board
- **Norfolk Health Overview & Scrutiny Committee (NHOSC):** Agenda papers relating to items on the HWB agenda include: Norfolk and Waveney Sustainability & Transformation Plan Update - October 2017
- **Healthwatch Norfolk** – the most recent HWN Board minutes/report relating to this agenda at this link: https://www.healthwatchnorfolk.co.uk/reports/board-papers/

Norfolk County Council

Health and Wellbeing Board
Minutes of the meeting held on 06 March 2018 at 10:30
in the Abbey Conference Centre, Norwich.

Present:	**Representing:**
William Armstrong	Healthwatch Norfolk
Cllr Yvonne Bendle	South Norfolk District Council
Cllr Bill Borrett	Adult Social Care Committee, NCC
James Bullion	Adult Social Services, Norfolk County Council
Cllr Penny Carpenter	Children's Services Committee, Norfolk County Council
Cllr Steve James	Breckland District Council
Melanie Craig	NHS Great Yarmouth & Waveney CCG
Cllr Emma Flaxman-Taylor	Great Yarmouth Borough Council
Laura Bloomfield	Voluntary Sector Representative
Antek Lejk	NHS North and South Norfolk Clinical Commissioning Groups
Joyce Hopwood	Voluntary Sector Representative
Cllr Elizabeth Nockolds	Borough Council of King's Lynn and West Norfolk
Jon Clemo	Voluntary Sector Representative
ACC Nick Davison	Norfolk Constabulary
Dr Louise Smith	Public Health, Norfolk County Council
Dr Liam Stevens	NHS Great Yarmouth & Waveney CCG
Dr Wendy Thomson	Norfolk County Council
Sara Tough	Children's Services, Norfolk County Council
Dr Paul Williams	West Norfolk Clinical Commissioning Group
Tracy Williams	Norwich Clinical Commissioning Group

Invitees Present:	**Representing:**
Cllr Mary Rudd	Waveney District Council
Jonathan Williams	East Coast Community Healthcare
Tony Osmanski	East Coast Community Healthcare

Officers Present:	
Hollie Adams	Clerk
Linda Bainton	The Senior Planning & Partnerships Officer
Chris Butwright	The Head of Public Health Performance & Delivery
Suzanne Meredith	The Deputy Director of Public Health (Healthcare Services)
Maureen Orr	The Democratic Support and Scrutiny Team Manager

1. Apologies

1.1 Apologies were received from: Ms C Allen, Dr Hilary Byrne, Ms J Cave, Dr Anoop Dhesi, Mr S Evans-Evans, Cllr A Grant (Cllr E Flaxman-Taylor substituting), Mr L Green, Mr J Green, Mrs P Hewitt, Cllr A Proctor, Cllr K Maguire and Ms J Rodziewicz.

Also absent were: Mr J Bacon, Cllr D Bills, Ms R Fallon-Williams, Cllr P Claussen, Mr M Davies, Mr D Mobbs, Cllr M Prior, Ms J Smithson, and Mr J Webster.

2. Election of Vice-Chair (CCG)

2.1 The Director of Public Health nominated Tracey Williams for the Vice-Chair CCG

(Clinical Commissioning Group) representative role; all Norfolk CCGs supported this nomination. Tracy Williams was **duly appointed** as CCG Vice-Chair for the remainder of the ensuing council year.

3. Chairman's Opening Remarks

3.1 The Chairman welcomed attendees to the meeting, in particular ACC Nick Davison as his first HWB (Health and Wellbeing Board) meeting, Cllr Mary Rudd, Cllr Flaxman-Taylor, and Dr Paul Williams from West Norfolk CCG.

4. Minutes

4.1 The minutes of the meeting held on the 27 September 2017 were agreed as an accurate record and signed by the Chairman.

4.2 Ms J Hopwood raised a concern related to paragraph 6.2, point 3; she felt the voluntary sector were not adequately represented on the Board. The Chairman pointed out there were 3 voluntary sector representatives; Ms Hopwood felt they should be more involved in decision making processes. The Chairman reminded Members that all Board Members could suggest agenda items for discussion and encouraged voluntary sector representatives to do so.

5. Actions arising from minutes

5.1
- Paragraph 6.2, point 3; it had been decided to continue with two Vice Chairs; one from the CCGs, who were statutory members of the Board, and the other from the District Councils, who were elected by the public to represent their views;
- Paragraph 6.3, point 2; the HWB's revised terms of reference, as agreed at the September 2017 meeting of the HWB, had been approved at the Norfolk County Council meeting on 11 December 2017 and the Council constitution updated;
- Paragraph 8.3, point 2; the refreshed Local Transformation Plan for Norfolk and Waveney 2017-18 had been signed off by the CCGs and by NHSE;
- Paragraph 10.2, point 3; Norfolk Health Overview & Scrutiny Committee had begun to investigate physical health checks for adults with learning disabilities; this was covered under item 10 of the agenda;
- As agreed, information had been sent to Board members about:
  - Item 8: Children and Young People's mental health and emotional wellbeing; the potential new 'Thrive' service model; the CAMHS service re-design Vision along with a briefing for general use;
  - Item 9: Hospital Discharge in Norfolk including information on the BCF High Impact Change plan around voluntary sector involvement in the Home from Hospital scheme and a housing review;
  - Item 10: Transforming Care Partnership (Services for Adults with a Learning Disability) Housing Plan.

6. Declarations of Interests

6.1 No interests were declared.

7. Sustainability and Transformation Partnership (STP) - Vision for the future model of Primary Care in Norfolk and Waveney

7a. An Integrated Care System

7a.1 The Board considered the report setting out the opportunities for improved health services and integrated care from the invitation to submit an expression of interest to become one of eight STPs in a 'second wave' of Integrated Care Systems.

7a.2.1 Mr A Lejk, STP Executive Lead, introduced the report, advising that Government were seeking systems to become integrated to achieve a single financial model planned around population need; planning services around wellbeing and prevention would allow people to remain independent for longer and would require organisations to work together to shift resources towards a self-sustainable model.

7a.2.2 The submission would be made available after the meeting; see appendix A.

7a.2.3 NHS England would provide feedback on the submission and the STP would come back to the HWB at its meeting on 2 May 2018 for a further discussion, when more detail would be available. This would be followed by a consultation.

7a.2.4 Members spoke in support of the prevention priority outlined in the submission; the Chairman noted this involved using existing services more efficiently and focusing the system on the needs of the patient.

7a.2.5 East Coast Community Healthcare had endorsed the submission the previous week and circulated it to their governing bodies.

7a.3 The Health and Wellbeing Board unanimously **RESOLVED** to **SUPPORT** the Expression of Interest to become an Integrated Care System, subject to agreement by Trust Boards, Governing Bodies and Council Committees.

7b. Vision for the future model of Primary Care in Norfolk and Waveney

7b.1 The Board considered the report updating members on the Norfolk and Waveney Sustainability and Transformation Partnership (STP), with a focus on the vision for the future model of primary care in Norfolk and Waveney.

7b.2 Ms M Craig, STP Sponsor for the Primary and Community Care Workstream, gave a presentation (see appendix B) and highlighted:

- The Strategic workforce planning area led by NHS England aimed to tackle decline in GP numbers;
- Increased national demand on GPs impacted on the declining numbers;
- University of East Anglia's medical school was a positive resource for Norfolk for training and retaining doctors and medical staff;
- The "GP practice forward view plan" encouraged GP surgeries to expand their team structures to include a wider range of professionals.

7b.3.1 Members discussed how primary and community healthcare could improve outcomes for patients and carers and the view was expressed that the voluntary and community sectors and district councils working together to integrate services was important.

7b.3.2 One of the biggest barriers to integration was felt to be information sharing, particularly

for the health sector; the public were often fearful of their information being shared and debating the benefits of this with them could be useful. Difficulties were caused by the inability to share information between organisations within the NHS. The Chairman felt a single, separate regulator and compatible ICT systems would support sharing of information and hoped the STP would support this.

7b.3.3 It was noted that £1m was put into social prescribing from the Better Care Fund (BCF) and Public Health annually; to ensure further investment it would be important to capture evidence of impact. In relation to the new prevention based social work model, discussions were being held with other local authorities about information sharing, and HWB members were encouraged to be bold about information-sharing - not break the law but addressing the myths.

7b.3.4 Members noted some of the actions taking place across the county by the district councils which were making a positive impact. These included the Community Connectors in GP surgeries and the "home from hospital" scheme piloted in South Norfolk, and the "Living Independently in Later Years" service in West Norfolk. Members also noted that discussions were being held with the Queen Elizabeth Hospital about West Norfolk District Council staff supporting patients with housing queries prior to discharge.

7b.3.5 Plans for the resource model to support the vision were queried and Ms Craig replied that, as a large proportion of budgets were spent on emergency admissions to hospital and social care, it was important to shift towards a prevention model and integrate services.

7b.3.6 The support in place to help GPs adjust to the culture shift was discussed and it was noted that, while some practices had embraced change, it was not being discussed widely and more peer to peer discussions would be useful. Information on 'One Norwich' was given and their use of training and forums to share information between practices. East Coast Community Care reported that GPs had found resistance to change from some staff; some practices were seen to want to maintain a personal identity.

7b.3.7 New innovations and ways of working would be important to encourage doctors to apply for roles in more remote practices. The use of information technology would also be important, for example encouraging online booking, although it needed to be understood that such changes were not intended to replace the phone or receptionist but instead to provide a wider variety of options.

7b.3.8 A key way forward in addressing our workforce challenge might be to make best use of our workforce assets. It was recognised, however, that there was also a nursing workforce challenge and a survey of practice based staff found a possible future lack in nursing staff due to upcoming retirements; work was underway to encourage student nurses to work in GP practices. It was noted that nurse recruitment in the community was facilitated by staff leaving roles in hospitals to return to work in their home areas and therefore discussion with hospitals would be helpful. Hiring specialist nurses and therapists was recognised to be more challenging.

7b.4 1. The Health and Wellbeing Board unanimously **NOTED** with concern the workforce challenges facing the sustainability of general practice, especially in recruitment of GPs;

2. Given these workforce challenges the Health and Wellbeing Board unanimously **RESOLVED** to **APPROVE** the strategic direction of primary care development, including proposals to:
    - promote self-care and responsible health seeking behaviours from the public;
    - widen the range of staff working in general practice;
    - introduce new consultation and communication methods;
    - a focus for GPs on people with the most difficult health problems;
    - bring GP practices to work more closely together.

8. Norfolk's Joint Health and Wellbeing Strategy 2018-22

8.1 The Health and Wellbeing Board (HWB) received the report outlining a summary of key points from the HWB workshop, which had focused on developing the strategic approach to the next Joint Health and Wellbeing Strategy.

8.2.1 Members discussed how they might work towards simpler system governance in practice with fewer organisations while maintaining a streamlined service. It was recognised that the current system was complex, involving a large number of different organisations working towards similar outcomes, and so looking at each different domain, challenging it and finding the right level might be the best approach to simplification; the Chairman felt that organisations commissioning in complementary ways would reduce the divisions between them and support common strategies to be adopted.

8.2.2 It was suggested that using the term "people" rather than "patients" would be more appropriate in promoting the wellbeing perspective in the strategy.

8.2.3 The Chairman commented that he was looking into whether it was possible to extend the remit of the HWB to include Waveney and whether this would require external agreement.

8.2.4 Members recognised that, given the urgency in the system highlighted by the cost of emergency admissions, there was a need to achieve a balance in the Strategy of both actions which would make an impact in the shorter term, as well as actions which would make an impact over the long term. It was noted that, for example, the plans being put in place through the STP prevention work stream and with district councils would support people to stay healthy and would have both short term and long term outcomes for the population.

8.4 The Health and Wellbeing Board unanimously:

1. **AGREED** the Board's strategic approach, based on the outcomes of the workshop before Christmas;
2. **ENDORSED** the draft Strategic Framework, which will form a core element of the Strategy;
3. All HWB Partners **AGREED** to sign up to the HWB Joint Strategy according to the timetable outlined in section 4, through their formal organisational mechanisms

9. Pharmaceutical Needs Assessment (PNA) 2018

9.1 The Board considered the report outlining the Pharmaceutical Needs Assessment for 2018 and heard a presentation; see appendix C.

9.2.1 The Board heard that the assessment concluded that the number and distribution of

pharmaceutical service provision in Norfolk is adequate and that no current need had been identified for more pharmaceutical providers at this time.

9.2.2 The Chairman supported the document and thanked the Deputy Director of Public Health for her presentation.

9.3 The Health and Wellbeing Board **RESOLVED** to:

1. **APPROVE** the publication of the new Norfolk Pharmaceutical Needs Assessment 2018 by April 2018, in line with the HWB's statutory responsibilities;
2. **ENDORSE** the PNA recommendations at paragraph 2.3 of the report;
3. **CELEBRATE** the value of Community Pharmacies - the contribution they make to health and wellbeing and their potential for making a positive contribution in future

10. Health and Wellbeing Board (HWB) and health scrutiny - briefing note

10.1 The Board received the report outlining and clarifying the complementary roles of the Health and Wellbeing Board and health scrutiny.

10.2.1 The Director of Public Health clarified that this report had been brought to highlight the differences between the role and remit of the HWB and the Health and Overview Scrutiny Committee (HOSC). The two bodies are complementary; HOSC focussing on existing performance and the HWB on future strategy.

10.2.2 Members noted that the report made the distinction between the roles of the two Committees clear.

10.3 The Health and Wellbeing Board **NOTED** the contents of the briefing.

The date of the next meeting was Wednesday 2 May 2018. The venue would be confirmed nearer the time.

The Meeting Closed at 12.23

Mr B Borrett, Chairman,

Health and Wellbeing Board

Health and Well Being Board

Item No 6

Report title:	**Norfolk and Waveney STP – Update on integrating health and care services**
Date of meeting:	**6 March 2018**
Responsible Chief Officer:	**Antek Lejk, STP Executive Lead**

Strategic Impact

The organisations involved in the Norfolk and Waveney Sustainability and Transformation Partnership (STP) are focussed on working closely together to improve the health and wellbeing of local people. We want to look beyond our existing partnership arrangements and start working as a more integrated system.

- People living in Norfolk and Waveney need access to good quality and cost effective health and care services. The STP partner organisations have clear responsibilities to work together to achieve this, exercised through the Health Overview and Scrutiny Committee.
- People's health and care needs are often closely linked and effective co-ordination and integration of services is required for an effective and seamless response.
- We want to move away from the transactional relationships between the different parts of our health and care system to integrated delivery based on population health need. Our aim is to help people stay healthy at home and reduce the number of people falling into crisis or emergency care.

Executive summary

This paper provides an update on the integration of health and care services in Norfolk and Waveney. It follows on from the paper presented to the March 2018 meeting of the Norfolk Health and Wellbeing Board about the Expression of interest for an Integrated Care System.

Recommendations:

The Health and Wellbeing Board is asked to:

- Note and comment on the update on the integration of health and care services in Norfolk and Waveney.

1. Integrating health and care services in Norfolk and Waveney

1.1 Over the past two years local health and care organisations have been working increasingly closely in order to provide better care to people living in Norfolk and Waveney. Our Sustainability and Transformation Partnership has made good progress and was rated as 'Advanced' by NHS Improvement last year.

1.2 Our ambition is to continue to further integrate our services so that people receive a more seamless service and more coordinated care. We know that when health and care services work closely together it is not only good for patients, but it also makes it is easier for staff to do their jobs effectively. We spend £2.6billion on health and social in Norfolk and Waveney every year and further integration will enable us to make the best use of that money.

1.3 In February we outlined our ambitions for closer working in our expression of interest to become an integrated care system or ICS. We're encouraged by the feedback we've received from NHS England, who've told us that they want to work with us over the next six to twelve months so that we are fully prepared and ready to become an ICS.

1.4 We believe that becoming an ICS will help us to accelerate the improvement in Norfolk and Waveney's health and care system. We're looking forward to working closely with our local health and wellbeing boards, councillors and others to develop our plans for closer working and our ICS in the coming months.

2. Financial implications

2.1 The financial implications of becoming an integrated care system will need to be scoped out and decisions managed as the process evolves. The statutory partners involved in our STP will continue to have control through existing governance structures over any financial commitments they choose to make. These will be considered by the relevant trust board, governing body or County Council committee.

3. Issues, risks and innovation

3.1 Norfolk and Waveney is well-placed to lead innovation in health and care, for the benefit of local people. We are recognised as having a strong track record of integrated services and integrated commissioning and our STP has been assessed as 'Advanced'. We will continue to develop our approach to integration.

3.2 A risk register will be maintained during the development of our integrated care system.

Officer Contact

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

Officer Name:	**Tel No:**	**Email address**:
Jane Harper Smith	01603 224227	jane.harper-smith@norfolk.gov.uk

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Report title:	**Norfolk & Waveney Sustainability & Transformation Partnership (STP) – Update on Acute Care Workstream**
Date of meeting:	**2 May 2018**
Sponsor:	**Christine Allen, CEO James Paget University Hospitals Foundation Trust**

Reason for the Report

The purpose of this paper is to update members of the Health and Wellbeing Board (HWB) on the work of the STP Acute Care workstream, with a focus on the recent Acute Speciality Sustainability Review involving Cardiology, Radiology and Urology.
This report also makes sets out the work between health providers to seek efficiencies, and greater service sustainability, for some back office functions.

Report summary

The Norfolk Acute Hospitals Group (NAHG) commissioned specialist advisors to complete the Acute Speciality Sustainability Review of Cardiology, Radiology & Urology services.

This report provides an update on the Acute Sustainability Review and the actions undertaken by the NAHG to date.

Reference is made to the programme of work looking to secure efficiency and greater resilience of some common back office functions such as the procurement function.

Recommendations:

The HWB is asked to:

1. Support the strategic direction of joint working focused around Cardiology, Radiology and Urology.
2. Note that the service redesign seeks to ensure sustainable and resilient services across the Norfolk and Waveney system

1. Background

1.1 NHS England's Five Year Forward View sets out a clear direction for a long-term sustainable NHS and articulates why change is needed, and what it will look like. Long-term health conditions - rather than illnesses susceptible to a one-off cure - now take 70% of the health service budget.

1.2 To respond to this challenge, and as part of the Norfolk and Waveney Sustainability and Transformation Plan (STP), the three acute trusts within Norfolk - James Paget University Hospitals Foundation Trust (JPUH), Queen Elizabeth Foundation Trust Hospitals of King's Lynn (QEH), and Norfolk and Norwich University Hospitals Foundation Trust (NNUH) have formed the Norfolk Acute Hospitals Group (NAHG).

Its aim is to accelerate the scale and pace of collaboration and to bring together the clinical and operational teams to explore clinical networks, common guidelines, balance demand and capacity, and consider shared recruitment opportunities.

1.3 This will help shape the way services are provided to over 893,000 in Norfolk and Waveney (approx. 230,000 in Great Yarmouth and Waveney). The overall population is rising at a similar pace to the England average, however, the rate at which people over 65 years of age is increasing is disproportionately at a much higher rate than the wider population. In addition, life expectancy in Norfolk is 6.3 years lower for men and 4.2 years lower for women. The population is getting older and people are living longer with long-term conditions such as heart disease. This translates into increasing demand for local services. Older people typically require more support from health and care services and are more likely to suffer from complex co-morbidities, and conditions such as cancer, which can impact on outcomes and make treatment more difficult and costly.

1.4 During 2016 an initial review of seven specialties, carried out by KPMG, was commissioned by the NAHG looking at capacity and demand issues and where greatest impact could be made for the benefit of patients. It defined which services were under greatest pressure and faced the most pressing challenges as health needs and medical practices change.

1.5 The second phase, the Acute Speciality Sustainability Review focused on the three specialties of Cardiology, Radiology and Urology. These were considered priorities to ensure they are sustainable in long-term, and equitable for patients across the whole of Norfolk and Waveney. The Norfolk Acute Hospitals Group (NAHG) commissioned Specialist advisors, who undertook this work during the period of October 2017 – February 2018.

1.6 A number of proposed options were developed for each service. These options have been considered by the clinical and leadership teams of each Trust with the NAHG discussing the preferred option for each speciality on 30th April 2018.

1.7 As part of the review there were engagement events with service users held towards the end of 2017; Norwich 22th November 2017, Kings Lynn 27th November 2017 & Great Yarmouth 1st December 2017 and in Beccles 7th March 2018. These were facilitated by HealthWatch Norfolk and Suffolk respectively.

2. Acute Speciality Sustainability Review Update

2.1 The NAHG commissioned external support on behalf of the three Trusts to address issues of clinical, operational and financial sustainability for Cardiology, Radiology and Urology services across the Trusts.

2.2 For clarity the key facts for each of these specialities is set out in the table below.

Radiology	• Radiology - medical imaging to diagnose and sometimes treat diseases and injuries inside the body. A number of different methods are used to view what's going on within the body such as: x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), nuclear medicine. • Interventional radiology uses procedures with the guidance

	of imaging techniques. • Usually radiology is a support service, and the Radiologists work closely with other clinicians to help manage illnesses and injuries, including cancer and trauma patients. • In the last 10 years CT scans have increased by over 10% per year and MRI scans by 12% each year • Equipment such as MRI scanners need replacing • Demand for radiology services are increasing and will continue to do so. Will an older population the prevalence of cancer is increasing for which radiology services are called upon. Variation in treatment needs to be tackled alongside the need to diagnose faster. • There is a shortage of radiologists with District hospitals in particular relying on expensive bank, agency and locum support.
Cardiology	• Cardiology – medical specialty that involves the diagnosis and treatment of people with diseases and disorders of the heart. Cardiologists are specialists in diseases of the heart and care for patients with a range of disorders including heart attacks, palpitations and angina. Cardiologists may treat heart diseases with drugs or undertake procedures such as fitting pacemakers. • Some cardiology services require special equipment and skill, so not all hospitals are able to provide these. NNUH provide these for JPUH, and Papworth Hospital provides them for QEH. • Demand for cardiology services continues to increase. Nationally echo cardiology saw a 43% increase between 2010-2016. Patients with congenital heart disease are living longer and require life-long follow-ups. Cardiovascular disease accounts for 30% of acute medical admissions nationally. • There is a shortage of cardiologists.
Urology	• Urology focusses on the health of the urinary system for men and women, and reproductive tract for men. Some of the work relates to cancer treatment, e.g. prostate cancer. • There are elements of urology care that require specialist skill, so not all hospitals are able to provide these. NNUH provide these for both QEH and JPUH where necessary. • Between 10-12% of people referred to the urology departments require surgery. • There is a shortage of urologists (JPUH operates a 1 in 4 consultant on call rota which significantly impacts recruitment and retention).

2.3 The external support worked on a full review and business case development for the three specialties on behalf of the NAHG. This involved working with clinical and operational teams to identify the current difficulties and challenges faced by these services. The review was underpinned by the following principles:

- Solutions to be clinically led and owned by clinicians, evidence based and driven by informed wider health community.

- Services to be of high quality, sustainable, offering care closest to home in appropriate settings, which are viable and affordable.
- The review ensured community and stakeholder engagement in the widest sense, to allow the development of business cases in a transparent and open way outlining sustainable service proposals.

2.4 This detailed review led to the development of business cases for each of the specialities, outlining proposed options for their future organisation. These were presented to the three acute trusts in February 2018. The business cases have been considered by the respective clinical and leadership teams in advance of further consideration by the NAHG on 30th April 2018.

2.5 Since commencing the review, the three acute hospitals in Norfolk have been accepted as one of four early adaptor sites in the country for radiology. With the support of NHS Improvement an approach to build upon the above work is being developed for radiology. This work is ongoing.

3. Acute Speciality Sustainability – The Proposed Future State Models

3.1. Appendix 1 sets out the future state models as proposed for cardiology, radiology and urology.

3.2. In all three specialities, the proposed future state model from this work is to establish a networked model supported by a single clinical team across Norfolk. The NNUH will, in all three specialities, act as the 'centre' and the JPUH and QE as 'units'. Specialist work will be undertaken at the centre, and non-specialist work will be undertaken at each of the units. The clinical team would work across organisational boundaries to ensure the most effective sharing of skills and knowledge across Norfolk.

3.3. Such a model could involve either a 'service level agreement' between the NNUH and district hospitals or a joint single leadership team and overarching board similar to the effective Eastern Pathology Alliance arrangement already in place.

3.4. Such a model brings greater resilience and sustainability to service provision whilst having little impact on the patient experience. Indeed such a model could result in fewer referrals from the unit to hub for routine work providing a positive patient impact.

4. Seeking efficiency through joined up back office functions

4.1. In partnership with other providers in the Norfolk and Waveney STP, there is a programme of work looking at efficiency opportunities through joining up back office functions. This work extends beyond the need to secure efficiency savings as some functions are in the lowest cost quartile nationally, and the focus is also on service and function sustainability. Such work includes opportunities through the joint procurement of clinical and non-clinical supplies; opportunities for joining up some back office services etc. This work is currently underway and is reported back to the Norfolk & Waveney STP.

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

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Appx

James Paget University Hospitals NHS Foundation Trust

Norfolk and Norwich University Hospitals NHS Foundation Trust

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

Norfolk Acute Hospitals Group
Acute Speciality Sustainability Review – Phase 2

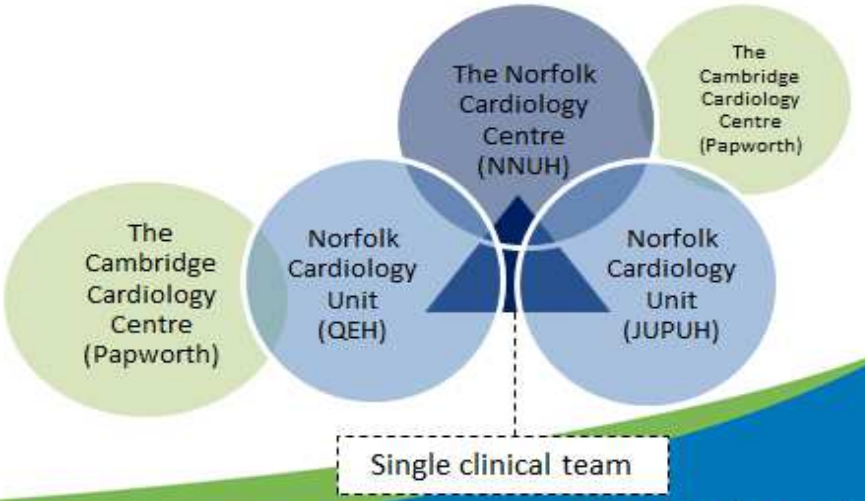
www.attain.co.uk

Cardiology Clinical Model (Future State)

Definition:
A networked model supported by a single clinical team working across Norfolk. The NNUH site will act as the "centre" and the JPUH and QEH act as the "units." Complex and specialist work will be undertaken at the centre, and non-specialist work will be undertaken at each of the units. The clinical team will work across organisational boundaries to ensure the most effective sharing of skills and knowledge across Norfolk. A joint strategy for equipment will be developed to optimise assets to deliver high quality and safe clinical care, minimise capital expenditure.

Key principles:

- The range of services provided at the cardiology centre and units will be scoped and agreed.
- NNUH will provide "centre" level care for the population of Norfolk and Waveney.
- NNUH will provide a range of "unit" level care for the population of Norwich and North Norfolk
- JPUH will provide "unit" level care for the population of Great Yarmouth and Waveney
- QEH will provide "unit" level care for the populations of Kings Lynn and West Norfolk.
- The range of services provided at the cardiology centre and units will be scoped and reviewed. The QEH/NNUH scope of care and arrangements may differ from JPUH/NNUH due to the current joint working between QEH and Papworth Hospital
- Where clinically safe, care will be close to home and patients in the centre will be repatriated as soon as clinically appropriate.
- There is some overlap in working to enable some dynamic load balance in the system.
- There is an additional option to run a central clinical team which would work to ensure that care for cardiology patients across Norfolk is equitable and makes best use of skills and capacity available across the county.



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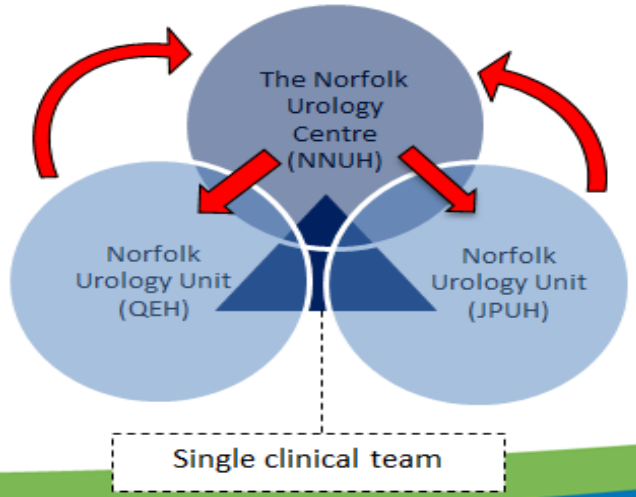
Urology Clinical Model (Future State)

Definition:
A networked model supported by a single clinical team working across Norfolk. The NNUH site will act as the "centre" and the JPUH and QEH act as the "units." Complex and specialist work will be undertaken at the centre, and non-specialist work will be undertaken at each of the units. In a phased implementation, out of hours care will be provided by the centre, where staffing levels and on-call support can be optimised, making appropriate use of technology to support the units. The clinical team will work across organisational boundaries to ensure the most effective sharing of skills and knowledge across Norfolk.

Key principles:

- The range of services provided at the urology centre and units will be scoped and agreed.
- NNUH will provide "centre" level care for the population of Norfolk and Waveney.
- NNUH will provide a range of "unit" level care for the population of Norwich and North Norfolk
- JPUH will provide "unit" level care for the population of Great Yarmouth and Waveney
- QEH will provide "unit" level care for the populations of Kings Lynn and West Norfolk.
- Where clinically safe, care will be close to home and patients in the centre will be repatriated as soon as clinically appropriate.
- Out of hours work will be arranged as all emergency work managed by the centre, enabled by technology where clinically appropriate.
- There is some overlap in working to enable some dynamic load balance in the system.
- There is an additional option to run a central clinical team which would work to ensure that care for urology patients across Norfolk is equitable and makes best use of skills and capacity available across the county.



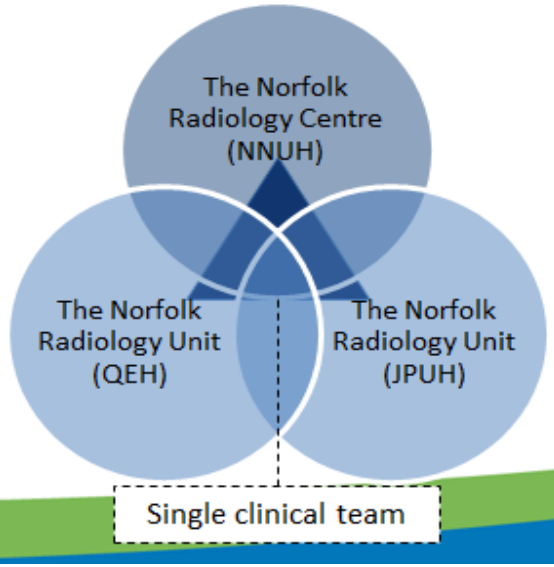
Out of hours
- Urology centre provides advice, support and cover for any urology inpatients and clinical interdependencies
- Urology emergencies sent to urology centre

Radiology Clinical Model (Future State)

Definition:
A networked model supported by a single clinical team working across Norfolk. All sites will have functioning radiology departments, however the NNUH site will act as the "centre" for complex image acquisition and complex interventional radiology procedures. JPUH and QEH will act as the "units", where the in hours and out of hours image acquisition and image reporting provision will be scoped and reviewed to ensure optimised use of staff and equipment. The clinical team will be managed centrally and work across organisational boundaries to ensure the most effective sharing of skills and knowledge across Norfolk, in in particular balancing of reporting workload. A joint strategy for equipment will be developed to ensure economies of scale and "purchasing power" is maximised across the three organisations.

Key principles:

- The range of services provided at the radiology centre and units will be scoped and agreed.
- NNUH will provide "centre" level care for the population of Norfolk and Waveney.
- NNUH will provide a range of "unit" level care for the population of Norwich and North Norfolk
- JPUH will provide "unit" level care for the population of Great Yarmouth and Waveney.
- QEH will provide "unit" level care for the populations of Kings Lynn and West Norfolk.
- There is significant overlap in working to maximise opportunity to load balance across the three trusts to manage activity effectively especially where image reporting is site agnostic and does not affect the patient accessibility.
- The clinical team will be managed centrally to ensure that care for radiology patients across Norfolk is equitable and makes best use of skills and available capacity across the county. Recruitment and training of staff will be managed by the single clinical team to maximise the desirability and opportunities, and accelerate growth in training schemes especially reporting for non-radiologists.



Health and Wellbeing Board

Item 8

Report title:	**Integration – a vision for Norfolk Adult Social Services and review of the Better Care Fund 2017/18**
Date of meeting:	**2 May 2018**
Sponsor:	**James Bullion, Executive Director, Adult Social Services, Norfolk County Council**

Reason for the Report

Integration of health and social care is about placing individuals at the centre of the design and delivery of care with the aim of improving individual outcomes, satisfaction and value for money. The Health and Wellbeing Board (HWB) oversees the implementation of the Better Care Fund which accounts for some £56m of health and social care monies.

Report summary

Norfolk County Council is committed to pursuing integration, and there is a strong foundation of collaboration across the health and care system on which to build. Alongside change and transformation in the NHS, under the auspices of the STP, Adult Social Services is on a journey of change and has a clear vision for strengthening integration. This report does two things: 1. It sets out the high level position for Adult Social Services on integration for the future; 2. It reports on the Better Care Fund (BCF) for 2017/18, and provides a more detailed look at our work on social prescribing, which is incorporated into our BCF and Integration Plan.

There has been good progress through BCF and Integration Plan and the initiatives funded through BCF have made an important contribution to Sustainability & Transformation Partnership (STP) priorities.

A significant amount of iBCF (improved BCF) funding has been invested into initiatives that contribute to addressing performance on Delayed Transfers of Care (DTOC) across the system, as this has been the only mandatory metric most at risk of not being delivered to target. The iBCF funding has been focused on areas in the recently developed High Impact Change Model (HICM) that social care can influence effectively, such as Trusted Assessors, Enhanced Home Support Services and Active Assessment Units (bed based reablement).

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

Social prescribing is an example of how we've used iBCF to pursue STP and BCF objectives.

Recommendations:

The HWB is asked to:

1. Consider system progress in relation to integration in Norfolk over the past year
2. Endorse Adult Social Services vision for integration and agree to commit to collaborate on developing and implementing the model

1. Steps towards integration

1.1 Norfolk County Council and the NHS in Norfolk and Waveney have a sound track record on integration.

1.2 Community health and community social care teams work to a single management structure, allowing more seamless and co-ordinated services to be developed and delivered. This front-line integration is mirrored by integrated commissioning arrangements, with all commissioners of adult social care and support in joint posts with the Clinical Commissioning Groups (CCGs).

1.3 Integration between health and social care is critical to the Norfolk and Waveney Sustainability & Transformation Plan (STP) – in good health, and to Adult Social Services transformation strategy Promoting Independence.

1.4 Both are driven by the pressures of demography, increasing complexity of peoples' needs, and financial pressures. Both have the aim of 'shifting left' to prevent ill health and dependency by earlier intervention and building on people's own assets and strengths.

1.5 For Adult Social Services, creating better co-ordinated and more effective services with NHS partners will improve outcomes and experience for people, but also manage demand.

1.6 As wide-ranging change and transformation gains pace under the STP, Adult Social Services is committed to continuing to be a strong partner with health and has developed a set of principles to underpin future integration arrangements. These are a commitment to:

- A strong social care approach with strong leadership of social work
- A standard level of service across the county with delivery devolved locally
- Strong links with primary care – we don't want to first meet people in hospital
- Simple processes, swift solutions
- Saving money and avoiding demand
- Fewer organisations for the public to deal with
- Providing for the local population within a clear local budget
- Ensuring that social care does not become dominated by a medical model
- A focus on person-centred care and personalisation, choice and control

2. Our working model for integration

2.1 Our working model for integration is based around the following:

- We will work with primary care partners to shape new local care services across the 5 localities and to be delivered in around 20 clusters
- We will work closely with GPs to identify people most at risk especially to avoid admission to hospital
- Build on our existing joint management with community health services to create a joint health and social care offer to primary care
- Refresh joint commissioning arrangements for health and social care, being clear about what is commissioned locally, and what is commissioned once at scale across Norfolk

- Work with health colleagues to build strong community mental health services and to ensure people with learning disabilities are able to live their lives to the full in their homes and communities and working with our hospitals to get people home safely and promptly
- Put in place core components to support integrated care including connected IT systems, better use of estates, co-location, information sharing.

3. Norfolk's Better Care Fund (BCF) and Integration Plan 2017-19

3.1 The HWB is responsible for developing and implementing the strategic plan for the Norfolk Better Care Fund (BCF). At its meeting on 12 July 2017, the HWB considered a draft of the BCF and Integration Plan and related appendices, followed by a report at its meeting on 27 September 2017 updating on the submission to NHS England (NHSE) on 11 September 2017. On 21 December 2017, the Norfolk BCF and Integration Plan was formally approved by NHSE. An important element of the Plan is social prescribing and progress on this is also included in this report.

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

3.3 The HWB oversees Norfolk's BCF programme, in line with its strategic oversight of the wider system and pursuit of an integrated, sustainable health and wellbeing system. Adult Social Services (ASS) and CCG Chief Officers are responsible for ensuring the plan is delivered and appropriately reported to NHSE on a quarterly basis.

3.4 Funding for the plan is by a section 75 agreement and totals almost £70m for each of 2017-18 and 2018-19. This includes Disabled Faculties Grant capital funding of nearly £7m. An additional £20m iBCF (improved BCF) funding for 2017-18 rising to £34m in 2019-20 was also been granted in the 2017 spring budget, though this is non-recurring.

3.5 The Progress Report (Appendix 1) provides a review against the five priority areas identified in the plan:

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

3.6 It also provides an update on progress against the High Impact Change Model (HICM). The HICM is a mandatory national BCF condition in the BCF 2017-19 and Norfolk's Plan included an action plan for the eight identified system changes:

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

3.7 The HICM supports system-wide integrated working and in Norfolk the use of iBCF funding has helped to accelerate progress on three of the eight changes. There is

further work to be undertaken to progress work on the model across the Norfolk health and social care system.

4. Delivering the plan

4.1 Regular monitoring and quarterly reporting has enabled Chief Officers of ASS and CCGs to have the required management oversight of the plan. The Progress Report at Appendix 1 provides a summary of our position in Norfolk for the HWB.

Progress against the five priorities

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

HICM

4.3 Work is underway across all eight of the required changes. We have made good progress with:

- Multi-disciplinary/multi-agency discharge teams, including the voluntary and community sector
- Home First Discharge to Assess
- Trusted Assessor
- Enhanced Care in Care Homes

4.4 With key initiatives now in place, impact is expected to accelerate and be demonstrated through improvements in transfers of care.

4.5 The main challenge to delivering the HICM has proved to be ensuring consistency across the three acute systems.

Metrics

4.6 Please see section 2.10 of the Progress Report in Appendix 1. The implementation of Norfolk County Council's (NCC's) new social care IT system, Liquid Logic, has impacted on reporting, with data cleansing and checking still being undertaken for some of the metrics.

4.7 Three of the four mandatory metrics are on target. The metric that is not on target is Delayed Transfers of Care (delayed days). Performance has not been on target and peaked in October 2017, performance improved during November and December but declined slightly in January. February's performance has seen an improvement

5. Social Prescribing and Community Support

5.1 Social prescribing is incorporated into our BCF and Integration Plan. It is an agreed priority for primary care (GP Forward View 2016) and locally for the Norfolk and Waveney STP. The model has a long history and there are many variations. Typically, schemes focus on improving physical and mental wellbeing through providing time limited access to a connector or navigator who will help them identify personal challenges and make a plan to overcome them. Connectors develop really good knowledge of the full range of local services and less formal community activities and assets which they help people to access. Although evaluation of benefits has been mixed, schemes have been popular with people who used them and there is increasing evidence of positive impacts on health and wellbeing.

5.2 NCC is investing £1.9m from Adult Social Care and Public Health over the next two years to ensure that social prescribing is available across Norfolk. The new initiative

will build on and enable further development of existing models where these are already in place (LILY for older people in West Norfolk; the South Norfolk District Council connectors; Neighbourhoods That Work in Great Yarmouth). CCGs, district councils and voluntary sector umbrella providers have been involved in developing the models which are being designed to reflect the local make up of services, needs, priorities and assets.

5.3 In addition to GPs and other local routes, the service will be accessed through the NCC front door and libraries. The connectors will work closely with district council hubs. They will also establish close working relationships with other key roles such as the integrated care co-ordinators working across health and social care and the NCC development workers. One objective is to grow and consolidate the early help that people have in their own local communities. The funding includes some additional help for community groups and activities where this will help fill local gaps and support new community activities to flourish.

5.4 There will be a single evaluation of the initiative which will look to measure any impacts on aspects of demand for primary and secondary health provision (GP visits, prescribing etc.) and need for formal packages of care, in addition to understanding the outcomes on wellbeing for people.

5.5 Loneliness and isolation are key factors in why people struggle to manage long term conditions effectively. Adult Social Services is also investing in help to tackle social isolation as part of a £1.3m annual investment in additional community support. The approach has been planned with partners alongside the development of the social prescribing models. Support will include:

- Mapping assets in local communities
- Enabling the development of community activities for people who are lonely
- Volunteering for friendship and to help people develop a sense of purpose
- Outreach including for people living in rural areas
- I:I and peer support

5.6 Following procurement, Community Action Norfolk and Voluntary Norfolk will lead partnerships which will work closely with district councils, social prescribing connectors and community groups to provide a comprehensive response for people who are isolated and lonely. In West Norfolk, the Borough Council of King's Lynn and West Norfolk will lead this initiative, working with many local voluntary and community groups.

5.7 Some of the funding for community support (£0.5m) will be used to support district council schemes in Norwich, King's Lynn and Great Yarmouth to tackle rough sleeping and in all of the districts to provide more help to prevent vulnerable people becoming homeless.

Officer Contact

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Norfolk's Better Care Fund and Integration Plan 2017-19: Progress Report for 2017-18

1. Introduction

1.1 The Better Care Fund (BCF) initiative was established by Government to encourage closer working at local level between health, housing and adult social care through creation of a pooled fund.

1.2 Previously national guidance had been for these plans to be prepared for one year only, but for 2017 it was decided that they should be for two years to ensure longer planning timescales and should incorporate integration plans. Other key changes have been the in-year funding announcement of supplementary non-recurrent Improved Better Care Funding (iBCF) which has enabled quicker implementation of some initiatives and imposition of a national High Impact Change Model (HICM) designed to improve hospital discharge arrangements.

1.3 The requirement for the Health and Wellbeing Board to oversee the programme locally remains in place, as does quarterly reporting against four key targets for emergency hospital admissions; delayed discharges from hospital; long-term admissions to care homes and success of reablement.

1.4 As a consequence of changes to the financial framework (the iBCF), final national guidance was delayed significantly, meaning that Norfolk's Better Care Fund and Integration Plan 2017-19 was not agreed by the Health and Wellbeing Board until September 2017 and not formally signed off by NHS England until December 2017. A copy of the Plan can be found here

1.5 The Plan sets the context for BCF and integration in Norfolk, so the detail of that will not be repeated here. However it should be reiterated that the Plan is aligned closely with the Norfolk and Waveney Sustainability and Transformation Plan and reflects its guiding principles. It dovetails with Norfolk County Council's (NCC's) Promoting Independence Strategy and Clinical Commissioning Group (CCG) commissioning intentions for 2017-19. Also, it incorporates district council Prevention and Promoting Independence initiatives.

2. Delivery of the Plan

2.1 **Progress against the Plan for 2017-18**

This report reviews progress that has been made during 2017-18 in delivering the key elements identified in the 2017-19 Plan. These include:

- Norfolk's five identified priorities
- High Impact Change Model (HICM)
- iBCF Initiatives
- Performance against metrics

2.2 Norfolk's Five Priorities

Norfolk identified five priority areas to focus its BCF activity:

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

2.3 **Priority 1**: Locality Integrated Care Programme Infrastructure

The Primary and Community Care workstream of the Norfolk and Waveney STP is progressing at pace with five Local Delivery Boards set up (one for each CCG footprint) with a focus on the development of New Models of Care. This will enable further integration between primary, community, social care, the voluntary sector and district councils. Areas of activity include:

- Integrated social work and community health staff, based around GP surgeries
- Engagement with Early Help Hubs
- Risk stratification of patients
- A well-developed multi-disciplinary team (MDT) approach delivered through Integrated Care Teams
- The Supported Care Service for North and South CCGs

All activities in this priority have been progressed as planned for this year. Next year will see more targeted work on risk stratification to embed a countywide approach.

Successes include a countywide approach to the role of Integrated Care Coordinators supporting multi-disciplinary teams and the introduction of the Supported Care Service. This latter service aims to enable adult patients, including frail older people and those with long-term conditions, to stay safe and well at home, with over 80% of referrals to the service avoiding a hospital admission.

2.4 **Priority 2**: Care Homes

The Norfolk system is engaged with the Enhanced Health Care in Care Homes framework as a basis for reducing admissions from care homes to hospital and is collaborating to support improvement in the quality of care offered. This is also a HICM priority.

This work has progressed well and all milestones have been achieved. Further investment has been agreed for the coming year to ensure the pace and impact of this work can be maintained.

Norfolk has developed the care homes dashboard to show admissions to hospital, use of 111 and quality ratings by care homes. It has been adopted by NHS England and is being presented and promoted as a model of good practice. It highlights a reduction in avoidable hospital admissions to hospital from care homes for 2017/18 compared to 2016/17 (based on data from the first half of each year).

- North Norfolk: 8.3%
- Norwich: 35.3%
- South Norfolk: 14.6%

- West: 15.8%

From 1 April 1 2018 the CCGs will be purchasing their business intelligence services from the Arden GEM Commissioning Support Unit (CSU) which should enable inclusion of GY&W data in the existing Norfolk dashboard, so providing data consistency across the STP area.

2.5 **Priority 3**: The Home Environment

This area of work covers interventions in the home that focus on housing as an enabler to improve health and wellbeing and in particular, the use of Disabled Facilities Grant (DFG) funding.

The expenditure of nearly £7m for 2017-18 was overseen and distributed by seven district councils and spent primarily on statutory DFGs. However work is ongoing with the districts to expand and diversify services provided to better support vulnerable people to return to their homes after a health incident.

A separate report on progress in localities has been prepared (Annex A to follow).

2.6 **Priority 4**: Out of Hospital Schemes

Activities to support out of hospital schemes include:

- Review of Information and Advice Services
- Intermediate Care Strategy Planning
- Delivery of the HICM
- Social Prescribing

Use of the iBCF funding has enabled significant progress to be made on this priority, with the introduction of; active assessment units, enhanced home support services, trusted assessment facilitators and the recruitment of six additional Discharge to Assess social workers to support hospital discharge. These schemes are expected to impact on the Delayed Transfer of Care (DToC) metric and contribute to an improvement in performance, as well as continuing to help maintain our rate of non-emergency admissions.

To progress work on social prescribing, Norfolk County Council is investing £1.9m from Adult Social Care and Public Health over the next 2 years to ensure that social prescribing is available across Norfolk. CCGs, district councils and voluntary sector umbrella providers have been involved in developing the models which are being designed to reflect the local make up of services, needs, priorities and assets.

2.7 **Priority 5**: Crisis Response

Initiatives include:

- Services for Carers
- Early Intervention Vehicles (EIVs)
- The Enhanced Home Support Service
- Norwich Escalation Avoidance Team (NEAT):
- West Norfolk Rapid Assessment Team

All milestones for this priority have been met. Further work will be undertaken in year two of the plan to analyse the impact of initiatives.

An example of effective work in this priority area is the new carer's support service 'Carers Matter Norfolk', which was launched in October 2017 and continues to support unpaid carers in Norfolk. Through the BCF part of a shared commitment, it offers a 'carer-led' support service and telephone support plus information and guidance to carers. The milestones to evaluate procurement and award a contract for new services between June 2017 to September and for the new services to commence by 1 October 2017 were all met.

2.8 High Impact Change Model (HICM)

The HICM aims to focus support on helping local system partners minimise unnecessary hospital stays and encouraging them to consider new interventions for future winters when pressures are greatest.

It offers a practical approach to supporting local health and care systems to manage patient flow and discharge. It can be used to self-assess how local care and health systems are working currently, and to reflect on, and plan for, action that can be taken to reduce delays throughout the year.

The model identifies eight system changes which will have the greatest impact on reducing delayed discharge:

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

As part of the BCF plan 2017 -19 Norfolk submitted a HICM plan (see Annex B) showing progress against the eight areas of the plan. Each has been rated as either green or amber, with all actions having been completed, though there was some slippage in timescales. Whilst plans are in place for all eight changes in the model, some are more established than others.

Most progress has been made on the areas of change where iBCF monies have been invested, such as Home First Discharge to Assess and trusted assessors. With key iBCF initiatives now in place, impact is expected to accelerate and be demonstrated through improvements in transfers of care.

The main challenge to delivering the HICM has proved to be ensuring consistency across the three acute systems. Further work is planned to review the model and update the plans to maximise impact.

2.9 iBCF Initiatives

2.9.1 The Chancellor's Budget in March 2017 announced £2bn additional non-recurrent funding for social care, of which Norfolk received £18.561m in 17/18, to be followed by £11.901m in 2018/19 and £5.903m in 2019/20. The funding is paid as a direct grant to councils by the DCLG and as a condition of the grant, councils were required to pool the funding into their BCF.

2.9.2 The guidance received from DCLG requires that the funding is used by local authorities to provide stability and extra capacity in the local care system. Specifically, the grant conditions require that the funding is used for the purposes of:

a. Meeting social care needs
b. Reducing pressure on the NHS supporting people to be discharged from hospital when they are ready
c. Ensuring that the local social care provider market is stabilised

2.9.3 Plans for the use of the funding were reported to Adult Social Care Committee in July and were subsequently agreed with Norfolk's Clinical Commissioning Groups.

The plans included £9.1m earmarked to help support the local care provider market, rising to £10.8m in 2018-19. This was additional to budget plans already agreed for 2017-18, so in-year was targeted on managing the impact of new legislation on providers, managing the impact of market failures and amending pre-banded contracts for working age adults. The funding assigned for this purpose was not used in full and is part of the iBCF funding carried forward within reserves to ensure that it remains earmarked as planned. In particular, the iBCF will support the market through funding the 2018-19 impact of the residential and nursing care cost of care review, implementing the additional cost of the new home support framework, managing the impact of the national living wage on sleep in care provision and purchasing packages of care. By 2019-20 it is expected that £33m of the £34m iBCF funding will be spent on either sustaining the market through prices increases or protection of social care, which will mean buying an increased volume of care with the care provider market

2.9.4 The Adult Social Care Committee receives an update on the iBCF within the Adult Social Care Finance Monitoring Report. The latest published information for period 10 (Jan) 2017-18 is attached at Annex C.

2.9.5 Funding has enabled us to:

a) Strengthen our Social Work capacity. By mid-February 40 appointments had been made to new roles in the service.

b) Invest with Public Health in a countywide approach to social prescribing, enabling primary care services to refer patients with social, emotional or practical needs to a range of local, non-clinical services. This is being taken forward on CCG boundaries, working with Districts Council, CCGs & the voluntary sector. Locality plans have been developed, with services commencing between January and June 2018.

c) Appoint five Trusted Assessment Facilitators across the three acute hospitals. This role has been developed with care providers. The service commenced in January 2018 in the Norfolk & Norwich University Hospital and all three hospitals had this service in place by early March.

d) Open new Active Assessment Units. This is an occupational therapy-led service, designed to maximise people's independence and reduce permanent admissions to residential care, reduce hospital admissions and support safe and timely hospital discharge.

A unit at Benjamin Court in Cromer has nine beds available with services having commenced in February and a further nine to be available later in 2018. The East Norfolk scheme, provided by Burgh House, currently has four beds. The

unit opened early January and by the end of February had already provided services to seven people. A West Norfolk unit will open later this year.

e) Commission three independent flats within a 24-hour housing with care setting at Dell Rose Court in Norwich, supporting people who have been assessed as being medically fit for discharge from hospital, but unable to return to their home safely. Flats are fully contained and have been equipped to replicate a home from home environment. Referrals to the service commenced early February 2018.

f) Establish the Enhanced Home Support Service, a small, flexible and enabling service which provides targeted home support to reduce delayed discharges from the three acute hospitals and unnecessary admissions from the community.

This is a three-year pilot service, free to the service user for visits over a period of up to 72 hours and delivered in partnership with three Home Support providers: Carewatch, Allied Health Care and The Carers Trust.

The service can offer support around meal preparation, personal care, shopping, welfare checks, medication monitoring and facilitation of the access to and the use of community resources and assistive technology solutions. It is suited to individuals with a low level of short term need. The service launched early February and by the end of the month had provided services to 30 individuals.

g) Open an additional six beds/flats commissioned as “step down” and admission avoidance from mental health hospitals jointly funded with NSFT with social care support to provide suitable discharge destinations. The service commenced in July 2017.

2.9.6 Where investment in social care is evidenced to provide wider system benefits the expectation is that financial support will be sought from across health and social care to enable new ways of working to continue beyond the project timescales. Where benefits cannot be evidenced or wider financial support from the health sector is not available, it is expected that the interventions will need to be stopped at the end of the projects.

2.10 Metrics

2.1 A BCF data dashboard is produced and monitored on a quarterly basis and a summary dashboard is included in Annex D.

The four main metrics that BCF activity is monitored against are:

- Reduction in non-elective admissions
- Rate of permanent admissions to residential care per 100,000 population (65+)
- Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
- Delayed Transfers of Care (delayed days)

For the 2017/18, Norfolk has been on track to meet target for three of the four metrics.

Reduction in non-elective admissions

- On track to meet target

The total figure for 2017/18 at January 2018 is approximately 77,838 (a rate of 10,713 per 100,000 population); below the target for this period of approximately 78,934 (10,863 per 100,000).

Enhanced Care in Care Homes work is having a countywide impact on the reduction of non-elective admissions from Care Homes, along with a range of community initiatives such as the creation of the Norwich Emergency Avoidance Team (NEAT).

Rate of permanent admissions to residential care per 100,000 population (65+)

- On track to meet target

There is a continued reduction in permanent admissions based on improved practices and a focus on strength based social work practice, underpinned by good performance in reablement.

Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

- On track to meet target

Performance in reablement services continues to have a positive impact on this metric. Up to January 2018 96% of older people (65 and over) were still at home 91 days after discharge from hospital into reablement / rehabilitation services. This is well above the target of 90%.

It should be noted that due to the introduction of Liquid Logic, the new social care system, January's figures remain unconfirmed. However, the figures are in line with reporting prior to the introduction of Liquid Logic.

Delayed Transfers of Care (delayed days)

- Not on track to meet target

Performance has not been on target and peaked in October 2017, performance improved during November and December but declined slightly in January. February's performance has seen an improvement there were 2242 total delayed days in February 2018, of which 890 were attributable to Social Care. This is a 17% decrease from January 2018, where there were 1078 Social Care delays.

3. Financial Implications

3.1 Funding for the plan is agreed via a section 75 agreement and totals almost £70m for each of 2017-18 and 2018-19. This includes DFG capital funding of nearly £7m.

3.2 Following the announcement of the one-off iBCF grants for 2017-18, 2018-19 and 2019-20, the use of the grant was agreed by NCC and health partners at the end of July 2017. A three-year plan was agreed that also took account of recurrent iBCF funding. The plan was focused on protection of social care, help to support the care market and initiatives to improve discharge from hospital, in line with national guidance.

3.3 Due to the timing of the grant announcement and finalisation of plans, it was not expected to be able to spend all the 2017-18 grant in year and carry forward has been agreed, both as part of the original plan and within monthly monitoring of progress. This has enabled initiatives to be planned in a structured way, with a clear commitment for pilot schemes to run for an agreed period to enable proper evaluation of benefits and assessment of the cost benefits for future funding. For example, these include,

social prescribing, enhanced home support and accommodation based reablement, which have been initiated mainly in Quarter 4 of 2017-18. The County Council has set the budget for 2018-19 to ensure that the funding is carried forward for the purposes agreed. At Period 10, the planned carry forward of iBCF funding to future years was £10.971m from a total grant of £18.561m.

4. Governance

4.1 The Health and Wellbeing Board oversees Norfolk's BCF programme, in line with its strategic oversight of the wider system and pursuit of an integrated, sustainable health and wellbeing system. Adult Social Care and CCG Chief Officers are responsible for ensuring the plan is delivered and appropriately reported to NHS England on a quarterly basis.

4.2 Feedback to NHS England on year one required identification of two key successes observed in Norfolk toward driving integration in 2017/18. Those chosen were:

- Strong, system-wide governance and systems leadership, through the Health and Wellbeing Board partnership, including buy-in from elected representatives and health organisation leaders, plus regular meetings of senior CCG and NCC leaders
- Empowering users to have choice and control through an asset based approach, shared decision making and co-production especially via Implementation of the three conversation model which promotes an asset-based approach to social care in innovation sites

4.3 Feedback to NHS England on year one also required identification of two key challenges observed in Norfolk toward driving integration in 2017/18Those chosen were:

- Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rural factors) particularly in respect of the ageing population and providing services in rural areas, resulting in unprecedented pressures on the local health and social care system
- Integrated electronic records and sharing across the system with service users. The implementation of Liquid Logic has impacted on the availability of social care data between September 2017 and January 2018. The complexity of 5 CCGs (one half in county), 3 acute trusts and 2 community providers complicates joint planning and record sharing

4.4 The BCF risk register is monitored and reviewed regularly with the most significant risks being:

- Inability to adequately reduce DToC across the system.
  Mitigating actions include introduction of iBCF initiatives, appointment of a capacity manager, weekly monitoring of DToC, and a system-wide review

- Workforce capacity and/or skill set insufficient to deliver quality services in some sectors.
  Mitigating actions include a STP workforce workstream, a Sector Skills plan and development of a European Social Fund bid to address capacity and skills issues

5. Conclusion and next steps

5.1 Norfolk's Better Care Fund and Integration Plan 2017-19 has made good progress in year one.

5.2 The five priority areas have delivered against the identified milestones. Priorities for year two include countywide development of risk stratification and analysis of the impact of a number of new initiatives that have been developed to support integration and keep people at home. It is considered that these assist in continuing to prevent emergency admissions and are impacting on a reduction in delayed transfers of care.

5.3 The iBCF has been used to support the BCF priorities and has enabled delivery of key elements of the HICM. System-wide delivery of HICM remains a challenge and this will be a focus for the next year.

5.4 The various BCF initiatives continue to deliver performance that ensures most targets are met. Performance against DToC is an area of concern, but with an increased focus on HICM, the implementation of iBCF initiatives, a planned review of health & social care DToC and ongoing joint working, performance is expected to improve.

5.5 The Better Care Fund and Integration Plan 2017-19, has evidenced effective and innovative working through the delivery of, Supported Care, the Enhanced Care in Care Homes Initiative, Supported Care Programme, Social Prescribing, IEVs and use of the iBCF. Work is underway to address identified challenges and risks are being managed.

5.6 The progress review for 17/18 will be used to refresh and update the plan to ensure that year two is targeted on the correct priorities and on supporting the delivery of the desired outcomes and impacts.

Report prepared by:

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Borough Council of King's Lynn & West Norfolk

Prevention and Promoting Independence -the District Council Contribution to the Better Care Fund Outcomes in Norfolk

Issue : 5

Martin Sands
10/04/18

Prevention and Promoting Independence
The district council contribution to the Better Care Fund Outcomes
1917/18 update

1. Introduction

This document is intended to show the activities and interventions of the District Councils in Norfolk that help residents to live independently at home, whether supporting them to continue living independently, enabling them to resume living independently after a stay in hospital or care home, or preventing the need for more serious interventions in the first place.

2. Document Overview

The document consists of a number of sections, the first section shows the activities and interventions that are common across all of the seven district councils in Norfolk. Then there are a further seven sections, one for each of the district councils, that show the activities and interventions that are specific to the individual councils. Those activities or interventions provided in the Better Care Fund/ Disabled facilities Grant Locality Plans are shown in *'italicised text'* to distinguish them from other activities or interventions provided.

Each of these sections contains a table that is split into three columns to indicate whether the activity or intervention is intended to help with "living well" (Prevent development of needs), "Maintain Independence" (Early Intervention), "Reablement at Home" (Reablement). Activities or interventions that fit into more than one heading are shown across multiple columns as appropriate.

The seven appendices are the specific BCF/DFG Locality plans produced by each of the seven district councils and integrated commissioners representing their Clinical Commissioning Group and Norfolk County Council. These contain the detailed descriptions of the activities and interventions being undertaken within these plans.

Prevention and Promoting Independence

The district council contribution to the Better Care Fund Outcomes 1917/18 update

<table>
<tr><th>Issue/Aim:</th><th>Living Well (Universal Pathway)</th><th>Maintaining Independence</th><th>Reablement at Home</th></tr>
<tr><th>Type of activity:</th><th>Prevention</th><th>Early Intervention</th><th>Reablement</th></tr>
<tr><td rowspan="5">Services/Initiatives Common to all District Councils</td><td colspan="3">Disabled Facilities Grant
Grant funded home adaptations recommended by and Occupational Therapist. Including improving access to bedroom and bathing facilities, cooking and food preparation, improving the safety within the resident’s home.</td></tr>
<tr><td colspan="3">Integrated Housing Adaptation Team – Continuous Improvement Plan
Review and amend existing processes to provide a more efficient and streamlined approach to providing Disabled Facilities adaptations. Agreed target for delivery is an average of 140 calendar days from initial enquiry to completion of the works.</td></tr>
<tr><td colspan="3">IHAT Housing Needs Reports –
Produce housing needs reports to support Housing Options team to identify suitable properties for those people who need an adapted/adaptable property.</td></tr>
<tr><td>Housing standards
Supporting residents to ensure that their homes are healthy and safe environments to live.</td><td></td><td>Housing Options
Enabling moves to more suitable accommodation, where appropriate.</td></tr>
<tr><td></td><td></td><td>Hospital Discharge
Working in partnership with hospitals to provide a common streamlined pathway for referral to ensure residents are able to return home or access suitable alternative accommodation prior to discharge from hospital.</td></tr>
</table>

Prevention and Promoting Independence

The district council contribution to the Better Care Fund Outcomes 1917/18 update

Issue/Aim:	Living Well (Universal Pathway)	Maintaining Independence	Reablement at Home
Type of activity:	**Prevention**	**Early Intervention**	**Reablement**
Breckland District Council	***Discretionary Reable Grant*** *To broaden the eligibility criteria for the Breckland Discretionary Adaptation grant (Reable) to include a greater proportion of clients who can benefit from the streamlined service.*		
	Breckland Agency Service Establish a Breckland Agency service to extend the support offered to clients in the provision of adaptations.		
	Handyperson Service *Reintroduce a Handyperson Service for Breckland residents.*		
			Fast Track Hospital Discharge Process *Develop process to use the Discretionary Reable grant to fast track Hospital Discharge cases*
			Appointment at Triage *To introduce 'appointment at triage' stage to eliminate the waiting list for assessment.*

Prevention and Promoting Independence

The district council contribution to the Better Care Fund Outcomes 1917/18 update

Issue/Aim:	Living Well (Universal Pathway)	Maintaining Independence	Reablement at Home
activity:	Prevention	Early Intervention	Reablement
Broadland District Council	**Handyperson Plus -** Provides a small repair and maintenance programme, including the introduction of minor adaptions to help vulnerable residents remain safe in their homes. Assessment and support procedure provides information and guidance. Referral procedure to community services, and advocacy for benefit claims.		
	HIA interventions - Providing support for vulnerable people to stay healthy and independent in their own properties. Assistance with major/minor repairs and adaptations. Ensuring incomes are maximised; assistance with benefit and charity applications referrals to ancillary services and for financial assistance.		
	GP Clusters and MDTs - *Identification of those most at risk of hospital admission at a GP surgery. Co-operation between Integrated Care Co-ordinators and HIA enabling a focused personal intervention with the individuals providing access to the range of housing and benefit related support that the District provides. Referral to other agencies to assist vulnerable people to remain living independently in their own homes.*		
	Energy Advice: - to keep vulnerable residents warm in their own homes.- Provide energy advice on costs, suppliers, insulation and affordable options. Provide access to financial assistance for system repair and replacement where available.		
	Early Help Hub - A multi-agency team located at the Broadland District Council offices working in partnership to advise, support and assist individuals and families. The aim is to work with individuals and families as early as possible to prevent the need for more formal responses. Other council departments link into the hub;		
	Debt and Welfare Advice		
	Community at Heart (inc Community Projects Officer) Takes a whole council approach to getting more closely involved with our communities, building productive relationships and raising awareness of key initiatives between communities and ourselves. Also aims to build more trust and understanding for residents in terms of the role of the council and see first-hand the work of the councillors they voted for. Link to external community roles and groups including those relating to Health and Social Care; for example, NCC Development Workers, Integrated Care Coordinators and Adult Social Care's 3 Conversations Assistant Practitioners Provides Secretariat function to the Broadland Dementia Action Alliance		
	Falls Prevention Slipper Exchanges as part of Local Public Health Offer(LPHO) activity	**Smoking prevention -** LPHO activity-Smoke free parks and sports pitches signs requesting adults refrain from smoking in these areas.	
	LPHO Activity - Excess Winter Death Prevention Activities include: Energy team attending Aylsham Age Wise event, Thorpe St Andrew Heat and Eat Event – direct mailing to recipients of Guaranteed Pension Credit, Slow Cooker workshop (attendees receive free slow cooker), stands from other organisations		
	Community Groups and activities - Set up and/or enabled by BDC such the Marriott's Way 10k race; social physical activity groups; 3 parkruns and council produced cycling & walking leaflets	**Broadly Active -** A programme of physical activity and behaviour change therapy prescribed by a health professional to help manage and reduce the effects of chronic health problems such as coronary heart disease, diabetes, hypertension, anxiety, depression etc. Patients are referred at early stage and as part of a rehabilitation programme after hospital intervention	
	Active Norfolk Activity Pathway The development of outcome focused district level sport and physical activity locality plans co-produced between Active Norfolk, district councils and partner organisations		
	Why Weight A twelve week, tier 2, local weight management plan encouraging individuals to better understand their relationship with food. Education sessions combined with behaviour change therapy encourage lifestyle changes rather than short-term dieting. Suitable for anyone 16+ with a BMI of 25 or more so suitable for early intervention through to complementary treatment for the seriously ill returning home.		

Prevention and Promoting Independence

The district council contribution to the Better Care Fund Outcomes 1917/18 update

Issue/Aim:	Living Well (Universal Pathway)	Maintaining Independence	Reablement at Home
Type of activity:	**Prevention**	**Early Intervention**	**Reablement**
Great Yarmouth Borough Council	**Social Prescribing** Utilising the Connector roles mentioned below, the local VCS provision and GP surgeries to deliver a comprehensive offer that includes a range of advice and guidance plus personal development, support and navigation and community based self-help.		**Healthy Homes Assistance** Speedily undertakes works to a patient's property to facilitate safe hospital discharge or to prevent admission to hospital.
	Housing related Support Services Sheltered housing accommodation based service and outreach floating support service both keeping older people living at home independently safe & well.		**Assistive Technology – I'm Going Home** 24/7 hospital discharge service using temporary Yare Care community alarms and keysafe.
	Safe at Home HIA Services Providing housing repair and adaptation advice and support service. Includes full design service and support to seek funding. Also provide a Handyperson service.		**Great Yarmouth Community Housing** Comprehensive repair and adaption service for tenants of GY Community Housing.
	Early Help Hub - A multi-agency early intervention and collaboration hub where cases are discussed to avoid crisis interventions		
	Neighbourhoods that Work Building stronger communities and encouraging self-help using Community Connectors, Life Connectors, Skill Connectors and Community Development Workers		
	Yare Care Community Alarms - Utilising assistive technology to support independent living and provide 24/7 access to emergency help.		
	Making Every Adult Matter / Housing First Working collaboratively with a homeless hostel provider to provide housing first then combine it with supportive treatment services, education and employment		
	Sport and Leisure Providing accessible and affordable indoor leisure provision to encourage greater participation and promote healthy living		
	Tenancy Services The council is a stock owning authority providing quality accommodation at affordable rents and provides a comprehensive estate management service that supports & promotes wellbeing.		
	Emergency Repairs & Discretionary Loans Recycling existing loans when repaid to provide funding for emergency repair works for vulnerable households		

Prevention and Promoting Independence

The district council contribution to the Better Care Fund Outcomes 1917/18 update

<table>
<tr><th>Issue/Aim:</th><th>Living Well (Universal Pathway)</th><th>Maintaining Independence</th><th>Reablement at Home</th></tr>
<tr><th>Type of activity:</th><th>Prevention</th><th>Early Intervention</th><th>Reablement</th></tr>
<tr><td rowspan="12">Kings Lynn & West Norfolk Borough Council</td><td colspan="3">Handyperson Service - To provide a low level minor adaptations and repairs service focusing on prevention and early interventions</td></tr>
<tr><td colspan="3">Discretionary ADAPT grant- Raise limit from 6K to 12k</td></tr>
<tr><td colspan="3">Provision of Hardship Fund - To assist with client contributions where a client cannot raise the funds required.</td></tr>
<tr><td colspan="3">Provision of loan fund
To assist with cases where total costs exceed the maximum allowable £30K and the client cannot pay the costs above the 30K limit.</td></tr>
<tr><td colspan="2">Early Intervention Initiative –
Target identified cohorts of people with advice, information and low level initiatives such as a prevention home assessment, dementia assessment, home safety assessment, and energy tune up.</td><td>Fast Track Hospital Discharge Pilot:-
Development of Fast Track modular Ramping service and fast track stairlift service</td></tr>
<tr><td colspan="2">Lily
Ask LILY is a service focused on combatting loneliness and reducing isolation to support health and wellbeing. Available online, by telephone, via LILY Advisors at community locations or a home visit, adults can access advice, information and help to engage with social activities..</td><td>Handyman to assist Hospital Discharge:- Use of handyman service to support hospital with minor adaptations for Hospital discharge.</td></tr>
<tr><td colspan="2">Minor adaptation works grant
Introduce non-means tested minor adaptations grant for works under £1000</td><td>Lily:- Link into hospital teams to offer assistance to patients being discharged home.</td></tr>
<tr><td>Assistive Technology – (help people stay safely at home) - develop project to focus on key areas in partnership with Locality Social Care team.</td><td colspan="2">Relocation Grant
To help fund relocation costs in cases where adaptations cannot be made to the current property or moving is a more cost effective solution.</td></tr>
<tr><td>Energy Advice
To assist clients with general advice and funding information about heating problems.</td><td colspan="2">Partnership working with health and community teams
Identifying a streamlined pathway and referral template to enable community therapy teams to send in referrals for minor and major adaptations. To provide training workshops throughout the year to cross-train the multi-disciplinary teams in specialist areas</td></tr>
<tr><td colspan="2">Partnership working with Care Navigators
To work closely with other Organisations that provide support and co-ordinated care for over 75’s in the west. To provide a stream lined process for referrals and to share relevant information about clients that may be accessing these services. To consider a hot desk arrangement within the IHAT</td><td>Non Means tested Hospital discharge Grant
To assist with a fast-track process for delivery of ramps and stair lift adaptations for hospital discharge</td></tr>
<tr><td colspan="2">Prevention Grant
To assist with the provision of minor adaptations for cases that are identified as in health need but have not yet reached care act eligibility</td><td>Amend Safe and Secure and Careline Grants
To provide discretionary assistance for minor repairs and Careline equipment.</td></tr>
<tr><td></td><td>Emergency Repair Grant
To assist with urgent minor repairs -</td><td>Assistive Technology – to assist with safe discharge from hospital - pilot project to focus on AT to help with safe discharge form hospital</td></tr>
</table>

Prevention and Promoting Independence

The district council contribution to the Better Care Fund Outcomes 1917/18 update

Issue/Aim:	Living Well (Universal Pathway)	Maintaining Independence	Reablement at Home
Type of activity:	**Prevention**	**Early Intervention**	**Reablement**
North Norfolk District Council	**Early Help** Hub collaboration meetings supporting timely interventions and Referral system between hub partners		**Hospital Discharge** Working in partnership with local hospitals to ensure residents are able to return home or access suitable alternative accommodation prior to discharge from hospital.
	Energy Advice Energy advice and signposting. Access to Norfolk Big Switch and Save.		
	Support of local implementation of national campaigns This includes but is not limited to promotions such as Stay Well This Winter, Flu Clinics etc		

Prevention and Promoting Independence

The district council contribution to the Better Care Fund Outcomes 1917/18 update

Issue/Aim:	Living Well (Universal Pathway)	Maintaining Independence	Reablement at Home
Type of activity:	**Prevention**	**Early Intervention**	**Reablement**
Norwich City Council	**Handyperson Scheme** Carrying out all general repairs, DIY, gardening, painting and decorating. Subsidised rates for older and vulnerable residents including up to two hours free labour on council tax reduction.		
	Discretionary Adaptations Grant *Discretionary grant of up to £5,000, for clients applying for a disabled facilities grant, toward the client contribution required by the means test.*		
	Preventing Admission to Hospital Grants *Non means tested grant of £10,000 and fast track adaptations and improvement service (28 days) to avoid admittance to hospitals.*		
	Domestic abuse outreach service Commissioned domestic abuse outreach service to provide adults, children and young people in Norwich who are currently in an abusive relationship with the necessary advice and support to help them and their children live more safely and independently.		***Hospital Discharge Grants (plus fast track service)*** *Non means tested grant of £10,000 and fast track adaptations service (28 days) to enable timely discharge of inpatients.*
	The Consortium - Commissioned service to deliver a range of social welfare advice, casework and representation services in order to reduce financial and social exclusion and inequalities.		
	Financial Assistance for Home Improvement for vulnerable home owners *Means tested grants and loans of up to £35k to carry out repairs to tackle or prevent hazards prejudicial to health in the home*		
	Social Prescribing - Working through Tuckswood and Gurney GP practices to help people address underlying issues early through linking into services within the community.	**Safe at Home Grants** Grants up to £2,500 to help people living with dementia and vulnerable home owners to maintain suitable and safe homes.	
	Energy Advice - Including loft clearance, insulation and heating grants and help to reduce energy bills.	**Tenancy Sustainment Team** Supporting tenants to remain in their own home	
	Support of local health and well-being initiatives Includes but not limited to Healthy Norwich, digital inclusion, promoting applications for free school meals and Healthy Start amongst new and expectant mothers.	**Norwich Early Help Hub** Working with partners to make sure individuals and families receive the most appropriate and effective support as soon as possible.	***Hospital Discharge Process-*** Working in partnership with NNUH, NCH&C, CCSRS and ASSD to update hospital discharge process to ensure residents are able to return to suitable accommodation (their own home or an alternative).
	Support of local implementation of national campaigns Including but not limited to Stay Well This Winter, Electrical Safety First.	**Money Advice Team** Providing money and debt advice to tenants.	

Prevention and Promoting Independence

The district council contribution to the Better Care Fund Outcomes 1917/18 update

Issue/Aim:	Living Well (Universal Pathway)	Maintaining Independence	Reablement at Home
Type of activity:	**Prevention**	**Early Intervention**	**Reablement**
South Norfolk Council	**Handyperson Scheme** Carrying out all general repairs, DIY, gardening, painting and decorating. Subsidised rates for our older and vulnerable residents including up to two hours free labour on a means-tested benefit.		
	Social Prescribing Working through South Norfolk's GP practices, Community Connectors help people address underlying issues early rather than continuing to use clinical or medical services unnecessarily through linking into services within the community.	**FIRST Officers** *Financial Independence, Resilience, Support and Training* is a multi-specialism support provision which will be able to provide a holistic package of support to residents of South Norfolk on a variety of issues	**Hospital Discharge (District Direct)** Working in partnership with NNUH to update the processes for Hospital discharge to ensure residents are able to return home or access suitable alternative accommodation prior to discharge from hospital.
	Energy Advice Including insulation and heating grants and help to reduce energy bills		**District Direct Hospital Discharge Grant** The District Direct Hospital Discharge Grant (max £3000) is intended to assist our residents who are able to return home from hospital, but are being prevented from doing so because there are factors at their home (that can be speedily remedied), that prevent them from doing so.
	Support of local implementation of national campaigns This includes but is not limited to promotions such as Stay Well This Winter, Flu Clinics etc.	**Early Help Flexible Fund** Available to support residents with one off small value solutions as part of a wider request for support from the Early Help Hub	
	Triage team Team based within the early help hub who identify and triage those residents on first enquiry about independent living	**Independent living team** Supporting residents to remain in their own home	

Appendix 1 – Breckland Locality Plan

Breckland Council Better Care Fund Locality Plan 2017/18-18/19	
Area covered:	**Breckland Council**
DFG Funding:	BCF Allocation – 2017/18 £1,003,721 2018/19 TBC

Overview:

One of the core purposes of the Council's Housing Team is 'If you want to stay at home, we'll support you to live more independently'

This purpose has been developed to reflect the statutory duty of the Council but also the current and future aspirations of the organisation.

The first objective is to fast track assessments for property adaptations at first contact. The Council has recently developed a Housing Support Hub with the capacity to triage and where appropriate deal with the majority of customer enquiries coming into the housing service, including requests for adaptation assessments. This team has been developed using intelligence which is based on the type and frequency of enquiries historically logged with the Housing Service. It is proposed that following the initial triage, appointments are scheduled at first point of contact based on level of complexity therefore working to a position of no waiting list.

This is particularly useful in terms of hospital discharge where it is proposed that through close engagement with the acute hospitals serviced by the Breckland area, the Housing Support Hub will become a key feature of the respective hospital's discharge process. By developing the multi-disciplined approach of the Hub a decision can be made at first point of what service would be most appropriate to successfully support an expedited discharge.

This way of working can also be exercised when considering elected surgeries and Breckland is committed to where possible preventing an admission but where this is unavoidable and where an adaptation is required will through the above process be in a position to carry out these works to aide a discharge and support the residents recuperation.

In addition, the service is currently considering the intelligence held by the Council to forecast those customers who may require an adaptation in the future and where possible prevent this from occurring. This includes the use of triggers and a collective approach from all Council departments to ensure that the organisation fully understands requests which are being made and what support in addition to what is being asked for is considered and where necessary put in place.

The Council is also reviewing the Reable Grant, Breckland's discretional property adaptations grant in order that this supports the above way of working.

Appendix 1 – Breckland Locality Plan

Delivery for 2017/18-18/19:

Activity in 2017/18 and proposed activity 2018/19

IHAT Continuous Improvement Plan – Breckland is committed to the common objectives of the IHAT continuous improvement plan and the goal to reduce end to end times to 140 days.

2017/18 update - Breckland has reduced the number of people on the waiting list to nil, in addition applicants are triaged and appointments made for initial assessment at first point of contact. The 140 days end to end objective has not been achieved, this is in part due to the clearing of and the associated historic waiting time accrued whilst waiting for the initial assessment.

2018/19 proposal - No Change

Hospital Discharge "Common Referral Pathway" – Work in partnership with hospitals to provide a common streamlined pathway for referral to ensure residents are able to return home or access suitable alternative accommodation prior to discharge from hospital. Breckland is unusual in so far as our catchment covers 3 key hospitals – N&N; Bury and Kings Lynn.

2017/18 update - Breckland has contributed to the successful pilot of District Direct, N&N hospital discharge process. The District has also been supportive and contributed to the proof of concept resulting in the NHS looking to finance the initiative on a permanent basis.

2018/19 proposal - No Change

Hospital Discharge "Fast Track Service" – Develop process to use the Discretionary Reable grant to fast track Hospital Discharge cases. This will require the acceptance of third party assessments of need and agreement of emergency timescales with contractors.

2017/18 update – See below

Discretionary Reable Grant - To broaden the eligibility criteria for the Breckland Discretionary Adaptation grant (Reable) to include a greater proportion of clients who can benefit from the streamline service. Subject to ratification, we will make Reable grants available to £14,000 (currently £7000)

2017/18 update – Reable grant currently at £7000

2018/19 proposal - It is still proposed that the discretional grant (Reable) will be reviewed to take into account the increase in general work costs and to ensure that the District can provide and maintain a fast-tracked adaptations service.

Handyperson Service – as part of the proposed agency service it is intended to reinstate a handyperson service to cover the Breckland area

2017/18 update – Breckland currently outsources its handyperson responsibilities to other neighbouring authorities.

2018/19 proposal - This remains an objective of the proposed new Home Improvement Company.

Appendix 1 – Breckland Locality Plan

Appointment at Triage - To introduce 'appointment at triage' stage to eliminate the waiting list for assessment. A private occupational therapist is currently being used to assist in reducing the current waiting list. Within 3 months (July 17) it is intended that appointments for assessment will be offered at the triage stage.

2017/18 update – Achieved – see above

2018/19 proposal – No Change

Breckland Agency Service - Establish a Breckland Agency service to extend the support offered to clients in the provision of adaptations. Options for the appropriate service delivery model are due to be considered by Breckland Councillors summer 2017

2017/18 update – The Council remains committed to provide a high quality works and expedited adaptation and grants service and are currently looking at options in terms of future delivery.

Appendix 2 – Broadland Locality Plan

Area covered:	**Broadland District Council**
DFG Funding:	**BCF Allocation – 2017/18 £766,244** **2018/19 TBC**
Expected demand for DFGs in 2018/19 and planned delivery:	
Expected Demand - 138 recommendations. Planned Delivery - 138	

In the following table, please include your proposal with innovative ideas and practice to support people to live independently at home.

Whilst putting together your proposal(s) please consider:

- the wider contribution of Districts
- how activity can contribute towards reduction in admissions to acute and care homes and support hospital discharge

Proposal 1 – Targeted approaches: Social Prescribing
Describe proposal in this box. Include: • The objective of the scheme: Further develop a programme where those most at risk of hospital admission and Adult Social Care cases are referred for wider support from the District Council as part of the prevention offer. • Some background (if relevant) on what has happened before. District Councils offer a range of housing and benefit related support to assist vulnerable people to remain living independently in their own homes. This could include adaptations, advice on appropriate benefits, energy efficiency advice, grants/loans for home repairs, a handy person service, community and 3rd sector support and general housing advice. The gateway to this support is through Home Improvement Agency Staff (HIA). Currently referrals are through an open process but a targeted approach has been developed at a single GP surgery in the Northern Locality for those most at risk of hospital admission. The scheme has moved the preventative approach forward for this cohort of people. The previous three month program has demonstrated considerable success to the satisfaction of the surgery involved and relative partners who operate through the survey. However some refinement of the process is required and further demonstration of the outcomes that are a result of the process. Therefore to move the procedure forward an intervention is proposed at an alternative GP surgery within Broadland District Council's boundary. • An overview of the scheme and activity that would take place The proposal is to develop and refine the provision of the wider support available from District Councils using the HIA as a conduit and establish a cost based approach that demonstrates financial benefits to the surgeries, adult social care and the NHS as a whole achieved by the

multidisciplinary approach taken by HIA officers.
Aimed at those who are at greatest risk of admission and a sample of certain initial demand into Adult Social Care to identify whether this support would aid them / their carer if not already in place.

The new procedure will be influenced by the evaluation of the original Aylsham pilot which is currently being developed in co-operation with the CCG's involved. If the approach evidences that such support further increases the independence of referred patients (if not already receiving such support), reduces admissions and demonstrates financial savings then a business case will be developed detailing the sustainability of the scheme.

Rationale/Evidence base

Detail your rationale/ evidence base here

Developing integrated approaches to ensure services are identifying and wrapping provision around those who are most at risk of hospital admission. The pilot at Aylsham has demonstrated that where the nature of the case allows, there are alternative ways of responding to demand into Adult Social Care rather than a full social care assessment.

Outcomes

Use this space to detail your expected outcomes

- Reduced emergency admissions within targeted cohort of people
- Dedicated prevention offer available to those most at risk
- Reduce reliance on care packages
- Reduced admission to care homes
- Potential for a reduction in carer breakdown
- Increased patient experience
- Potential for reduction in delayed transfers of care

Update

Two successful projects have been delivered involving two surgeries in the Northern locality area. A further intervention has been initiated in the North CCG locality. Evaluation is proceeding. No further intervention is anticipated at present as part of the locality procedure.

Proposal 2 – Targeted approaches: More than 2 adaptations

Describe proposal in this box.

Include:

- The objective of the scheme

Determine whether those who have been referred for more than 2 housing adaptations are known to MDTs – to avoid hospital admission. It is likely that this cohort would be known to

teams but it would be advantageous to be assured as this may highlight those that should be part of an MDT.

- An overview of the scheme and activity that would take place.

  This project would help inform those people who may be in need of an MDT approach, if not already identified. This may be a way of ensuring that those needs which may increase from a health and social care perspective are targeted as a priority, and enabled to maintain their independence via an MDT approach.

Rationale/Evidence base

Detail your rationale/ evidence base here

Developing integrated approaches to ensuring services are identifying and wrapping provision around those who are most at risk of hospital admission.

Outcomes

Use this space to detail your expected outcomes

- Reduced emergency admissions within targeted cohort of people
- Dedicated prevention offer available to those most at risk
- Potential for a reduction in carer breakdown
- Increased patient experience

Update

We shall initiate correspondence with Adult Social Care regarding the continued value of this process.

Proposal 3 – Improving End to End Times for the Adaptation Process

- The objective of the scheme

  To reduce the start to finish time for Disabled Facilities Grant aided adaptations to 140 days.

- Some background (if relevant) on what has happened before

  Previously, Integrated Housing Adaption Teams (IHAT's) consisting of collocated Occupational Therapists and District Council Staff were developed. This resulted in the start to finish times for adaptations to be provided reducing to an average across Norfolk of 243 days.

- An overview of the scheme and activity that would take place

  Demand will be assessed and approaches will be taken to remove waste from the system.

Rationale/Evidence base

Detail your rationale/ evidence base here

- Adaptations provided through DFG's have been proven to delay admission to residential care for an average of 4 years and to reduce the amount of formal and informal domiciliary care required. Therefore, the sooner such adaptations are provided the better in terms of this

preventative effect.

Outcomes

Reduction in the start to finish time for DFG adaptations to 140 days.

Update

Progress has been made and applicants are now generally seen within four weeks of an assessment which should be reflected in reduced start to finish times as this feeds through. We will continue to analyse the process and identify time efficiencies that can be implemented.

Proposal 4 – Provide Low level adaptions through the Handyperson+ Service (BCF funding increase dependant).

Describe proposal in this box.

Include:

- The objective of the scheme

To provide low level adaptions as part of a proactive response to residents who access the handy person scheme.
Broadlands Handy Person plus service currently provides a service for eligible residents to have small works done within their dwellings. The plus element of the service involves a **peas**

- If funding from BCF allows the Handy person will install low level adaptions as result of an initial assessment.

Rationale/Evidence base

Detail your rationale/ evidence base here

- Low level adaptations will be specifically based on accident prevention. They are therefore a preventative tool as opposed to higher level adaption that are preventative but also provide the opportunity for residents to stay in their own homes.

Outcomes

- These low level low cost adaptions are expected to reduce demand on GP surgeries and hospital emissions.

Update

33 low level grants have been approved to date. Subject to Cabinet approval the cap on this grant will be raised to £750

Appendix 2 – Broadland Locality Plan

Proposal 5 – DFG Top up Grants for contributions below £2000 (BCF funding increase dependant)

Describe proposal in this box.

Include:

An overview of the scheme and activity that would take place.

- Discretionary grant of up to £2,000 for clients applying for a disabled facilities grant. This will go towards the client contribution required by the means test.

Rationale/Evidence base

Detail your rationale/ evidence base here

The preventative element of DFG funding has been well documented relating to decreased pressure on care packages and care homes and a reduction in hospital emissions. Providing a top up fund is likely to increase the take up of these grants where a moderate contribution is required.

Outcomes

Widening affordability will increase the number of adaptions which will increase the preventative effect of the service.

Update

This proposal has not been moved forward and will be replaced with further proposals relevant to Better Care Fund.

Proposal 6 – Health Improvement Grants to upgrade inefficient heating systems (Max £4500)

A proposal to provide means tested boiler replacement for defective or non-condensing boilers or storage heaters for residents with health issues. The scheme will continue a current project and will be subject to cabinet approval and accessibility aligned to available funds.

Rationale/Evidence base

Detail your rationale/ evidence base here

Replacing an inefficient boiler enhances the efficiency of heating systems for vulnerable persons and therefore affects the affordability of staying warm with all the health benefits this provides.

Outcomes

Reduce demand for residents and health and care services

Appendix 2 – Broadland Locality Plan

Proposal 7 – Extended Financial Assistance
A new proposal to provide a top up grant or loan additional to £30K DFG. The proposal will be subject to cabinet approval and accessibility aligned to available funds.
Rationale/Evidence base
This proposal will provide further financial assistance where the current cap of £30K will not provide the funds necessary to complete the adaptions at a property.
Outcomes
Reduce demand for residents for health and care services.

Proposal 8 – Architect Grant
A new proposal to provide a means tested architect fee grant for complex cases. The proposal will be subject to cabinet approval and accessibility aligned to available funds.
Rationale/Evidence base
Complex cases are stalled where structural works require pricing prior to approval. The only option for the pricing procedure is for the applicant to finance the architect fee prior to approval hence the stall and sometimes abandonment of the procedure. A grant to cover these costs will help to ensure a smooth process for complex cases where structural works usually in the form of an extension are required.
Outcomes
Fluid procedure and reduced cancelation where complex works are required which will lead to reduced demand for residents for health and care services.

Proposal 9 – Get You Home Grant
A Get You Home Grant of up to £1000 to pay for essential maintenance works at residents' properties identified through the District Direct Service and other hospital referral routes. The proposal will be subject to cabinet approval and accessibility aligned to available funds.
Rationale/Evidence base
The grant would be used for trade services such as plumbing and electrical works and other works beyond the scope of the handy person plus service or one off capital expenses, such as purchasing necessary furniture or appliances or skip hire for decluttering.
Outcomes
Outcome aimed at reducing Hospital ward pressure and to assist resident to return to their homes at the earliest opportunity.

Appendix 3 – Great Yarmouth Locality Plan

Better Care Fund & Disabled Facilities Grant Locality Plan 2017/18 – 18/19 (Update February 2018)	
Area covered:	Great Yarmouth Borough Council
DFG Funding:	BCF Allocation - 2017/18 £1,021,403 2018/19 £TBC

Overview:

This locality plan has been jointly developed by Great Yarmouth Borough Council, Norfolk County Council and Great Yarmouth and Waveney CCG in response to the BCF/DFG allocation for 2017/18 and 2018/19 and in accordance with the BCF guidance which states:

The Disabled Facilities Grant (DFG) will again be allocated through the Better Care Fund. Local housing authority representatives are required to be involved in developing and agreeing the plan, in order to ensure a joined-up approach to improving outcomes across health, social care and housing.

This document provides an overview of delivery up to the end of February 2017 and sets out the proposals and aims for the funding for 2018/19.

Key considerations

It is important to note the following which has been part of the conversation to develop this joint plan;

- Capital contribution by Great Yarmouth Borough Council: Should the Council require further financing to meet its statutory DFG function then approval to borrow would be sought. The Borough also provides discretionary loans as and when funds are available as a result of existing loans being repaid.
- The current funding of the Home Improvement Agency Service (Safe at Home) via the Clinical Commissioning Group: This helps to fund the caseworker role which not only supports vulnerable applicant through the DFG process but also provides Information and Advice to people who contact the HIA. It is recognised that if this was withdrawn, it would significantly impact on the capacity of the HIA to support the delivery of the outcomes associated with BCF/ DFG.
- As agreed the £36,251 underspend from 2016/17 has been rolled forward into 2017/18, helping to deliver the outcomes of this locality plan.
- Additional officers (1.86 fulltime equivalent) have been employed by Great Yarmouth Borough Council to deliver the projects set out in the plan and to help deliver similar project outcomes in Waveney for 2018/19. Capitalising revenue through the charging of fees for each job has generated insufficient income to maintain the additional officer posts and these rolls are now being supported by additional funding from Norfolk County Council, Suffolk County Council and Waveney District Council.

Expected demand and planned delivery for 2017/18:

Disabled Facilities Grant

The table below sets out the delivery associated with disabled facilities grants for 2014 to 2017

Year	Completions	Total Spend	Average Cost
2014/2015	118	£606,497	£5,139
2015/2016	118	£687,974	£5,830

2016/2017	115	£898,967	£7,817

Activity 2017/18

Type of work	No. applications received	No. applications approved	Value of approvals (£)	Value of payments made (£)	Completions	Outstanding commitment
Disabled Facilities Grant	101	100	£843,679	£888,194	117	£317,961

The 2016/17 Locality Plan set out parameters for utilising any underspend on DFG because there was a recognition that while there is significant demand for DFG it isn't always possible to covert that in a timely fashion into actual jobs.

Healthy Homes Assistance and **I'm Going Home** are two projects that have evolved out of the 2016/17 plan. These projects have used surplus BCF / DFG funding to enable people to return and / or remain at home. The projects have targeted delayed hospital discharge cases and admission prevention through A&E.

DFG Locality Plan for Great Yarmouth

Proposal 1:

Health Homes Assistance

The objective of this scheme is to ensure that any BCF surplus funding is used and targeted at specific people to either enable timely hospital discharge or provide a proactive prevention service that prevents hospital admission. This is done using grants for works up to £10,000

This surplus funding is to be used to target cohorts of people where improvements made to their home will deliver a clear benefit to their health and wellbeing and subsequently a reduction in demand for services.
The cohorts currently identified are;

- Hospital discharge cases
- Measures' to prevent hospital admission e.g. falls prevention

Works under £1,000 (Grant, not means tested)

Eligibility - Anyone identified as being in the target groups listed. Assistance restricted to three separate applications in any twelve month period.

Applicants must be referred by a health care professional using the Healthy Homes Referral Form. Social Work Duty, Out of Hospital Team, GPs, etc. – Key is that there is a health outcome.

Works over £1,000 (Grant, means tested, for works up to £10,000)

Eligibility - Anyone identified as being in the target groups listed. Assistance for works costing more than £1,000 is restricted to a single application in any twelve month period with a maximum of £10,000 in any 5 year period. However works under £1,000 can still be applied for separately. Where Healthy Homes Assistance is used in conjunction a Disabled Facilities Grant (DFG) application the maximum combined total grant available is £30,000 (less any means tested contribution).
Applicants must be referred by a health care professional using the Healthy Homes Referral Form. Social Work Duty, Out

of Hospital Team, GPs, etc. – Key is that there is a health outcome.

2017/18 Results

Progress and Delivery

A full-time technical officer and a part-time support officer were appointed at the end of November 2016 to develop and implement the locality plan. The Healthy Homes Assistance scheme was developed in conjunction with key partners in health and social care, the aims of the scheme and measures were agreed.

The officers took time to shadow key frontline staff from other organisations to learn about the issues they faced and how the Healthy Homes Assistance scheme could support their work. This informed the referral process which was developed to be quick and easy to use.

Officers attended promotional events to raise awareness of the Healthy Homes Assistance scheme and to network with other organisations, which has developed the knowledge of the officers and avoided duplication of work.

The Healthy Homes Assistance was ready to commence taking referrals on 3rd January 2017

The table below sets out the activity to date from 1st April 2017.

Type of work	No. applications received	No. applications approved	Value of approvals	Value of payments made (£)	Completions	Outstanding commitment
Healthy Homes Assistance	144	133	£134,327	£111,073	121	£26,198

Outcomes

Healthy Homes Assistance key outcome has been hospital admission prevention. To date 92% of completed cases in 2017/18 have featured work to prevent hospital admission.

Referrals for works under £1,000 are typically taking on average 21 days. The ***quickest turnaround to date has been 1 day*** and the longest 66 days. The 66 day case required the fabrication of a set of made to measure galvanised handrails.

The CCG report cost savings of £112,106 to the local NHS trusts as a direct result of the works undertaken by the project since 1st April 2017. Savings calculations for social care and the wider society are yet to be undertaken.

Client Feedback

- Mrs E no longer has painful shoulders as a result of struggling to managing her husband wheelchair over internal thresholds in the home and Mr E now feels comfortable asking his wife to help him get around the house as she is no longer in pain.
- Mrs B tells us she feels like her old self again as she feels clean because she can now bath herself safely again
- Mr M can sleep in his own bed again and is no longer at risk of falling when going upstairs

Practioner feedback

- Impressed with the speed at which the works can be delivered.

Appendix 3 – Great Yarmouth Locality Plan

Aims and objectives for 2018/19

So far Healthy Homes Assistance has made significant impact both in terms of savings through timely appropriate intervention and to the lives of people receiving the service.

The aims and objectives for 2018/19 will be around continuing the service with a view to making it both sustainable and integral to the overall wellbeing offer in Great Yarmouth

The service has attracted a lot of interest and there is a desire to expand the scheme. One of the aims is to explore linking up with GP surgeries around admission prevention and linking into the social prescribing service that is starting to be delivered in the borough.

A further aim will be to explore how this service aligns with other services and commissioning priorities locally. If the scheme is seen as being of value exploring how the money the system has to invest through the CCG and Adult Social Care can support and enhance what is being delivered.

Proposal 2:

I'm Going Home

For a very short period of time the patient is supported by a range of services working closely to ensure the patient reaches a point where they can remain at home without the further need for care and support or with a care and support package that is then charged for.
The package could comprise of:

- Yare Care Community Alarm
- Key safe
- Physical works to the patients home that facilitates hospital discharge and improved health
- Access to 24/7 monitoring for up to 6 weeks
- Wellbeing calls from the control centre
- Support from the Out of Hospital Team / swifts
- Potential to add in assistive technology

Benefit to Patients

- Patients feel more confident about leaving hospital knowing They are discharged with the knowledge that they have access to 24/7 emergency support and reassurance
- They have access to the out of hospital & swift team
- They have a health, care and support package that will enable them to get well at home.
- There's a coordinated & holistic approach to discharge, which takes into account medical need plus social needs and wellbeing.

Benefit to Organisations

- Timely and safe hospital discharge.
- Increased patient confidence on leaving hospital meaning they are less likely to be readmitted
- Cost benefits of enabling someone to return home more quickly.
- Coordinated approach to discharge – every organisation contributing to the package has full knowledge & understanding of patient requirements plus there is a shared responsibility and commitment to managing patient expectations.
- Encourages integrated working beyond health & social care

I'm Going Home started taking referrals on 1st February 2017

Appendix 3 – Great Yarmouth Locality Plan

2017/18 Results

Progress & Delivery

- 15 alarm units with roaming sim facility and temporary key safes are held by health and social care teams in a number of key locations ready for use.
- Training was provided to teams at the James Paget University Hospital and East of England Ambulance Service.
- A 24/7 referral process is in operation.

The table below sets out the activity to date from 1st April 2017.

Scheme	No. Referrals	No. Installations	Capital investment	No. calls received by the alarm centre	*No. of physical responses deployed	No. of clients taking on the paid service
I'm Going Home	68	68	£0	364	83	13

*Physical responses deployed include the out of hospital team, the swift response team and the ambulance service.

Outcomes

- ***158*** hospital bed days saved
- Equalling ***£32,655***** savings

**The savings have been calculated using local data sets agreed with the CCG.

Both client and practioner feedback has been very positive and the scheme is attracting a lot of local attention. Clients and their families have reported feeling safer leaving hospital with a temporary alarm, one daughter said ***'I would not have felt safe having dad home without the I'm Going Home package'***. Practioners involved in issuing the alarms have said '***the service is invaluable'*** and ***'it's brilliant it's made hospital discharge instantaneous'***

Aims and objectives for 2017/18 – 18/19

I'm Going Home has in 8 weeks of operation made significant impact both in terms of savings by facilitating hospital discharge and to the lives of people receiving the service.

The aims and objectives for 2017/18 and 18/19 will be around continuing the service with a view to making it sustainable and a service which is seen as integral to the overall wellbeing offer in Great Yarmouth

The service has attracted a lot of interest and there is a desire to expand the scheme. Discussions are due to take place with GP surgeries and with the voluntary sector to see how services can link more closely to improve the package of support on offer at the point of discharge and to prevent further hospital admissions.

There will be future evaluation of the scheme which will review progress and consider options for future delivery. This will be reported to partners in order to help inform the discussions on future funding beyond March 2019.

Appendix 4 – Kings Lynn and West Norfolk Locality Plan

Better Care Fund & Disabled Facilities Grant Locality Plan 2018/19	
Area covered:	**West Norfolk Borough**
DFG Funding:	**BCF Allocation - 2017/18 £1,352,170** **2018/19 £TBC**

Overview:

2016/17 allows for a budget of £1,748,225
2017/18 allows for a budget of £2,147,470
2018/19 allows for a budget of **£TBC**

This Plan shows the work that has taken place in 2017/18 and what the aims and proposals are for the next year.

Predicted spend is **- £2,050,508**

Expected demand and planned delivery for 2018/19:

Year	Completions	Total Spend	Average Cost
2015/2016 – Adaptation Works	162	£927,666	£4,614
2016/2017 – Adaptation Works Prevention Works	280 895	£1,391,701 £77,073.03	£4,970 £86.11
2017/2018 – Adaptation Works Prevention Works	367 472	£1,966,506 £52,259	£5358 £112
2018/19 – Adaptation Works Handy Person Works	TBC TBC		

Appendix 4 – Kings Lynn and West Norfolk Locality Plan

Activity in 2017/18;

- The hospital discharge pilot continues to see referrals into Care & Repair from the QEH, the Handy Person Service assisting with discharge, Lily Advisor service in the QEH on a regular basis and continued partnership working with the community and health teams.
- The number of those trained, marketing events and referrals continue to grow for Lily.
- Finalisation of the new Housing Assistance Policy is being implemented amending some grants and creating some new ones.
- Efficient and effective implementation for electronic triage, calls flow to CIC, a framework contract and further competency training during the last year. The new Assessment process is still being worked on.
- New Assistive Technology kit has been ordered and paperwork is being drawn up, there are 17 '3rings' kits available.

Proposals for 2018/19;

Hospital Discharge Pilot continuing to focus on;

- Fast track hospital discharge pilot
- Non means tested hospital discharge grant
- Handyperson to assist hospital discharge
- Ask LILY will further develop to support all adults to reduce social isolation and support health and wellbeing.
- Ask LILY will work with Community Action Norfolk to deliver social prescribing project.
- Partnership working with health and community teams

Early Intervention Initiative continuing to look at;

- Ask LILY
- Identifying cohorts of potential clients

Development of the Borough Councils Private Sector Housing Investment Policy;

- Finalisation of the new Private Sector Housing Investment Policy ready for approval and sign off
- Amending some existing grants, including;
  Discretionary ADAPT grant, provision of hardship fund, provision of loan fund, minor adaptation works grant, relocation grant and prevention grant

Progress the IHAT Continuous Improvement Plan;

- Continuing to look at productive and efficient ways to improve the service

Development of the new Assistive Technology proposal;

- 2 main areas focusing on helping people stay at home and assisting with safe discharge from hospital

Appendix 4 – Kings Lynn and West Norfolk Locality Plan

DFG Locality Plan for West Norfolk

Proposal 1:

Hospital Discharge Pilot

This objective is to establish a formalised approach with staff across Housing, Health and Social Care to join up provision of services and reach more people at an earlier point in the process of discharge from hospital or care.

Fast Track Hospital Discharge Pilot

The IHAT has worked with the local Queen Elizabeth Hospital to develop a fast track service for those clients in need of modular ramps or stair lift. This sees the development of a new referral system for this to happen through the Hospital Discharge teams sending referrals through to Care & Repair. For example when elective surgery is planned for amputees there is an automatic referral for the provision of modular ramps and / or stair lift.

Non means tested Hospital discharge grant

This has been written into the new Private Sector Housing Investment Policy to assist with a fast-track process for delivery of ramps and stair lift adaptations for hospital discharge.

Handyperson to assist Hospital discharge

This has seen one of the Borough Council's Handy Persons being able to assist the Queen Elizabeth Hospitals 'man in a van'. This has seen the Handy Person covering leave and completing environmental surveys, providing / dropping off equipment and fitting grab rails.

LILY Advisor Service

Link into hospital teams to offer assistance to patients being discharged home, offering advice and information. This has seen LILY being promoted throughout the Hospital and with relevant teams.

Partnership working with health and community teams

Identifying a streamlined pathway and referral template to enable community therapy teams to send in referrals for minor and major adaptations. To provide training workshops throughout the year to cross-train the multi-disciplinary teams in specialist areas.

2017/18 Results

Fast Track Hospital Discharge Pilot

- 22 hospital cases referred from the QEH in 2017/18 into IHAT, these are being monitored and

discussed with Lead QEH OT at regular meetings to look at the pathway and outcomes of these cases. They are a mix of bariatric, end of life, amputee and other type cases which is enabling us to look at amending the locality plan for 2018/19.

- Non means tested hospital discharge grant – this has been included within the new Housing Assistance policy going through panel and cabinet sign off currently.

Handyperson to assist hospital discharge

- This has continued throughout 2017/18 and we are monitoring the jobs specified to the HPS as a learning tool and discussing this feedback with the Lead QEH OT in regular meetings.

Ask LILY Advisor Service

- LILY Advisors in the Hospital 9 am – 5 pm, Monday to Friday
- No longer funded from February 2018 (funding now agreed)
- Awaiting outcome of Social Isolation funding bid (funding now agreed)
- Infopoint now installed at the QEH direct line to CIC LILY queue
- Marketing Assistant promoting council services once a month at the hospital

Partnership working with health and community teams

- 59 health referrals received since project initiation (7 in 2016/17 and 52 in 2017/18).
- Continued training workshops on the assessment template and process and manager meetings (health, IHAT & social care) throughout 2017/18 to discuss progress and outcomes of cases.
- The IHAT Team have tracked and evidenced the savings in time on various cases to show the benefits of this integrated process, this has been a very successful piece of work for the West in 2017/18.

All of the above will continue in 2018/19, an additional part of this proposal is the current plan to place a Housing specialist role based at the QEH (Monday to Friday) initially for a 12 month period. The role will be split between IHAT and Housing team funded by the district. This role will build on the existing work and relationships already in place but will include developing relationships within the Social Care / Social Worker team at the QEH to assist with the referral pathway and building knowledge / understanding between the two organisations.

Aims and objectives for 2018/19

- Housing specialist role based at the QEH (Monday to Friday) initially for a 12 month period.
- Continue closer working with the Community Health teams – making sure all colleagues have been trained in the IHAT process and providing on-going training. A third workshop / training session is planned for April 2018 – this will see another group of community therapists attending. Identifying other teams and organisations that this training may be relevant for and organising this in due course to make sure as many colleagues are using this referral route as possible.
- Continue to develop the work established between the Handy Person and the QEH.

- Continue the work around fast-track modular ramps and stair lift cases – make sure all colleagues are using this referral route.
- Continue the Ask LILY Advisors to be available in the hospital Monday to Friday 9 am – 5 pm to assist with advice and information.
- On-going hospital training planned for; Rapid Assessment Team, Rehab Team, West Newton Team, also considering hosting a stand and advertising LILY on the West Wing entrance.

Proposal 2:

Early Intervention Initiative

Target identified cohorts of people with advice, information and low level initiatives such as a prevention home assessment, dementia assessment, home safety assessment.

Ask LILY

Preventative service bringing together services, organisations and social activities adults. Accessed online, by telephone and via LILY Advisors at community locations or a home visit.

Identifying Cohorts

Handyperson Service – to provide a low level minor adaptations and repairs service focusing on prevention and early interventions.

Frequent callers – working with the call handling centre for the Careline alarms and local CCG to determine whether there are small cohorts of frequent callers who may need assistance from local services that may include other Assistive Technology and Care & Repair.

Care Navigators – plans are being established to develop the working relationship between the IHAT with the Care Navigators. A meeting has taken place to introduce the two teams and identify joint working between the two services.

Referral protocol – Care Navigators work in West Norfolk with patients who are high need. These are likely to be clients who need the services of IHAT / Careline / Handy Person Service. So working with this client base means we have an opportunity to speed up the IHAT process and get to people in need sooner.

Other areas of work with the Care Navigators is for them to access to health information databases used by IHAT, understanding the Care Navigators holistic assessments and training for the Care Navigators on DFG's / IHAT.

2017/18 Results

Identifying Cohorts of potential clients

The Handyperson Service has continued throughout 2017/18 to focus on providing a low level, minor adaptations / equipment prevention service. The service has delivered approximately 472

minor adaptation jobs. The new Housing Assistance policy has included a small menu of low level grants covering minor adaptations, dementia works and an emergency repair grants. We are piloting using contractors off the framework to complete minor jobs to see if this is value for money and to provide cover for sickness.

Frequent Callers

Contacting clients who have activated their alarm frequently due to anxiety, to date 114 clients have been contacted and referred to the following services:
12 x information
27 x LILY
23 x Handy Person Service
9 x Care & Repair

Future of LILY

Update on activities / work to date:
40 LILY Advisors
1902 entries on Ask LILY website plus 208 activities
676 staff and volunteers trained
50 Marketing and publicity events
417 organisations contacted
1102 community events attended
1078 onward referrals made
Additional BC funding allocated to support delivery until 31.03.2018

Aims and objectives for 2018/19

The Handy Person Service will continue in 2018/19, providing low level minor adaptations and repairs service focusing on prevention and early interventions.

To work with Community Action Norfolk to develop social prescribing.

To continue Ask LILY, expanding to 18 years.

Partnership working with Care Navigators to work closely with other organisations that provide support and co-ordinated care for over 75's in the West. To provide a stream lined process for referrals and to share relevant information about clients that may be accessing these services. To consider a hot desk arrangement within the IHAT.

LILY to increase activity in all areas, develop the service for the local area by using LILY Advisors and members of the public to shape the service into the future. Ask Lily has secured funding for the next 3 years from Norfolk County Council Combating Loneliness and Reducing Social Isolation (Western CCG area)

Appendix 4 – Kings Lynn and West Norfolk Locality Plan

Proposal 3:

PSHP (Private Sector Housing Investment Policy)

Within the IHAT team the aim is to develop and edit the current Private Sector Housing Investment Policy to make this work better and be much more accessible for the customer. Current considerations include;

Discretionary ADAPT grant

Raise limit from £6,000 to £12,000

Provision of Hardship Fund

To assist with client contributions where a client cannot raise the funds required

Provision of loan fund

To assist with cases where total costs exceed the maximum allowable £30,000 and the client cannot pay the costs above the £30,000 limit

Minor adaptation works grant

Introduce non-means tested minor adaptations grant for works under £1000

Relocation Grant

To help fund relocation costs in cases where adaptations cannot be made to the current property or moving is a more cost effective solution

Prevention Grant

To assist with the provision of minor adaptations for cases that are identified as in health need but have not yet reached care act eligibility

2017/18 Results

- Finalisation of the new 'Housing Assistance Policy' ready for approval and sign off
- Amending some existing grants, but also including; a Housing Review Panel as part of the process for complex cases, provision of a loan fund for top ups, minor adaptation works grant for works under £1000, relocation grant, prevention grant and Careline & an AT initiative.
- Policy was approved by Corporate Performance Panel 19th of February to progress to Cabinet in April.

Aims and objectives for 2018/19

- The new Housing Assistance Policy to go to Cabinet to be approved on 29th May 2018.
- Review the new Housing Assistance Policy and track a cohort of cases

Appendix 4 – Kings Lynn and West Norfolk Locality Plan

Proposal 4:

IHAT Continuous Improvement Plan

The overall goal of the Improvement Plan is to transform from a reactive to a more proactive service. In order to do this the IHAT service needs to be efficient and able to handle the demand in a timely fashion.

2017/18 Results

Continuing to look at productive and efficient ways to working to improve the service:-

- Electronic triage process has been implemented and streamlines the initial contact and triage of the enquiry / person.
- Calls transfer to CIC for both C & R and Careline – implemented and has created a smooth pathway for new enquiries allowing access to all services – LILY, Careline and IHAT / HPS.
- A Framework contract has been in place since April 2017, 20 contractors in total and a Schedule of Rates. We have included a technical survey within the SOR to utilise contractor skills / time instead of a Technical Officer – this helps manage demand and free the TO's up for more complex feasibilities.
- Competency training has covered stair lift assessments within the Client Officer and AP team and is including some access / ramp cases with guidance from the IHAT OT. A peer group meeting takes place each week with the IHAT OT for CO's / AP to have cases signed off. Handypersons also present cases to the Assessment team.
- The waiting list in West remains above 100 due to demand as the team itself has been constant but demand continues to rise. There has been a private OT join the team for a number of months in 2017/18 to help reduce the waiting list.
- Data / case reports for all client officers, AP and TO's have been created to allow for closer case management, The IHAT Co-ordinator will be building in the 7 stages targets into the reports to allow for early identification of a stage going over target and for officers to respond.
- New Assessment Process (using the district systems only and minimal input into Liquid Logic) – this is currently being worked on in some areas and will be implemented fully into 2018/19 once signed off by County managers. There will be an IHAT Peer group workshop across the County to implement the process.

Aims and objectives for 2018/19

- Implement New Assessment Process
- Continue seeking improvements with the goal being to reduce the average time taken to provide an adaptation (enquiry to completion of works) from 240 calendar days to 140 calendar days.
- Continued aim to reduce the waiting list to 56.

- Further developing competency training – ramps.
- Continued competency training including access – ramps and modular ramps.
- Look at the opportunities of mobile working for both the Client Officers and Technical Officers.

Proposal 5:
Assistive Technology (new proposal)

2017/18 –

- Working with NCC
- Joint recruitment explored, but not progressed.
- Last meeting with AT service manager on 09.01.2018, advised a further review of the AT team taking place.
- Offered "a desk" at Kings Court, still looking into training to reduce the number of visits required, but NCC not able to progress at the moment.
- Limited AT training available, awaiting the launch of the Telecare Service Association training portal.

Hospital –

- £100,000 allocated by BC.
- 1 x Additional Careline Officer recruited.
- A number of equipment demonstrations have taken place.
- Have met with Lead OT and RAT team twice and agreed that '3rings' and 'Pebbell' equipment will support HD.
- Ordered equipment, currently drawing up paperwork. 17 full '3rings' kits available, grant funded for 12 weeks.
- Starting with RAT team – likely to install 5 initially.
- '3rings' monitored by the clients relatives.
- Working on Pebbell / PNC compatibility so hope to monitor via Herefordshire Housing call centre.

Assistive Technology – (help people stay safely at home) – develop project to focus on key areas in partnership with Locality Social Care team.
Careline Community Service are working with the Norfolk County Council Assistive Technology team to look at;

- Training and development opportunities for Careline Officers.
- Completing straightforward AT installations (if possible, considering N-able in West Norfolk).
- AT assessors to carry community alarms for installation in West Norfolk / North Norfolk when required by a client.
- AT assessors to work from Kings Court with the Careline Community Service team.
- To work with NCC / CCG colleagues to identify cohorts of clients to enable AT to form part of early prevention initiatives to improve home safety.
- Research new technologies and develop a proposal around assistive technology which can support clients with long term medical conditions, reducing the requirement for GP / Hospital visits.

Appendix 4 – Kings Lynn and West Norfolk Locality Plan

Assistive Technology – to assist with safe discharge from hospital – pilot project to focus on AT to help with safe discharge form hospital.

- To identify cohorts of patients who would benefit from a community alarm / assistive technology at the point of discharge and imbed in the discharge process, enabled by amendments to the PSHP.
- To consider whether hospital volunteers can be trained in the installation of community alarms.
- Research new technologies and develop a proposal around the piloting of new technologies including telehealth and telecare, aiming to reduce the number of re-admissions within 90 days.

Aims and objectives for 2018/19

- AT Hospital Pilot.
- Complete TSA training to help develop joint working with NCC.
- As Above - Continue to develop the project and track progress

Appendix 5 – North Norfolk Locality Plan

Area covered:	North Norfolk District Council
DFG Funding:	BCF Allocation - 2017/18 £1,030,087 2018/19 £TBC
Expected demand for DFGs in 2018/19 and planned delivery:	
Circa 150 grants at an average of £7,000	

In the following table, please include your proposal with innovative ideas and practice to support people to live independently at home.

Whilst putting together your proposal(s) please consider:

- the wider contribution of Districts
- how activity can contribute towards reduction in admissions to acute and care homes and support hospital discharge

Proposal 1 – Delivery of Disabled Facilities Grant
Describe proposal in this box. Include: • The objective of the scheme: To deliver adaptations as per the Council's statutory duty, employing best practice and innovation wherever possible. • Some background (if relevant) on what has happened before The delivery of adaptations has been evolving since the implementation of the North Norfolk IHAT in November 2012 and will continue to evolve in line with the proposals made by the IHAT Managers Group and IHAT Strategy Group • An overview of the scheme and activity that would take place It is expected that following the changes made within the North Norfolk IHAT (implementation of the Preventative Assessment, roll out of training for Community OTs to make direct recommendations, charging for technical and professional support, capitalisation of maintenance/extended warranties for equipment and closer working with the Early Help Hub and referral from the new social prescribing and loneliness and isolation services) will result in the full budget being spent. The Council continues to look at how it can reduce the length of time taken to deliver adaptations in line with the Government's request and will be working towards delivering adaptations in 140 days in line with the achievement of authorities in Warwickshire which employ a similar model to the IHAT.
Rationale/Evidence base
Detail your rationale/ evidence base here

Appendix 5 – North Norfolk Locality Plan

The Council has a statutory duty to deliver adaptations through Disabled Facilities Grant and the Government has requested that local housing authorities do everything they can to reduce the length of time taken to deliver adaptations and has increased the DFG allocation to enable this to happen.

Outcomes

Use this space to detail your expected outcomes

- Reduced emergency admissions in particular resulting from falls (steps and stairs, getting in and out of the bath)
- prevention offer
- Potential for a reduction in carer breakdown
- Improved customer journey/satisfaction.
- Potential for reduction in delayed transfers of care
- Improved health and wellbeing
- Increased independence and ability to access community facilities

Proposal 2 – Targeted approaches: GP Clusters and MDTs

Describe proposal in this box.

Include:

- The objective of the scheme:

  Determine whether those most at risk of hospital admission have been assessed for a housing adaptation as part of the prevention offer.
- Some background (if relevant) on what has happened before.

  Currently a referral for housing adaptations is an open process and is dependent on a request for an assessment for an adaptation being made. This approach ensures that a targeted response is considered to those most at risk of hospital admission thus furthering the preventative approach taken to this cohort of people.
- An overview of the scheme and activity that would take place

  Multi-Disciplinary Team working is in place for the top 2% of people identified most at risk of hospital admission. The proposal is to pilot within 2 GP practices (one in the East and one in the West of the district) a desk top review of this cohort interrogating IT systems (CareFirst/LAS and M3) to identify which have and which have not had an adaptation intervention and to consider whether an adaptation intervention or further assessment/review of the adaptation would assist in helping to manage health conditions to increase independence and reduce/delay potential hospital admission/residential care placement.

  Next steps are dependent on the output from the pilot(s). If this approach evidences that looking at a population group in this way further increases their independence (if not already had a housing adaptation assessment) then be rolled out across all GP surgeries and form part

of the MDT process.

Rationale/Evidence base

Detail your rationale/ evidence base here

Developing integrated approaches to ensuring services are identifying and wrapping provision around those who are most at risk of hospital admission.

Outcomes

Use this space to detail your expected outcomes

- Reduced emergency admissions within targeted cohort of people
- Dedicated prevention offer available to those most at risk.
- Potential for a reduction in carer breakdown
- Increased patient experience.
- Potential for reduction in delayed transfers of care

Proposal 3 – Targeted approaches: More than 2 adaptations

Describe proposal in this box.

Include:

- The objective of the scheme

Determine whether those who have been referred for 2 housing adaptation or more are known to MDTs – to avoid hospital admission. It is likely that this cohort would be known to teams but it would be advantageous to be assured as this might indicate those that should be part of an MDT.

- An overview of the scheme and activity that would take place.

This project would help inform those people who may be in need of an MDT approach, if not already identified. This may be a way of ensuring those needs who may increase from a health and social care perspective are targeted as a priority and enabled to maintain their independence via an MDT approach

Rationale/Evidence base

Detail your rationale/ evidence base here

Developing integrated approaches to ensuring services are identifying and wrapping provision around those who are most at risk of hospital admission

Outcomes

Use this space to detail your expected outcomes

- Reduced emergency admissions within targeted cohort of people
- Dedicated prevention offer available to those most at risk.

- Potential for a reduction in carer breakdown
- Increased patient experience.

Proposal 4 – Implement proposals that have already been tested with good outcomes

Describe proposal in this box.

Include:

- The objective of the scheme

Implement the roll out of use of the preventative assessment by trusted assessors. This is a county-wide initiative.
Some background (if relevant) on what has happened

- Before referrals for assessment would be received from Health OTs and the assessment undertaken by a Social Services OT/AP. This initiative negates the needs for a further assessment and uses the information gathered by Health OTs as trusted assessors thus speeding up the process, improving the customer journey and increasing capacity in the system An overview of the scheme and activity that would take place

It is estimated that this initiative will assist in moving closer to the 140 day target for provision of adaptations through DFG

Rationale/Evidence base

Detail your rationale/ evidence base here

The assessment process is impacting on the ability to progress with adaptations at pace.

Outcomes

- Reduced emergency admissions within targeted cohort of people
- Dedicated prevention offer available to those most at risk.
- Potential for a reduction in carer breakdown
- Increased service user experience.

Appendix 5 – North Norfolk Locality Plan

Proposal 5 – Options for use of any underspend

Describe proposal in this box.

Include:

- An overview of the scheme and activity that would take place

The DFG budget for North Norfolk was underspent in 2016/17 and there is potential for the budget to be underspent in 2018/19 if the number of recommendations is not generated to deliver the estimated number of completed DFGs. The Council would like to work with partners to utilise any potential underspend on capital schemes that will reduce the need for adaptations and support residents to live independently in the community and would like consideration to be given to the following;

- Improving dementia provision at Housing with Care schemes
- Subsidising the cost of new supported housing schemes (where required)
- Subsidising the cost of new build wheelchair accessible properties
- Funding the adaptation of properties within the current social housing stock that lend themselves to adaptation and which are not currently tenanted in order to meet the needs of those whose current property cannot be adapted (mainly households with children)
- Purchasing properties on the open market to meet the needs of households who needs are not currently being met and form whom there are no other solutions to meeting their needs

Rationale/Evidence base

Detail your rationale/ evidence base here

Utilisation of all available capital funds to meet shared strategic priorities

Outcomes

Use this space to detail your expected outcomes

- Dedicated prevention offer available to those most at risk.
- Increased service experience
- Reduction in delayed transfers of care
- Specific support available within the local community

Appendix 6 – Norwich Locality Plan

Better Care Fund & Disabled Facilities Grant Locality Plan 2018/19	
Area covered:	**Norwich City Council**
DFG Funding:	**BCF Allocation - 2017/18 £969,369** **2018/19 £TBC**

Overview

1. Within Norwich, the HIA/District Authority has is delivering the 2017/18 BCF DFG plan with a budget £969,369. This plan shows what the aims and proposals are for the next year.

Planned activity for 2018/19

2. Through the BCF, our Home Improvement Team will continue to deliver DFGs, discretionary DFG top up grants, and financial assistance for home improvement to vulnerable home owners on the following basis:
    a. DFGs of up to £30,000 for appropriate and necessary adaptations which are reasonable and practicable
    b. DFG discretionary top up of up to £35,000 for cases where major adaptations or relocations are required, and it is not possible to provide a cost-effective solution in the existing home of the client with a mandatory disabled facility grant
    c. Financial assistance of up to £35,000 for vulnerable people who own their own home outright or who have a mortgage, but cannot afford to pay for essential repairs. This is means tested, and is linked financial ability to pay for works, and the amount of equity in the home.
    d. Safe at home grants of up to £2,500 to provide dementia specific adaptations, emergency repairs or investigative works where disabled facilities grants are not suitable.

3. We will also deliver the following three proposals; two continue to be developed and one is a new proposal:
    a. Hospital discharge scheme – continued activity
    b. Adaptations assistance project – continued activity
    c. Preventing admission to hospitals – new activity

4. All the work of the Home improvement team supports people to live independently at home and provide health and wellbeing in the community. They provide a client-centred approach ranging from prevention and promotion of health and wellbeing to specific targeted interventions for people, for example, those living with dementia. It is expected that the proposals will maximise the potential for the physical environment to support vulnerable and disabled people, through access to adaptations and a range of housing options as well as ancillary services. The proposals will also contribute to the metrics of the better care fund:
    a. Non-elective admissions
    b. Admissions to residential care homes
    c. Effectiveness of reablement
    d. Delayed transfers of care

5. Compared to the total annual NHS budget, the cost savings to health and social care provided by the individual locality proposals are marginal. However, when considered in conjunction with our wider activities and interventions in regard to prevention and promoting independence (see Appendix 1), much can be achieved, particularly in terms of prevention and cost savings, from the cumulative effect of marginal gains.

Appendix 6 – Norwich Locality Plan

Proposal 1: Hospital discharge scheme & grant

6. Our hospital discharge scheme formed part of our previous set of plans and has been well received to date. In October 2016, we introduced a hospital discharge grant (non-means tested) of up to £10,000 to enable inpatients to access support and funding to tackle disrepair and adaptations in a timely manner. For straightforward adaptations and repairs, we aim to respond to the hospital discharge team by 3pm on the day of referral. Where more complex works are required, one of our case workers will visit the client in hospital to arrange access to the property and for works to be completed. We aim to complete these works in around 28 calendar days, compared with 144 calendar days for non-inpatient home improvement team referrals.

7. We carry out a follow up with clients three months after works are completed. This includes a customer satisfaction questionnaire and a follow up call, providing us with the ability to measure the value of the work carried out in terms of the client's health and well-being. Where key safes are fitted, a follow up call will be made a week after the works are complete to identify whether there are any other needs or services that we can help with, for example, income maximisation, handyperson service, living in fuel poverty, and onward referrals to other support agencies.

8. Over the course of these set of plans, evidence will be gathered to demonstrate a reduction in delayed transfer of care cases linked to housing related issues, and the cost savings to health and social care as a result of our interventions.

Aims and objectives for 2018/19

9. Further work is required to ensure that clinicians are aware of what activities local authorities' can provide to aid a timely discharge and that they are utilised in all cases where appropriate. In addition, it has been recognised that as local authorities, we need to work collaboratively to offer a single point of referral for health professionals to refer to for all local authority housing and home improvement related services.

10. A small task and finish group has been formed, made up of staff from districts across the county and the Norfolk and Norwich University Hospital (NNUH), to review the hospital discharge process, including the existing hospital discharge and homelessness prevention protocol[1]. The process will include discharge from all the hospitals in Norwich (NNUH, NCH&C , CCSRS and Hellesdon). There are a number of actions that will be carried out as part of this process which will enable a lean and efficient service to be delivered.

11. The first task is to produce a short list of simple questions that a patient can answer on admission that will highlight the need for any housing issues and wider needs to be addressed outside of the clinical setting. Draft questions will be based on the following:
    a. Where do you live when you're not in hospital?
    b. Do you own your home, or who do you pay your rent to?
    c. Do you find it difficult getting into and around your house, in/out of the bath, or up and down the stairs?
    d. Do you find it hard to carry out small repairs and odd jobs around the home and garden?
    e. Do you have contact with one or more people on a frequent basis?
    f. Do you often feel cold in your own home?

[1] Following the death of a homeless patient on the streets of Norwich some three years ago, the uncoordinated hospital discharge practice was highlighted by the Coroner's Office which led to the development of the NNUH hospital discharge and homeless prevention protocol.

g. Do you feel unable to pay your gas and electricity bill?

12. Unsafe housing can often be the reason why people are admitted into hospital in the first place, particularly through cold and trip hazards. These dangers have been estimated to cost the NHS over £600m every year in England[2]. By carrying out this '60 second' home health check, we can identify people to help and target BCF to make adaptations and improvements to their properties.

13. Further areas to focus on as part of the hospital discharge scheme include work with:
    a. the hospital discharge team to pilot a housing representative to be co-located in the discharge hub at the NNUH to support the ward co-ordinators in identifying at the earliest opportunity patients who will require district services to enable a timely discharge
    b. the network used for hospital discharge services in the community (including the Red Cross and Settle In service) to ensure that they are aware of the support and interventions available through the local housing authorities
    c. the hospital discharge team and public health to review the discharge data and identify pinch points on the process
    d. the homeless/housing outreach project based out of City Reach
    e. the East Anglian Ambulance Service to ensure that they are aware of the support and interventions available through the local housing authorities and identify the need for works to the property
    f. the pre-elective admissions team to produce a pathway where housing need can be identified before a patient is admitted creating a streamlined patient pathway.
    g. the wider partners including adult social care, CCGs and the community and voluntary sector to explore avenues of engagement (this links with our Community Pharmacy/Safe at Home proposal detailed further on in the plans).

Proposal 2: Adaptations assistance project

14. Applicants for disabled facilities grants are required to undertake a statutory means-test which determines what their contribution towards the works should be. This calculates a nominal loan value that the applicant could afford to support. The reality, however, is that many clients with small contributions have insufficient savings or the spare income to support a loan and this is reflected in a drop-out rate from applicants in that category which is has grown to around 25% (or approximately 40 cases a year at current demand levels).

15. The current mandatory means test is complex and tends to penalise those with housing costs that are higher than the standard amount specified or where the standard allowances for overall living costs are too low. It therefore works against the government's intentions to increase preventative spending on disabled adaptations. This means that a significant number of disabled residents in Norwich are not receiving appropriate and necessary adaptations which will enable them to live safely and independently in their homes despite government funding being made available for this purpose.

16. In order to ensure that applicants do not withdraw and that full use is made of the better care fund, we have recently introduced an adaptations assistance grant of up to £5,000 toward the contribution required by the means-test. The council can limit the risk of overspending the better care fund allocation by making the offer of the top-up grant dependent on available funds. If demand increases to a point where there is insufficient available capital to offer a top-up then the client would be offered a choice of proceeding with a disabled facilities grant only (including any contribution) or waiting for funding to become available. The council would not, therefore, be in breach of its statutory duty to approve a disabled facility grant to an eligible applicant. The offer of adaptations assistance grants would be suspended at the point at which the predicted year-end

[2] *https://www.hsj.co.uk/*

expenditure reached 90% of the available capital budget.

17. Applications for disabled facility grants cannot be placed on a waiting list due to the requirement to determine them within a six month period. However, there is the ability under the governing legislation to delay payment for up to six months to enable budgets to be managed across financial years. That mechanism, combined with the proposed suspension point should enable the capital funding to be kept within budget.

18. National research[3] has shown that people, who have an adaptation in their home and later move into care, do so some four years later than those who have not had adaptions carried out. With a residential care plan costing around £27,000 per year compared to the average disabled facilities grant costing less than £6,000, adaptations can have a major impact for social care budgets.

19. Since the introduction of the grant towards the end of January 2017 we have been able to process 12 additional referrals, subsequently helping those people who would ordinarily not have received the necessary adaptations to enable them to live safely and independently in their homes.

Aims and objectives for 2018/19

20. Although a formal evaluation will not be done until the end of year, initial evaluation of this scheme suggests that it is a success.

21. At the time of writing this report 35 families had accessed the assistance. It has not had a significant effect on the allocated budget but has resulted in adaptations going ahead when otherwise they may not have.

Proposal 3: Preventing Admission to Hospital Grant

22. Our hospital discharge scheme is limited to being reactive work dealing with issues as and when they arise. Using the extra £100k allocated to the city council from central government in January 2018, the city council implemented a preventing admission to hospital grant.

23. This grant is in effect a mirror of the Hospital Discharge Grant but with the purpose of avoiding unnecessary admittance to hospital caused by unsafe or unsuitable housing related issues.

24. The grant is a £10k non means tested grant with the only qualifying criteria being a referral from either the Norwich Escalation Avoidance team (NEAT) or the councils own environmental strategy team, through their cosy city initiative(who have been working to identify vulnerable people whose health is at risk due to poor heating and insulation).

Aims and objectives for 2018/19

25. It is our intention to continue to offer this type of financial assistance for the duration of this set of plans to enable us to make full use of the better care funding. An evaluation of the project will take place towards the end of 2018/19 to assess its success and the value of offering such assistance.

26. Further work is needed to build on our relationship with NEAT, which will be achieved by attending their weekly multi-disciplinary team meetings where prevention cases will be discussed and solutions identified.

[3] Linking Disabled Facilities Grants to Social Care Data, Foundations 2015

Appendix 6 – Norwich Locality Plan

27. The home improvement team will carry out a follow up with clients three months after works are completed. This will include a customer satisfaction questionnaire and if necessary a follow up call, providing us with the ability to measure the value of the work carried out in terms of the client's health and well-being.

Appendix 7 – South Norfolk Locality Plan

South Norfolk CCG Better Care Fund Locality Plan 2018/19 South Norfolk Council	
Area covered:	**The South Norfolk Council administrative area of the South Norfolk CCG**
DFG Funding:	**BCF Allocation - 2017/18 £780,666** **2018/19 £TBC**

Overview:

South Norfolk Council believe that a housing authority has much to offer health and social care. To us, housing is simple. A suitable, stable and secure home in the community supports people in being healthier and happier – which is the most important thing to everyone. But also, by embedding housing in the integration agenda we can be instrumental in helping health and social care reduce their costs.

The right home environment can protect and improve health and wellbeing and prevent physical and mental ill-health; it can enable people to manage their health and care needs, including long-term conditions, and ensure positive care experiences by integrating services in the home; it can allow people to remain in their own home for if they choose.

The right home environment is proven to delay and reduce the need for primary care and social care interventions, including admission to long-term care settings; prevent hospital admissions; enable timely discharge from hospital and prevent re-admissions to hospital and enable rapid recovery from periods of ill-health or planned admissions

Our approach to the home environment has been prepared in consultation with Norfolk Public Health, the South Norfolk Clinical Commissioning Group and the Norfolk Health and Wellbeing Board and is set out in the South Norfolk "Prevention and Promoting Independence" document. The activities described below comprise our main contributions to the Norfolk Better Care Fund Plan for 18/19 and 19/20.

Progress and performance will be reported to the South Norfolk Early Help Strategic Board.

Delivery for 2018/19

Proposed Activity in 2018/19

1. **Living Independently at home** – our aim is to reduce the average time taken from enquiry to completion to the Norfolk agreed target of 140 days. We will implement the improvements identified in our review of the system to ensure an effective delivery chain.

2. **Hospital Discharge (District Direct)** – in partnership with the Norfolk and Norwich University Hospital we will develop and embed the District Direct model to ensure barriers to discharge are identified at the earliest opportunity and a housing pathway agreed that ensures patients can return home at an appropriate time and are not put at risk by being discharged inappropriately.

3. **Care & Repair Service (Home Improvement Agency)** – we will continue to commission a home improvement agency to support vulnerable people to remain in their homes.

4. **District Direct Grants** – administered by the Care & Repair Service to support hospital discharge

5. **Handyperson Scheme** – we will continue to commission a Handyperson to support vulnerable people to remain in their homes.

6. **Social Prescribing** – we will pilot Social Prescribing services in GP practices to provide social and community based alternative for people presenting at the surgeries with non-medical issues

Activity 1 – Living Independently at Home (18/19)

Housing Adaptations – South Norfolk is committed to the Norfolk objective of reducing the average time for completion of non-priority case adaptations from 243 days to140 days and 55 days for priority cases.

Health Occupational Therapists (OT's) based in Community teams will undertake Disabled Facility Grant assessments, removing the need for two assessments.

Assistant Practitioners (AP's) and Home Improvement Agency Case Officers accredited to undertake stair lift assessments, releasing more time for OT's to deal with complex cases

Minor adaptations, repairs and home safety checks will be delivered through a Council managed Handyperson Service. Grants and discounts will be available to eligible residents.

Private sector housing residents will be assisted through the adaptation process

Poor housing, unsuitable housing and precarious housing circumstances affect our physical and mental health. The health of older people, children, disabled people and people with long-term illnesses is at greater risk from poor housing conditions. The home is a driver of health inequalities, and those living in poverty are more likely to live in poorer housing, precarious housing circumstances or lack accommodation altogether.

Activity 2 - Hospital Discharge

District Direct supports patients and hospital staff to identify and overcome barriers to discharge via a dedicated district resource within the integrated hospital discharge hub. The aim is to support residents to return home in a timely manner from hospital to an environment that meets their needs with the necessary support in place.
District Direct pilot includes:
• A dedicated District Direct officer based within the integrated hospital discharge hub
• Support to DISCOs to identify at an early stage patient vulnerable to delayed discharge,

developing and promoting the referral process and gaining patient consent
• Assessment and action plan to remove the barriers preventing patients from returning home
• Patient follow up to support sustainable independent living at home
We have raised concerns over the current allocation of places in Housing with Care schemes where high void levels have result in lost rent to landlords and underutilised care provision. Whilst a review of the schemes is being undertaken we are exploring interim alternative use of the accommodation including use as discharge beds.

Focus will be placed on identifying housing need at the earliest stage of the patient pathway including working through GP Practices to support patients assessed as needing elective medical interventions.

The protocol will be applicable to all the hospitals in Norwich (NNUH, NCH&C and CCSRS).

Future development

2.0/3.0 FTE employed by South Norfolk Council to be based within the NNUH Integrated Discharge Hub
Development of District Direct referral routes from A&E department
Support the hospital campaign to transfer people from being bed-based to day room facilities
Share best practice within mental health and community hospitals
Roll out to James Paget and Queen Elizabeth hospital

Activity 3 – South Norfolk Care & Repair Service (18/19 budget £tbc**)**

South Norfolk Care and Repair assists older, disabled and vulnerable people to live a good life for longer, offering reliable information and advice and supporting them to make modifications to their homes as their health and needs change, especially through later years. This model of providing low level early support has been consistently recommended by the DCLG and more recently in the Better Care Fund guidance from the DoH.

South Norfolk Council recognises the value of this service and despite Adult Social Care withdrawing support will continue to provide the service, prioritising vulnerable people in the private housing sector.

Activity 4 – District Direct Grants (18/19 £tbc)

The District Direct Hospital Discharge Grant (Appendix One) is intended to assist our residents who are able to return home from hospital, but are being prevented from doing so because there are factors at their home (that can be speedily remedied), that prevent them from doing so. Enabling that speedy discharge enables the hospitals to make better use of their resources, freeing up expensive bed space and increasing health service capacity and resilience. More importantly for some of our

residents, the speedy move back to their own homes improves their chances of recovery and lessens the likelihood of readmission and loss of life expectancy.
This grant is intended to compliment and not replace other support and assistance that may be available, either from the Council or other agencies.
It differs from the Disabled Facility Grant as it is addressing the immediate need which may be short term/temporary in nature, for example a resident returning home to recuperate. However, it could also be used to compliment a DFG by enabling a person with longer term needs to be able to return home with a support/care package whilst their longer-term needs could be addressed with a DFG, are fully assessed and understood.
We have set the maximum grant at £3000 to enable us to fund items that have been suggested by other agencies, however the experience from other parts of the country where such assistance is being provided indicates the average grant to be less than £500. With the most common works being installation of key-safes to allow carer access, and temporary ramping to doors to enable wheelchair access. This type of work could normally be undertaken by our Handyperson Service.
The type of work that could be funded has been included for example purposes not intended to be a definitive list. We have focussed on the intended outcome of the grant and the grant parameters in order to enable flexible responses and solutions to what will be invariably individual circumstances.

Activity 5 - Handyperson Scheme (18/19 £tbc)

South Norfolk has delivered a handyperson service since 2004. The scheme is designed to deliver small repairs and 'odd jobs' around the home to people who may find it difficult to carry out these jobs for themselves.

The scheme addresses property maintenance, minor adaptations, home-security, home safety and falls prevention all at the same time, as well as engaging with older people who are not currently in receipt of services, or who are suffering isolation. This is in line with the government's vision for efficient, holistic handyperson services. Unsafe housing can often be the reason why people are admitted into hospital in the first place, particularly through cold and trip hazards.

Referrals are received from partner agencies to for fitting key safes, grab rails etc to enable provision of care.

Activity 6 - Social Prescribing (18/19 £tbc)

Social prescribing aims to help people address underlying issues early - rather than using clinical or medical services unnecessarily. Social prescribing and building community capacity forms a central part of the Norfolk NHS Sustainability and Transformation Plan (STP) to address demand on health services.

South Norfolk Council employed Community Connectors are being embedded in South Norfolk's 13 GP practices (covering 18 sites) utilising district council, community and partners'

infrastructure and resources. Relationships are in place with practices to enable fast mobilisation. Early estimates indicate that the district wide provision could deliver £950k of savings to the health sector over 2 years.
Activity 7 – Triage team (18/19 £tbc)
Dedicated triage team within the early help hub to triage all independent living enquiries – identifying those residents who would benefit from smaller adaptations delivered through the handyperson or community support; completing ASC triage assessment for residents identified as benefiting from a Disabled Facilities Grant.

Appendix 1, Annex B

High Impact Change Model Mileston

Change descriptor **e Plan**		**Norfok wide**	**Key dates**
Early Discharge Planning. In elective care, planning should begin before admission. In emergency/unscheduled care, robust systems need to be in place to develop plans for management and discharge, and to allow an expected dates of discharge to be set within 48 hours.	**Current Position**	All 3 acutes have a planned approach in place, but have identifed areas for improvement. Some will be at a local system level, others at County / whole system level	April 2017
	Planned Activity	Increased focus on supporting the red to green approach and board and ward round attendance. (Local) Increased focus use of ICCs & MDTMs in GP surgeries.(Local) Plan to be developed to improve discharge date planning across the system including community hospitals.(System wide) Appointment of a Capacity Manager post to understand, monitor and facilitate capacity across the system (System wide)	Work commenced July 17 Systemwide plan to be approved October 17 By October 17
Systems to Monitor Patient Flow. Robust Patient flow models for health and social care, including electronic patient flow systems, enable teams to identify and manage problems (for example, if capacity is not available to meet demand), and to plan services around the individual.	**Current Position**	Silver systems in place at two acutes NNUH & QEH, with dashbords and information monitored daily. JPH takes Red & Green bed day approach.	April 2017
	Planned Activity	JPH A&E delivery board to review plans linking with NNUH and QEH. (Systemwide) Consider introduction of electronic patient flow systems (Local / Systemwide)	A&E Joint Delivery Board to have approved plan by Oct 17
Multi-disciplinary/Multi-Agency Discharge Teams, including the Voluntary and Community Sector. Co-ordinated discharge planning based on joint assessment processes and protocols, and on shared and agreed responsibilities, promotes effective discharge and good outcomes for patients	**Current Position**	Across the system plans are established to mature, with daily MTD meetings taking place. Involvemnt of voluntary sector and housing varies across the system. In NNUH; D2A in place with care providers, ASC and community health provider. CHC assessments increasingly undertaken outside hospital (D2A).	April 2017
	Planned Activity	Review involvement of voluntary sector and housing. (Local) Expand Social prescribing wider than GPs (Systemwide)	Plans shared with stakeholders Sept 17
Home First/Discharge to Assess. Providing short-term care and reablement in people's homes or using 'stepdown' beds to bridge the gap between hospital and home means that people no longer need wait unnecessarily for assessments in hospital. In turn, this reduces delayed discharges and improves patient flow.	**Current Position**	Due to the varience in DTOC figures acrsoss the whole system each acute has a slightly different current model and future plan. Development of Intermediate Care Strategy Discharge to asses review undertaken with Emergency Care Improvement Programme (ECIP)	April 2017 June 2017 July 17
	Planned Activity	**Discharge to assess** Proposals to joint A & E Board for a programme of work to support Pathway 1 (System wide). Existing Pathway 3 work in East & Central being evaluated with support from Healthwatch to inform future investemnt in posts to support D2A (System wide) **Home First** Commissioning to support increased capacity and improve sustainability in the Home Care Sector (system wide) Crisis Homecare – To include; Home support wrap around service, Enhanced flexible dementia offer. (systemwide) Micro Commissioning to support Homecare (local) Bed Based Reablement – Delivery models being developed (system wide)	August 2017 September 2017 October 2017

Seven-Day Service. Successful, joint 24/7 working improves the flow of people through the system and across the interface between health and social care, and means that services are more responsive to people's needs	**Current Position**	Plans are in place system wide for social care services, including availability of Care Arranging Services at weekends. Local schemes are in place such as Healthy Homes Project and Hospital Care at Home	April 2017
	Planned Activity	Further work is required at both system wide and local level to: Define the core level of services that are required at weekends. Clarify 7 day service not 7 day working. What this means for health services?	Ongoing
Trusted Assessor. Using trusted assessors to carry out a holistic assessment of need avoids duplication and speeds up response times so that people can be discharged in a safe and timely way	**Current Position**	No consistent system wide approach in place, some local examples of Trusted Assesor models at QEH	
	Planned Activity	**Systemwide model** Research of Trusted Assessor Models undertaken. Planning commenced at Health & Social Care Consultative Forum. Data analysis to inform demand. Meetings with all 3 Acutes. Meetings with representatives of the provider market to support co production. Link with Enhanced Health in Care Homes Project.	July 2017 August 2017 September 2017
Focus on Choice. Early engagement with patients, families and carers is vital. A robust protocol, underpinned by a fair and transparent escalation process, is essential so that people can consider their options, the voluntary sector can be a real help to patients in considering their choices and reaching decisions about their future care.	**Current Position**	Local arrangemnts in place including contracts with CHS Healthcare working within a Trust to expedite a range of patients – predominantly family choice / self-funders.	
	Planned Activity	Each acute is looking at their current system with a focus on how Discharge Coordinators link with Integrated Care Coordinators / GP surgeries / Local voluntary organisations. (Local)	Ongoing
Enhancing Health in Care Homes. Offering people joined-up, co-ordinated health and care services, for example by aligning community nurse teams and GP practices with care homes, can help reduce unnecessary admissions to hospital as well as improve hospital discharge.	**Current Position**	Well established project with a clear forward looking plan.	April 2017
	Planned Activity	Development of a robust care homes dashboard. Workforce development. Develop and introduce a falls prevention tool for care homes. Improve the pathway between hospital and care homes. Introduce a communication tool to support decision to support decision making by care home staff. Target support at care homes making most use of 999.	30th June 2017 30th Sept 2017 30th November 2017 31st December 2017 31st March 2018

Improved Better Care Fund (iBCF) - Summary table and February Update

Planning priority	Grant Condition	Description	2017/18 £m	2018/19 £m	2019/20 £m	Impact	Activity and progress
Protect	Meeting Social Care Needs	**iBCF1** Funding required to manage shortfall in recurrent pressures and protect social care services	1.9	11.9	22.2	Over the three-year period this funding will ensure that vital service provision such as homecare is maintained and people are supported to maintain their independence and stay out of hospital.	Funding is part of budget planning for adult social care as a whole - over 80% of spend is with the market.
Sustain	Reduce pressure on the NHS and stabilise Social Care provider market	**iBCF2** Support the care market and develop resilience against the impact of specific recurrent market pressures	9.1	10.8	10.8	Recent legislation on National Minimum Wage and the cost of care presents additional pressures to the care sector that require supporting if provision is to remain sustainable. Market failure presents a risk to individuals but also the system overall funding here will support integrity of the care market.	This is about sustaining the Market. In line with cost of care, legislation and market pressures – the aim is to develop a sustainable approach. Funding is targeted on specific needs such as legislative change, but some funding will be carried forward to 2018-19 where this enables funding to be targeted in a more sustainable way.
Sustain	Meeting Social Care Needs	**iBCF3** Managing recurrent capacity with Deprivation of Liberty cases (DOLs) when alternative funding finishes	0	0.2	0.2		To support delivery of this service from 2018-19 when current funding will no longer be available.
Sustain	Reduce pressure on the NHS and meet social care need	**iBCF4** Managing capacity – strengthen social work to assist people at discharge and to prevent admissions	2.6	2.5	0.0	Social work is core to ensuring people's needs are met quickly and effectively. Supporting capacity of social work will strengthen the prevention offer, ensure people receive support that meets their needs and is fundamental to ensuring that people are able to leave formal care	As part of enhancing our capacity a recruitment campaign for 50 practitioners and 15 team managers is fully underway.

Improved Better Care Fund (iBCF) - Summary table and February Update

Planning priority	Grant Condition	Description	2017/18 £m	2018/19 £m	2019/20 £m	Impact	Activity and progress
						settings as soon as they are medically fit. Resources here will enable services to be flexed according to pressure within the system. Investing in social work will reduce pressures on the NHS and supports the Promoting Independence agenda. The invest to save element will be realised through better management of needs and management of flow through the system. **Note**: of the £2.6m in 2017/18, £1m will need to be carried forward into 2018/19 to reflect recruitment timescales, therefore £3.5m will be spent in 2018/19. For 2019/20 it is the intention for the investment to remain at 2018/19 levels (£3.5m) but the additional capacity should be self-financing through savings delivered in the Purchase of Care budget.	By mid-February 40.25 fte appointments had been made to new roles in the service. There are currently 12.75 new capacity Social Worker vacancies to fill. Interviews took place early Feb, with 3 appointable candidates to allocate to a locality. The West is particularly difficult to recruit and a campaign is running specifically for this locality with 3 interviews for Social Workers and 1 for a Team Manager taking place at the end of February.
Invest and Improve	Reduce pressure on the NHS	**iBCF5** Expansion of prevention schemes – social prescribing and community/care navigation schemes – Invest to save	0.7	0.7	0.0	Social prescribing has been evidenced to divert demand from formal care services, especially hospitals. Combined with an offer that builds on community resilience and capacity this initiative is designed to support demand management initiatives and enhance community ability to respond to need.	Supporting the development of existing initiatives working with CCGs, Public Health and District Councils. This will be taken forward on CCG boundaries. Working with Districts, CCGs & voluntary sector. Locality plans have been developed services will commence between January and June 2018, when a formal launch of the whole service will take place.

Improved Better Care Fund (iBCF) - Summary table and February Update

Planning priority	Grant Condition	Description	2017/18 £m	2018/19 £m	2019/20 £m	Impact	Activity and progress
Invest and Improve	Reduce pressure on the NHS	**iBCF6** Respond to care pressures – micro commissioning invest to save pilot	0.1	0.1	0.0	Homecare is a key service in ensuring people can stay out of hospital and be discharged quickly when they are medically fit. Micro commissioning initiatives have been shown to have a positive impact on homecare capacity in similar rural areas. Increased capacity in the system is designed to be sustainable without additional funding after the first two years.	Investment in support to micro enterprises to deliver Home Support. Community Catalyst have been engaged to support this work and initial scoping discussions undertaken to identify our approach to localised development.
Invest and Improve	Reduce pressure on the NHS	**iBCF7** Managing transfers of care – Trusted assessor	0.2	0.2	0.2	Managing transfers of care and implementing the HICM requires a number of joint initiatives between social care and health partners. Key elements of the pathway are trusted assessor and discharge to assess. The implementation of these will be supported by an enhanced, wrap around, home care offer and additional capacity in reablement beds – these initiatives will support the reduction of delayed transfers of care and provide a better quality of care for people in this pathway.	The Trusted Assessment Facilitator role has been developed in tandem with providers who were involved in the recruitment into the new posts. Funding from the project has also supported the development of a bed capacity tracking system. There are 5 Trusted Assessment Facilitators across the 3 acutes, the service commenced on 22 January in NNUH. The full team will be in place by 28 February 2018. 1 Facilitator in QEH 2 Facilitators in NNUH 2 Facilitators in JPUH (1 funded by Suffolk CC)
Invest and Improve	Reduce pressure on the NHS	**iBCF8** Managing transfers of care – through invest to save programme for example discharge	5.1	0.5	0.2	Many of these initiatives are to be run as pilots to evaluate outcomes and put in place sustainable funding based on the part of the system where benefits accrue. There will be a requirement to carry	Recruitment for six discharge to assess social workers, was completed in December 2017. The service is now in place.

Improved Better Care Fund (iBCF) - Summary table and February Update

Planning priority	Grant Condition	Description	2017/18 £m	2018/19 £m	2019/20 £m	Impact	Activity and progress
		to assess; home support wrap around service; accommodation based reablement and active assessment beds				forward an element of the 2017/18 funding depending on the progress and timing of implementing each pilot.	Accommodation based reablement is implemented within the county, with 14 units currently operational. The enhanced home support service is operational providing unplanned, short term same day home support for up to 72 hours across all five CCG areas in Norfolk.
Invest and Improve	Reduce pressure on the NHS	**iBCF9** Enhanced community offer for carers - 3 year invest to save pilot	0.1	0.1	0.1	Carers are key to supporting people to stay safe and independent. Additional funding here will work alongside newly commissioned carers service to ensure that carers are fully supported to have a good quality of life.	Using the Home First model this is being linked with iBCF 8 and 9 to provide crisis management services.
Invest and Improve	Reduce pressure on the NHS	**iBCF10** Enhanced flexible dementia offer - 3 year invest to save pilot	0.2	0.2	0.2	Providing support that enables people with dementia to stay in their own homes is a priority for both health and social care. This funding will enhance the existing offer and allow innovations in service to be implemented and tested for success. This service will support people with dementia to be discharged safely from formal care settings.	Using the Home First model this is being linked with iBCF 8 and 10 to provide crisis management services.

Improved Better Care Fund (iBCF) - Summary table and February Update

Planning priority	Grant Condition	Description	2017/18 £m	2018/19 £m	2019/20 £m	Impact	Activity and progress
Invest and Improve	Reduce pressure on the NHS	**iBCF11** Reduce DTOC mental health services	0.4	0.4	0.4	Providing sufficient support when people with mental health problems leave formal care services is crucial in ensuring people can settle and establish their independence. We are working with mental health colleagues to formulate the most effective mechanisms that will support discharge from hospitals and formal care settings.	There are an additional six beds/flats commissioned as "step down" and admission avoidance from mental health hospitals jointly funded with NSFT with social care support to provide suitable discharge destinations. All units are fully occupied. Increased staff capacity, 4 additional staff includes; 1fte SW for OPMH 1fte Assistant practitioner for OPMH 1fte Assistant practitioner for Hosp SW Team 1fte AMHP for Duty Team
			20.4	**27.7**	**34.3**		
Funded by:	iBCF as per 2017 Spring Budget		-18.6	-11.9	-5.9	Non -recurrent funding	
	iBCF as per 2015 Spending Review		-1.9	-15.8	-28.4		
	Total		**-20.4**	**-27.7**	**-34.3**		

Norfolk County Council

Appendix 1, Annex D
Better Care Fund Monitoring Dashboard

Meeting target | Within 5% of target | > 5% over target

Norfolk County Council		Better Care Fund - KPI Dashboard (March 2018)												Clinical Commisioning Groups NHS					
Indicator	CCG	2017/18 Performance																	
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Q1	Q2	Q3	Q4	YTD	Target
Total non-elective admissions in to hospital (general & acute), all ages, per 100,000 population	Great Yarmouth	917	974	932	929	878	876	939	974	990	1,037			2,823	2,683	2,903		9,446	-
	Norwich	1,616	1,749	1,717	1,693	1,586	1,658	1,739	1,829	1,805	1,754			5,082	4,937	5,373		17,146	-
	North Norfolk	1,322	1,340	1,348	1,329	1,343	1,295	1,377	1,445	1,547	1,547			4,010	3,967	4,369		13,893	-
	South Norfolk	1,535	1,677	1,687	1,651	1,637	1,708	1,768	1,724	1,844	1,863			4,899	4,996	5,336		17,094	-
	West Norfolk	1,969	2,185	2,038	2,036	1,914	1,936	1,953	1,990	2,052	2,186			6,192	5,886	5,995		20,259	-
	Norfolk Total	**7,359 (1,012.8)**	**7,925 (1,090.7)**	**7,722 (1,062.8)**	**7,638 (1,051.2)**	**7,358 (1,012.7)**	**7,473 (1,028.5)**	**7,776 (1,070.2)**	**7,962 (1,095.8)**	**8,238 (1,133.8)**	**8,387 (1,147.0)**			**23,006 (3,166.3)**	**22,469 (3,092.4)**	**23,976 (3,299.8)**		**77,838 (10,712.9)**	**78934 (10,863.8)**

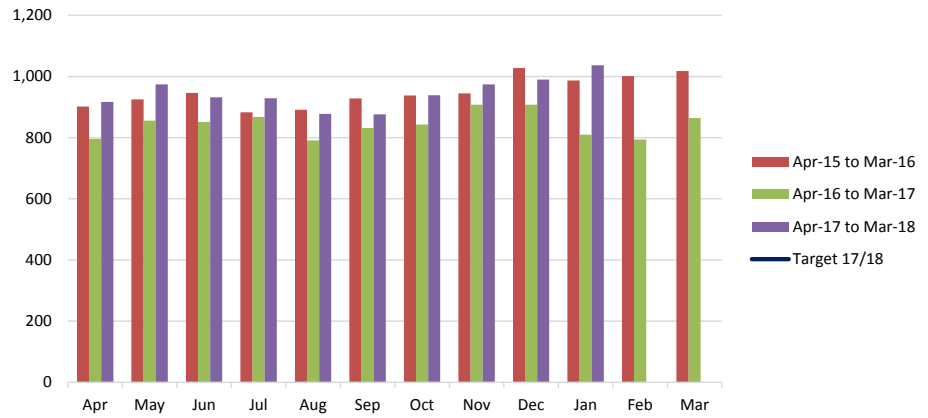
Overview of performance

Metric	Key issues and discussion points	Definition	Source notes
Total non-elective admissions in to hospital (general & acute), all ages, per 100,000 population	**Lower** is better.	A Non-Elective Admission is one that has not been arranged in advance. It may be an emergency admission, a maternity admission or a transfer from a Hospital Bed in another Health Care Provider.	NHS Digital Secondary Uses Service (SUS) data. Population taken from ONS 2014 based projections for 2017/18. Quarterly targets are apportioned equally between each of the three months. Roundwell Medical Practice moved from South Norfolk CCG to Norwich CCG on 1st Apr 2017, but has been assigned to Norwich for all three financial years to ensure figures are comparable.

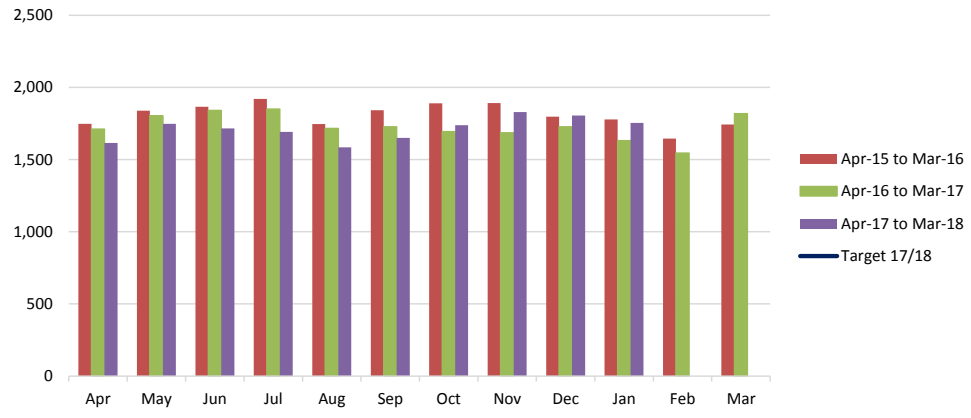
Better Care Fund Monitoring Dashboard

Non-elective admissions (general and acute) by CCG

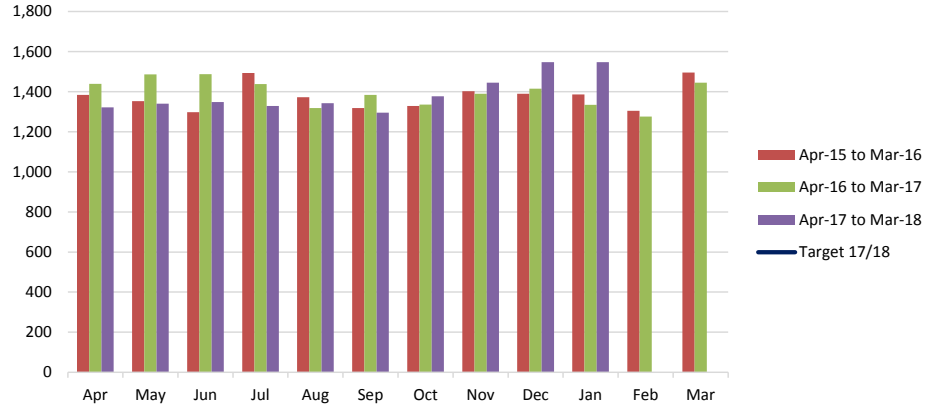
Great Yarmouth



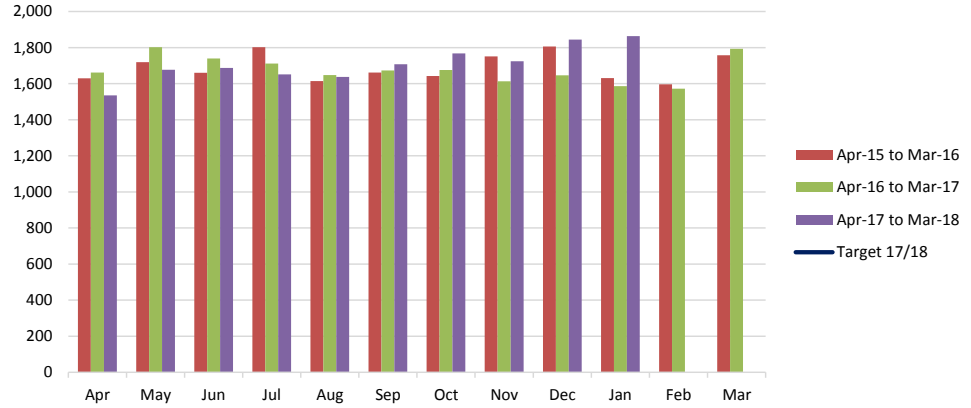
Norwich



North Norfolk



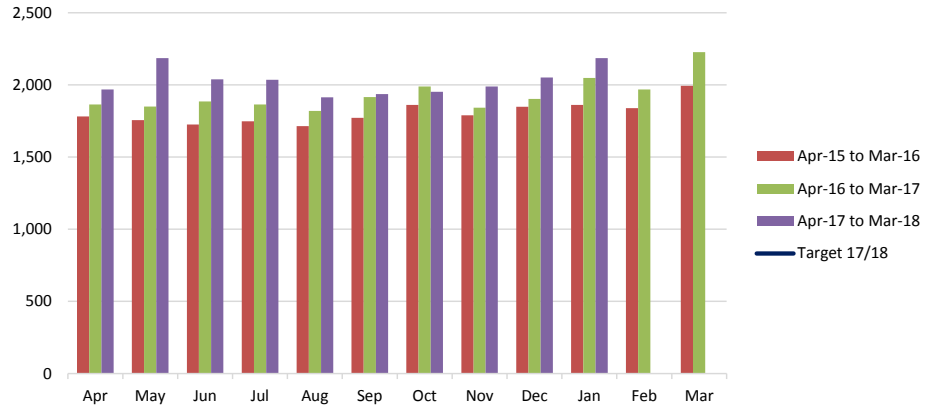
South Norfolk



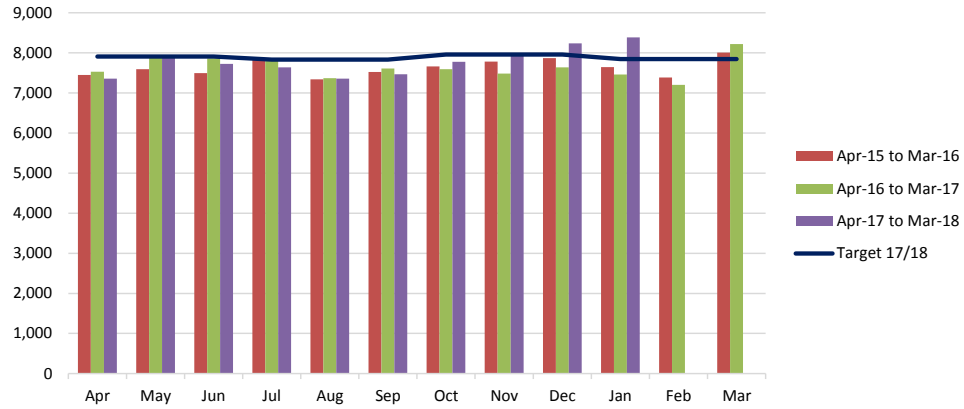
Better Care Fund Monitoring Dashboard

Non-elective admissions (general and acute) by CCG

West Norfolk



Norfolk Total



Better Care Fund Monitoring Dashboard

Meeting target	Within 5% of target	> 5% over target

Norfolk County Council	Better Care Fund - KPI Dashboard (March 2018)	Clinical Commisioning Groups NHS

Indicator	Trust	2017/18 Performance																
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Q1	Q2	Q3	Q4	YTD	Target
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+)	NNUH	1,110	933	847	844	820	955	1,637	1,215	936	1,268			2,890	2,619	3,788		7,675	-
	QEH	150	163	171	297	361	336	231	211	226	311			484	994	668		1,973	-
	JPH	86	119	181	113	84	37	115	324	181	108			386	234	620		962	-
	Norfolk Acute Total	**1,346**	**1,215**	**1,199**	**1,254**	**1,265**	**1,328**	**1,983**	**1,750**	**1,343**	**1,687**			**3,760**	**3,847**	**5,076**		**10,610**	-
	NSFT	528	460	458	340	318	373	499	442	320	277			1,446	1,031	1,261		2,569	-
	NCHC	447	577	643	668	433	530	549	573	528	518			1,667	1,631	1,650		3,799	-
	Norfolk Total	**2,489 (342.6)**	**2,467 (339.5)**	**2,521 (347.0)**	**2,513 (345.9)**	**2,254 (310.2)**	**2,430 (334.4)**	**3,192 (439.3)**	**2,940 (404.6)**	**2,406 (331.1)**	**2,688 (367.6)**			**7,477 (1,029.1)**	**7,197 (990.5)**	**8,538 (1,175.1)**		**18,423 (2,535.6)**	**13566 (1,867.1)**
(Responsible organisation)	NHS	1,260	1,237	1,274	1,321	1,413	1,413	1,622	1,607	1,103	1,562			3,771	4,147	4,332		**10,041**	8784
	Social Care	1,167	1,216	1,201	1,140	831	1,016	1,542	1,232	1,213	1,078			3,584	2,987	3,987		**8,052**	4461
	Both	62	14	46	52	10	1	28	101	90	48			122	63	219		**330**	321

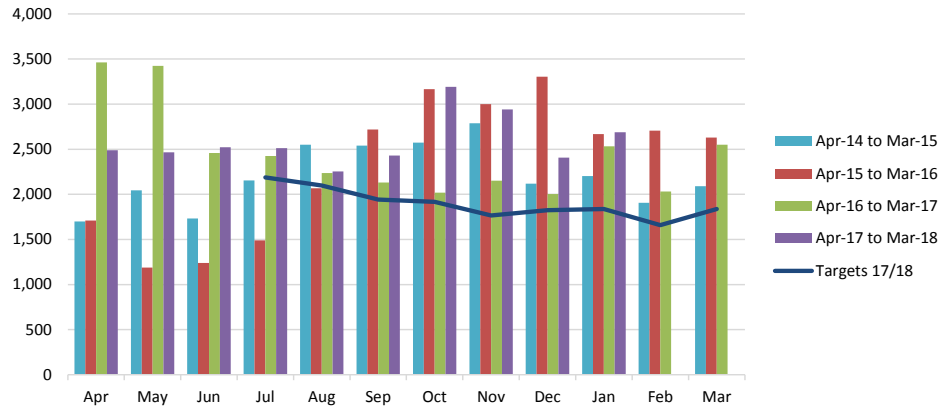
Overview of performance

Metric	Key issues and discussion points	Definition	Source notes
Delayed transfers of care from hospital per 100,000 population	**Lower** is better.	**Numerator**: Total number of delayed transfers of care for those aged 18+. **Denominator**: ONS 2014 based population projection for 2017.	NHS Monthly Situation Report data. Norfolk population taken from ONS 2014 based projections for 2017/18. Rates are not shown by Trust as populations are not available at hospital level. There was no target for Q1 2017/18.

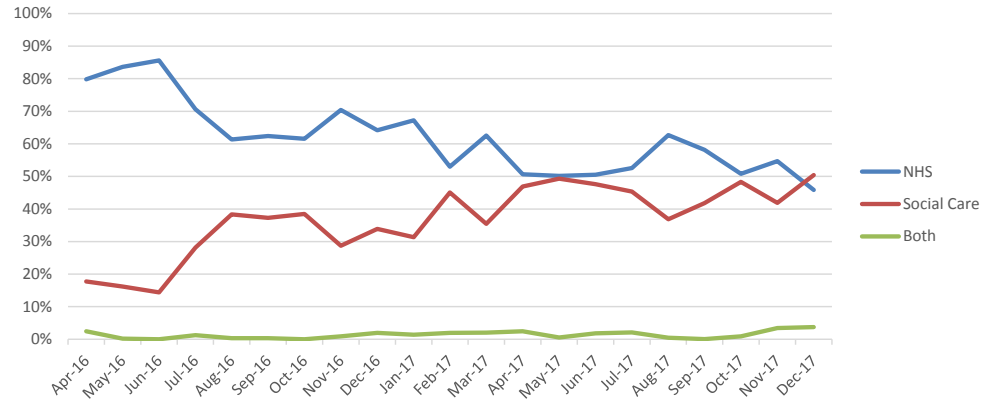
Better Care Fund Monitoring Dashboard

Delayed Transfers of Care

Norfolk Total



Responsible Organisation (Norfolk Total)



Better Care Fund Monitoring Dashboard

Supporting metrics

Meeting target | Within 5% of target | > 5% over target

Norfolk County Council		Better Care Fund - KPI Dashboard (March 2018)												Clinical Commisioning Groups NHS					
Indicator	CCG	2017/18 Performance																	
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Q1	Q2	Q3	Q4	YTD	Target
Local metric: 65+ Estimated diagnosis rate for people with dementia	GY & Waveney	61.7%	61.2%	61.1%	61.0%	62.1%	62.4%	62.5%	62.7%	62.7%	62.8%			61.3%	61.8%	62.6%		62.8%	68.0%
	Norwich	62.3%	61.7%	61.3%	61.1%	60.7%	60.5%	60.6%	61.4%	61.1%	60.3%			61.8%	60.8%	61.0%		60.3%	68.0%
	North Norfolk	61.4%	61.6%	61.3%	61.5%	61.3%	61.1%	60.8%	61.2%	61.0%	60.4%			61.4%	61.3%	61.0%		60.4%	68.0%
	South Norfolk	62.5%	62.9%	63.2%	62.6%	63.6%	63.4%	63.6%	64.5%	64.5%	64.1%			62.9%	63.2%	64.2%		64.1%	68.0%
	West Norfolk	64.8%	63.7%	63.6%	63.5%	62.9%	62.5%	62.6%	62.5%	61.5%	60.8%			64.0%	63.0%	62.2%		60.8%	68.0%
	Norfolk Total	**62.4%**	**62.2%**	**62.1%**	**61.9%**	**62.2%**	**62.1%**	**62.1%**	**62.5%**	**62.2%**	**61.8%**			**62.2%**	**62.0%**	**62.3%**		**61.8%**	**68.0%**
Long-term support needs of older people (aged 65+) met by admission to residential and nursing care homes, per 100,000 population	GY & Waveney	11	11	16	18	12	14	14	11	12	15			38	44	37		134	-
	Norwich	26	21	19	20	19	16	20	17	18	14			66	55	55		190	-
	North Norfolk	18	20	23	24	23	22	21	23	28	12			61	69	72		214	-
	South Norfolk	15	22	32	18	32	22	21	34	28	30			69	72	83		254	-
	West Norfolk	30	27	22	32	22	25	22	21	11	18			79	79	54		230	-
	Norfolk Total	**102 (47.2)**	**101 (46.7)**	**112 (51.8)**	**112 (51.8)**	**108 (49.9)**	**99 (45.8)**	**99 (45.8)**	**107 (49.5)**	**98 (45.3)**	**93 (42.3)**			**315 (145.7)**	**319 (147.5)**	**304 (140.6)**		**1,031 (476.8)**	**1142 (528.1)**
Proportion of older people (aged 65+) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	GY & Waveney	92.9%	95.1%	95.5%	94.5%	93.3%	90.9%							95.5%	90.9%			90.9%	90.0%
	Norwich	94.6%	92.2%	94.0%	94.2%	94.9%	93.5%							94.0%	93.5%			93.5%	90.0%
	North Norfolk	94.9%	95.9%	95.8%	95.5%	95.8%	94.0%							95.8%	94.0%			94.0%	90.0%
	South Norfolk	94.0%	95.7%	93.4%	91.0%	88.1%	93.2%							93.4%	93.2%			93.2%	90.0%
	West Norfolk	91.5%	91.9%	94.3%	95.8%	96.3%	96.3%							94.3%	96.3%			96.3%	90.0%
	Norfolk Total	**93.7%**	**94.0%**	**94.6%**	**94.2%**	**93.7%**	**94.1%**						**96%***	**94.6%**	**94.1%**		**96%***	**96%***	**90.0%**

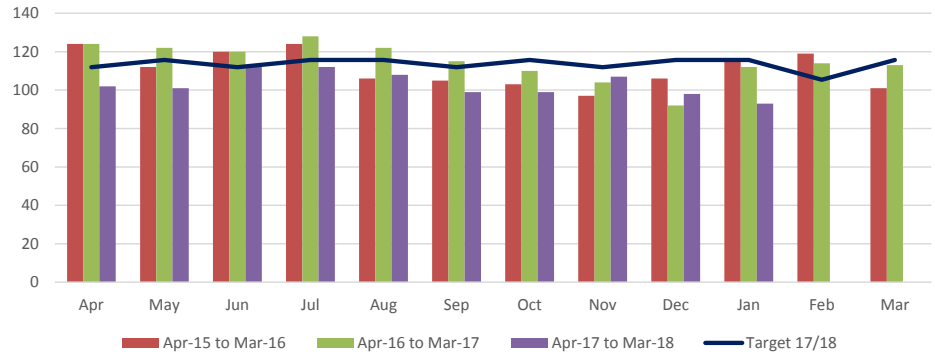
Better Care Fund Monitoring Dashboard

Overview of performance

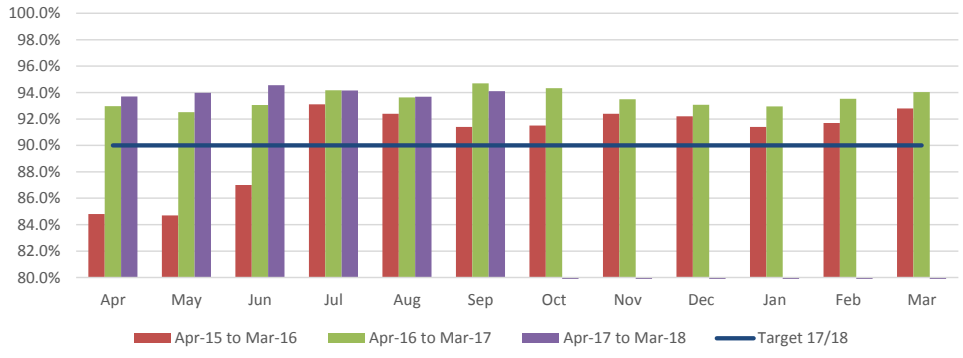
Metric	Key issues and discussion points	Definition	Source notes
Local metric: 65+ Estimated diagnosis rate for people with dementia	**Higher** is better.	The number of people detected in the population that have dementia as a % of prevalence. Same as the detection rate.	Quality Outcomes Framework (QOF) Recorded Dementia Diagnoses
Long-term support needs of older people (aged 65+) met by admission to residential and nursing care homes, per 100,000 population	**Lower** is better.	**Numerator**: Number of council-supported permanent admissions of older people to residential/nursing care. **Denominator**: Number of older residents (aged 65+) in area.	Social Care data taken from CareFirst. Based on Adult Care Localities which are coterminous with the corresponding CCGs. Population taken from ONS 2014 based projections for 2017/18.
Proportion of older people (aged 65+) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	**Higher** is better.	**Numerator**: Number of older people discharged from hospital at home, in extra housing or an adult placement scheme setting three months after the date of their discharge from hospital. **Denominator**: Number of older people (aged 65+) offered rehabilitation services following discharge from acute or community hospital.	*** This is an unconfirmed figure because of the transition from CareFirst to LiquidLogic may mean there are differences in how the system counts. If there are changes needed to be made, we will issue a final confirmed figure in the next quarter.**

Supporting metrics

Permanent admission of older people (Norfolk Total)



Effectiveness of reablement (Norfolk Total)



Report title:	**Health and Wellbeing Board – Governance and systems leadership**
Date of meeting:	**2 May 2018**
Sponsor:	**Dr Louise Smith, Director of Public Health**

Reason for the Report

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

Report summary

This report highlights some key areas of the HWB's governance arrangements in terms of membership and current ways of working and invites members to consider and make comments on proposals for change.

Recommendations:

The HWB is asked to:

1 Agree that the Chair of the N&W Sustainability & Transformation Partnership (STP) and the N&W STP Executive Lead become full members of the HWB (para 2.3)

2 Agree that the cabinet member for Community Health and Safety at Waveney District Council becomes a full member of the HWB (para 2.5)

3 Agree that there should be provision for members of the public to ask questions in line with procedural rules (as outlined in Appendix B)

4 Recommend that Norfolk County Council be asked to consider amending its constitution accordingly to enable the changes above (para 4.1)

1. Background

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

1.2 The Board works in the rapidly developing health and care landscape and it regularly reviews its governance to ensure it continues to be effective and is well placed to pursue its strategic priorities. The Board last reviewed its governance in September 2017 and introduced a number of changes to bring the arrangements up to date, strengthen the HWB's governance and streamline its working practice. The report is available at this link: Governance and System Leadership approach - September 2017.

2. Membership

2.1 The HWB has a key role in the strategic oversight of the Sustainability & Transformation Partnership's (STP) ambitions for delivering sustainable health and social care services across Norfolk and Waveney. The role will develop as the system works towards an integrated health and care system for Norfolk and Waveney, to drive improvement (see item 6 on this agenda).

2.2 The Chair of the Norfolk & Waveney Sustainability & Transformation Partnership (currently Rt Hon Patricia Hewitt) is invited to join all Board meetings and the STP Executive Lead (Antek Lejk is the outgoing Executive Lead) has held a place on the HWB by virtue of his role as Chief Executive of the South Norfolk & North Norfolk CCGs.

2.3 In order to strengthen the links between the HWB and the Sustainability & Transformation Partnership (STP) **it is proposed that:**

- The Chair of the N&W Sustainability & Transformation Partnership and the N&W STP Executive Lead become full members of the HWB

2.4 The work of the HWB continues to develop and respond to the changing health and wellbeing agenda. The Board's discussions often include the Waveney area - for example, around the STP, and also the Local Transformation Plan (Children and Young Peoples' mental health), and the Transforming Care Partnership (Services for Adults with a Learning Disability). In response to a request, the cabinet member for Community Health and Safety at Waveney District Council has been invited to join all HWB meetings since last autumn.

2.5 In order to strengthen these arrangements **it is proposed that:**

- The cabinet member for Community Health and Safety at Waveney District Council becomes a full member of the HWB

2.6 The proposed HWB membership is at **Appendix A.** It is recommended that Norfolk County Council be asked to consider amending its constitution accordingly.

3. How the Board conducts its work

3.1 The HWB holds formal meetings four times a year and, when relevant, these can include private informal discussions to enable the Board's strategy development. The Board also sets aside a half day each year for an informal development session to focus on specific issues in more detail.

Public questions

3.2 The HWB's formal meetings are held in public, although currently there is no provision for public questions at Board meetings. To strengthen these arrangements and provide greater democratic accountability, **it is proposed** that the HWB makes provision for members of the public to ask questions in accordance with the County Council's procedural rules. This is in line with a growing number Health and Wellbeing Boards around the country who have some form of provision for public participation.

3.3 The County Council has procedures for questions by members of the public at its service committees and it is proposed that these are adapted for use by the Health and Wellbeing Board as outlined **in Appendix B**.

4. Next steps

4.1 If agreed, these changes to the Board's membership and terms of reference would require change in the County Council's Constitution. **It is recommended** that Norfolk County Council be asked to consider amending its constitution accordingly. The process for changing the Council's Constitution and involves approval by the Council's Constitution Advisory Group, Policy & Resources Committee and then the County Council.

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.

Health & Wellbeing Board

Representing	Membership	Substitute
Adult Social Care Committee, Norfolk County Council (NCC)	Cllr Bill Borrett*	Cllr Shelagh Gurney
Adult Social Services, NCC	James Bullion*	Debbie Bartlett
Borough Council of King's Lynn & West Norfolk	Cllr Elizabeth Nockolds	Cllr Sam Sandell
Breckland District Council	Cllr Paul Claussen	Cllr Trevor Carter
Broadland District Council	Cllr Andrew Proctor	Cllr Roger Foulger
Children's Services Committee, NCC	Cllr Penny Carpenter	Cllr Stuart Dark
Children's Services, Norfolk County Council	Sara Tough *	Sarah Jones
Director of Public Health, NCC	Dr Louise Smith *	
Great Yarmouth Borough Council	Cllr Andy Grant	Cllr Emma Flaxman-Taylor
Healthwatch Norfolk	William Armstrong*	Alex Stewart
NHS England, East Sub Region Team	Simon Evans-Evans	
NHS Great Yarmouth & Waveney CCG	Dr Liam Stevens*	
NHS Great Yarmouth & Waveney CCG	Melanie Craig	
NHS Norwich CCG	Tracy Williams*	
NHS Norwich CCG	Jo Smithson	
NHS North Norfolk CCG	Dr Anoop Dhesi *	
NHS North and South Norfolk CCG	Antek Lejk/Helen Stratton	
NHS South Norfolk CCG	Dr Hilary Byrne*	
NHS West Norfolk CCG	Dr Paul Williams*	
NHS West Norfolk CCG	John Webster	
Norfolk Constabulary	ACC Paul Sanford	ACC Nick Davison
Norfolk County Council	Cllr David Bills	
Norfolk County Council	Dr Wendy Thomson	
North Norfolk District Council	Cllr Maggie Prior	
Norwich City Council	Cllr Kevin Maguire	Adam Clark
Police and Crime Commissioner	Lorne Green	Dr Gavin Thompson
South Norfolk District Council	Cllr Yvonne Bendle	Cllr Florence Ellis
Sustainability & Transformation Partnership (Chair)	Rt Hon Patricia Hewitt	
Sustainability & Transformation Partnership (Executive Lead)	Antek Lejk	
Voluntary Sector Representative	Dr Joyce Hopwood	Laura Bloomfield
Voluntary Sector Representative	Dan Mobbs	Elly Wilson
Voluntary Sector Representative	Dr Janka Rodziewicz	Jon Clemo
Waveney District Council	Cllr Mary Rudd	
Standing invitation to attend Board meetings:		
East Coast Community Healthcare CIC	Jonathan Williams	Tony Osmanski
James Paget University Hospital NHS Trust	Christine Allen	Anna Davidson
Norfolk Community Health & Care NHS Trust	Roisin Fallon-Williams	Geraldine Broderick
Norfolk Independent Care	John Bacon	
Norfolk & Norwich University Hospital NHS Trust	Mark Davies	John Fry
Norfolk & Suffolk NHS Foundation Trust	Julie Cave	Gary Page
Queen Elizabeth Hospital NHS Trust	Jon Green	Edward Libbey

* Denotes statutory member

Questions by the public at the Health and Wellbeing Board

1. **How to ask a question**
   A question must be put in writing and in advance:

   a) **At least 2 working days' notice** of the question is given in writing to the Head of Democratic Services; e.g. by 5pm on the Friday preceding the Health and Wellbeing Board meeting on a Wednesday

   Or

   b) If the question relates to **urgent matters**, and it has **the consent of the chairman** to whom the question is to be put, and the content of the question is given to the Head of Democratic Services **by 4pm on the day before the meeting**.

2. **Who may ask a question and about what**
   A person resident in Norfolk, or who is a non-domestic ratepayer in Norfolk, or who pays Council Tax in Norfolk, may ask at a public meeting of the Health and Wellbeing Board through the Chairman any question within the terms of reference of the Health and Wellbeing Board about a matter for which the Board has collective responsibility or particularly affects the Board. This does not include questions for individual Board members where responsibility for the matter sits with the individual organisation.

3. **Rules about questions**

   a) **Number of questions** - At any public Health and Wellbeing Board meeting, the number of questions which can be asked will be limited to one question per person plus a supplementary. No more than one question plus a supplementary may be asked on behalf of any one organisation. No person shall be entitled to ask in total under this provision more than one question, and a supplementary, to the Health and Wellbeing Board in any six month period.

   b) **Other restrictions** - Questions are subject to a **maximum word limit** of 110 words. Questions that are in excess of 110 words will be disqualified. **The total time for public questions will be limited to 15 minutes**. Questions will be put in the order in which they are received

   c) **Supplementary questions** - One supplementary question may be asked without notice and should be brief (fewer than 75 words and take less than 20 seconds to put). It should relate directly to the original question or the reply. The Chairman may reject any supplementary question s/he does not consider compliant with this requirement.

4. **Response**
   The Chairman shall exercise his/her discretion as to the response given to the question and any supplementary.

   Not attending - If the person asking the question indicates they will not be attending the Board meeting, a written response will simply be sent to the questioner.

   Attending - If the person asking the question has indicated they will attend, response to the questions will be made available at the start of the meeting and copies of the questions and answers will be available to all in attendance. The responses to questions will not be read out at the meeting.

Supplementary question - The Chairman may give an oral response to a supplementary question or may require another Member of the Board or Officer in attendance to answer it. If an oral answer cannot be conveniently given, a written response will be sent to the questioner **within seven working days** of the meeting.

Written response - If the person who has given notice of the question is not present at the meeting or if any questions remain unanswered within the 15 minutes allowed for questions, a written response will be sent **within seven working days** of the meeting.

5. Rejection of a question

The Head of Democratic Services may reject a question if it:

(a) Is not about a matter for which the Board has collective responsibility or particularly affects the Board;

(b) Is defamatory, frivolous or offensive or has been the subject of a similar question in the last 6 months or the same as one already submitted under this provision;

(c) Requires the disclosure of confidential or exempt information, as defined in the Council's Access to Information Procedure Rules

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