Health & Wellbeing Board

(Additional Meeting)

Date: **Tuesday 1 April 2014**

Time: **9:30am to 11:30am (*Note earlier start time)***

Venue: **Room 16, Abbey Conference Centre, Norwich**

Membership	Substitute	Representing
William Armstrong	Alex Stewart	Chair, Healthwatch Norfolk
Cllr Brenda Arthur		Norwich City Council
Cllr Yvonne Bendle (Vice-Chairman)	Cllr Lisa Neal	South Norfolk Council
Stephen Bett	Jenny McKibben	Norfolk's Police and Crime Commissioner
Harold Bodmer	Catherine Underwood	Director Community Services
Dr Jon Bryson	Ann Donkin	South Norfolk Clinical Commissioning Group
Pip Coker	Dan Mobbs	Voluntary Sector Representative
T/ACC Nick Dean	C/Sup Jo Shiner	Norfolk Constabulary
Dr Anoop Dhesi	Mark Taylor	North Norfolk Clinical Commissioning Group
Tracy Dowling		Director of Operations & Delivery, NHS England, East Anglia Team
Richard Draper	Dan Mobbs	Voluntary Sector Representative
Andy Evans	Kate Gill	Great Yarmouth & Waveney Clinical Commissioning Group
Cllr Angie Fitch-Tillet	Mark Taylor	North Norfolk District Council
Anne Gibson		Acting Managing Director, Norfolk County Council
Joyce Hopwood	Dan Mobbs	Voluntary Sector Representative
Cllr James Joyce		Cabinet Member, Safeguarding Children, Norfolk County Council
Cllr Penny Linden	Cllr Marlene Fairhead	Great Yarmouth Borough Council
Sheila Lock	Michael Rosen	Director Children's Services
Dr Ian Mack (Vice-Chairman)	Sue Crossman	West Norfolk Clinical Commissioning Group
Lucy Macleod		Interim Director of Public Health
Cllr Elizabeth Nockolds		King's Lynn and West Norfolk Borough Council
Dr Chris Price	Jonathon Fagge	Norwich Clinical Commissioning Group
Cllr Andrew Proctor	Cllr Roger Foulger	Broadland District Council
Cllr Daniel Roper **(Chairman)**		Cabinet Member, Public Protection, Public Health, Trading Standards, Fire & Rescue, Norfolk County Council
Cllr Lynda Turner		Breckland District Council
Cllr Sue Whitaker		Cabinet Member, Adult Social Services, Norfolk County Council

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

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

Nicola Tuck on 01603 223053
or email committees@norfolk.gov.uk

1	**Apologies**	Chair	
2	**Minutes** To confirm the minutes of the meeting held on 8 January 2014	Chair	Page **3**
3	**Members to Declare any Interests** If you have a Disclosable Pecuniary Interest in a matter to be considered at the meeting and that interest is on your Register of Interests you must not speak or vote on the matter. If you have a Disclosable Pecuniary Interest in a matter to be considered at the meeting and that interest is not on your Register of Interests you must declare that interest at the meeting and not speak or vote on the matter. In either case you may remain in the room where the meeting is taking place. If you consider that it would be inappropriate in the circumstances to remain in the room, you may leave the room while the matter is dealt with. If you do not have a Disclosable Pecuniary Interest you may nevertheless have an Other Interest in a matter to be discussed if it affects: - your well-being or financial position - that of your family or close friends - that of a club or society in which you have a management role - that of another public body of which you are a member to a greater extent than others (in your ward). If that is the case then you must declare such an interest but can speak and vote on the matter.	Chair	
4	**To receive any items of business which the Chairman decides should be considered as a matter of urgency**	Chair	
	Items for Business		
5	**Norfolk Better Care Fund – final submission** Report of the Director of Community Services, NCC, and the Chief Officers of each of the CCGs • Norfolk Better Care Fund Final Plan • Informal notes of the Chair and Vice Chairs meeting held 12 February 2014	Harold Bodmer and CCGs representatives	Page **18**
	Close		
	Future Board meetings dates - all are on Wednesdays: • 16 April 2014 – Abbey Conference Centre, Room 16 • 16 July 2014 • 22 October 2014		

Norfolk County Council
at your service

Health and Wellbeing Board
Minutes of the meeting held on Wednesday 8 January 2014
at 9.30am in Room 16, Abbey Conference Centre, Norwich

Present:

Mr D Roper, Norfolk County Council – Chairman

William Armstrong	Healthwatch Norfolk
Brenda Arthur	Norwich City Council
Cllr Yvonne Bendle	South Norfolk Council
Harold Bodmer	Director of Community Services, NCC
Dr Jon Bryson	South Norfolk Clinical Commissioning Group
Pip Coker	Voluntary Sector representative
Dr Anoop Dhesi	North Norfolk Clinical Commissioning Group
Tracy Dowling	Director of Operations & Delivery, NHS England, East Anglia Team
Angie Fitch-Tillett	North Norfolk District Council
Anne Gibson	Chief Executive (Acting) NCC
Joyce Hopwood	Voluntary Sector Representative
Cllr Penny Linden	Great Yarmouth Borough Council
Sheila Lock	Interim Director of Children's Services, NCC
Dr Ian Mack	West Norfolk Clinical Commissioning Group
Lucy Macleod	Acting Director of Public Health
Jenny McKibben	Deputy Police and Crime Commissioner
Elizabeth Nockolds	Kings Lynn & West Norfolk Borough Council
Dr Chris Price	Norwich Clinical Commissioning Group
Cllr Andrew Proctor	Broadland District Council
Dr John Stammers	Great Yarmouth & Waveney Clinical Commissioning Group
Cllr Lynda Turner	Breckland District Council
Stephen Wells	West Norfolk Clinical Commissioning Group
Sue Whitaker	Cabinet Member Adult Social Services, NCC

Others present:
Debbie Bartlett, Head of Planning, Performance and Partnerships, NCC

1 Apologies

Apologies were received from Cllr James Joyce, Norfolk County Council, Andy Evans, Gt Yarmouth & Waveney CCG (Dr John Stammers substituted), Stephen Bett, Norfolk Police & Crime Commissioner (Jenny McKibben substituted), Richard Draper, Voluntary Sector Representative, and T/ACC Nick Dean, Norfolk Constabulary.

2 Welcome

The Chairman welcomed those members of the Board who were attending their first meeting.

3 Minutes of the Health and Wellbeing Board meeting held on 23 October 2013.

The minutes of the Health and Wellbeing Board (H&WB) meeting held on 23 October 2013 were agreed as a correct record and signed by the Chairman.

4 Matters Arising

Norfolk County Council Budget Consultation
Once the budget had been set by Norfolk County Council following the 'Putting People First' Budget consultation, the Board would discuss the possible impacts on the work of the H&WB and its priorities.

5 Declarations of Interest

There were no declarations of interest.

6 To receive any items of business

There were no items of urgent business.

7 Developing a Norfolk Joint Health and Wellbeing Strategy 2014-17

7.1 The Board received and noted a report from the Interim Director of Public Health providing an outline draft Joint Health and Wellbeing Strategy 2014-17 for consideration by the Board. It was anticipated that the final Strategy would be presented to the Board at its meeting in April.

7.2 The Board considered each priority individually, with the following points being noted during the discussion:

Generic

- Explicit wording was needed setting out the county-wide approach and what the Board would do at a county level, as well as what it would do at a local level, acknowledging that there would be localised delivery mechanisms.
- The Health and Wellbeing Board needed to ensure it was sufficiently ambitious and challenging in its Strategy to fulfil its community leadership role.
- The key outcome measures would be included within the detailed operational plan which would sit beneath the Strategy. There would be reference to them, together with the Board's overall ambition, in the Strategy. Once the Board had agreed the outline plan, the Strategy Group would then consider the detail of the key outcome measures.
- The phrase "pilot project" would be replaced with the words "demonstration project", which better reflected their role in demonstrating good practice.

Priority 1 – Giving Every Child the Best Start in Life

- A narrative was needed to explain the links to other, existing key county-wide strategies - for example, there were clear links with the Early Help Strategy and the interface with the safeguarding agenda.
- There was also a need to keep a strong focus on tackling inequality and being able to respond support the most vulnerable.
- The Joint Strategic Needs Assessment (JSNA) provided key information around the three priorities, and it might be useful to carry out further interpretation of the JSNA against the priorities in order to target vulnerable groups.
- It was suggested that consideration should be given to including reference to breast feeding initiation and continuation, sexual exploitation and also to including children of offenders, especially those whose parents had been imprisoned.
- It might be the appropriate point to take this developing priority around early years

to the newly set up Children's Partnership.

Priority 2 – Reducing the Prevalence of Obesity

- Consideration should be given to the link between obesity and mental health issues as it was felt there was a strong crossover. It was expected that the operational plan would provide further detail. There also needed to be a clear statement on obesity in priority one.
- There were opportunities for the district councils and South Norfolk District Council drew the Board's attention to the fact that they were already offering the services of mobile gyms and that a programme of improving leisure centres was underway.
- There could be a role for the Norfolk Commissioning Academy in promoting integration across a wide range of services.
- The work on the pilot project was in the formative stages and had been included for demonstration only. Other areas would be included in the final strategy.
- There were concerns about delivery and an operating model was needed to be clear about how the Board was adding value to all the work that was already underway around obesity
- The Strategy Group would be able to drive, support and encourage the delivery of the strategy once it was finalised.

Priority 3 – Improved Quality of Life for People with Dementia and their Carers

- The Board noted that the Norfolk Older People's Strategic Partnership had completed this section of the Strategy and that it covered the subject in detail.
- There was a suggestion that it should be linked or merged with the existing Dementia Strategy and that it should link in with the Dementia-friendly communities work underway in parts of Norfolk. In taking this forward, it would be helpful if the H&WB would position itself for the Norfolk part of the Norfolk & Suffolk Dementia Alliance, as the deliverers.
- It was noted that Members and staff of Breckland District Council had been trained in dementia-friendly awareness
- It was suggested that this priority was not ambitious enough as currently drafted and that there could be more about prevention
- There was a suggestion that consideration be given to including carers who faced domestic abuse. It was also suggested that the Harwood Care and Support Charter could be used as a reference in the strategy in relation to feedback and complaints

RESOLVED to agree that the H&WB Strategy Group should further develop the draft Strategy, taking on board the Board's comments and views, and bring a final draft Strategy to the next meeting.

8 Clinical Commissioning Groups – Commissioning Intentions

8.1 The Board received and **noted** the information provided by the five Clinical Commissioning Groups (CCGs) including their presentations, copies of which are attached at Appendices B-F.

8.2 The following key points were noted:

- The contribution to addressing health inequalities was being picked up through an emphasis on the prevention agenda.
- There were opportunities for integration around children's issues, starting perhaps with mapping GP practices around Children's Services clusters.

- End of Life care and Bereavement Care was an important issue and needed a greater focus
- It would be useful for the Board to have a way of arriving at a collective view about the overarching risks in the system and about the challenges that faced.
- CCGs were currently in the process of producing their 2-year plans and these would be brought to the next meeting of the Board.

9 Integration and the Better Care Fund

9.1 The Board received a report, presented by the Director of Community Services, on the new Better Care Fund, which is a national initiative requiring the creation of a pooled budget for the commissioning of integrated health and social care services. The report outlined the structure of the fund arrangements and set out progress on developing plans between partners in the geographies of the Clinical Commissioning Groups.

9.2 The following points and actions were noted during the discussion:

- The 'first cut' of the plan needed to be approved by the Health and Wellbeing Board prior to its submission on 14 February 2014, setting out how the "must have" issues would be delivered and a proposal around a local performance measure.
- That this Fund was not new money, it was from a number of existing budgets - it was a mechanism for supporting integrated working and a catalyst for whole system improvement. It would be challenging to the system as a whole.
- Although the plan would need to align with the Clinical Commissioning Groups' 2-year and 5 year plans, there was a need to look longer term and focus on the outcomes we are trying to achieve – using innovation in service and different ways of working.

RESOLVED to delegate the sign off of the Better Care Fund plan to the Chairman, Vice-Chairmen and the Director of Community Services, with input from any Board Member. The Plan would be circulated to the Board for their comments prior to sign-off.

10 Support for Parents and Carers of Children and Young People accessing Mental Health Services

10.1 The Board received a briefing paper by the Chief Officer, North Norfolk Clinical Commissioning Group outlining how parents/carers of children and young people accessing mental health services were routinely involved in their treatment and care. The report also described the mechanisms through which parents/carers in need of separate or additional targeted or specialist mental health support were enabled to access adult mental health services. The report was presented by the Assistant Director, Integrated Mental Health/Learning Disabilities Commissioning.

10.2 The Board considered that it would be useful to have information about how well the process was working and, in particular, to seek the views of practitioners and users of the service. The Interim Director of Children's Services offered to convene a group and invite representatives from a number of well-established forums, including the NCC In-Care Council, to attend to give their views.

RESOLVED to take up the offer by the Director of Children's Services to convene a small Group with a user and practitioner perspective and bring an updated report to a future meeting of the H&WB.

11 Pharmaceutical Needs Assessment (PNA)

11.1 The Board received and **noted** the report by the Interim Director of Public Health, NCC outlining the purpose of a Pharmaceutical Needs Assessment (PNA), the responsibilities of the H&WB in relation to production of the assessment and the timelines for production of a new PNA for Norfolk which would come into effect from April 2015.

12 Autism Self-Assessment Framework

12.1 The Board received a report by the Director of Community Services, NCC outlining the Government's strategy 'Fulfilling and Rewarding Lives' which set out the long term vision for transforming the lives of, and outcomes for adults with autism, with an emphasis placed on the requirement for local, specialised services.

The report also outlined the requirement for completion of an Autism Self Assessment in all areas which would reflect the position of Norfolk services in relation to the needs of people with Autistic Spectrum conditions. It also highlighted the requirement that the completed Self Assessment Framework be presented to the relevant HWB by the end of January 2014.

12.2 The following points were noted in response to questions from the Board:

- Items which were RAG rated 'red' were regularly considered by the Adult Autism Steering Group and the Group were currently trying to set up a central mechanism to record data relating to the number of people diagnosed with autism who met the eligibility criteria for social care (irrespective of whether or not they received benefits).
- Membership of the Adult Autism Steering Group consisted of representatives from service users, carers, CCG representatives, housing representatives, Norfolk Community Health and Care, Norfolk County Council and Acute Trusts. This was a wide range of people and the Group also co-opted representatives as and when necessary.
- Work was currently taking place to establish an IT system capable of recording data in a meaningful way.
- It was noted that voluntary sector providers of services to adults with Learning Disabilities intended to review the Autism SAF and provide feedback to the commissioner.

RESOLVED to endorse the Norfolk Autism Self Assessment Framework (SAF).

13 Report of the Cambridgeshire, Norfolk and Suffolk Joint Health Scrutiny Committee on Proposals for Liver Resection Services.

13.1 The Board received a report by the Head of Planning, Performance and Partnerships, NCC outlining a recommendation to the Health and Wellbeing Board from the Cambridgeshire, Norfolk and Suffolk Joint Health Scrutiny Committee from its recent review of proposals by NHS England for the reconfiguration of liver resection services affecting patient pathways for the populations of Cambridgeshire, Norfolk and Suffolk.

13.2 The recommendation to the Health and Wellbeing Board was that work should take place to explore innovative solutions to transport issues for patients and their families/carers who needed to access specialised health care services.

13.3 The Board had also been sent, for information, a report from NHS England setting out the review undertaken of surgical services for metastatic liver resection. A copy of this report is attached at Appendix A to these minutes.

13.4 The following points were noted in response to questions from the Board:

- Transport options needed to be published and made available for all patients of the services, as well as their relatives, to ensure that they were in receipt of the relevant information. This included specialist nursing staff in order to enable them to guide patients and their families through the available transport options.
- It would be useful to build on existing good practice, for example, work on integrated transport in Breckland involving the Assistant Director Environment, Transport and Development, Norfolk County Council.
- It was suggested that an audit could be carried out to ascertain what transport options were currently available and then to look at how these services could be improved – using innovative approaches.

RESOLVED to work with the Assistant Director, Environment, Transport and Development, Norfolk County Council to explore innovative solutions to transport issues for patients and their families/carers who need to access specialised health care services

14 Healthwatch Norfolk

The H&WB received and **noted** the Healthwatch Norfolk minutes of the meeting held on 16 September 2013. The next meeting would be held on 20 January 2014.

The Chairman of Healthwatch agreed to give a brief presentation at the next HWB meeting for the Board to receive an update on the activities undertaken by Healthwatch.

15 NHS England

15.1 The Board received a verbal update from Tracy Dowling, Director of Operations and Delivery, NHS England East Anglia Team and noted feedback on the Local Quality Surveillance Group (QSG), during which the following points were noted:

15.2
- A risk summit regarding the East of England Ambulance Service would be held on 28 January. The Director of Operations and Delivery would give a report on the findings of the risk summit to the HWB at its next meeting.
- Concerns relating to the Norfolk and Suffolk Mental Health Trust and the current redesign of services were being reviewed, with particular focus on the services for Norfolk.
- The Improvement Plan for the Queen Elizabeth Hospital King's Lynn was being overseen by a governance committee and it was noted that good progress was being made..
- Checkpoint meetings had been held with the CCGs and all five have strong levels of assurance.
- The focus would continue on Accident and Emergency performance and Urgent Care. Winter plans were all solid and robust and performance was generally good at the James Paget Hospital and the Norfolk & Norwich University Hospital. Performance at the Queen Elizabeth Hospital, King's Lynn was continuing to improve.

15.3 The Chairman thanked the Director of Operations and Delivery, NHS England East Anglia Team, for the update.

16 Norfolk Health Overview and Scrutiny Committee

The Board received and noted the minutes from the Norfolk Health Overview and Scrutiny Committee meetings held on 10 October and 28 November 2013.

The next meeting would take place on **Wednesday 16 April 2014** at 10am. The venue is to be confirmed.

The meeting closed at 12.35pm

Chairman

Appendix A

Norfolk Health and Wellbeing Board
Report for Information

Surgical Metastatic Liver Resection Services

Report of NHS England

Summary
A review of surgical services for metastatic liver resection has been undertaken with the aim of ensuring high quality, safe and sustainable services for patients. The review has concluded that there should be a single surgical centre for East Anglia, working as part of a network with local services to achieve improved outcomes for patients. The review has concluded that the surgical service should be located at Addenbrookes, Cambridge.

Action
The Health and Wellbeing Board is asked to:
- Note the review undertaken
- Note the recommendations of the review

1. Background

1.1 A surgical resection service provides curative treatment for people with liver metastases. The National Institute for Clinical Excellence Colorectal Improving Outcomes Guidance (IOG) states that a liver metastases surgical resection service should serve a population base of at least 2 million, with all surgery taking place at a single specialist surgical centre for patients with liver metastases. The IOG seeks to improve outcomes for patients by introducing a dedicated, multidisciplinary team delivering high quality care in a single specialist surgical centre that will deal with sufficient numbers of patients to maximise clinical expertise.

1.2 NHS England became responsible for the commissioning of this service, in April 2013 and is required to commission a service that is compliant with the IOG. NHS England (East Anglia) has therefore been working to take forward the Review of surgical services for liver metastases within the boundaries of the Anglia Cancer Network region, which covers people living in Suffolk, Norfolk, Cambridgeshire, and north Bedfordshire, which was started in January 2011.

2. The Review

1.1 In 2011, the former Anglia Cancer Network engaged the former Midlands and East Specialised Commissioning Group (SCG) to lead the work needed to review specialist surgical services for patients with liver metastases. The aim of the review was to ensure that all patients have access to an IOG compliant service.

1.2 A Project Steering Group was set up in January 2011 to lead the review of the current service and to ensure broad representation from expert clinicians and commissioners, as well as patient representatives who had used the service. The review found that the number of people undergoing liver resection for colorectal

cancer metastases in the region was significantly lower than the national average, with five referral pathways for the population in the Anglia Cancer Network region:

a) Three centres within the network which are non IOG Compliant– The Ipswich Hospital Trust, Norfolk and Norwich University Hospitals NHS Foundation Trust undertaking approximately 25 resections/year and Cambridge University Hospitals NHS Foundation Trust undertaking approximately 45 resections/year (NB: The Ipswich Hospital has recently stopped their liver resection surgery).

b) Two centres outside the network which are IOG compliant– Basingstoke (as part of Hampshire Hospitals NHS Foundation Trust) for the Bedford referral pathway and University Hospitals Leicester for the Peterborough referral pathway

2.3 The Project Steering Group undertook a comprehensive review, which included seeking further advice from the National Cancer Action Team (NCAT). NCAT agreed to conduct a review into possible models that could be used to provide the service and advise on:

a) What the service should look like;
b) What organisations are best placed to deliver the service;
c) What should the expectations be for the reconfigured service?

2.4 In August 2012, the NCAT report was published and concluded that :

a. There is strong and compelling evidence to support the principle that centres that see more patients produce better short and long term outcomes than centres that don't see a smaller number of patients.

b. Whilst both centres (Norwich University Hospitals NHS Foundation Trust and Cambridge University Hospitals NHS Foundation Trust) do have good outcomes for patients, both centres are under performing with the amount of patients that are referred for liver resection surgery.

c. Multiple patient pathways that exist in the network are not sustainable in the long term and are likely to continue to impact on the local number of referrals

d. The team did not find any compelling reasons not to support an IOG compliant service. Developing a compliant service was felt most likely to deliver the service capable of delivering increased access to and the highest quality of surgery

e. One site, serving the population of potentially 2.9m is the preferred and recommended service configuration

2.5 The process to establish an IOG compliant service recommenced in September 2012 and following publication of the service criteria, two expressions of interest were received from CUHFT and NNUHFT to become the single centre for liver resection surgical services.

2.6 The bids were assessed using a scoring criteria developed by the Project Steering Group and an External Review Panel, made up of independent expert clinicians, a referring surgeon, a service specialist, a clinical nurse specialist and a patient representative who visited each provider to discuss their service proposal in detail.

2.7 The External Review Panel recommended that the single site surgical liver metastases service for the population of the Anglia Cancer Network region should be

developed at Cambridge University Hospitals NHS Foundation Trust (CUHFT). Only surgery and immediate follow up would occur at the single specialist surgical centre, ensuring that as many elements as possible of the pathway would be delivered locally.

2.8 Whilst the External Review Panel found that CUHFT was best placed to deliver the network wide service, a number of recommended actions were identified in the report. In summary, the key recommendations from the External Review Panel report were:

a) Consideration needed to be given to the transport needs of a rural and elderly population, especially from the more remote areas of the region.
b) Leadership of the network wide service needs review, and sufficient time needs to be given to this role.
c) Ensuring effective engagement of all referring units is key to this service.
d) A whole team approach to proactive working from the centre will ensure close team working with each of the referring Multi-Disciplinary Teams.
e) Proactive working from the specialist Liver Metastases surgery team to ensure improved referral and a demonstrable improvement in resection rates.
f) Ensuring at all times that the new model of working, whilst centralising surgery, should at the same time maximise those parts of the care pathway that can be delivered to patients locally.

2.9 A Joint Health Scrutiny Committee was established to consider the review and the recommendations.

3. Key issues for discussion

3.1 The guiding principle is that only surgery and immediate follow up will take place at the single specialist surgical centre. Patients will be supported by healthcare professionals across the network region collaborating throughout each stage of the patient journey, ensuring that as many elements as possible of the pathway will continue to be delivered locally as they are now.

4. Conclusions and recommendations

4.1 The Health and Wellbeing Board is asked to:

- Note the outcome of the review to support improved outcomes for patients.
- Note the preferred options for a single surgical centre.

Contact

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

Name	Tel	Email
Tracey Dowling	01223 708770	t.dowling@nhs.net

Appendix B

NHS West Norfolk Clinical Commissioning Group

Commissioning Intentions for health and care in West Norfolk in 2014/15 and beyond

Health and Wellbeing Board
8th January 2014

Informing the Strategic Vision 2014/15

- Collation of feedback following stakeholder engagement in summer 2013,
- WNCCG – external peer review to identify opportunities for improved commissioning (QOF requirements),
- Alignment with Public Health priorities 2014/15,
- Consideration of "fit" with longer term strategy for system sustainability,

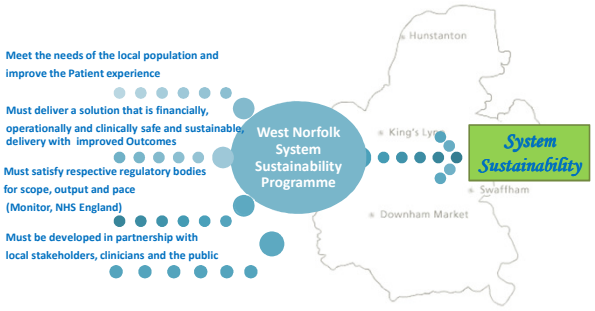
Four main aims:

- Commissioning integrated services for the patient population in order to improve quality of care,
- Improving the health and wellbeing of the people of W. Norfolk and addressing health inequalities,
- Preventing disease and premature death,
- Decreasing hospital admissions for long-term conditions,

WNCCG will continue to utilise available contractual levers and incentives and wherever possible will pool resources across health, social care, voluntary and independent sector

4

Strategic Direction – System Sustainability



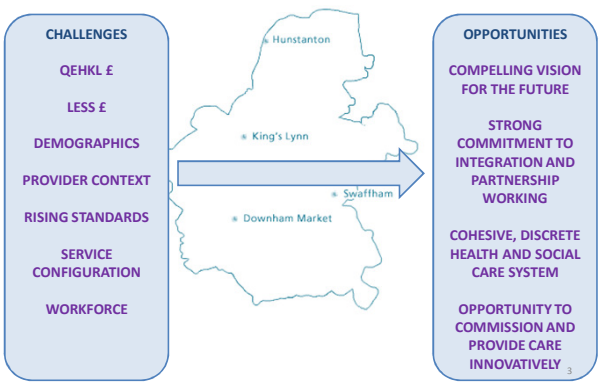
2

Key Areas of Commissioning Focus in 2014/15 (1)

- Dementia: improved early diagnosis, assessment and referral,
- Improving access to mental health services, through earlier identification, and transparent assessment and treatment pathways for service users and referrers,
- Integration of frail and elderly pathway: integration across "frail and elderly" pathway across health, social care, voluntary and independent sector,
- Continued focus on improvement in Urgent Care delivery including Paediatric urgent care and review local sustainability and community/ acute pathway interface,
- Cardiology – review local vs. clinical network and tertiary services,
- Pathway reviews: opportunity for community interventions:
  - Urology
  - Pain management
  - Gastro-intestinal
  - Ophthalmology

5

WEST NORFOLK SYSTEM SUSTAINABILITY CONTEXT



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Key Areas of Commissioning Focus in 2014/15 (2)

- Cancer: improved early diagnosis and intervention, and participation as pilot site for a national Macmillan End of Life Care at Home initiative,
- Ambulatory Care Sensitive conditions: increased treatment in community settings where clinically appropriate and improved hospital treatment pathways,
- Prescribing improvements: in line with best practice guidance regarding prescribing and benchmarking data, to ensure alignment with national standards,
- Collaboration with provider partners, patients and the public in commissioner led redesign programme to ensure long term system sustainability,
- GP Education: opportunity for heightened education to improve referral behaviour and strengthen clinically led commissioning,

In addition to the above, on-going work to continually improve patient safety, and clinical quality

6

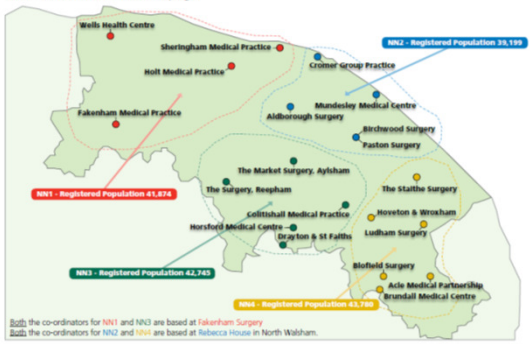
NHS
North Norfolk
Clinical Commissioning Group

High Level Commissioning Intentions 2014/15 & beyond

Dr Anoop Dhesi, Chairman

NHS
North Norfolk
Clinical Commissioning Group

North Norfolk CCG Practice Groupings



NHS
North Norfolk
Clinical Commissioning Group

Ensure the safety of services currently commissioned for people in North Norfolk

- Emergency Ambulance Services & wider unplanned care system
- Mental Health Services
- Ensure quality of care for looked after children

Prevent People from Dying Prematurely; Safe Care

Transform care such that a fully integrated Primary, Community, Social and Secondary Care service is a day to day reality for people in North Norfolk

Best Quality of Life for people with a LTC; Quick & Successful recovery from illness; Great experience of care; safe care.

Delivering all of the above in the most challenging Financial context

NHS
North Norfolk
Clinical Commissioning Group

So what will be different by 2015?

Delivering Integrated Care

- Every older person at risk is known about
- Their care across agencies co ordinated by dedicated staff
- Has a named GP
- Full health and social care team support
- Patient held care plans which can be "switched on 24/7"
- Volunteer support which better aligns across agencies
- Specialist advice from secondary care can be accessed without admission to hospital
- Development of more bespoke services in Community Hospitals
- Much more effective support for patients living in care homes
- Develop links with housing sector

Delivering Safe Care

- 60% minimum performance against 8 minute emergency response standard and 75% minimum performance against 19 minute emergency response standard
- Complete safe implementation of new mental health services by Norfolk & Suffolk Foundation Trust
- Ensure that all Looked after Children receive at least annual health checks

NHS
North Norfolk
Clinical Commissioning Group

NHS
North Norfolk
Clinical Commissioning Group

Any Questions?

NHS Norwich Clinical Commissioning Group

2014/15 Commissioning Intentions

Health & Wellbeing Board
8th January 2014

NHS South Norfolk Clinical Commissioning Group

High Level Commissioning Intentions 2014/15 & beyond

Dr Jon Bryson, Chairman

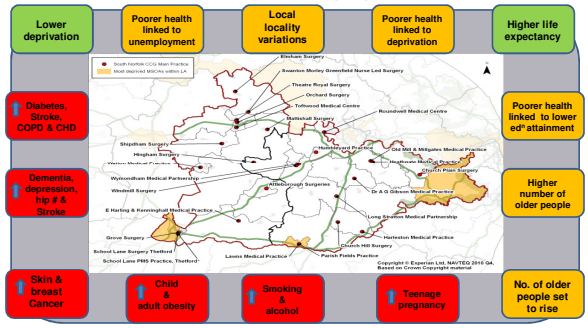
NHS Norwich Clinical Commissioning Group

Acute Care (Coordinating Commissioner)

- Operation Domino (all providers of urgent care) – further CQUIN investment in urgent care services
- Trauma & Orthopaedic Services – pathway improvements (access & choice)
- Stroke – further improvements in hyper-acute and acute care

NHS South Norfolk Clinical Commissioning Group

South Norfolk CCG (pop 223,000)

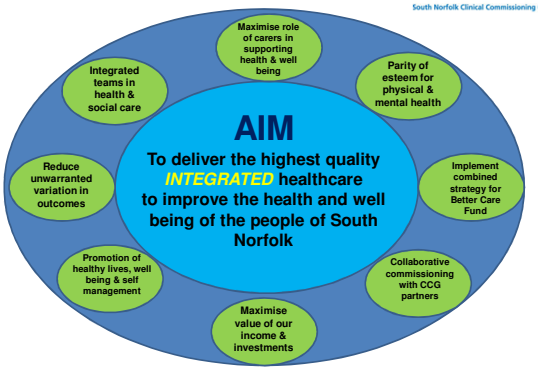


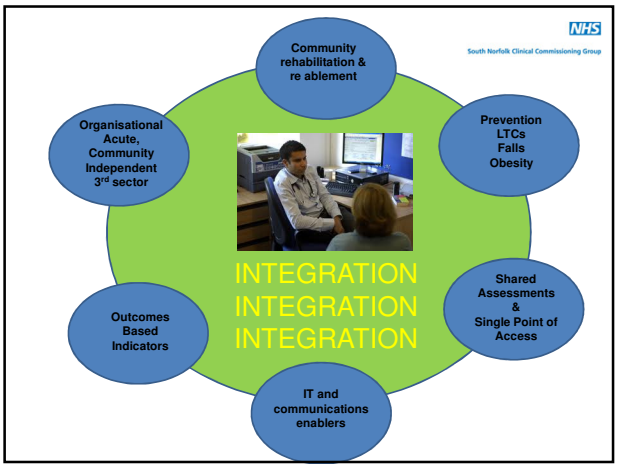
NHS Norwich Clinical Commissioning Group

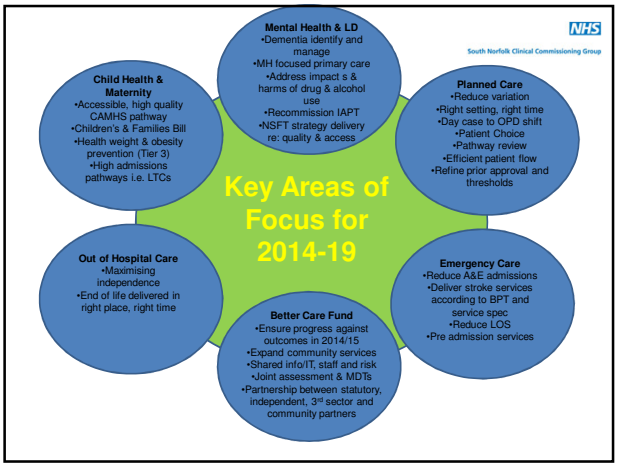
Community & Mental Health Services

- Patient Opinion – quality requirement for all major providers
- Continuing Healthcare – bringing CHC care into mainstream contracts for care continuity & cost efficiency
- End of Life Care – enabling choice & control (place of care)
- Community Mental Health – model redesign & re-procurement

NHS South Norfolk Clinical Commissioning Group







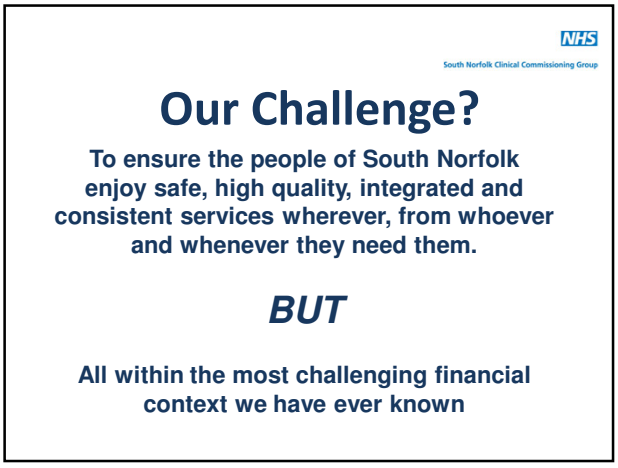
NHS
Great Yarmouth and Waveney Clinical Commissioning Group

HealthEast

Commissioning intentions 2014/15 and beyond

Andrew Evans
Chief Executive
January 2014

Better Health, Better Care, Better Value



Aiming to achieve

NHS
Great Yarmouth and Waveney Clinical Commissioning Group

HealthEast

- Focus on our whole population
- Integration across the public sector
- Best use of total resources
- Well-being not health alone
- Care at home and in the community
- Removal of perverse incentives
- Vertical integration effects
- Prevention and early treatment
- Sharing care, resources, risks and benefits with partners

Better Health, Better Care, Better Value

Contracting actions

NHS
Great Yarmouth and Waveney Clinical Commissioning Group

HealthEast

- Single operational management arrangements across pathways/disease areas required
- Respiratory care pilot- whole care approach
- Some movement from *Payment By Results*
- Out of hospital team
- 7 day working requirements
- Investing in primary care
- Virtual pooling of budgets with partners – CCs, D/BCs, NHS England
- Scrutiny of value for money of all contracts

Better Health, Better Care, Better Value

Report to Norfolk Health and Wellbeing Board

1 April 2014

Item 5

The Norfolk Better Care Fund – final submission

Cover Sheet

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

This report provides the two templates which are required to be approved by the Board by 4th April for the Norfolk Better Care Fund. The plan will then progress to NHS England and the Department of Health and Department for Communities and Local Government for final approval.

Key questions for discussion

Q.1 Does this plan reflect our vision and ambition for integrated health and care in Norfolk?

Q.2 What is the relationship between these plans and the CCGs wider strategic and operational plans and how will they impact on each other?

Q.3 How will the Board be assured of the delivery against the Norfolk Better Care Fund?

Q.4 What risks does this approach pose to the system and how are they to be mitigated?

Actions/Decisions needed

The Board is asked to:

- Approve the Norfolk Better Care Fund set out in templates 1 and 2.

Report to Norfolk Health and Wellbeing Board

1 April 2014

Item 5

The Norfolk Better Care Fund – final submission

Report of the

Director of Community Services
Chief Officer of NHS Great Yarmouth and Waveney Clinical Commissioning Group
Chief Officer of NHS Norwich Clinical Commissioning Group
Chief Officer of NHS North Norfolk Clinical Commissioning Group
Chief Officer of NHS South Norfolk Clinical Commissioning Group
Chief Officer of NHS West Norfolk Clinical Commissioning Group

Summary

The Board received a full briefing on the Better Care Fund in January 2014 and approved the subsequent 'first cut' of the Norfolk Better Care Fund templates in February.

Detailed work has been undertaken during the past few weeks to further develop the Norfolk Better Care Plan. This has been founded in system-wide partnerships. However, all parties are clear that the plans will require further development given the complexity of the changes proposed. Therefore, this proposal for Norfolk's Better Care Fund is a significant stage in the creation and delivery of ambitious transformation, sitting alongside wider operational and strategic plans. During 2014/15 partners will focus on starting to make an impact by transforming services followed by the full implementation of the fund from 2015/16.

Key changes which the Board will want to consider since the 'first cut' are:

- Some further refinement of the plans set out in template 1, but no substantive changes to vision and intent
- The submission of template 2 which sets out the finances and metrics. This was not completed at 'first cut' and reflects the activity and funding detail behind the ambition and schemes set out in template 1.

Attached is the final proposal for the Norfolk Better Care Fund made on behalf of Norfolk County Council and the five Norfolk Clinical Commissioning Groups.

Action required:

The Board is asked to:

- Approve the Norfolk Better Care Fund set out in templates 1 and 2.

1. Background

1.1 At the January meeting of the Norfolk Health and Wellbeing Board the Board received a report setting out the requirements of the Better Care Fund initiative. The report to the Board is available at the following link.

1.2 In February the Board approved the 'first cut' of the Norfolk Better Care Fund templates 1 and 2, as required by the national programme. The Board provided feedback to the commissioners developing the plan which has been addressed in this final plan.

1.3 The Health and Wellbeing Board is required to approve the final plan set out in updated templates 1 and 2 (attached) by 4th April 2014. NHS England will review and Ministers will then consider final plans to give approval to release funds.

2. Development since the 'first cut'

2.1 Detailed work has been undertaken within partnerships during the past few weeks to further develop the Norfolk BCF plan. Key changes which the Board will want to consider since the 'first cut' are:

- Further refinement of the details set out in template 1 as a consequence of developing plans, including updates on engagement. There are no substantive changes to vision and intent but details of schemes have been developed.
- Substantial work on finances and metrics to model the changes in activity and performance proposed through the integration programmes. This was not completed at 'first cut' and reflects the detail behind the ambition and schemes set out in template 1. It is however necessarily at an early stage of development and will be further refined.

2.2 All parties are clear that the plans will require further iterations of their development and over the coming months. Therefore, this proposal for Norfolk's Better Care Fund must be seen as a significant stage in the creation of ambitious transformation. The fund is positioned in a challenging funding environment and the allocated resources for 2015/16 are not sufficient to meet anticipated service demand. Therefore it is crucial that transformations are delivered during 2014/15 to create early impact to reduce these pressures. We will act to implement early.

3. Unit of planning for the Fund

3.1 A Better Care Fund plan is required for each Health and Wellbeing Board. The Norfolk Better Care Fund sets out the vision, schemes, finance and performance for the delivery of integration in health and care for the county of Norfolk.

At the 'first cut' stage it was agreed that the Norfolk Better Care Fund will reflect integration plans which are developed at CCG level i.e. there are 5 local integration plans for Norfolk which deliver the Norfolk Better Care Fund.

These local integration plans reflect the health and care systems which are established in Norfolk and are importantly reflective of the different needs of the local populations. Planning and delivery at CCG level will provide the necessary design tailored to local need and local leverage to deliver. There is an established approach to collaboration across areas for the benefit of service and individual outcomes e.g. the urgent care system relating to the central area, integration of community health and social care management. The Board will wish to ensure accountability for the picture for the whole of Norfolk.

Performance measures

3.2 The national indicators for the Better Care Fund are:

- admissions to residential and care homes;
- effectiveness of reablement;
- delayed transfers of care;
- avoidable emergency admissions; and
- patient / service user experience.

3.3 In addition, the partners are required to set an additional indicator of their choice. Indicators have been agreed on the basis of the local population priorities in order to focus improvement on an area where it is believed that this will support tangible improvements, particularly in reducing unnecessary admissions to acute hospital.

Great Yarmouth and Waveney	Experience of support with long term conditions
North Norfolk	Dementia assessments
Norwich	Experience of support with long term conditions
South Norfolk	Experience of support with long term conditions
West Norfolk	Dementia assessments

3.4 A substantial element of the fund will be dependent on achieving targets. Challenge and opportunity has been carefully considered in setting targets, with detailed activity to benchmark current performance, understand trajectories and the impact which schemes offer. The Health and Wellbeing Board will want to consider its role in understanding the impact on performance of the Better Care Fund both locally and across the county.

4. Conclusion

The Norfolk Better Care Fund will support the development of integrated care in local areas and clear plans are in place and are set out in template 1 and 2. It is recognised that these will require further development, focussed implementation and close monitoring.

5. **Action required:**

The Board is asked to:

- Approve the Norfolk Better Care Fund set out in templates 1 and 2.

List of Appendices:

Norfolk Better Care Fund template 1

Norfolk Better Care Fund template 2

Officer Contact

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

Officer Name	Tel No;	email address
Catherine Underwood	01603 224378	catherine.underwood@nhs.net

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

Norfolk's Better Care Fund planning template – Part 1

Please note - there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**NORFOLK COUNTY COUNCIL**
Clinical Commissioning Groups	**Great Yarmouth and Waveney**
	Norwich
	North Norfolk
	South Norfolk
	West Norfolk
Boundary Differences	Great Yarmouth and Waveney CCG includes Waveney which is part of Suffolk. Great Yarmouth and Waveney have ensured alignment with the Norfolk and Suffolk BCF plans. In addition, district and borough council boundaries are not co-terminous with CCGs and this will require us to work in partnership across boundaries.
Date agreed at Health and Well-Being Board:	**<dd/mm/yyyy>**
Date submitted:	**<dd/mm/yyyy>**
Minimum required value of BCF budget: 2014/15	**£3,482,000**
2015/16	**£62,461,000**
Total agreed value of BCF budget: 2014/15	**£5,644,000**
2015/16	**£62,461,000**

b) Authorisation and sign off

Signed on behalf of NHS Great Yarmouth and Waveney Clinical Commissioning Group	
By	Andrew Evans
Position	Chief Officer
Date	<date>
Signature:	
Signed on behalf of NHS Norwich Clinical Commissioning Group	
By	Jonathon Fagge
Position	Chief Officer
Date	<date>
Signature:	
Signed on behalf of NHS North Norfolk Clinical Commissioning Group	
By	Mark Taylor
Position	Chief Officer
Date	<date>
Signature:	
Signed on behalf of NHS South Norfolk Clinical Commissioning Group	
By	Ann Donkin
Position	Chief Officer
Date	<date>
Signature:	
Signed on behalf of NHS West Norfolk Clinical Commissioning Group	
By	Sue Crossman
Position	Chief Officer
Date	<date>
Signature:	
Signed on behalf of Norfolk County Council	
By	Anne Gibson
Position	Chief Executive
Date	<date>
Signature:	
Signed on behalf of Norfolk Health and Wellbeing Board	
By	Councillor Daniel Roper
Position:	Chair of Health and Wellbeing Board
Date	<date>
Signature:	

Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it.

Provider engagement across Norfolk
The Better Care Fund is developed through the existing joint planning arrangements between commissioners and providers in Norfolk. This is underpinned by our well-established integrated commissioning arrangements, where each CCG has an integrated commissioning team with the County Council. Each area has a programme providing a transformational approach to integration of health and care services. The major health and care providers in acute, community and mental health have been integral to the development of local integration models and are already engaged in the realisation of the local vision for services.

Clearly the shift from acute to community has a focused impact for NHS providers and this has been the subject of detailed discussion. The impact for the wider community of service providers is very clearly built in to the plans and has been explored during the development of this plan. Further detail will be developed as we progress.

Each of the plans sets out the strengthened role that the independent care sector will play as a key component of integration. Engagement with care providers through Norfolk County Council's work with Norfolk Independent Care (NIC) and the wider provider market has been examining the independent care sector role in an integrated world, particularly with a focus on dementia and admission avoidance. The BCF planning has been shared and discussed at the Joint Consultative Group between the Council and NIC. The CCGs joined the county's autumn Care Conference to speak directly to independent providers about integration and the opportunities ahead and this has been explored in some detail in local areas.

Each of the plans also sets out how voluntary and community services are anticipated to play in the future configuration of care and support, with a focus on collaboration for innovation and impact. There is a clear commitment to voluntary sector initiatives and to supporting community capacity to support those most at risk. Integration and subsequently the BCF has been a topic for discussion at the Joint Health and Social Care Voluntary Sector Forum, where draft plans have been shared. There has been some active commissioning of voluntary sector provision whilst the plan has been in development.

The Better Care Fund requires the funding for the Disabled Facilities Grant to be passed to the second tier local authorities in year one. However, the partners have clearly recognised that during the coming year they will seek to develop further the opportunities for working collaboratively with particular consideration areas such as housing and housing-related support, wider community initiatives, housing adaptations and home improvement. Links between housing support, district services and primary care have been successfully secured in pilot initiatives.

Provider engagement in Great Yarmouth and Waveney
Great Yarmouth and Waveney CCG hosts a System Leadership Partnership with full public sector and voluntary provider representation including Norfolk County Council, East Coast Community Health and Care (ECCH), Norfolk and Suffolk Foundation Trust (NSFT), James Paget Hospital (JPH) which has been involved in the Better Care Fund planning. A letter of intent has been signed by each commissioning organisation for the

area: CCG, Norfolk and Suffolk County Councils and Great Yarmouth Borough Council and Waveney District Council.

An integrated care system event was held in December 2013, attended by all public sector commissioners and providers from the area. At this event the declared intention to develop an Integrated Care System was fully debated alongside the opportunities presented by the Better Care Fund, including 7 day working, cohesive pathways, combining budgets and workforce. In addition to specific engagement events Great Yarmouth and Waveney CCG and Norfolk County Council also work closely with providers in health and social care on specific developments related to the integration agenda such as in developing the CCG Out of Hospital strategy which is a key element of the BCF plan.

This engagement with partners has guided Great Yarmouth and Waveney CCG's approach to their 2 year operational and 5 year strategic planning to improve outcomes for the public, provide better value for money and be more sustainable, where health, social services and district councils work together to meet individual needs.

Provider engagement in North Norfolk

North Norfolk CCG and its partners have the delivery of a fully integrated primary, community and social care service at the heart of its strategy. This is based on 4 integrated teams working as hubs of 4-5 general practices. North Norfolk has been working with the Sir John Oldham programme for long term conditions and has a well-developed programme to develop integration around a model which stakeholders and the Governing Body have agreed. NNCCG has a structure of established forums where integration is progressed:

The Integrated Care Programme Board is clinically led with community providers represented including Norfolk County Council, Norfolk Community Health and Care, Norfolk and Suffolk Foundation Trust. The board developed, agreed and signed off North Norfolk's Integrated Care Programme, including North Norfolk's Integration Pioneer Bid.

The North Norfolk and Rural Broadland Strategic Partnership has strategic representation from the CCG, Norfolk County Council Community Services, Children's services and Public Health, along with Broadland and North Norfolk District Councils. This group has the strategic lead on all developments that impact on the health and wellbeing priorities for North Norfolk and have been reviewed and agreed North Norfolk's Integrated Care Programme.

NNCCG has held two annual stakeholder events 2012 & 2013 which have engaged voluntary sector and community sector representatives to shape models of care and the voluntary sector's role in this shaped our local Integrated Care Programme modelling.

North Norfolk's Provider Forum details developments, key ambitions and helps inform the market of future key priorities for delivering better integrated care. A networking event at the forum in February 2014 was designed to help providers understand who is in their local market to facilitate improved joint working and local service development in particular with key NHS and social care providers.

Provider engagement in Norwich

Norwich CCG has established with partners a strong vision and model for the delivery of integrated care, focused around primary care hubs in the city. The NCCG Chair and CEO met key statutory health and social care providers in December 2013 to explore the Better Care Fund and from this to develop the vision. Participants contributed directly to

the four main elements of the outline model. A 'Blueprint' meeting with key stakeholders was held on 11 February, to further the shared development of the programme. Senior representatives of local health provider trusts contributed and there was strong buy-in to the proposed vision for a new integrated model of care

The NCCG Chair and CEO addressed a stakeholder conference of voluntary sector organisations working in Norwich in November 2013 and explored how the voluntary sector would be involved in future in the new funding landscape envisaged under the Better Care Fund. A newly established representative Voluntary Sector Steering Group had further discussions first on 6 January 2014 and has met since to help develop aspects of the Community Asset proposals.

A member of the Governing Body member joined the Norwich Provider Forum held on 4 February 2014 to discuss integration and the Fund with independent providers.

Provider engagement in South Norfolk
In the South Norfolk CCG area the development of Better Care Fund planning builds on and widens an established strategic commitment to deliver integrated care and support for frail older people. New and established mechanisms have been used for discussions and joint planning between commissioners and service providers to more integrated services. For South Norfolk this includes:

- Engagement, feedback and findings from frail older people initiatives where South Norfolk was an early adopter in the integrated care pilot.
- Contract related and other planning meetings during 2013/14 between commissioners and NHS providers and Norfolk County Council to plan and tailor current services towards greater integration in community provision.
- Consultation and planning around integrated service development at the well-attended multi-agency South Norfolk provider forum (quarterly meeting between commissioners and health social care support and voluntary sector providers). This has included a recent themed session on planning for dementia support and palliative care.
- A joint agency programme group which meets monthly to oversee, plan and coordinate the roll out of integration models and initiatives across South Norfolk.
- Establishing and working with an integration planning stakeholders group for SNCCG which includes representation from NHS provider managers and independent care provision.

Provider engagement in West Norfolk
In West Norfolk, the model of integration was initially developed as part of the pilot Integrated Care Organisations in 2009. West Norfolk has secured an agreed approach to integration through the West Norfolk Alliance. The CCG leads this group with senior membership from Norfolk County Council, Norfolk Community Health & Care NHS Trust, Queen Elizabeth Hospital NHS Foundation Trust, along with Borough Council of King's Lynn & West Norfolk, West Norfolk Voluntary and Community Action, Norfolk & Suffolk Foundation Trust. Together the Alliance partners aim to work with key stakeholders and private sector providers to take a whole-sector approach to providing health and social care in West Norfolk. This group developed the Integration Pioneer bid. (This bid was shortlisted and would have been successful but for the local acute hospital being placed in special measures).

Meetings with individual providers and quarterly health and social care Provider Forums have addressed the challenge and opportunities of greater integration. The regular

Integrated Care Organisation Steering Group meetings, launched as part of the national pilot, have continued in monitoring our local long-standing Integrated Care Organisation initiative. Future challenges and the contribution of greater partnership working has been a common theme.

c) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

Patient, user and public engagement across Norfolk
Norfolk's Better Care Fund plan has been founded on what people have told us matters to them in their care and health services. It is founded on consultation and engagement with the public, patients and service users which pre-dated the Better Care Fund. As part of Norfolk's engagement with the Integration Care Pilots, there was a programme of engagement with patients and a set of priorities which then underpinned the development of local integrated care. The key messages from the patients we engaged with were:

- I want better coordination of services
- I see the General Practice as the natural focus for care
- I want care delivered locally
- I want one person to act as my key worker and to know my story
- I do not want to have repeat assessments
- I want clear easy to use information such as a single telephone number.

At a county level, the Norfolk Making it Real group comprises representatives from user groups across the County and works in partnership with the Council to monitor the transformation of social care against the delivery of the Think Local Act Personal 'I statements'. The group has membership from disabled user forums, older people's forums, learning disability and mental health user groups, carers groups and from black and minority ethnic service users. It has committed to providing a route to test the impact of implementing the Better Care Fund alongside the wider programme of social care transformation and the experience of and outcomes for people using services.

The Care Bill proposes strengthened entitlements for carers which will be the subject of specific engagement in modelling the shape of future integrated services.

Each CCG area has a structure for engaging with patients, service users and the public.

Patient, user and public engagement in Great Yarmouth and Waveney
Great Yarmouth and Waveney CCG 'sees patients as the focus of all that they do'. Across the area there is active patient, carers, service user and public engagement. Commissioning Programme Boards include representation from patients, family carers, service users and the public. The views of these groups are regularly sought through Commissioning Programme Boards and wide range engagement events to inform the development of integration and future commissioning intentions. These include public consultations, working alongside our patient groups in our 26 GP practices, working with Healthwatch and our local Health Scrutiny Committees. Great Yarmouth & Waveney partners have listened to what patients and service users have said and included their views in strategic and operational planning including the overall approach to the Better Care Fund. The CCG also has a patient representative on the Board and the Better Care Fund has been fully discussed and debated in this forum with key focus on patient

experience and outcomes. Patients and customers have said clearly that they want to experience a joined up system.

Patient, user and public engagement in North Norfolk

Patients, service users and carers are central to planning health and care services in North Norfolk. Local people have been involved in the development the integrated care programme thorough the following mechanisms, which will also be used to monitor the success of implementation:

Annual Stakeholder events – In 2012 local people said they wanted joined up holistic care with a single point of access. A model was then developed and shared with stakeholders in 2013. This included discussions on how the voluntary sector can support integrated care.

Patient Conferences – The biannual patient conferences are attended by members of local Patient Participation Groups. The conference held in October 2013 looked at a vision for local integrated community services and this is being followed 29 April 2014 with a conference taking a detailed look at the North Norfolk integrated model of working and our vision for 2016.

Coaching for Health Focus Groups – a series of focus groups were held with local patients with Long Term Conditions to explore the importance of self-management in their care, in particular the use of coaching techniques by clinicians.

Referral Management Service – patients referred by General Practices into the North Norfolk Referral Management Centre are being contacted to give feedback on the services they received. Most of these people have a life-limiting condition and are also asked for general feedback, which has also been used to monitor issues around communication and the integration of services.

Partnership News – A quarterly newsletter is circulated to the NNCCG stakeholder database and to all Patient Participation Groups to keep them aware of the work of the CCG and ask for ideas and feedback, and to present opportunities for partnership working. The progress of North Norfolk CCG as it moves towards integrated care has been regularly documented.

The North Norfolk Living Well with Dementia – A project steering group includes a Healthwatch volunteer who cares for an elderly relative with dementia. Task and finish groups have been established to deliver the project outcomes and a local patient has been recruited; to advise from a carer perspective.

Planned engagement – NNCCG is in the process of planning engagement in the following areas that will impact on integrated care: falls survey, patient experience, supporting PPGs project.

Patient, user and public engagement in Norwich

NHS Norwich CCG has taken a multi-faceted approach to involvement and engagement of individuals, stakeholders and communities:

Health and Wellbeing Strategy Consultation - a three month consultation to allow patients, public and stakeholders to share their views with us on the proposed strategy including open meetings and a structured voluntary sector event.

The CCG has established the NHS Norwich Community Involvement Panel (CIP) - “You often hear about user involvement but co-production is far more than this. To me it is not just about being asked what I think of something but being a true equal partner and having the same influence to change things as everyone else. For change to happen and

work well it needs to be co-produced." *Member of the NHS Norwich CCG Community Involvement Panel*
The CIP is involved in a number of aspects of engagement within the CCG from informing and co-producing involvement activity advising on how to involve and when to involve communities to sitting on our internal Clinical Action Teams. By working in a co-productive way with members of our community the intention is to ensure that the CCG has developed and embedded co-production in the planning and development of services within the CCG and are working towards rolling this out within the Norfolk health commissioning system when working in partnership with our neighbouring CCGs.

Commissioning intentions 2014/15:
The CIP is currently in the process of working with the CCG regarding commissioning intentions, development of services around practice clusters and further involvement around the development of the Better Care Fund. This will be carried out by co-producing both the engagement activity and procurement of services for the coming year. It will include community services, out of hours/111, 7 day working and the Operation Domino urgent care programme.

Building a community asset based third sector:
The CCG is currently working with members from the third/voluntary sector on building the assets of the communities with the CCG area. We are actively involved with and work with the following groups which assist us to access 'hard to reach communities'

- Norfolk Equality and Diversity Council
- BME Health Forum
- Broadland Youth Advisory Board
- Norwich Youth Advisory Board
- Carers Council for Norfolk – Norwich branch
- Your Voice Membership – partner
- Community Relations Equality Board (CREB)
- INTRAN partnership – lead CCG
- Making it Real Steering Group
- Norfolk Equality and Diversity Council
- Norwich Older Peoples Forum.

A steering group has recently been established with members representing key strategic voluntary and community sector objectives to engage better and assist in developing CCG plans. The Better Care fund and the broader ambitions for a new Model of Care have been discussed with the group. Detailed discussion on the BCF itself took place at the Blueprint meeting on 11 Feb.

Patient, user and public engagement in South Norfolk
South Norfolk's Communication and Engagement Strategy is produced and coordinated by South Norfolk CCG's Engagement Lead and Governing Body Lay Member Representative for Patient and Public Involvement in conjunction with the wide range of organisations and groups that represent people who use health and social care services.

Engagement mechanisms include:

- Annual stakeholder event (most recently in November 2013)
- Working actively with Patient Participation Groups (PPGs) at each of the 24 GP practices in South Norfolk
- A key patient involvement event is being planned for 2014 with other CCGs to bring together representatives from all the PPGs

- Local strategic forums across South Norfolk CCG area to bring together key commissioners from health, social care and district councils with input from key provider, service user groups and local Healthwatch
- Regular attendance and input at health and social care forums in South Norfolk and Breckland, including Older People's forums, Youth Advisory Boards, Mental Health and Carers' Locality groups.
- The involvement of members of the public (people who use services and carers) in specific pieces of commissioning work.

The multi-agency integration stakeholders group includes regular input from the older people's forum and Healthwatch. It is looking to ensure a wider range of voices are involved in strategic planning for integrated services. Discussions are underway with local interested groups about what integration of health and social care means and will look like from the perspective of the people who use services, with particular emphasis in under-represented patient groups and communities. The existing local links will be built on, specifically with Breckland and South Norfolk Older People Forums; with Opening Doors (a self-advocacy organisation for people with learning disabilities) and with Equal Lives (a user led organisation for people with physical or sensory impairments, mental ill health and people with learning difficulties).

Patient and Public Involvement leads for the central planning cluster CCGs are collaborating to arrange for some joint engagement events to inform integration planning. South Norfolk CCG will also involve patients, people who use services and the public in co-producing the implementation programme, which will seek to:

- involve people across a range of mechanisms (including workshops, discussion forums, online questionnaires and information streams) and build on existing work with Healthwatch Norfolk and the 'Your Voice' engagement network in Norfolk, as well as current co-produced commissioning projects
- involve people at strategic levels of decision making to inform the vision, strategic and financial forward planning
- involve people as 'experts by experience' in key aspects of the implementation of the integration programme e.g. in service redesign, as researchers to gather further evidence of people's experience of health and social care services; to agree co-produced outcomes and measures; as evaluators of the impact of integrated services on the lives of people

Patient, user and public engagement in West Norfolk

The principles and plans around greater integration have been a regular topic in the range of patient, service user and public meetings since the establishment of West Norfolk Clinical Commissioning Group. These have include monthly Community Participation Panel meetings, regular very well attended Public Engagement events, public stakeholder events focussing on particular subject areas (e.g. a series of public events on dementia), as well as the development of a close working relationship with the West Norfolk Older Peoples Forum.

Future involvement will range from providing information (in various formats) about services, holding discussion groups, public meetings and events to invite feedback and to provide the opportunity for formal consultation where required.

The West Norfolk Alliance has adopted the Clinical Commissioning Group's principles for user group/ patient and public involvement, engagement and communication:

- To ensure that user groups/patients and public can share their experiences of

health and care services and that feedback will be used to inform the development of services;

- To provide opportunities for users/patients and the public to respond to, and comment upon, issues in order that they can influence decision about system structures and ensure that proposed models are convenient and effective;
- To ensure that patients and the public understand how their views will be used, which decisions they will be involved in, when decisions will be made and how they can influence the process, and publicise the ways in which their input has influenced decisions;
- To provide clear and timely information about services; which help people to access appropriate services.

d) Related documentation

Documents and Links

Norfolk County Council

Document or information title	Synopsis and links
Norfolk Joint Strategic Needs Assessment	A collection of information that covers **Norfolk's** population exploring health and wellbeing needs. Norfolk Insight – Joint Strategic Needs Assessment
Norfolk's Market Position Statement	Link to Provider Portal page that includes links to the 2012 Market Position statement, and updates that explain how this is being refreshed this year: Social Care Market Development
Norfolk Social Care benchmarking report 2012/13	Summary of performance and service data submitted nationally and benchmarked Norfolk Benchmarking Report 2012/13 doc – copy available on request
County Council Plan and Community Services Service Plan	Norfolk County Council's planning framework including the whole council plan, and links to the Community Services Service Plan: County Council Plan and Community Services Plan

Great Yarmouth & Waveney

Document or information title	Synopsis and links
Great Yarmouth and Waveney Commissioning intentions letter	The CCG commissioning intentions letter provides information about priorities and intentions for the coming year. www.greatyarmouthandwaveneyccg.nhs.uk/store/documents/20130930 2014to2015 commissioningintentionsletter.final.pdf
Great Yarmouth and Waveney CCG Engagement Strategy	This new strategy builds on extensive engagement completed during the development and publication of NHS GY&W Communications and Engagement Strategy. www.greatyarmouthandwaveneyccg.nhs.uk/store/documents/cestrategy.pdf
Great Yarmouth and Waveney expression of Interest in Becoming a Health and Social Care Integration Pioneer	Application for Great Yarmouth and Waveney to be an integrated pioneer project. Expression of Interest in Becoming a Health and Social Care Integration Pioneer doc – copy available on request
Great Yarmouth and Waveney 7 day working pioneer bid and 7 day transformation presentation day to the NHS Improving Quality Team.	Expression of interest for a 7 day service to the Transformational Improvement Programme. Expression of Interest – Seven Day Services Transformational Improvement Programme document – copy available on request Great Yarmouth & Waveney Integrated Care System document – copy available on request
Terms of Reference of the Great Yarmouth and Waveney System Leadership Partnership and Terms of Reference the Great Yarmouth and Waveney Integrated Care System Programme Board	To develop and oversee action plans and agreed programme work streams to ensure whole system engagement, commitment and implementation of the Integrated Care System principles.

North Norfolk

Document or information title	Synopsis and links
NNCCG Prospectus 2013-14	This Prospectus explains what North Norfolk Clinical Commissioning Group (NN CCG) is, who we are, what we do and how we plan to improve the health of the residents of North Norfolk
Communications and Engagement Strategy 2012-15	This document looks at strategic approaches to engagement as well as plans for future development
Information governance and data protection policy	This policy outlines the principles of Information governance and data protection that are applied to North Norfolk Clinical Commissioning Group (NNCCG / the Group) and its member practices
Commissioning intentions 2014/15	Summary of NNCCG Commissioning intentions
North Norfolk – A Health & Social Care Integration Pioneer	The expression of interest for North Norfolk to become a Health and Social Care Integration Pioneer
Integrated Care Programme Plan	Integrated Care Programme work streams and progress towards milestones (March 2014)
Integrated Care update to Board of Governors	Progress report (March 2014) on integrated care programme plan

Norwich

Document or information title	Synopsis and links
NCCG Prospectus 2013/14	This paper sets out the CCG priorities and approach to improving health and wellbeing in Norwich. http://www.norwichccg.nhs.uk/publications-policies/doc_download/115-prospectus-2013-2014
Central Norfolk CCG's Plan on a Page	This is the plan (item 13) agreed across the three central Norfolk CCGs.
NCCG Communications & Engagement Strategy	http://www.norwichccg.nhs.uk/publications-policies/doc_download/69-communications-and-engagement-strategy
Operation Domino (Paper submitted to Governing Body January 2014)	This paper describes the approach to addressing urgent care http://www.norwichccg.nhs.uk/publications-policies/doc_download/271-item-13-operation-domino-update
Norwich Healthy City Programme	NCCG Approach to Healthy Norwich is documented in 2013/2018 Health and Wellbeing Strategy http://www.norwichccg.nhs.uk/publications-

	policies/doc_download/1-health-and-wellbeing-strategy
Norwich City Council Housing Strategy	Housing Strategy 2013-18
Broadland District Council Housing Action Plan	Housing Strategy Action Plan

South Norfolk

Document or information title	Synopsis and links
South Norfolk Integration Project Plan for 2014-16	2 year project implementation plan for the use of the Better Care Fund and progress of health and social care integration in South Norfolk CCG area:
South Norfolk CCG Communications and Engagement Strategy 2012-16	SNCCG Communications & Engagement Strategy 2012-16
South Norfolk Commissioning Strategy 2012-16	SN Commissioning Strategy 2012-16
South Norfolk CCG plan on a page	SNCCG Plan on a Page
SSNCCG planning round papers for funding the SNCCG operational plan	Showing a number of workstreams and priorities for the CCG which are core to integration:

West Norfolk

Document or information title	Synopsis and links
Commissioning Intentions for health and care in West Norfolk in 2014/15 and beyond	Presentation to the Norfolk health and Wellbeing Board outlining the wider context within which sits the Integration Project. Commissioning Intentions for Health & Care in West Norfolk in 2014/15 and beyond doc – copy available on request
Developing the West Norfolk System Sustainability programme Phase 2	Narrative on the governance arrangements for the Integration Project West Norfolk Alliance – Developing the WN System Sustainability Programme – Phase 2 doc – copy available on request
"Integration Pioneer" submission	The original submission for "Integration Pioneer" status that continues to provide the strategic focus for the Integration project. Expression of Interest – Integration Pioneers

	Network doc – copy available on request
WNCCG Prospectus 2013-14	This Prospectus provides general information on the West Norfolk Clinical Commissioning Group
WNCCG Communications and Engagement Strategy 2013/14	This document details the WNCCG Communications and Engagement Strategy

VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

The vision across Norfolk
Norfolk is ambitious for integrated care and for the Better Care Fund. We have strong collaborations for integration with an excellent track record of innovating and piloting integrated approaches. We have already embedded integrated commissioning into our structures between CCGs and the Council and we have well-established partnerships on which we are confidently building.

We see the Better Care Fund as a catalyst for us to move forwards with ambition and confidence, not only to face the challenges in the current system, but to achieve the transformation needed to sustain the health and wellbeing of people in Norfolk for the future. We see the Fund as only the beginning and aspire to build much wider joint commissioning and collaborative approaches to delivering integrated care and therefore better outcomes for people. In terms of our approach to the Fund, we recognise the opportunities of pooling and aligning resources across a much wider scope of health and care, in order to support an ambitious integration agenda. The partners recognise that this carries risk but believe that the opportunities are substantial, so are committed to developing a shared understanding to manage this. Whilst the detail of this is still progressing, the Chief Officers of the CCGs and County Council Director of Community Services have developed a principles paper which sets out their underlying approach to the Fund and to the wider integration agenda. This signals the maturity of the partnership between the key commissioning organisations. (see appendix 1)

Norfolk's vision for the integration of health and social care has been developed through local partnerships led by the CCGs. It is based on the definition of National Voices - person-centred, co-ordinated care – with core key principles:

- **People will be able to access effective and co-ordinated care which is delivered at home or in their local community.** This will see services delivered closer to home and where they need to be provided in a specialist acute setting,

time spent there will be minimised through the support of a co-ordinated network of community based services.

- **Services will be shaped around the individual:** Healthcare and support will be built around what individuals need and what works for them. Services will be founded on a personalised approach which will be better at delivering the outcomes people seek because they are tailored to individual need.
- **People will be supported to manage their own care and wellbeing:** People will be empowered to manage their needs and health conditions so that they maintain their own wellbeing as far as possible to enhance quality of life and to reduce the call on formal services.
- **Primary care we be the heart of care co-ordination:** Primary care will be the core of our services. People will be able to connect with health and care services in their community and can be confident that their primary care services are well connected with a much wider range of help and support.
- **Planning should start at a local level:** In Norfolk, we think that it makes sense for most planning and development of services to take place at a local level. For this our basis is the geography of Clinical Commissioning Groups. However, we plan around acute services and at a county level when this is the most effective approach.

What difference will this make to patient and service user outcomes?
Patients and service users will be recognised as people first and foremost - living in a local community where they can feel included, safe and have a fulfilling life. They will have the right information and support to manage their long term conditions at home. Patients and service users will feel more in control of their care. They will have access to the information they need to make well-informed choices and support to do so if they need it. They will feel more satisfied with their care as it will fit them and their circumstances better. They will be confident that the team dealing with their care is well connected and has the right information about them to work in their best interests. They will feel treated with dignity and respect. Patients will be able to access specialist services with straightforward and understood processes and will be able to return back home as soon as this is the best place for them to be, with the support they need.

Norfolk is ambitious for integration and has a strong foundation of existing achievements. Whilst at this stage the pool will be set at the minimum requirement, this does not signal a moderate ambition, rather that we need further work to determine the wider budgets which will become part of the pool. We expect that we will swiftly move to substantially larger pools as we recognise the benefits of managing a fund across health and care as the underpinning to delivering the required transformation.

We recognise the need to manage transformation and planning at a number of levels: at CCG level, across the central system, across the county of Norfolk and indeed in collaboration with Suffolk County Council in Great Yarmouth and Waveney. The focus of integration planning is set at CCG level as this best represents the local population need. Given the scale of Norfolk's geography, the areas have distinctly different needs, health and care systems and community assets. The pooled budgets will be held between each CCG and the County Council and performance metrics and management are set to match in order to provide the necessary granularity. This we believe provides us with the strongest opportunity to manage effectively the change which is required. The wider system leadership and planning across the central system and the county will ensure that interrelationships between areas are addressed appropriately and that where

appropriate, initiatives are delivered collaboratively.

The vision for Great Yarmouth and Waveney

Within Great Yarmouth and Waveney (GYW) the vision is for a fully integrated care system. This is a radical, ambitious and transformational approach towards integration, working across two County Councils and two District Councils. Its prime purpose is to put patients and clients at the centre of services, with the needs of the person dictating the way the system responds, rather than their needing to move between organisational and artificial funding barriers. The GYW approach builds on a strong history of community engagement and input from the four distinct communities in Great Yarmouth and Waveney and builds on the successful operational integration of teams to date.

Partners in GYW seek to create an integrated care system, virtual at first, encompassing the activities of all of the local organisations responsible for health, social care and some District Council services. This will deliver high quality person friendly services in a co-ordinated way, removing organisational and transactional barriers and costs so that the maximum proportion of funding possible is used for the care of the population. The aim is to care for all sections of the community but the approach will focus particularly on those most needing care and help and those at risk of becoming so.

Local organisations across Great Yarmouth and Waveney including Norfolk and Suffolk County Councils, Great Yarmouth Borough Council, Waveney District Council, key providers such as James Paget University Hospitals NHS Foundation Trust (JPUH), East Coast Community Healthcare (ECCH), Norfolk and Suffolk Mental Health Trust, the local police, patient groups and the voluntary sector - have a common, united vision and drive to create a system-wide Integrated Care System (ICS). The previous PCT and successor CCG has and continues to work hard to develop the trust and relationships between all stakeholders and feel the time is right for them to achieve this goal. Stakeholders believe they have a unique opportunity as a discrete health and social care economy to realise their ambition of a truly integrated health and social care system.

To drive this vision forward, as well as the established GYW System Leadership Partnership, the system leaders have created an Integrated Care System Programme Board whose role is to develop and oversee action plans for delivery of the integrated system. Members are accountable to a range of audiences to deliver rapid progress towards an Integrated Care System. They will work closely in partnership with all local organisations responsible for health, county and district council services to ensure whole system engagement, commitment and implementation of ICS principles through aligned activities, sharing of budgets and pragmatic integrated projects.

Stakeholders believe that current national, regional and local position provides a massive opportunity for transformational change in the system, breaking down historic organisational barriers and radically re-thinking how care can be provided. In order to deliver better outcomes and greater efficiencies there needs to be more integrated approach to service provision with all organisations working more closely across organisational and professional boundaries and changing staff behaviours to encourage system and whole team working.

The vision for Norwich

In Norwich, integrated care – or person-centred coordinated care – is defined by National Voices from the perspective of the patient:

'I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me.'

Organisations and opinion leaders such as the Kings Fund have championed care integration as a significant element of any future model of health and care provision: *'Currently, fragmented services fail to meet the needs of the population. Greater integration can improve the patient experience and the outcomes and efficiency of care.'*

NHS Norwich CCG Governing Body gave consideration to the challenges of the Better Care Fund at its December meeting, which was attended by Norfolk County Council and leaders from main NHS providers. The Governing Body have approved an outline model of integrated care, which is ambitious in scope, and in due course, will seek to align a significant proportion of all CCG 'out of hospital' expenditure and the social care budget for the city.

NHS Norwich CCG have been selected by the Kings Fund as one of four national pioneers for developing integrated health and social care systems at scale and pace. They will be working with the CCG and health and social care partners for the next three years. They will advise, support, challenge, and problem solve as we bring Primary Care into locality systems, and bring community nursing, therapy, mental health, social care, and community assets into an integrated 7 day system. In May they will visit Norwich for the first of a series of system visits, and in June we will join representatives from the other three health systems for the first of a series of regular seminars to share experiences, challenges, solutions, and emerging good practice.

The vision for North Norfolk
Enabling people in North Norfolk to take control and have choices about how and where they receive effective, value for money care and support, to live healthy, fulfilling and independent lives, is at the heart of the North Norfolk vision for integration. All developments see those who require care and support as key partners in shaping, implementing and monitoring the operational and commissioning outcomes across the integrated partnership.

Over the next 5 years services will be transformed so that the population of North Norfolk, but especially older people and those with long term conditions have access to fully integrated primary and community health and social care services. In addition ensuring seamless access to community and specialist care and support when required, that is personalised to the individuals needs and delivered with compassion and dignity.

The vision for South Norfolk
South Norfolk CCG and Norfolk County Council see the Better Care Fund as an opportunity to build on their existing approaches in taking a key step from which to achieve the substantial integration of health, social care and allied services over the next 5 years. Prior to the announcement of the Better Care Fund SNCCG had already developed with stakeholders a strategic vision to achieve the full integration of services for frail older people. The Fund provides an opportunity to improve the lives of some of the most vulnerable people in our society, giving them control, placing them at the centre of their own care and support, and in doing so, providing them with a better care and quality of life. It will also support the aim of providing people with the right care, in the right place, at the right time, including a significant expansion of care in community settings.

The aspiration is captured in the following way in the draft SNCCG Operational Plan 2014-16: "We wish to see a health and social care system where the whole population (but especially older people and those with LTCs which impact their quality of life) have access to a fully integrated primary and community health and social care service.

Importantly, appropriate and timely access to more specialist healthcare that is safe and delivered with compassion and dignity is critical" (V3 9th March 2014)

The plans laid out for SNCCG in this document should be taken as blueprint activities which have been identified within the relatively limited time available for drawing up BCF plan proposals as potentially likely to produce important benefits if delivered in a more integrated way. Some of the activities are likely to change in detail (or in the relative priority accorded to them) as a result of the work to fully scope the models and impacts of models in 2014/15. The delivery of changed ways of working will substantially rely of remodelling of existing services and modelling the impacts on these current services will be one strand of this work.

SNCCG and Norfolk County Council will consider in detail the scope to add or supplement the BCF funding through remodelling and integrating aspects of mainstream health and social care activities which support the integration goals in the areas identified below. These activities are likely to include aspect of community nursing and therapy, social care assessment, care planning and packages, home care, reablement and funded low level prevention services. The achievement of comprehensive integration will require aligning elements of NCC and SCCG budgets beyond the Better Care Fund.

Some of the models which underpin the proposed activities below will be most cost effective if developed jointly with the CCGs in central planning cluster. The adaptations and other functions funded DFGs are already in scope for the Better care Fund "pool" but work will take place with South Norfolk and Breckland District Council to fully explore which other service elements offer potential to join up because this would provide a better and cost effective response to meeting local needs.

The vision for West Norfolk

In West Norfolk there is already a strong track record in taking a multi-agency approach to meeting the health and social care needs of the local population. These include:

- The continuation of an "Integrated Care Organisation" model following being one of the national pilot sites. This includes Integrated Care Co-ordinators acting as "boundary–spanners" between local health and social care systems and a Mutli-Disciplinary Team structure actively planning the care input of a cohort of risk stratified patients.
- An Integrated Commissioning Team, established under a Section 75 agreement and co-located with the local Clinical Commissioning groups
- The integrated management of the local community health and social care teams under a single operational manager at locality level.
- A strong multi-agency local prevention strategy that has already delivered a telephone/web-based "one-stop" information hub.
- The active engagement of all the key local partners, including housing and the voluntary sector, in developing a shared vision of the future design of health and social care services in West Norfolk.

The Better Care Fund schemes are one element of a much wider and more comprehensive "system sustainability" programme aimed at bringing about the radical redesign required to ensure the local health and social care system is fit for the future financial challenges. Underpinning this programme is the shared belief that greater integration is one of the cornerstones of an affordable and successful system. This will drive additional integration projects not listed in this document in such areas as workforce development and data sharing.

This vision is set out in the integration pioneer submission referenced above.

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

Aims across Norfolk
The overarching aims of integrated care are shared across Norfolk:

- To improve the quality of the services across health and social care for our local population
- Reduce inequalities of both access and outcomes
- To secure a stable future for all health and social care organisations
- To improve the efficiency in the provision of the services.

Key objectives which are shared across Norfolk are:

- To improve patient/service user experience of integrated care
- To reduce emergency admissions to hospital
- To reduce falls
- To reduce avoidable and emergency admissions to hospital
- To reduce admissions to residential and nursing homes
- To reduce ambulance conveyance to hospital
- To reduce delayed transfers of care
- Increased referrals to wider community, self-care & self-management based support.

The Norfolk BCF plan sets out 5 locally developed integration delivery models. Each of these local integration plans has a set of refined aims and outcomes reflecting local priorities (see reference documents). These integration plans have been co-produced locally and are based on local needs analysis, local gap analysis and evidence-based models of integration and service improvement. Each local plan sets out its aims and objectives as pertinent to the local area and the performance metrics that sit alongside these. The monitoring of the delivery of these will take place firstly at a local level between the integrated governance arrangements. This will allow the teams who are delivering change to have direct feedback on measurable impact of the changes they are implementing. Patient experience measures will provide a direct line of sight to the outcomes for individuals which will sit alongside the monitoring of activity in the health and care system. By placing monitoring at CCG level we keep a tight loop between local patients and users, local interventions and local impact. Transformation across the central system is part of the CCG planning and system management which is established through Operation Domino.

Alongside CCG level performance we continue to ensure that the impact and opportunities of change are well understood across Norfolk through integrated reporting

to chief officers and that they are managed collaboratively at the appropriate unit of planning or intervention.

Great Yarmouth and Waveney aims
The programme sets out that the differences it seeks to make to local residents' health and social care outcomes are that local people:

- Have a say on how local services will be delivered through a variety of engagement and consultation opportunities
- Will not have to navigate around a complex system to find the right information, care or service that meets their needs. Support will be available from care co-ordinators across all services so users have immediate access to knowledge so they can make informed choices
- Will have their health and care needs identified early before a crisis occurs
- Will have access to a range of local services that focus on supporting people to self-care and supporting primary prevention
- Will have control and choice over their care
- Will have a lead accountable co-ordinator when they need help who will ensure that the system works effectively, with a single care record

Norwich priorities

The outline model of integration for Norwich consists of four main elements:

1. **Primary Care Development** – Practices will be supported to develop locality clusters around populations of approximately 50,000 registered patients (4 localities within the Norwich CCG boundary). These practices will cooperate to develop shared Primary Care services for older patients, and those with long term conditions; with a particular focus on keeping patients independent, well and at home. Enhanced care in nursing homes, coordinated domiciliary visits, and a shared model of seven day access will be developed.
2. **Integrated Community Services** - Community, mental health, and social care services will be enhanced and reshaped to the same locality footprints. The locality model will enable a multi-disciplinary approach to care, and build relationships, coordination, and mutual confidence between provider organisations. A new approach to intermediate care will be developed – linking with Operation Domino – to enable quicker discharge home, with coordinated packages of health and social care to support reablement and recovery, and reduce the risk of readmission. As with primary care investment in seven day working and extended hours to match the patterns of demand will be sought.
3. **Information and Communication Technology** – This will be a key work stream at a system level. Every health and care professional needs to be able to access a single patient record, and the patient needs to be empowered to access and actively participate in the care record, and decisions about their future care. A Norfolk-wide approach, linking with Norfolk County Council's Norfolk Digital Ambition may be the appropriate footprint.
4. **Community Assets** – An asset-based approach will be developed to communities in Norwich. There will be investment in equipping patients and carers with the knowledge and skills for sustainable self-care; make the voluntary and not-for-profit sector a stronger player in the delivery of care both upstream and in partnership with statutory provision; and support communities to identify and

harness their internal assets: knowledge, skills, relationships, and facilities.

North Norfolk principles
The following key principles will be applied to all integrated service development to achieve this vision:

1. Integrate and where possible co-locate health and social care delivery teams (including primary care, community health, mental health, social care, voluntary/3rd sector providers),

2. Carers will be supported in their caring role and to have lives outside of this role, as key partners in providing the right care, at the right time in the right place.

3. Care and support services to be arranged around patients' and carers GP surgeries, via 4 locality integrated care 'hubs' with access to a wide range of integrated health, re-ablement, independence and wellbeing related support

4. Deliver joint assessment process across health and social care

5. Provide identified 'at risk' patients with professional leads who understand individual patient's social as well as medical contexts

6. Provide services which are simple to use, can be "switched on" via a single call with assessment by multiple partners, 7 days per week where practicable

7. A universal expectation that all services will be delivered closer to home with respect, compassion and a personalised approach, reflecting the physical health, mental health and emotional needs of the individual.

8. Enable people to self-care & self-manage to deliver improved patient experience

9. Greater and seamless local access to services with an emphasis on support and information that enables individual self-care & management

10. Ensure that patients and their carer's are able to take ownership of their individual circumstances by embed the service development principle for people using services of - "No decision about me without me"

Norwich, North and South Norfolk are developing a Central Norfolk model founded on shared principles, but which is built on operational models that address the significant geographic and demographic differences between urban and rural CCGs. The strategic approach is contained in the 5 Year Strategy and 'Plan on a Page' produced by the three CCGs working collectively.

South Norfolk principles
The following principles have been prospectively agreed for the South Norfolk CCG locality integration plan:

1. "The right care in the right place at the right time " – person centred care means people get the help they need in the ways that work for them
2. "Care closer to home" - Support services and spend will be focussed as much as possible on early intervention and prevention to keep people independent and well in their communities for longer
3. Integrated care is about how we work together to achieve the outcome of improving the health and wellbeing of our South Norfolk CCG population rather than about 'services' and 'delivery models'
4. There will be a wide range of information, support and care services and

resources which enable people to take more responsibility for their own care and to better manage their own health and wellbeing.

5. Health, social care and other organisations talk together effectively and are well linked up so that there is 'no wrong door' for people who need to access support and care
6. Better co-ordination is a key – people know who is involved in their care; who's doing what; who to contact if things change; there is one care plan and one key person holding the strands together
7. We will plan and design services with the people who use them.

West Norfolk aims

Set out in the West Norfolk CCG prospectus are the aims for West Norfolk.

1. Commissioning integrated services for the patient population in order to improve quality of care
2. Improving the health and wellbeing of the people of West Norfolk
3. Preventing disease and premature death
4. Decreasing hospital admissions for long-term conditions.

The over-arching aim for the West Norfolk Alliance Integration Plan is:

'Sustainable coordinated services with patients in control'

This is supported by the following principles in care:

- Independence, choice and quality
- One assessment, one plan
- No organisational boundaries
- Shared information and decisions

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery

How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care.

Detailing the planned changes

Detailed integration models and associated service changes are set out in the local plans which are attached as appendices. Given the complexity of the integrated planning, the detailed development of delivery plans is still in process with priorities, dependencies and timescales to be determined. This will form part of a comprehensive transformation programme approach to delivery of the Better Care Fund which is being developed in partnership and to which partners are committed. An area to be determined in the planning programme will be where changes are better implemented in collaboration across areas rather than locally. These decisions will be influenced by factors such as the nature of the change to be undertaken, the synergy between plans, potential efficiency versus the benefits of locally securing change. For example, the integration of community health and social care management is taking place through a countywide approach which will tailor service delivery into local systems requirements.

A countywide summary of key service changes:
There are common elements which are central to Norfolk's approach and which are set out below:

A culture of empowerment and personalisation with individuals and their families
All people working in our health and care services will be driven to empower people to direct their own care and to shape personalised services to meet their particular circumstances. Everyone with complex needs will jointly devise their care plan, use of personal budgets and personal health budgets will increase and people will have the information they need to manage their long term conditions. Carers support will be strengthened including improved access to flexible respite.

Primary care based integrated community services
Primary care will be the focus for co-ordinated care. We will build on our existing integrated care programmes to create joint community health and social work teams with single line management. These will be aligned with primary care in local areas allowing them to manage local resources to best meet the needs of local people.

Focused support for those most at risk of needing higher level care
We will apply risk stratification methodology to identify those people who are more likely to be admitted to hospital or a care home and we will target evidence-based interventions to prevent deterioration of their condition or circumstances.

Integrated admission avoidance
We will create effective intervention to avoid unnecessary emergency admissions. Urgent community responses will be applied to optimum effect, working with the ambulance service, building on our existing reablement and Swifts/Night Owls services.

Integrated pathways to ensure effective discharge
People will be able to access specialist hospital and residential services where these are necessary and we will create a strong networked approach to ensure their stay is no longer than clinically required. Integrated discharge arrangements will remove delays and we will secure alternative bed provision for people who no longer need acute care. Discharge back home will be planned early and implemented well.

Voluntary and community resources will be part of our networks
Voluntary and community enterprises will be part of the local network of co-ordinated care. There will be an ease of access to services within this network, allowing us to ensure that people are connected to the informal support which is available. We will also work with voluntary and community enterprises to enable them to alert us when people become at risk.

Independent social care providers will have a stronger part to play
Residential and nursing homes and providers of domiciliary care will be supported to care for people with more complex needs to promote earlier discharge from hospital or to avoid admission to hospital at the end of life. Hospitals, community health services and primary care will work more closely with these services to support them to make the strongest contribution they can to the co-ordinated care arrangements. This may mean contracting for specialist services, training and in-reach, incentivising new ways of working.

Optimum use of technology and equipment
Technology and equipment will be used to very best effect to deliver the aims of our strategy, supporting the successful management of complex conditions at home, enabling revised mix of staffing skills and to facilitate swift discharge. Our assumption

will be that for an individual with complex care needs there is a beneficial technology to be applied.

Supporting the workforce
People will work differently in order to make these changes happen. We will actively address culture change and workforce development, to support and empower staff to make the changes that are needed to work as one team. The new service arrangements will offer clear and joint career pathways for non-registered staff across all areas of provision as a priority.

Shared information
We will secure the permission and the mechanisms to share data about individuals and services. Existing integrated care co-ordinator roles will be extended so that all multi-disciplinary integrated teams have access to data from primary care, acute, community and social care. Using the NHS number, clinicians and practitioners will have the full picture of data for the individual. We will pilot a patient held electronic record in West Norfolk.

There will be visibility of commissioning data across health and care to support effective commissioning decisions: activity and spend at individual and cross-service level. Using this mechanism we will have a much improved understanding of patterns of service use, informing us of where interventions may be targeted and allowing us to create visibility of the 'Norfolk health and care pound' and how it is best spent.

Housing and housing support will be a core element of how we support people
The role of housing will be seen as a core consideration in our approach to health and care. Our district and borough councils and our social housing providers will be part of our integrated approach, to ensure that all opportunities are applied for housing to support health and wellbeing for those people who are most at risk. We will ensure information sharing allows us to focus on the right people and that we are able to address warmth, security, maintenance and engagement, which we know impact on health and wellbeing.

Great Yarmouth and Waveney schemes
The GYW integration plan focuses on the following 4 main areas to start the process of the move towards and integrated care system. Further details are set out in the reference documentation.

1. **Supporting independence by provision of community based support interventions** – to deliver a range of health and social care community based support interventions closer to people's homes, 7 days per week that maintain / regains independence, including the use of Personal Budgets to help prevent people's needs escalating.

2. **Integrated community health and social care teams including out of hospital teams and integrated community palliative care** – this continues work already underway in part of the CCG area and will include workforce development.

3. **Urgent care programme** – to deliver community care services that reduce admissions and achieve faster appropriate discharge and reduce delayed transfers of care.

4. **Support for people with dementia and older people with functional mental health problems living in the community** – to deliver specialist support to

people with dementia and their carers to avoid / delay admissions to hospital. / care and provide assessment of ongoing care needs

Norwich schemes:

Under the 4 headings of the model the schemes for Norwich are:

Primary Care

1. **Development of primary care localities** - GP Practices will be supported to develop locality clusters around populations of approximately 50,000 registered patients (4 localities within the Norwich CCG boundary). These practices will cooperate to develop shared primary care services for older patients, and those with long term conditions; with a particular focus on keeping patients independent, well, and at home. Enhanced care for nursing homes, coordinated domiciliary visits, and a shared model of seven day access will be developed.

2. **Risk stratification system, including primary care data -** Practices will be supported to identify and manage patients at high risk of hospital admission through the implementation of risk stratification modelling. Work with a technology partner will incorporate primary care and social care data into the model. The model will be launched in 2014, and developed and refined in preparation for the Better Care Fund investments in 2015.

Community Health & Care Services

3. **Integration of community health & care teams in Norwich localities** - Integrated community services - community, mental health, and social care services will be reshaped to the same locality footprints. The locality model will enable a multi-disciplinary approach to care, and build relationships, coordination, and mutual confidence between provider organisations. Through improved communication technology and the development of care coordination (below) we will place the responsible GP at the heart of an integrated virtual health and care team.

4. **Care co-ordination teams (CCG localities) -** The model of care coordination in Norwich has been tested for the last 12 months. Staff within Norfolk County Council – largely funded by the CCG – coordinate and organise a range of health and care interventions for patients identified as being at high risk of hospital admission, and those approaching end of life, in accordance with a care plan agreed with the patient. The service will be extended to seven day working, and capacity increased to enable care coordination for 2% of the population at greatest risk (approximately 4,200 patients).

5. **7 day case management for patients with complex health and care needs -** Case management has been operating in a limited form (case capacity 300-400 patients, 5 days a week) since April 2012. The service provides targeted proactive specialist nursing care for patients with complex long term conditions, and those approaching end of life, and is delivered by community matrons and senior community nurses at the patient's home. The services will be extended to seven day working, and capacity increased to 2% of the 65+ population (600 patients)

6. **Falls Prevention** – The falls services and the way falls are managed and monitored falls is being reviewed. Assessment, the falls pathway and medicine management will be improved and a dashboard to monitor local falls data and the impact of pathway improvements will be developed. Delivery of these improved services will be aligned with plans for primary care locality work.

7. **Seven day social care assessment and care management (community) –** Norwich's ambition is to build on the existing out of hours service for community social care. Discussions have taken place between Norfolk County Council and NCH&C about joint working to ensure seven-day cover as part of their integration of staff. For social care, a first step will be to consider extended hours opening to supplement the out of hours service already provided. NCC reablement staff are already able to arrange and switch on social care packages of care when needed outside normal office hours.

8. **Integrated end of life care -** A more integrated range of palliative care services will be developed which includes hospice, community support, daytime services, specialist nursing, rapid response and 24/7 care. Care at home services will be developed to support families more effectively.

9. **Integrated dementia care –** The advice, information and support services for people with dementia, their family and carers will be reviewed as will the range and commitment to providing intermediate care community beds (both health and social care), including for dedicated respite beds. Funding has been secured to develop a new housing with care scheme with separate dementia care beds and this is planned to open in 2016. Dementia is recognised as a long-term condition and better support will be developed through the local multi-disciplinary team engagement. Development of dementia friendly communities in Norwich will be sought, potentially aligning this with the Healthy Norwich initiatives.

10. **Integrated community mental health services** - Community mental health services will be shaped and delivered in the locality footprints. Mental health service provision will be embedded in the four integrated health & care teams and proactively work with partners to reduce demand on the unplanned care system. The service will need to be operational 7 days a week to contribute to the reduction of unplanned admissions and to support timely discharge.

11. **Integrated support for people with long-term conditions –** Analysis of the Norwich population shows that unplanned acute admissions for people with long-term conditions remains a concern. The excellent management of admissions is key to improving the patient experience and the ability to shift resources in the health and social care system into the community. Social care services will be protected by remodelling reablement, help at home services and other social care services during 2014/15 using Transformation Funding.

Intermediate Care

12. **Seven day supported discharge and intermediate care management –** a new approach to intermediate care will be developed – linking with Operation Domino – to enable quicker discharge home, with coordinated packages of health and social care to support reablement and recovery. The use of early supported discharge home direct from an acute setting will be increased, using 'virtual ward' methodology to ensure the patient receives appropriate medical and nursing care during their period of recovery to further reduce the risk of readmission. As with primary care investment in seven day working and extended hours will be sought.

Community Assets

13. **Supporting self-care (education, tools and resources) -** A partnership approach to patients, families, and communities in Norwich will be developed,

investing to equip patients and carers with the knowledge and skills for sustainable self-care, and ensure health professionals work with patients to develop self-management plans, including lifestyle changes. Better and more accessible information, advice and advocacy will be provided so that people are better placed to arrange their own care including through use of personal budgets.

14. **Development of voluntary and community 'pre-primary' intervention fund to maintain health, wellbeing, and independence -** The voluntary and not-for-profit sector will play a stronger player in the delivery of care both upstream and in partnership with statutory health and care provision; and communities will be supported to identify and harness their internal assets: knowledge, skills, relationships, and facilities. A local voluntary sector information hub will be developed to assist with care navigation. Norwich CCG is supporting a multi-agency Ageing Better application, led by the voluntary sector, focused on developing asset-based community development for older people living in Norwich.

15. **Carers –** Norwich CCG recognises the pivotal role that carers play in supporting friends and relatives and will aim to build on the newly commissioned jointly funded Carers Agency Partnership to ensure that the countywide arrangements are delivered in the best way for Norwich and to ensure that the partners are well-prepared to respond to proposed new statutory responsibilities.

16. **Housing support** –The existing partnership work between health (including public health), housing and social care aligned to our Healthy Norwich initiative will be built on to ensure that people are well supported to live independently at home. This includes further development and improvement of a wide range of support including supported housing, disability adaptations, community equipment services, assistive technology and the work of Home Improvement Agencies.

North Norfolk schemes

North Norfolk's Integrated Care Programme has developed robust foundations for delivering better integrated care over the past two years. The next phase of the programme seeks to build on this, using the opportunities provided by the Better Care Fund, to truly transform and integrate services further to deliver the best outcomes for people who access health and care services in North Norfolk.
The cornerstones that will deliver this and the changes that we will deliver are:

1. **Risk Stratification –** Identify those people at highest health risk or those who will benefit most from proactive support to enable patient centred community service interventions:
   - **Predictive risk stratification –** Identifying people earlier in their condition to prevent deterioration through self-care, self-management and voluntary sector interventions, to maintain independent living**, i**ncluding integrated falls management approaches
   - **Complex needs risk stratification -** Identifying those patients who will need or who are in an acute setting to deliver intensive case management approaches to facilitate faster discharges and prevent re-admittance
   - **Person centred end of life support -** As part of the Gold Standard Framework (GFS) integrated care meetings, we will ensure that the right integrated community support is available, for those people who are at the end of their lives that is delivered with dignity and respect for their choices.

2. **Integrated Community Care Teams –**Delivering timely, integrated quality care interventions. This includes
    a. Continuing to embed our integrated primary health, community health, mental health, social care and re-ablement teams, aligned to a GP practice in each of the 4 community hubs in North Norfolk.
    b. Continuing to have named key workers for each patient identified at risk and in need of an integrated care intervention.
    c. Continuing to provide integrated care coordinators to facilitate better
    d. Aligning district council services, ambulance and acute lead professionals, and voluntary/3rd sector services.
    - Maintaining Local Care Coordination centred around our 4 community hubs
    - Develop and deliver an approach to 7 day working that will deliver the best outcomes for those at most risk.
    - Development of shared assessment & referral process switched on via a single call

This will be supported by the delivery of:

a. Timely and targeted 7 day Social Care Assessment & Care Management
b. Localised & Integrated Community Health & Social Care 'Front Door' Services.
c. Integrated Community Health Social Care Occupational Therapy Services
d. Localised & integrated Reablement support.

3. **Community & Self Care Support –**Deliver community based support interventions, closer to people's homes, when people need them, that enable improved self-care & self-management, including the use of Personal Health Budgets and targeted support to carers in their caring role to enable independence within the community for longer. This includes the following:

'Front Door' Support Services	Self-Care & Self-Management	Commissioned Community Services
Norfolk First Support - Re-ablement	LTC - Patient / Carer Education Programmes	Volunteering & Befriending Services
Assessment & Care Management Social Care Centre of Expertise & Customer Service Teams	Low level psychological support e.g. coaching	Day Service / Opportunities
Assistive Technology	Medicine & pain management	Community Beds
Falls Preventions	Specialist nurses	Information Advice & Support Services
Equipment and Disabled Facilities Grants	Healthy Community Programmes	Carers Agency Partnership
Prevention / Development workers	Health Trainers	Village Agents

This will be supported by the delivery of:

a. Integrated development of a 'Help at Home' Programme – to deliver support in the home to maintain peoples independence for longer
b. Mental Wellbeing & Support Interventions: Inc. Work force Development for integrated care teams
c. Self-Care & Self-Management Interventions for Patients & Carers – Inc. LTC Education Programmes & Medicines Management/Health Coaching/Expert Patient/Assistive technologies
d. Voluntary sector services targeted to maintain independence & wellbeing – Inc. Volunteer Support to target Rural Isolation & Transport Solutions

4. **Integrated Care Approach to Falls Management –**. Deliver integrated falls management interventions (as a key indicator to reduce avoidable hospital admissions) that support people to remain independent for longer.

   This will be supported by the delivery of:

   a. Home Hazard Assessment & Interventions – E.g. Enhancement of a 'Homeshied' delivery model.
   b. Nursing, Care Home, Sheltered Housing & Housing with Care Falls Prevention Programme.
   c. Remodelling Community Falls Prevention Services (Linked to Ambulance Trust)

5. **Living Well With Dementia Programme** –Delivering Improved diagnosis of dementia across our Integrated Care Teams.by improving access to memory assessments, diagnosis education programmes, targeted screening, assessments, referrals and integrated community support

   This will be supported by the delivery of:

   a. Focused Carers Support for those supporting family members with dementia
   b. Dementia/Admiral Nurse IAA model delivered within NCC 'Front Door' service
   c. Dementia intensive home support. (24 Hour care, linked to Help at Home Prog)
   d. Specialist Mental Health Dementia Nursing Teams linked to A&E and Medical Assessment Units
   e. Specialist Mental Health Dementia Teams in the community (Dementia Intensive Support Teams)

6. **Urgent Care Programme –**To deliver improved pathways in and out of the acute hospital settings including improved, appropriate access to A&E, improved community care solutions to expedite faster, appropriate discharges and reduce any delayed transfers of care, including improved use of integrated community bed provision to support this.

   This will be supported by the delivery of:

   a. Timely and targeted 7 day Acute discharge planning & Post Discharge Support
   b. Remodelled Integrated Home from Hospital Service
   c. Remodelled Integrated Community beds Provision & Coordination to proactively manage acute access & discharge. Including End of Life Care, Continuing Health Care, Acute Rehabilitation & Dementia.
   d. GP Advice Line/Unplanned Care Centre/Rapid Response (OOH/111)
   e. Psychiatric Liaison Team's being in place at NNUH

f. Mental Health Frequently Attending/ Admitted Patient Scheme in place at NNUH

7. **Improving Mental Health Outcomes -** To ensure that functional mental health pathways are linked to whole system and person centred approaches to patients care.

   This will be supported by the delivery of:
   a. Provision of Alternative to Admission schemes
   b. Provision of "step down beds" from Mental Health Adult Acute wards
   c. Extension of CAMHs Intensive Support Team
   d. Development of community support advice and care services including peer support models

South Norfolk schemes

Key developments in integrated care in South Norfolk will build on the experience of integrated care pilots and other integration initiatives which have been tested.

1. **Integrated Primary Care Teams**

   People will be comprehensively supported because their care is closer to home with GPs and practices at the centre of teams in which access to skills, knowledge and to health and social care input is seamless. Specific activities include:

   - Linked workers identified for each GP surgery
   - Co-location of health and social care staff at Wymondham hub
   - Integrated Care Co-ordinators in post for each locality
   - Risk profiling and multi-disciplinary team meetings at each practice
   - Nominated integrated care Champion at each practice
   - Integrated care practice reviewed by professional leads
   - Scoping alignment of front door service to integrated care teams
   - Named key worker and care plan for each at risk patient
   - Review and development systems for sharing records
   - Effective medicines management programme
   - Multi-disciplinary team established in each locality
   - Fully integrated community health teams: 7 day working, multi-disciplinary, clinically led.

2. **Supporting independence, well-being and self-care**

   People feel more confident about managing their condition and able to defer the move to more intensive provision for as long as possible. This will require some shift in service delivery from dealing with crises to focus on effective prevention. Specific activities include:

   - Alignment of local voluntary sector prevention and advice services at GP practices
   - Scope range of community self-care support services including tele-coaching/ peer support
   - Developing range of community support for vulnerable people in winter
   - A range of health and wellbeing activities and services
   - Continuing to develop home improvement agency and home adaptations services
   - Ongoing development of integrated community equipment service

- Scoping options for improved use of telecare and telehealth
- Redesign/development of community transport services
- Recommissioning health volunteers prevention service
- Alignment of voluntary sector contracts to integrated care outcomes
- Developing range of community support for carers
- Development of more supported housing options as alternative to residential care
- Joint health and social care working to ensure that carers have their needs fully assessed and supported.

3. **Integrated care for people with dementia**
   GPs, patients and carers feel confident that there are appropriate support services available following diagnosis. Specific activities include:
   - Development of dementia planning beds to support early discharge
   - Increased rate of diagnosis, communications and support to patients and public engagement
   - Ongoing development of community initiatives (dementia friendly communities, support and advice services, pabulum cafes, peer support, care farm models)
   - Review, evaluation and forward planning for dementia support teams to include 24/7 support
   - Dementia/ complexity in later life specialist as part of locality MDTs
   - Evaluation of Admiral Nurse pilot in mid Norfolk
   - Ongoing training and support to care homes and home support/ care services
   - Provision of a range of support for people with dementia in their own homes
   - Development of menu of respite options for carers of people with dementia.

4. **Integrated falls prevention**
   Provide integrated falls management interventions which reduce hospital admissions that result from falls and allow people to remain living independently for longer Specific activities include:
   - Strength and balance training services (including peer support trainers)
   - Working with social care and housing partners to deliver home hazard assessment and intervention
   - Vision assessment and referral
   - Medication reviews
   - Development of South Norfolk fall prevention strategy which works on the principle that the prevention of fall is ‘everyone’s business’.

5. **Integrated services to reduce hospital admission and enable timely discharges**
   People feel confident feel more confident about managing their long term conditions. Services are arranged to deliver the ‘right intervention at the right time’ to prevent unnecessary hospital admission and to support timely discharge. Specific activities include:
   - Linking with central cluster CCGs through Project Domino to reduce use of A&E, enable timely discharge, effective packages of care to support self-management and recovery and to reduce risks of readmission
   - Agreeing ongoing remit and development of reablement and rehabilitation services including voluntary sector provision and nursing care at home service
   - Developing 7 day social care assessment (including carers assessment and care management) as mainstream provision

- Ensuring 7 day admissions to care homes and homecare services are available when required
- Scoping development of early supported discharge teams and 'discharge to assess'
- Development of Ogden Court as community resource
- Integrated system to manage the flow of patients in and out of community beds.

6. **Supporting effective mental health care**
   Effective liaison and support enables mental health problems to be picked up in a timely way, especially where there are concurrent physical health problems, and promotes effective management and recovery. Specific activities include:
   - Ensuring the principle of Parity of Esteem is built into commissioning approaches to integration
   - Collaborating with central planning unit CCGs to ensure there is effective psychiatric liaison in acute hospital settings
   - Ensuring effective accommodation and housing support to facilitate discharge from mental health acute settings
   - Identification and prevention of mental health needs in people with LTCs
   - Good access to psychological therapies
   - The ongoing development of peer advice and support options
   - Mental health support at GP practice level.

7. **Supporting good end of life care**
   Patients and carers have planned ahead, are in control of their care at the end of their life and feel confident the right support will be there when they need it. Specific activities include:
   - Developing South Norfolk CCG end of Life strategy
   - Specialist EOL support and advice for care services
   - Development of a range of palliative care services hospice, community, rapid response
   - Provision of integrated care at home services with crisis provision (24/7) to support families
   - Identification of GP or consultant specialists in the community to support EOL planning and care
   - Developing a range of palliative care services which include hospice, community support, daytime services, specialist nursing, rapid response and 24/7 care.

West Norfolk schemes

1. **Integrated care organisation – further development of the model** There is currently a well-established “Integrated Care Organisation” model across West Norfolk involving primary care/community health/social care. This includes risk stratification and regular multi-disciplinary team meetings to discuss high risk patients. Building on these firm foundations, we plan to introduce a range of additional key partners – housing, voluntary and independent sectors – to form a more holistic virtual team around the GP surgery. There are already plans to commission a new Care Navigator service to provide a closer link between the patient (and carer) and the health and social care support system and develop a more integrated approach towards the use of the range of alternative models

contained within the generic term of “intermediate care” beds within both community hospitals and independent sector care homes.

2. **Integrated re-ablement service** The further development of the local re-ablement service able to tackle those multiple aspects of an individual’s life that maximise the potential for independence. This will entail initially developing closer collaboration between the existing range of services. This “partnership” will develop a shared vision, a common assessment tool with straight forward cross-referral mechanisms and a shared evaluation system to measure outcomes at individual, service and partnership levels. Once the model has been tested, the best service model will be determined, in particular whether a more formal “alliance” model might best strengthen the partnership approach.

3. **Integrated services to reduce hospital admissions and enable timely discharges** There is a shared commitment to developing improved pathways in and out of the local acute hospital to limit unnecessary attendances, expedite discharge and minimise any delayed transfers of care. In addition there is a commitment to ensuring that people in West Norfolk will receive the same standard of health and social care regardless of the day of the week. This commitment extends across the whole health and social care sector and will be a common theme in all commissioning activity.

4. **Supporting independence, well-being and self-care** An important element in the overall integration initiative is the provision of services that support people to maximise their ability to live independently and where this may be limited through a level of frailty or illness, the focus remains firmly on the individual exercising as much control and self-management as possible. For people with significant needs, this ethos will underpin the involvement of every health and social care service. For people with lesser needs, this will involve a strengthening of the partnership with those sectors – principally the voluntary sector - that deliver services aimed at tackling issues that might threaten an individual’s health or independence e.g. life-style ,social isolation, poverty. Although the relationship with the voluntary sector will be at the heart of this scheme, on a wider level an outcome-based approach to commissioning will be adopted across all sectors and the focus will be extended through taking a multi-sector approach to ensuring the individual experiences a seamless service regardless of whether elements might be provided by more than one agency or provider.

5. **Development of a local Dementia diagnosis and support model focused around primary care** West Norfolk partners are acutely aware that whilst West Norfolk has one of the highest populations of older people, it has one of the lowest dementia diagnosis rates. They plan to build on the pan-Norfolk work of the Norfolk and Suffolk Dementia Alliance in providing targeted training (including the training of a number of local cross-sector “dementia champions”) by developing a robust structure to deliver community-based diagnosis and support.

Alignment to wider plans

The Better Care Fund reflects the detailed operational plans of the CCGs and the strategic priorities of Norfolk County Council’s strategic plan. The aims and objectives of the Better Care Fund align closely with the Norfolk Health and Wellbeing Strategy which is in development, as follows:

- **Integration – of activity and outcomes, making services more joined up for those receiving them**
  The BCF is a tremendous catalyst for integration and the Norfolk plan sets out a shared countywide vision and core components alongside the models for implementing transformation of health and care services in the CCG areas. The County Council and each Clinical Commissioning Group are explicit about their ambition to see a wider pooling of budgets although still developing the detail of the scope of this. The Norfolk integration approach has been founded on the experience of service users and the partners are committed to this being the key test of success.

- **Prevention – moving intervention much further upstream and making a difference before problems become acute.**
  The Norfolk vision and plans set out how strengthening community and early interventions are key to managing the quality of care and an efficient system. There is a clear commitment to the tiers of prevention – ranging from community engagement and information and advice, through self-care and carers support into the close attention paid to those most at risk through the risk stratification and integrated teams approach. The recognised challenge is to move into prevention from acute care and the Norfolk plan sets out both the commitment and the methods to achieve this.

- **Reducing Inequalities in health and wellbeing outcomes**
  It has been through the development of the Norfolk plan that the commissioners have reached their decision to drive changes at a local level and this is in order to reflect the differences in different areas. Given the scale of Norfolk's geography and diversity, developments will be addressed through targeted work. It becomes clear that performance targets need to be set for local areas so that they represent local need. In particular the adoption of the local indicators – dementia assessments and experience of long term conditions – is a reflection of local need. The twin priorities of dementia and long term conditions are at the heart of Norfolk's plan. This reflects population profiles and analysis of the most crucial cohorts for intervention to reduce avoidable admissions and to improve user and patient experience.

  The Norfolk plan is founded on the analysis of local needs set out in the Joint Strategic Needs Assessment which has provided the foundation for local strategic and operational planning in the County Council and CCGs and which drives the targeted local interventions. Although Norfolk can be seen as a rural county, this masks The Better Care Fund for Norfolk sits within the strategic planning of the CCGs and the Council and meets high level ambition and operational requirements.

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

Commissioners will be working closely with partners towards the savings quantified in Everybody Counts, recognising the part integrated health and care plays through the

Better Care Fund. Targets have been set to reflect local challenges and opportunity.

West Norfolk
The wider West Norfolk Alliance "System Sustainability" Programme is addressing the sustainability for the local acute sector at its centre. The integration initiatives being funded through the Better Care Fund aim to make a major contribution to that programme through managing demand on the acute sector, particularly on urgent care. The detailed implications are being developed and are reflected in these plans and the wider CCG operating plan.

Norwich, North Norfolk and South Norfolk
Operation Domino has provided the collaborative and integrated programme to address the operation of acute services. The CEO of Norwich CCG has presented the Norwich Model of Care enshrined in the Better Care Plan to the NNUH Board.

Collectively, South, North and Norwich CCGs have commissioned a significant piece of work from a national consultancy to ensure consistency and alignment of strategic, operational and financial intentions between the three CCGs, Norfolk and Norwich, University Hospital and Norfolk County Council. This will cover acute activity but also out-of hospital strategies. There will also be an assessment of the impact of planned interventions over a five period both from a quality and financial perspective.

Great Yarmouth and Waveney
GYW CCG is working with providers in acute and community health to foster a strategic alliance between JPUH and ECCH. It plans that JPUH will retain its provision of a full service DGH, but drawing on the opportunities for a networked approach with NNUFT wherever appropriate, in order to ensure highest standards of clinical safety, but also ensure sustainability of services. The CCG remains very clear that the relative isolation of some of our residents means we need strong local services.

The CCG will be working closely with partners towards achieving the savings in the acute sector, namely 15% reductions in non-elective activity and 20% efficiency savings in planned care. Further financial modelling is currently being developed to ensure these savings are realised as a system in order not to destabilise any individual provider.

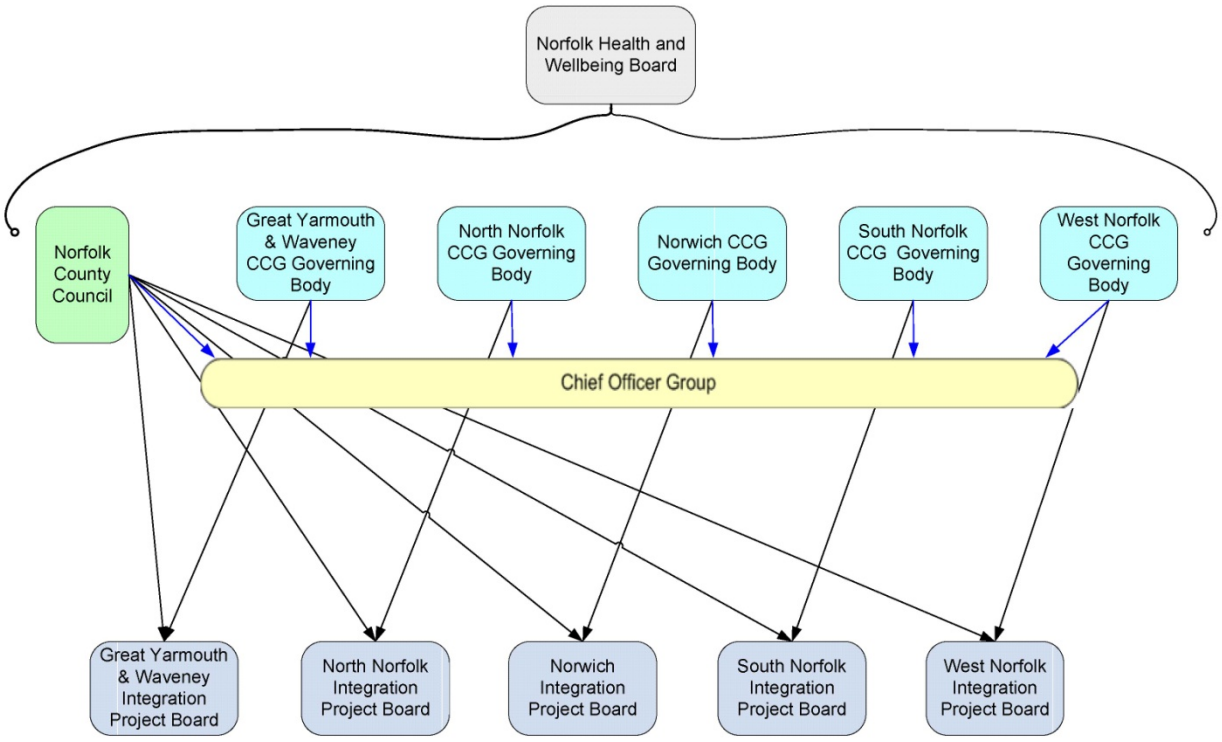
A key element of maintaining a balanced financial position over the next five years is to reduce capacity within the system which should result in less use of acute beds. This capacity will be replaced by our innovative out of hospital team, supported as necessary by additional care home capacity locally. Emergency admissions have reduced compared to 2012/13 and we plan to build on the fact that our increasingly integrated working between health and social care is starting to manage down demand. Closing capacity will prevent beds freed up by reduced emergency demand being filled,

Vital to service planning in the future will be not only what we provide and where, but what we no longer provide, either in a particular setting or at all. An integral part of the financial plans is to achieve the potential reduction in hospital activity. What we must drive, in collaboration with our partners, is a radical transformation of how services are provided which will enable public funds to be used more cost effectively, across all sectors.

The local health system will only remain financially sustainable through integration and collaborative commissioning, through working closely with providers and ensuring that future decisions are made for the benefit of the local system.

Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes:



Norfolk Health and Wellbeing Board will provide the whole system governance of the delivery of this plan. The Chief Officers Group (CCG chief officers and Norfolk County Council's Director of Community Services) will provide the executive level governance and oversight of performance outcomes and will secure accountability to the Norfolk Health and Wellbeing Board.

Within each partner organisation there is established governance set out below:

Norfolk County Council
The Health and Wellbeing Board is a democratic committee of the Council. The Community Services Performance Board will monitor performance at a local and countywide level, with a specific remit of ensuring that the Council's duties in relation to social care are met.

Great Yarmouth and Waveney
Great Yarmouth and Waveney System Leadership Partnership and the Integrated Commissioning System Programme Board provide governance to the integrated care system programme. A sub-committee of the CCG Board will manage the Integrated Care System programme.

North Norfolk
North Norfolk Integrated Care Programme Board reports through the NNCCG Executive

Team to the NNCCG Governing Body.

Norwich
Norwich CCG Governing Body will provide governance to the integration programme.

South
South Norfolk CCG Governing Body will provide overall governance supported by the Senior Management Team (comprised of lead clinicians and senior officers).

West Norfolk
The BCF work stream reports to an Alliance Operational Steering Group chaired by the CCG Director of Operations with senior local operational managers from across Alliance partner organisations. This group reports to the Alliance Oversight Group with CEO level representation from each of the Alliance partners.

2) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services.

Protecting social care in Norfolk means that people in need of care and support will receive the services they need in spite of budget reductions and increased demand. Our approach is founded on a whole system approach to health and care services. We recognise that without appropriate care and support, health and wellbeing will not thrive. We are committed to delivering the right service – whether health or care - at the right time and in the right place and to challenge the unnecessary boundaries between health and care services.

Protecting social care services means that people in Norfolk will have access to social care services to which they have an entitlement under the existing eligibility criteria but we will not be constrained by eligibility. We recognise that care and support can prevent escalating needs and we are committed to ensuring care services are available when this is the most effective way to meet needs, as part of an integrated system of care.

Our approach will be that we will seek over time to allocate resource to provide the best outcomes for the Norfolk pound. Whilst this will reflect the statutory requirements for access to services, our shared mission is to improve our services such that effective intervention and targeted support not only improve outcomes but manages demand.

The commitment to the protection of social care is also set out in the principles document appendix 1.

Please explain how local social care services will be protected within your plans.

We will retain existing arrangements to transfer NHS funding to the local authority for care services which have a health benefit. Increased investment for year one will focus on access to assessment, including 7 days, and services supporting reablement. Social services faces further cuts over the coming three years.

We will invest to retain the existing eligibility criteria for social care in Norfolk so that people with substantial and critical needs can access assessment, care management

and service provision in an efficient and timely way, including 7 day access. We will secure availability of social care assessment and care provision within a transformational framework, whereby investment is targeted at managing longer term demand and cost.

The allocation of resources for the protection of social care services is included in the funding allocated to schemes on spreadsheet 2 rather than as a separate line.

The implementation of the Care Bill will be supported as described in the Better Care Fund. Our acknowledged expectation is that the increase in access to care services will be reflected by an increase in resource due to the implementation of the Care Bill and the cost effectiveness of social care in the mixed economy of services.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

The **Central Norfolk Unplanned Care Clinical** network (North Norfolk, Norwich and South Norfolk CCGs), through its Project Domino initiative, has overseen the implementation of additional services for winter 2013-14 to ease pressure upon Norfolk and Norwich University Hospital. This has included system commitment to seven day working across hospital, community, primary and social care to tackle delayed discharge:

- Seven day hospital social work service to provide weekend social workers to support discharge and prevent delay
- Agreement with independent sector providers of intermediate care beds that they will receive new admissions seven days per week
- Development of a six bed short term unit for older people with complex dementia needs in Mid Norfolk by April 2014 to aid the discharge of people seven days per week who may be delayed in hospital due to the lack of provision especially suited to their needs.
- Range of domiciliary care services and support services (including reablement service) that operate seven days per week. Current commissioning work to look at volunteering services which support people 'home from hospital' to see how they can be expanded in order for people to access them 7 days per week

Norwich, North Norfolk and South Norfolk are developing their plans for local seven day services in their integration plans (see their respective sections under 'Vision and Schemes'). Social care services have been piloting 7 day working and refining the proposal for implementation.

In **Great Yarmouth and Waveney** there are plans for the implementation of 7 day services to support early discharge. The CCG and partners have successfully bid to be an early adopter for the Seven Day Services Transformational Improvement Programme. A recently established 7 day transformation programme steering group will ensure there is a co-ordinated approach to deliver.

The local acute contract will include the requirement for the JPH to have an action plan to deliver the 10 clinical standards as part of the seven day service requirement within the service and improvement plan section.

The GY&W "Out of Hospital" strategy is a key 7 day service initiative. The first Out of Hospital Team (which is an integrated team of health and social care workers) to support one of the two main centres of urban population is effective from April 2014. The Out of Hospital teams will operate 24 hours a day, 7 days per week and will be expanded over the course of the next 2 years to cover the whole of the GY&W area, once the model has been tested and refined.

In **West Norfolk** the commitment to 7 day working is set out in the Alliance model (see appendix).

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

Each CCG and the Local Authority is committed to using the NHS Number as the primary identifier in correspondence across health and care services.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

Norfolk County Council has confirmed that it will use of the NHS number as its primary identifier for all new contacts. There is substantial work to be undertaken to apply the NHS number to existing records but the work to do so is being progressed.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

We are committed to the necessary standards.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements; professional clinical practise and in particular requirements set out in Caldicott 2.

We are committed to the necessary IG controls and will work with Caldicott Guardians to ensure these are secured.

Norfolk County Council has recently entered into a major contract with Hewlett Packard in partnership with Microsoft and Vodaphone. It has been agreed that integration of health and care is a key delivery priority for this programme. NCC and CCGs are holding an envisioning event in early April to scope this in collaboration with the University of East Anglia.

Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

Across Norfolk:
Following the integrated care pilot in Norfolk, the core model has been rolled out across the county founded on multi-disciplinary teams based around primary care which identify those most at risk and plan care in a co-ordinated manner. The team is supported by integrated care roles which are non-clinical roles supporting the co-ordination of information and services across health and care. There are a variety of approaches to risk stratification.

Great Yarmouth and Waveney
The stated ambition is for joint multi-disciplinary teams working together, undertaking joint assessments with the lead case management role being taken by the person that makes most sense for the individual. This will often be the lead social care professional undertaking the lead on-going care management role but will sometimes be others, for example the Occupational Therapist who has had the most involvement or the Nurse Case Manager. Whoever it is will be working on behalf of the whole team, always linking back to the team, and thus a seamless service can be provided without the individual having to be referred multiple times and handed off at each point. Data on the proportion of the adult population identified as at high risk of hospital admission is collected at GP Practices but at this stage isn't available at CCG level. Further work will need to be undertaken to establish this.

North Norfolk
A key development in North Norfolk is the local Predictive Risk Stratification tool. This is based on work developed as part of the Long Term Conditions Programme led by Sir John Oldham, which North Norfolk were signed up to. This tool has been developed to identify those patients earlier in their long term condition, to help target proactive self-management and community support interventions, that prevent deterioration of their condition and maintain independence. The assessment and intervention options are discussed as part of a MDT meeting with key community health, mental health, Social and Primary care professionals, all of whom are aligned to specific practices. This process also involves identifying a key professional leads to manage and support if interventions are identified. The process is supported by dedicated Integrated Care Coordinators who facilitate meetings and the subsequent referrals.

The table outlines the risk stratification model, based on the data provided in trailing the tool (from April 2013 December 2013). It details the process for targeting the people who receive an Integrated Care Team review and who can be allocated a lead worker.

North Norfolk CCG population **Initial filter at 25%**	168,894 42,224	**Notes** Initial filter on 20 specific areas finds approx 25% all patients
North Norfolk CCG practices	20	
Patients reviewed per practice before IC meeting (by GPs)	60	GPs use their clinical knowledge to review patients, typically this may also include community matrons visiting patients at home, reviews of medications and putting in place any other identified clinical need
Review meetings per year	8	Integrated care meetings are typically held every 6-8 weeks and often part of acute case manager reviews and Gold Standard Framework (GFS) meetings
Patients reviewed per year	9,600	
Patients reviewed as a % of total population per year	5.7%	
Proportion of reviewed patients receiving IC assessment	33%	Approximately 1/3rd of patients reviewed by GPs are identified with an integrated care need. The GP practice seeks patient's consent to share access to health records before patients are discussed in an integrated care setting. Once consent has been obtained integrated care co-ordinators check social care records to share complete picture of patient at integrated care meetings.
Number of patients receiving integrated care review per year	3,200	This model assumes that patients are reviewed/assessed once at an integrated care meeting; in practice these complex patients are discussed more than once so this calculation is an upper estimate. A lead professional is allocated based on the primary need of the individual.
Proportion of patients assessed as a % of total population per year	1.9%	

Norwich

The current approach to the identification of patients most at risk of hospital admissions is through clinicians at MDT meetings. NCCG will provide a predictive risk tool to be used in primary care. There are real opportunities to align this workstream with the Primary Care GMS Contract for 2014/2015. It is currently proposed that the enhanced service identifies the top 2% of adult population to avoid unplanned admissions and proactive case management. This includes personalised care plans, accountable GP's and care coordinators. There are also other changes to the contract which would see a named GP for all patients aged 75 and over.

South Norfolk

Local people at high risk of hospital admission have an agreed accountable lead professional. The model developed in South Norfolk CCG area, in collaboration between commissioners, GP Practices and the key community healthcare providers includes the following elements:

- Multi-factorial risk profiling processes and multi-disciplinary assessment/ care planning at GP practice level. Multi-disciplinary team meetings are happening regularly at most GP practices in South Norfolk. Those individuals identified as being at high risk with ongoing care needs are allocated a lead professional: social worker, community nurse, mental health nurse or therapist
- Some good examples of collaborative approaches to assessment including: pilot at community hospital of nurse-led social care assessment (signed off by Social Care professional) and reablement service are able to complete a Community

Care assessment during their intervention in order to identify those people with longer term care needs and to speed up and make easier the transition to social care provision

- South Norfolk CCG serves a resident population of 231,956 (all ages) of which 48,676 are aged 65 or over (18.58%). Data collected from GP practices during 2013-14 shows the following information:

Reporting period	Aug- Dec
Number of practices	14
Patients identified as at 'high risk' of hospital admission	717
Patients with joint care plan (from MDT meeting) and allocated lead professional	329 (45.9% of those identified as high risk)

West Norfolk

All patients considered within the West Norfolk Integrated Care Organisation Multi-Disciplinary Teams (MDT) structure are allocated an agreed lead professional and have a joint health and care plan. A locally-developed risk stratification model is utilised based on two main criteria:

- Data related to frequency of attendance at the acute hospital and/or use of the range of community-based out-of-hours services (i.e. patients currently in crisis and requiring a multi-disciplinary approach to avoid admission to the acute hospital and/or a care home); and
- The clinical judgement of members of the MDTs (patients considered likely to drop into crisis without a multi-disciplinary intervention).

Modelling is being undertaken to determine the numbers and percentages of people at high risk and with a joint care plan/accountable professional.

RISKS
Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers.

Risk	Risk rating	Mitigating Actions
Failure to reduce acute admissions as a consequence of the implementation of integrated care.	High	We will implement models with a clear evidence base. We will monitor closely the emerging trends and take early action to mitigate risk.
Failure to be able to move funding from acute care to community care to match changing pattern of service.	High	We will work closely with our provider services to understand and to support their planning for future sustainability to ensure it aligns with the BCF.
Failure to secure the workforce capacity and culture change to deliver the required changes.	High	We will initiate in 14/15 a programme of workforce development to support change. We will invest non-recurrent funding to secure capacity to manage change where this is required.
Insufficient social care provision as the County Council implements its budget reductions and as a consequence of any further budget reductions which may emerge.	High	We have agreed an approach to protect access to social care services. We will monitor the impact of the Council's budget reductions at a joint governance level.
Failure to meet the performance requirements and therefore secure funding for 2015/16	High	Clear planning and monitoring of schemes and impact. Detail of risk sharing to be developed between the partners.
Introduction of the Care Bill in 2016 leading to increased demand for social care which is not yet fully scoped.	HIgh	The County Council will continue to develop its intelligence about implications and to share these within the whole system governance.
Implementation of Better Care Fund requires new models of operation across health and social care. Failure to move towards new models of care risks destabilising both sectors.	High	Development of an integrated approach to the system and shared approach to risk. Alongside this they will establish clear targets and performance monitoring so they are able to identify early any concerns and to take mitigating actions.

The shared risk approach to funding agreed locally means that protection of social care services and current health provision may be in jeopardy if recurring savings are not delivered from planned pump priming work in 2014/15	High	Joint management of transformation during 2014/15 and close tracking of change with remedial action taken if needed. Agreement of the protection of social care in the initial plan.

Appendix 1

PRINCIPLES OF THE BETTER CARE FUND IN NORFOLK

Purpose of paper

This short paper sets out headline principles to support Norfolk County Council, Great Yarmouth and Waveney CCG, North Norfolk CCG, Norwich CCG, South Norfolk CCG and West Norfolk CCG to work together across the whole system to maximise the opportunities under the Better Care Fund (BCF) to support integration and maximise the efficiencies available within the system. Once these principles are agreed, they can be used to support more detailed work up of pooled and aligned budgets. Our district council partners will also be involved in ongoing discussions about the development of integrated health and care systems.

Principles of the Better Care Fund

The following six principles are set out by the Department of Health for the Better Care fund:

- Plans to be jointly agreed
- Protection for social care services (not spending)
- As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
- Better data sharing between health and social care, based on the NHS number
- Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional
- Agreement on the consequential impact of changes in the acute sector.

Our ambition

- Pool and align appropriate budgets to maximise the potential efficiencies available across the health and social care system. We will do this by working together to redesign services through working at scale
- Use the BCF as a catalyst to achieve functional pooled arrangements with the explicit intention of extending the scope and scale of the BCF.

Recognising financial pressures within the system

- A key requirement of the BCF is to support social care and a substantial sum will be required across the county to support social care pressures within the system. This includes current S256 spend and funding to support the anticipated costs of the Care Bill
- At the same time, the CCGs have significant cost pressures before contributing to the BCF which will also need to be managed
- As a result, system savings of are needed to support all of the pressures within the health and social care economy. Using the BCF pooled budget, these financial pressures will be mitigated by
    - At scale system redesign, bringing health and social care services together
    - Using the opportunities of scale to pool and align funds for larger budgets, with proportionately lower percentages of absolute savings required (although we will encourage maximising savings), together with risk share arrangements
- The extent of the pooled/aligned budgets and the extent of targeted savings will be determined by each CCG and Norfolk County Council.

Working within the pooled and aligned funds

- The pooled and aligned funds will include agreed budget lines/contracts from Norfolk County Council and the CCGs
- They may also include budget lines/contracts from public health and NHS England, but this is subject to agreement with those bodies
- We expect that mental health and children's services will be included as appropriate, when possible
- Principles around risk share and savings have yet to be agreed, but may include:
    - The financial impact of any over or under performance within a contract placed into the pooled fund.
    - Savings from pooled budgets are employed to directly reduce the system financial pressures and maintain the existing level of health and social care service in order to ensure safe levels of service while transformation takes place.
- Any additional savings made from increased efficiencies will be available proportionately to the amount each commissioner has in the pooled fund (per individual budget line or overall to be determined) or by agreement would be jointly invested in the health and social care system
- The commissioners retain individual sovereignty but operate through section 75 agreements or similar
- Pooled funds will be held by either the CCGs or Norfolk County Council with a new overarching governance groups set up to monitor progress, track spend etc.

By 31 March 2014

- Agree BCF proposal for presentation to the Health and Wellbeing Board to meet the conditions set out in national guidance:

    1. Plans to be jointly agreed
    2. Protection for social care services (not spending)
    3. As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
    4. Better data sharing between health and social care, based on the NHS number
    5. Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional
    6. Agreement on the consequential impact of changes in the acute sector

- Agree the headline areas where we will pool and align budgets, with a view to moving beyond the minimum BCF transfer in order to maximise the savings potential available from a larger fund, and proportionately lower percentage savings required by the system
- Terminology may differ between organisations, but the areas for pooling or alignment are likely to include services as set out below which are commissioned by both health and social care:
    - Residential and nursing home placements (including cost reductions in CHC placements)
    - Homecare and day services
    - Reablement services
    - Community equipment
    - Carers support

- Mental health and dementia community support
- Workforce development to support integration
- Section 256 services
- Out of hospital teams/services
- Voluntary sector commissioning
- Integrated palliative care
- Integrated falls service

Activity during 2014/15

- Agree the redesign activities required based on the BCF plan for each area, including streamlined management and co-location of teams. Put cross-system work in place to design new models of care
- Work through the detail of how the list of pooled and aligned budgets/services impacts on contracting going forward, in terms of how contracts are re-let when they expire
- Agree the target savings from each initiative which contributes to the overall system savings plan needed to balance the pooled fund and aligned budgets.
- Put in place, at pace, redesigned and more effective/efficient services which provide better care at lower overall system cost
- Agree the monitoring mechanisms for redesign programmes of work and savings to be realised
- Consider elements of acute activity which could be included in the pooled or aligned funds during 2015/16.

Activity during 2015/16

- Increase coverage to all areas wherever possible, in order to fully implement the whole system transformation.

TEMPLATE - PART TWO

Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16. It is important that these figures match those in the plan details of planning template part 1 . Please insert extra rows if necessary

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15 /£	Minimum contribution (15/16) /£	Actual contribution (15/16) /£
Norfolk County Council		£ 3,482,000	£ 6,080,000	£ 6,080,000
Great Yarmouth and Waveney CCG			£ 7,120,000	£ 7,120,000
North Norfolk CCG			£ 11,553,000	£ 11,553,000
Norwich CCG		£ 2,162,000	£ 12,245,000	£ 12,245,000
South Norfolk CCG			£ 14,020,000	£ 14,020,000
West Norfolk CCG			£ 11,443,000	£ 11,443,000
BCF Total		**£ 5,644,000**	**£ 62,461,000**	**£ 62,461,000**

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

Great Yarmouth and Waveney

The delivery of the local BCF schemes and attaining the targets will be essential in sustaining the health and social care system. Robust risk sharing arrangements will be developed that balance the emphasis on community support and mitigate risks if the delivery against target is impeded.This BCF Plan currently just identifies planned spend for the minimum BCF allocation in the Great Yarmouth area, but it is anticipated that during 2014/15 further work will be undertaken to increase the size of the pooled budget so that the savings /benefits will be released from a much bigger pooled fund.

Contingency plan:		2015/16	Ongoing
Outcome 1: Reduced Emergency Admissions to Acute Hospital	Planned savings (if targets fully achieved)	£600,000	£600,000
	Maximum support needed for other services (if targets not achieved)	£600,000	£600,000
Outcome 2: Reduced permanent admissions to care homes	Planned savings (if targets fully achieved)	£175,000	£175,000
	Maximum support needed for other services (if targets not achieved)	£175,000	£175,000

North Norfolk

The delivery of the local BCF schemes and attaining the targets will be essential in sustaining the health and social care system. Robust risk sharing arrangements will be developed with acute and community providers, that balance the emphasis on community support and mitigate risks if the delivery against target is impeded.

Reduction in Permanent admissions of older people (aged 65 and over)	Planned savings (if targets fully	£470,000	£470,000
	Maximum support needed for other services (if targets not achieved)	£470,000	£470,000
Reduction in avoidable hospital admissions	Planned savings (if targets fully achieved)	£345,830	£345,830
	Maximum support needed for other services (if targets not achieved)	£345,830	£345,830
Reduction in the number of short & long stay falls	Planned savings (if targets fully achieved)	£338,308	£338,308
	Maximum support needed for other	£338,308	£338,308

Norwich

The new model of care will be delivered through the local BCF schemes which in turn are included in the more detailed Operational Plan. Delivery of the targets will be instrumental in sustaining the integrated health and social care system and we will use transformation funding in 2014/15 to underpin development of the new model. This will depend in part on a risk-sharing agreement between Norwich CCG and Norfolk County County. Appropriate risk-sharing agreements will be developed with acute and community providers ensuring that they support the ambition and minimise collective risks of not hitting BCF targets. So whilst savings in the contingency plan section below are low in comparison with the shift in resources needed to effect change, plans are predicated on a wider programme of change that goes beyond inclusion of savings against the BCF metrics alone. For example work on falls and reducing seasonal deaths will have an impact on reducing avoidable emergency admissions, but the quantification of these has not yet been fully modelled.

Contingency plan:		**2015/16**	**Ongoing**
Outcome 1: Reduced Emergency Admissions to Acute Hospitals	Planned savings (if targets fully achieved)	£557,000	£557,000
	Maximum support needed for other services (if targets not achieved)	£557,000	£557,000

South Norfolk

The successful delivery of integrated services from 2015/16 onwards will entail health and social care comissioners working in particular with the major public providers to utlise some key resources in different ways. Robust and effective risk sharing agreements between commissioners and with the major community providers will need to be in places to ensure the acheivement of agreed outcomes and mitigation and sharing of the consequences if these are not met.

Contingency plan:		**2015/16**	**Ongoing**
Outcome 1: Reduction in avoidable acute admissions	Planned savings (if targets fully achieved)	£570,000	£570,000
	Maximum support needed for other services (if targets not fully achieved).	£570,000	£570,000
Outcome 2: Reduced permanent admissions to residential care homes	Planned savings (if targets fully achieved)	£582,000	£582,000
	Maximum support needed for other services (if targets not fully achieved).	£582,000	£582,000

West Norfolk

If the planned improvements are not achieved then the level of emergency hospital admissions will be higher than planned; this increased cost would need to be funded from the BCF. It is proposed that BCF schemes may be pilotted initially so that those that do not deliver the required benefits can be stopped at short notice so as to release funding back to the BCF. The details of this arranegment will be developed over the coming months by the West Norfolk BCF Oversight Group that is being established.

Contingency plan:		**2015/16**	**Ongoing**
Outcome 1	Planned savings (if targets fully achieved)	£165,000	£165,000
	Maximum support needed for other services (if targets not achieved)	£165,000	£165,000
Outcome 2	Planned savings (if targets fully	£378,000	£378,000
	Maximum support needed for other	£378,000	£378,000

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please add rows to the table if necessary.

Locality	BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
			Recurrent /£	Non-recurrent /£	Recurrent /£	Non-recurrent /£	Recurrent /£	Non-recurrent /£	Recurrent /£	Non-recurrent /£
Great Yarmouth	GY&W 1 Supporting Independence by provision of community based support interventions	Various	£ 440,000	£ -	£ 230,000	£ -	£ 3,100,000	£ -	£ 340,000	£ -
Great Yarmouth	GY&W2 Integrated Communtiy Health and Social Care Teams including Out of Hospital Team, palliative care	NCC/ECCH	£ -	£ -	£ -	£ -	£ 1,500,000	£ -	£ 160,000	£ -
Great Yarmouth	GY&W3 Urgent Care Programme including integrated care home and home care commisioning to facilitate hospital discharge	Various	£ -	£ -	£ -	£ -	£ 2,000,000	£ -	£ 220,000	£ -
Great Yarmouth	GY&W4 Support for people with dementia and older people with functional mental health problems living in the community	NSFT/NCC	£ -	£ -	£ -	£ -	£ 520,000	£ -	£ 55,000	£ -
			£ 440,000	**£ -**	**£ 230,000**	**£ -**	**£ 7,120,000**	**£ -**	**£ 775,000**	**£ -**
North Norfolk	NN1: Predictive Modelling & Complex Need Risk Stratification	Primary Care		N/A	N/A	N/A	N/A	N/A	N/A	N/A
North Norfolk	NN2: Integrated Community Care Teams	NCC/NCHC/NSFT	£ 142,600		£ 168,369		£ 2,310,600		£ 230,828	
North Norfolk	NN3: Independence, Self-Care & Self-Management Programme	Vol Sector	£ 106,950				£ 1,732,950		£ 173,121	
North Norfolk	NN4: Integrated Falls Management Programme	NCC/NCHC	£ 128,340		£ 196,483		£ 2,079,540		£ 207,745	
North Norfolk	NN5: Living Well with Dementia Programme	NCC/NCHC/NSFT	£ 106,950				£ 1,732,950		£ 173,121	
North Norfolk	NN6: Urgent Care Programme	NCC/NCHC/NSFT	£ 142,600				£ 2,310,600		£ 230,828	
North Norfolk	NN7: Improving Mental Health Outcomes Programme	NSFT	£ 85,560				£ 1,386,360		£ 138,497	
			£ 713,000	**£ -**	**£ 364,852**	**£ -**	**£ 11,553,000**	**£ -**	**£ 1,154,139**	**£ -**
Norwich	Primary Care Development	NCCG		£ 1,056,000	£ 120,000		£ 445,000		£ 20,000	
Norwich	Community Health & Care services	NCCG, NCC, NCH&C	£ 575,000	£ 856,000	£ 100,000		£ 6,400,000		£ 291,000	
Norwich	Intermediate Care	NCCG, NCC	£ 181,000	£ -	£ -		£ 4,100,000		£ 187,000	
Norwich	Community Assets	NCCG, NCC		£ 250,000	£ 30,000		£ 1,300,000		£ 59,000	
			£ 756,000	**£ 2,162,000**	**£ 250,000**	**£ -**	**£ 12,245,000**	**£ -**	**£ 557,000**	**£ -**

South Norfolk	SN1. Integrated primary care teams	SNCCG	£ 129,900		£ 56,250		£ 2,103,000		£ 172,800	
South Norfolk	SN2. Supporting independence wellbeing and self care	NCC/ NCH&C	£ 86,600		£ 37,500		£ 1,402,000		£ 115,200	
South Norfolk	SN3. Integrated care for people with dementia	NSFT	£ 129,900		£ 56,250		£ 2,103,000		£ 172,800	
South Norfolk	SN4. Integrated falls prevention	NCHC	£ 129,900		£ 56,250		£ 2,103,000		£ 172,800	
South Norfolk	SN5. Integrated services to support hospital discharge and avoid admissions	NCH&C/ NCC	£ 173,200		£ 75,000		£ 2,804,000		£ 230,400	
South Norfolk	SN6. Supporting good mental health	N&SFT	£ 129,900		£ 56,250		£ 2,103,000		£ 172,800	
South Norfolk	SN7. Good end of life care	NCH&C	£ 86,600		£ 37,500		£ 1,402,000		£ 115,200	
			£ 866,000	**£ -**	**£ 375,000**	**£ -**	**£ 14,020,000**	**£ -**	**£ 1,152,000**	**£ -**
West Norfolk	Integrated care organisation	tbc	£ 126,000		£ 77,000		£ 2,034,000	£ -	£ 160,000	£ -
West Norfolk	integrated reablement service	tbc	£ 174,000		£ 107,000		£ 2,822,000	£ -	£ 221,000	£ -
West Norfolk	Integrated services to reduce hospital admissions and enable timely discharges	tbc	£ 203,000		£ 122,000		£ 3,278,000	£ -	£ 256,000	£ -
West Norfolk	Supporting independence, wellbeing and self-care	tbc	£ 105,000		£ 65,000		£ 1,707,000	£ -	£ 134,000	£ -
West Norfolk	Development of a local dementia diagnosis service and support model focused around primary care	tbc	£ 99,000		£ 61,000		£ 1,603,000	£ -	£ 125,000	£ -
			£ 707,000	**£ -**	**£ 432,000**	**£ -**	**£ 11,444,000**	**£ -**	**£ 896,000**	**£ -**

Capital funding

Countywide	DFG to district councils						£ 3,752,000			
Countywide	Social Care Capital funding						£ 2,327,000			

Total		**£ 3,482,000**	**£ 2,162,000**	**£ 1,651,852**	**£ -**	**£ 62,461,000**	**£ -**	**£ 4,534,139**	**£ -**

Outcomes and metrics
Great Yarmouth

Metrics		Current Baseline (as at….)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	739.8	N/A	702.5
	Numerator	159		151
	Denominator	21491		21495
		(April 2012 - March 2013)		(April 2014 - March 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	86.14	N/A	90.10
	Numerator	87		91
	Denominator	101		101
		(April 2012 - March 2013)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	11.3	10.9	10.4
	Numerator	79		
	Denominator	707969	714561	720888
		2012-13	(April - December 2014)	(January - June 2015)
Avoidable emergency admissions (composite measure)	*Metric Value*	2410.0	1078.6	1288.7
	Numerator	2348	1066	1274
	Denominator	97424	98833	98833
		(April 2012 - March 2013)	(April - September 2014)	(October 2014 - March 2015)
NHS 2:1: Proportion of people feeling supported to manage their long term condition.	*Metric Value*	73.6	N/A	75.2
	Numerator	524		539
	Denominator	712		717
		(April 2012 - March 2013)		*(April 2014 - March 2015)*

Outcomes and metrics
North Norfolk

Metrics		Current Baseline (as at….)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	808.4	N/A	764.5
	Numerator	369		349
	Denominator	45648		
		(April 2012 - March 2013)		(April 2014 - March 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	85.52	N/A	90.00
	Numerator	124		130
	Denominator	145		145
		(April 2012 - March 2013)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	11.3	10.9	10.4
	Numerator	79		
	Denominator	707969	714561	720888
		2012-13	(April - December 2014)	(January - June 2015)
Avoidable emergency admissions (composite measure)	*Metric Value*	2100.0	998.0	1211.0
	Numerator	3564	1696	22058
	Denominator	169733	169962	169962
		(April 2012 - March 2013)	(April - September 2014)	(October 2014 - March 2015)
NHS 2:6i: Estimated diagnosis rate for people with dementia.	*Metric Value*	42.6	N/A	60.5
	Numerator	1542		2229
	Denominator	3617		3684
		(April 2012 - March 2013)		*(April 2014 - March 2015)*

Outcomes and metrics
Norwich

Metrics		Current Baseline (as at….)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	715.2	N/A	715.2
	Numerator	244		244
	Denominator	34116		34116
		(April 2012 - March 2013)		(April 2014 - March 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	91.37	N/A	91.37
	Numerator	127		127
	Denominator	139		139
		(April 2012 - March 2013)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	11.3	10.9	10.4
	Numerator	79		
	Denominator	707969	714561	720888
		2012-13	(April - December 2014)	(January - June 2015)
Avoidable emergency admissions (composite measure)	*Metric Value*	2029.0	948.0	1160.0
	Numerator	3966	2021	2472
	Denominator	195472	213058	213058
		(April 2012 - March 2013)	(April - September 2014)	(October 2014 - March 2015)
NHS 2:1: Proportion of people feeling supported to manage their long term condition.	*Metric Value*	78.2	N/A	79.4
	Numerator	892		905
	Denominator	1140		1140
		(April 2012 - March 2013)		*(April 2014 - March 2015)*

Outcomes and metrics
South Norfolk

Metrics		Current Baseline (as at….)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	659.6	N/A	659.6
	Numerator	341		341
	Denominator	51969		51696
		(April 2012 - March 2013)		(April 2014 - March 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	92.70	N/A	92.70
	Numerator	166		166
	Denominator	179		179
		(April 2012 - March 2013)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	11.3	10.9	10.4
	Numerator	79		
	Denominator	707969	714561	720888
		2012-13	(April - December 2014)	(January - June 2015)
Avoidable emergency admissions (composite measure)	*Metric Value*	1793.0	992.0	1221.0
	Numerator	4262	2272	2808
	Denominator	237758	239831	239831
		(April 2012 - March 2013)	(April - September 2014)	(October 2014 - March 2015)
NHS 2:1: Proportion of people feeling supported to manage their long term condition.	*Metric Value*	72.9	N/A	73.0
	Numerator	1043		1044
	Denominator	1430		1430
		(April 2012 - March 2013)		*(April 2014 - March 2015)*

Outcomes and metrics
West Norfolk

Metrics		Current Baseline (as at….)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	757.3	N/A	721.3
	Numerator	316		301
	Denominator	41729		41729
		(April 2012 - March 2013)		(April 2014 - March 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	86.44	N/A	88.94
	Numerator	102		105
	Denominator	118		118
		(April 2012 - March 2013)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	11.3	10.9	10.4
	Numerator	79		
	Denominator	707969	714561	720888
		2012-13	(April - December 2014)	(January - June 2015)
Avoidable emergency admissions (composite measure)	*Metric Value*	2576.0	2520.0	2400.0
	Numerator	4460	2100	2000
	Denominator	173133	166816	166816
		(April 2012 - March 2013)	(April - September 2014)	(October 2014 - March 2015)
NHS 2:6i: Estimated diagnosis rate for people with dementia.	*Metric Value*	35.0	N/A	45.0
	Numerator	1020		1336
	Denominator	2916		2970
		(April 2012 - March 2013)		*(April 2014 - March 2015)*

Outcomes and metrics
Norfolk summary

Metrics		Current Baseline (as at….)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	778.7	N/A	672.5
	Numerator	1515		1386
	Denominator	194680		206093
		(April 2012 - March 2013)		(April 2014 - March 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	88.68%	N/A	90%
	Numerator	610		619
	Denominator	690		690
		(April 2012 - March 2013)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	11.3	10.9	10.4
	Numerator	2403		
	Denominator	707969	714561	720888
		2012-13	(April - December 2014)	(January - June 2015)
Avoidable emergency admissions (composite measure)	*Metric Value*	2126	1335	890
	Numerator	18600	11860	7907
	Denominator	874729	888500	888500
		(April 2012 - March 2013)	(April - September 2014)	(October 2014 - March 2015)
NHS 2:1: Proportion of people feeling supported to manage their long term condition.	*Metric Value*	67.70%	N/A	76%
	Numerator	4170		4434
	Denominator	5834		5834
		(April 2012 - March 2013)		*(April 2014 - March 2015)*
NHS 2:6i: Estimated diagnosis rate for people with dementia.	*Metric Value*	36.60%	N/A	47.47%
	Numerator	4702		6143
	Denominator	12941		12941
		(April 2012 - March 2013)		*(April 2014 - March 2015)*

Norfolk County Council
at your service

Health and Wellbeing Board
Notes of the meeting held on Wednesday 12 February 2014
at 4pm in Room 519, County Hall, Norwich

Present:

Dan Roper, Norfolk County Council – Chairman
Yvonne Bendle, South Norfolk District Council – Vice-Chairman
Ian Mack, West Norfolk Clinical Commissioning Group – Vice-Chairman
Harold Bodmer, Director of Community Services, Norfolk County Council

Debbie Bartlett, Head of Performance, Planning & Partnerships, NCC
Catherine Underwood, Director of Integrated Commissioning, NCC
Linda Bainton, Planning Performance & Partnerships, NCC
Helen Adcock, Consultant in Public Health Medicine, NCC
Julie Mortimer, Committee Officer, NCC (Notes).

1 Better Care Fund – 'First Cut' of the plan for approval

1.1 The Chairman and Vice-Chairmen met with the Director of Community Services to consider the 'first cut' of the Norfolk Better Care Fund Plan which needed to be signed off by the Health and Wellbeing Board by 14 February 2014.

1.2 The Director of Integrated Commissioning outlined the process to date, what had been achieved so far and the key elements for the next stage of the process. It was noted that the plan represented a 'work in progress' and that the next stage of development would include robust challenge through a peer review process as well as feedback from NHS England. The draft Plan would be submitted to the Boards of the five Norfolk Clinical Commissioning Groups for their approval.

1.3 The first cut of the plan had been circulated to the Health and Wellbeing Board for their comments and responses had been received from:

- Pip Coker, VCS representative on the Board.
- Claire Collen, Voluntary Sector Engagement Project Management, Voluntary Norfolk.
- Richard Draper, VCS representative on the Board and Chairman of the Norfolk Specialist Partnership.
- Equal Lives, Member of Norfolk Specialist Partnership.
- Joyce Hopwood, VCS representative on the Board.

1.4 The group discussed the first cut of the Plan and considered the responses received and the following common themes and challenges were identified:

- Engagement with the voluntary and community sector.
- Mental health services.
- The 'voices' of carers.
- The role of Housing.
- Potential over-emphasis on older people.

- Focus on prevention/early intervention.
- Local variation between CCG areas, as against the need for overall coherence.
- Presentational issues and clarity, given the constraints of the template.
- The role of the Health and Wellbeing Board going forward.

1.5 The meeting **agreed**:

- The 'first cut' of the Norfolk Better Care Fund for submission to NHS England as a work in progress.

- The feedback provided by Board members should inform the next stage of the development of the draft Plan.

- That the key issues included:

    - The inclusion/strengthening of mental health, carers, the role of housing, prevention/early intervention, etc, as noted in paragraph 1.4 above.
    - Clarity about the role of the voluntary sector and engagement with the sector.
    - Clarity about engagement of providers in general.
    - The need for a description of what was county-based activity.
    - How local and not local issues could be clearly identified.

- An extra-ordinary meeting of the Health and Wellbeing Board would be arranged specifically for the discussion and sign-off of the Final version of the Norfolk Better Care Fund Plan, before its submission to NHS England on 4 April. (This meeting would take place on Tuesday 1 April 2014 at 9.30am. The venue to be confirmed).

The meeting closed at 5.20pm

Chairman